STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
55 FARMINGTON AVENUE ● HARTFORD, CONNECTICUT 06105-3730

DEPARTMENT OF REVENUE SERVICES
450 COLUMBUS BOULEVARD ● HARTFORD, CONNECTICUT 06103-1837

DRS DECLARATORY RULING NO. 2016-1
DSS DECLARATORY RULING

HOSPITAL USER FEE

FACTS:

On or about November 30, 2015, the Connecticut Hospital Association and various of its member Hospitals (collectively, the "Petitioners"),[1] through their counsel, filed petitions for declaratory ruling ("Petitions") with the Department of Social Services ("DSS") and Department of Revenue Services ("DRS") (collectively, the "Departments"). R. at 1-42.[2] Said Petitions pertain to the application of the tax on the net patient revenue of hospitals set forth in Chapter 211a of the Connecticut General Statutes ("Hospital User Fee") to the Petitioner Hospitals. See id. Specifically, the Petitioners requested that the Departments rule on the following five issues:

1. Whether the General Assembly unconstitutionally delegated the setting of the rate and base year of the Hospital User Fee to DSS in violation of the Connecticut Constitution?
2. Whether the methodology outlined in the DSS email dated October 16, 2015, setting the tax rate and base year of the Hospital User Fee at 6% and 2013, respectively, is an unenforceable regulation under Conn. Gen. Stat. § 4-167?
3. Whether the Hospital User Fee violates the Equal Protection Clause of the United States Constitution, U.S. Cons., amend. XIV § 1?
4. Whether the Hospital User Fee has been implemented in a manner that is inconsistent with Chapter 211a of the Connecticut General Statutes and not permitted under the federal Medicaid Act, 42 U.S.C. § 1396 et seq., and the regulations promulgated thereunder?
5. Whether Departments' administration of the Hospital User Fee is arbitrary and capricious and an abuse of discretion, subject to being overturned pursuant to the Connecticut Uniform Administrative Procedures Act, Conn. Gen. Stat. § 4-183?

See id. Upon examination of the Petitions, the Departments determined that certain of the issues posed by the Petitioners require the Departments to make findings of fact.

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[1] The Petitioners were originally the Connecticut Hospital Association, The William W. Backus Hospital, Bridgeport Hospital, Bristol Hospital, The Hospital of Central Connecticut, Danbury Hospital, Day Kimball Hospital, Greenwich Hospital, Griffin Hospital, Hartford Hospital, The Charlotte Hungerford Hospital, Lawrence + Memorial Hospital, Manchester Memorial Hospital, Middlesex Hospital, MidState Medical Center, Milford Hospital, Norwalk Hospital, Rockville General Hospital, Saint Francis Hospital and Medical Center, Saint Mary's Hospital, St. Vincent's Medical Center, Stamford Hospital, Waterbury Hospital, Windham Hospital, and Yale-New Haven Hospital. See R. at 1-42. By notice dated September 7, 2016, Bridgeport Hospital, Greenwich Hospital, and Yale-New Haven Hospital withdrew from the Petitions. See R. at 1976-79. By notice dated September 20, 2016, Lawrence + Memorial Hospital withdrew from the Petitions. See R. at 3042-45.

[2] An index of the record is attached hereto as Appendix 1.

Accordingly, pursuant to Conn. Gen. Stat. § 4-176(e)(2), by letter dated January 29, 2016, the Departments set the matter for specified proceedings as follows:

(a) By February 16, 2016, the Departments shall request specific information, documentation, and/or affidavits from the petitioners;

(b) By March 16, 2016, the petitioners shall provide the information, documents, and/or affidavits requested by the Departments in (a);

(c) By March 30, 2016, the Departments shall provide the petitioners with administrative notice as to any additional documents it will rely on to make its decision;

(d) By April 13, 2016, the petitioners shall have the opportunity to respond to the documents of which the Departments take administrative notice;

(e) After collecting the documents pursuant to (a) – (d) above, the Departments reserve the right to hold an evidentiary hearing and/or ask for additional information, documents and/or affidavits if necessary; and

(f) The Departments shall jointly or separately issue a declaratory ruling on or before May 28, 2016.

R. at 47-52.[3] Consistent with said proceedings, on or about February 16, 2016, the Departments made a Request for Information, Documents, and Affidavits ("Request for Information") from the Petitioners. R. at 58-72. The Petitioners requested, and were granted, certain amendments to the Request for Information. R. at 92-101, 173-94, 218-24, 225-27, 228-31, 233-36, 248-53. Additionally, the Petitioners requested, and were granted, additional time to respond to the Request for Information.[4] The Petitioners provided certain of the information and documents requested on

[3] In said letter, the Departments proposed two alternative schedules for the specified proceedings. By letter dated February 4, 2016, the Petitioners choose the schedule set forth above. R. at 53-55. The schedule was modified by agreement on March 29, 2016, June 3, 2016, July 22, 2016, August 15, 2016, and September 1, 2016. R. at 241-57, 737, 810-12, 1301-02, and 1970-73.

[4] The Petitioners agreed to modify the schedule based upon their request for additional time. R. at 218-224, 241-57. Accordingly the revised schedule was as follows:

(a) On February 16, 2016, the Departments requested specific information, documentation, and/or affidavits from the petitioners;

(b) On March 3, 2016, the Departments issued amended requests for specific information, documentation, and/or affidavits from the petitioners, at the request of the petitioners;

(c) On March 16, 2016, the Departments agreed to certain modifications to the requests for specific information, documentation, and/or affidavits from the petitioners, at the request of the petitioners, as set forth below;

(d) By April 29, 2016, the petitioners shall provide the information, documents, and/or affidavits requested by the Departments in (b), as modified by (c);

April 29, 2016. R. at 433-75. The Petitioners provided additional information after the due date for response on May 2, 2016, May 3, 2016, May 11, 2016, and August 23, 2016. R. at 2018, 2023, 500-74, and 1322-24.

Upon review of the information produced, the Departments determined that the Petitioner Hospitals' responses to the Request for Information contained inconsistencies, omissions, and mistakes. R. at 779-98. Accordingly, by letter dated July 11, 2016, the Departments informed the Petitioners of these inconsistencies, omissions, and mistakes and gave the Petitioners the opportunity to revise their responses. Id. On or about July 18, 2016, the Petitioners notified the Departments that they would like to take the opportunity extended by the Departments to provide additional information and context for their original responses and to correct any errors and omissions. Accordingly, by letter dated July 19, 2016, the Departments modified the schedule accordingly. R. at 802-04. The Petitioners agreed to said revised schedule by letter dated July 22, 2016. R. at 810-12.

On or about July 28, 2016, the Petitioners submitted a letter containing part of their response to the Departments letter of July 11, 2016 explaining that certain documents already submitted in the record provided responses to certain information that the Departments believed had been omitted. R. at 863-912. By letter dated August 8, 2016, the Petitioners provided their remaining responses to the Departments' letter of July 11, 2016. R. at 1065-85. In doing so, the Petitioners' produced additional documentation, which clarified and corrected certain inconsistencies, omissions, and errors. Id. The Petitioners produced additional information after the due date for response on August 10, 2016.[5] R. at 1086-88.

Throughout this process, the Petitioners maintained that their original production fully satisfied their requirement to respond to the Departments' Request for Information. However, the fact that the Petitioners produced previously omitted documents and information in addition to correcting

(e) By May 13, 2016, the Departments shall provide the petitioners with administrative notice as to any additional documents they will rely on to make their decisions;

(f) By May 27, 2016, the petitioners shall have the opportunity to respond to the documents of which the Departments take administrative notice;

(g) After collecting the documents pursuant to (b) – (f) above, the Departments reserve the right to hold an evidentiary hearing and/or ask for additional information, documents and/or affidavits if necessary; and

(h) The Departments shall jointly or separately issue a declaratory ruling on or before July 11, 2016.

See id.

[5] The Petitioners proposed modifying the schedule based upon their request to amend their responses as follows:

(a) On or before August 8, 2016, the petitioners will respond to the Departments' letter dated July 11, 2016, including providing any corrected or missing information or documents.

(b) On or before August 29, 2016, the Departments will issue their declaratory rulings.

See R. at 802-04. The Departments accepted the Petitioners' proposal by letter dated July 19, 2016. See id. The Petitioners confirmed their agreement to this schedule by letter dated July 22, 2016. See R. at 810-12.

what was clearly inaccurate information demonstrates that the Petitioners original production was not fully accurate or complete. See R. at 1065-85.

Additionally, consistent with above-described specified proceedings, on May 13, 2016, the Departments notified the Petitioners of certain documents of which the Departments would take administrative notice. R. at 576-702. In said notification, the Departments granted the Petitioners the opportunity to respond to such documents. See id. The Petitioners responded to the May notification by letter dated May 27, 2016, which has been made part of the record at 719-31.

On August 8, 2016 and August 12, 2016, the Departments notified the Petitioners of additional documents of which the Departments took administrative notice. R. at 916-1064. In each such notification, the Departments granted the Petitioners the opportunity to respond to such documents. R. at 1265-99.

On August 15, 2016, by conference call, the Petitioners requested both that the Departments provide certain additional information regarding all of the documents of which the Departments had taken administrative notice and that the Departments extend their time for responding to the Departments letters of August 8, 2016 and August 12, 2016. In the interest of giving the Petitioners a full and fair opportunity to respond, the Departments agreed to these requests and provided such explanations on August 22, 2016.[6] R. at 1312-21. The Petitioners responded by letter dated August 29, 2016, which has been made part of the record at 1346-77.[7]

[6] As part of the process of agreeing to provide additional information regarding the documents of which administrative notice had been taken, the schedule of specified proceedings was modified as follows:

(a) On or before August 22, 2016, the Departments will provide certain information for all documents of which they have taken administrative notice;
(b) On or before August 29, 2016, the Petitioners will respond to documents of which the Departments are taking administrative notice, including any responses to Item a. above; and
(c) On or before September 8, 2016, the Departments will issue the declaratory ruling.

See R. at 1301-02.

[7] The Petitioners also counter-designated documents. See R. at 219-31, 1346-77, 1980-89. In addition, the Petitioners responded to the Departments' explanations as to why the Departments took administrative notice of documents so noticed and the Petitioners also provided responses to the additional documents that were designated for administrative notice on August 8 and 12, 2016. In their August 29, 2016 letter, although the Petitioners noted that they appreciated the explanations provided by the Departments, they still "believe[d] the provided explanations are insufficient to allow us to meaningfully object and respond to the documents," especially when a website or other document has been noticed "for undisclosed reasons." The Petitioners further asserted that, as a result, they "have not been provided with a meaningful opportunity to object to or explain or rebut these documents." The Departments determine that the detail of explanation already provided is sufficient for the Petitioners to have a fair opportunity to respond to the documents. Specifically, the Petitioners have had the opportunity to review, rebut, and counter-designate documents based on the actual documents identified by the Departments as well as the explanations. In essence, the Petitioners are seeking the opportunity to rebut the substance of the Departments' position in the Declaratory Ruling, which goes far beyond the opportunity to respond to the documents themselves.

Notably, the Petitioners did not even assert, let alone demonstrate, that the Departments' consideration of any of the documents and the inclusion of said documents in the record for the proceeding could prejudice the Petitioners. For many documents, the Petitioners have broadly asserted that a document is not relevant to the Departments' issuance of the Declaratory Ruling. However, as demonstrated by the citations and analysis of the various documents

In addition to the proceedings specified by the Departments, the Petitioners requested the opportunity to submit supplemental evidence and supplemental briefing. See R. at 259-64, 359-62. Given that this is not a contested matter under the Uniform Administrative Procedures Act ("UAPA"), such a procedure was not contemplated when the Departments set the matter for specified proceedings. However, in the interest of giving the Petitioners a full and fair opportunity to present any and all evidence and arguments that they deemed relevant, the Departments granted both requests. See id. The Petitioners choose not to submit supplemental evidence. The Petitioners requested to expand the scope and length of a proposed brief, which the Departments granted. See R. at 491-94, 711-14. The Petitioners did submit a supplemental brief on or about June 15, 2016, which has been made part of the record at 738-78.

Accordingly, based on the evidence in the record, which includes all information and evidence submitted by the Petitioners and those documents of which the Departments have taken administrative notice, as well as the legislative history regarding the implementation of the Hospital User Fee, the Departments make the following findings of fact.

A. Background Regarding Provider Taxes

This matter concerns Connecticut's tax on the net patient revenue of hospitals, which tax is codified in Chapter 211a of the Connecticut General Statutes.[8] Said tax, which is also commonly referred to as the "Hospital User Fee," is a health-care related tax, also known as a provider tax under Title XIX of the Social Security Act (the "Medicaid Act"), which governs the Medicaid program. See 42 U.S.C. § 1396b(w).

By way of brief background, under the Medicaid Act, states can choose to establish a Medicaid program, which is a partnership between state and federal governments to provide health care and long-term care services and support to eligible low-income and disabled individuals. See 42 U.S.C. § 1396 et seq. Specifically, a state's Medicaid program makes payments to health care providers who perform covered services for individuals enrolled in Medicaid. See 42 U.S.C. §§ 1396a and 1396d. These payments are made in connection with a variety of service categories, including inpatient and outpatient hospital services, as well as other categories listed in federal law and regulations. See, e.g., 42 U.S.C. § 1396d(a).

The federal government and the states jointly fund each state's Medicaid program. See 42 U.S.C. § 1396b. More specifically, if the state's Medicaid program meets the requirements set forth in the Medicaid Act, the state can be eligible to receive federal funding. See id. As part of these federal requirements, states are required to fund their portion of the costs of the Medicaid program using specific funding sources. The portion of the costs of the Medicaid program born by the state is called the "state's share." If the state's program meets federal requirements, the federal government will provide the state with matching funds. These matching funds are referred to under the Medicaid Act as federal financial participation (FFP). See id. The U.S. Centers for

throughout this Declaratory Ruling, the Departments find that each document so cited is relevant to the questions raised in the Petitions—and thus relevant to the issuance of the Declaratory Ruling.

[8] Chapter 211a also contains the state's tax on the gross receipts of ambulatory surgical centers.

Medicare and Medicaid Services (CMS), is charged with administering the federal portion of the Medicaid Program.[9] DSS is the state agency that has been designated by the state of Connecticut to administer Connecticut's Medicaid program, including submitting claims to CMS for FFP. See Conn. Gen. Stat. § 17b-260.

As referenced above, in order to receive FFP, states are required to fund their portion of the costs of the Medicaid program using specific funding sources. See 42 U.S.C. § 1396b. One source of revenue states may use to fund their Medicaid program is provider taxes. See id. The Medicaid Act sets forth requirements with which state provider taxes must comply. See 42 U.S.C. § 1396b(w). If the state's provider taxes do not comply with these requirements, the state will be penalized by CMS through a reduction in FFP. 42 U.S.C. § 1396b(w)(1).

42 U.S.C. § 1396b(w) describes requirements that provider taxes must comply with in order to avoid CMS imposing a penalty on the state's FFP. Under 42 U.S.C. § 1396b(w), provider taxes may be imposed on one or more classes of health care items of services. 42 U.S.C. § 1396b(w)(3)(A). There are nineteen (19) classes of health care items and services that may be taxed, which include inpatient hospital services and outpatient hospital services.[10] 42 C.F.R. § 433.56. Under federal law, a provider tax must be broad-based and uniform, unless CMS grants a waiver of either or both of those requirements and in all situations, must not include a hold harmless provision. 42 U.S.C. § 1396b(w)(3); 42 C.F.R. § 433.68(b).

A provider tax will meet the "broad-based" requirement if it "is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State…or is imposed with respect to all non-Federal, nonpublic providers in the class." 42 U.S.C. § 1396b(w)(3)(B)(i); 42 C.F.R. § 433.68(c). If a state wishes to exempt certain providers from a tax, the state may request a waiver of this requirement from CMS. In order to obtain such a waiver, the state must demonstrate to CMS that the proposed tax is "generally redistributive" and that "the amount of the tax is not directly correlated to payments" from Medicaid for the same services that are being taxed. 42 U.S.C. § 1396b(w)(3)(E)(ii). This is done through a statistical test known as the P1/P2 test.[11] 42 C.F.R. § 433.68(e)(1). In general, a tax will pass the P1/P2 test if, in aggregate,

[9] Specifically, 42 U.S.C. § 1396b describes how CMS calculates FFP. FFP is calculated by multiplying the state share by a specific percentage at which federal funds match state funds. This percentage is referred to as the federal medical assistance percentage (FMAP).

[10] The federal government has established the following classes of services: inpatient hospital services, outpatient hospital services, nursing facility services, services of intermediate care facilities, physicians' services, home health care services, outpatient prescription drug services, services of managed care organizations, ambulatory surgical center services, dental services, podiatric services, chiropractic services, optometric/optician services, psychological services, therapist services, nursing services, laboratory and x-ray services, emergency ambulance services, and other health care items or services for which the State has enacted a licensing or certification fee. 42 CFR § 433.56(a).

[11] The P1/P2 test involves dividing two numbers. P1 is the proportion of the tax that would have been collected from revenue that the providers received from Medicaid payments if the tax applied to all providers within the class, without any exemptions. P2 is the proportion of the tax that is to be collected from revenue that the providers received from Medicaid payments, but only including the providers actually proposed to be subject to the tax (i.e., excluding any providers that the state proposes to exempt from the tax). 42 C.F.R. § 433.68(e)(1). The purpose of this statistical test is to ensure that any tax redistributes funds from providers with lower Medicaid percentages to providers with higher Medicaid percentages—thereby preventing states from enacting a tax that is primarily designed to generate federal Medicaid matching funds by requiring that the tax must redistribute funds in the manner specified by the statistical test.

the hospitals that are subject to the tax have a higher portion of their revenue from treating patients who receive Medicaid than the hospitals that are proposed to be exempted from the tax.

A provider tax will meet the "uniformity" requirement if the same tax rate is applied to all items or services within a class. For example, the uniformity requirement will be met if "in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State…." 42 U.S.C. § 1396b(w)(3)(C)(III). Stated simply, if a tax is imposed on the revenue of a class of items or services, in order to be considered uniform, the tax must be imposed at a uniform rate for all the revenue associated with the provision of all items or services that make up that class. 42 C.F.R. § 433.68(d)(1)(iii).[12] If a state wishes for its provider tax to include credits, exclusions, or deductions, the state may request a waiver from CMS. 42 C.F.R. § 433.68(d)(2)(i).

Finally, in order to be considered a permissible provider tax, the tax must not include prohibited hold harmless provisions. 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(b)(3). Federal law defines several types of prohibited hold harmless provisions. 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f). Specifically, a provider tax, and the associated payments made to health care providers under Medicaid, cannot directly or indirectly hold the provider harmless for the tax: a provider tax cannot include "any direct or indirect payment, offset, or waiver…that…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).

In order to determine whether a tax includes an indirect hold harmless provision, CMS applies a two pronged test to examine whether the tax correlates to payments made to the taxpayers. The first prong of the test provides that no indirect hold harmless provision exists if the tax rate is less than six per cent (6%). 42 C.F.R. § 433.68(f)(3)(i)(A). This is referred to as the safe-harbor tax rate. If the tax rate is greater than six per cent (6%), under the second prong of the test, an indirect hold harmless clause will be deemed to exist if "75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments." 42 C.F.R. § 433.68(f)(3)(i)(B). The maximum tax rate allowed under federal law is whatever tax rate will pass both prongs of this test.

As a consequence of the federal requirement that a provider tax must not include a hold harmless provision, some providers must pay more in tax than they receive in payments, and some providers must pay less in tax than they receive in payments. Accordingly, any consideration of the tax must also take into account the manner in which the providers are paid under the state's Medicaid program in order to ensure that there is no prohibited hold harmless provision that would result in federal penalties for an impermissible tax.

[12] If the tax imposed is a licensing fee on a class of services, in order to be considered uniform, the tax must be the same amount for every provider who furnishes that class of services. 42 CFR § 433.38(d)(1)(i). If the tax imposed is a "bed tax," or a tax imposed on the number of beds a provider has, in order to be considered uniform, the tax must be the same for each bed each provider has. 42 CFR § 433.38(d)(1)(ii). If the tax is imposed on the revenue of a class of items or services, in order to be considered uniform, the tax must be imposed at a uniform rate for all the revenue associated with the provision of all items or services that make up that class. 42 CFR § 433.38(d)(1)(iii).

If the state's provider taxes do not comply with federal requirements, the federal government may penalize the state and reduce the state's FFP. See 42 U.S.C. § 1396b(w)(1)(A); 42 C.F.R. § 433.70(b).

Connecticut currently has four provider taxes. In 2005, Connecticut enacted the first of the provider taxes currently in effect: a resident day user fee imposed on nursing homes. In 2011, Connecticut expanded its provider taxes to include a resident day user fee on intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and the Hospital User Fee. In 2016, Connecticut further expanded its provider taxes to include a tax on the gross receipts of ambulatory surgical centers. This Declaratory Ruling pertains to the Hospital User Fee.

More detail regarding the enactment of the Hospital User Fee is set forth below.

B. History of the Enactment of the Hospital User Fee

In early 2011, Governor Dannel Malloy, when faced with an approximately $3.2 billion projected budget deficit for the following state fiscal year (SFY) 2012, proposed a significant number of changes to Connecticut tax law in order to raise revenue to support his proposed budget. See Senate Bill 1007, § 37; 2011 Conn. Pub. Acts 6, § 104; 2011 Conn. Pub. Acts 61, § 45; 2011 Conn. Pub. Acts 233, §17. Said changes included the imposition of new taxes on the provision of electric generation services,[13] an expansion of the state's sales and use tax,[14] and an increase of tax rates applicable to several other taxes.[15] As part of this proposal, the Governor proposed expanding Connecticut's provider taxes to include a resident day user fee imposed on ICF/IIDs and a tax on the net patient revenue of hospitals. See Governor's Bill 1013, §§ 31-34 and 36-38 (2011).

[13] See Senate Bill 1007, § 37. The General Assembly did enact an electric generation tax in 2011. See 2011 Conn. Pub. Acts 6, § 104; 2011 Conn. Pub. Acts 61, § 45; 2011 Conn. Pub. Acts 233, § 17.

[14] The Governor proposed imposing the sales and use tax on sales of the following services: services rendered in the voluntary evaluation, prevention, treatment, containment or removal of hazardous waste or other contaminants of air, water or soil are included as taxable services to industrial, commercial or income-producing real property; valet parking provided at any airport; yoga instruction provided at a yoga studio; motor vehicle storage services; packing and crating services; motor vehicle storage services; packing and crating services; motor vehicle washing, waxing and detailing services, whether or not automated; motor vehicle towing and road services; intrastate transportation services provided by livery services, with certain exceptions, including nonemergency medical transportation provided under the Medicaid program, certain paratransit services and dial-a-ride services; barber and beauty shop services, including hair cutting, styling, and coloring; noncommercial vessel repair, maintenance and cleaning services, including any contract of warranty and service related to such vessel, and noncommercial vessel towing services; pet grooming, pet boarding services, and pet obedience services; services in connection with a cosmetic medical procedure; and manicure and pedicure services. See Senate Bill 1007, §§ 21, 22, 23, and 24. In addition, the Governor proposed increasing the general sales and use tax rate, increasing the room occupancy tax rate, and creating a new tax rate that applied to sales of certain luxury items. See Senate Bill 1007, §§ 25 and 27. Many of the changes proposed by the Governor and described in this footnote were ultimately adopted by the General Assembly in 2011. See 2011 Conn. Pub. Acts 6; 2011 Conn. Pub. Acts 61.

[15] The Governor proposed increasing the cigarette tax rate, increasing the tobacco products tax rate, increasing the alcoholic beverages tax rates, lowering the exemption level for gift and estate tax purposes, and increasing the number of income tax brackets and income tax rates. See Senate Bill 1007, §§ 10, 11, 13, 14, 17, 30, 40, and 41. Many of the changes proposed by the Governor and described in this footnote were ultimately adopted by the General Assembly in 2011. See 2011 Conn. Pub. Acts 6; 2011 Conn. Pub. Acts 61.

Additionally, the Governor proposed modifying the resident day user fee imposed on nursing homes to collect more revenue.

The purpose of imposing a tax on hospitals was two-fold – (1) to raise revenue from uniquely situated taxpayers who were the beneficiaries of certain government programs and (2) to take advantage of provisions in federal law that would result in the state receiving increased funding from the federal government. 2016 Conn. Pub. Acts 3, May spec. sess., § 121. To achieve these goals without incurring substantial financial federal penalties to the state's FFP, the Hospital User Fee needed to comply with federal Medicaid provider tax requirements.

In consideration of these requirements, in section 31 of Bill 1013, the Governor proposed implementing the following tax on hospitals: "For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter at the maximum rate allowed under federal law."[16] Governor's Bill 1013, § 31 (2011). In May of 2011, the General Assembly adopted a tax on hospitals similar to the Governor's proposed version through the enactment of Public Act 11-6, An Act Concerning the Budget for the Biennium Ending June 30, 2013, and Other Provisions Relating to Revenue.[17]

Specifically, section 146 of said Act provided that

> For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter at the rate of four and six-tenths per cent.

2011 Conn. Pub. Acts 6, § 146.[18] Under this version of the tax, each hospital was required to report the amount of its net patient revenue to DRS on a quarterly basis and pay tax on said net patient revenue at a rate of four and six-tenths per cent (4.6%). Id.[19] As such, the amount of tax

[16] In section 36 of Bill 1013, the Governor proposed implementing the following tax on ICF/IIDs: "For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a resident day user fee on each intermediate care facility for the mentally retarded in this state, which fee shall be the product of the facility's total resident days during the calendar quarter multiplied by the user fee, as determined by the Commissioner of Social Services pursuant to section 37 of this act." Governor's Bill 1013, § 36 (2011). Proposed revisions to the nursing facility user fee were included in section 35 of the Governor's Bill. Id. § 35.

[17] Governor Malloy signed Public Act 11-6 into law on May 4, 2011.

[18] The Act also codified the Governor's proposals to impose a new resident day user fee on intermediate care facilities and increase the resident day user fee imposed on nursing homes. 2011 Conn. Pub. Acts 6, §§ 150-153.

[19] Subsection (b) of 2011 Conn. Pub. Acts 6, § 146 provides, in pertinent part, that

> Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, ***stating specifically the name and location of such hospital, and the*** **[**amounts of its hospital gross earnings, its net revenue and its gross revenue**]** ***amount of its net patient revenue for the calendar quarter ending the last day of the preceding month.*** Payment shall be made with such return. Each hospital shall file such return electronically with the department and make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether the hospital would otherwise have been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

2011 Conn. Pub. Acts 6, § 146 (emphasis supplied).

to be paid each month would have varied from month to month. Additionally, under this structure, certain hospitals were exempt from the tax, including governmental, psychiatric, specialty, and children's hospitals.[20] 2011 Conn. Pub. Acts 6, § 145(1).

Based upon a review of the plain language of Public Act 11-6, the tax on hospitals set forth in said Public Act had the potential to violate the federal Medicaid requirements summarized above and would be very difficult to administer. Specifically, if the tax amount varied, it would be impossible to know the tax amounts in advance in order to perform the required P1/P2 test necessary for a waiver of the broad-based requirements.

As referenced above, a provider tax must be broad-based, meaning it must apply to all items or services in the class of service being taxed and all providers who provide said class of services. 42 C.F.R. § 433.68(c). If a state seeks to exempt certain providers, the state must obtain a waiver from CMS and demonstrate that the tax is "generally redistributive" and passes the P1/P2 test. As the tax codified in Public Act 11-6 exempted certain hospitals from the tax including governmental, psychiatric, specialty and children's hospitals, the state would have needed to obtain a waiver and demonstrate that the tax passed the P1/P2 test. 42 C.F.R. § 433.68(e). In order to do so, the state would have had to demonstrate that in comparing the revenue that is taxed with the revenue providers receive from the Medicaid program, non-Medicaid services are taxed.

However, under the tax on hospitals as codified in Public Act 11-6, the amount of revenue taxed and the amount of revenue that providers receive from the Medicaid program would have varied from period to period. As such, while the state might have been able to demonstrate that for some periods the tax would have passed the P1/P2 test based on projected revenue, it was not possible to know for certain in advance that the tax would pass that test, and it is conceivable that in one or more future years, the tax could have failed the P1/P2 test.

Additionally, under federal Medicaid law, said tax could not include a "hold harmless" provision, meaning that the payments that were made to the hospitals under the state's Medicaid program could not correlate to the amount of tax paid. 42 C.F.R. § 433.68(b)(3). Stated another way, some providers must pay more in tax than they received in payments, and some providers must pay less in tax than they received in payments. With a variable tax that changed from period to period, those providers that paid more in tax than they received in payments and vice versa could also change from period to period. As such, it is possible that for one or more future periods, the tax might violate this requirement if the amount of tax paid directly correlated with the amount of

[20] These hospitals were exempt from the tax by virtue of being excluded from the definition of hospitals subject to tax. Specifically, under section 102 of Public Act 11-44, "hospital" was defined to mean:

> any health care facility or institution, as defined in section 19a-630, which is licensed as a short-term general hospital by the Department of Public Health but does not include (A) any hospital which, on October 1, 1997, is within the class of hospitals licensed by the department as children's general hospitals, or (B) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant to chapter 920.

2011 Conn. Pub. Acts 6, § 145(1). Consistent with the definition set forth above, only licensed short-term general hospitals are subject to the tax. As such, psychiatric and specialty hospitals were not subject to the tax. Additionally, the definition specifically excludes children's hospitals and government run hospitals.

payments the state made, making this version of the tax difficult to administer and potentially subject to future federal penalties of the state's FFP if it later fell out of compliance.

Accordingly, during the course of the 2011 legislative session and before the tax was implemented, the General Assembly fundamentally altered the structure of this tax from the version set forth in Public Act 11-6. Specifically, the General Assembly transformed the tax from a tax on net patient revenue each hospital accrued per quarter, which was set forth in Public Act 11-6, to a set user fee charged to hospitals, which became codified in Public Acts 11-44 and 11-61 ("Hospital User Fee").

The General Assembly began the process of adopting a different structure to the Hospital User Fee through the enactment of Public Act 11-44, An Act Concerning the Bureau of Rehabilitative Services and the Implementation of the Provisions of the Budget Concerning Human Services and Public Health. To that end, section 103 of Public Act 11-44 provides, in pertinent part that

> For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter **[**at the rate of four and six-tenths per cent**]** The rate of such tax shall be up to the maximum rate allowed under federal law. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship.

2011 Conn. Pub. Acts 44, § 103(a). As evidenced by the above-quoted language, the General Assembly amended the provisions of the Hospital User Fee so that instead of imposing a tax on net revenue each hospital accrued per quarter, the hospitals would pay a set fee, calculated by DSS in consultation with the Office of Policy & Management (OPM), using one year's net patient revenue as a base.[21]

At the time Public Act 11-44 was enacted, although the General Assembly had clearly transitioned from a tax to a fee, the General Assembly had not yet determined how much revenue was necessary for the Hospital User Fee to generate in order to balance the budget, or even how much money the Hospital User Fee could generate and still comply with federal requirements.[22] As such, the

[21] These changes ensured that the Hospital User Fee would both comply with the Medicaid requirements set forth above as well as the various objectives that the General Assembly had for the Hospital User Fee. Specifically, the primary objective of the General Assembly in enacting the Hospital User Fee was to generate a certain amount of revenue. The manner in which the Hospital User Fee was to generate revenue was two-fold: (1) through the collection of tax revenue from hospitals and (2) through obtaining matching funds from the federal government by using some of the tax revenue to fund the state's share of additional Medicaid payments to the hospitals (specifically additional disproportionate share hospital [DSH] payments and newly proposed inpatient hospital supplemental payments). Additionally, the General Assembly sought to exempt certain types of hospitals from the tax. These goals had to be achieved working within the requirements and restrictions of federal Medicaid requirements in order to avoid losing revenue through penalties. As described more fully in Ruling 4, the system for calculating the Hospital User Fee set forth in Public Acts 11-44 and 11-61 accomplished this.

[22] The legislative history of the enactment of Public Act 11-44 reflects that during the 2011 legislative session, the General Assembly charged DSS and OPM with determining the maximum amount of revenue that could be raised from the Hospital User Fee, with the most minimal impact on the hospitals themselves. The state retained the law firm of Covington & Burling LLP in order to assist DSS and OPM in determining if different versions of the Hospital

General Assembly did not include a specific percentage as the rate for the Hospital User Fee within the statute itself. Rather, the General Assembly put in place a general formula or "system" under which the Hospital User Fee would be calculated. The formula set forth in statute contained: (1) who would be required to pay the fee, (2) who would be exempt from the fee, and (3) how the fee would be calculated (upon a "tax base" of "net patient revenue"). Additionally, the statute incorporated by reference all of the federal Medicaid requirements set forth above by mandating that the fee comply with federal law. The final piece of the equation, the amount of revenue the General Assembly determined had to be raised, would be legislated through the codification of the

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User Fee complied with federal Medicaid Requirements. These different versions of the Hospital User Fee were colloquially known as different "formulas" and "models" for the Hospital User Fee.

Specifically, Representative Walker remarked that

> The Administration, the current Administration, when they started to do the actual formulas and developing the formulas -- and by the way, they -- they actually have a consultant who has been working with them to develop this. This is not just OPM creating it, they actually have an actuary in Washington, Covington and Burlington [sic.], I think it is the name of the group. They've been looking at different types of formulas, using either distressed municipalities.
>
> Using the fact that the number of beds, the location, the density of the communities and they've come up with different scenarios. And the one that has probably come around that everybody has seen has been the one that was distributed, I believe, April 28th. And I believe that one had the least number of, as you put it, winners and losers in the -- in that formula.
>
> But the reason why many of them were impacted was because of the number of Medicaid clients that they serve in those hospitals. We have not gotten a solid formula that we can actually say is the one that we're going to go with. But the Connecticut Hospital Association has stepped up to the plate to work with our Department of Social Services and Office of Policy [and] [M]anagement to try and look at how we could best equitably distribute the dollars so that there are no winners and losers per se, as you might refer to them. Through you, Madam Speaker.

Connecticut House Transcript, 5/26/2011. Additionally, in the Senate, when questioned about the Hospital User Fee, Senator Harp remarked as follows:

> SENATOR RORABACK: Thank you, Madam. President.
>
> Through you to Senator Harp, does Senator Harp know whether there exists today a definitive determination of the consequences of hospital tax, like a final ruling as to who's going to be taxed what?
>
> Through you, Mr. President to Senator Harp.
>
> THE CHAIR: Senator Harp.
>
> SENATOR HARP: Thank you very much. Through you, Mr. President, as last I learned of the hospital tax, the Connecticut Hospital Association had recommended a run and a taxing mechanism that all of the hospitals had signed off on. I believe that that run has been sent to the consultants in Washington who are determining whether or not it will pass CMS muster. I haven't heard that it will not.

Connecticut Senate Transcript, 5/24/2011.

final revenue estimates that support the budget. See 2016 Conn. Pub. Acts 3, May spec. sess., § 119.[23]

The legislative history regarding the enactment of Public Act 11-44 confirms that the General Assembly intended to set forth a formula for the calculation of the fee, the final variable of which (the total revenue to be collected) would be codified at a later point. Public Acts 11-6, 11-44, and 11-61 all originated as bills to implement the state budget, which means that they fall within the primary jurisdiction of the legislature's Appropriations Committee. Therefore, during the floor debate in the House and the Senate, the co-chair of the Appropriations Committee for each chamber was responsible for explaining the bill to the other legislators. During the 2011 legislative session, the co-chairs of the Appropriations Committee were Senator Toni Harp and Representative Toni Walker. To this end, Senator Harp (the Senate co-chair of the Appropriations Committee) remarked as follows when questioned about the Hospital User Fee by another legislator:

> SENATOR RORABACK: . . . Through you, Mr. President, Senator Harp, my first question goes to the so-called hospital tax. Mr. President, through you to Senator Harp, does this implementer bill lay out how the hospital tax is going to work?
>
> THE CHAIR: Senator Harp.
>
> SENATOR HARP: Thank you very much, Mr. President.
>
> I believe that this bill sets out broad language. It does not indicate individual runs however.
>
> THE CHAIR: Senator Roraback.
>
> SENATOR RORABACK: Thank you, Mr. President. And through you to Senator Harp, I, to me the most -- one of the most if not the most distressing part of the budget that we passed was our inability to know what the consequences of the hospital tax would be on any particular hospital.
>
> And through you, Mr. President to Senator Harp, does she know, does this bill reveal us what the results of the hospital tax will be to any particular hospital?
>
> Through you, Madam President to Senator Harp.
>
> THE CHAIR: Senator Harp.

[23] In section 119 of Public Act 16-3, the General Assembly codified its intent in enacting the Hospital User Fee. Specifically, section 119 provides, in pertinent part that "the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was that on and after July 1, 2011, **the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget**, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis." 2016 Conn. Pub. Acts 3 § 119 (May Spec. Sess.) (emphasis supplied).

> SENATOR HARP: Thank you very much. It doesn't precisely indicate the impact to any individual hospital. It just sets up a system wherein we can move forward with the tax program.

Connecticut Senate Transcript, 5/24/2011.[24] Senator Harp's comments quoted above confirm that the Hospital User Fee enacted in Public Act 11-44 was simply a structure for the user fee. The final piece of the formula, the amount the user fee had to collect, would be codified in the revenue estimates as part of the General Assembly's process of finalizing the state budget for the SFY 2012-2013 biennium. This legislative history specifically confirms that the General Assembly intended for the Hospital User Fee to generate a specific amount of revenue.

The General Assembly further confirmed the transformation of the Hospital User Fee from a tax to a user fee through the enactment of Public Act 11-61, An Act Implementing the Revenue Items in the Budget and Making Budget Adjustments, Deficiency Appropriations, Certain Revisions to Bill of the Current Session and Miscellaneous changes to the General Statutes. To that end, in section 79 of Public Act 11-61, the General Assembly made final revisions to the Hospital User Fee. Specifically, the General Assembly removed the requirement that hospitals file a tax return with DRS reporting "the amount of its net patient revenue [for the calendar quarter ending the last day of the preceding month]." 2011 Conn. Pub. Acts 61, § 79. Instead, the General Assembly required hospitals to file a tax return reporting "the amount of its net patient revenue as determined by the Commissioner of Social Services." Id. As such, thereafter, hospitals no longer reported to DRS the amount of net patient revenue that accrued each quarter, rather the hospitals were only to report to DRS the amount of fee they were obligated to pay.

Additionally, at the time Public Act 11-61 was enacted, the General Assembly had determined how much revenue the Hospital User Fee could collect and comply with federal law and how much the General Assembly needed the Hospital User Fee to collect to support additional payments made to the hospitals as set forth in the budget.[25] As such, the General Assembly adjusted appropriations made to hospitals under the Medicaid program to support payments made to said hospitals in connection with the Hospital User Fee. The debate in the House and Senate regarding House Bill 6652, which became Public Act 11-61, confirms this intention. To that end, Senator Harp remarked as follows in response to questions about the amendments to the budget:

> SENATOR HARP: Thank you, very much, Mr. President.
>
> I think the biggest change that you see in this budget, in terms of an expenditure, one of the things that -- that is the dollars that we put in for the hospital tax. It's about $ 39. 4 million, in Fiscal Year '12, and 36-point -- $ 36 million, in Fiscal Year '13. When we

[24] See also Connecticut House Transcript 5/26/2011 (Representative Walker: "Currently, nobody is exempt right now because we are still – we're still working on exactly how the distribution is going to be made. The amount in the bill has been set as a placeholder. And I'm glad you asked me that because when we -- I -- answered questions from some of your colleagues earlier. The rates are not going to change. Nothing is going to change, it's going to -- the only thing that is going -- is still being negotiated and worked on is how the distribution is made. But the actual amount, the bottom line is not going to be changing. So right now, we have not really determined any way or how much anybody is going to get until that time. Then I will be able to answer your question, sir. Through you.")

[25] Note, during the 2011 June Special Session, the General Assembly made further revisions to the budget through the enactment of Public Act 11-1 (June Spec. Sess.). Said changes did not impact the Hospital User Fee.

> passed the budget, we were not certain about the runs and what kinds of things would be in and would be out and how much it would cost to actually come up with something that is favorable to all hospitals.
>
> And I believe that when we debated this the last time, I indicated that we had submitted the run that was given by the Connecticut Hospital Association to Washington to see if it would be passed by the Center for Medicare and Medicare Services. And that was actually something that they thought they would approve of, and it just cost us a little bit more. And since it brought us to consensus on the hospital tax, this particular budget actually adds those dollars to do that.

Connecticut Senate Transcript, 6/7/2011.[26] Senator Harp further remarked as follows:

> SENATOR McLACHLAN: -- Madam President.
>
> And thank you, Senator Harp, for your assistance with this -- with these questions; actually I'll have a couple of others for you.
>
> The hospital tax in Section 67 appears to -- this bill appears to increase, if I'm not mistaken, the hospital tax by over $ 75 million. Is this -- translate into an increase in spending from the budget previously adopted by the Legislature?
>
> Through you, Madam President.
>
> SENATOR HARP: Thank you.
>
> Through you, Madam President, the -- the -- the dollars, there is an increase in the distribution of the hospital tax so that what is taxed actually goes back to the hospitals. It's about 39. 4 million in Fiscal Year '12, and 36 million in Fiscal Year '13. Those dollars, as you know, then we receive federal reimbursement for approximately half of that. So all together, it's around 33 million. And I think that that ultimately provides some of the excess revenue that we discussed earlier today.
>
> …
>
> SENATOR HARP: Through you, Mr. President.
>
> The -- the -- the large -- the largest item in the increased spending is the increase that is required to implement the hospital tax. In Fiscal Year '12, it's 39. 4 million, and in Fiscal Year '13, it is 36-point -- well, 36 million and some change.
>
> . . .

[26] Remarks on Public Act 11-61 are set forth in Appendix 2, which contains relevant excerpts from the 2011 House and Senate session transcripts that the Departments have discovered discussing the enactment of the Hospital User Fee in 2011.

SENATOR KISSEL: Thank you, very much, Mr. President.

My notes indicate that contained in the appropriation changes in Section 67 is an additional appropriation of 39. 5 million, in Fiscal Year 2012, and 36. 1 million, in 2013, to reflect the revised structure and distribution of proceeds from the hospital tax. And I'm just wondering. I know that there was some discussion earlier this afternoon regarding that. But my first question is that are these funds needed to implement an alternative proposal as formulated by individuals outside the Legislature?

Through you, Mr. President.

THE CHAIR: Senator Harp.

SENATOR HARP: Thank you, very much, Mr. President.

Through you, it's my understanding that after viewing numerous runs by the Administration and the Legislative Branch, the Connecticut Hospital Association proposed a plan to the Administration that the majority of the hospitals had signed off on. And the numbers that we see in our budget now reflect their plan.

Connecticut Senate Transcript, 6/7/2011.[27] Consistent with the above-quoted debate regarding the amendments to the budget, it is clear that upon adoption of said amendments to the budget, the

[27] The following contains additional remarks made on the Hospital User Fee:

SENATOR KANE: Thank you, Madam President.

And just a quick question in regards to the hospital tax, because I know that'll get discussed later. But in -- in the OFA analysis, it talks about this 39 million, in Fiscal Year '12, and 36 million, in Fiscal Year '13. Are -- and from the spending side that I'm concerned with, are we -- we're going to approve this implementer, possibly, with this expenditure, without any knowledge of how it's being spent.

Can you speak to how it is being spent? Through you.

THE CHAIR: Senator Harp.

SENATOR HARP: Thank you, very much.

It's going to be redistributed to the hospitals who pay the tax.

THE CHAIR: Senator Kane.

SENATOR KANE: Thank you, Madam President.

I -- I kind of figured that, but I curious more specifically how it would be spend or -- or distributed, as you say.

Through you.

THE CHAIR: Senator Harp.

SENATOR HARP: Thank you, very much, Madam President.

I – there's a formula that ultimately indicates how -- how the dollars will be distributed, and I think it has to do with the number of Medicaid patients, number of Medicaid days, Medicare days, unemploying – let's see -- uncompensated care; those types of things relate to the manner in which it will be redistributed.

There are a series of -- of what I would consider six hospitals who lost money over the last five years, who will be -- not be taxed on outpatient revenue. And so they will basically -- would have been losers, had we taxed them on outpatient revenue. And those six hospitals are Milford Hospital, New Milford Hospital, Johnson & Memorial, Waterbury Hospital, the Hospital of St. Raphael's, and Bristol Hospital.

Through you, Madam –

THE CHAIR: Senator Kane.

SENATOR HARP: -- President.

SENATOR KANE: Thank you, Madam President.

I -- I -- it seems as if you have that formula available to you. Are we privy to that same formula? Through you, Madam President.

THE CHAIR: Senator Harp.

SENATOR HARP: Thank you, very much.

I think it's available through your caucuses, perhaps.

Through you, Madam President.

THE CHAIR: Senator Kane.

SENATOR KANE: Madam President, no, we do not have that formula. Is -- is there any way for us to get a copy of that? Through you.

SENATOR HARP: Thank you.

THE CHAIR: Senator Harp.

SENATOR HARP: Through you, Madam President, I believe it's the CHA plan, so I think you can get it through the -- the Connecticut Hospital Association.

THE CHAIR: Senator Kane.

SENATOR KANE: I can't get it from you?

Through you, Madam President.

THE CHAIR: Senator Harp.

SENATOR KANE: (Inaudible.)

SENATOR HARP: Oh, certainly. If you want it from me, you can certainly get it from me.

General Assembly had determined the amount of revenue the Hospital User Fee needed to generate to support the budget and the corresponding payments that could be made to hospitals as a result of the enactment of the Hospital User Fee.

As the structure of the tax on hospitals had been fundamentally altered from a tax on net patient revenue that accrued quarterly to a set user fee designed to obtain a certain set amount of funds, under Conn. Gen. Stat. § 2-35, the General Assembly was required to revise the revenue estimates to take into account this amendment. Under Conn. Gen. Stat. § 2-35, the General Assembly is required to include revenue estimates in each state budget, which estimates "shall not be less than the total net appropriations made from each fund." Conn. Gen. Stat. § 2-35(b).[28] Additionally, "if any revisions in such estimates are required by virtue of legislative amendments to the revenue measures proposed by [the joint standing committee of the General Assembly having cognizance of matters relating to state finance, revenue, and bonding], changes in conditions or receipt of new information since the original estimate was supplied, [said committee shall] meet and revise such estimates and, through its cochairpersons, report to the Comptroller any such revisions." Id. This was also particularly necessary for the Hospital User Fee as said estimates set forth the final variable for the Hospital User Fee formula.

As such, the General Assembly, through the Finance, Revenue, and Bonding Committee, complied with the requirements set forth in Conn. Gen. Stat. § 2-35 and did so through the adoption of the revised revenue estimates which are part of the record at 581-82. The revised revenue estimates were adopted at a meeting held on June 24, 2011. The minutes of said meeting are part of the record at 583-85. The revised revenue estimates include the increase in revenue attributable to the revised Hospital User Fee.

More specifically, the revenue attributable to the Hospital User Fee is set forth in the "Miscellaneous" category of taxes for the SFY 2012-2013 revenue estimates. In the original budget adopted by the General Assembly set forth in Public Act 11-6, the Miscellaneous Taxes were estimated to generate $514,200,000 in revenue for fiscal year 2012 and $521,200,000 in revenue for fiscal year 2013. 2011 Conn. Pub. Acts 6, § 155.

As set forth above, after the General Assembly transformed the tax on hospitals into the Hospital User Fee, it amended the budget in order to comply with Conn. Gen. Stat. § 2-35 and to provide the final variable necessary to calculate the Hospital User Fee. Specifically, as referenced above, the General Assembly determined how much revenue it could generate under federal Medicaid and how much it needed to generate from Hospital User Fee to support the budget. Additionally, the General Assembly, through the procedure set forth in Conn. Gen. Stat. § 2-35 and the Finance, Revenue, and Bonding Committee, adopted revised revenue estimates necessary to support the

SENATOR KANE: Oh, great.

Connecticut Senate Transcript, 6/7/2011.

[28] See also Roger Sherman Liberty Ctr., Inc. v. Williams, 52 Conn. Supp. 118, 126, 28 A.3d 1026, 1032–33 (Super. Ct. 2011) ("The court is persuaded that there is a budget process, not a single instantaneous act of budget creation, for this biennium. The text of the budget bill itself indicates that the budget process is ongoing, and cannot be complete, until further steps are taken. Since the plaintiffs brought this action, the state arrived at a tentative agreement with SEBAC, the governor submitted revised budget numbers to the legislature, and the passage of P.A. 11–61 adjusted the budget to reflect those revisions.").

appropriations made in Public Act 11-61. As set forth in R. 581-82, the revenue estimates for the Miscellaneous Taxes were revised to be $542,200,000 in revenue for SFY 2012 and $546,700,000 in revenue for SFY 2013. As set forth in the state budget prepared by the General Assembly's Office of Fiscal Analysis (OFA), $349.1 million of this revenue was attributable to the Hospital User Fee for each of SFY 2012 and 2013. OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part II, Summary & Schedules, at 58, see Appendix 3.[29]

Accordingly, consistent with the language of section 103 of Public Act 11-44, as amended by section 79 of Public Act 61, and in accordance with the state budget as adopted by the General Assembly as described above, DSS, in consultation with OPM, was required to calculate the amount of user fee due from each hospital in a manner that would raise $349.1 million of revenue in order to comply with the mandate made by the General Assembly through the Finance, Revenue, and Bonding Committee set forth in the revenue estimates and the appropriations set forth in the revised budget. Furthermore, the Hospital User Fee needed to be structured in a way that would comply with federal Medicaid provider tax requirements and other applicable federal Medicaid payment requirements while also supporting the $399 million in payments referenced above.

The General Assembly did not change the amount of revenue that the Hospital User Fee was required to generate for SFY 2014-2015. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. As such, for said biennium, DSS, in consultation with OPM, was required to calculate the amount of user fee due from each hospital in a manner that would raise $349.1 million of revenue in order to comply with the mandate made by the General Assembly in the revenue estimates and the appropriations set forth in the budget.

In 2015, as part of the budget process, General Assembly increased the amount to be raised by the Hospital User Fee to $556 million. 2015 Conn. Pub. Acts 244, § 56; 2015 Conn. Pub. Acts 5, June spec. sess., § 496. The details of this increase are set forth in the in the state budget prepared by

[29] In describing the final budget as adopted by the General Assembly, the legislative Office of Fiscal Analysis described in detail both the structure of the Hospital User Fee as well as the structure of the associated increased Medicaid supplemental and DSH payments to hospitals. See Appendix 3. Specifically, as part of the description of the various changes to taxes and other revenue items, the Hospital User Fee was described as follows:

> Hospital User Fee - A user fee on general hospital's inpatient and outpatient revenue. This fee is assessed at 5.5% on inpatient revenue and 3.83% on outpatient revenue. Hospitals that experienced an aggregate loss in excess of 1% over the past five years are exempt from the outpatient fee. Proceeds of the hospital user fee are appropriated back to the hospital system via a Medicaid rate increase, thereby garnering additional federal matching revenue for the state. Effective July 1, 2011.

OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part II, Summary & Schedules, at 54. As noted above, a few pages later in the same budget book, the Hospital User Fee was listed as generating $349.1 million. Id. at 58. Similarly, within the DSS portion of the budget book, the reimbursement system was described, where the Hospital User Fee would support the state share of $131 million in new Medicaid supplemental payments to hospitals and $268,486,847 in additional DSH payments, for a total of $399,486,847 in additional payments, which were to be offset by $199,743,424 in FFP—and therefore result in $199,743,424 in net additional state share payments to hospital. OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part 1: Agency Detail, at 320-321. By subtracting the state share of the additional payments from the total amount to be collected by the Hospital User Fee, the overall structure needed to result in $149 million in net gain to the state budget for each of SFY 2012 and 2013. All of these elements are reflected in the final version of the state budget that was adopted by the General Assembly.

OFA. OFA, Connecticut State Budget, FY 16 & FY 17 Budget, at 507. In the section regarding revenue impact, those changes are listed as increasing the amount of the user fee by $207 million (from $349 million to $556 million). Id. at 483.

Further affirming the manner in which the Hospital User Fee is calculated, the General Assembly recently codified a statement of intent regarding the Hospital User Fee.

C. General Assembly's Codification of its Intent with Respect to the Hospital User Fee

The General Assembly codified a statement of intent regarding the Hospital User Fee through the enactment of sections 119 through 121 of Public Act 16-3 of the May Special Session. Specifically, the General Assembly stated that

> Consistent with section 12-263b of the general statutes, as amended by this act, the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was that on and after July 1, 2011, the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis. In said public acts, the General Assembly charged the Commissioner of Social Services, in consultation with the Office of Policy and Management, with calculating the amount of tax due from each hospital within the limitations and requirements set forth in subsection (w) of 42 USC 1396b, including determining the base year for the tax, in order to obtain the funds set forth by the General Assembly in the state budget. As part of the administration of the tax, the Commissioner of Social Services was required to notify the hospitals of the amount of tax due. Such calculations and notifications do not constitute regulations for purposes of chapter 54 of the general statutes.

2016 Conn. Pub. Acts 3, May spec. sess., § 119. The General Assembly also amended the language of Conn. Gen. Stat. § 12-263b to clarify this intent as follows:

> (a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. The rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly. Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed in order to ensure conformance with the state budget adopted by the General Assembly…

2016 Conn. Pub. Acts 3, May spec. sess., § 120.[30]

[30] Additionally, the General Assembly clarified that the purpose of the Hospital User Fee was to raise revenue from uniquely situated health care providers and, in order to do so, the user fee had to comply with federal Medicaid law.

Consistent with the above-quoted language, the language of section 103 of Public Act 11-44, as amended by section 79 of Public Act 61, and the legislative history regarding the enactment of the Hospital User Fee, the Departments find that the Hospital User Fee, as enacted in 2011, was a set fee on hospitals. Additionally, under said fee, DSS, in consultation with OPM, was required to calculate the amount of user fee due from each hospital in a manner that would raise the amount of revenue set forth in the revised revenue estimates and support the appropriations set forth in the revised budget. Accordingly, the rate of the user fee was a formula, the variables of which were set forth in Conn. Gen. Stat. § 12-263a, the codified revenue estimates, and federal Medicaid law. Said calculation was required to comply with federal Medicaid law and exempt certain hospitals.

The budget adopted by the General Assembly for SFY 2012-2013 mandated that the Hospital User Fee raise $349.1 million dollars in revenue for each year of the biennium. See R. at 581-82; OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part II, Summary & Schedules, at 58. The budget adopted by the General Assembly for SFY 2014-2015 also mandated that the Hospital User Fee raise $349.1 million dollars in revenue for each year of the biennium. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. The budget adopted by the General Assembly for SFY 2016-2017 increased the amount of revenue the Hospital User Fee was required to generate to $556 million. See 2015 Conn. Pub. Acts 244, § 56; 2015 Conn. Pub. Acts 5, June spec. sess., § 496; OFA, Connecticut State Budget, FY 16 & FY 17 Budget, at 483.

As set forth more fully below, the Departments find that DSS, in consultation with OPM, complied with the requirements imposed upon it by the General Assembly through the statutory language governing the Hospital User Fee.

D. DSS's Implementation of the Hospital User Fee

As referenced above, the General Assembly charged DSS, in consultation with OPM, with calculating the user fee that each hospital would have to pay in order to achieve the revenue set forth in the revised revenue estimates. Specifically, and as explained above, the General Assembly set forth the following variables in said calculation in statute: (1) the taxpayers subject to the Hospital User Fee, (2) the taxpayers exempt from the Hospital User Fee, and (3) the base upon which the Hospital User Fee was to be calculated. Additionally, the General Assembly provided DSS with the amount that the Hospital User Fee was required to generate by codifying revenue estimates and revising said estimates in accordance with Conn. Gen. Stat. § 2-35. Accordingly, by statute, DSS was required to calculate the Hospital User Fee due from each hospital using the

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2016 Conn. Pub. Acts 3, May spec. sess., § 121. To that end, the General Assembly asserted that

> The intention of section 145 of public act 11-6, as amended by section 102 of public act 11-44, was that the definition of net patient revenue set forth in section 12-263a of the general statutes complies with and is consistent with subsection (w) of 42 USC 1396b, 42 CFR 440.10 and 42 CFR 440.20. Furthermore, the primary purpose of the tax on the net patient revenue of hospitals was to raise revenues from uniquely situated health care providers that receive certain benefits under the state's Medicaid program.

Id.

variables set forth above and in a manner that complied with federal Medicaid law. As set forth more fully below, the Departments find that DSS implemented the Hospital User Fee in a manner designed to ensure that the requirements imposed upon it by the General Assembly and federal Medicaid law were met.

Conn. Gen. Stat. § 12-263a provides, in pertinent part, that:

> (a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. **The rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly. Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed in order to ensure conformance with the state budget adopted by the General Assembly. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship**. Effective July 1, 2012, and for the succeeding fifteen months, the rates of such tax, the base year on which such tax shall be assessed, and the hospitals exempt from the outpatient portion of the tax based on financial hardship shall be the same tax rates, base year and outpatient exemption for hardship in effect on January 1, 2012.
>
> (b) Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue as determined by the Commissioner of Social Services. Payment shall be made with such return. Each hospital shall file such return electronically with the department and make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether the hospital would otherwise have been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

Conn. Gen. Stat. § 12-263b (emphasis supplied). Additionally, Conn. Gen. Stat. § 12-263a provides as follows:

> As used in sections 12-263a to 12-263e, inclusive:
>
> (1) "Hospital" means any health care facility or institution, as defined in section 19a-630, which is licensed as a short-term general hospital by the Department of Public Health but does not include (A) any hospital which, on October 1, 1997, is within the class of hospitals licensed by the department as children's general hospitals, or (B) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant to chapter 920;

> (2) "Net patient revenue" means the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services;
>
> (3) "Commissioner" means the Commissioner of Revenue Services;
>
> (4) "Department" means the Department of Revenue Services.

Conn. Gen. Stat. § 12-263a. Consistent with the above-quoted language, DSS was statutorily required to calculate the amount of user fee each hospital was obligated to pay based on the net patient revenue of each of the hospitals. Additionally, as set forth above, the General Assembly required DSS to calculate the Hospital User Fee to ensure that it generated sufficient funds to meet the revenue estimates set forth in each state budget. Finally, DSS had to ensure that governmental, psychiatric, specialty, and children's hospitals were exempt from the Hospital User Fee and financially distressed hospitals were exempt from paying user fee on accrued payments earned by a hospital for the provision of outpatient services. DSS's calculations were required to comply with federal Medicaid requirements.

In order to comply with all of these requirements imposed by the General Assembly (including the requirements specifically enumerated in the text of the statute as well as the requirements of the state budget adopted by the General Assembly as confirmed by the clarifying legislation), DSS needed to take the following steps in order to implement the Hospital User Fee:

> (1) determine the amount of net patient revenue each hospital had accrued in a given year;
> (2) select a base year with sufficient net patient revenue for the fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law;
> (3) determine those hospitals that met the statutory definitions of exempt hospitals;
> (4) calculate the amount of fee each hospital owed in order to comply with federal Medicaid provider tax requirements and also to achieve the amount of revenue set forth in the revenue estimates and payments set forth in the state budget; and
> (5) obtain a waiver from CMS of the broad-based requirement for those hospitals statutorily exempt from Hospital User Fee.

First, as Conn. Gen. Stat. § 12-263b defines the tax base to be the hospitals' "net patient revenue," DSS was required to determine what the amount of net patient revenue accrued by each hospital in a given year. In order to do so, DSS reviewed reports filed by the hospitals with the Department of Health, Office of Health Care Access (OHCA).

Under Conn. Gen. Stat. § 19a-644, hospitals are required to file reports with OHCA containing detailed financial data including an annual report and a twelve months actual filing. In the twelve months actual filing, hospitals are required to report information regarding their net patient revenue and inpatient and outpatient revenue. Conn. Agencies Regs. § 19a-643-206. Specifically, under Conn. Agencies Regs. § 19a-643-206, hospitals are required to report as follows:

> The hospital's twelve months actual filing for the most recently completed fiscal year shall consist of the following required information components to be submitted annually to the

> Office by March 31st in accordance with sections 19a-649 and 19a-676 of the Connecticut General Statutes:. . .(9) A summary of gross revenue, net revenue, other operating revenue, revenue from operations, operating expenses, utilization statistics, case mix index, full time equivalent employees and related statistical analyses; . . . (11) A summary of inpatient and outpatient accrued charges and payments, accrued discharges, case mix index, other required data elements and a net revenue reconciliation to net revenue as defined by the office . . . .

Id. Consistent with the above-quoted regulation, hospitals are required to include in their twelve month actual filing detailed information regarding their inpatient and outpatient accrued charges and payments. Hospitals are required to affirm through the filing of an affidavit that the data submitted on the twelve month actual filing is true and accurate. Specifically, all hospitals affirm that

> The information submitted both electronically and in hard copy to the Department of Public Health, Office of Health Care Access division, that is contained in the Hospital's FY 2009 Twelve Months Actual Filing concerning its actual results from operations, is true, accurate and consistent with the FY 2009 Twelve Months Actual Filing General Instructions provided to the Hospital by the Department of Public Health, Office of Health Care Access Division.

See R. at 2167-2448. This same affirmation was required for affidavits submitted in connection with FFY 2013 as well. See id. OHCA is required to review the hospitals' annual and twelve-month filings and must report on its review of those filings by September first of each year. Conn. Gen. Stat. § 19a-670.

Accordingly, consistent with DSS's obligation to calculate the amount of user fee due by determining the amount of net patient revenue each taxpayer had in each year, DSS reviewed the twelve month actual reports of the hospitals. Under Conn. Gen. Stat. § 12-263b, net patient revenue is defined to be "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." Conn. Gen. Stat. § 12-263b. As the twelve month actual reports included certified disclosures by the hospitals of their net patient revenue including "inpatient and outpatient accrued payments," DSS used the information set forth therein to determine how much net patient revenue a hospital had in a given year.

In mid-2011, when the General Assembly enacted the Hospital User Fee, the latest year's reporting available was for FFY 2009 because OHCA is required to release the results of its review of the hospitals' filings by September 1st of each year. See Conn. Gen. Stat. § 19a-670. DSS reviewed these reports to determine whether said year had sufficient net patient revenue for the Hospital User Fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law. DSS found that said year also contained sufficient net patient revenue to raise the $349.1 million required annually without exceeding the federal maximum percentage while at the same time exempting all hospitals exempt from the user fee under Conn. Gen. Stat. §§ 12-263a and 12-263b.[31] Additionally, the revenue

[31] DSS could not simply apportion the amount of fee due from each hospital proportional to net patient revenue for any given year. This is because the General Assembly had mandated that certain hospitals were exempt from the user fee. Specifically, the statute applied only to facilities "licensed as a short-term general hospital" and excluded

from said year and associated distribution of payments made to hospitals complied with federal requirements for the Hospital User Fee including that the user fee must be broad-based.

As certain hospitals were specifically exempt from the Hospital User Fee under Conn. Gen. Stat. §§ 12-263a and 12-263b, DSS was required to calculate the amount of Hospital User Fee to both exempt said hospitals as set forth in Chapter 211a and comply with the broad-based requirements. DSS was also required to request a waiver of the broad-based requirements from CMS.

Accordingly, using the data from the twelve month actual filings submitted to OHCA, DSS conducted several calculations in order to apply for a waiver from CMS. As part of the waiver application process, DSS performed the P1/P2 test, which showed that the user fee was generally redistributive despite exempting certain hospitals. R. at 632-52. The results of said test were set forth in a waiver application DSS submitted to CMS on June 7, 2011.[32]

Additionally, as part of the waiver application process, DSS was required to demonstrate that the Hospital User Fee and associated Medicaid payments did not hold the taxpayers harmless for the tax, either directly or indirectly. Accordingly, DSS included in the waiver application the use of the proceeds of the user fee and payments made to the hospitals in order to demonstrate that those payments did not hold harmless any taxpayer directly or indirectly as payments[33] were not directly correlated to the tax. Id.

children's hospitals and publicly operated hospitals. Conn. Gen. Stat. § 12-263a(1). Because short-term general hospitals are licensed separately from other types of hospitals, that definition thus excluded chronic disease hospitals and other specialty hospitals. Id.; see also Conn. Agencies Regs. § 19-13-D1(b). In addition, the statute provided that DSS "may, in consultation with the Secretary of [OPM] and in accordance with federal law, exempt a hospital from the user fee on outpatient services based on financial hardship." Conn. Gen. Stat. § 12-263b(a). As detailed in the waiver application, a hospital was determined to be financially distressed if it had aggregate net losses of more than one percent of aggregate revenue for the five year period of 2005-2009 (the most recent years for which full year data was available when the user fee was first implemented in mid-2011). R. at 632-52.

[32] Most of these calculations occurred during the 2011 legislative session, as DSS and OPM were charged with assisting the General Assembly in calculating how much the Hospital User Fee could raise. The General Assembly adopted DSS's and OPM's recommendations through the codification of the revenue estimates and, thereafter, DSS had no discretion to amend how much revenue the Hospital User Fee could raise.

[33] In addition to federal Medicaid provider tax requirements, federal Medicaid payment requirements further constrained the ability to make specific payments. In particular, supplemental payments, along with all hospital Medicaid payments, must comply with upper payment limits (UPLs), which limit total Medicaid payments to a group of facilities "to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles…." 42 C.F.R. §§ 447.272 (inpatient) and 447.321 (outpatient). In addition, DSH payments are subject to various restrictions, including the overall state DSH allotment, as well as hospital-specific DSH limits, which varied over time. 42 C.F.R. Part 447, Subpart E; 42 U.S.C. § 1396r-4.

After ensuring that payments would conform to the amounts specified in the state budget approved by the General Assembly, DSS also needed to ensure that those payments complied with the federal Medicaid payment requirements described above. Further, changes in payment methodology, including the establishment of the supplemental payments, required DSS to obtain CMS approval of a Medicaid State Plan Amendment (SPA). 42 C.F.R. § 430.12(c). As part of the SPA process, CMS carefully reviews each SPA to ensure it complies with applicable federal requirements, including the structure of any provider taxes used for state funding as well as compliance with UPL and other requirements. See CMS, State Medicaid Director Letter, SMD # 10-020, Revised State Plan Amendment Review Process, October 1, 2010, p. 6, R. at 968; see also SPAs 11-031, 12-002, 13-029, 16-013 and related documents, R. at 1267-1269, 653-697, 3014-3041.

CMS approved DSS's waiver application effective July 1, 2011. Accordingly, DSS calculated the amount of Hospital User Fee due from each of the hospitals subject to the user fee in a manner consistent with CMS's waiver approval. Specifically, DSS apportioned the total revenue that needed to be raised from the Hospital User Fee consistent with each hospitals' net patient revenue for FFY 2009 and the distribution that the user fee had to comply with in order to avoid containing a hold harmless provision. On September 30, 2011, DSS notified the hospitals by email of their required tax amounts for SFY 2012-2013. R. at 586-89.

In 2013, the General Assembly did not make any changes to the Hospital User Fee for the state budget for SFY 2014-2015. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. Accordingly, on July 18, 2013, DSS notified the hospitals of their required user fee amounts for SFY 2014-2015, which were the same as the amounts for SFY 2012-2013, except that the amount for St. Raphael's Hospital was added to Yale-New Haven Hospital to reflect those hospitals' merger. R. at 590-94.

The budget adopted by the General Assembly for SFY 2016-2017 increased the amount of revenue the Hospital User Fee was required to generate to $556 million. In order to implement these changes, DSS was required to

> (1) determine the amount of net patient revenue each hospital had accrued in a given year;
> (2) select a base year with sufficient net patient revenue for the fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law;
> (3) determine those hospitals that met the statutory definitions of exempt hospitals;
> (4) calculate the amount of fee each hospital owed in order to comply with federal Medicaid provider tax requirements and also to achieve the amount of revenue set forth in the revenue estimates and payments set forth in the state budget; and
> (5) obtain a waiver from CMS of the broad-based requirement for those hospitals statutorily exempt from Hospital User Fee.

DSS again reviewed the twelve month actual filings hospitals filed with OHCA. DSS reviewed the reports available to determine a year in which (1) all hospitals subject to the user fee existed and (2) there was sufficient net patient revenue for the Hospital User Fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law. Specifically, FFY 2009 would no longer work as a base year because it did not contain sufficient revenue to support the Hospital User Fee. In mid-2015, when the General Assembly increased the amount of revenue that the Hospital User Fee was required to generate, the latest year's reporting available was for FFY 2013. See Conn. Gen. Stat. § 19a-670.

DSS included these payment amounts in the waiver application to CMS to demonstrate that the Hospital User Fee complied with the federal prohibition on any direct correlation between tax and payment amounts as well as the prohibition on any form of specified hold harmless provision. Specifically, by analyzing each hospital's tax payments against the DSH and supplemental payments, DSS showed to CMS that given the overall redistribution, there was no direct correlation. R. at 632-52. CMS approved the waiver on August 26, 2011, including the exempt categories as well as an overall approval of the structure of the tax. Id.

Said year was selected as it contained sufficient net patient revenue to raise the $556 million required annually without exceeding the federal maximum percentage, while at the same time exempting all hospitals exempt from the user fee under Conn. Gen. Stat. §§ 12-263a and 12-263b. Additionally, the revenue from said year and associated distribution of payments made to hospitals complied with federal requirements for the Hospital User Fee, including that the user fee must be broad-based.

As certain hospitals were specifically exempt from the Hospital User Fee under Conn. Gen. Stat. §§ 12-263a and 12-263b, DSS was required to calculate the amount of Hospital User Fee to both exempt said hospitals as set forth in Chapter 211a and comply with the broad-based requirements. DSS was also required to request a waiver of the broad-based requirements from CMS.

Accordingly, using the data from the twelve month actual filings submitted to OHCA, DSS conducted several calculations in order to apply for a waiver from CMS. As part of the waiver application process DSS performed the P1/P2 test, which showed that the user fee was generally redistributive despite exempting certain hospitals. R. at 632-52. The results of said test were set forth in a waiver application DSS submitted to CMS on June 26, 2015. Id.

Additionally, as part of the waiver application process, DSS was required to demonstrate that the Hospital User Fee and associated Medicaid payments did not hold the taxpayers harmless for the user fee either directly or indirectly. Accordingly, DSS included in the waiver application the use of the proceeds of the user fee and payments made to the hospitals in order to demonstrate that those payments did not hold harmless any taxpayer, directly or indirectly, as payments[34] were not directly correlated to the user fee. Id.

[34] In addition to federal Medicaid provider tax requirements, federal Medicaid payment requirements further constrained the ability to make specific payments. In particular, supplemental payments, along with all hospital Medicaid payments, must comply with upper payment limits (UPLs), which limit total Medicaid payments to a group of facilities "to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles…." 42 C.F.R. §§ 447.272 (inpatient) and 447.321 (outpatient). In addition, DSH payments are subject to various restrictions, including the overall state DSH allotment, as well as hospital-specific DSH limits, which varied over time. 42 C.F.R. Part 447, Subpart E; 42 U.S.C. § 1396r-4.

After ensuring that payments would conform to the amounts specified in the state budget approved by the General Assembly, DSS also needed to ensure that those payments complied with the federal Medicaid payment requirements described above. Further, changes in payment methodology, including the establishment of the supplemental payments, required DSS to obtain CMS approval of a Medicaid State Plan Amendment (SPA). 42 C.F.R. § 430.12(c). As part of the SPA process, CMS carefully reviews each SPA to ensure it complies with applicable federal requirements, including the structure of any provider taxes used for state funding as well as compliance with UPL and other requirements. See CMS, State Medicaid Director Letter, SMD # 10-020, Revised State Plan Amendment Review Process, October 1, 2010, p. 6, R. at 968; see also SPAs 11-031, 12-002, 13-029, 16-013 and related documents, R. at 1267-1269, 653-697, 3014-3041.

DSS included these payment amounts in the waiver application to CMS to demonstrate that the Hospital User Fee complied with the federal prohibition on any direct correlation between user fee and payment amounts as well as the prohibition on any form of specified hold harmless provision. Specifically, by analyzing each hospital's tax payments against the DSH and supplemental payments, DSS showed to CMS that given the overall redistribution, there was no direct correlation. R. at 632-52. CMS approved the waiver on August 26, 2011, including the exempt categories as well as an overall approval of the structure of the user fee. Id.

On October 7, 2015, CMS approved the waiver, which was effective July 1, 2015. Id. Accordingly, DSS calculated the amount of Hospital User Fee due from each of the hospitals subject to the user fee in a manner consistent with CMS's waiver approval. Specifically, DSS apportioned the total revenue that needed to be raised from the Hospital User Fee consistent with each hospital's net patient revenue for 2013 and the distribution that the user fee had to comply with in order to avoid containing a hold harmless provision. On October 16, 2015, DSS notified the hospitals through a posting on its website and by email of the amount of user fee due for SFY 2016-2017. R. at 584-609.

E. DRS's Implementation of the Hospital User Fee

By statute, DRS had a limited role in the implementation of the Hospital User Fee. Specifically, DRS was charged with the collection of the Hospital User Fee from the hospitals. See Conn. Gen. Stat. § 12-263b ("Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue as determined by the Commissioner of Social Services. Payment shall be made with such return. Each hospital shall file such return electronically with the department."). DRS complied with this obligation by promulgating guidance regarding how the Hospital User Fee was to be collected and issuing an electronically filed tax return.

F. Summary of the Petitioners' Submissions Regarding the Content of the Revenue Used in the Tax Base (net revenue reported by the Petitioners to OHCA for FFY 2009 and 2013).

As noted above, in their Petitions, the Petitioners made various factual assertions, including an allegation that the net revenue figures reported by the hospitals to OHCA on their twelve month actual filings (also referred to herein as the OHCA reports), which was the basis for calculating the User Fee amounts, included services outside of the federal tax classes of inpatient and outpatient hospital services. R. at 16-17, 37-38. The Departments do not find that the Petitioners' allegations are supported by any evidence in the record.

As referenced above, DSS uses each Petitioner Hospital's net patient revenue as reported to OHCA in their twelve month actual filings in order to determine the amounts of revenue the Petitioner Hospitals accrued through the provision of inpatient and outpatient hospital services that are subject to the tax. Specifically, DSS used the total of "Inpatient Accrued Payments" and "Outpatient Accrued Payments" as reported by each hospital to OHCA on Report 550[35] in order to determine the base amounts subject to the tax for each Petitioner Hospital.

[35] Report 550 is part of the twelve month actual filing and, as is explained more fully in Ruling 4, is a reconfiguration of data from other reports in the twelve month actual filing in which the Petitioner Hospitals input data regarding their inpatient accrued payments and outpatient accrued payments.

As the Petitioner Hospitals have claimed that the Hospital User Fee was imposed upon accrued payments from services that were not properly subject to the Hospital User Fee, the Departments attempted to obtain from the Petitioner Hospitals lists of those services for which they included accrued payments on the OHCA Reports. More specifically, in the Departments' Request for Information, the Departments requested information in order to determine both who billed for, and therefore, provided the services subject to tax and what those services were that were subject to tax.[36]

Upon review of the documents that the Petitioners submitted, the Department find that the Petitioner Hospitals billed for, and therefore provided, all of the services subject to the Hospital User Fee.[37] The specific evidence upon which the Departments make this finding are spreadsheets that the individual Petitioner Hospitals created and produced in response to the Departments' Request for Information, which set forth the national provider identifier (NPI) associated with all payment each Petitioner Hospital reported on its OHCA reports.

Under federal regulations implementing the Health Insurance Portability and Accountability Act (HIPAA), various types of providers, including hospitals, are required to use an NPI when submitting claims for payment for providing health care services. See 45 C.F.R. 162, Subpart D. Accordingly, the NPI the provider uses to bill for its services serves to identify the provider that furnished the services. The Petitioner Hospitals provided the NPIs that they used to bill for all of the services for which they reported payments on their twelve month actual filings. Each valid NPI reported by each Petitioner Hospital was an NPI associated with each said Petitioner Hospital. As such, the Departments find sufficient evidence to demonstrate that the Petitioner Hospitals were the entities that billed for, and as such furnished, the services subject to the Hospital User Fee. Accordingly, the Departments find that all services subject to the Hospital User Fee were provided by a Petitioner Hospital.

The Departments further find no evidence to suggest that services other than inpatient and outpatient hospital services were subject to the Hospital User Fee. Specifically, in questions 8, 19, 30, and 41 of their Request for Information dated March 3, 2016, the Departments asked the Petitioner Hospitals to "describe the types of services the hospital provided in connection with" the accrued payments reported by the petitioner to OHCA as net patient revenue (separately for inpatient and outpatient hospital services for FFY 2009 and FFY 2013). Rather than listing out specific types of services that the Petitioner Hospitals performed and billed for, such as hospital

[36] The Departments note that only the Petitioner Hospitals have this information. As such, the Departments are completely reliant on what information the Petitioner Hospitals choose to provide and the manner in which they provide said information. As set forth more fully herein, the Petitioner Hospitals declined to provide the Departments with certain vital information regarding the types of services upon which the Hospital User Fee was imposed. As the Petitioner Hospitals have declined to provide this information, the Departments are unable to find, as the Petitioners urge, that the Hospital User Fee was imposed on services other than those properly subject to the tax.

[37] A health care provider, including a hospital, is only authorized to bill for services actually performed by the provider, which, for providers that are entities, such as hospitals, inherently includes services provided by individuals employed, under contract to, or closely affiliated with the entity. See, e.g., 45 C.F.R. § 162.1101; 42 C.F.R. § 447.10; 42 C.F.R. §§ 424.5, 424.33, 424.51, 424.73. There are civil and criminal penalties for false billing, such as if a provider improperly submitted claims for services not performed by the provider (including by individuals employed by, under contract to, or closely affiliated with the provider). See, e.g., 18 U.S.C. §§ 287 and 1347; 31 U.S.C. § 3729; and 42 U.S.C. §§ 1307, 1320a-7a, and 1320a-7b.

laboratory services or outpatient hospital behavioral health services, the Petitioner Hospitals simply set forth the nineteen classes of provider taxes and ascribed dollar amounts to each such class.

When the Departments again asked for information regarding the specific types of services for which the Petitioner Hospitals reported payments on their twelve month actual filings, the Petitioner Hospitals responded that their response to questions 8, 19, 30, and 41 was in fact answered by their responses to questions 9, 20, 31, and 42. In questions 9, 20, 31, and 42, the Departments asked the Petitioner Hospitals to "describe the specific method of billing for such services used by the hospital, including all specific billing codes and any other specific identifiers or codes used for billing services." In response to these questions, the Petitioner Hospitals listed out various ranges of billing codes that they claim are associated with each of the nineteen classes of provider taxes.[38] The Departments received no evidence that any of services associated with the codes were actually subject to the User Fee. Moreover, as set forth in footnote 38, multiple services may be associated with the same billing code.[39]

Accordingly, and as is set forth more fully in Ruling 4, the Departments find that there is no evidence to suggest that services other than inpatient and outpatient hospital services were subject to the Hospital User Fee.

With the factual findings set forth above as background, the Departments rule on the following issues presented in the Petitions.

[38] In their letter dated July 28, 2016, the Petitioners responded to the Departments' letter dated July 11, 2016, in which the Departments indicate that the Petitioners had not fully responded to Requests for Information 8, 19, 30, and 41. Those requests asked the Petitioners to "identify and describe the type or types of payments the hospital provided" in connection with inpatient and outpatient hospital services net revenues reported to OHCA. Specifically, the Petitioners indicated that they had responded to said questions by listing billing codes that correspond to each service, along with producing the National Uniform Billing Committee standards. The Petitioners further indicate that, in general, they used the categories within those standards to categorize the services. Billing codes have definitions that roughly correspond to certain services. Those definitions have significant limits, however, because many billing code definitions are terse, vague, and sometimes overlapping. The Departments are taking those responses under consideration even though those responses are still not descriptions of actual services provided.

[39] Despite this limitation, the Departments have attempted to analyze the Petitioners' allegations based on the billing codes provided and, in doing so, have found no evidence that the Hospital User Fee was imposed on any services not properly subject to said User Fee.

ISSUES:

1. Whether the General Assembly unconstitutionally delegated the setting of the rate and base year of the Hospital User Fee to DSS in violation of the Connecticut Constitution?
2. Whether the methodology outlined in the DSS email dated October 16, 2015, setting the tax rate and base year of the Hospital User Fee at 6% and 2013, respectively, is an unenforceable regulation under Conn. Gen. Stat. § 4-167?
3. Whether the Hospital User Fee violates the Equal Protection Clause of the United States Constitution, U.S. Cons., amend. XIV § 1?
4. Whether the Hospital User Fee has been implemented in a manner that is inconsistent with the Act and not permitted under the federal Medicaid Act, 42 U.S.C. § 1396 et seq., and the regulations promulgated thereunder?
5. Whether Departments' administration of the Hospital User Fee is arbitrary and capricious and an abuse of discretion, subject to being overturned pursuant to the Connecticut Uniform Administrative Procedures act, Conn. Gen. Stat. § 4-183?

RULINGS:

1. The General Assembly has not delegated authority to set a tax rate of the Hospital User Fee and, as such, has not violated the Connecticut Constitution. Additionally, the General Assembly's delegation of authority to DSS does not constitute an unconstitutional delegation of authority.
2. The Departments find that neither DSS nor DRS enacted an illegal regulation in violation of the UAPA.
3. The Hospital User Fee does not violate the Equal Protection Clause of the fourteenth amendment to the United States Constitution.
4. The Departments have not implemented the Hospital User Fee in a manner inconsistent with Chapter 211a of the Connecticut General Statutes or Title XIX of the Social Security Act, which governs the Medicaid program.
5. The Departments have not administered the Hospital User Fee in an arbitrary and capricious manner, nor have they abused the discretion afforded to them under the Hospital User Fee.

DISCUSSION:

1. The Departments find that the Hospital User Fee does not violate Article Second of the Connecticut Constitution.

The Petitioners have raised two challenges to the Hospital User Fee under the Connecticut Constitution. First, the Petitioners allege that the General Assembly has unconstitutionally "cede[d] and delegate[d] an inherently legislative function to an administrative agency to determine the applicable tax rate and base year" in violation of Article Second of the Connecticut Constitution. R. at 5, 25. In the alternative, the Petitioners allege that, if the Departments determine that the General Assembly did not cede to DSS "an inherently legislative function," the Hospital User Fee still violates Article Second of the Connecticut Constitution as the General Assembly has "fail[ed] to provide an intelligible principle (or, indeed, any principle) to guide DSS's process for setting the tax rate," also, in violation of Article Second of the Connecticut Constitution. Id. The Departments address each challenge to the constitutionality of the Hospital User Fee below.

A. It is the Petitioners' burden to prove beyond all reasonable doubt the validity of their constitutional challenges.

Before taking up the Petitioners' constitutional challenges, it is important to note the heavy burden that falls upon the Petitioners in bringing said constitutional challenges. Statutes are presumed to be constitutional, and, in order to succeed in bringing a constitutional challenge, a party must prove beyond a reasonable doubt that the statute is unconstitutional. Adams v. Rubinow, 157 Conn. 150, 152, 251 A.2d 49, 54 (1968) ("Because of the separation of powers, one claiming that a legislative enactment is invalid on the ground that it is unconstitutional must establish its invalidity on that ground beyond a reasonable doubt."). Specifically, the Connecticut Supreme Court has stated that "[a] validly enacted statute carries with it a strong presumption of constitutionality, [and] those who challenge its constitutionality must sustain the heavy burden of proving its unconstitutionality beyond a reasonable doubt." A. Gallo v. Commissioner of Environmental Protection, 309 Conn. 810, 822, 73 A.3d 693 (2013) (internal quotation marks omitted.); see also Bottone v. Town of Westport, 209 Conn. 652, 657-58, 553 A.2d 576, 579 (1989) ("The party challenging a statute's constitutionality has a heavy burden of proof; the unconstitutionality must be proven beyond all reasonable doubt.").[40]

In order to sustain this burden, a party must demonstrate that there is no possible way to construe the challenged statute such that it does not violate the Connecticut Constitution. To that end, the Connecticut Supreme Court has stated that "where a statute reasonably admits of two

[40] See also Hardware Mut. Cas. Co. v. Premo, 153 Conn. 465, 470-72, 217 A.2d 698, 701-702 (1966) ("In the first place, because of the fundamental separation of powers, legislation cannot be stricken down by the courts on the ground of unconstitutionality unless its invalidity on that ground is proven beyond a reasonable doubt. . . . A corollary of this principle is the rule that no one has standing to attack the constitutionality of a statute unless he alleges facts which, if proven, would establish that, in its impact upon him, the legislation attacked adversely affects his constitutionally protected rights. . . . . Of course the fact that the plaintiffs originally chose to seek a declaratory judgment in nowise changes or relieves them from the burden of proof resting on them."); Wilson v. Conn. Product Dev. Corp., 167 Conn. 111, 114, 355 A.2d 72, 75 (1974) ("This court has long held that every presumption will be made in favor of the constitutionality of a legislative act. . . . Parties challenging the constitutionality of an act in a proceeding seeking declaratory relief have the burden of showing its invalidity beyond a reasonable doubt.").

constructions, one valid and the other invalid on the ground of unconstitutionality, courts should adopt the construction which will uphold the statute even though that construction may not be the most obvious one." Adams v. Rubinow, 157 Conn. 150, 153, 251 A.2d 49, 55 (1968).

Accordingly, the Petitioners are required to prove beyond a reasonable doubt that the merits of their challenges to the Hospital User Fee under Article Second of the Connecticut Constitution by demonstrating that no valid construction of the Hospital User Fee exists. However, as set forth herein, the Departments find that the Petitioners have failed to meet their burden to prove beyond a reasonable doubt that the Hospital User Fee violates the Connecticut Constitution.

B. In order to sustain a challenge to the Hospital User Fee under Article Second of the Connecticut Constitution, the Petitioners must establish beyond a reasonable doubt that the General Assembly vested DSS with powers reserved exclusively for the legislative department or, alternatively, failed to provide sufficiently precise standards for the administration of the Hospital User Fee.

The Petitioners have alleged that Hospital User Fee violates the separation of powers doctrine set forth in Article Second of the Connecticut Constitution by vesting DSS with an inherently legislative power, the power to impose a tax. R. at 5, 25. Accordingly, in order to evaluate the merits of the Petitioners' allegations, the Departments must first review the separation of powers doctrine and the scope of the powers afforded to the legislative branch and executive branch.

As referenced above, the separation of powers doctrine pertains to Article Second of the Connecticut Constitution, which sets forth the powers vested in each of the three branches of government. Specifically, Article Second of the Connecticut Constitution prescribes the scope of authority afforded to each branch of government as follows:

> The powers of government shall be divided into three distinct departments, and each of them confided to a separate magistracy, to wit, those which are legislative, to one; those which are executive, to another; and those which are judicial, to another. The legislative department may delegate regulatory authority to the executive department; except that any administrative regulation of any agency of the executive department may be disapproved by the general assembly or a committee thereof in such manner as shall by law be prescribed.

Conn. Const. art. II. Consistent with the above, the separation of powers doctrine provides that, generally, powers that are vested in each of the three departments of the state government are reserved for each said department and may not be exercised by or delegated to another department of government. See Massameno v. Statewide Grievance Comm., 234 Conn. 539, 551–52, 663 A.2d 317, 325 (1995);[41] see also Univ. of Connecticut Chapter AAUP v. Governor, 200 Conn.

[41] The Connecticut Supreme Court has stated that

> that the primary purpose of this constitutional doctrine is to prevent commingling of different powers of government in the same hands. . . . The constitution achieves this purpose by prescribing limitations and duties for each branch that are essential to each branch's independence and performance of assigned powers. . . . This court has stated: "It is axiomatic that no branch of government organized under a constitution may

386, 394-95, 512 A.2d 152, 157 (1986) ("A statute will be declared unconstitutional if it (1) confers on one branch of government the duties which belong exclusively to another branch; . . . or (2) . . . confers the duties of one branch of government on another branch which duties significantly interfere with the orderly performance of the latter's essential functions.").[42]

Accordingly, the General Assembly, as the legislative department, is both vested with the power to make laws and is prohibited from delegating its authority to make laws to any other branch of government under Article Second of the Connecticut Constitution. See State v. Stoddard, 126 Conn. 623, 627, 13 A.2d 586, 588 (1940).[43] However, the roles of the General Assembly, in making laws, and the executive branch, in executing said laws, are, by necessity, closely intertwined. See Massameno, 234 Conn. at 552. Consequently, it is widely acknowledged that the roles, powers, and functions of these departments overlap. See id. To this end, the Connecticut Supreme Court has explicitly stated that

> The separation of powers doctrine serves a dual function: it limits the exercise of power within each branch, yet ensures the independent exercise of that power. Nevertheless, it cannot be rigidly applied always to render mutually exclusive the roles of each branch of government. As we have recognized, "the great functions of government are not divided in any such way that all acts of the nature of the function of one department can never be exercised by another department; such a division is impracticable, and if carried out would result in the paralysis of government. Executive, legislative and judicial powers, of necessity overlap each other, and cover many acts which are in their nature common to more than one department." In re Application of Clark, 65 Conn. 17, 38, 31 A. 522 (1894), superseded by statute as stated in State v. Sanabria, 192 Conn. 671, 696, 474 A.2d 760 (1984).

Massameno, 234 Conn. at 552.[44] Article Second of the Connecticut Constitution explicitly acknowledges the interconnectedness of the executive and legislative departments by affirmatively

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> exercise any power that is not explicitly bestowed by that constitution or that is not essential to the exercise thereof." . . ..

Massameno v. Statewide Grievance Comm., 234 Conn. 539, 551–52, 663 A.2d 317, 325 (1995).

[42] The Petitioners have not raised a challenge to the Hospital User Fee under the theory that the Hospital User Fee "confers the duties of one branch of government on another branch which duties significantly interfere with the orderly performance of the latter's essential functions." Univ. of Connecticut Chapter AAUP, 200 Conn. at 394-95. Accordingly, the Departments do not address this issue in this Declaratory Ruling.

[43] State v. Stoddard, 126 Conn. 623, 627, 13 A.2d 586, 588 (1940) ("The Constitution of this state provides for the separation of the governmental functions into three basic departments, legislative, executive and judicial, and it is inherent in this separation, since the lawmaking function is vested exclusively in the legislative department, that the Legislature cannot delegate the lawmaking power to any other department or agency. In the establishment of three distinct departments of government the Constitution, by necessary implication, prescribes those limitations and imposes those duties which are essential to the independence of each and to the performance by each of the powers of which it is made the depositary.").

[44] See also Univ. of Connecticut Chapter AAUP v. Governor, 200 Conn. 386, 394, 512 A.2d 152, 157 (1986) ("We have held, however, that the separation of powers doctrine cannot always be rigidly applied. . . .; we held that there are activities in which more than one branch of government may participate. 'Executive, legislative, and judicial powers, of necessity overlap each other, and cover many acts which are in their nature common to more than one department. These great functions of government are committed to the different magistracies in all their fullness, and

asserting that the Connecticut General Assembly, as the legislative branch, can delegate certain regulatory authority to the executive branch. See Conn. Const. art. II ("The legislative department may delegate regulatory authority to the executive department; except that any administrative regulation of any agency of the executive department may be disapproved by the general assembly or a committee thereof in such manner as shall by law be prescribed.").

The scope of General Assembly's authority to delegate regulatory authority to the executive branch is well-defined. To that end, the Connecticut Supreme Court has held

> [a] Legislature, in creating a law complete in itself and designed to accomplish a particular purpose, may expressly authorize an administrative agency to fill up the details by prescribing rules and regulations for the operation and enforcement of the law. In order to render admissible such delegation of legislative power, however, **it is necessary that the statute declare a legislative policy, establish primary standards for carrying it out, or lay down an intelligible principle to which the administrative officer or body must conform, with a proper regard for the protection of the public interests and with such degree of certainty as the nature of the case permits, and enjoin a procedure under which, by appeal or otherwise, both public interests and private rights shall have due consideration**. . . . If the Legislature fails to prescribe with reasonable clarity the limits of the power delegated or if those limits are too broad, its attempt to delegate is a nullity.

State v. Stoddard, 126 Conn. 623, 628, 13 A.2d 586, 588 (1940) (citations omitted) (emphasis supplied). As such, in order to be considered a permissible delegation of authority, the General Assembly is required to set forth sufficiently precise standards for the executive branch to follow.

In sum, the General Assembly would violate Article Second of the Connecticut Constitution in enacting a law if said law confers upon the executive or judicial branch the authority to impose a law or if the law delegates regulatory authority to the executive branch, but fails to contain sufficiently precise standards. In the present matter, the Petitioners have alleged that the Hospital User Fee violates Article Second of the Connecticut Constitution in both ways, by: (1) conferring upon the executive branch power reserved for the legislative branch and (2) lacking sufficiently precise standards for DSS to follow in administering said User Fee.

Accordingly, consistent with the above-described principles of law, in order to raise successful challenges to the Hospital User Fee under Article Second of the Connecticut Constitution, the Petitioners must demonstrate beyond a reasonable doubt that the scope of authority the General Assembly delegated to DSS exceeded what is permissible for the General Assembly to delegate or that the General Assembly failed to provide sufficiently precise standards for the administration of the Hospital User Fee. As described more fully below, the Departments find that the Petitioners have failed to demonstrate either that the Hospital User Fee contains an impermissible delegation of authority or lacks sufficiently precise standards for the administration of the User Fee.

involve many incidental powers necessary to their execution, even though such incidental powers in their intrinsic character belong more naturally to a different department.'").

C. The Petitioners have failed to prove beyond a reasonable doubt that, through the Hospital User Fee, the General Assembly conferred upon the DSS duties which belong exclusively to the legislative branch of government.

As set forth above, in the first of the Petitioners' two challenges to the Hospital User Fee under Article Second of the Connecticut Constitution, the Petitioners allege that the General Assembly has unconstitutionally "cede[d] and delegate[d] an inherently legislative function to an administrative agency to determine the applicable tax rate and base year." R. at 5, 25. Essentially, the Petitioners allege that the Hospital User Fee does not contain the necessary elements of a tax law, but rather confers upon DSS the authority to determine these elements, namely the tax rate and base year. The Departments find that the Hospital User Fee contains all elements necessary for the imposition of a tax and, as such, does not confer upon DSS duties exclusively reserved for the General Assembly.

As noted above, the power to impose a tax is an inherently legislative function,[45] whereas the executive branch is charged with the administration of a tax.[46] As such, the Departments must determine whether the Hospital User Fee confers upon DSS the power to impose or the power to simply carry out the administration of said Fee. The United States Supreme Court's articulation of the distinction between making a law and executing a law is instructive in considering this inquiry:

> 'The true distinction, therefore, is, between the delegation of power to make the law, which necessarily involves a discretion as to what it shall be, and conferring an authority or discretion as to its execution, to be exercised under and in pursuance of the law. The first cannot be done; to the latter no valid objection can be made.'

J.W. Hampton, Jr., & Co. v. United States, 276 U.S. 394, 407, 48 S. Ct. 348, 351 (1928). Consistent therewith, the Departments must first determine whether, under the Hospital User Fee, DSS has the power to determine what the Hospital User Fee would be or is simply charged with calculating the user fee that the General Assembly has imposed. The first step of this analysis lies with defining the essential elements of a tax law and determining whether the General Assembly delegated to DSS the authority to determine said components in connection with the Hospital User Fee.

The Connecticut Supreme Court has held that, in order for a tax law to be considered "a law complete in itself," said law must include the following:

> As long as revenue legislation sets out with specificity the **rate of the tax, the instances where it is to be imposed and those who will be liable to pay it, there is no impermissible delegation of legislative power merely because the details of regulation**

[45] See Kellems v. Brown, 163 Conn. 478, 488, 313 A.2d 53, 59 (1972) ("The taxing power is an inherent attribute of sovereignty, and as such unlimited in character and scope, save as limitations may be self-imposed. Under our form of government its exercise is vested in the legislative department which may exercise it for lawful purposes in its discretion both as regards the choice of subject-matter of taxation and the extent and manner of the tax, save as constitutional limitations may intervene, and in the case of the states, save also as the property and agencies of the national government within their borders are not within the reach of their sovereignty.").

[46] Conn. Const. art. IV § 12 ("[The Governor] shall take care that the laws are faithfully executed.").

> **and enforcement are left to administrative action**. The plaintiffs have not established that the act unconstitutionally delegates to the tax commissioner any of the legislative powers of the General Assembly or that the standards the act prescribes for the exercise of the administrative and enforcement powers granted to the commission are not precise enough to serve as a 'sufficient guide for the exercise of the discretion' which he must exercise.

Kellems v. Brown, 163 Conn. 478, 498-501, 313 A.2d 53, 64-65 (1972) (emphasis added). Stated simply, a tax law must include three components: a rate, a tax base, and the taxpayers upon which the tax is levied.

The Connecticut Supreme Court has also defined the scope of permissible delegation regarding a tax law:

> [t]here is a clear distinction between the legislative function of defining and imposing a tax, which function is nondelegable, and the ministerial and administrative procedures to be followed in the assessment and collection of the tax. . . . **The power granted to an administrative board or official may include, but is not limited to, the establishment of filing requirements, the hearing of administrative appeals, the finding of facts, and the determination of when as opposed to how and to what extent a tax may be imposed**. . . . In the comprehensive and complex area of taxation of income, it is neither uncommon nor unwise for a legislature to defer to the expertise of an official or group of officials in the areas of regulations and administration. . . . The legislature cannot delegate its power to make a law, but it **can make a law to delegate a power to determine some fact or state of things upon which the law makes, or intends to make, its own action depend**. To deny this would be to stop the wheels of government. There are many things upon which wise and useful legislation must depend which cannot be known to the law-making power, and must therefore be a subject of inquiry and determination outside of the halls of legislation.' . . .

Kellems v. Brown, 163 Conn. 478, 498-501, 313 A.2d 53, 64-65 (1972) (emphasis supplied). The above-quoted statement aptly illustrates one of the most basic tenets of the separation of powers doctrine that, while the legislative branch may impose a tax, it is the executive branch of government, typically DRS, that is charged with calculating the amount of tax due from individual taxpayers. To that end, as is evidenced by the above-quoted statement, the Connecticut Supreme Court has found it appropriate for the General Assembly to delegate to the executive branch those tasks necessary for the performance of such calculations including developing tax returns, finding of facts related to a taxpayer's tax liability, the issuance of assessments, and the holding of administrative hearings and appeals.[47]

[47] Connecticut's tax code contains numerous examples of circumstances under which the Commissioner of Revenue Services is charged with calculating the amount of tax due from taxpayers including: (1) creating tax returns, (2) examining those tax returns filed with the Commissioner, (3) determining whether the amount of tax reflected on said returns is accurate, (4) issuing assessments and refunds of tax underpaid and overpaid, and (5) reviewing taxpayers' administrative protests of assessments and disallowances of claims for refund. See, e.g., Conn. Gen. Stat. §§ 12-205 (". . . on forms prescribed or furnished by the Commissioner of Revenue Services . . .."); 12-204 ("The commissioner shall . . . examine [the return] and, in the case any error is disclosed by such examination, shall, . . ., notify the taxpayer

As set forth more fully below, the Departments find that the Hospital User Fee contains all three necessary elements of a tax law. Moreover, the Departments find that the actions taken by DSS in implementing and administering the Hospital User Fee are ministerial in nature as they relate simply to calculating the appropriate amount of fee due and, as such, were properly performed by DSS.

i. The Departments find that the General Assembly did not delegate authority to set the tax rate of the Hospital User Fee to DSS.

As set forth above, the Petitioners' chief attack on the Hospital User Fee under Article Second of the Connecticut Constitution is that the General Assembly delegated authority to set a tax rate to DSS. R. at 5, 25. Stated another way, the issue presented is whether DSS, in calculating the amount of Hospital User Fee due from the hospitals, exercised the inherently legislative function of setting a tax rate. As described more fully below, the Departments find that the Petitioners' attack is predicated on a fundamental misunderstanding of what a tax rate is. The Petitioners appear to be under the mistaken belief that a tax rate must be a percentage and that the act of calculating the amount of tax due from a taxpayer using a formula set forth in statute is the same as setting a tax rate. Neither position is accurate. Rather, a tax rate can be a formula and the act of calculating the amount of tax due is a ministerial action that is not the equivalent of setting a tax rate. Accordingly, the Departments find that the General Assembly did not delegate authority to set the tax rate of the Hospital User Fee to DSS.

It is well-established that a tax rate can take many forms – from a simple percentage set forth in statute, see, e.g., Conn. Gen. Stat. § 12-202,[48] to a complex equation, see, e.g., Conn. Gen. Stat. § 12-211.[49] Given that the majority of federal and state taxes are not as simple as multiplying one

and State Comptroller thereof. . .."); 12-208 ("The commissioner shall promptly consider each such application and may grant or deny the hearing requested.").

[48] Conn. Gen. Stat. § 12-202 governs the insurance premiums tax imposed upon domestic insurance companies. Said statute provides, in pertinent part, that "[t]he rate of tax on all net direct insurance premiums received on and after January 1, 1995, shall be one and three-quarters per cent." Conn. Gen. Stat. § 12-202.

[49] Conn. Gen. Stat. § 12-211 governs the retaliatory tax imposed upon foreign insurance companies doing business in Connecticut. Said statute provides, in pertinent part, that

> When by the laws of any other state or foreign country any premium or income or other taxes or any fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions are imposed upon Connecticut insurance companies doing business in such other state or foreign country, or upon the authorized agents thereof, which are in excess of such taxes, fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions directly imposed upon insurance companies, or upon the authorized agents thereof, of such other state or foreign country doing business in Connecticut, as long as such laws continue in force the same obligations, prohibitions and restrictions of whatever kind, computed by the Commissioner of Revenue Services on an aggregate state-wide or foreign-country-wide basis, shall be imposed upon insurance companies and authorized agents thereof of such other state or foreign country doing business in Connecticut.

Conn. Gen. Stat. § 12-211. As evidenced by the language of the statute, the retaliatory tax is computed by the Commissioner of Revenue Services, using a complex formula which, in simple terms, provides that the retaliatory tax on a foreign insurance company will be the difference between taxes Connecticut imposes on insurance companies and the taxes imposed on Connecticut insurance companies by the foreign insurance companies' domicile. No specific

type of income by one set percentage, the state and federal tax codes are riddled with complicated equations designed to tax different types of income and different amounts of income at variable rates. See, e.g., Conn. Gen. Stat. §§ 12-458h and 12-700a;[50] see also Skinner v. Mid-Am. Pipeline Co., 490 U.S. 212, 214, 109 S. Ct. 1726, 1732, 104 L. Ed. 2d 250 (1989).[51] As such, it is well-established in both federal and state law that in setting forth a tax, the legislature need not set forth a specific percentage, but might, out of necessity, set forth an equation or formula as a tax rate. Michigan Cent. R. Co. v. Powers, 201 U.S. 245, 293-94, 26 S. Ct. 459, 462, 50 L. Ed. 744 (1906).

Over one hundred years ago, in the matter of Michigan Central Railroad Company v. Powers, the United States Supreme Court settled the matter as to whether a tax must include a specific percentage. Specifically, in that matter, the United States Supreme Court discussed whether a Michigan tax on railroads violated the federal and state Constitutions. Id. at 291-94. The United States Supreme Court described the tax at issue as follows:

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percentage is set forth in statute – rather the "rate" of the retaliatory tax is an equation dependent upon specific variables unique to each individual taxpayer.

[50] Conn. Gen. Stat. § 12-700a is commonly referred to as the Connecticut Alternative Minimum Tax. Stated simply, the Connecticut Alternative Minimum Tax is a tax imposed on certain individuals, estates, and trusts in addition to the regular Connecticut income tax. The calculation of said tax, however, is far from simple. To this end, Conn. Gen. Stat. § 12-700a, provides as follows:

> Every resident individual, as defined in section 12-701, subject to and required to pay the federal alternative minimum tax under Section 55 of the Internal Revenue Code shall pay, in addition to the tax imposed under section 12-700, the net Connecticut minimum tax. The tax shall be the difference computed by subtracting the tax imposed under subsection (a) of section 12-700 from the Connecticut minimum tax, as provided in subdivision (26) of subsection (a) of section 12-701. The provisions of this subsection shall apply to resident trusts and estates, as defined in said section 12-701, and, wherever reference is made in this section to resident individuals, such reference shall be construed to include resident trusts and estates, provided any reference to a resident individual's Connecticut adjusted gross income shall be construed, in the case of a resident trust or estate, to mean the resident trust or estate's Connecticut taxable income.

Conn. Gen. Stat. § 12-700a(a). (Subsection (a) of 12-700a applies to resident individuals. The Departments note that subsections (b) and (c) of 12-700a contain similarly complex formulas for determining alternative minimum tax liability for nonresidents and part-year residents.) Based on the above, an individual who is subject to the federal alternative minimum tax under Section 55 of the Internal Revenue Code must pay the "net Connecticut minimum tax," which is defined as the amount by which the Connecticut minimum tax exceeds the basic personal income tax. In order to calculate the Connecticut Alternative Minimum Tax, one must navigate through lengthy definitions and the complex equations set forth therein. See Conn. Gen. Stat. § 12-701(a)(23) ("federal tentative minimum tax"), (24) ("adjusted federal tentative minimum tax"), (25) ("net Connecticut minimum tax"), (26) ("Connecticut minimum tax"), (27) ("adjusted net Connecticut minimum tax"), (29) ("federal alternative minimum taxable income"), and (30) ("adjusted federal alternative minimum taxable income").

[51] Skinner v. Mid-Am. Pipeline Co., 490 U.S. 212, 214, 109 S. Ct. 1726, 1732, 104 L. Ed. 2d 250 (1989) ("From its earliest days to the present, Congress, when enacting tax legislation, has varied the degree of specificity and the consequent degree of discretionary authority delegated to the Executive in such enactments. See, e.g., Act of Mar. 3, 1791, ch. 15, § 43, 1 Stat. 209 (in the case of fines assessed for nonpayment of liquor taxes, "the secretary of the treasury of the United States [has] ... power to mitigate or remit such penalty or forfeiture ... upon such terms and conditions as shall appear to him reasonable") (First Congress); Act of July 6, 1797, ch. 11, § 2, 1 Stat. 528 (in lieu of collecting stamp duty enacted by Congress, the Secretary of the Treasury may "agree to an annual composition for the amount of such stamp duty, with any of the said banks, of one per centum on the amount of the annual dividend made by such banks") (Fifth Congress). See generally Field v. Clark, 143 U.S. 649, 683–689, 12 S.Ct. 495, 501–504, 36 L.Ed. 294 (1892) (longstanding practice of Congress delegating authority to the President under the Taxing Clause "is entitled to great weight").")

> . . . the rate of taxation imposed upon the railroad and other corporate property is the average rate of taxation upon other property subject to ad valorem taxes, and that average rate is ascertained by dividing the total tax levy on all such property by the value of the property.

Id. at 291. Essentially, under Michigan's railroad tax, the tax rate was not a specific percentage, but rather the executive branch was required to derive the rate by determining the average rate of tax paid on other property subject to ad valorem taxes. See id. at 292 ("'A fair reading of this language of the statute, we think, leads to the conclusion that the board of assessors has imposed upon it the duty, ministerial in character, of determining by a computation from data, which the law provides for placing in its hands, the rate of taxation which other property in the state is subjected to, as it appears by assessment rolls which are supposed to contain an accurate and true assessment of all property at its full cash value.'").

The United States Supreme Court examined the issue of whether the inclusion of a formula as the tax rate, instead of a set percentage, constituted an unconstitutional delegation of authority:

> The first and principal matter of attack is the 'average rate.' It is contended that the fixing of the rate of taxation is a legislative function; that in ascertaining the average rate by the method described there is no exercise of the legislative judgment, but that it is determined by the action of the various local assessing and taxing boards, who, though charged with no duty of inquiry as to the necessities of the state or the proper rate of taxation of railroad property, are in fact the only officials exercising any discretion and judgment.

Id. at 293-94.[52] The United States Supreme Court determined that this "attack" levied upon Michigan's railroad tax was not valid. Stated another way, the United States Supreme Court determined that the act of calculating the percentage of the tax using a formula was not the equivalent of setting a tax rate. Rather, the tax rate was the formula, and the calculation of the percentage was simply a ministerial function.

Specifically, the United States Supreme Court found as follows:

> . . . in the case at bar there is no abandonment by the legislature of its functions in respect to taxation. **The statute prescribes, as the rate of taxation upon railroad property, the average rate of taxation on all other property subject to ad valorem taxes**. It provides the most direct way for ascertaining such average rate,-deducing it from a consideration of all the other rates. **No authority is given to the local assessors to apply their judgment to the question of the railroad rate**. Their authority in respect to the matter of taxation is precisely the same as it was before and independently of this statute. Their duty is to act according to their judgments in respect to local taxes committed to their charge. When they

[52] Said Court also raised the question as to whether such a delegation would violate federal law as well as state law. See id. at 294 ("There might be a question whether, even if there were a clear delegation of legislative functions to other departments of the state government, it would be void under the Federal Constitution."). The United States Supreme Court did not provide an answer to this issue, because it determined that the subject tax did not delegate authority to the executive branch. Id.

> have finished their action, taken, as it must be assumed to have been, in conscientious discharge of the duties assigned, from it, by a simple mathematical calculation, the average rate of taxation is determined. If the legislature should be convened after they have finished their action and then prescribe the average rate thus mathematically deduced as the rate of railroad taxation, no question could be made of its validity. It would be obviously a legislative determination of the rate of taxation. **Is it any the less a legislative determination that it assumes that the various local officials will discharge their duties honestly and fairly, with reference to local necessities, and independently of the effect upon the railroad rate, and directs that the mathematical computation be made by a board of ministerial officers, and, thus made, shall become the railroad rate of taxation?** Why is it necessary that the legislature be convened to add its formal approval of the integrity of the action of the local officers? **May it not intrust the mathematical computation to the state board of assessors, and if so, may it not likewise act upon the assumption that the local assessors will discharge their duties with an eye single to those duties, and irrespective of the effect upon the railroad rate?**

Id. at 294-95 (emphasis supplied). As evidenced by the above-quoted decision, the United States Supreme Court found that a tax rate may be an equation or formula set forth in statute rather than a precise rate. Id. at 294 ("The statute prescribes, as the rate of taxation upon railroad property, the average rate of taxation on all other property subject to ad valorem taxes."). Entrusting an administrative agency to perform mathematical computations to derive a percentage for the tax does not constitute delegation of the authority to set the tax rate, but is simply the executive branch ensuring that the laws are faithfully executed.[53]

[53] Similarly, Connecticut's courts have long recognized that the executive branch's act of calculating the amount of a fee due from a taxpayer does not constitute the exercise of the "taxing" power. In 1944, the Court of Common Pleas considered whether an assessment made against a milk dealer under Connecticut's Milk Marketing Act contained an unconstitutional delegation of authority. Hammerberg v. Farmers Co-op., 12 Conn. Supp. 465, 466 (Com. Pl. 1944). The assessment at issue was levied upon the taxpayer, a milk dealer, as follows:

> a producer-dealer, who during any month receives or purchases less than two thousand five hundred quarts of milk from producers, shall pay to the administrator an amount for expenses reasonably incurred by the administrator in administering such order, but such amount shall not exceed two cents per hundred pounds of milk received or purchased from producers.

Id. at 466 (Com. Pl. 1944). Essentially, each milk dealer was required to pay the state an amount calculated by the administrator to cover the administrator's expenses. The statute provided a maximum amount for the fee. The money collected was used to fund expenses incurred under the Milk Marketing Act. The milk dealer did not pay the assessment, and the administrator brought suit to enforce the assessment. The milk dealer alleged that

> Section 338f(c) (7) of the 1941 Supplement of the General Statutes constitutes an allegal delegation of the legislative power of the General Assembly to an administrative official in that it gives to the plaintiff administrator uncontrolled power to levy a tax according to his unregulated discretion and thus violates the Connecticut Constitution Article 2nd and Article 3rd, section 1 and the Constitution of the United States, Amendment 14.

Id. at 467. Applying the principles set forth in State v. Stoddard, the Court found as follows:

> A state legislature has the power to require persons under regulation to contribute to the payment of administrative expenses as a reasonable and appropriate means for the accomplishment of the purposes of a regulatory statute. . . . This exaction from those who are regulated is not to be regarded strictly as an exercise

Consistent therewith, Connecticut's tax code is littered with examples of circumstances under which the tax rate is a formula and DRS is charged with performing similar computations to those referenced above in Michigan Central Railroad Company v. Powers. See Conn. Gen. Stat. §§ 12-211, 12-458h, and 12-700a.[54] One such example is set forth in footnote 49 above, which describes

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> of the taxing power, but rather a regulatory assessment incidental to the purposes of the legislative regulation. . . .
>
> The defendant's demurrer attacks section 338f(c) (7) claiming that it gives the plaintiff administrator "uncontrolled power to levy a tax according to his unregulated discretion." The Legislature has designated the persons who may be required to pay as those who are "subject to an order" issued by the Administrator pursuant to authority specifically granted in detail by the Act. Certain dealers handling less than a named fixed quantity of milk are designated as exempt. The Administrator is limited to an assessment "for expenses reasonably incurred by the administrator in administering such order"; and the Legislature has further controlled the amount which may be assessed by providing that it "shall not exceed two cents per hundred pounds of milk received or purchased from producers" which sum may be divided equally between dealer and producer. In other words, the Legislature has authorized an assessment of two cents per hundredweight provided that if the reasonable expense of administration is less, then the assessment must be less. The complaint alleges an assessment of two cents per hundredweight. Whether the "reasonable expenses" of administration justify an assessment equal to the limit prescribed by the Legislature, or the prescribed limits are too broad, present questions to be determined on an issue of fact. In discussing the validity of regulations made by an administrative authority the Supreme Court said in H. Duys & Co., Inc. v. Tone, 125 Conn. 300, 312: "The Legislature having by its enactments declared policies and fixed primary standards, may validly confer on administrative officers power to 'fill up the details' by prescribing rules and regulations to promote the spirit and purpose of the legislation and its complete operation."

Id. at 467–70. As evidenced by the above-quotation, the Court of Common Pleas found that (1) a fee need not have a specific percentage and (2) the act of calculating an assessment is not the same as imposing a tax.

[54] One such example is set forth in Conn. Gen. Stat. § 12-458h, wherein the Commissioner of Revenue Services is specifically charged with calculating the motor vehicle fuels tax rate applicable to the sale or use of diesel fuel on annual basis. See Conn. Gen. Stat. § 12-458h. Conn. Gen. Stat. § 12-458h(a)(1) provides as follows:

> ***The Commissioner of Revenue Services shall, on or before June 15, 2008, and on or before the fifteenth day of June thereafter, calculate, in accordance with subsection (b) of this section, the applicable tax rate per gallon of diesel fuel on the sale or use of such fuel during the twelve-month period beginning on the next succeeding July first***, and shall notify each distributor, the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to finance, revenue and bonding, and the Secretary of the Office of Policy and Management of such applicable tax rate.

Conn. Gen. Stat. § 12-458h(a)(1) (emphasis supplied). Upon review of the above-quoted language, it is clear that the General Assembly did not provide the Commissioner of Revenue Services with a set percentage applicable to the sale of diesel. To the contrary, the General Assembly specifically directs that the Commissioner of Revenue Services calculate the applicable percentage in accordance with the provisions of subsection (b) of Conn. Gen. Stat. § 12-458h. As explained below, subsection (b) of Conn. Gen. Stat. § 12-458h provides the Commissioner of Revenue Services with the following formula for calculating the tax rate for diesel:

> (1) The applicable tax rate per gallon of diesel fuel shall be the sum of (A) the fixed rate per gallon, as defined in this subdivision, and (B) the product calculated in accordance with subdivision (2) of this subsection. The sum shall be rounded to the nearest one-tenth of a cent. For purposes of this subdivision, "the fixed rate per gallon" on the sale or use of diesel fuel during the twelve-month period beginning on the first day of July in 2008, 2009 and 2010 is twenty-six cents, and on the sale or use of diesel fuel during the twelve-month period beginning on the first day of July in 2011, and each year thereafter, is twenty-nine cents.

Connecticut's retaliatory tax imposed against foreign insurance companies operating in Connecticut. Specifically, Conn. Gen. Stat. § 12-211 provides that

> When by the laws of any other state or foreign country any premium or income or other taxes or any fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions are imposed upon Connecticut insurance companies doing business in such other state or foreign country, or upon the authorized agents thereof, which are in excess of such taxes, fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions directly imposed upon insurance companies, or upon the authorized agents thereof, of such other state or foreign country doing business in Connecticut, as long as such laws continue in force the same obligations, prohibitions and restrictions of whatever kind, computed by the Commissioner of Revenue Services on an aggregate state-wide or foreign-country-wide basis, shall be imposed upon insurance companies and authorized agents thereof of such other state or foreign country doing business in Connecticut.

> (2) The commissioner shall multiply (A) the average wholesale price per gallon of diesel fuel, as determined in accordance with subdivision (2) of subsection (a) of this section, by (B) the tax rate specified in subdivision (1) of subsection (b) of section 12-587. The tax rate so specified shall be the tax rate in effect for the twelve-month period beginning on the next succeeding July first.

Thus, like the Hospital User Fee, Conn. Gen. Stat. § 12-458h contains no set percentage. Rather, like the Hospital User Fee, Conn. Gen. Stat. § 12-458h provides the Commissioner of Revenue Services with the formula to calculate said percentage. As such, as the Commissioner of Social Services did for purposes of the Hospital User Fee, the Commissioner of Revenue Services simply calculates the amount of tax due from the sale or use of diesel using the formulaic rate set forth in Conn. Gen. Stat. § 12-458h.

Another provision in the state's Tax Code wherein a tax rate is set forth in the form of a formula as opposed to a specific percentage can be found in the state's Income Tax. The specific provision is Conn. Gen. Stat. § 12-700a. Conn. Gen. Stat. § 12-700a is commonly referred to as the Connecticut Alternative Minimum Tax. Stated simply, the Connecticut Alternative Minimum Tax is a tax imposed on certain individuals, estates, and trusts in addition to the regular Connecticut income tax. The formula to calculate said tax, however, is far from simple. To this end, Conn. Gen. Stat. § 12-700a, in part, provides as follows:

> Every resident individual, as defined in section 12-701, subject to and required to pay the federal alternative minimum tax under Section 55 of the Internal Revenue Code shall pay, in addition to the tax imposed under section 12-700, the net Connecticut minimum tax. The tax shall be the difference computed by subtracting the tax imposed under subsection (a) of section 12-700 from the Connecticut minimum tax, as provided in subdivision (26) of subsection (a) of section 12-701. The provisions of this subsection shall apply to resident trusts and estates, as defined in said section 12-701, and, wherever reference is made in this section to resident individuals, such reference shall be construed to include resident trusts and estates, provided any reference to a resident individual's Connecticut adjusted gross income shall be construed, in the case of a resident trust or estate, to mean the resident trust or estate's Connecticut taxable income.

Conn. Gen. Stat. § 12-700a(a). Upon review of the above-quoted language, it is clear that the General Assembly provided the Commissioner of Revenue Services with a complicated formula that must be followed in order to determine the amount of tax that is owed on such income. Like Connecticut's retaliatory tax discussed herein, the Connecticut General Assembly defined the different variables that make up the formula for determining the Connecticut Alternative Minimum Tax. The amount of Connecticut Alternative Minimum Tax that is owed is determined using an equation that is dependent upon these specific variables unique to each individual taxpayer.

Conn. Gen. Stat. § 12-211. As is readily apparent from the language above, the retaliatory tax contains no set percentage. Instead, the tax rate is a formula. The General Assembly defines the different variables that make up the formula, which formula is, in simple terms, the difference between taxes Connecticut imposes on insurance companies and the taxes imposed on Connecticut insurance companies by the foreign insurance companies' domicile. The "rate" of the retaliatory tax is an equation dependent upon specific variables unique to each individual taxpayer. Retaliatory taxes such as Connecticut's have long withstood constitutional challenges.[55]

Given the above, the Departments find that a tax rate need not be a specific percentage, but rather may also be a formula or methodology for calculating the tax rate and tax amount. Consistent therewith, the actions taken by an administrative agency in calculating the amount of tax due under a formula do not constitute exercising the legislative power of imposing a tax. Rather, said actions are ministerial in nature and properly performed by an executive branch agency.

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[55] See, Metro. Life Ins. Co. v. Ins. Comm'r of State of Md., 58 Md. App. 457, 473, 473 A.2d 933, 941–42 (1984) (emphasis supplied) ("Metropolitan acknowledges the tendency reflected in Pressman v. Barnes and Governor v. Exxon Corp. to allow greater latitude in legislative delegation, a tendency which Davis suggests is nationwide among State courts (Administrative Law Treatise, supra, § 3:14), but argues that such liberality is confined to regulatory statutes and does not apply to tax laws. We find neither authority nor justification for such a distinction. The Supreme Court expressly rejected that kind of argument in Hampton & Co. v. United States, supra, 276 U.S. at 409, 48 S.Ct. at 352, and for good reason. The complex and varying fact patterns that justify administrative flexibility in implementing regulatory statutes are also a problem in the enforcement of tax laws, as witness the myriad of regulations and administrative rulings by the Internal Revenue Service and, in Maryland, by the Comptroller of the Treasury. See COMAR, Title 03.Upon this authority, we find neither an unconstitutional vagueness nor an improper delegation in § 61(1). The Legislature has told the Insurance Commissioner to regard local taxes as though they were imposed by the State, and, as twenty-six other State legislatures have done, has left it to him to determine the most appropriate method of doing so. **That is not, in our judgment, a delegation of the power to make law, but rather the authority to implement and enforce the expressed legislative will**."); see also Gallagher v. Motors Ins. Corp., 605 So. 2d 62, 71 (Fla. 1992)

Additionally, in various contexts in which a tax statute sets forth a methodology for calculating the rate (rather than an explicit numerical rate percentage), other states' Supreme Courts have routinely found no delegation of authority to have occurred. See Wesley Med. Ctr. v. McCain, 226 Kan. 263, 271-72, 597 P.2d 1088, 1095 (1979) (emphasis supplied) ("We can not imagine a more detailed guideline for administering a law than that provided in K.S.A. 1975 Supp. 44-710a. **The administrative agency was delegated only the task of computing the tax rate pursuant to the legislative formula**. We see nothing in the "array method" of computation involving administrative discretion which could be called whim or caprice. We are of the opinion the legislature did not delegate legislative authority to the Department of Human Resources in violation of the constitution."); Anderson v. Tiemann, 182 Neb. 393, 402, 155 N.W.2d 322, 329 (1967) (emphasis supplied) ("The plaintiff's contentions with respect to unconstitutional delegation of legislative power extend also to the provisions of L.B. 377 which require the State Board of Equalization and Assessment to set the rate of tax on or before November 15 of each year for the taxable year beginning during the subsequent calendar year. **Section 15 of L.B. 377, in at least five subsections, explicitly sets out the computations to be made by the state board, the method and manner in which the computations shall be adjusted and determined, and the specific standards to be used in setting the rate of tax**. The discussion as to delegation of legislative authority to the Tax Commissioner and the rules set out above also apply with respect to the delegation of authority to the State Board of Equalization and Assessment. **L.B. 377 constitutes a valid and lawful delegation of authority to the State Board of Equalization and Assessment and does not violate the Constitution of Nebraska nor of the United States.**").

In the present matter, the Petitioners have alleged that the Hospital User Fee does not contain a tax rate, but rather confers upon DSS the authority to set the rate. Through the specified proceedings undertaken in connection with the Petitions, the Departments have taken evidence and found facts regarding the enactment and implementation of the Hospital User Fee. Consistent with this evidence, and a review of Conn. Gen. Stat. §§ 12-263a and 12-263b and the legislative history associated therewith, the Departments hold that the General Assembly did not confer upon DSS the authority to set a tax rate. Rather, it is clear from the language of the statute, the General Assembly's codified statement of intent, and the actions undertaken by DSS in implementing the Hospital User Fee that DSS was not charged with setting the tax rate, but rather simply calculated the amount of tax due from each taxpayer using the formulaic rate set forth by the General Assembly. Specifically, the formula includes Conn. Gen. Stat. §§ 12-263a and 12-263b, the state budget adopted by the General Assembly, and the federal statutes and regulations incorporated by reference into the state statutes.

a. The components of the formula that dictates the tax rate of the Hospital User Fee are set forth in state statute, codified revenue estimates, and federal Medicaid law.

As set forth more fully in the Facts explicated above, the General Assembly charged DSS, in consultation with OPM, with calculating the user fee that each hospital would have to pay in order to achieve the revenue set forth in the revised revenue estimates. To that end, Conn. Gen. Stat. § 12-263a provides, in pertinent part, that:

> (a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. **The rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly. Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed in order to ensure conformance with the state budget adopted by the General Assembly. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship**. Effective July 1, 2012, and for the succeeding fifteen months, the rates of such tax, the base year on which such tax shall be assessed, and the hospitals exempt from the outpatient portion of the tax based on financial hardship shall be the same tax rates, base year and outpatient exemption for hardship in effect on January 1, 2012.
>
> (b) Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue as determined by the Commissioner of Social Services. Payment shall be made with such return. Each hospital shall file such return electronically with the

> department and make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether the hospital would otherwise have been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

Conn. Gen. Stat. § 12-263b, as amended by 2016 Conn. Pub. Acts 3, May spec. sess., § 120 (emphasis supplied). As evidenced by the above-quoted statute, the General Assembly set forth the following variables in said calculation in statute: (1) the taxpayers subject to the Hospital User Fee, (2) the taxpayers exempt from the Hospital User Fee, and (3) the tax base upon which the Hospital User Fee was to be calculated. Additionally, the statute incorporated by reference all of the federal Medicaid requirements set forth above by mandating that the fee comply with federal law, which requirements include a maximum amount that the tax can be.

As also set forth more fully above, not all of the components of the Hospital User Fee were set forth in Conn. Gen. Stat. § 12-263b. Rather, as the legislative history demonstrates, what was set forth in Conn. Gen. Stat. § 12-263b was "a system wherein [the General Assembly] can move forward with the tax program." Connecticut Senate Transcript, 5/24/2011; see also 2016 Conn. Pub. Acts 3, May spec. sess., § 119.[56] The General Assembly provided DSS with the final variable of the Hospital User Fee, the amount that the Hospital User Fee was required to generate, by codifying revenue estimates and revising said estimates in accordance with Conn. Gen. Stat. § 2-35. Specifically, through codification of the revenue estimates in 2011, the General Assembly charged DSS with calculating the Hospital User Fee to raise a total of $349.1 million in revenue annually for SFY 2012 and 2013. See R. at 581-82; OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part II, Summary & Schedules, at 58. This amount of revenue that needed to be collected from the Hospital User Fee remained unchanged in the state budget and revenue estimates for SFY 2014 and 2015. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. The General Assembly revised this variable in 2015 to reflect that the Hospital User Fee was required to raise a total of $556 million in revenue annually for SFY 2016 and 2017. In both cases, DSS needed to calculate the details of the tax by solving for the variables in the formula after starting with the total amount of tax that needed to be collected. See 2015 Conn. Pub. Acts 244, § 56; 2015 Conn. Pub. Acts 5, June spec. sess., § 496; OFA, Connecticut State Budget, FY 16 & FY 17 Budget, at 483.

Given the above, the Departments find that state statute, codified revenue estimates, and federal Medicaid law define a formula that dictates the rate of the Hospital User Fee.

[56] In section 119 of Public Act 16-3, the General Assembly codified its intent in enacting the Hospital User Fee. Specifically, section 119 provides, in pertinent part that "the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was that on and after July 1, 2011, **the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget**, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis." 2016 Conn. Pub. Acts 3 § 119 (May Spec. Sess.) (emphasis supplied).

b. The General Assembly has clarified that the Hospital User Fee contains a rate, which is a formula set forth in state statute, codified revenue estimates, and federal Medicaid law.

The General Assembly codified a statement of intent regarding the Hospital User Fee through the enactment of sections 119 through 121 of Public Act 16-3 of the May Special Session. Specifically, the General Assembly stated that

> Consistent with section 12-263b of the general statutes, as amended by this act, the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was that on and after July 1, 2011, the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis. In said public acts, the General Assembly charged the Commissioner of Social Services, in consultation with the Office of Policy and Management, with calculating the amount of tax due from each hospital within the limitations and requirements set forth in subsection (w) of 42 USC 1396b, including determining the base year for the tax, in order to obtain the funds set forth by the General Assembly in the state budget. As part of the administration of the tax, the Commissioner of Social Services was required to notify the hospitals of the amount of tax due. Such calculations and notifications do not constitute regulations for purposes of chapter 54 of the general statutes.

2016 Conn. Pub. Acts 3, May spec. sess., § 119. The General Assembly also amended the language of Conn. Gen. Stat. § 12-263b to confirm that it should be implemented in accordance with this intent as follows:

> (a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. The rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly. Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed in order to ensure conformance with the state budget adopted by the General Assembly….

2016 Conn. Pub. Acts 3, May spec. sess., § 120.[57]

[57] Additionally, the General Assembly clarified that the purpose of the Hospital User Fee:

> The intention of section 145 of public act 11-6, as amended by section 102 of public act 11-44, was that the definition of net patient revenue set forth in section 12-263a of the general statutes complies with and is consistent with subsection (w) of 42 USC 1396b, 42 CFR 440.10 and 42 CFR 440.20. Furthermore, the primary purpose of the tax on the net patient revenue of hospitals was to raise revenues from uniquely situated health care providers that receive certain benefits under the state's Medicaid program.

2016 Conn. Pub. Acts 3, May spec. sess., § 121.

The Petitioners' contest the validity of 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119-121 by claiming that such legislation is impermissible retroactive legislation. Specifically, in their Memorandum in Support of Petition for Declaratory Ruling ("Petitioners' Brief"), the Petitioners allege that sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., "attempt to create retroactive legislative intent and new statutory language that is wholly irrelevant to the resolution of the Petition." R. at 762. As explained more fully below, the Departments find that sections 119-121 of 2016 Conn. Pub. Acts 3 (May Spec. Session) contain express statements of the intention of the General Assembly with regard to its enactment of the Hospital User Fee and a corresponding clarifying amendment of Conn. Gen. Stat. § 12-263b. As this legislation is clarifying in nature, said sections do not constitute impermissible retroactive legislation. Accordingly, the Departments are bound to follow said legislation.

As noted above, the Petitioners raise several arguments with regard to these sections in their Brief. Each of these arguments ultimately turns on whether sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., are clarifying in nature. As explained more fully below, the Departments find that sections 119 and 121 are express statements of legislative intent and, therefore, are facially clarifying in nature. See 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119 ("Consistent with section 12-263b of the general statutes, as amended by this act, the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was . . .") and 121 ("The intention of section 145 of public act 11-6, as amended by section 102 of public act 11-44, was . . ."). Even though the Departments find that this express clarifying language in the statute is already sufficient to establish that said legislation is clarifying rather than an impermissible retroactive substantive change to the existing statute, the Departments consider the question as to whether the amendments to Conn. Gen. Stat. § 12-263b made in section 120 of 2016 Conn. Pub. Acts 3, May spec. sess., are clarifying in nature in order to fully and fairly consider the Petitioners' objections to said legislation.

In order to make such a determination, the Departments review the principles established by the Connecticut Supreme Court to determine the effect of subsequent statutory amendments on previously enacted legislation. As the Connecticut Supreme Court has stated, "[t]his court has a long tradition of embracing clarifying legislation" and has "affirmed the applicability of legislative clarifications to pending litigation." Greenwich Hosp. v. Gavin, 265 Conn. 511, 520, 829 A.2d 810, 815 (2003). In so doing, the Connecticut Supreme Court specifically determined that "[i]mplicit in our decisions allowing the legislature to clarify its intent in prior legislation was the recognition that pending cases, even those that eventually spawned the clarifying legislation, could be affected." Id.

The Connecticut Supreme Court has articulated the following principles as governing its review of subsequent statutory amendments to previously enacted legislation:

> The principles by which we determine the effect of a subsequent statutory amendment on earlier legislation are well established. "We recognize the usual presumption that, in enacting a statute, the legislature intended a change in existing law. City of Shelton v. Commissioner, 193 Conn. 506, 513, 479 A.2d 208 (1984); Vartuli v. Sotire, 192 Conn. 353, 364 n. 12, 472 A.2d 336 (1984); 1A J. Sutherland, Statutory Construction (4th Ed.

> Sands 1984) § 22.30. This presumption, however, like any other, may be rebutted by contrary evidence of the legislative intent in the particular case. Shelton v. Commissioner, supra, at 513–14, 479 A.2d 208." State v. Magnano, 204 Conn. 259, 277, 528 A.2d 760 (1987).

Andersen Consulting, LLP v. Gavin, 255 Conn. 498, 516–17, 767 A.2d 692, 703–04 (2001). The Connecticut Supreme Court has further stated:

> "In determining the intended effect of a later enactment on earlier legislation, two questions must be asked. 'First, was the act intended to *clarify* existing law or to *change* it? Second, if the act was intended to make a change, was the change intended to operate retroactively?' ... Circle Lanes of Fairfield, Inc. v. Fay, 195 Conn. 534, 540, 489 A.2d 363 (1985)." (Emphasis in original.) State v. Magnano, supra, 204 Conn. at 277, 528 A.2d 760.[58]

Id. at 517. Accordingly, the Departments must examine whether the General Assembly, in enacting sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., intended to clarify or change the Hospital User Fee. The Connecticut Supreme Court has provided the following guidance in making such a determination:

> "Whether to apply a statute retroactively or prospectively depends upon the intent of the legislature in enacting the statute. . . . In order to determine the legislative intent, we utilize well established rules of statutory construction. Our point of departure is General Statutes § 55–3, which states: **No provision of the general statutes, not previously contained in the statutes of the state, which imposes any new obligation on any person or corporation, shall be construed to have retrospective effect**. The obligations referred to in the statute are those of substantive law.... Thus, we have uniformly interpreted § 55–3 as a rule of *presumed* legislative intent that statutes affecting *substantive* rights shall apply prospectively only. . . . This presumption in favor of prospective applicability, however, may be rebutted when the legislature clearly and unequivocally expresses its intent that the legislation shall apply retrospectively. In re Daniel H., 237 Conn. 364, 372, 678 A.2d 462 (1996); accord Bayusik v. Nationwide Mutual Ins. Co., 233 Conn. 474, 483–84, 659 A.2d 1188 (1995); Miano v. Thorne, 218 Conn. 170, 175, 588 A.2d 189 (1991). Where an amendment is intended to clarify the original intent of an earlier statute, it necessarily has retroactive effect.... . . . **We generally look to the statutory language and the pertinent**

[58] In applying this test, the Connecticut Supreme Court has held that if the legislation

> was intended to clarify, rather than to change, existing law, we do not reach the second question in retroactivity analysis, namely, whether, under the circumstance where the legislature intended a *change* to existing law, it intended the change to have retroactive effect. See State v. Magnano, supra, 204 Conn. at 284, 528 A.2d 760; see also Circle Lanes of Fairfield, Inc. v. Fay, supra, 195 Conn. at 540–41, 489 A.2d 363. "Where an amendment is intended to clarify the original intent of an earlier statute, it necessarily has retroactive effect." State v. Magnano, supra, at 284, 528 A.2d 760.

Id. at 523 (footnote omitted). As explained herein, the Departments find that the amendments to Conn. Gen. Stat. § 12-263b made in section 120 of 2016 Conn. Pub. Acts 3 were intended to clarify existing law. As such, as recognized by the Connecticut Supreme Court, these amendments have retroactive effect.

> **legislative history to ascertain whether the legislature intended that the amendment be given retrospective effect. . . .**

Id. at 517-18 (emphasis supplied). As directed by the Connecticut Supreme Court, the Departments must look to the statutory language and the pertinent legislative history to ascertain whether the General Assembly intended that sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., are clarifying in nature and should be afforded retroactive effect. Given the foregoing, the task the Departments are charged with is determining whether sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., affect the substantive rights of the taxpayers, namely the hospitals.[59] As set forth more fully below, each section simply clarifies the manner in which the Hospital User Fee is to operate. None of the sections fundamentally impact the substantive rights of a taxpayer by changing either the tax burden levied on the taxpayer or the manner in which the taxpayer was notified of said burden. The clarifying legislation did not impact any of the elements of the Hospital User Fee; after the clarifying legislation was enacted the Hospital User Fee the same taxpayers were subject to the tax, the same property was subject to the tax, and the tax was to be calculated and implemented in the same manner. As a result, the clarifying legislation did not change any taxpayer's tax liability and thus did not affect any taxpayer's rights.

To that end, it is clear from the plain language of section 119 of 2016 Conn. Pub. Acts 3, May spec. sess., that said provision was intended to clarify rather than change the Hospital User Fee. As set forth above, said section clearly and plainly provides that it is a statement of legislative intent: "the intention of section 146 of public act 11-6, as amended by section 103 of public act

[59] If the legislation were to impact the substantive rights of the taxpayer, the Departments would have to determine whether taxpayers' constitutional due process rights were violated under the standard set forth by the United States Supreme Court in United States v. Carlton:

> This Court repeatedly has upheld retroactive tax legislation against a due process challenge. . . . Some of its decisions have stated that the validity of a retroactive tax provision under the Due Process Clause depends upon whether "retroactive application is so harsh and oppressive as to transgress the constitutional limitation." . . . The "harsh and oppressive" formulation, however, "does not differ from the prohibition against arbitrary and irrational legislation" that applies generally to enactments in the sphere of economic policy. . . . The due process standard to be applied to tax statutes with retroactive effect, therefore, is the same as that generally applicable to retroactive economic legislation:
>
> "Provided that the retroactive application of a statute is supported by a legitimate legislative purpose furthered by rational means, judgments about the wisdom of such legislation remain within the exclusive province of the legislative and executive branches....
>
> "To be sure, ... retroactive legislation does have to meet a burden not faced by legislation that has only future effects.... 'The retroactive aspects of legislation, as well as the prospective aspects, must meet the test of due process, and the justifications for the latter may not suffice for the former'.... But that burden is met simply by showing that the retroactive application of the legislation is itself justified by a rational legislative purpose." . . .

United States v. Carlton, 512 U.S. 26, 30–31, 114 S. Ct. 2018, 2021–22, 129 L. Ed. 2d 22 (1994). However, as the Departments determine that the legislation is clarifying and does not impact the substantive rights of taxpayers, the Departments do not reach this question. See Greenwich Hosp. v. Gavin, 265 Conn. 511, 829 A.2d 810 (2003); Andersen Consulting, LLP v. Gavin, 255 Conn. 498, 767 A.2d 692 (2001); Oxford Tire Supply, Inc. v. Commissioner of Revenue Services, 253 Conn. 683, 755 A.2d 850 (2000).

11-44 and section 79 of public act 11-61, was . . .." 2016 Conn. Pub. Acts 3 May, spec. sess., § 119.

Moreover, section 119 simply confirms the manner in which the Hospital User Fee was to be implemented and levies no new tax burden on taxpayers. Said legislation clarifies that "the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis." As set forth more fully in the Facts, this is exactly the manner in which the Hospital User Fee was implemented – DSS, in consultation with OPM, calculated the amount of Hospital User Fee due from each taxpayer in order to achieve the amount of revenue set forth in the revenue estimates, as detailed in the state budget prepared by OFA.[60,61]

[60] Most of these calculations occurred during legislative sessions, as DSS and OPM were charged with assisting the General Assembly in calculating how much revenue the Hospital User Fee could raise. The General Assembly adopted DSS's and OPM's recommendations through the codification of the revenue estimates and, thereafter, DSS had no discretion to amend how much the revenue the Hospital User Fee could raise.

The Petitioners claim that DSS's actions in assisting the General Assembly constitute setting the tax rate: "the Governor established the increased rate and chose the new base year, and that the General Assembly simply incorporated the Governor's new tax rate and base year into the budget, assuming, along with OFA, that 'no legislation is required.'" R. at 770. While it is true that DSS assisted the General Assembly in the development of the budget, said actions to not constitute the setting of a tax rate. Rather, once the General Assembly codified the revenue estimates, DSS was required to calculate the amount due from each hospital under the Hospital User Fee to generate that much total revenue.

[61] In their Brief, the Petitioners allege that this was not the manner in which the Hospital User Fee was implemented. Specifically, the Petitioners allege that "the legislative history demonstrates that the legislature contemplated and then rejected providing a specific tax rate *after* initially choosing a specific rate." R. at 766. They further claim that the legislature has attempted to provide retroactive legislative intent that identifies a procedure – not supported in practice, the language of the statute, or the legislative history of the statute." Id. As a result, the Petitioners further urge "that DSS and DRS should reject this tortured attempt to recast the intent of the legislation enacted five years ago." Id. The Petitioners' support for this argument appears to be that they believe (1) that the General Assembly specifically rejected a rate, (2) that the timing of the budget conflicts with the clarifying legislation, and (3) that the tax rate could not be reverse engineered from the OFA documents. R. at 766-69. The Departments find none of these allegations credible, and address each below, in turn.

The Petitioners first allege that the "legislative history verifies deliberate rejection of a specific tax rate and deliberate delegation of responsibility for the tax rate and base." R. at 768. The Petitioners' support for this allegation is the fact that Public Act 11-6 included a rate of 4.6% whereas Public Act 11-44 removed said rate. As explained more fully in the Facts, the version of tax on hospitals set forth in Public Act 11-6 was fundamentally altered from a tax on net patient revenue each hospital earned per quarter to a set User Fee designed to generate a specific amount of revenue. This is confirmed by Appropriations Committee Co-Chairperson Senator Harp's comments on the Senate floor that the framework which would be codified in Chapter 211a was simply "a system wherein we can move forward with the tax program." Connecticut Senate Transcript, 5/24/2011. Accordingly, the legislative history confirms and is consistent with the clarifying legislation.

The Petitioners also allege that "[t]he timing of the budget codification in relation to the legislation begs the question of how the legislature could have known in May and June of 2011 when it passed the three public acts what OFA would write in the final version of the budget on July 14, 2011. The final version of the OFA-prepared budget, from which the tax rate allegedly can be reverse engineered, was not available when the legislature enacted the provisions. The claim that it is determinative of legislative intent is simply not credible." R. at 768. As set forth above in the Facts, the General Assembly did not know how much Hospital User Fee could generate when it enacted Public Act

The General Assembly further clarified that said statute, as a provider tax, was required to comply with federal Medicaid requirements. See 2016 Conn. Pub. Acts 3, May spec. sess. § 119, ("In said public acts, the General Assembly charged the Commissioner of Social Services, in consultation with the Office of Policy and Management, with calculating the amount of tax due from each hospital within the limitations and requirements set forth in subsection (w) of 42 USC 1396b, including determining the base year for the tax, in order to obtain the funds set forth by the General Assembly in the state budget."). Again, this simply confirms the manner in which the Hospital User Fee was to be implemented. Finally, in section 119, the General Assembly clarified the manner in which DSS was to notify the taxpayers of their tax due: "Such calculations and notifications do not constitute regulations for purposes of chapter 54 of the general statutes." 2016 Conn. Pub. Acts 3, May spec. sess. § 119,. As described more fully below, this clarification made the language of the Hospital User Fee consistent with the notification requirements in the other two provider taxes in effect at the time the Hospital User Fee was enacted.

Consistent with the analysis above, no provision of section 119 imposed a new substantive tax burden upon the taxpayers subject to the Hospital User Fee. Accordingly, the plain language of section 119 confirms that the General Assembly was simply clarifying, not substantively changing, the Hospital User Fee.

Moreover, it is clear from the plain language of section 120 of 2016 Conn. Pub. Acts 3, May spec. sess., that said provision was intended to clarify rather than change the Hospital User Fee. As explained below, the General Assembly has simplified the task of determining its intention by codifying an express statement of its intent in enacting the Hospital User Fee in sections 119 and 121 of 2016 Conn. Pub. Acts 3, May spec. sess. Upon review of the amendments to Conn. Gen. Stat. § 12-263b that are contained in section 120 of 2016 Conn. Pub. Acts 3, May spec. sess., it is apparent that said amendments are consistent with the statement of intent contained in section 119 of said public act. To be more precise, and as explained below, each amendment to Conn. Gen. Stat. § 12-263b ties directly to this statement of intent. Moreover, each such amendment does not change the manner in which the Hospital User Fee was calculated. Consequently, as the General Assembly's statement of intent is clarifying in purpose, the corresponding amendments it made to Conn. Gen. Stat. § 12-263b are also clarifying in nature.

11-44. That is why it set up the system that it did – so that it could set the amount of the Hospital User Fee would generate when the budget was codified. See also Roger Sherman Liberty Ctr., Inc. v. Williams, 52 Conn. Supp. 118, 126, 28 A.3d 1026, 1032–33 (Super. Ct. 2011) ("The court is persuaded that there is a budget process, not a single instantaneous act of budget creation, for this biennium. The text of the budget bill itself indicates that the budget process is ongoing, and cannot be complete, until further steps are taken."). Accordingly, the legislative history confirms and is consistent with the clarifying legislation.

Finally, the Petitioners allege that that the tax rate could not be reverse engineered from the OFA documents. R. at 768. However, contrary to the Petitioners assertions, as set forth more fully in the Facts, the OFA budget books explicitly state the amount of tax to be raised. These specific excerpts are set forth in Appendix 3. Accordingly, the budget books confirm and are consistent with the clarifying legislation.

Consistent with the above, the Departments do not find the Petitioners' allegations that the clarifying legislation contradicts the legislative history persuasive.

To this end, subsection (a) of Conn. Gen. Stat. § 12-263b was amended as follows: "[t]he rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly." 2016 Conn. Pub. Acts 3, May spec. sess., § 120. In section 119 of said Public Act, the General Assembly specifically stated that it "would set the rate of the tax on the net patient revenue of hospitals" and clarified that it would did so "by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis."[62] 2016 Conn. Pub. Acts 3, May spec. sess., § 119. It is readily apparent that the General Assembly amended the language of Conn. Gen. Stat. § 12-263b to more closely conform said statute to these statements of intent. Stated simply, the General Assembly clarified in section 119 of 2016 Conn. Pub. Acts 3 (May Spec. Session) that it would set the rate of the Hospital User Fee and amended Conn. Gen. Stat. § 12-263b in section 120 of said public act to reflect this clarification.

This clarification does not impose upon any greater or lesser tax burden than was in effect when the Hospital User Fee was enacted. This clarification had no impact on the manner in which the Hospital User Fee was calculated and, as such, was not a material change, but rather, was simply a clarifying statement. To that end, as set forth more fully above, in 2011, 2013, and 2015, DSS calculated the amount of Hospital User Fee due from each hospital in a manner consistent with the above-quoted statement of legislative intent. After the codification of 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119 and 120, hospitals owed the exact same amount of Hospital User Fee as they had before. Furthermore, the General Assembly's clarifying language is consistent with the

[62] These statements directly contradict the Petitioners' claim that the General Assembly unlawfully delegated the authority to set the rate of the Hospital User Fee to DSS. Through these statements the General Assembly clearly and unequivocally clarifies that it—not DSS–set the rate of the Hospital User Fee.

The Petitioners, however, claim that "there is no evidence that the General Assembly has ever had any role in setting the tax rate through the budget process as indicated in Section 119 of the Implementer Bill," and that "such revenue estimates generally have no legal effect." R. at 771-72. As support for these claims, the Petitioners state that revenue estimates do not impact the tax rates of the personal income tax, sales and use tax, corporation business tax, public services taxes, estate taxes, insurance premiums taxes, electric generation taxes, alcoholic beverages taxes, nursing home provider taxes, and admissions and dues taxes. The Departments dispute the accuracy of both statements.

To that end, the setting of tax rates often is a direct part of the budget process and the taxes upon which the revenue estimates are based are often amended through budget implementer acts, as the Hospital User Fee was in 2011 along with the resident day user fees on nursing homes and ICF/IIDs. Moreover, each of the taxes that the Petitioners cite to as evidence that the revenue estimates do not impact taxes differ from the Hospital User Fee as they are each variable taxes, not set fees. For example, the insurance premiums tax is a tax of 1.75% of the net direct premiums a taxpayer earns each calendar year. The Hospital User Fee, on the other hand, is a set fee that does not change from year to year unless the General Assembly directs that it raise more revenue. As such, whether or not revenue estimates have any impact on said taxes is immaterial as the General Assembly is not attempting to raise a set amount of revenue from each said tax. Rather, the revenue generated from each tax will vary from year to year depending on how much income the taxpayers generate. Accordingly, the Departments find that the Petitioners' allegations are not accurate.

Finally, even if the Departments take the Petitioners allegations to be true, nothing precludes the General Assembly from using the budget process to set a tax rate by setting the amount of revenue a fee is required to generate in the revenue estimates and budget book simply because it does not do so in other contexts. To that end, there is no law that precludes the General Assembly from doing so.

legislative history regarding the enactment of the Hospital User Fee. During the 2011 legislative session, Appropriations Committee Co-Chairperson Senator Harp clearly stated that the framework which would be codified in Chapter 211a was simply "a system wherein we can move forward with the tax program." Connecticut Senate Transcript, 5/24/2011. Accordingly, as the statement of intent and clarification to Chapter 211a set forth in 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119 and 120 did not change the manner in which the Hospital User Fee was calculated but rather simply confirmed the Senator's comments, it is clear that said provisions simply clarify, and do not change, the Hospital User Fee.

Moreover, subsection (a) of Conn. Gen. Stat. § 12-263b was further amended as follows: "Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services."[63] 2016 Conn. Pub. Acts 3, May spec. sess., § 120. Upon review of section 119 of 2016 Conn. Pub. Acts 3, May spec. sess., the purpose of the above-quoted amendment is also obvious. To this end, in section 119 of said public act the General Assembly clarified that DSS was charged with "calculating the amount of tax due from each hospital" under the Hospital User Fee and "notify[ing] the hospitals of the amount of tax due." 2016 Conn. Pub. Acts 3, May spec. sess., § 119. The General Assembly further clarified that "[s]uch calculations and notifications do not constitute regulations for purposes of chapter 54 of the general statutes." Id. Again, it is readily apparent that the General Assembly amended the language of Conn. Gen. Stat. § 12-263b to more closely conform said statute to these statements of intent. Stated simply, the General Assembly clarified in section 119 of 2016 Conn. Pub. Acts 3, May spec. sess., that the Departments were not required to enact regulations, but were simply required to both calculate and notify the hospitals of the amount of tax due and amended Conn. Gen. Stat. § 12-263b in section 120 of said public act to reflect this clarification.[64]

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[63] The language of the Hospital User Fee is consistent with the obligations imposed upon DSS in connection with two other provider taxes: the resident day user fees imposed on nursing homes and ICF/IIDs. By way of example, the resident user fee imposed against ICF/IIDs provides, in pertinent part, that

> On or before July 1, 2011, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee ***and promptly notify the commissioner and the intermediate care facilities for individuals with intellectual disabilities of such amount***.

Conn. Gen. Stat. § 17b-340b (emphasis supplied). The language of the Resident Day User Fee imposed against Nursing Home Providers is identical. See Conn. Gen. Stat. § 17b-321 ("On or before July 1, 2005, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount."). Like the Hospital User Fee, the statute does not indicate that such notification must be in the form of a regulation, as other statutes require. As such, DSS is similarly exempt from the UAPA for purposes of setting the rate of the resident day user fees.

[64] The Petitioners claim that the General Assembly's clarification that the notification that DSS made to the hospitals regarding the amount of Hospital User Fee each said hospital owed is irrelevant. Specifically, the Petitioners claim that

> In Section 119 of the Implementer Bill, the General Assembly claims that "[s]uch calculations and notifications do not constitute regulations for purposes of Chapter 54 of the general statutes." However, such a conclusory statement has no probative value in determining whether the special notice or other communications constitute regulations.

R. at 764. As set forth more fully in Ruling 2, the actions taken by DSS in calculating the amount of user fee due from each taxpayer are not, as the Petitioners claim, regulations or "public statements to hospitals, in general, covering policies and procedures governing the application of the Hospitals Tax." Id. DSS articulated no policies or procedures

This clarification does not impose upon DSS any additional requirements regarding notification than were in effect when the Hospital User Fee was enacted. Accordingly, this clarification had no impact on the manner in which hospitals were notified of the Hospital User Fee and, as such, has not materially changed the Hospital User Fee. Rather, the General Assembly's statement of intent simply clarified that the Hospital User Fee was intended to operate in a manner similar to two of the state's other provider taxes.

As explained herein, there can be no dispute that the General Assembly provided a clarification of its intent in enacting the Hospital User Fee in section 119 of 2016 Conn. Pub. Acts 3, May spec. sess. Furthermore, there can be dispute that the amendments to Conn. Gen. Stat. § 12-263b that are contained in section 120 of said public act are consistent with this statement of intent. Consequently, as the General Assembly's statement of intent is clarifying in purpose, the corresponding amendments it made to Conn. Gen. Stat. § 12-263b are also clarifying in nature.

Finally, it is clear from the plain language of section 121 of 2016 Conn. Pub. Acts 3 May spec. sess. that said provision was intended to clarify rather than change the Hospital User Fee. As set forth above, said section clearly and plainly provides that it is a statement of legislative intent: "[t]he intention of section 145 of public act 11-6, as amended by section 102 of public act 11-44, was . . .." 2016 Conn. Pub. Acts 3, May spec. sess., § 121. Moreover, in said section, the General Assembly simply clarifies that the Hospital User Fee, as a provider tax, was required to comply with federal Medicaid requirements. See 2016 Conn. Pub. Acts 3, May spec. sess., § 121 ("the definition of net patient revenue set forth in section 12-263a of the general statutes complies with and is consistent with subsection (w) of 42 USC 1396b, 42 CFR 440.10 and 42 CFR 440.20."). Moreover, said provision codifies the General Assembly's purpose in enacting the Hospital User Fee: "the primary purpose of the tax on the net patient revenue of hospitals was to raise revenues from uniquely situated health care providers that receive certain benefits under the state's Medicaid program." Id. This clarifying language did not substantively impact the taxpayers in any manner, but rather simply confirmed the manner in which the Hospital User Fee was to be implemented and the purpose behind the Hospital User Fee.[65]

in performing said calculations. Rather, DSS simply calculated the amount of Hospital User Fee due from each hospital, an action the Commissioner of Revenue Services routinely performs in connection with all of the taxes he administers. The clarifying legislation simply confirms that, like two of Connecticut's other provider taxes, DSS was simply required to notify each hospital of the amount of User Fee due.

[65] The Petitioners argue that 2016 Conn. Pub. Acts 3, May spec. sess. "[v]iolates the United States Constitution because it is a Bill of Attainder." R. at 776-77. The Petitioners allege that 2016 Conn. Pub. Acts 3, May spec. sess., "was intended to, and effectively does, punish this small group of hospitals by imposing on them the highest tax rate of any other taxpayers in Connecticut." R. at 777. As explained below, 2016 Conn. Pub. Acts 3, May spec. sess., does not constitute a Bill of Attainder.

As the Petitioners state, Article 1, Section 10 of the United States Constitution provides that "[n]o State shall . . . pass any Bill of Attainder." The United States Supreme Court has described a bill of attainder as "a law that legislatively determines guilt and inflicts punishment upon an identifiable individual without provision of the protections of a judicial trial." Selective Serv. Sys. v. Minnesota Pub. Interest Research Grp., 468 U.S. 841, 846–47, 104 S. Ct. 3348, 3352, 82 L. Ed. 2d 632 (1984).

The United States Supreme Court has recognized that "[t]he proscription against bills of attainder reaches only statutes that inflict punishment on the specified individual or group." Selective Serv. Sys. v. Minnesota Pub. Interest Research

Grp., 468 U.S. 841, 851, 104 S. Ct. 3348, 3354, 82 L. Ed. 2d 632 (1984). The Connecticut Supreme Court has summarized the three-part test for determining if a statute is a punishment as follows:

> "[T]he [United States] [Supreme] Court [has] applied three tests to determine whether legislative punishment of the type contemplated by the [b]ill of [a]ttainder [c]lauses was imposed: [1] ***the historical test, involving punishment traditionally judged to be prohibited*** by the [b]ill of [a]ttainder [c]lause, . . ., including death, imprisonment, banishment, punitive confiscation of property by the sovereign and, in more recent times, laws barring designated individuals or groups from participation in specified employments or vocations, . . .; [2] **the functional test, which analyz[es] whether the law under challenge, viewed in terms of the type and severity of burdens imposed, reasonably can be said to further nonpunitive legislative purposes**, . . .; and [3] **the motivational test, which inquire[s] whether the legislative record evinces a congressional intent to punish**, ...

Hogan v. Dep't of Children & Families, 290 Conn. 545, 579–80, 964 A.2d 1213, 1232 (citations omitted) (emphasis supplied). As explained below, the clarifying legislation does not meet any of these tests for legislative punishment.

First, the Departments have not found, nor have the Petitioners cited any authority where the imposition of a tax has been found to be the type of "punishment" traditionally engaged in by legislatures as a means of punishing individuals for wrongdoing. To the contrary, it is widely held and accepted that taxes are not a punishment. As United States Supreme Court Justice Oliver Wendell Holmes, Jr. has famously stated, "***Taxes are what we pay for civilized society***." Compania Gen. de Tabacos de Filipinas v. Collector of Internal Revenue, 275 U.S. 87, 100, 48 S. Ct. 100, 105, 72 L. Ed. 177 (1927) (emphasis supplied). See Knight v. C. I. R., 64 T.C.M. (CCH) 1519 (T.C. 1992), aff'd, 29 F.3d 632 (9th Cir. 1994) ("Federal income taxation is not a "punishment" for some sort of wrongdoing. Rather, it is a law to raise revenue to run the Government, and all persons who are within the ambit of the law and have sufficient income are subject to such taxation. Consequently, "It is wholly irrelevant to speak of a bill of attainder in . . . [a] civil proceeding involving . . . [a taxpayer's] income tax liability." . . .). Accordingly, as the imposition of a tax is not a punishment that has historically been associated with bills of attainder, the Departments find that the clarifying amendments made to the Hospital User Fee by sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., do not meet the legal test for legislative punishment.

Second, the Hospital User Fee and the clarifying amendments made thereto by 2016 Conn. Pub. Acts 3, May spec. sess., "reasonably can be said to further nonpunitive legislative purposes." Selective Serv. Sys. v. Minnesota Pub. Interest Research Grp., 468 U.S. 841, 851–52, 104 S. Ct. 3348, 3354–55, 82 L. Ed. 2d 632. As fully explained herein, the Hospital User Fee was enacted in 2011 and was enacted for very specific purposes – (1) to raise revenue from uniquely situated taxpayers who were the beneficiaries of certain government programs and (2) to take advantage of the provisions of federal law that would result in the state receiving increased funding from the federal government. Through sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., the General Assembly simply clarified its intent in enacting the Hospital User Fee. In fact, in section 121 of 2016 Conn. Pub. Acts 3, May spec. sess., the General Assembly confirms that "the primary purpose of the tax on net patient revenue of hospitals was to raise revenues from uniquely situated health care providers that receive certain benefits under the state's Medicaid program." 2016 Conn. Pub. Acts 3, § 121, May spec. sess. As such, there can be no dispute that the Hospital User Fee was enacted for valid regulatory purposes and that the clarifying amendments thereto made by sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess. were consistent with said purposes. Accordingly, as the clarifying amendments made to the Hospital User Fee by sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess. can "reasonably . . . be said to further nonpunitive legislative purposes," the Departments find that said provisions do not meet the functional test for legislative punishment. Selective Serv. Sys. v. Minnesota Pub. Interest Research Grp., 468 U.S. 841, 851–52, 104 S. Ct. 3348, 3354–55, 82 L. Ed. 2d 632.

Finally, for 2016 Conn. Pub. Acts 3, May spec. sess., to meet the motivational test, the legislative record thereto must establish an intent on the part of the General Assembly to punish the hospitals. To this end, the Petitioners have failed to provide any evidence from the legislative record that even remotely indicates an intent on the part of the General Assembly to punish hospitals. Moreover, the Departments find no such evidence. To the contrary, as set forth more fully in Ruling 3, hospitals were to receive certain benefits from the tax by receiving additional payments they otherwise would not receive. Therefore, as the legislative record is devoid of any intent on the part of the General

For all the reasons discussed above, the Departments find that sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., were intended to clarify the provisions of the Hospital User Fee and impose no new substantive burden on taxpayers. Accordingly, the Departments find that 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119-120 are clarifying in nature, not illegal retroactive legislation. As 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119-120 were "intended to clarify the original intent of an earlier statute, it necessarily has retroactive effect," and, accordingly, said provisions are applicable to the present appeal. Andersen Consulting, LLP, 255 Conn. at 423. [66]

Assembly to punish the hospitals, the Departments find that the clarifying amendments made to the Hospital User Fee by sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., do not meet the motivational test for legislative punishment.

Therefore, for all of the foregoing reasons, the Departments find that sections 119-121 of 2016 Conn. Pub. Acts 3, May spec. sess., do not constitute a Bill of Attainder in violation of the United States Constitution.

[66] In their Brief, the Petitioners also claim that Public Act 16-3, May spec. sess., §§ 119-121 violates the contracts clause of the United States Constitution by interfering with provider agreements that the Petitioners have entered into in order to participate in the state's Medicaid program. See R. at 775. As a general matter, the Petitioners' claim that the clarifying legislation violates the contracts clause of the United States Constitution fails because, as discussed above, that legislation did not make any substantive changes to the statute as enacted in 2011. Rather, it confirmed the legislative intent as it existed in 2011. Because it did not make any changes to the statute as it existed in 2011, the Departments find that it did violate any existing contracts.

Even if it were found that Public Act 16-3, May spec. sess., §§ 119-121 did make changes, which the Departments find that it did not, that legislation still did not impair any of the Petitioners' rights under their Medicaid provider agreements. While the provider agreement is certainly a type of contract, it does not confer any rights on any of the Petitioners that could even potentially have been violated by Public Act 16-3, May spec. sess., §§ 119-121. As the U.S. Court of Appeals for the Second Circuit has confirmed, language similar to the Connecticut Medicaid provider agreement does not give providers any right to "continued and uninterrupted participation in Medicaid. Therefore, no property interest exists" in the contract. Kelly Kare, Ltd. V. O'Rourke, 930 F.2d 170, 175-176 (2d Cir. 1991). In addition, as noted above, the terms of the provider agreement do not give providers any specific rights at all, other than a right to terminate the agreement. See Provider Agreement ¶ 33(c), R. at 3012. Even implicitly, the provider agreement is limited to the general concept that in exchange for each of the Petitioners agreeing to providing health services to Medicaid members and complying with applicable enrollment, coverage, reimbursement, and billing requirements, the Provider Agreement enables DSS to pay each of the Petitioners for providing such services. See e.g., Provider Agreement ¶¶ 2, 5, R. at 3007.

This limited scope of providers' participation in Medicaid as being limited to receiving payment from DSS for providing covered services to Medicaid members is confirmed in the DSS provider participation regulations, which are "general requirements to which providers of Medical Assistance Program goods and services shall adhere in order to participate in, and receive payment from, the Connecticut Medical Assistance Program." Conn. Agencies Regs. § 17b-262-522. Similarly, specific to hospitals, the current operational policies for both inpatient and outpatient hospitals, which are being implemented pursuant to Conn. Gen. Stat. §§ 17b-10 and 17b-239 with the force of regulation pending adoption of final regulations, also confirm that the participation of hospitals in Medicaid is for the purpose of receiving payment for covered services provided to Medicaid members. See, e.g., DSS Inpatient Hospital Operational Policy §§ 17b-262-900, 17b-262-902; DSS Outpatient Hospital Operational Policy §§ 17b-262-967, 17b-262-969, R. at 1901, 1905-06, 1937, 1942. Thus, a provider's participation in Medicaid—and therefore also the provider's rights under the provider agreement, relate only to the provider's ability to receive payment from DSS for providing covered services to Medicaid members. The provider agreement—and the provider's participation in Medicaid—therefore does not relate to the Hospital User Fee.

In their Brief, the Petitioners argue that the Hospital User Fee statute is "inextricably and integrally tied to the Medicaid program and the Provider Agreements." R. at 775. While the Hospital User Fee was initially proposed at the same time as the supplemental payments and increased DSH payments, those payments are fundamentally separate from

Consistent with the above-quoted statement, the Departments find that the General Assembly has explicitly confirmed that the Hospital User Fee contained a tax rate, the variables of which were set forth in Conn. Gen. Stat. § 12-263a, the codified revenue estimates, and federal Medicaid law.

c. The actions taken by DSS to implement the tax reflect that the General Assembly did not confer upon DSS authority to impose a tax rate. Rather, DSS's authority was limited to calculating tax due using the formula set forth in statute.

That the Hospital User Fee contains a rate is further supported by actions that DSS took to implement the fee, which, as described more fully below, appear to be ministerial in nature. Stated another way, DSS had no discretion as to what the formula would be, but rather was charged with calculating the amount of tax due from each taxpayer to be consistent with the formula provided by the General Assembly.

Specifically, as referenced above, by statute, DSS was required to calculate the Hospital User Fee due from each hospital using the variables set forth above and in a manner that complied with federal Medicaid law. In order to comply with all of these requirements imposed by the General Assembly (including the requirements specifically enumerated in the text of the statute as well as the requirements of the state budget adopted by the General Assembly as confirmed by the clarifying legislation), DSS needed to take the following steps in order to implement the Hospital User Fee:

(1) determine the amount of net patient revenue each hospital had accrued in a given year;
(2) select a base year with sufficient net patient revenue for the fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law;
(3) determine those hospitals that met the statutory definitions of exempt hospitals;
(4) calculate the amount of fee each hospital owed in order to comply with federal Medicaid provider tax requirements and also to achieve the amount of revenue set forth in the revenue estimates and payments set forth in the state budget; and
(5) obtain a waiver from CMS of the broad-based requirement for those hospitals statutorily exempt from Hospital User Fee.

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the Hospital User Fee because federal law specifically prohibits any direct correlation between those payments and the Hospital User Fee and also prohibits a variety of hold harmless provisions that would connect payment amounts to Hospital User Fee amounts. See 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f). In addition, Public Act 16-3, May spec. sess., §§ 119-121 does not make any changes to supplemental payments or any other Medicaid payments. Moreover, changes to the supplemental payments are not relevant to this petition, which solely relates to the Hospital User Fee itself. Specifically, none of the questions raised in the Petitions seek to invalidate or change the supplemental payments. In any case, the Petitioners have opportunities to challenge supplemental payments and other Medicaid payments in separate contexts, which they have routinely exercised. See Conn. Gen. Stat. § 17b-238(b). Those challenges are not relevant to this Declaratory Ruling, however.

For all of these reasons, the Departments find that Public Act 16-3, May spec. sess., §§ 119-121 did not violate the contracts clause of the United States Constitution.

First, as Conn. Gen. Stat. § 12-263b defines the tax base to be the hospitals' "net patient revenue," DSS was required to determine what the amount of net patient revenue accrued by each hospital in a given year. In order to do so, DSS reviewed reports filed by the hospitals with the Department of Health, Office of Health Care Access (OHCA).

Accordingly, consistent with DSS's obligation to calculate the amount of user fee due by determining the amount of net patient revenue each taxpayer had in each year, DSS reviewed the twelve month actual reports of the hospitals. Under Conn. Gen. Stat. § 12-263b, net patient revenue is defined to be "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." As the twelve month actual reports included certified disclosures by the hospitals of their net patient revenue including "inpatient and outpatient accrued payments," DSS used the information set forth therein to determine how much net patient revenue a hospital had in a given year.

In mid-2011, when the General Assembly enacted the Hospital User Fee, the latest year's reporting available was for FFY 2009 because OHCA is required to release the results of its review of the hospitals' filings by September 1st of each year. See Conn. Gen. Stat. § 19a-670. DSS reviewed these reports to determine whether said year had sufficient net patient revenue for the Hospital User Fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law. DSS found that said year also contained sufficient net patient revenue to raise the $349.1 million required annually without exceeding the federal maximum percentage, while at the same time exempting all hospitals exempt from the user fee under Conn. Gen. Stat. §§ 12-263a and 12-263b.[67] Additionally, the revenue from said year and associated distribution of payments made to hospitals complied with federal requirements for the Hospital User Fee including that the user fee must be broad-based.

As certain hospitals were specifically exempt from the Hospital User Fee under Conn. Gen. Stat. §§ 12-263a and 12-263b, DSS was required to calculate the amount of Hospital User Fee to both exempt said hospitals as set forth in Chapter 211a and comply with the broad-based requirements. DSS was also required to request a waiver of the broad-based requirements from CMS.

Accordingly, using the data from the twelve month actual filings submitted to OHCA, DSS conducted several calculations in order to apply for a waiver from CMS. As part of the waiver application process, DSS performed the P1/P2 test, which showed that the user fee was generally

[67] DSS could not simply apportion the amount of fee due from each hospital proportional to net patient revenue for any given year. This is because the General Assembly had mandated that certain hospitals were exempt from the user fee. Specifically, the statute applied only to facilities "licensed as a short-term general hospital" and excluded children's hospitals and publicly operated hospitals. Conn. Gen. Stat. § 12-263a(1). Because short-term general hospitals are licensed separately from other types of hospitals, that definition thus excluded chronic disease hospitals and other specialty hospitals. Id.; see also Conn. Agencies Regs. § 19-13-D1(b). In addition, the statute provided that DSS "may, in consultation with the Secretary of [OPM] and in accordance with federal law, exempt a hospital from the user fee on outpatient services based on financial hardship." Conn. Gen. Stat. § 12-263b(a). As detailed in the waiver application, a hospital was determined to be financially distressed if it had aggregate net losses of more than one percent of aggregate revenue for the five year period of 2005-2009 (the most recent years for which full year data was available when the user fee was first implemented in mid-2011). R. at 632-52.

redistributive despite exempting certain hospitals. R. at 632-52. The results of said test were set forth in a waiver application DSS submitted to CMS on June 7, 2011.

Additionally, as part of the waiver application process, DSS was required to demonstrate that the Hospital User Fee and associated Medicaid payments did not hold the taxpayers harmless for the tax either directly or indirectly. Accordingly, DSS included in the waiver application the use of the proceeds of the user fee and payments made to the hospitals in order to demonstrate that those payments did not hold harmless any taxpayer, directly or indirectly, as payments were not directly correlated to the tax. Id.

CMS approved DSS's waiver application effective July 1, 2011. Accordingly, DSS calculated the amount of Hospital User Fee due from each of the hospitals subject to the user fee in a manner consistent with CMS's waiver approval. Specifically, DSS apportioned the total revenue that needed to be raised from the Hospital User Fee consistent with each hospitals' net patient revenue for 2009 and the distribution that the user fee had to comply with in order to avoid containing a hold harmless provision. On September 30, 2011, DSS notified the hospitals by email of their required tax amounts for SFY 2012-2013. R. at 586-89.

In 2013, the General Assembly did not make any changes to the Hospital User Fee for the state budget for SFY 2014-2015. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. Accordingly, on July 18, 2013, DSS notified the hospitals of their required user fee amounts for SFY 2014-2015, which were the same as the amounts for SFY 2012-2013, except that the amount for St. Raphael's Hospital was added to Yale-New Haven Hospital to reflect those hospitals' merger. R. at 590-94.

The budget adopted by the General Assembly for SFY 2016-2017 increased the amount of revenue the Hospital User Fee was required to generate to $556 million. In order to implement these changes, DSS was required to

> (1) determine the amount of net patient revenue each hospital had accrued in a given year;
> (2) select a base year with sufficient net patient revenue for the fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law;
> (3) determine those hospitals that met the statutory definitions of exempt hospitals;
> (4) calculate the amount of fee each hospital owed in order to comply with federal Medicaid provider tax requirements and also to achieve the amount of revenue set forth in the revenue estimates and payments set forth in the state budget; and
> (5) obtain a waiver from CMS of the broad-based requirement for those hospitals statutorily exempt from Hospital User Fee.

DSS again reviewed the twelve month actual filings hospitals filed with OHCA. DSS reviewed the reports available to determine a year in which (1) all hospitals subject to the user fee existed and (2) there was sufficient net patient revenue for the Hospital User Fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law. Specifically, FFY 2009 would no longer work as a base year because

it did not contain sufficient revenue to support the Hospital User Fee. In mid-2015, when the General Assembly increased the amount of revenue that the Hospital User Fee was required to generate, the latest year's reporting available was for FFY 2013. See Conn. Gen. Stat. § 19a-670. Said year was selected as it contained sufficient net patient revenue to raise the $556 million required annually without exceeding the federal maximum percentage, while at the same time exempting all hospitals exempt from the user fee under Conn. Gen. Stat. §§ 12-263a and 12-263b. Additionally, the revenue from said year and associated distribution of payments made to hospitals complied with federal requirements for the Hospital User Fee, including that the user fee must be broad-based.

As certain hospitals were specifically exempt from the Hospital User Fee under Conn. Gen. Stat. §§ 12-263a and 12-263b, DSS was required to calculate the amount of Hospital User Fee to both exempt said hospitals as set forth in Chapter 211a and comply with the broad-based requirements. DSS was also required to request a waiver of the broad-based requirements from CMS.

Accordingly, using the data from the twelve month actual filings submitted to OHCA, DSS conducted several calculations in order to apply for a waiver from CMS. As part of the waiver application process DSS performed the P1/P2 test, which showed that the user fee was generally redistributive despite exempting certain hospitals. R. at 632-52. The results of said test were set forth in a waiver application DSS submitted to CMS on June 26, 2015. Id.

Additionally, as part of the waiver application process, DSS was required to demonstrate that the Hospital User Fee and associated Medicaid payments did not hold the taxpayers harmless for the user fee, either directly or indirectly. Accordingly, DSS included in the waiver application the use of the proceeds of the user fee and payments made to the hospitals in order to demonstrate that those payments did not hold harmless any taxpayer, directly or indirectly, as payments were not directly correlated to the user fee. Id.

On October 7, 2015, CMS approved the waiver, which was effective July 1, 2015. Id. Accordingly, DSS calculated the amount of Hospital User Fee due from each of the hospitals subject to the user fee in a manner consistent with CMS's waiver approval. Specifically, DSS apportioned the total revenue that needed to be raised from the Hospital User Fee consistent with each hospital's net patient revenue for 2013 and the distribution that the user fee had to comply with in order to avoid containing a hold harmless provision. On October 16, 2015, DSS notified the hospitals through a posting on its website and by email of the amount of user fee due for SFY 2016-2017. R. at 584-609.

Consistent with the above, the actions taken by DSS in implementing the Hospital User Fee were simply steps necessary to calculate the amount of fee due from each hospital using the formula set forth in statute. DSS did not exercise its own judgment with respect to any component of the formula. DSS could not determine that the Hospital User Fee should generate more revenue. DSS was bound by the revenue estimates. DSS could not determine that other services should be subject to tax. DSS was bound by the definition set forth in statute. DSS could not determine what types of hospitals were subject to the tax. DSS was bound by the definition set forth in statute. DSS could not determine the maximum percentage the tax could be. DSS was bound by federal Medicaid law. The only discretion afforded to DSS was the selection of a year's net patient

revenue upon which the fee would be based. As described more fully below, DSS only had the appearance of discretion as it was implicitly bound by the definition of taxpayers subject to tax, the revenue estimates, and federal Medicaid law.

Put simply, DSS was charged with applying a formula to calculate the amount of Hospital User Fee from each hospital, not determining what the rate of the Hospital User Fee should be.

For all of the reasons discussed above, the Departments find that the Hospital User Fee contains a tax rate and that said rate takes the form of a complex formula. DSS had no discretion as to what the formula would be, but rather was charged with calculating the amount of tax due from each taxpayer to be consistent with the variables provided by the General Assembly. Accordingly, the Departments find that the General Assembly did not delegate authority to set the tax rate of the Hospital User Fee to DSS.

ii. The Departments find that the General Assembly did not delegate authority to define the tax base of the Hospital User Fee to DSS.

As referenced above, the second element a tax law must include in order to be "a law complete in itself,"[68] is a defined tax base. In their Petitions, the Petitioners' allege that the General Assembly conferred upon DSS authority to define the tax base as DSS was charged with the "selection of the base year." R. at 5, 25. As described more fully below, the Departments find that the tax base is set forth in statute and, as such, the General Assembly did not confer upon DSS the authority to set the tax base.

Black's Law Dictionary provides the following definition of tax base: "[t]he total property, income, or wealth subject to taxation in a given jurisdiction. 2. The aggregate value of the property being taxed by a particular tax." Tax Base, Black's Law Dictionary (10th ed. 2014). Stated simply, a tax base is the property subject to tax. Accordingly, the Departments must determine whether the Hospital User Fee defines what property will be subject to said Fee.

Given that the Hospital User Fee is a fee that is calculated upon one year's income, rather than a tax which is imposed upon each year's income, the tax base of the Hospital User Fee has multiple components. Specifically, as a tax base includes "[t]he total property, income, or wealth subject to taxation," any definition of the tax base must include both the type of income subject to the tax and the year upon which the fee will be calculated.

Upon a review of the legislative history regarding the implementation of the Hospital User Fee and the language of the statute itself, the Departments find that the statute explicitly defines the type of income subject to tax and implicitly defines the year upon which the fee will be calculated.

a. The Hospital User Fee explicitly defines the type of income subject to tax.

As set forth above, Conn. Gen. Stat. § 12-263b provides that the Hospital User Fee is "a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter." Conn. Gen. Stat. § 12-263b(a). As such, the type of income subject to tax is net patient revenue, which is further

[68] Kellems v. Brown, 163 Conn. 478, 498-501, 313 A.2d 53, 64-65 (1972).

defined as "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." Conn. Gen. Stat. § 12-263a(2). Given the plain language of these statutes, there can be no dispute that the General Assembly clearly set forth that the type of revenue subject to the Hospital User Fee is accrued payments from inpatient and outpatient hospital services.

Given that the statute explicitly defined the type of revenue subject to the Hospital User Fee, DSS was not granted any authority to define this component of the tax base. By way of example, DSS could not choose to impose the fee on revenue the hospitals accrued from the operation of their gift shops, as said revenue falls outside of the scope of net patient revenue as set forth in Conn. Gen. Stat. § 12-263a(2). DSS could not choose to impose the fee on donations that the hospitals received, as said revenue falls outside the scope of net patient revenue as set forth in Conn. Gen. Stat. § 12-263a(2). DSS could not choose to impose the fee on interest or capital gain income the hospitals accrue, as said revenue falls outside the scope of net patient revenue as set forth in Conn. Gen. Stat. § 12-263a(2). If DSS were to do so, it would operate beyond the scope of its statutory mandate.

Consistent with the above, the Departments find that the Hospital User Fee contains a definition of the type of income subject to tax. DSS had no discretion as to what the tax base could be and could not impose a fee on anything other than net patient revenue. Accordingly, the Departments find that the General Assembly did not delegate authority to set the tax base of the Hospital User Fee to DSS.

b. The Hospital User Fee implicitly defines the year upon which the tax will be levied.

As referenced above, the second component of a tax base is the year upon which the tax is imposed. Most taxes are applied to a present income, transaction, or value of property. As such, statutes typically require that the tax be paid on that present value. The Hospital User Fee is a set fee, however, that does not necessarily change from year to year, but rather is required to generate a certain amount of income. As such, the year upon which the tax is calculated is a single year, rather than the present year.

Under Conn. Gen. Stat. § 12-263b, the General Assembly appears to give DSS discretion to select the year upon which the tax will be calculated. Conn. Gen. Stat. § 12-263b ("The Commissioner of Social Services shall determine the base year on which such tax shall be assessed."). However, as with the tax rate, DSS's authority to select the base year was limited implicitly by the fact that the Hospital User Fee had to generate a certain amount of revenue and that the tax rate could not exceed the maximum rate allowed under federal law. See 2016 Conn. Pub. Acts 3, May spec. sess., § 119.[69] Additionally, as the Hospital User Fee was imposed on all hospitals as defined by

[69] In section 119 of Public Act 16-3, the General Assembly codified its intent in enacting the Hospital User Fee. Specifically, section 119 provides, in pertinent part that "the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was that on and after July 1, 2011, **the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget**, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis." 2016 Conn. Pub. Acts 3 § 119 (May Spec. Sess.) (emphasis supplied).

Conn. Gen. Stat. § 12-263a(a), all hospitals subject to the tax had to be in existence for the year that was selected.

As such, while Conn. Gen. Stat. § 12-263b appears to give DSS discretion to select a base year, such authority was eroded by the requirements that the Hospital User Fee generate a certain amount of revenue, the maximum rate allowed under federal law, and that all hospitals subject to the tax had to be in existence for the year that was selected. Stated another way, although the statute says that DSS may select the base year, DSS was required to do so in a manner consistent with statutory requirements. Essentially, DSS's determination of the base year was really just a calculation of what year had sufficient revenue to support the Hospital User Fee.

The manner in which DSS "selected" the year demonstrates that the General Assembly did not confer upon DSS authority to select a base, but rather bound DSS by implicit requirements. In mid-2011, when the General Assembly enacted the Hospital User Fee, the latest year's reporting available was for FFY 2009 because OHCA is required to release the results of its review of the hospitals' filings by September 1st of each year. See Conn. Gen. Stat. § 19a-670. DSS reviewed these reports to determine whether said year had sufficient net patient revenue for the Hospital User Fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law. DSS found that said year also contained sufficient net patient revenue to raise the $349.1 million required annually without exceeding the federal maximum percentage while at the same time exempting all hospitals exempt from the user fee under Conn. Gen. Stat. §§ 12-263a and 12-263b.[70] Additionally, the revenue from said year and associated distribution of payments made to hospitals complied with federal requirements for the Hospital User Fee including that the user fee must be broad-based.

Moreover, there is a specific policy reason behind why the General Assembly did not set forth a specific year in statute, but rather required the selection to be done by DSS in connection with performing the calculations set forth in the formula governing the rate of tax. That is, because the Hospital User Fee is a set fee designed to raise a certain amount of revenue, in the event that the General Assembly changed the amount of revenue the Fee was required to generate, it might be

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The Petitioners claim that section 119 "is irrelevant because the Hospitals Tax unambiguously delegates the authority to set the tax base to DSS . . .The Hospitals Tax is not ambiguous with regard to the delegation of authority to the Commissioner of Social Services to set the tax base year." R. at 763. As support for this statement, the Petitioners cite to well-established principles of statutory construction including "If, after examining [the text of the statute], the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extra textual evidence of the meaning of the statute shall not be considered." Id. However, the Petitioners' own reading of the Hospital User Fee leads to "absurd and unworkable results," which further confirms the appropriateness of turning to the clarifying legislation for guidance.

[70] DSS could not simply apportion the amount of fee due from each hospital proportional to net patient revenue for any given year. This is because the General Assembly had mandated that certain hospitals were exempt from the user fee. Specifically, the statute applied only to facilities "licensed as a short-term general hospital" and excluded children's hospitals and publicly operated hospitals. Conn. Gen. Stat. § 12-263a(1). Because short-term general hospitals are licensed separately from other types of hospitals, that definition thus excluded chronic disease hospitals and other specialty hospitals. Id.; see also Conn. Agencies Regs. § 19-13-D1(b). In addition, the statute provided that DSS "may, in consultation with the Secretary of [OPM] and in accordance with federal law, exempt a hospital from the user fee on outpatient services based on financial hardship." Conn. Gen. Stat. § 12-263b(a). As detailed in the waiver application, a hospital was determined to be financially distressed if it had aggregate net losses of more than one percent of aggregate revenue for the five year period of 2005-2009 (the most recent years for which full year data was available when the user fee was first implemented in mid-2011). R. at 632-52.

necessary to select a different year that had additional net patient revenue to tax without violating the federal maximum rate. This is exactly what happened in 2015. The General Assembly increased the amount of revenue the Fee had to generate. The FFY 2009 base year lacked sufficient revenue to tax. As such, DSS was required to find another year that had sufficient revenue to tax to achieve the revenue estimates without exceeding the maximum rates. FFY 2013 was the only year that had sufficient revenue available to tax. Also, hospital mergers changed the landscape of the tax, restricting the selection of the base year to FFY 2013.[71]

Consistent with the above, the Departments find that DSS had limited discretion to select the base year for the Hospital User Fee. Rather, the base year had to be selected to achieve the revenue estimates without violating the federal Medicaid requirements.

Given that DSS has limited discretion to determine either component of the tax base (the type of revenue subject to the Hospital User Fee and the year to which the Hospital User Fee will apply), the Departments find that the General Assembly did not confer upon DSS the authority to define the tax base.

iii. The Departments find that the General Assembly has not delegated authority to determine the taxpayers subject to the Hospital User Fee to DSS.

As set forth above, a tax law must identify those taxpayers subject to the tax in order to be "a law complete in itself."[72] The plain language of the Hospital User Fee unequivocally demonstrates that said fee clearly identifies those taxpayers subject to the fee. Specifically, Conn. Gen. Stat. § 12-263b provides that the Hospital User Fee is "a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter." Conn. Gen. Stat. § 12-263b(a). Specifically, the statutory definition of hospital includes only facilities "licensed as a short-term general hospital" and excludes children's hospitals and publicly operated hospitals. Conn. Gen. Stat. § 12-263a(1). Because short-term general hospitals are licensed separately from other types of hospitals, that definition thus excludes chronic disease hospitals and other specialty hospitals. Id.; see also Conn. Agencies Regs. § 19-13-D1(b). In addition, the statute provided that DSS "may, in consultation with the Secretary of [OPM] and in accordance with federal law, exempt a hospital from the tax on…outpatient services based on financial hardship." Conn. Gen. Stat. § 12-263b(a). Accordingly, the statute describes those taxpayers that are and that are not subject to the tax. As such, the Departments find that the statutes governing the Hospital User Fee explicitly defined those taxpayers subject to tax.

iv. Given that all components of a tax law are set forth in statute by the General Assembly, the Departments find that the Hospital User Fee does not confer upon DSS the authority to determine what a law should be. Accordingly, the Hospital User Fee does not violate Article Second of the Connecticut Constitution.

Consistent with the above, the Departments find that "[t]he General Assembly specifically levied the tax, prescribed the rate and defined the income subject to taxation as well as the persons who

[71] Yale-New Haven Hospital purchased the assets of St. Raphael's Hospital effective on or about September 12, 2012.
[72] Kellems v. Brown, 163 Conn. 478, 498-501, 313 A.2d 53, 64-65 (1972).

are required to pay" the Hospital User Fee. See Kellems v. Brown, 163 Conn. 478, 500, 313 A.2d 53, 64 (1972). Accordingly, the Departments have determined that the General Assembly did not confer upon DSS authority to impose a tax, as it set forth all essential elements in statute, and the Departments hold that the Hospital User Fee does not unconstitutionally delegate authority to DSS to set a tax rate or base year.

D. The Petitioners have failed to prove beyond a reasonable doubt that the General Assembly failed to provide sufficiently precise standards for the Departments' administration of the Hospital User Fee.

As set forth above, in addition to challenging the Hospital User Fee under Article Second of the Connecticut Constitution on the basis that said Fee confers a legislative function to DSS, the Petitioners have also alleged that said Fee violates Article Second of the Connecticut Constitution because it lacks sufficiently precise standards. R. at 5, 25. Specifically, the Petitioners allege that, if the Departments determine that the General Assembly did not cede to DSS "an inherently legislative function," the Hospital User Fee still violates Article Second of the Connecticut Constitution as the General Assembly has "fail[ed] to provide an intelligible principle (or, indeed, any principle) to guide DSS's process for setting the tax rate," also, in violation of Article Second of the Connecticut Constitution. Id. The Departments find that, upon review of the entire statutory scheme governing the Hospital User Fee and the legislative history associated therewith, it is clear the Hospital User Fee contains sufficiently precise standards for the Departments' administration of said Fee, as DSS has been afforded very little discretion. Accordingly, the Departments hold that the Hospital User Fee does not violate Article Second of the Connecticut Constitution on this basis.

As referenced above, Article Second of the Connecticut Constitution affirmatively asserts that the Connecticut General Assembly, as the legislative branch, can delegate certain regulatory authority to the executive branch. See Conn. Const. art. II ("The legislative department may delegate regulatory authority to the executive department; except that any administrative regulation of any agency of the executive department may be disapproved by the general assembly or a committee thereof in such manner as shall by law be prescribed.").

The scope of General Assembly's authority to delegate regulatory authority to the executive branch is well-defined. To that end, the Connecticut Supreme Court has held that

> [a] Legislature, in creating a law complete in itself and designed to accomplish a particular purpose, may expressly authorize an administrative agency to fill up the details by prescribing rules and regulations for the operation and enforcement of the law. In order to render admissible such delegation of legislative power, however, **it is necessary that the statute declare a legislative policy, establish primary standards for carrying it out, or lay down an intelligible principle to which the administrative officer or body must conform, with a proper regard for the protection of the public interests and with such degree of certainty as the nature of the case permits, and enjoin a procedure under which, by appeal or otherwise, both public interests and private rights shall have due consideration**. . . . If the Legislature fails to prescribe with reasonable clarity the limits of the power delegated or if those limits are too broad, its attempt to delegate is a nullity.

State v. Stoddard, 126 Conn. 623, 628, 13 A.2d 586, 588 (1940) (citations omitted) (emphasis supplied).[73] As such, in order to be considered a permissible delegation of authority, the General Assembly is required to set forth sufficiently precise standards for the executive branch to follow.

The test for determining whether the standards set forth in statute are sufficiently precise is as follows:

> The test for constitutionally sufficient standards to govern the exercise of delegated powers requires only that the standards be as definit[e] as is reasonably practicable under the circumstances." (Internal quotation marks omitted.) . . . "[T]he legislative process would frequently bog down if the General Assembly were constitutionally required to appraise beforehand the myriad situations to which it wishes a particular policy to be applied.... To require any more specificity in the standards ... would hamper the flexibility needed [for the department to carry out its duties].

Rudy's Limousine Service, Inc. v. Dept. of Transp., 78 Conn. App. 80, 90-91 826 A.2d 1161, 1167-68 (2003). Stated another way, "the statute must contain a rule or standard to guide or restrain the exercise of the power delegated to the administrative officials so that they will not be accorded the uncontrolled power to grant or withhold approval according to their unregulated discretion." Santoro v. Rockwell, 14 Conn Supp. 379, 382 (1947). Accordingly it is appropriate to examine (1) what standards or guides are set forth in statute and (2) how much discretion a statute affords the executive branch to determine whether it contains sufficiently precise standards. If the statute provides the executive branch with unfettered discretion, the delegation will lack sufficiently precise standards. Id.

In the present matter, the Departments find that the General Assembly provided DSS with extensive guidelines to implement the Hospital User Fee, which are set forth in Chapter 211a of the Connecticut General Statutes, federal Medicaid law, and the state budget. In doing so, the General Assembly afforded DSS very little, if any, discretion in implementing the Hospital User Fee.

In order to evaluate whether the Hospital User Fee contains sufficiently precise standards for the Departments' administration, it is first necessary to understand the scope of delegation afforded to the Departments under the Hospital User Fee. As referenced above, the Hospital User Fee sets forth a complex formula under which DSS is required to calculate the amount of Fee due from hospitals in order support the appropriations for payments to hospitals and supply the revenue set forth in the revenue estimates the variables of which are set forth in Chapter 211a of the Connecticut General Statutes, federal Medicaid law, and the state budget.

[73] Jennings v. Connecticut Light & Power Co., 140 Conn. 650, 670, 103 A.2d 535, 546 (1954) ("The challenge of unconstitutional delegation of legislative power is successfully met if the statute declares a legislative policy, establishes primary standards for carrying it out or lays down an intelligible principle to which the agency must conform with a proper regard for the protection of the public interest, and affords a resort to the courts for the protection of both the public interest and private rights."); see also St. John's Roman Catholic Church Corp. v. Town of Darien, 149 Conn. 712, 721, 184 A.2d 42, 46-47 (1962).

Specifically, Conn. Gen. Stat. § 12-263b sets forth a number of variables for the formula that DSS is required to use to calculate the Hospital User Fee: (1) the taxpayers subject to the Hospital User Fee, (2) the taxpayers exempt from the Hospital User Fee, and (3) the base upon which the Hospital User Fee was to be calculated. Additionally, the statute incorporated by reference federal Medicaid requirements by mandating that the fee comply with federal law, which requirements include a maximum amount that the tax can be, as well as the P1/P2 statistical test required for a waiver to exempt the categories of hospitals excluded from the user fee, and the federal prohibitions on a direct correlation between user fee and payment amounts or any other prohibited hold harmless provision.

To that end, federal Medicaid law sets forth the following requirements that the Hospital User Fee must have complied with: a provider tax must be broad-based and uniform, unless CMS grants a waiver of either or both of those requirements and in all situations, must not include a hold harmless provision. 42 U.S.C. § 1396b(w)(3); 42 C.F.R. § 433.68(b).[74]

[74] A provider tax will meet the "broad-based" requirement if it "imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State…or is imposed with respect to all non-Federal, nonpublic providers in the class." 42 U.S.C. § 1396b(w)(3)(B)(i); 42 C.F.R. § 433.68(c). If a state wishes to exempt certain providers from a tax, the state may request a waiver of this requirement from CMS. In order to obtain such a waiver, the state must demonstrate to CMS that the proposed tax is "generally redistributive" and that "the amount of the tax is not directly correlated to payments" from Medicaid for the same services that are being taxed. 42 U.S.C. § 1396b(w)(3)(E)(ii). This is done through a statistical test known as the P1/P2 test. The P1/P2 test is performed by dividing P1 (the proportion of tax revenue applicable to Medicaid if the tax applied to all providers within the class) by P2 (the proportion of tax revenue applicable to Medicaid excluding any categories of providers that the state proposes to exempt in the waiver). 42 C.F.R. § 433.68(e)(1). In general, a tax will pass the P1/P2 test if, in aggregate, the providers that are subject to the tax have a higher portion of their revenue from treating patients who receive Medicaid than the providers that are proposed to be exempted from the tax.

A provider tax will meet the "uniformity" requirement if the same tax rate is applied to all items or services within a class. For example, the uniformity requirement will be met if "in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State…." 42 U.S.C. § 1396b(w)(3)(C)(III). Stated simply, if a tax is imposed on the revenue of a class of items or services, in order to be considered uniform, the tax must be imposed at a uniform rate for all the revenue associated with the provision of all items or services that make up that class. 42 C.F.R. § 433.68(d)(1)(iii).[74] If a state wishes for its provider tax to include credits, exclusions, or deductions, the state may request a waiver from CMS. 42 C.F.R. § 433.68(d)(2)(i).

Finally, in order to be considered a permissible provider tax, the tax must not include prohibited hold harmless provisions. 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(b)(3). Federal law defines several types of prohibited hold harmless provisions. 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f). Specifically, a provider tax, and the associated payments made to health care providers under Medicaid, cannot directly or indirectly hold the provider harmless for the tax. Specifically, a provider tax cannot include "any direct or indirect payment, offset, or waiver…that…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).

As a consequence of the federal requirement that a provider tax must not include a hold harmless provision, some providers must pay more in tax than they received in payments, and some providers must pay less in tax than they received in payments. Accordingly, any consideration of the tax must also take into account the manner in which the providers are paid under the state's Medicaid program in order to ensure that there is no prohibited hold harmless provision that would result in federal penalties for an impermissible tax.

Finally, the General Assembly provided DSS with the final variable of the Hospital User Fee, the amount that the Hospital User Fee was required to generate, by codifying revenue estimates and revising said estimates in accordance with Conn. Gen. Stat. § 2-35. Specifically, through codification of the revenue estimates in 2011, the General Assembly charged DSS with calculating the Hospital User Fee to raise a total of $349.1 million in revenue annually for SFY 2012 and 2013. See R. at 581-82; OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part II, Summary & Schedules, at 58. This amount of revenue that needed to be collected from the Hospital User Fee remained unchanged in the state budget and revenue estimates for SFY 2014 and 2015. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. The General Assembly revised this variable in 2015 to reflect that the Hospital User Fee was required to raise a total of $556 million in revenue annually for SFY 2016 and 2017. In both cases, DSS needed to calculate the details of the tax by solving for the variables in the formula after starting with the total amount of tax that needed to be collected. See 2015 Conn. Pub. Acts 244, § 56; 2015 Conn. Pub. Acts 5, June spec. sess., § 496; OFA, Connecticut State Budget, FY 16 & FY 17 Budget, at 483. Given the above, the Departments find that state statute, codified revenue estimates, and federal Medicaid law clearly define a formula that is the rate of the Hospital User Fee.

Consistent with the above, the volume of guidelines the General Assembly provided to DSS to govern its administration of the Hospital User Fee is extensive. Moreover, given the extensive guidelines set forth in statute, the scope of discretion afforded to DSS was very limited. As set forth above, the Departments have found that the Departments were not delegated any authority to set the tax rate, base, or taxpayers upon which the tax would be imposed. Rather, the Departments were charged with simply calculating the amount of tax due under the formula established by the General Assembly.

The primary force of the Petitioners' challenge to the Hospital User Fee here appears to be premised upon a belief both that DSS set the rate of tax and that DSS was not required to comply with the General Assembly's mandate that the Hospital User Fee generate a certain amount of revenue and comply with federal law. R. at 6-7, 27. Specifically, the Petitioners have alleged that the Hospital User Fee

> simply contains no standard, intelligible or otherwise, to guide DSS's selection of a tax rate. The relevant language provides only that "[t]he rate of [the] tax shall be up to the maximum rate allowed under federal law. Conn. Gen. Stat. § 12-263b(a). Thus, the statute permits DSS to choose any number of rates – from zero to 6% - and every one of those

In order to determine whether a tax includes an indirect hold harmless provision, CMS applies a two pronged test to examine whether the tax correlates to payments made to the taxpayers. The first prong of the test provides that no indirect hold harmless provision exists if the tax rate is less than six per cent (6%). 42 C.F.R. § 433.68(f)(3)(i)(A). This is referred to the safe-harbor tax rate. If the tax rate is greater than six per cent (6%), under the second prong of the test, an indirect hold harmless will exist if "75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments." 42 C.F.R. § 433.68(f)(3)(i)(B). The maximum tax rate allowed under federal law is whatever tax rate will pass both prongs of this test.

> rates would have been entirely proper for *no reason* other than the fact that they were equal to or less than 6%."

R. at 8, 28. The analysis performed by the Petitioners above, in focusing on one specific line of the statute, is contrary to the manner in which the Hospital User Fee operates and well-established principles of statutory construction. To that end, and as set forth extensively above, the Hospital User Fee is a set fee designed to raise a specific amount of revenue. DSS does not select the "rate" of the fee as the Petitioners suggest, but rather is charged with calculating the amount of fee due from each hospital using the formula set forth in statute. The line in the Hospital User Fee prescribing that the rate of the tax cannot exceed the maximum rate under federal law is only one component of the system of tax set forth in the Hospital User Fee. Reviewing this component alone is meaningless. The entire framework of the Hospital User Fee must be examined in order to understand how each individual component works to create the formula that dictates how the tax rate of the Hospital User Fee is to be calculated.

When the Hospital User Fee is viewed in its entirety rather than by its component parts, it is clear that DSS did not have the ability to select any rate from 0% to 6%. Rather, DSS had to calculate the amount of fee due from each hospital in order to generate the amount of revenue codified in the revenue estimates. If DSS were to "select" the rate at 0%, DSS would have violated the mandate set forth by the General Assembly.

The Petitioners make this same error with respect to their allegations regarding lack of standards with respect to the selection of the base year. To this end, the Petitioners allege that Chapter 211a "similarly provides no intelligible parameters to guide selection of the base year." Again, the Petitioners appear to be looking at one component part of the Hospital User Fee without considering the entire framework of the Fee. To that end, as described more fully above, while the General Assembly appears to give DSS discretion to select the year upon which the tax will be calculated, Conn. Gen. Stat. § 12-263b ("The Commissioner of Social Services shall determine the base year on which such tax shall be assessed."), such apparent authority is eroded by the requirements that the Hospital User Fee generate a certain amount of revenue, the maximum rate allowed under federal law, and that all hospitals subject to the tax had to be in existence for the year that was selected. Stated another way, although the statute says that DSS may select the base year, DSS was required to do so in a manner consistent with statutory requirements.

DSS's lack of authority in selecting the base year is evident in DSS's calculation of the tax for periods beginning in SFY 2016. As referenced above, the General Assembly increased the amount of revenue the Hospital User Fee was required to generate in 2015 for state fiscal years 2016 and 2017. In doing so, given the limitations on the maximum rate of tax imposed by the federal government, DSS could no longer calculate the tax using federal fiscal year 2009 as the base year – there was simply not enough net patient revenue to tax in that year without exceeding the maximum rate permitted under federal law. Moreover, hospitals had merged, resulting in different taxpayers subject to the tax. Accordingly, DSS had to select a year with sufficient net patient revenue to tax to achieve the amount set forth in the revenue estimates without violating federal Medicaid law. Federal fiscal year 2013 was the only such year that would comply with these requirements.

Essentially, in order to support their argument that the Hospital User Fee lacks any standards governing DSS's administration of the tax, the Petitioners view individual lines in the Hospital User Fee in a vacuum rather than viewing said lines in the context of the overall statutory "system" set forth by the General Assembly. The Departments note that doing so not only misportrays the Hospital User Fee, but is also contrary to well-established principles of statutory construction. See Lopa v. Brinker Int'l, Inc., 296 Conn. 426, 433, 994 A.2d 1265, 1269–70 (2010) (" 'It is a basic tenet of statutory construction that the legislature [does] not intend to enact meaningless provisions.... [I]n construing statutes, we presume that there is a purpose behind every sentence, clause, or phrase used in an act and that no part of a statute is superfluous.... Because [e]very word and phrase [of a statute] is presumed to have meaning ... [a statute] must be construed, if possible, such that no clause, sentence or word shall be superfluous, void or insignificant.' "); see also Chatterjee v. Comm'r of Revenue Servs., 277 Conn. 681, 691, 894 A.2d 919, 925 (2006); Scholastic Book Clubs, Inc. v. Comm'r of Revenue Servs., 304 Conn. 204, 217, 38 A.3d 1183, 1190 (2012).

To that end, when the Hospital User Fee is properly viewed as a system set up to calculate, on the basis of net patient revenue, a fee from taxpayers, the sum total of which is a set amount articulated in the revenue estimates, it is abundantly clear that the statues governing the Hospital User Fee contain sufficiently precise standards. Given this statutory scheme, the Departments find that DSS had little, if any, discretion in administering said tax, but rather was required to calculate the amount of tax due from each hospital consistent with the formula set forth by the General Assembly. In fact, given the extensive statutory scheme governing the administration of the Hospital User Fee which contains several state statutes, detailed requirements in federal statute, extensive federal regulations, the state budget, and the budget book adopted by the General Assembly that was prepared by OFA to codify the state budget, there are ample standards to guide DSS's actions.

Consistent with the above, the Departments find that, upon review of the entire statutory scheme governing the Hospital User Fee and the legislative history associated therewith, the Hospital User Fee contains sufficiently precise standards for the Departments' administration of said Fee. Accordingly, the Departments determine that the Hospital User Fee does not violate Article Second of the Connecticut Constitution on this basis.

E. Conclusion

For all of the reasons discussed above, the Departments find that the Petitioners have failed to meet their burden to show beyond a reasonable doubt that the Hospital User Fee violates Article Second of the Connecticut Constitution.

2. The Departments find that neither DSS nor DRS enacted an illegal regulation in violation of the Uniform Administrative Procedure Act (UAPA).

The Petitioners have alleged that the Departments were required to enact regulations in order to implement the Hospital User Fee. Specifically, the Petitioners have alleged that

> DRS is precluded from collecting the tax imposed on the net patient revenue of each hospital pursuant to Conn. Gen. Stat. § 12-263b because the Hospitals Tax rate and base was promulgated through an unenforceable regulation. The email distributed by DSS to revise the tax base and tax rate imposed on the net patient revenue of each hospital pursuant to the Act for state fiscal years 2016 and 2017 is a "regulation" under the APA. The regulation is unenforceable by DRS because it was not enacted by DSS according to the procedures and rules provided by the APA.

R. at 29. Similarly, in the Petition that they filed with DSS, the Petitioners have alleged that the notification from DSS regarding the amounts that each hospital owed under the Hospital User Fee for SFY 2016-2017 is an unenforceable regulation. R. at 8-9.

The Departments find that neither DSS nor DRS was required to enact a regulation in order to implement the Hospital User Fee for a number of reasons. Specifically, the "regulation" the Petitioner alleges DSS was required to promulgate is already set forth in statute. Under Chapter 211a, DSS was simply charged with calculating the amount of tax due from each hospital, and DRS was charged with the collection of said amount. Accordingly, the Departments find that DSS did not enact an illegal regulation in violation of the Uniform Administrative Procedure Act (UAPA) through the calculation of the Hospital User Fee and setting of the base year and DRS was not and is not precluded from collection of said Fee.[75]

A. The Petitioners bear the burden of establishing that the Departments enacted an illegal regulation.

The Petitioners bear the burden of establishing that the Departments were required to and failed to establish a regulation setting forth the tax rate and base year. To that end, the Connecticut Supreme Court has held that

> . . . ordinarily the validity of an administrative regulation can be challenged only by one directly harmed by its application. Such a challenge requires a showing of some type of personal harm or injury or proof that an individual's rights have been prejudiced or violated by the regulation. . . . **Thus, where as here, a party challenges the failure of an administrative agency either to adopt or publish sufficient procedural rules, that party bears not only the burden of overcoming the presumption of validity that**

[75] The Petitioners' UAPA challenge addresses only the 2015 DSS email notifying the hospitals of their amounts owed under the Hospital User Fee for SFY 2016-2017. See R. at 8-10, 29-30. Therefore, the Departments consider only the Hospital User Fee for SFY 2016-2017 in this section. See id. In any case, if the Petitioners had raised a UAPA challenge to the Hospital User Fee for prior state fiscal years, the Departments would find that DSS was not required to enact a regulation for those years either for the same reasons set forth herein for SFY 2016-2017.

> **attaches to the agency regulations that exist; . . . ; but must also demonstrate some prejudice as a result of the agency's alleged failure**. . . .

Goldberg v. Ins. Dep't of State of Conn., 207 Conn. 77, 83–84, 540 A.2d 365, 368 (1988) (citations omitted) (emphasis supplied). Accordingly, the Petitioners must establish that the Departments have both failed to enact a regulation when required and that this alleged failure prejudiced the Petitioners in some manner. As set forth more fully below, the Departments find that the Petitioners have not met this burden as the Departments were not required to enact a regulation.

B. An agency regulation is a rule that has substantial impact on rights and obligations of parties who may appear before the agency in the future. The application of law to facts does not constitute regulation making.

Under the UAPA, a "regulation" is defined as:

> each agency statement of general applicability, without regard to its designation, that implements, interprets, or prescribes law or policy, or describes the organization, procedure, or practice requirements of any agency. The term includes the amendment or repeal of a prior regulation, but does not include (A) statements concerning only the internal management of any agency and not affecting private rights or procedures available to the public, (B) declaratory rulings issued pursuant to section 4-176, or (C) intra-agency or interagency memoranda;

Conn. Gen. Stat. § 4-166(16). Conn. Gen. Stat. §§ 4–168, 4–169, 4–170, and 4–172 set forth procedures that agencies are required to follow in adopting regulations. Subsection (c) of Conn. Gen. Stat. § 4-168 provides "(n)o regulation adopted after January 1, 1972, is valid unless adopted in substantial compliance with this section." Conn. Gen. Stat. § 4-168(c).

In general, when an agency's "rule has a substantial impact on the rights and obligations of parties who may appear before the agency in the future, it is a substantive rule, i.e., a 'regulation' requiring compliance with the UAPA." Salmon Brook Convalescent Home, Inc. v. Comm'n on Hosps. & Health Care, 177 Conn. 356, 362 (1979) (citation omitted). This "does not mean that every administrative decision which may have precedential significance beyond the facts and party before it becomes ipso facto a regulation." Sweetman v. State Elections Enforcement Comm'n, 249 Conn. 296, 317 (1999) (citations and internal quotation marks omitted). Further, "administrative agencies must necessarily interpret statutes which are made for their guidance and they may do so without reference to regulations." Id. (citations and internal quotation marks omitted). Thus, an agency's actions do not necessarily constitute a regulation when an agency was "interpreting [a] statute…which it was charged with administering." Id. at 319 (citing Eagle Hill Corp. v. Comm'n on Hosps. & Health Care, 2 Conn. App. 68, 77 (1984)).

Consistent with the above, in order to be considered an "illegal regulation" the conduct the Petitioners have challenged must be a "statement of general applicability" that "has a substantial impact on the rights and obligations of taxpayers." See Conn. Gen. Stat. § 4-166(16); Salmon Brook Convalescent Home, Inc., 177 Conn. at 362. An agency, in applying facts and circumstances to a particular law, will not be deemed to be engaged in regulation-making. See

Eagle Hill Corp. v. Comm'n on Hosps. & Health Care, 2 Conn. App. 68, 77, 477 A.2d 660, 666 (1984) ("It was interpreting the statute, which was enacted for its guidance and which it was charged with administering, by "the filtering of a set of facts through the law ...." Connecticut Life & Health Ins. Guaranty Assn. v. Jackson, supra, 357, 377 A.2d 1099. It did not engage in regulation-making.").

Accordingly, the question the Departments must determine is whether the challenged conduct is a "substantive rule [that] establishes a standard of conduct which has the force of law." Cheshire Convalescent Ctr., Inc. v. Comm'n on Hosps. & Health Care, 34 Conn. Supp. 225, 239–40, 386 A.2d 264, 270–71 (Com. Pl. 1977).

C. The Departments were not required to enact a regulation to set the tax rate and base for the Hospital User Fee, as the tax rate and base are already set forth in statute.

It is axiomatic that an agency is not required to enact a regulation setting forth what is already set forth in statute. Yet, this appears to be exactly what the Petitioners allege that the Departments were required to do. To this end, the Petitioners allege that "the Hospitals Tax rate and base was promulgated through an unenforceable regulation. The email distributed by DSS to revise the tax base and tax rate imposed on the net patient revenue of each hospital pursuant to the Act for state fiscal years 2016 and 2017 is a 'regulation' under the APA." R. at 29; see also R. at 8-9. However, as discussed more fully in Ruling 1 above, and summarized below, both the tax rate and base are set forth through the formula described in statute. As such, neither Department was required to enact a regulation setting forth either the tax rate or base.[76]

[76] Despite the fact that by statute DRS's role in the implementation of the Hospital User Fee was limited to collecting the tax due from the taxpayers, the Petitioners have alleged that DRS enacted illegal regulations by setting the tax rate and tax base. To this end, the Petitioners have stated that

> DRS is governed by the rule making procedures of the APA. Conn. Gen. Stat. § 12-2(a)(2). For purposes of adopting regulations for the Act, DRS has not implemented separate rules of practice. Id. DRS did not make its determination of the tax rate and tax base available for public inspection nor did DRS post the determination or a notice of the adoption of the regulation on its electronic platform for regulations. DRS has not met its burden of proving that it provided notice of its adoption of the regulation as required under the APA. Thus, the regulation is unenforceable and DRS is precluded from collecting the Hospitals Tax.

R. at 30. As DRS performed none of the actions the Petitioners have inexplicably ascribed to it (i.e. setting the tax rate and base), nor was DRS even involved in the calculation of the tax, the Departments cannot conceive as to how DRS enacted an illegal regulation. Accordingly, the Departments must find that DRS did not enact an illegal regulation in violation of the UAPA.

Additionally, the Petitioners have alleged DRS "delegated" the authority to set the tax rate to DSS:

> The Act bestows upon the Commissioner of DRS the power to prescribe or furnish the forms required to report the Act and also requires that all returns, and accompanying payment, be made to DRS. In addition, the Act states that "the rate of [the tax] shall be up to the maximum rate allowed under federal law." The Act does not expressly state the agency responsible for setting the rate. However, DRS has issued administrative guidance to delegate to DSS the power to set the tax rate for the Act. Specifically, the DRS guidance states the "DSS will determine a hospital's net patient revenue and the hospital net patient revenue tax." Connecticut Department of Revenue Services Special Notices, SN 2011(15). DSS's email stating the revised

i. The General Assembly explicitly set forth a tax rate in statute.

Conn. Gen. Stat. § 12-263a provides, in pertinent part, that:

> (a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. **The rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly. Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed in order to ensure conformance with the state budget adopted by the General Assembly. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship**. Effective July 1, 2012, and for the succeeding fifteen months, the rates of such tax, the base year on which such tax shall be assessed, and the hospitals exempt from the outpatient portion of the tax based on financial hardship shall be the same tax rates, base year and outpatient exemption for hardship in effect on January 1, 2012.

Conn. Gen. Stat. § 12-263b, as amended by 2016 Conn. Pub. Acts 3, May spec. sess., § 120 (emphasis supplied). As evidenced by the above-quoted statute, the General Assembly set forth the following variables in statute: (1) the taxpayers subject to the Hospital User Fee, (2) the taxpayers exempt from the Hospital User Fee, and (3) the tax base upon which the Hospital User Fee was to be calculated. Additionally, the statute incorporated by reference all of the federal Medicaid requirements set forth above by mandating that the fee comply with federal law, which requirements include a maximum amount that the tax can be.

As also set forth more fully above, not all of the components of the Hospital User Fee were set forth in Conn. Gen. Stat. § 12-263b. Rather, as the legislative history demonstrates, what was set forth in Conn. Gen. Stat. § 12-263b was "a system wherein [the General Assembly] can move forward with the tax program." Connecticut Senate Transcript, 5/24/2011; see also 2016 Conn. Pub. Acts 3, May spec. sess., § 119. The General Assembly provided DSS with the final variable

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> tax base and rate of the Act is an act by DSS that implements and prescribes the Act and thus, implements and prescribes Connecticut law. Accordingly, DSS's email is a regulation under the APA. . . .

R. at 29-30. DRS does not have the authority to delegate the task of setting a tax rate to anyone. Under Article Second of the Connecticut Constitution, only the General Assembly has the authority to set a tax rate. To that end, as set forth herein, the General Assembly did in fact set forth the tax rate in the form of a formula. As such, the General Assembly was not required to, and, in fact, did not, "expressly state the agency responsible for setting the rate." Rather the General Assembly charged DSS with calculating the amount of tax due, which is very different from setting a tax rate or base. The DRS guidance the Petitioners cite above confirms this - "DSS will determine a hospital's net patient revenue and the hospital net patient revenue tax."

Accordingly, given that the General Assembly set forth the tax rate and base in statute and DSS was charged with calculating the amount of tax due, the Petitioners' assertion that DRS either set the tax rate and base or delegated the authority to do so to DSS is wholly without foundation in law or fact.

of the Hospital User Fee, the amount that the Hospital User Fee was required to generate, by codifying revenue estimates and revising said estimates in accordance with Conn. Gen. Stat. § 2-35. Specifically, through codification of the revenue estimates in 2011, the General Assembly charged DSS with calculating the Hospital User Fee to raise a total of $349.1 million in revenue annually for SFY 2012 and 2013. This amount of revenue that needed to be collected from the Hospital User Fee remained unchanged in the state budget and revenue estimates for SFY 2014 and 2015. The General Assembly revised this variable in 2015 to reflect that the Hospital User Fee was required to raise a total of $556 million in revenue annually for SFY 2016 and 2017. In both cases, DSS needed to calculate the details of the tax by solving for the variables in the formula after starting with the total amount of tax that needed to be collected. Given the above, the Departments find that state statute, codified revenue estimates, and federal Medicaid law clearly define a formula that is the rate of the Hospital User Fee.

In section 119 of Public Act 16-3, the General Assembly codified its intent in enacting the Hospital User Fee. Specifically, section 119 provides, in pertinent part that "the intention of section 146 of public act 11-6, as amended by section 103 of public act 11-44 and section 79 of public act 11-61, was that on and after July 1, 2011, **the General Assembly would set the rate of the tax on the net patient revenue of hospitals by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget**, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis." 2016 Conn. Pub. Acts 3 § 119 (May Spec. Sess.) (emphasis supplied).

Consistent with the above, the Departments find that tax rate is already set forth in statute. See Michigan Cent. R. Co. v. Powers, 201 U.S. 245, 294-95, 26 S. Ct. 459, 463 (1906). As such, DSS was not required to enact a regulation setting forth the tax rate. Similarly, the tax base is set forth in statute.

ii. The General Assembly explicitly set forth a tax base in statute.

As referenced above, the tax base is: "[t]he total property, income, or wealth subject to taxation in a given jurisdiction. 2. The aggregate value of the property being taxed by a particular tax." Tax Base, Black's Law Dictionary (10th ed. 2014). Stated simply, a tax base is the property subject to tax. Conn. Gen. Stat. § 12-263b provides that the Hospital User Fee is "a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter." Conn. Gen. Stat. § 12-263b(a). As such, the type of income subject to tax is net patient revenue, which is further defined as "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." Conn. Gen. Stat. § 12-263a(2). Given the plain language of these statutes, there can be no dispute that the General Assembly clearly set forth that the type of revenue subject to the Hospital User Fee is accrued payments from inpatient and outpatient hospital services.

Under Conn. Gen. Stat. § 12-263b, the General Assembly appears to give DSS discretion to select the year upon which the tax will be calculated. Conn. Gen. Stat. § 12-263b ("The Commissioner of Social Services shall determine the base year on which such tax shall be assessed."). However, as with the tax rate, DSS's authority to select the base year was limited implicitly by the fact that the Hospital User Fee had to generate a certain amount of revenue and that the tax rate could not exceed the maximum rate allowed under federal law. See 2016 Conn. Pub. Acts 3, May spec.

sess., § 119. Additionally, all hospitals subject to the tax had to be in existence for the year that was selected.

As such, while Conn. Gen. Stat. § 12-263b appears to give DSS discretion to select a base year, all such authority was eroded by the requirements that the Hospital User Fee generate a certain amount of revenue, the maximum rate allowed under federal law, and that all hospitals subject to the tax had to be in existence for the year that was selected. Stated another way, although the statute says that DSS may select the base year, DSS was required to do so in a manner consistent with statutory requirements.

Accordingly, the tax base of the Hospital User Fee is also prescribed by statute.

iii. As the Hospital User Fee tax rate and base are set forth in statute, the Departments were not required to enact a regulation setting forth said tax rate and base.

Where the General Assembly has already prescribed all of the details of a policy, there is no need for the agency charged with administering the statute to adopt a regulation. Such a regulation would be redundant and unnecessary. For example, in Sweetman, the Connecticut Supreme Court held that the State Elections Enforcement Commission was not required to adopt guidelines as regulations because they simply described the requirements that were already prescribed by the General Assembly. Sweetman, 249 Conn. at 318-19; see also Foodways National, Inc. v. Crystal, No. 0503231, 1994 WL 248167, at *5-6 (Conn. Super. Ct. May 17, 1994, Blue, J.), rev'd on other grounds, 232 Conn. 325 (1995) ("the Commissioner's action in this case was one of adjudication rather than regulation. That act of adjudication required the Commissioner to interpret the statute before him. In doing so, he did not violate the UAPA.").

As set forth above, neither Department set the tax rate or base for the Hospital User Fee. Accordingly, given that the Departments did not set the tax rate or base of the Hospital User Fee, the Departments could not have enacted an illegal regulation by setting said tax rate and base. Consistent therewith, DSS's authority under the Hospital User Fee was simply to calculate the amount of tax due from each hospital. As described more fully below, DSS did not create a "substantive rule [that] establishes a standard of conduct which has the force of law," rather, DSS simply "filter[ed] a set of facts through the law." Salmon Brook Convalescent Home, Inc., 177 Conn. at 362; Eagle Hill Corp., 2 Conn. App. at 77.

D. The Departments were not required to enact a regulation to calculate the amount of the Hospital User Fee due from each taxpayer as such actions were simply "filtering a set of facts through the law."

The Petitioners appear to contend that the Departments should have promulgated a regulation containing DSS's calculations as to the amount of Hospital User Fee due from each taxpayer. To that end, the Petitions provide as follows: "DSS's email stating the revised tax base and rate of the Act is an act by DSS that implements and prescribes the Act and thus, implements and prescribes Connecticut law. Accordingly, DSS's email is a regulation under the APA." R. at 8-9, 29. However, as described above, DSS was not delegated authority to set the tax rate. Rather, DSS's authority was limited to the calculation of the amount of fee due from each hospital using the

formula set forth by the General Assembly. Such an action does not constitute creating a "substantive rule [that] establishes a standard of conduct which has the force of law." Salmon Brook Convalescent Home, Inc., 177 Conn. at 362. Rather, DSS simply "filter[ed] a set of facts through the law." Eagle Hill Corp., 2 Conn. App. at 77.

To that end, as described above, DSS's actions in calculating the amount of tax due from the Petitioners for the periods at issue are as follows. The budget adopted by the General Assembly for SFY 2016-2017 increased the amount of revenue the Hospital User Fee was required to generate to $556 million. 2015 Conn. Pub. Acts 244, § 56; 2015 Conn. Pub. Acts 5, June spec. sess., § 496. In order to implement these changes, DSS was required to

> (1) determine the amount of net patient revenue each hospital had accrued in a given year;
> (2) select a base year with sufficient net patient revenue for the fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law;
> (3) determine those hospitals that met the statutory definitions of exempt hospitals;
> (4) calculate the amount of fee each hospital owed in order to comply with federal Medicaid provider tax requirements and also to achieve the amount of revenue set forth in the revenue estimates and payments set forth in the state budget; and
> (5) obtain a waiver from CMS of the broad-based requirement for those hospitals statutorily exempt from Hospital User Fee.

First, DSS reviewed the reports available to determine a year in which (1) all hospitals subject to the tax existed and (2) said year had with sufficient net patient revenue for the Hospital User Fee to achieve the amount of revenue set forth in the revenue estimates without exceeding the maximum percentage permitted under federal Medicaid law. In mid-2015, when the General Assembly increased the amount of revenue that the Hospital User Fee was required to generate, the latest year's reporting available was for FFY 2013. Said year was selected as it contained sufficient net patient revenue to raise the $556 million required annually without exceeding the federal maximum percentage while at the same time exempting all hospitals exempt from the tax under Conn. Gen. Stat. §§ 12-263a and 12-263b. Additionally, the revenue from said year and associated distribution of payments made to hospitals complied with federal requirements for the Hospital User Fee including that the Fee be broad-based.

Accordingly, using the data from the twelve month actual filings submitted to OHCA, DSS conducted several calculations in order to apply for a waiver from CMS. As part of the waiver application process, DSS performed the P1/P2 test, which showed that the user fee was generally redistributive despite exempting certain hospitals. R. at 632-52. The results of said test were set forth in a waiver application DSS submitted to CMS on June 26, 2015. Id.

Additionally, as part of the waiver application process, DSS was required to demonstrate that the Hospital User Fee and associated Medicaid payments did not hold the taxpayers harmless for the user fee either directly or indirectly. Accordingly, DSS included in the waiver application the use of the proceeds of the user fee and payments made to the hospitals in order to demonstrate that those payments did not hold harmless any taxpayer directly or indirectly as payments were not directly correlated to the user fee. Id.

On October 7, 2015, CMS approved the waiver, which was effective July 1, 2015. Id. Accordingly, DSS calculated the amount of Hospital User Fee due from each of the hospitals subject to the user fee in a manner consistent with CMS's waiver approval. Specifically, DSS apportioned the total revenue that need to be raised from the Hospital User Fee consistent with each hospitals' net patient revenue for 2013 and the distribution that the user fee had to comply with in order to avoid containing a hold harmless provision. On October 16, 2015, DSS notified the hospitals through a posting on its website and by email of the amount of user fee due for SFY 2016-2017. R. at 584-609.

Consistent with the above, it is clear that the actions taken by DSS in implementing the Hospital User Fee were simply steps necessary to calculate the amount of fee due from each hospital using the formula set forth in statute. DSS did not exercise its own judgment with respect to any component of the formula. DSS could not determine that the Hospital User Fee should generate more revenue. DSS was bound by the revenue estimates. DSS could not determine that other services should be subject to tax. DSS was bound by the definition set forth in statute. DSS could not determine what hospitals were subject to the tax. DSS was bound by the definition set forth in statute. DSS could not determine the maximum percentage the tax could be. DSS was bound by federal Medicaid law. The only discretion afforded to DSS was the selection of a year's net patient revenue upon which the fee would be based. As described more fully above, DSS only had the appearance of discretion as it was implicitly bound by the definition of taxpayers subject to tax, the revenue estimates, and federal Medicaid law.

Put simply, DSS was charged with applying a formula, not determining the rate of the Hospital User Fee should be. Accordingly, DSS did not have the discretion to make substantive rules when it implemented the Hospital User Fee.[77] As discussed above, the General Assembly had already prescribed the details of the Hospital User Fee and did not leave any discretion to DSS to make substantive determinations. Rather, DSS simply "filtered" the applicable data (net patient revenue of the hospitals not exempt from the tax) through the formula prescribed by the General Assembly in order to calculate the amount of Hospital User Fee due from each hospital. Essentially, DSS simply applied the law to the individual facts and circumstances of each hospital.[78] Such an action does not require the enactment of a regulation.

[77] The Departments' role in implementing the Hospital User Fee is completely different from the agency's role in Salmon Brook, where the Commission on Hospitals and Health Care had "a delegated discretion, which, to be properly exercised, where it has binding consequences, must obey the…UAPA. The commission was thus granted broad rulemaking authority by the legislature's delegating to it some considerable segment of its legislative authority." Salmon Brook, 177 Conn. at 363 (citation omitted). Specifically, in that case, the Commission on Hospitals and Health Care had statutory authority to regulate nursing home rates within broad parameters but the commission implemented those broad parameters by setting substantive "guidelines" that the court found were regulations that should have been adopted through the UAPA process. Id. at 358-60.

[78] The Departments note that the task DSS is charged with, calculating the amount of tax due from taxpayers, is a task the Commissioner of Revenue Services is charged with performing in connection with nearly every tax DRS administers. By way of example, under the Sales and Use Taxes set forth in Chapter 219, "[i]f the [Commissioner of Revenue Services] is not satisfied with the return or returns of the tax or the amount of tax required to be paid to the state by any person, the commissioner may compute and assess the amount required to be paid upon the basis of the facts contained in the return or returns or upon the basis of any information which is in or that may come into the commissioner's possession." Conn. Gen. Stat. § 12-415; see, e.g., Conn. Gen. Stat. § 12-204;12-233; 12-486a; 12-728. To require the Commissioner to enact a regulation each time he calculates the amount of tax due from a taxpayer

The foregoing is consistent with the fact that, under Chapter 211a, the General Assembly has not required the Departments to enact regulations to notify taxpayers of the amount of tax due, but rather merely required DSS to notify the hospitals of the amount of user fee due from each said hospitals.

E. Under statute, DSS's notification to each hospital of the amount it owes under the Hospital User Fee does not require the enactment of a regulation.

As described above, DSS calculated each tax amount individually for each hospital subject to the Hospital User Fee. For administrative simplicity and transparency, DSS notified all hospitals of their individually calculated user fee amounts in a single communication by email and by posting the rates on the DSS website. Given that DSS was simply required to calculate the amount of tax due, it follows that DSS was only required to notify the hospitals of said amount, not enact a regulation. This is consistent with the language of the Hospital User Fee set forth in Chapter 211a.

The General Assembly recently confirmed that calculations and notifications necessary to implement the Hospital User Fee are not regulations. Specifically:

> Consistent with section 12-263b of the general statutes, as amended by this act, the intention…was that on and after July 1, 2011, the General Assembly would set the rate of the tax…by setting forth the amount of funds that said tax would generate through codifying the revenue estimates adopted for purposes of each state budget, which is documented in the final version of each state budget prepared by the Office of Fiscal Analysis. In said public acts, the General Assembly charged the Commissioner of Social Services, in consultation with the Office of Policy and Management, with calculating the amount of tax due from each hospital within the limitations and requirements set forth in subsection (w) of 42 USC 1396b, including determining the base year for the tax, in order to obtain the funds set forth by the General Assembly in the state budget. As part of the administration of the tax, the Commissioner of Social Services was required to notify the hospitals of the amount of tax due. **Such calculations and notifications do not constitute regulations for purposes of chapter 54** of the general statutes.

2016 Conn. Pub. Acts 3, May spec. sess., § 119 (emphasis added). This clarifying language confirms that the General Assembly only intended for DSS to notify the hospitals of the amount of tax that each hospital owed. To that end, the General Assembly revised the language of the Hospital User Fee to make such intent clear: "Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services." 2016 Conn. Pub. Acts 3, May spec. sess., § 120(a). As can be seen from this revision to the language of the Hospital User Fee, the

is not administratively feasible and would paralyze his ability to collect taxes. It logically follows that it is equally inappropriate for the Commissioner of Social Services to enact a regulation every time he calculates a tax liability under the Hospital User Fee. No greater administrative obligations should be imposed on the Commissioner of Social Services simply because he is charged with administering fewer taxes.

General Assembly has made explicitly clear that DSS was not required to enact a regulation, but was merely required to notify hospitals of the amount of tax due.[79]

Further confirming that DSS was not required to adopt a regulation in order to implement the Hospital User Fee, Chapter 211a does not require DSS to adopt a regulation to notify taxpayers of the amount of tax due, even though other tax statutes specifically require the agency to adopt regulations. It "is a basic tenet of statutory construction that the legislature [does] not intend to enact meaningless provisions.... [I]n construing statutes, we presume that there is a purpose behind every sentence, clause, or phrase used in an act and that no part of a statute is superfluous." Echavarria v. Nat'l Grange Mutual Ins. Co., 275 Conn. 408, 415 (2005) (internal citations and quotation marks omitted). Further, because "the legislature knows how to convey its intent expressly," if language is omitted, "one could infer that the legislature did not intend" to include such language. State v. Kevalis, 313 Conn. 590, 604 (2014) (internal citations and quotation marks omitted). As a consequence, the "legislature's direction…in one section of the statutory scheme strongly supports our conclusion that it intended to omit such a requirement from" another section. NRT New England, LLC v. Jones, 162 Conn. App. 840, 850 (2016). See Sikorsky Aircraft Corp. v. Comm'r of Revenue Servs., 297 Conn. 540, 559, 1 A.3d 1033, 1045 (2010) ("Where a statute, with reference to one subject contains a given provision, the omission of such provision from a similar statute concerning a related subject ... is significant to show that a different intention existed.... That tenet of statutory construction is well grounded because [t]he General Assembly is always presumed to know all the existing statutes and the effect that its action or non-action will have upon any one of them.").

When the General Assembly determines that regulations are necessary to implement tax policy, it specifically requires DRS to adopt regulations, but such a requirement does not exist for the Hospital User Fee. For example, Conn. Gen. Stat. § 12-701(c) provides that "[t]he [DRS] commissioner shall, by regulation, define the term 'derived from or connected with sources within this state' as used in this chapter." Conn. Gen. Stat. § 12-701(c). Similarly, in the context of

[79] The language of the Hospital User Fee was specifically modified in order to be consistent with the obligations imposed upon DSS in connection with two other provider taxes: the resident day user fees imposed on nursing homes and ICF/IIDs. Like with the Hospital User Fee, specific language in the resident day user fees exempts DSS from the requirements of the Connecticut Uniform Administrative Procedures Act. By way of example, the resident user fee imposed against ICF/IIDs provides, in pertinent part, that

> On or before July 1, 2011, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee ***and promptly notify the commissioner and the intermediate care facilities for individuals with intellectual disabilities of such amount***.

Conn. Gen. Stat. § 17b-340b (emphasis supplied). The language of the Resident Day User Fee imposed against Nursing Home Providers is identical. See Conn. Gen. Stat. § 17b-321 ("On or before July 1, 2005, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount."). Like the Hospital User Fee, the statute does not indicate that such notification must be in the form of a regulation, as other statutes require. As such, DSS is similarly exempt from the UAPA for purposes of setting the rate of the resident day user fees.

Given that the three provider taxes were intended to operate in the same manner, those statutes confirm the General Assembly's intention that DSS simply notify taxpayers of the amount of Hospital User Fee due rather than adopt regulations.

property tax revaluations, OPM "shall adopt regulations…which an assessor shall use when conducting a revaluation." Conn. Gen. Stat. § 12-62(g). Likewise, DRS "shall, by regulations adopted in accordance with chapter 54, provide standards for providing any such claim for credit" regarding the sales tax. Conn. Gen. Stat. § 12-408(2)(B). In contrast, in Chapter 211a, there is no language requiring DSS or DRS to adopt regulations, which makes sense, because DSS is simply calculating the amount of tax due.

This is consistent with DRS's obligation in connection with the calculation of tax due from taxpayers. As set forth in footnote 78, calculating the amount of tax due from taxpayers, is a task the Commissioner of Revenue Services is charged with performing in connection with nearly every tax DRS administers. By way of example, under the Sales and Use Taxes set forth in Chapter 219, "[i]f the [Commissioner of Revenue Services] is not satisfied with the return or returns of the tax or the amount of tax required to be paid to the state by any person, the commissioner may compute and assess the amount required to be paid upon the basis of the facts contained in the return or returns or upon the basis of any information which is in or that may come into the commissioner's possession." Conn. Gen. Stat. § 12-415. To require the Commissioner of Revenue Services to enact a regulation each time he calculates the amount of tax due from a taxpayer is not administratively feasible and would paralyze the Commissioner's ability to collect taxes. Rather, as set forth in statute, the Commissioner is only required to notify the taxpayer of an assessment. See Conn. Gen. Stat. § 12-415 ("[t]he commissioner shall give to the retailer or person storing, accepting, consuming or otherwise using services or tangible personal property written notice of the commissioner's assessment."); see, e.g., Conn. Gen. Stat. § 12-204;12-233; 12-486a; 12-728.

For similar reasons, in other contexts as well, courts have recognized that it is neither required nor feasible for an agency to enact regulations when the agency is implementing a statute that requires variations to adjust to individual circumstances. For example, in considering whether there was probable success on the merits for a temporary injunction, the court found that the Department of Environmental Protection had sufficient authority under statute to "destroy undesirable or diseased wildlife, to provide for the protection and management of wildlife, and to manage state forests and parks." Friends of Animals, Inc. v. Rocque, No. CV-00-0801973, 2000 WL 1624830, at *6 (Conn. Super. Ct. Oct. 5, 2000, Schuman, J.). Based on this analysis, the court found that "[t]he Commissioner [of Environmental Protection] should not have to go through the formalities of rule-making to announce every new variable of environmental and wildlife management that arises before every new hunting or trapping season." Id. In another context, the Maryland Court of Appeals found that the Developmental Disabilities Administration within the Maryland Department of Health and Mental Hygiene was not required to adopt a regulation to establish an annual growth cap for its provider-contractors. See Dept. of Health & Mental Hygiene, 343 Md. 336, 346-348 (1996); see also Idaho State Tax Comm'n v. Beacom, 131 Idaho 569, 571-572 (1998) (finding that adoption of a tax form does not constitute a regulation subject to formal rulemaking requirements).

In the context of the Hospital User Fee, DSS is performing the same function as DRS normally does in calculating the amount owed by each taxpayer and notifying the taxpayer of the amount due. As the act of calculating the amount of tax due from a taxpayer is not a "statement of general applicability," but rather is simply the "filtering [of] a set of facts through the law," it logically follows that nether DRS or DSS would be required to enact regulations to perform such actions.

See Salmon Brook Convalescent Home, Inc., 177 Conn. at 362; Eagle Hill Corp., 2 Conn. App. at 77. As such, the suggestion that DSS was required to enact a regulation to calculate the amount of Fee due is not consistent with the obligations normally imposed upon the Commissioner of Revenue Services or the definition of regulation set forth in the UAPA.

Consistent with the above, the Departments determine that they were not required to enact a regulation to calculate the amount of fee due from taxpayers or to notify taxpayers of the amount of Hospital User Fee due from each said taxpayer both because (1) the language of the Hospital User Fee does not require DSS to do so, and because (2) the General Assembly has specifically clarified that DSS was not to do so. To impose such a requirement on DSS would not be administratively feasible and would not comply with the definition of regulation set forth in the UAPA.

F. The Departments did not enact an illegal regulation in violation of the UAPA in implementing the Hospital User Fee, as the tax rate and base year are set forth in statute.

For all of the reasons discussed above, the Departments find that the acts of setting the tax rate and base year were performed by the General Assembly through the statutes governing the Hospital User Fee. Accordingly, neither Department was required to enact a regulation to set forth either the tax rate or base year. Moreover, the actions taken by DSS to implement the Hospital User Fee and calculate the amount of tax due from taxpayers do not fall within the definition of a "regulation" for purposes of the UAPA, as the General Assembly specifically confirmed in the recent clarifying legislation. 2016 Conn. Pub. Acts 3, May spec. sess., § 119. Rather, said actions are simply the "filtering [of] a set of facts through the law." See Eagle Hill Corp., 2 Conn. App. at 77. Accordingly, the Departments find no illegal regulation that could be held to be unenforceable. Consequently, there is no basis for the Petitioners' allegation that DRS is "precluded from collecting the Hospitals Tax."

As set forth above, in order to succeed in their challenge under the UAPA, the Petitioners must have established that the Departments have both failed to enact a regulation when required and that this alleged failure prejudiced the Petitioners in some manner. However, the Departments find that the Petitioners have not met this burden as the Departments were not required to enact any such regulation.

3. The Hospital User Fee does not violate the equal protection clause of the fourteenth amendment to the United States Constitution.

The Petitioners claim that the Hospital User Fee violates the equal protection clause of the fourteenth amendment to the United States Constitution. R. at 10, 30. The Petitioners' sole basis for this challenge to the Hospital User Fee is the Petitioners' allegation that said Fee "creates an utterly arbitrary classification by imposing the tax on providers that are functionally indistinguishable from health care providers that are exempt from the tax." Id. As described more fully below, the Departments find no evidence that the Hospital User Fee violates the equal protection clause of the fourteenth amendment to the United States Constitution.

A. It is the Petitioners' burden to prove beyond a reasonable doubt the validity of their constitutional challenges.

A heavy burden falls upon the Petitioners in bringing a challenge under the fourteenth amendment of the United States Constitution. Specifically, the Petitioners are required to establish that the Hospital User Fee is unconstitutional by "**establish[ing] its invalidity on that ground beyond reasonable doubt**. . . . (W)here a statute reasonably admits of two constructions, one valid and the other invalid on the ground of unconstitutionality, courts should adopt the construction which will uphold the statute even though that construction may not be the most obvious one. . .. Of course, the fact that the plaintiffs chose to request a declaratory judgment, upon stipulation of facts, in nowise changes or relieves them of the burden of proof resting on them." Kellems v. Brown, 163 Conn. 478, 486, 313 A.2d 53, 58 (1972) (emphasis supplied).

To that end, states are afforded broad discretion in their classification of property for purposes of taxation under the equal protection clause of the fourteenth amendment. As such, the presumption of constitutionality can only be overcome by an explicit demonstration that a classification is hostile and oppressive. Id. at 487-88. Specifically, the Connecticut Supreme Court has found that

> In Connecticut, the power to levy taxes is vested in the General Assembly. . . . In selecting the subjects of taxation, legislatures have been allowed broad discretion. 'The latitude of discretion is notably wide in the classification of property for purposes of taxation and the granting of partial or total exemptions upon grounds of policy.' . . . 'The broad discretion as to classification possessed by a legislature in the field of taxation has long been recognized. This Court fifty years ago concluded that 'the fourteenth amendment was not intended to compel the states to adopt an iron rule of equal taxation,' and the passage of time has only served to underscore the wisdom of that recognition of the large area of discretion which is needed by a legislature in formulating sound tax policies. Traditionally classification has been a device for fitting tax programs to local needs and usages in order to achieve an equitable distribution of the tax burden. It has, because of this, been pointed out that in taxation, even more than in other fields, legislatures possess the greatest freedom in classification. Since the members of a legislature necessarily enjoy a familiarity with local conditions which this Court cannot have, ***the presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes. The burden is on the***

> ***one attacking the legislative arrangement to negative every conceivable basis which might support it.'***

Id. (emphasis supplied). Accordingly, in order to demonstrate beyond a reasonable doubt that the Hospital User Fee violates the equal protection clause, the Petitioners must make an explicit demonstration that the Hospital User Fee is hostile and oppressive towards hospitals and negate every conceivable basis upon which the Hospital User Fee may be deemed to be valid.

As set forth herein, the Departments find that the Petitioners have not met their burden to prove beyond a reasonable doubt that the Hospital User Fee violates the equal protection clause of the fourteenth amendment to the United States Constitution.

B. The Departments must determine whether the classification of "hospitals" for purposes of the Hospital User Fee is rationally related to a legitimate government purpose.

The equal protection clause of the fourteenth amendment to the United States Constitution protects against arbitrary and unreasonable classifications of persons. To this end, section 1 of the fourteenth amendment provides as follows

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; ***nor deny to any person within its jurisdiction the equal protection of the laws***.

U.S. Cons. amend. XIV § 2 (emphasis supplied). This "does not mean that a State may not draw lines that treat one class of individuals or entities differently from others. The test is whether the difference in treatment is an invidious discrimination." Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356, 359, 93 S. Ct. 1001, 1003 (1973).[80]

The level of scrutiny with which courts examine a state's statute to determine whether or not it contains "invidious discrimination" depends on whether the classification impacts a suspect class or fundamental right. See Batte-Holmgren v. Comm'r of Pub. Health, 281 Conn. 277, 295, 914 A.2d 996, 1007–08 (2007). "If, in distinguishing between classes, the statute either intrudes on the exercise of a fundamental right or burdens a suspect class of persons, the court will apply a strict scrutiny standard [under which] the state must demonstrate that the challenged statute is necessary to the achievement of a compelling state interest.... If the statute does not touch upon either a fundamental right or a suspect class, its classification need only be rationally related to some legitimate government purpose in order to withstand an equal protection challenge." Id. As the

[80] See Nordlinger v. Hahn, 505 U.S. 1, 10, 112 S. Ct. 2326, 2331, 120 L. Ed. 2d 1 (1992) ("Of course, most laws differentiate in some fashion between classes of persons. The Equal Protection Clause does not forbid classifications. It simply keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike.").

Hospital User Fee does not impact a fundamental right or burden a suspect class of persons, the appropriate standard of review is rational basis review.[81]

The Connecticut Supreme Court has summarized the rational basis test as follows:

> "Under the rational basis test, [t]he court's function ... is to decide whether the purpose of the legislation is a legitimate one and whether the particular enactment is designed to accomplish that purpose in a fair and reasonable way." In general, the Equal Protection Clause is satisfied so long as there is a plausible policy reason for the classification, . . . the legislative facts on which the classification is apparently based rationally may have been considered to be true by the government decisionmaker, . . . and the relationship of the classification to its goal is not so attenuated as to render the distinction arbitrary or irrational.. . .

D.A. Pincus and Co., Inc. v. Meehan, 235 Conn. 865, 876, 670 A.2d 1278, 1286 (1996). Accordingly, the Departments must determine whether the classification of "hospitals" for purposes of the Hospital User Fee is rationally related to a legitimate government purpose. The rational basis for the classification need not be the actual basis contemplated by the General Assembly. Rather "it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature.... In other words, a legislative choice is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data." Id. at 877.

Consistent therewith, the Departments' inquiry into whether the Hospital User Fee violates the equal protection clause of the fourteenth amendment to the United States Constitution is two-pronged. See MERSCORP Holdings, Inc. v. Malloy, 320 Conn. 448, 462-63, 131 A.3d 220, 229-30 (2016). The Departments must first determine "whether the challenged statute[] seek[s] to accomplish a legitimate public purpose" before considering "whether the [alleged] disparate treatment imposed by [the Hospital User Fee] is rationally related to the goal." Id.

C. The Departments find that the Hospital User Fee is rationally related to a legitimate government purpose.

As referenced above, the Petitioners claim that the Hospital User Fee violates the equal protection clause of the fourteenth amendment to the United States Constitution. R. at 10, 30. The Petitioners

[81] See Miller v. Heffernan, 173 Conn. 506, 509, 378 A.2d 572, 576 (1977) ("Where legislation neither containing a suspect classification nor impinging upon a fundamental right is challenged on equal protection grounds, the burden is on the complaining party to establish that the statutory distinction is without rational basis. . . . This standard is even more stringent where the challenged legislation pertains to taxation. . . . As [the Connecticut Supreme Court] emphasized in Kellems v. Brown, . . . " 'in taxation, even more than in other fields, legislatures possess the greatest freedom in classification. Since the members of a legislature necessarily enjoy a familiarity with local conditions which this Court cannot have, the presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes. The burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it.' "). The Petitioners have not alleged, nor is there any evidence, that the contested classification impinges on a fundamental right. As such, the Departments employ rational basis review of the Petitioners challenge to the Hospital User Fee.

sole basis for this challenge to the Hospital User Fee is the Petitioners' allegation that said fee "creates an utterly arbitrary classification by imposing the tax on providers that are functionally indistinguishable from health care providers that are exempt from the tax." Id. Accordingly, the Departments must determine whether the difference in treatment between hospitals and other health care providers rationally furthers a legitimate state interest. Upon examination, the Departments find that the Hospital User Fee rationally furthers a legitimate state interest. Specifically, said fee raises revenue from uniquely situated health care providers in order to fund certain benefits said providers receive under the state's Medicaid program that are different from benefits available to any other type of provider, as well as to fund other government programs. Accordingly, the Departments find that said fee does not violate the equal protection clause of the fourteenth amendment to the United States Constitution.

i. The Departments find that the Hospital User Fee seeks to accomplish the legitimate public purpose of raising revenue.

The first prong of the inquiry into whether the Hospital User Fee violates the equal protection clause of the fourteenth amendment to the United States constitution is whether the User Fee seeks to accomplish a legitimate public purpose. See MERSCORP Holdings, Inc., 320 Conn. at 462. The Departments find that the primary purpose for which the Hospital User Fee was enacted, to raise revenue, is a legitimate public purpose.

The General Assembly recently codified the purpose of the Hospital User Fee as follows: "the primary purpose of the tax on the net patient revenue of hospitals was to raise revenues from uniquely situated health care providers that receive certain benefits under the state's Medicaid program." 2016 Conn. Pub. Acts 3, May spec. sess., § 121. As such, the General Assembly has confirmed that the purpose of the Hospital User Fee is to raise revenue.

Moreover, the manner in which the Hospital User Fee was enacted further confirms that its primary purpose was to raise revenue. To that end, the Hospital User Fee was enacted as part of a "general revenue act." See Lublin v. Brown, 168 Conn. 212, 224, 362 A.2d 769, 775 (1975). During the 2011 legislative session, the Hospital User Fee was introduced as part of Governor Dannel Malloy's comprehensive plan to combat a $3.2 billion projected budget deficit. Said plan included the imposition of new taxes on the provision of electric generation services, an expansion of the state's sales and use tax, and an increase of tax rates applicable to several other taxes. See Senate Bill 1007, § 37; 2011 Conn. Pub. Acts 6, § 104; 2011 Conn. Pub. Acts 61, § 45; 2011 Conn. Pub. Acts 233, §17. As part of this proposal, the Governor proposed implementing a tax on hospitals, which tax eventually became the Hospital User Fee through the enactment of Public Acts 11-6, 11-44, and 11-61. See Governor's Bill 1013, §§ 31-34 and 36-38. Moreover, Public Acts 11-6, 11-44, and 11-61 all originated as bills to implement the state budget and the revenue that the Hospital User Fee raised was paid into the state's general fund for purposes of supporting appropriations made from said fund.[82] Given that the Hospital User Fee was enacted as part of a

[82] The budget adopted by the General Assembly for SFY 2012-2013 mandated that the Hospital User Fee raise $349.1 million dollars in revenue for each year of the biennium. See R. at 581-82; OFA, Connecticut State Budget, FY 12 & FY 13 Biennium, Part II, Summary & Schedules, at 58. The budget adopted by the General Assembly for SFY 2014-2015 also mandated that the Hospital User Fee raise $349.1 million dollars in revenue for each year of the biennium. See 2013 Conn. Pub. Acts 184, § 113; 2013 Conn. Pub. Acts 247, § 112; 2014 Conn. Pub. Acts 47, § 55; see also

comprehensive plan to raise revenue through the imposition of new taxes and expansion of old taxes, the Departments find that the primary purpose of the Hospital User Fee was to raise revenue.

"It is well established that raising revenues is a legitimate purpose—often the primary purpose—of a tax or a fee. See Harbor Ins. Co. v. Groppo, 208 Conn. 505, 511, 544 A.2d 1221 (1988) (tax); Eagle Rock Sanitation, Inc. v. Jefferson County, United States District Court, Docket No. 4:12–CV–00100–EJL–CWD, 2013 WL 6150779 (D. Idaho November 22, 2013) (fee)." MERSCORP Holdings, Inc. v. Malloy, 320 Conn. 448, 462, 131 A.3d 220, 229 (2016). In MERSCORP Holdings Inc. v. Malloy, the Connecticut Supreme Court found that a fee effectuated the legitimate public purposes of "raising additional revenues," "compensating for fees allegedly lost," and "helping balance the state budget." Id.; see also Harbor Ins. Co. v. Groppo, 208 Conn. 505, 511, 544 A.2d 1221, 1224 (1988) ("We find that § 12–210 is rationally related to its legitimate purpose of raising revenue"); Carmichael v. S. Coal & Coke Co., 301 U.S. 495, 514, 57 S. Ct. 868, 875, 81 L. Ed. 1245 (1937) ("This Court has long and consistently recognized that the public purposes of a state, for which it may raise funds by taxation, embrace expenditures for its general welfare.").

Accordingly, the Departments conclude that the primary purpose for which the Hospital User Fee was enacted, to raise revenue, is a legitimate public purpose. The Departments now turn to the question of whether the imposition of the Hospital User Fee upon hospitals to the exclusion of other health care providers is rationally related to the purpose of raising revenue.[83]

OFA, Connecticut State Budget, FY 14 & FY 15 Budget, Agency Detail, at 269. The budget adopted by the General Assembly for SFY 2016-2017 increased the amount of revenue the Hospital User Fee was required to generate to $556 million. See 2015 Conn. Pub. Acts 244, § 56; 2015 Conn. Pub. Acts 5, June spec. sess., § 496; OFA, Connecticut State Budget, FY 16 & FY 17 Budget, at 483.

[83]The Petitioners urge the Departments to follow the decisions of two New Hampshire trial courts, which held that New Hampshire's hospital tax violated equal protection. As described more fully in footnote 112, these decisions are distinguishable on the facts. To that end, the Court found that "there is an insufficient government interest that supports" the New Hampshire hospital tax. Catholic Medical Ctr. v. N.H. Dep't of Revenue Administration, Nos. 216-2011-CV-00955, 216-2011-CV-00850, and 218-2011-CV-01394, 2014 WL 1509834, at *5 (N.H. Super. Ct. Apr. 8, 2014) (Mangones, J.) (emphasis added). More specifically, the Court found that "the primary, if not the sole, purpose of the [hospital tax] had been to bring federal funds to the State treasury, with the hospitals acting as pass-through intermediaries." Id. at *4 The Court further found that instead of following this "primary purpose" New Hampshire simply let funds lapse into their General Fund. Id. at *4-5. On this basis, the New Hampshire court concluded that the New Hampshire hospital tax did not support a legitimate purpose. Id. at *5. As a preliminary matter, the Departments note that this analysis is fundamentally flawed because equal protection analysis under the fourteenth amendment does not require that a statute achieve any specified primary purpose:

> To be sure, the Equal Protection Clause does not demand for purposes of rational-basis review that a legislature or governing decisionmaker actually articulate at any time the purpose or rationale supporting its classification. . . . Nevertheless, this Court's review does require that a purpose may conceivably or "may reasonably have been the purpose and policy" of the relevant governmental decisionmaker. . . .

Nordlinger v. Hahn, 505 U.S. 1, 15, 112 S. Ct. 2326, 2334–35, 120 L. Ed. 2d 1 (1992) (citations omitted). As such, the New Hampshire trial court's analysis is fundamentally flawed. Moreover, even if that analysis were correct, the Departments find the case to be inapplicable to Connecticut's Hospital User Fee because the "primary purpose" of Connecticut's Hospital User Fee is simply to raise revenue; 2016 Conn. Pub. Acts 3, May spec. sess., § 121; not to "bring federal funds to the state treasury." There is no evidence that Connecticut has failed to follow this primary purpose. Accordingly, the Departments find that the New Hampshire trial court's analysis is not applicable to the present matter.

ii. The imposition of the Hospital User Fee on hospitals is rationally related to the legitimate government purpose of raising revenue for a number of reasons.

As referenced above, in the second prong of the equal protection analysis, the Departments must determine whether the imposition of the Hospital User Fee on hospitals accomplishes the purpose of raising revenue "in a fair and reasonable way" or if "the relationship of the classification to its goal is not so attenuated as to render the distinction arbitrary or irrational." D.A. Pincus and Co., Inc. v. Meehan, 235 Conn. 865, 876, 670 A.2d 1278, 1286 (1996). Said purpose need not be the actual purpose contemplated by the General Assembly "and may be based on rational speculation unsupported by evidence or empirical data." Id. at 877. As described more fully below, the Departments find that there are many conceivable rational bases for why the General Assembly choose to levy the Hospital User Fee upon hospitals to the exclusion of other health providers including that (1) hospitals are not similarly situated to other health care providers, (2) hospitals can bear the burden of the Hospital User Fee more readily than other health care providers, and (3) hospitals benefit from the programs the Hospital User Fee helps fund. Accordingly, the Departments find that the Hospital User Fee does not contain an impermissible classification.

The Departments make this determination in view of the unique deference that Courts have historically afforded states in imposing taxes under the equal protection clause of the fourteenth amendment and, accordingly, review the standards typically employed in such analyses.

a. In order to succeed in their challenge under the equal protection clause of the fourteenth amendment, the Petitioners must establish that the imposition of the Hospital User Fee on hospitals is hostile and oppressive.

The equal protection clause to the fourteenth amendment does not require that states impose taxes equally or uniformly. See Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356, 360-65, 93 S. Ct. 1001, 1003-04 (1973). To that end, the United States Supreme Court has noted that

> The States have a very wide discretion in the laying of their taxes. When dealing with their proper domestic concerns, and not trenching upon the prerogatives of the National Government or violating the guaranties of the Federal Constitution, the States have the attribute of sovereign powers in devising their fiscal systems to ensure revenue and foster their local interests. Of course, the States, in the exercise of their taxing power, are subject to the requirements of the Equal Protection Clause of the Fourteenth Amendment. But that clause imposes no iron rule of equality, prohibiting the flexibility and variety that are appropriate to reasonable schemes of state taxation. **The State may impose different specific taxes upon different trades and professions and may vary the rate of excise upon various products. It is not required to resort to close distinctions or to maintain a precise, scientific uniformity with reference to composition, use or value.**'

Id. (emphasis supplied).[84] Connecticut has long exercised this power to select the particular property, trade, and professions upon which it will impose its taxes. Kellems v. Brown, 163 Conn.

[84] Nordlinger v. Hahn, 505 U.S. 1, 11, 112 S. Ct. 2326, 2332, 120 L. Ed. 2d 1 (1992) ("In general, the Equal Protection Clause is satisfied so long as there is a plausible policy reason for the classification, . . .the legislative facts on which the classification is apparently based rationally may have been considered to be true by the governmental

478, 492–93, 313 A.2d 53, 61 (1972). Consistent therewith, the Connecticut Supreme Court has acknowledged that Connecticut's "long-standing pattern of taxation has been to single out particular items with exclusion or exemption of myriad others." Id.[85]

Furthermore, both the Connecticut and United States Supreme Courts have acknowledged that "'[a] legislature is not bound to tax every member of a class or none.' Carmichael v. Southern Coal & Coke Co., supra, 301 U.S. 509, 57 S.Ct. 872. 'This Court has repeatedly held that inequalities which result from a singling out of one particular class for taxation or exemption, infringe no constitutional limitation.' Id." See United Illuminating Co. v. City of New Haven, 179 Conn. 627, 640, 427 A.2d 830, 837 (1980). This is because of "the economic reality that when a legislative body makes a taxing decision it almost inevitably will be involved in shifting tax burdens from

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decisionmaker, . . . , and the relationship of the classification to its goal is not so attenuated as to render the distinction arbitrary or irrational, ... This standard is especially deferential in the context of classifications made by complex tax laws. [I]n structuring internal taxation schemes the States have large leeway in making classifications and drawing lines which in their judgment produce reasonable systems of taxation.").

[85] See Kellems v. Brown, 163 Conn. 478, 492–93, 313 A.2d 53, 61 (1972) ("For example, the property tax base in Connecticut, even as it applies to tangible property, has been continuously narrowed, the net effect being to levy a tax on only certain items of personal property and real estate; the Connecticut conveyance tax applies only to certain real estate and not to conveyances of other types of property, such as stocks and bonds; the sales tax is applicable only to particular sales of personal property; and taxes on business net income are levied only if the business happens to be a corporation. These value judgments, as to how broad or narrow to base a tax, must, of necessity, be left to the legislative branch of government under our separation of powers doctrine. Any attempt by the courts to unscramble any part of the complex scheme of state taxation, substituting their own judgment for what is or is not a sound tax policy would subvert the function of the judicial branch and ignore a policy of judicial restraint enunciated by the United States Supreme Court on many occasions in the past.").

The Petitioners urge the Departments to follow the decisions of two New Hampshire trial courts, which held that New Hampshire's hospital tax violated equal protection. As described more fully in footnote 112, these decisions are distinguishable on the facts. Moreover, the Departments find that the analysis of ostensibly impermissible classification under New Hampshire law set forth in said decision is not applicable to an analysis of the federal equal protection clause. To that end, in one of the cases, the New Hampshire trial court noted that under New Hampshire law "Property can be classified for tax purposes. The taxpayers cannot." Northeast Rehabilitation Hosp. v. N.H. Dep't of Revenue Administration, No. 2182012CV00185, 2014 WL 10679796, at *3 (N.H. Super. Ct. Feb. 7, 2014) (McHugh, J.). Said court predicated its decision on this principle: "A close look at the statute and rules reveals that the statutory scheme does indeed impermissibly classify taxpayers." Id. at *4. Stated simply, in New Hampshire, that court held, that taxpayers cannot be classified, only property can be classified. The New Hampshire trial court extended this rationale to the federal equal protection clause. Id. However, neither the Connecticut or United States Supreme Courts have followed such a principle in analyzing whether a tax law violates the equal protection clause of the fourteenth amendment. To that end, the Connecticut Supreme Court has long held that

> In the choice of subjectmatter there is no restriction not constitutional, short of one imposed by lack of jurisdiction. 'Whether it be persons, or property or possession, franchise or privilege, or occupation or right,' the legislative power to tax extends to it. 'It reaches to every trade or occupation, to every object of industry, use, or enjoyment;' in fact to every subject over which the sovereignty of the state extends, and is coextensive with that sovereignty.

Kellems, 163 Conn. at 488; See also Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356, 359–60, 93 S. Ct. 1001, 1004, 35 L. Ed. 2d 351 (1973) ("The State may impose different specific taxes upon different trades and professions and may vary the rate of excise upon various products. It is not required to resort to close distinctions or to maintain a precise, scientific uniformity with reference to composition, use or value.'"). Accordingly, the Departments find that the New Hampshire trial court's analysis of New Hampshire law is not applicable to the Hospital User Fee.

one group to another." Stafford Higgins Indus., Inc. v. City of Norwalk, 245 Conn. 551, 57-, 715 A.2d 46, 56 (1998).

Accordingly, as legislators are in the best position to understand the economic situation of their states, courts have long afford states substantial deference in selecting those classes upon which they will impose taxes. United Illuminating Co. v. City of New Haven, 179 Conn. 627, 641, 427 A.2d 830, 837 (1980).[86] In accordance with this deferential standard, one challenging a taxing statute bears the burden of demonstrating beyond a reasonable doubt that the challenged classification is hostile and oppressive. Stafford Higgins Indus., Inc. v. City of Norwalk, 245 Conn. 551, 569, 715 A.2d 46, 56 (1998). The Connecticut Supreme Court has held that in order to sustain this burden, "the challenger must establish that the legislature 'selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group.'" Id.

Given the foregoing, in order to prevail on their equal protection challenge, the Petitioners must both "negative every conceivable basis which might support"[87] the Hospital User Fee and demonstrate that the Hospital User Fee was enacted because it was hostile and oppressive discrimination against hospitals. As described more fully below, the Departments find that there are many conceivable rational bases for imposing the Hospital User Fee on hospitals and there is no evidence that the Hospital User Fee was enacted because it was hostile and oppressive discrimination against hospitals. Accordingly, the Petitioners have failed to demonstrate that no conceivable basis supports the Hospital User Fee.

b. There is a rational basis for the Hospital User Fee because it is conceivable that the General Assembly imposed the Hospital User Fee on hospitals because they are not similarly situated to other health care providers.

As discussed above, there is a rational basis for the General Assembly to have adopted the Hospital User Fee, sufficient to overcome an equal protection challenge, so long as any conceivable reason for the tax is sufficient to support it. As described more fully herein, the Departments find that it is conceivable that the General Assembly imposed the Hospital User Fee on hospitals because they are not similarly situated to other health care providers. Specifically, short-term general hospitals[88]

[86] United Illuminating Co. v. City of New Haven, 179 Conn. 627, 641, 427 A.2d 830, 837 (1980) ("'The broad discretion as to classification possessed by a legislature in the field of taxation has long been recognized.... (T)he passage of time has only served to underscore the wisdom of that recognition of the large area of discretion which is needed by a legislature in formulating sound tax policies.... It has ... been pointed out that in taxation, even more than in other fields, legislatures possess the greatest freedom in classification. Since the members of a legislature necessarily enjoy a familiarity with local conditions which this Court cannot have, the presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes....'").

[87] Kellems v. Brown, 163 Conn. 478, 486, 313 A.2d 53, 58 (1972) ("the presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes. The burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it.").

[88] The Hospital User Fee applies only to those hospitals licensed as short-term general hospitals. Conn. Gen. Stat. § 12-263a. For clarity, unless otherwise specified, throughout this Declaratory Ruling, the term "hospital" means a short-term general hospital.

are subject to a different regulatory regime than any other health care provider, and, as such, the General Assembly may have determined that there were significant advantages to imposing the Hospital User Fee on hospitals. To that end, Hospitals are authorized within the scope of their license to provide a wider range of services than any other health care provider and are compensated differently than any other health care provider. Given these differences between hospitals and other health care providers, it was rational for the General Assembly to impose the Hospital User Fee on hospitals to the exclusion of other categories of health care providers.[89]

As a preliminary matter, the Departments note that the General Assembly recently confirmed in clarifying legislation that hospitals are uniquely situated compared to other categories of health care providers. To this end, and as referenced above, in Public Act 16-3 of the May special session, the General Assembly codified a statement of intent regarding the Hospital User Fee. Specifically, in section 121 of said Public Act, the General Assembly affirmed that:

> The intention of section 145 of public act 11-6, as amended by section 102 of public act 11-44, was that the definition of net patient revenue set forth in section 12-263a of the general statutes complies with and is consistent with subsection (w) of 42 USC 1396b, 42 CFR 440.10 and 42 CFR 440.20. **Furthermore, the primary purpose of the tax on the net patient revenue of hospitals was to raise revenues from uniquely situated health care providers that receive certain benefits under the state's Medicaid program.**

2016 Conn. Pub. Acts 3, May spec. sess., § 121 (emphasis added). The above-quoted language makes clear both that the General Assembly views hospitals as "uniquely situated health care providers" and that hospitals receive certain benefits under Connecticut's Medicaid program that are not available to other categories of providers. As described more fully below, said differences are apparent from the unique regulatory scheme that governs hospitals, which allows hospitals to provide fundamentally different services than any other category of health care provider and receive unique benefits from the state government, which no other health care providers receive.

[89] Courts have found whether a challenged class is similarly situated to other individuals to both be a prerequisite to raising an equal protection challenge and a rational basis for treating classes differently. Recently, the Connecticut Supreme Court affirmed its long-standing position that "[t]o prevail on an equal protection claim, a plaintiff first must establish that the state is affording different treatment to similarly situated groups of individuals. . .. [I]t is only after this threshold requirement is met that the court will consider whether the statute survives scrutiny under the equal protection clause." MERSCORP Holdings, Inc. v. Malloy, 320 Conn. 448, 460, 131 A.3d 220, 229 (2016); Markley v. Dep't of Pub. Util. Control, 301 Conn. 56, 68, 23 A.3d 668, 678 (2011). Accordingly, it is a prerequisite to challenging a statute on equal protection grounds that the classes being compared be similarly situated.

Courts, however, often "assume without deciding that the similarly situated requirement is satisfied" in considering whether a statute violates the equal protection clause. In doing so, courts have often found that differences between classes provide a rational basis for differing treatment under a statute. See Batte-Holmgren v. Comm'r of Pub. Health, 281 Conn. 277, 308, 914 A.2d 996, 1015 (2007).

(1) Hospitals differ from all other health care providers because hospitals provide fundamentally different services than other health care providers.

The Departments find fundamental differences between the nature and scope of services performed in a hospital compared to any other category of health care provider. More specifically, under Connecticut law, hospitals are permitted to perform a broader range of services than any other health care provider, are authorized to provide more acute care than any other health care provider, and are the only health care provider that can provide certain types of services.

By way of brief background, the Hospital User Fee is imposed on hospitals licensed by the Connecticut Department of Public Health (DPH) as short-term general hospitals. See Conn. Gen. Stat. § 12-263a(1). DPH regulations define short-term general hospital as a "short term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a **wide range** of acute conditions, including injuries." Conn. Agencies Regs. § 19-13-D1(b)(1)(A) (emphasis supplied).

DPH regulations governing the licensure categories require all short-care general hospitals to have certain minimum departments and facilities including a "clinical laboratory, blood bank, pathological services, a radiology department and an operating room." Conn. Agencies Regs. § 19-13-D3(f). Additionally, hospitals may choose to have other departments and facilities, including surgery, obstetrics, psychiatry, anesthesia, and others. See Conn. Agencies Regs. § 19-13-D3. This broad scope of license allows hospitals to provide services in both an inpatient and outpatient setting. Most other providers are not permitted to provide services in both settings. By way of example, the outpatient clinic license authorizes the clinic to provide certain outpatient services, but not inpatient services. See Conn. Agencies Regs. § 19-13-D8t. The chronic and convalescent nursing home license authorizes the provider to provide certain inpatient services, but not outpatient services. See Conn. Agencies Regs. § 19-13-D45.

Hospitals are also authorized to provide a wide range of levels of care, ranging from routine clinic procedures to intensive services such as those provided in intensive care units (ICUs). See Conn. Agencies Regs. § 19-13-D3. Other health care providers are limited to less acute levels of care than hospitals are authorized to provide. For example, other health care providers such as chronic and convalescent nursing homes and freestanding mental health residential living centers are not authorized within the scope of their license to have intensive care units. See Conn. Agencies Regs. § 19-13-D45.

In addition to being able to provide a broader range of services than any other health care provider, there are also certain services that only hospitals can provide, including emergency and trauma services. For example, unlike other categories of providers, hospitals are uniquely authorized and equipped to provide more specialized, intensive, and emergent services. Under DPH regulations, only hospitals are authorized—and in fact required "to provide adequate care for persons with acute emergencies at all hours." Conn. Agencies Regs. § 19-13-D3(j)(2). In a 2015 report, the American Hospital Association (AHA) highlighted that "hospitals must provide 24/7 access to care, including access to specialized services" and that the hospital emergency department "is the only health care resource that is staffed 24/7 and equipped to respond immediately to patients with

widely differing types and severity of medical conditions and injuries." American Hosp. Ass'n, There Because We Care, at 2, 4 (March 2015), R. at 1046, 1048.[90] As the AHA noted, these attributes are unique to hospitals and include not only standard emergency services, but also disaster readiness and response. Id. at 12-15, R. at 1056-1059. As a result, the AHA explains that "hospitals are at the center of every emergency that our nation may confront…." Id. at 12, R. at 1056. Further emphasizing hospitals' unique role, DPH regulations also require all hospitals to participate in the statewide trauma system, including requiring all hospitals to apply to the American College of Surgeons for the verification of trauma centers (although that regulation does not necessarily mean that all hospitals in Connecticut have actually received verified trauma status). See Conn. Agencies Regs. §§ 19a-177-3 and 19a-177-4.

As with emergency and trauma services, only hospitals are equipped to provide a broad array of highly specialized and complex services, especially for intensive conditions and those that require cutting edge treatments and technologies. See David M. Cutler and Fiona Scott Morton, "Special Communication: Hospitals, Market Share and Consolidation," 310 JAMA (Journal of the American Medical Association) 1964, 1966-1969 (Nov. 13, 2013), R. at 1221, 1223-1226.[91] In

[90] In their letter dated August 29, 2016, the Petitioners objected to the Departments taking administrative notice of this article because they claim that it includes "generalizations and assumptions" rather than evidence. See R. at 1370. The Petitioners further "question the appropriateness of taking administrative notice of a document developed by a non-government, third-party." Id.

The Departments note that they took administrative notice of this document because it was prepared by the American Hospital Association, which is the hospitals' leading national trade association. As such, the Departments find that said document contains credible evidence of the differences between hospitals and other health care providers. Moreover, as noted above, "it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature.... In other words, a legislative choice is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data." D.A. Pincus and Co., Inc., 235 Conn. at 877. Accordingly, even if said article contains "generalizations and assumptions" such rational speculation is sufficient evidence to undermine an equal protection challenge and highly appropriate for the Departments to rely upon. Stated simply, the information set forth in this article contains the exact type of reasoning that "rationally may have been considered to be true by the government decision-maker." Nordlinger, 505 U.S. at 11. For equal-protection analysis is irrelevant as to whether the information is accurate, although the Departments believe that it is given that it comes from the hospitals' own trade organization. D.A. Pincus and Co., Inc., 235 Conn. at 877. Accordingly, the Departments find that the Petitioners' objection to this article are without foundation in law or fact, and, as such, the Petitioners have failed to demonstrate how the inclusion of this document in the record prejudices them.

[91] In their letter dated August 29, 2016, the Petitioners objected to the Departments taking administrative notice of this article because they claim that it includes "generalizations and assumptions" rather than evidence. See R. at 1370. The Petitioners further "question the appropriateness of taking administrative notice of a document developed by a non-government, third-party." Id.

The Departments note that they took administrative notice of this document, and similar scholarly articles, because it is a scholarly journal article that describes various ways in which hospitals' market power differs from other health care providers. As such, the Departments find that said document contains credible evidence of the differences between hospitals and other health care providers. Moreover, as noted above, "it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature.... In other words, a legislative choice is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data." D.A. Pincus and Co., Inc., 235 Conn. at 877. Accordingly, even if said article contains "generalizations and assumptions" such rational speculation is sufficient evidence to undermine an equal protection challenge and highly appropriate for the Departments to rely upon. Stated simply, the information set forth in this article contains the exact type of reasoning that "rationally may have been considered to be true by the

practice, a substantial portion of the most intensive and specialized services are typically provided in hospitals. See id. Because these services are valued, they often result in higher prices. See id.; see also Susan Adler Channick, The ACA, Provider Mergers and Hospital Pricing: Experimenting with Smart, Lower-Cost Health Insurance Options, William & Mary Policy Review, Vol. 6, No. 2, p. 2 (2015), R. at 1229-1230.[92] In the CMS conditions of participation for Medicare and Medicaid, hospitals that choose to provide a variety of specialized services, including surgical, anesthesia, nuclear medicine, rehabilitation, and respiratory care services must meet various requirements to ensure those services are delivered properly. See 42 C.F.R. 482, Subpart D.[93]

Moreover, only hospitals can provide and bill for observation services, the purpose of which is "to determine the need for further treatment or for inpatient admission." See CMS, Medicare Claims Processing Manual, Chapter 6, § 20.6.[94] Medicare defines observation services as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Id. Specifically, observation services can include a variety of outpatient hospital services while a patient remains in the hospital, services for which the hospital can bill and be reimbursed by Medicare and other payers. See id. Other categories of providers are not able to provide observation services as defined by Medicare, further highlighting that hospitals have a broader scope of services than other categories of health care providers.

Because hospitals are permitted to provide such a broad array of services, the service they provide are fundamentally different from similar services provided by other providers by virtue of the extensive support services that hospitals maintain. By way of example, many health care providers can administer medicine. If medicine is administered in a hospital, the patient has the benefit of

government decision-maker." Nordlinger, 505 U.S. at 11. For equal-protection analysis is irrelevant as to whether the information is accurate, although the Departments believe that it is given that it is published in a well-respected scholarly journal. D.A. Pincus and Co., Inc., 235 Conn. at 877. Accordingly, the Departments find that the Petitioners' objection to this article are without foundation in law or fact, and, as such, the Petitioners have failed to demonstrate how the inclusion of this document in the record prejudices them.

[92] The Petitioners objected to this document on the same basis as the article referenced immediately above and the Departments incorporate their response set forth in the previous footnote by reference.

[93] Hospitals also have a unique role in providing services for individuals with greater needs. The AHA report referenced above also notes hospitals' safety net role in providing services for individuals with high medical needs as well as providing charity care and other services to needy individuals. See AHA, at 10-11, R. at 1054-55. In contrast to other safety-net providers, such as federally qualified health centers (FQHCs), which focus on providing primary care, hospitals are equipped to provide a broad range of services and levels of care. See 42 U.S.C. §§ 254b(a)(1) and (b)(1). Further, the AHA commissioned a report, which indicated that compared to patients treated in physician offices, the patients in hospital outpatient departments have a variety of different characteristics. Report Prepared for AHA, KNG Health Consulting LLC, Comparison of Care in Hospital Outpatient Departments and Physician Offices, Final Report, February 2015, p. 4, R. at 1004-43. For all these reasons, hospitals have a unique position in the health care system that is unlike other categories of health care providers.

[94] In their letter dated August 29, 2016, the Petitioners objected to this and similar CMS documents that describe the Medicare program, as well as comparable DSS documents that describe Connecticut's Medicaid program. See R. at 1365-66, 1371. The Petitioners objected only that the referenced documents were not specified with enough detail to enable them to respond to said documents. In any case, all of these documents are general CMS agency documents, which describe the Medicare programs. Those documents are all publicly accessible and are all commonly accepted documents used in the ordinary course of business of those programs. Accordingly, as these documents constitute agency guidance, the Departments find that it is appropriate for the Department to rely on said documents.

the hospital's emergency department if he or she has an adverse reaction to medicine. Additionally, many providers perform diagnostic tests. At a hospital which includes many departments in one facility, a patient is likely to receive results on a much more accelerated timeline than from a doctor or clinic that does not have the means on site to process said tests. Accordingly, even though other health care providers may be able to provide some of the same services as hospitals, there are many intangible benefits that hospitals implicitly provide to their patients which make the services that they provide fundamentally different.

In sum, hospitals are authorized to provide a broader array of services than any other health care provider, are authorized to provide a more acute care of service than any other health care provider, and are the only health care provider authorized to provide certain types of services. These differences result in the provision of uniquely enhanced services to patients, which no other health care provider can provide. As described more fully below, hospitals are compensated for these intangible benefits.

(2) Hospitals are compensated differently than other categories of health care providers.

In addition to providing a broader scope of services than any other category of healthcare provider, hospitals are also paid differently by payers than other categories of health care providers. In general, hospital care is usually more expensive than similar services provided by other categories of health care providers. See Cutler and Morton, supra, at 1966, R. at 1223. The AHA report discussed above also acknowledges that hospitals are typically reimbursed at higher rates than other categories of health care providers, such as ambulatory surgical centers. Specifically, in that report, the AHA opposes proposals to pay the same amount for hospitals and other categories of providers because, the AHA argues: "Paying the same amount for services regardless of where they are provided in a hospital or other setting fails to recognize the added cost hospitals incur to maintain 24/7 access, serve as the health care safety net and be at the ready when disaster strikes." AHA, supra, p. 18, R. at 1062.[95] The hospitals are uniquely compensated for the breadth and scope of the services they provide. To this end, and as described more fully below, hospitals are permitted to charge facilities fees in certain significant contexts that are not available for other categories of health care providers, particularly when a hospital acquires a physician practice. While a hospital can charge facility fees for facility services at a physician practice that was acquired by the hospital, a non-hospital freestanding physician practice cannot charge facility fees. In addition, hospitals are permitted to charge for services performed in off-site facilities as if they were performed in the hospital, in contexts that are not available for other categories of health care providers. As a reflection of the unique services hospitals provide, under Medicare and Medicaid, hospitals are compensated differently than any other health care provider.

(a) Unlike various other categories of providers, hospitals charge facility fees in addition to professional fees for physician and other practices affiliated with the hospital.

[95] By stating that this particular proposal—equalizing payment for outpatient surgery regardless of the setting—would reduce hospital revenue by $2.6 billion (presumably by Medicare), the AHA implicitly acknowledges that in the area of outpatient surgery alone, hospitals receive approximately $2.6 billion more than if they were reimbursed in the same manner as non-hospital settings for those services. See id.

Unlike various other categories of health care providers, hospitals charge facility fees for the use of the hospital and its associated resources. See Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees, April 16, 2014, at 6, R. at 990.[96] While there are other types of health care providers that can charge facility fees in certain contexts, due to their extremely broad license and resources referenced above, only hospitals can effectively charge facility fees for virtually any service. Independent physician practices and other providers can only charge for their professional fees, not facility fees, but, as discussed below, if the hospital acquires the practice, it can charge both professional and facility fees. Based on this advantage, hospitals are uniquely situated compared to other categories of health care providers.

(b) Unlike other categories of providers, hospitals can take advantage of the provider-based status rule to be able to charge for services provided in off-site locations as if they were provided at the hospital.

As a result of Medicare's provider-based status option, hospitals have more flexibility than other categories of providers to structure how they can charge facility fees for services provided by health care providers that they acquire. See 42 C.F.R. § 413.65. The provider-based status regulation enables a hospital to bill for services provided by another provider acquired by the hospital as if the service were provided in the hospital, so long as various requirements are met, including ownership, control, maximum distance from the hospital's main campus, and other factors. See id. Under the provider-based status rule, if a hospital acquires or establishes a physician practice, it can either treat the practice as a free-standing separate entity or use the provider-based model. Id.; 42 U.S.C. §§ 1395*l*(t)(1)(B) and (t)(21). If the hospital chooses the provider-based model, the hospital can charge both for the physicians' fees (albeit somewhat reduced to reflect that the hospital is providing facility overhead) and also for the hospital's facility fees. See id. Since 2002, the CMS regulation has enabled hospitals to obtain provider-based status for providers that they acquire so long as they meet various requirements, although they are not required to seek and obtain actual approval from CMS for provider-based status. CMS, Medicare

[96] In their letter dated August 29, 2016, the Petitioners objected to the Departments taking administrative notice of this article because they claim that it includes "generalizations and assumptions" rather than evidence. See R. at 1369. The Departments note that they took administrative notice of this document, and similar scholarly articles, because it is scholarly journal article that describe various ways in which hospitals' market power differs from other health care providers. As such, the Departments find that said document contains credible evidence of the differences between hospitals and other health care providers. Moreover, as noted above, "it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature.... In other words, a legislative choice is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data." D.A. Pincus and Co., Inc., 235 Conn. at 877. Accordingly, even if said article contains "generalizations and assumptions" such rational speculation is sufficient evidence to undermine an equal protection challenge and highly appropriate for the Departments to rely upon. Stated simply, the information set forth in this article contains the exact type of reasoning that "rationally may have been considered to be true by the government decision-maker." Nordlinger, 505 U.S. at 11. For equal-protection analysis is irrelevant as to whether the information is accurate, although the Departments believe that it is given that it is published in a well-respected scholarly journal. D.A. Pincus and Co., Inc., 235 Conn. at 877. Accordingly, the Departments find that the Petitioners' objection to this article are without foundation in law or fact, and, as such, the Petitioners have failed to demonstrate how the inclusion of this document in the record prejudices them.

Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates; Final Rule, 57 Fed. Reg. 49982, 50086, 50088 (Aug. 1, 2002).

Hospitals in Connecticut have also been using the provider-based status model to be able to charge facility fees and bill as if the service were provided in the hospital for various types of physician practices and certain other types of providers that they acquire. See Report of the Connecticut Attorney General, supra, at 6-7, R. at 990-91. The Petitioners produced copies of their "HOSPITAL/CAH MEDICARE DATABASE WORKSHEET," which is completed as part of the accreditation process required for participation in Medicare and Medicaid (through DPH, which acts as the surveying agency on behalf of CMS). Those worksheets indicate, among other things, the provider-based off-site locations operated by each hospital. Based on a review of those worksheets, the Petitioners operate a wide variety of off-site provider-based locations. In addition, also in the record are various letters from CMS approving provider-based status for various types of providers acquired by several of the petitioner hospitals, such as laboratories, radiation therapy centers, surgical centers, cancer centers, radiology facilities, clinics, sleep study centers, and others—many of which are listed as off-campus facilities.[97] The practical result of this flexibility, which is unique for hospitals, is that by acquiring other providers or establishing physician practices or clinics, the hospital is able to increase the ability to bill for and collect revenue far beyond what is available to a free-standing physician practice. See Report of the Connecticut Attorney General, supra, at 6-7, R. at 990-91. This structure of a hospital being able to bill in such a manner for the wide range of services included in the scope of a hospital license is uniquely available to hospitals, not other categories of health care providers. See id.

(c) Medicare reimburses hospitals differently than any other category of provider, including various differences between hospitals and non-hospital providers for similar services.

Medicare provides for unique payment systems both for inpatient and outpatient hospital services, which are different from payment methodologies for any other category of provider. A DSS survey of selected Medicare reimbursement methodologies, which was prepared for use in this ruling and which includes specific analysis between how selected services are reimbursed when provided by a hospital versus non-hospital providers, is attached as Appendix 5 to this Declaratory Ruling. The Departments hereby incorporate said survey which is incorporated by reference as if fully set forth herein.

Services defined by Medicare as inpatient hospital services are reimbursed through the inpatient prospective payment system (IPPS). The IPPS is fundamentally different from the Medicare reimbursement methodology for any other category of providers because it includes services not reimbursed by Medicare for any other category of provider and is calculated in a manner different from the methodology for Medicare payment to any other category or provider. The IPPS is largely based on payment weights associated with the severity of groups of patient diagnoses (known as diagnosis-related groups or DRGs), with several additional adjustments and factors. See 42 U.S.C. § 1395ww. No other category of provider is reimbursed under IPPS or any other

[97] The record only includes a sample of letters because the Departments were unable to obtain all letters from CMS during the tight timeframe in which the Petitioners sought to have the ruling issued. CMS provided the Departments with those letters that were readily available. See R. at 920-61.

similar methodology by Medicare. As examples of differences between Medicare reimbursement of hospitals under IPPS compared to other categories of providers, IPPS includes payment for items that are not paid to any category of provider other than hospitals, such as graduate medical education (GME) and indirect medical education (IME) costs incurred by the hospital in training resident physicians. See id. § 1395ww(h). Similarly, those hospitals that have residents in an approved GME program receive additional payments for Medicare discharge to reflect higher costs of teaching hospitals compared to other hospitals. See id. § 1395ww(d)(5)(B). In addition, special payment is also available in certain circumstances for new medical services or technologies. See id. § 1395ww(d)(5)(K). These and other attributes of IPPS are available only to hospitals and are thus fundamentally different from the Medicare reimbursement methodology available to any other category of providers.

Services defined by Medicare as outpatient hospital services are reimbursed through the outpatient prospective payment system (OPPS). No other category of provider is reimbursed by Medicare under the outpatient hospital OPPS. The OPPS is largely based on ambulatory payment classifications (APCs), which are designed to group services based on similar clinical characteristics and costs plus various other adjustments and factors. See 42 U.S.C. § 1395*l*(t). OPPS is developed based on groups of covered services, including various factors such as wage adjustment factors, outliers, and others adjustments. See id. Similar to IPPS, the outpatient hospital OPPS is also unique to hospitals; no other health care provider is reimbursed in that manner.

As described above, unlike other health care providers, hospitals are reimbursed by Medicare using IPPS for inpatient hospital services and the outpatient hospital OPPS for outpatient hospital services. Those methodologies are calculated in a manner differently than other reimbursement methodologies. In addition, there are also various differences in how Medicare reimburses for similar services when provided in a hospital setting (including a setting where the hospital has an off-campus facility with provider-based status, as discussed above) compared to when it is provided by a non-hospital provider. As referenced above, a DSS survey of these differences in Medicare reimbursement is attached as Appendix 5 to this Declaratory Ruling, which is incorporated by reference as if fully set forth herein. As a general example, under the provider-based status rules discussed above, a hospital can bill for a facility fee for services provided by hospital-affiliated physicians, podiatrists, and chiropractors, but independent practitioners can only bill for their professional services.[98] See Medicare Claims Processing Manual, chapter 12. As another example, behavioral health services in independent settings are generally paid by Medicare using the physician fee schedule, which provides for specific fees for each service, whereas Medicare typically pays a hospital for providing behavioral health services using IPPS or OPPS, as applicable. See id. Additional details on differences in Medicare reimbursement between hospitals and non-hospital providers, including differences in reimbursement for similar services, are included in Appendix 5.

[98] Hospital-based physicians and other practitioners are paid a modestly reduced "facility-based" rate to account for the fact that the hospital provides facility overhead, but the independent practitioners cannot charge facility fees. As demonstrated by the figures in the MEDPAC report described below, the overall payment to hospitals counting both facility fees and professional fees are substantially more than if the hospitals were paid in the same manner as non-hospital providers. See MEDPAC, Report to the Congress: Medicare Payment Policy, March 2016, Chapter 3, Hospital Payment Policy, p. 61 (March 2016), R. at 1117.

(d) Connecticut's Medicaid program provides for different coverage and reimbursement for hospitals than any other category of provider, including differences in payment between hospital and non-hospital providers for similar services.

As with Medicare, Connecticut's Medicaid program also reimburses hospitals differently than other categories of providers. Under federal Medicaid law, states are only required to reimburse for certain services and may choose to reimburse for other services (optional benefit categories).[99] Inpatient and outpatient hospital services are both among the fairly small list of mandatory Medicaid benefit categories for categorically needy beneficiaries, which means that state Medicaid programs are required to cover inpatient and outpatient hospital services. 42 C.F.R. § 440.210. A DSS summary and analysis of Connecticut Medicaid's reimbursement methodologies for selected services, which was prepared for use in this ruling and which includes specific analysis between how selected services are reimbursed when provided by a hospital versus a non-hospital provider, is attached as Appendix 4 to this Declaratory Ruling, which is incorporated by reference as if fully set forth herein. Another fundamental difference between hospitals and other categories of providers in Medicaid is that hospitals represent the largest share of Medicaid spending among various categories of providers. In Connecticut, total payments to hospitals in SFY 2016 were approximately $1.78 billion for Medicaid, representing approximately 29.7% of Connecticut's Medicaid program spending for SFY 2016. See DSS, Medicaid Category of Service Expenditure Report (2016), R. at 1106.

Connecticut Medicaid's reimbursement methodologies for hospitals differ dramatically from the reimbursement methodologies available to any other benefit category. Until the end of calendar year 2014, Connecticut's Medicaid program reimbursed for inpatient hospital services using a system of interim per diem rates that were later compared to the lower of costs based on each hospital's Medicare cost report or the discharge rate multiplied by the number of discharges plus pass-through costs. See, e.g., Medicaid State Plan Amendments (SPAs) 11-031 and 12-002, R. at 1267-1269 and 656-665.[100] The difference resulted in additional payment to or from the hospital,

[99] The optional benefit categories are any services defined in 42 C.F.R. 440, Subpart A that are not required to be provided in a state's Medicaid program under its Medicaid State Plan pursuant to 42 C.F.R. §§ 440.210 and 440.220. 42 C.F.R. § 440.225. Examples of optional services include services provided by licensed practitioners in independent practice other than physicians or dentists; private duty nursing services; clinic services; physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders provided by providers in independent practice; diagnostic, screening, preventive, and rehabilitative services, and others. See 42 C.F.R. Part 440.

[100] The Medicaid State Plan, which is maintained by the state and subject to review and approval by CMS, sets forth the description of a state's Medicaid program that must be followed in order for the state to receive FFP for providing Medicaid services. See 42 C.F.R. § 430.12. A Medicaid State Plan Amendment (SPA) is an amendment to the Medicaid State Plan, which is proposed by the state and subject to review and approval by CMS. See id. A SPA must be submitted in various circumstances, including to reflect changes in the operation of the Medicaid program, such as a change in the methodology for reimbursing health care providers. See id.; see also 42 C.F.R. § 447.205.

In their letter (the two-page letter) dated May 27, 2016, Petitioners claim that "there are miscellaneous pages such as an envelope, a fax transmittal sheet, and an isolated, seemingly out-of-order page from the State Plan identified as 'Page 32.'" R. at 721. The envelope and fax cover sheet simply give context to the text of approved SPA 12-002. Attachment 4.19-A, Page 32 is listed at the end, even though it is non-consecutive, because that page addresses

as applicable. See id. Especially because of the variety of costs included in each hospital's Medicare cost report, that reimbursement methodology was completely different than the reimbursement methodology available to any other category of provider. More recently, starting January 1, 2015, Connecticut's Medicaid program adopted an IPPS similar to Medicare, using DRGs for most services,[101] with a variety of adjustments, including outlier payments. See SPA 15-003, R. at 1273-1293. No other category of Medicaid provider has access to any other similar type of reimbursement methodology.

For outpatient hospital services, a key difference—and advantage—for hospitals under Medicaid nationally, as well as in Connecticut's Medicaid program, is that the definition of the outpatient hospital services benefit category is extremely broad, which enables hospitals to provide and bill for a much wider variety of services than any other category of provider. See 42 C.F.R. § 440.20(a).[102] Because hospitals can bill for virtually any service within the Medicaid outpatient hospital benefit category, hospitals can be reimbursed for services that may not even be covered in non-hospital settings, such as services provided by non-physician licensed practitioners, as well as physical therapy, occupational therapy,[103] speech and language pathology services, and audiology services, which are optional categories when provided by independent practitioners. See 42 C.F.R. §§ 440.60 and 440.110.

In addition to the breadth of the outpatient hospital services benefit category, the Connecticut Medicaid program's reimbursement methodology for outpatient hospital services is different than the methodology available to any other category of provider. Until June 30, 2016, Connecticut Medicaid's reimbursement of outpatient hospital services was based on revenue center codes, which reimbursed in a variety of methods, including fixed fees, ratios of cost to charge, or fixed daily rates for a description of various services. See, e.g., SPA 15-034, R. at 1294-1296. No other reimbursement methodology included ratios of cost to charge. That attribute was a substantial advantage for hospitals that chose to increase their charges so that the payment was higher. More recently, beginning July 1, 2016, Connecticut Medicaid's reimbursement methodology for

reimbursement for private psychiatric hospitals and SPA 12-002 simultaneously addressed both that provider category as well as acute care general hospitals. The intervening pages were omitted because they were not modified by SPA 12-002. The documents immediately following the approved SPA pages for SPA 12-002 relate to SPA 13-029. SPA 12-002 is included for the purpose of indicating the general amount and structure of the hospital supplemental payments for SFY 2012-2013 and describing the inpatient hospital reimbursement methodology in effect prior to January 1, 2015.

[101] Specifically, Connecticut's Medicaid program uses the All Patient Refined Diagnosis-Related Groups methodology and associated grouper software to calculate the DRGs, which is different from the methodology and grouper used by Medicare.

[102] CMS specifically confirmed the extremely broad nature of the outpatient hospital benefit category in Medicaid when it briefly attempted to narrow the definition due to CMS concerns about payment at "high levels customary for outpatient hospital services instead of the levels associated with the other covered benefits." CMS, Proposed Rule, Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition, 72 Fed. Reg. 55158, 55159 (Sept. 28, 2007). However, in response to substantial opposition, CMS rescinded that regulation change before it took effect, so that the current broad definition of outpatient hospital services has remained in effect. CMS, Final Rule, Medicaid Program: Rescission of School-Based Administration / Transportation Final Rule, Outpatient Hospital Services Final Rule, and Partial Rescission of Case Management Interim Final Rule, 74 Fed. Reg. 31183, 31184 (June 30, 2009).

[103] By way of example, in Connecticut's Medicaid program, services provided by occupational therapists in independent practice are covered only when provided to individuals under age 21. However, in a hospital setting, occupational therapy services are covered when provided to an individual of any age.

outpatient hospital services now uses an OPPS similar to Medicare, where most services are reimbursed using an APC methodology, which packages various services into groups of services estimated to account for similar amounts of hospital resources, plus various other adjustments, including outliers and geographic adjustments. See, e.g., DSS Public Notice and Draft Language for SPA 16-016, R. at 1193-1201.[104] The current system of Connecticut Medicaid's new OPPS is also unique to hospitals, which means that no other category of provider has access to any similar reimbursement methodology under Connecticut's Medicaid program.

As detailed in the DSS analysis in Appendix 4, similar to Medicare, unlike independent physicians and other practitioners, under Connecticut's Medicaid program, hospitals can bill for facility fees in addition to the professional fees for hospital-affiliated physicians and other practitioners. This analysis compares Connecticut Medicaid's reimbursement methodology and expenditure data for several services in both the hospital and non-hospital setting that were in effect for FFY 2013. In general, this analysis shows that the method of payment to hospitals varies substantially from the method of paying for similar services provided by non-hospital providers, with hospitals often paid using broad revenue codes that are paid either a fixed fee or a ratio of cost to charge (where the payment is a percentage of the hospital's charges). As noted above, ratios of cost to charge were a unique methodology only available to hospitals, not other categories of providers. As a fixed fee example, while a freestanding rehabilitation clinic received $88.95 for the initial occupational evaluation and $53.97 for reevaluations, a hospital would receive the fixed daily rate of $97.24 for either an initial evaluation or for a re-evaluation. See Appendix 4. In addition, for occupational therapy treatment services, a hospital would always be paid the fixed daily rate of $97.24, whereas a freestanding rehabilitation clinic received payment based on specific services as reflected on its fee schedule (with an average amount paid per date of service in FFY 2013 of $96.81). See id. In sum, as shown in detail on the analysis in Appendix 4 of this Declaratory Ruling, for most types of services, Connecticut's Medicaid program reimburses hospitals in a substantially different manner than other health care providers.

(e) Hospitals are among a small group of providers that receive funds from the Medicare and Medicaid Electronic Health Records Incentive Programs and hospitals receive unique benefits from those programs that are not available to other categories of providers.

Hospitals also receive unique benefits through both the Medicare and Medicaid electronic health records (EHR) incentive programs. The Medicare and Medicaid EHR incentive programs were both added by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is part of the American Recovery and Reinvestment Act (ARRA), P.L. 111-5. Those programs provide incentive payments to a limited category of providers, including hospitals, critical access hospitals, and eligible professionals (specified categories of health care practitioners) in exchange for the provider first adopting and then demonstrating meaningful use of EHR systems. Although eligible professionals are required to choose either to participate in the Medicare or Medicaid EHR incentive program, not both, hospitals are uniquely able to participate in both programs. See 42 C.F.R. § 495.10(e). In addition to that fundamental difference, each program has general requirements, as well as certain requirements that apply only to hospitals (as

[104] Because SPA 16-016 is effective July 1, 2016, pursuant to 42 C.F.R. § 430.20, it is due to be submitted to CMS on or before September 30, 2016, but has not yet been submitted to CMS.

well as different requirements that apply only to eligible professionals). See 42 C.F.R. §§ 495.104, 495.304(e), 495.306(c)(2), 495.310(f) and (g). Accordingly, hospitals are treated unlike any other category of provider for purposes of eligibility for and requirements of participating in the Medicare and Medicaid EHR Incentive Programs.

(f) Hospitals are among a small group of providers eligible to participate in the section 340B drug discount program.

Similar to reimbursement differences, another advantage available only to hospitals and a limited group of other categories of providers is the drug discount program established pursuant to section 340B of the Public Health Service Act. See 42 U.S.C. § 256b. Those benefits are available to limited categories of providers that meet the definition of "covered entity," including hospitals, which results in an advantage to hospitals that participate in the program that is not available to many other categories of providers. See id. These discounts enable hospitals to receive revenue from Medicare that substantially exceeds the lower costs of providing drugs that were obtained using the 340B discount because Medicare "does not currently adjust the OPPS payment rates for the lower drug acquisition cost at 340B hospitals, resulting in substantial differences between Medicare payment rates and the acquisition costs of Part B drugs at these hospitals." MEDPAC [Medicare Payment Advisory Commission][105], Report to the Congress: Medicare Payment Policy, March 2016, Chapter 3, Hospital Payment Policy, pp. 57, 79 (March 2016), R. at 1113, 1135. In addition, MEDPAC noted that Medicare spending growth in nominal dollars on Medicare Part B drugs at 340B hospitals rose substantially, from $0.5 billion in 2004 to $3.5 billion in 2013. MEDPAC, Report to the Congress: Overview of the 340B Drug Pricing Program, pp. 12-13 (May 2015), R. at 1168-1169. MEDPAC includes several potential explanations for this increase, including from incentives resulting increased payment for services in outpatient hospital departments compared to non-hospital settings. See id. at 14, R. at 1170. Hospitals therefore receive unique benefits from Medicare reimbursement due to the 340B drug discount program.

(g) Hospitals benefit financially from the differences in payer reimbursement methodologies for hospitals compared to non-hospital providers.

The practical effect of the differences in payers' reimbursement methodology for hospitals compared to other categories of providers in significant. MEDPAC noted a substantial shift towards hospital outpatient spending due to hospital acquisition of physician offices, which it also notes resulted in increased spending due to the higher amounts charged in the hospital setting compared to the freestanding office setting. See MEDPAC March 2016 Report, at 61-62, R. at 1117-1118.[106] Specifically, MEDPAC estimated that Medicare spent $1.3 billion more in 2014 "than it would have if payment rates for E&M [evaluation and management] office visits in

[105] MEDPAC is an independent federal congressional agency established by federal statute to advise Congress regarding the Medicare program. See 42 U.S.C. § 1395b-6.

[106] Congress partially reduced the scope of the provider-based status option in section 603 of the Bipartisan Budget Act of 2015, which amends 42 U.S.C. § 1395*l*(t), effective for dates of service on and after January 1, 2017, to remove the option of provider-based status for new off-campus HOPDs (but does change provider-based status for on-campus HOPDs and existing off-campus HOPDs that were billing for services furnished prior to November 2, 2015). 42 U.S.C. §§ 1395*l*(t)(1)(B) and (t)(21) (added by P.L. 114-74, § 603, 129 Stat. 597-598); see also MEDPAC March 2016 Report, at 62, R. at 1118.

HOPDs [hospital outpatient departments] were the same as freestanding office rates," plus $325 million higher Medicare beneficiary cost-sharing paid to hospitals. Id. at 61, R. at 1117. Notably, those payment differences are solely for E&M visits, although other categories of service also are paid at substantially higher amounts in the hospital setting compared to the non-hospital freestanding setting. See id.; see also Channick, supra, at 11, R. at 1239. In commercial insurance as well, hospitals are typically paid at higher rates (up to double) than for comparable services in a non-hospital setting. See Channick, at 11, R. at 1239.[107]

For all of the reasons described above, the Departments find that hospitals are uniquely situated compared to other health care providers because they are subject to a completely different set of regulatory requirements.

(3) It was rational for the General Assembly to impose the Hospital User Fee on hospitals to the exclusion of all other health care providers, because hospitals are subject to different regulatory requirements than any other health care provider.

As discussed above, the Departments find that hospitals are subject to different regulatory requirements than other health care providers. To that end, hospitals can provide a wider range of services than any other health care provider. Consequently, hospitals are able to provide their patients with intangible benefits such as being able to perform tests more quickly and being able to provide support services that other health providers cannot. As a result, hospitals are compensated differently than any other health care provider. These sorts of distinctions between classes have long been recognized as rational justifications for differing tax treatment of one type of business from another.[108]

[107] As discussed above, Connecticut's Medicaid program reimbursement methodology for hospitals is fundamentally different from the reimbursement for non-hospital providers for various types of services. Due to the complexity of those differences, it is not feasible to determine how much hospitals would be paid if they were reimbursed in the same manner as non-hospital providers for each type of service.

[108] By way of example, in Batte-Holmgren v. Comm'r of Pub. Health, the Connecticut Supreme Court examined whether a smoking ban imposed on restaurants, cafes, and other public facilities, but not private clubs and casinos violated the equal protection clause. See id. at 296-308. The Court "assume[d], without deciding, that restaurants and cafés are situated similarly to casinos and private clubs with respect to the statutory scheme in order to proceed with equal protection analysis." Id. at 295. The Court concluded, however, that "the legislature reasonably could have determined that the legal status of the casinos differs significantly from that of restaurants and cafés and that this difference provides a rational basis for exempting them from the smoking ban legislation," essentially asserting that it is conceivable that the General Assembly exempted casinos from the ban because they are not similarly situated to restaurants and cafés. Id. at 308. There are many examples of situations in which different regulatory schemes have justified differing treatment of hospitals. See also Harbor Ins. Co. v. Groppo, 208 Conn. 505, 513, 544 A.2d 1221, 1225 (1988) ("Next, Harbor argues that the distinction drawn between it and insurers that did not have a surplus line business in Connecticut prior to becoming licensed in Connecticut is discriminatory, because similarly situated insurers are treated differently. Section 12–210(a), however, requires only insurers that previously have been permitted to insure certain property and risks in Connecticut, upon becoming licensed in this state, to pay a tax on the business that they have previously conducted. The two classes of insurers simply are not similar: one has written business in this state and has enjoyed the benefits of writing such business, the other has not written any business in this state and has received no Connecticut business benefits. Moreover, Harbor has not referred us to any case holding unconstitutional, on an equal protection analysis, a state taxing scheme recognizing this argument."). New Haven Water Co. v. Town of N. Branford, 174 Conn. 556, 564, 392 A.2d 456, 459 (1978) ("As the plaintiff properly asserts, the private water companies in the public service company category form a distinct class, unique as to product, purpose

To that end, the United States Supreme Court has historically upheld state statutes that impose different taxes on different types of corporate structures against equal protection challenges. See Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356, 359, 93 S. Ct. 1001, 1003 (1973).[109] In Lehnhausen v. Lake Shore Auto Parts Co., the United States Supreme Court reviewed the history of cases in which differing treatment of corporations and individuals was examined and, in doing so, noted the fundamental differences between corporations and individuals:

> **'(I)t could not be said, . . ., that there is no substantial difference between the carrying on of business by the corporations taxed, and the same business when conducted by a private firm or individual. The thing taxed is not the mere dealing in merchandise, in which the actual transactions may be the same, whether conducted by individuals or corporations, but the tax is laid upon the privileges which exist in conducting business with the advantages which inhere in the corporate capacity of those taxed, and which are not enjoyed by private firms or individuals.** These advantages are obvious, and have led to the formation of such companies in nearly all branches of trade. The continuity of the business, without interruption by death or dissolution, the transfer of property interests by the disposition of shares of stock, the advantages of business controlled and managed by corporate directors, the general absence of individual liability, these and other things inhere in the advantages of business thus conducted, which do not exist when the same business is conducted by private individuals or partnerships. It is this distinctive privilege which is the subject of taxation, not the mere buying or selling or handling of goods, which may be the same, whether done by corporations or individuals.' Id., at 161—162, 31 S.Ct., at 353.

Id. at 361–62 (emphasis supplied). Essentially, the Court is noting that the intangible differences between individuals and corporations may provide justification for imposing different taxes on different corporate structures despite the fact that they might perform similar services.

Similarly, given all of the intangible benefits hospitals provide their patients, the Departments cannot find that the services performed in a hospital are the same as services performed by other health care providers, as the Petitioners urge. Rather, like the difference between corporations and individuals, services performed in hospitals have many intangible benefits that services performed by other health care providers do not have. Stated another way, services provided by a hospital come with additional benefits simply by virtue of being performed in a hospital setting. As such, services that other providers may be able to provide are amplified and enhanced simply by virtue of being provided by a hospital. Specifically, in hospitals patients receive the benefit of additional support services, twenty-four hour access to services, emergency services, the ease of all services being consolidated under one roof, a higher level of acuity in treatment, and more specialized staff

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and consumer needs, and are highly regulated by statute and by the state's public utility regulating body. We conclude that the record in this case does not support a conclusion that there is no rational relation whatsoever between Public Act No. 439 and a valid legislative purpose and the trial court, therefore, properly did not base its decision on any constitutional grounds.").

[109] In Lehnhausen v. Lake Shore Auto Parts Co., the United States Supreme Court examined whether an ad valorem tax Illinois imposed on the personal property of corporations and non-individuals violated the equal protection clause of the fourteenth amendment. Id. at 358. The tax was not imposed on the personal property of individuals. Id. The Court found that the tax did not violate equal protection.

and equipment. By way of example, if a patient has a routine outpatient procedure done at a hospital which turns into an emergency, the hospital is equipped to deal with the emergency and the patient's long-term inpatient care. If a patient has a routine outpatient procedure done at an ambulatory surgical center which turns into an emergency, the ambulatory surgical center may be able to ameliorate the emergency somewhat, but any long-term inpatient care would have to be done at a hospital. As such, Connecticut does not permit ambulatory surgical centers to perform certain services, but rather restricts the provision of such services to hospitals, which are better equipped to deal with those services.

Given the significant benefits that services performed in a hospital have over services performed elsewhere, the Departments find no support for the Petitioners' assertion[110] that services provided by hospitals are identical to services provided by other service providers. Moreover, the very revenue upon which the Hospital User Fee is imposed demonstrates this difference. Specifically, as referenced above, the Hospital User Fee is imposed upon "the net patient revenue of each hospital in this state." The term "net patient revenue" is defined to mean "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." Conn. Gen. Stat. § 12-263a(2).[111] As discussed above, no other health care institution license authorize a provider to provide such a wide variety of both inpatient and outpatient services. As such, because the General Assembly seeks to tax net patient revenue as defined by the statute for both inpatient and outpatient revenue from a single category of provider, such a tax can only be levied on hospitals.

[110] The Petitioners allege as follows:

> The General Assembly's classification of taxable health care providers is exactly the type of arbitrary classification the Equal Protection Clause prohibits. The taxable providers and nontaxable providers provide identical services to patients. For a patient, the choice between one provider or another could be a matter of convenience. But the General Assembly in dividing taxable and non-taxable providers, arbitrarily decided that services at one facility are taxable, while services at the other are exempt. That same patient could receive the same medical treatment for the same medical condition – perhaps even by the same doctor – at either facility. The General Assembly ignored this reality and arbitrarily decided that treatment at one facility is taxable, but the same treatment at the other is exempt. Because the law singles out hospitals for disfavorable treatment without a legitimate basis for doing so, the Act violates the Constitution's guarantee of "equal protection of the laws."

R. at 11, 31. Given the substantial amount of evidence that suggests that services performed in a hospital are fundamentally different than services performed by other providers, the Departments do not find that the services are the same. To that end, as set forth more fully above, there are certain services for which patients cannot simply choose to a hospital or another service provider including emergency services and trauma services. For example, if a patient has a heart attack, he or she cannot choose to go to an ambulatory surgical center or an outpatient clinic. Only a hospital can provide the services the patient needs. Moreover, for those services for which a patient can choose to go to a hospital or another service provider, hospitals may be preferable as service provided in hospitals have enhanced benefits that other providers may not be able to offer including twenty-four hour access, specialized staff and equipment, faster results, and the support services of an emergency department should something go wrong. Accordingly, the Departments cannot conclude that services provided in the hospital setting are the same as those other providers perform.

[111] As explained in the clarifying legislation described above, the definitions of inpatient hospital services conform to the federal definitions in 42 U.S.C. § 1396b(w) and 42 C.F.R. §§ 440.10 and 440.20(a). See 2016 Conn. Pub. Acts 3 of the May spec. sess., § 121.

Given that the services provided by hospitals are fundamentally different than those provided by other health care providers, it was rational for the General Assembly to impose the Hospital User Fee on hospitals to the exclusion of other health care providers. Accordingly, the unique regulatory scheme that governs hospitals justifies treating hospitals different from other health care providers for purposes of the Hospital User Fee. As discussed more fully below, this unique regulatory scheme has given hospitals the ability to more easily shoulder the burden of the Hospital User Fee than any other health care providers.[112,113]

[112] The Petitioners urge the Departments to follow the decisions of two New Hampshire trial courts, which held that New Hampshire's hospital tax violated equal protection. However, these two decisions were predicated on an "Agreed Statement of Facts," which indicated that "[t]he services are identical whether they are offered by a hospital or a non-hospital entity." Northeast Rehabilitation Hosp. v. N.H. Dep't of Revenue Administration, No. 2182012CV00185, 2014 WL 10679796, at *1-2 (N.H. Super. Ct. Feb. 7, 2014) (McHugh, J.); see also Catholic Medical Ctr. v. N.H. Dep't of Revenue Administration, Nos. 216-2011-CV-00955, 216-2011-CV-00850, and 218-2011-CV-01394, 2014 WL 1509834, at *2 (N.H. Super. Ct. Apr. 8, 2014) (Mangones, J.) (emphasis added) (finding that "As indicated by the **uncontested facts** of this case, both hospitals and non-hospitals perform a wide range of identical services. . ."). Based on these agreed upon facts in those cases, the New Hampshire trial courts found that New Hampshire's hospital tax violated the equal protection clause. However, because the Departments find that Connecticut hospitals do not perform identical services as other health care providers, the Departments find that these New Hampshire trial court decisions are not applicable to Connecticut's Hospital User Fee.

[113] As further evidence that they are subject to a different regulatory scheme than any other health care provider, due to their breadth and their large role in the health care system, hospitals are subject to different regulatory requirements than other categories of providers. Recognizing this role, some of the requirements give hospitals greater flexibility than other providers, while other requirements impose more stringent requirements. Ultimately, the regulatory requirements further demonstrate that hospitals function in a different regulatory environment than any other category of health care provider.

Hospitals are subject to various regulatory requirements that are different than those imposed on other categories of providers, reflecting hospitals' broader scope of services, as well as regulatory requirements that are more flexible than for other categories of providers. The most fundamental regulatory differences between hospitals and other health care providers is that the short-term general hospital license authorizes hospitals to provide a broader array of health care services than other providers. See Conn. Agencies Regs. § 19-13-D1. Related to this broader scope of license than other categories of health care providers, hospitals are also required to comply with detailed sets of requirements, also as detailed in the licensing regulations.

Similarly, the conditions of participation for Medicare and Medicaid require hospitals, in order to receive Medicare and Medicaid payment, to comply with a very detailed set of requirements, including detailed accreditation requirements by an approved accreditation agency. See 42 C.F.R. 482. Although there are also conditions of participation for other institutional categories of providers (such as home health agencies, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities), no such detailed requirements exist for non-institutional categories of providers. Even compared to other categories of institutional providers (and other providers with detailed requirements, such as laboratories and end-stage renal disease facilities), the conditions applicable to hospitals are unique due to the much broader scope of services provided by hospitals than any other institutional category of providers. See 42 C.F.R. Chapter IV, Subchapter G. In addition, as discussed above, the provider-based status regulation gives hospitals additional flexibility to charge for services performed by various types of providers controlled by the hospital as if the services were provided in the hospital itself, notably enabling hospitals to charge both for facility and professional fees for physician groups acquired by the hospital. See 42 C.F.R. § 413.65.

Presumably recognizing that hospitals are larger and more highly regulated than other categories of providers, hospitals have more flexibility in certain contexts than other categories of health care providers. Although the two statutes referenced here give hospitals additional flexibility not afforded to other categories of providers, specific health care payers may require more stringent requirements as a condition of payment. For example, unlike other categories of health care providers, hospitals have the flexibility to designate any licensed health care provider and any certified ultrasound or nuclear medicine technologist to perform specified oxygen-related services in the hospital.

See Conn. Gen. Stat. § 19a-903b. As another example, only hospitals are included in a statute that authorizes hospitals to administer specified care to patients without a physician's order in accordance with a physician-approved hospital policy and under circumstances specified in the statute. Conn. Gen. Stat. § 19a-490k.

Unlike any other category of health care provider, state statute specifically authorizes hospitals to take land in order to enlarge the hospital, if it meets various requirements. See Conn. Gen. Stat. § 19a-645. No other category of health care provider has this type of power to exercise a property taking authority similar to eminent domain.

Also recognizing their unique role in the health care system compared to any other category of provider, hospitals are likewise subject to requirements that are more stringent than those imposed on other categories of health care providers. For similar reasons as the differences in regulatory requirements discussed above, hospitals are subject to more stringent requirements in certain circumstances, often reflecting their uniquely broad role in the health care system. The most prominent requirement is the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals, as a condition of Medicare payment to provide screening and stabilizing treatment for all individuals with emergency medical conditions or in active labor, regardless of the individual's ability to pay. See 42 U.S.C. § 1395dd. Hospitals that violate EMTALA are subject to civil penalties and civil enforcement. See id. § 1395dd(d). This broad requirement to provide emergency and active labor services is unique to hospitals. Although FQHCs are also required to provide services to individuals regardless of their ability to pay, they predominantly provide primary care services, which are fundamentally different services than the emergency services required for hospitals to provide under EMTALA and FQHCs are funded in a completely different manner from hospitals. See 42 U.S.C. §§ 254b and 1396a(bb). In the report referenced above, the AHA highlighted hospitals' unique obligations under EMTALA. See AHA, supra, at 11, R. at 1055. Because EMTALA applies only to hospitals, the AHA claims that "thus, for many of America's uninsured and other low-income vulnerable people, the hospital ED [emergency department] has become the primary point of access for health care services." Id.

Hospitals are among a limited categories of health care providers subject to certificate of need (CON) requirements, where state approval is required for specified changes to the hospital and/or its programs. See Conn. Gen. Stat. §§ 19a-630 and 19a-638. While several general situations require a CON for any category of provider subject to CON requirements, hospitals are uniquely required to obtain a CON from OHCA also for the "termination of inpatient or outpatient services offered by a hospital." Conn. Gen. Stat. § 19a-638(a)(5). Also unique to hospitals, additional CON review requirements apply to transactions involving the transfer of ownership of a hospital. See Conn. Gen. Stat. §§ 19a-639(d) and (e). Similarly, specific requirements apply to the sale of a nonprofit hospital (including its assets, operations, or a change in control) to a for profit entity, including requiring CON approval by OHCA and the Attorney General. See Conn. Gen. Stat. §§ 19a-486 to 19a-486h. Thus, hospitals are subject to different CON requirements than other categories of health care providers.

State statutes and regulations impose unique reporting requirements on hospitals that are not required for any other category of health care provider. Specifically, hospitals must submit annual reports, audited financial statements, information regarding uncompensated care, specified discharge and other data, and data regarding revenues to OHCA for review. Conn. Gen. Stat. §§ 19a-644, 19a-649, 19a-654, and 19a-676. Although a portion of Conn. Gen. Stat. § 19a-654 applies to any outpatient surgical facility, all of the other reporting requirements described above apply only to hospitals, not to any other category of health care provider.

Some of the requirements reflect hospitals' large role in the health care system, including the scope of expenditures from patients and payers for hospitals' services. For example, unlike any other category of health care provider, state statute specifically requires hospitals to file their charges for services with OHCA and establishes various requirements regarding hospitals' reimbursement arrangements with specified health care payers and required procedures. Conn. Gen. Stat. § 19a-646; see also Conn. Gen. Stat. § 19a-681. Similarly, state statute specifies requirements involving hospitals' collections practices, including requiring hospitals to file debt collection reports with OHCA. See Conn. Gen. Stat. §§ 19a-673 to 19a-673b. Another billing limitation under state statute incorporates the Medicare restrictions on hospitals billing for hospital-acquired conditions beyond Medicare. See Conn. Gen. Stat. § 19a-903. Hospitals are also required to provide specific information regarding itemized bills to patients and payers. Conn. Gen. Stat. § 19a-509 (as amended by Public Act 16-95, § 5, effective October 1, 2016). Hospitals (including hospital-affiliated health

c. It is conceivable that the General Assembly imposed the Hospital User Fee on hospitals because they can bear the burden of taxation better than other health care providers.

Another rational basis for the Hospital User Fee is that the unique regulatory scheme that governs hospitals also allows hospitals to possess a greater market power than any other health care provider. As such, it is conceivable that the General Assembly choose to tax hospitals over all other health care providers because they were better able to bear the burden of taxation, which has historically been a rational justification for the imposition of a tax.

The fact that hospitals can provide a broader array of services than any other category of health care provider also means that hospitals are positioned to have more revenue, a broader referral network, and a more dominant market position than other categories of health care providers. Nationally, hospitals "are often the center" of large health systems that include a wide variety of health care providers representing "medical care across the continuum." David M. Cutler and Fiona Scott Morton, "Special Communication: Hospitals, Market Share and Consolidation," 310 JAMA (Journal of the American Medical Association) 1964 (Nov. 13, 2013), R. at 1221. Higher hospital prices often result from demand for "hospitals that are usually either part of a large consolidated health system or have a university affiliation, or offer unique Level 1 services." Susan Adler Channick, The ACA, Provider Mergers and Hospital Pricing: Experimenting with Smart, Lower-Cost Health Insurance Options, William & Mary Policy Review, Vol. 6, No. 2, p. 2

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systems and hospital-affiliated providers) are also required to provide detailed notifications regarding billing practices, especially facility fees. Conn. Gen. Stat. § 19a-508c (as amended by Public Act 16-77, § 2, effective June 2, 2016).

Unrelated to billing, state statute provides for a variety of specific requirements unique to hospitals. For example, there are specific requirements regarding a hospital's use of "hospital bed funds," which are funds or other property donated to the hospital to provide medical care, which are requirements unique to hospitals. See Conn. Gen. Stat. § 19a-509b. In the area of operations, only hospitals are subject to a state statute that imposes mandatory limits on overtime for nurses working in hospitals. Conn. Gen. Stat. § 19a-490*l*. As another example, state statute imposes specific requirements on hospitals, but not other categories of health care providers, regarding preparing a policy regarding interpreter services for non-English-speaking patients and ensuring the availability of interpreter services to "patients whose primary language is spoken by a group comprising not less than five per cent of the population residing in the geographic area served by the hospital." Conn. Gen. Stat. § 19a-490i. Unique to hospitals, state statute requires hospitals to comply with specific discharge planning requirements. Conn. Gen. Stat. § 19a-504c. In addition, as noted above, state statute requires hospitals to include two or more available home health care agencies to patients as part of the discharge plan and to disclose to patients if the hospital has an ownership or investment interest in a home health care agency or receives compensation for referring patients to a home health care agency. Conn. Gen. Stat. § 19a-504d.

State statute also imposes unique public health requirements on hospitals that go beyond the requirements imposed on any other category of health care provider. For example, hospitals have unique duties regarding infectious diseases, including various reporting requirements. See Conn. Gen. Stat. § 19a-904. In response to infections common in hospitals, state statute requires hospitals to develop a plan to reduce methicillin-resistant staphylococcus aureus infections. See Conn. Gen. Stat. § 19a-490p. Hospitals, unlike other providers, are subject to a requirement to make available to DPH its plan for remediation of medical and surgical errors. Conn. Gen. Stat. § 19a-490j. As another example, as referenced above, DPH regulations require all hospitals to participate in the statewide trauma system, including requiring all hospitals to apply to the American College of Surgeons for the verification of trauma centers (although as noted above, that regulation does not necessarily mean that all hospitals have actually received such verification). See Conn. Agencies Regs. §§ 19a-177-3 and 4.

(2015), R. at 1230. Part of this trend includes "vertical consolidation," which involves "hospitals consolidating with other health care provider entities" and which has increased dramatically in recent years. Cutler and Morton, at 1965-66, R. at 1222-23. This consolidation translates into increased market power for hospitals, especially for a "tertiary care hospital" or a "flagship academic medical center," which are valued by many for "perceived higher quality," which translates into increased market power. See id. at 1966-67, R. at 1223-24. These hospitals provide unique services, such as "advanced, technology-driven treatment." See id. As the center of health systems, hospitals are generally in a stronger position than other categories of health care providers to negotiate higher rates from health care payers. See id. at 1967, R. at 1225. This market power typically translates into higher prices. Channick, at 2, R. at 1230.

Relatedly, hospitals, both individually and as the centers of health systems, have continued to consolidate with other hospitals and health systems, further increasing their market concentration and market power. See id. at 1965-67, R. at 1222-24. Hospitals are uniquely positioned to have market power for these reasons: "Because it provides acute care services and maintains patient records, the hospital knows the identities of patients who need post-discharge convalescent goods and services. The hospital also controls direct access to these patients before they are discharged, because it can prevent suppliers of home health care nursing services or DME from soliciting business in the hospital." Roger D. Blair & James A. Burt, Leveraging Monopoly Power Through Hospital Diversification, 1 Stan. J.L. Bus. & Fin. 287, 289 (1995), R. at 1203-04. A hospital can use these and other advantages to further bolster its referral network, especially if it acquires owners or control interests in other health care providers through a health system or other arrangement. See id. at 299-302, R. at 1209-11. Recognizing this unique position of hospitals to control referral, state statute requires hospitals to include two or more available home health care agencies to patients as part of the discharge plan and to disclose to patients if the hospital has an ownership or investment interest in a home health care agency or receives compensation for referring patients to a home health care agency. Conn. Gen. Stat. § 19a-504d.

These national trends are equally present in Connecticut, where hospitals are also the dominant player in increasingly consolidated health systems. See Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees, April 16, 2014, pp. 1, 4, R. at 985, 988. The central reason for this consolidation is to "give the hospitals a larger referral base, which in turn enhances the hospitals' negotiating leverage with payers" and generally results in higher prices for health care. Id. at 4; see also Cutler and Morton, supra, at 1967-68, R. at 1224-25. In particular, by acquiring physician practices and employing physicians, the hospital helps ensure that those physicians will refer their patients for other services provided by the hospital. See id.

Further capitalizing on their overall market power, hospitals have additional sources of revenue that are less available to other categories of health care providers. As one example, nonprofit hospitals and hospital-controlled health systems commonly engage in fundraising and are also able to earn non-medical business income through sources such as gift shops, cafeterias, fitness centers, parking fees, and other activities. See, e.g., AHS Hosp. Corp v. Town of Morristown, 28 N.J. Tax 456, 472-475, 481-484, 526-531, 533-534 (N.J. Tax Ct. 2015). Because hospitals generally are large entities that operate on a larger scale than other categories of health care providers, those additional activities are generally more available to hospitals.

Nationally, hospitals receive substantially more revenue than other categories of providers. The CMS Office of the Actuary produces various types of data and analyses about National Health Expenditures, which show that hospital expenditures represent a substantially larger share of expenditures than any other type of provider. In the 2014 National Health Expenditures, which is the most current year publicly available, total national health expenditures were approximately $3.03 trillion, with hospital care accounting for approximately $972 billion, nearly one-third of the total. CMS, Office of the Actuary, 2014 National Health Expenditures by Type of Expenditure and Program, Table 19, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/. Other categories of providers represented markedly smaller portions of the national health expenditures: the next highest category was "physician and clinical services," representing approximately $604 billion and then prescription drugs at approximately $298 billion, and all other provider categories represented less than $200 billion each. Id.

Available data indicates that health expenditure distribution within Connecticut is similarly dominated by hospital expenditures. The most recent available data from CMS on national health expenditures broken out by state is 2009. Based on that data, the total health expenditures in Connecticut for 2009 were approximately $30.3 billion, of which hospital expenditures was approximately $9.2 billion. CMS, Office of the Actuary, National Health Expenditure Data, Total All Payers State Estimates by State of Provider (2011), available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/. As with the national data, the categories of provider other than hospital represented substantially less than that amount: the next highest category was "physician and clinical services," representing approximately $6.8 billion; prescription drugs, representing approximately $4.0 billion; nursing home care, representing approximately $3.2 billion; and "other health, residential, and personal care," representing approximately $2.78 billion. Id. Other categories represented less than $2 billion each. Id. The reasons for these differences are inherent in the hospitals' broad licensure and business model, which are additional differences between hospitals and other categories of health care providers, as discussed below.

At the same time as hospitals represent a higher share of health expenditures than other provider categories, there are substantially fewer hospitals than the other categories of providers that receive large shares health care of expenditures in Connecticut (but still smaller than hospitals). Based on current licensure data from the Department of Public Health, there are 27 licensed general hospitals (which is the category of hospital subject to the Hospital User Fee), compared to 17,662 individuals licensed as physicians, 326 entities licensed within a class of providers related to nursing facilities,[114] and 702 entities licensed as pharmacies. See Connecticut eLicense Web Portal, available at: http://www.elicense.ct.gov (accessed on August 8, 2016).

All of these factors show that hospitals have a dominant role in the health care system, which enables them to have greater overall market power than any other category of health care provider.

[114] That figure includes entities licensed as chronic and convalescent nursing home (216 entities), chronic and convalescent nursing homes and rest homes with nursing supervision (12 entities), residential care facilities (97 entities), and rest homes with nursing supervision (1 entity). See DPH licensure data, available at http://www.elicense.ct.gov (retrieved August 8, 2016).

The Connecticut Supreme Court has noted that it is appropriate to levy taxes on certain corporate structures that can bear the burden of taxation better than others. To that end, in MERSCORP Holdings, Inc. v. Malloy, the Connecticut Supreme Court examined whether recording fees imposed on a mortgage nominee operating a national electronic database which were three times higher than other recording fees violated equal protection. MERSCORP Holdings, Inc. v. Malloy, 320 Conn. 448, 451, 131 A.3d 220, 230 (2016). In doing so the Court found that one rational basis for the imposition of these higher fees on said mortgage nominee was that the mortgage nominee could bear the burden of such fees:

> the legislature might simply have concluded that a large corporation such as MERS, which is involved in nearly two thirds of the nation's residential mortgage transactions, is better able to shoulder high recording fees than are smaller mortgagees. Although it is true that large banks, loan servicing companies, and other well-heeled mortgagees may be no less able to afford such fees, a statute subject to rational basis review can be under inclusive without running afoul of the equal protection clause.

Id. at 464. Consistent with the above it is rational for a state government to impose a tax on taxpayers who may more easily bear the burden of taxation.

As is evidenced by the foregoing, hospitals have greater market power than other health care providers and generate more revenue than other health care providers. Accordingly, the Departments find that it was rational for the General Assembly to raise revenue by imposing the Hospital User Fee on hospitals to the exclusion of all other health care providers, because hospitals are better positioned to shoulder the burden of taxation than any other health care provider.

d. Another rational basis for the Hospital User Fee is that it is conceivable that the General Assembly imposed the Hospital User Fee on hospitals because hospitals receive benefits as a result of the Hospital User Fee.

The revenue raised by the Hospital User Fee is, in part, used to fund the state's Medicaid program and to obtain funding for the Medicaid program. Hospitals receive unique benefits under the state's Medicaid program as a result of this increased revenue. Accordingly, given that hospitals were benefiting indirectly from the tax, it is rational that the General Assembly imposed the tax on hospitals.

As noted in the Facts, the purpose of imposing a tax on hospitals was two-fold – (1) to raise revenue from uniquely situated taxpayers who were the beneficiaries of certain government programs and (2) to take advantage of provisions in federal law that would result in the state receiving increased funding from the federal government. 2016 Conn. Pub. Acts 3, May spec. sess., § 121. Specifically, as is also explained more fully in the Facts, states that have health care provider taxes that use the provider taxes to fund their state Medicaid program are eligible to receive additional matching funds from the federal government. In Connecticut, some of the proceeds from the tax went directly to funding the state's Medicaid program in order to obtain these matching funds.

Unlike most other categories of health care providers, under Medicaid hospitals receive substantial supplemental payments in addition to the standard payment methodologies. Specifically, hospitals receive inpatient supplemental payments from a fixed pool of funds that is allocated based on each hospital's share of Medicaid revenues, with maximum caps per hospital. See SPA 16-013, R. at 3015-17. In addition, small independent hospitals that meet specified criteria also receive additional supplemental payments, in addition to both the standard payment methodologies and also in addition to the general supplemental payment pool. See SPA 15-042, R. at 1297-99.[115] Both of these payment pools are substantial. The overall inpatient hospital supplemental payments totaled approximately $150 million for SFY 2016 and the small hospital pool was capped at approximately $14 million in SFY 2016. The actual total paid amount for hospital supplemental payments in SFY 2016 was approximately $163 million. See DSS, Medicaid Category of Service Expenditure Report (2016), R. at 1106. Supplemental payment amounts varied in previous state fiscal years.[116]

Accounting for both standard payment methodologies and supplemental payments, hospitals receive a very substantial amount of Medicaid payments each year. Across the categories of inpatient hospital services, outpatient hospital services, hospital supplemental payments, and hospital retroactive adjustments, in SFY 2016 Connecticut's Medicaid program paid hospitals approximately $1.78 billion (not counting Medicaid EHR Incentive Program payments). See DSS, Medicaid Category of Service Expenditure Report (2016), R. at 1106.[117] That figure is higher than any other category of provider and represents approximately 29.7% of the Medicaid program's approximately $5.99 billion expenditures for SFY 2016 (not counting amounts expended by other state agencies). See id.

Accordingly, the Departments find that hospitals receive unique benefits from the state through the state's Medicaid program, which treats hospitals differently than other categories of health care

[115] In addition, Connecticut's Medicaid program had a single supplemental payment for FQHCs based on volume that was applicable for a portion of SFY 2014 and was capped at $10 million. Unlike the hospital supplemental payments, however, the FQHC supplemental payment was not designed to be a key portion of their reimbursement methodology, it was a much smaller amount, and it was for a limited period of time. See Approved SPA 13-038, R. at 1270-72.

[116] In addition to supplemental payments, for many years, hospitals also received substantial amounts of disproportionate share hospital (DSH) payments through Connecticut's Medicaid program. Supplemental payments for previous years were in approximately the following amounts: SFY 2012: $131 million; SFY 2013: $121 million; SFY 2014: $229.8 million (including both the general pool and the small hospital pool); SFY 2015: $95.6 million (including both the general pool and the small hospital pool); and SFY 2016: $163 million (including both the general pool and the small hospital pool). Medicaid DSH payments are additional payments intended to offset uncompensated care for both Medicaid and uninsured patients receiving hospital services, which are available only to hospitals, not any other category of health care provider. See 42 U.S.C. § 1396r–4. For SFY 2012 and SFY 2013, the total DSH payments (counting DSH payments for both of those years) were approximately $470 million. From SFY 2014 to present, DSH payments total approximately $100,000 annually.

[117] As explained in the cover letter from DSS to various legislators transmitting that document, R. at 1100-1101, said document reflects actual Medicaid paid amounts from DSS's Medicaid account for SFY 2016, not expenditures based on dates of service and also not including Medicaid amounts appropriated to and spent by state agencies other than DSS. Using that document, these figures were obtained from the portion of the document, R. at 1106 entitled "Medicaid Total" from the rows entitled "Hospital Inpatient," "Hospital Outpatient," "Hospital Supplemental Payment," and "Hospital Retro" on the column entitled "YTD TOTAL MEDICAID." In addition, as shown on the comparable lines in the portion of that document entitled "HUSKY B", R. at 1107, Connecticut's Children's Health Insurance Program (CHIP), also known as HUSKY B, paid hospitals approximately an additional $8.06 million in SFY 2016.

providers in a variety of ways and paid hospitals approximately $2.4 billion in SFY 2016. Given that hospitals were receiving unique benefits under the state's Medicaid program, it was rational for the General Assembly to have the hospitals bear some of the cost of the program through the imposition of the Hospital User Fee.

iii. The Plaintiffs have failed to negate every conceivable basis upon which the Hospital User Fee might be sustained. Additionally, the Plaintiffs have failed to demonstrate that the Hospital User Fee was imposed because it would have an adverse effect upon hospitals.

As set forth above, in order to prevail on their equal protection challenge, the Petitioners must both "negative every conceivable basis which might support"[118] the Hospital User Fee and demonstrate that the Hospital User Fee was enacted because it would have an adverse effect upon hospitals.[119] As described more fully above, the Departments find that there are many conceivable rational bases for imposing the Hospital User Fee on hospitals. To that end, it was rational for the General Assembly to raise revenue by imposing the Hospital User Fee on hospitals because they are subject to a different regulatory regime than other health care providers, because they are better able to bear the burden of taxation than other providers, and because they directly benefit from the program funded in part by the fee. Furthermore, there is no evidence that the Hospital User Fee was enacted because it was oppressive and hostile discrimination against hospitals. To the contrary, the Hospital User Fee was imposed to raise revenue and obtain federal funds which would, in part, serve to benefit the hospitals through their participation in the state's Medicaid program. Accordingly, the Departments find that the Petitioners have failed to demonstrate that no conceivable basis supports the Hospital User Fee.

Given the foregoing, Departments find that the Hospital User Fee rationally furthers a legitimate state interest of raising revenue by taxing uniquely situated hospitals that may bear the burden of taxation better than other health care providers and that also receive certain benefits from the revenue raised as a result of the fee.

C. Conclusion

For all of the reasons discussed above, the Departments find that the Petitioners have failed to meet their burden to show that the Hospital User Fee violates the equal protection clause of the United States Constitution.

[118] Kellems v. Brown, 163 Conn. 478, 486, 313 A.2d 53, 58 (1972) ("the presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes. The burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it.").

[119] Stafford Higgins Indus., Inc. v. City of Norwalk, 245 Conn. 551, 569, 715 A.2d 46, 56 (1998).

4. The Departments have not implemented the Hospital User Fee in a manner inconsistent with Chapter 211a of the Connecticut General Statutes or Title XIX of the Social Security Act, which governs the Medicaid program.

The Petitioners broadly allege that the Hospital User Fee was both implemented by the Departments in a manner inconsistent with Chapter 211a of the Connecticut General Statutes and not permitted under the federal Medicaid Act. The Petitioners specifically allege that the Hospital User Fee "impermissibly taxes many other categories of health care services" in addition to the federal provider tax classes of inpatient hospital services and outpatient hospital services. R. at 12, 33. As set forth more fully below, the Departments find that the Hospital User Fee has been implemented in a manner consistent with Chapter 211a of the Connecticut General Statutes. Additionally, the Departments find that the Hospital User Fee as implemented complies with the federal Medicaid Act.

A. Federal law governing provider taxes.

As referenced above, in order to receive FFP, states are required to fund their portion of the costs of the Medicaid program using specific funding sources. See 42 U.S.C. § 1396b. One source of revenue states may use to fund their Medicaid program is provider taxes. See 42 U.S.C. § 1396b. The Medicaid Act sets forth requirements with which state provider taxes must comply. See 42 U.S.C. § 1396b(w). If the state's provider taxes do not comply with these requirements, the state will be penalized by CMS through a reduction in FFP. 42 U.S.C. § 1396b(w)(1).

42 U.S.C. § 1396b(w) describes requirements that provider taxes must comply with in order to avoid CMS imposing a penalty on the state's FFP. Under 42 U.S.C. § 1396b(w), provider taxes may be imposed on one or more classes of health care items of services. 42 U.S.C. § 1396b(w)(3)(A). There are nineteen (19) classes of health care items and services that may be taxed, which include inpatient hospital services and outpatient hospital services.[120] 42 C.F.R. § 433.56. Under federal law, a provider tax must be broad-based and uniform, unless CMS grants a waiver of either or both of those requirements and in all situations, must not include a hold harmless provision. 42 U.S.C. § 1396b(w)(3); 42 C.F.R. § 433.68(b).

A provider tax will meet the "broad-based" requirement if it is "imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State…or is imposed with respect to all non-Federal, nonpublic providers in the class." 42 U.S.C. § 1396b(w)(3)(B)(i); 42 C.F.R. § 433.68(c). If a state wishes to exempt certain providers from a tax, the state may request a waiver of this requirement from CMS. In order to obtain such a waiver, the state must demonstrate to CMS that the proposed tax is "generally redistributive" and that "the amount of the tax is not directly correlated to payments" from Medicaid for the same services that

[120] The federal government has established the following classes of services: inpatient hospital services, outpatient hospital services, nursing facility services, services of intermediate care facilities, physicians' services, home health care services, outpatient prescription drug services, services of managed care organizations, ambulatory surgical center services, dental services, podiatric services, chiropractic services, optometric/optician services, psychological services, therapist services, nursing services, laboratory and x-ray services, emergency ambulance services, and other health care items or services for which the State has enacted a licensing or certification fee. 42 C.F.R. § 433.56(a).

are being taxed. 42 U.S.C. § 1396b(w)(3)(E)(ii). This is done through a statistical test known as the P1/P2 test.[121]

A provider tax will meet the "uniformity" requirement if the same tax rate is applied to all items or services within a class. For example, the uniformity requirement will be met if "in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State…." 42 U.S.C. § 1396b(w)(3)(C)(III). Stated simply, if a tax is imposed on the revenue of a class of items or services, in order to be considered uniform, the tax must be imposed at a uniform rate for all the revenue associated with the provision of all items or services that make up that class. 42 C.F.R. § 433.68(d)(1)(iii).[122] If a state wishes for its provider tax to include credits, exclusions, or deductions, the state may request a waiver from CMS. 42 C.F.R. § 433.68(d)(2)(i).

Finally, in order to be considered a permissible provider tax, the tax must not include prohibited hold harmless provisions. 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(b)(3). Federal law defines several types of prohibited hold harmless provisions. 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f). Specifically, a provider tax, and the associated payments made to health care providers under Medicaid, cannot directly or indirectly hold the provider harmless for the tax. Specifically, a provider tax cannot include "any direct or indirect payment, offset, or waiver…that…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).

In order to determine whether a tax includes an indirect hold harmless provision, CMS applies a two pronged test to examine whether the tax correlates to payments made to the taxpayers. The first prong of the test provides that no indirect hold harmless provision exists if the tax rate is less than six per cent (6%). 42 C.F.R. § 433.68(f)(3)(i)(A). This is referred to as the safe-harbor tax rate. If the tax rate is greater than six per cent (6%), under the second prong of the test, an indirect hold harmless will exist if "75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments." 42 C.F.R. § 433.68(f)(3)(i)(B). The maximum tax rate allowed under federal law is whatever tax rate will pass both prongs of this test.

[121] The P1/P2 test involves dividing two numbers. P1 is the proportion of the tax that would have been collected from revenue that the providers received from Medicaid payments if the tax applied to all providers within the class, without any exemptions. P2 is the proportion of the tax that is to be collected from revenue that the providers received from Medicaid payments, but only including the providers actually proposed to be subject to the tax (*i.e.*, excluding any providers that the state proposes to exempt from the tax). 42 C.F.R. § 433.68(e)(1). The overall purpose of this statistical test is to ensure that any tax redistributes funds from providers with lower Medicaid percentages to providers with higher Medicaid percentages—and thereby prevents states from enacting a tax that is primarily designed to generate federal Medicaid matching funds based on primarily taxing providers' Medicaid revenues.

[122] If the tax imposed is a licensing fee on a class of services, in order to be considered uniform, the tax must be the same amount for every provider who furnishes that class of services. 42 CFR 433.38(d)(1)(i). If the tax imposed is a "bed tax," or a tax imposed on the number of beds a provider has, in order to be considered uniform, the tax must be the same for each bed each provider has. 42 CFR 433.38(d)(1)(ii). If the tax is imposed on the revenue of a class of items or services, in order to be considered uniform, the tax must be imposed at a uniform rate for all the revenue associated with the provision of all items or services that make up that class. 42 CFR 433.38(d)(1)(iii).

As a consequence of the federal requirement that a provider tax must not include a hold harmless provision, some providers must pay more in tax than they received in payments, and some providers must pay less in tax than they received in payments. Accordingly, any consideration of the tax must also take into account the manner in which the providers are paid under the state's Medicaid program in order to ensure that there is no prohibited hold harmless provision that would result in federal penalties for an impermissible tax, especially regarding increased payments that are being made in connection with the imposition of the tax. If the state's provider taxes do not comply with federal requirements, the federal government may penalize the state and reduce the state's FFP. See 42 U.S.C. § 1396b(w)(1)(A); 42 C.F.R. § 433.70(b).

With the above as background, the Departments turn to both of the issues raised by the Petitioners.

B. The scope of the Departments' review of the Petitioners' claims regarding the Medicaid Act is limited.

As referenced above, the Petitioners have sought clarification as to whether Hospital User Fee was both implemented by the Departments in a manner inconsistent with Chapter 211a of the Connecticut General Statutes and not permitted under the federal Medicaid Act. As an initial matter, the Departments note that the latter of these two issues is not properly before the Departments, as only the federal government has the authority to enforce the federal provider tax requirements.

As referenced above, the Medicaid Act prescribes a set of conditions under which states may receive federal funding through their Medicaid programs. Congress is authorized to set these conditions and provide federal funding by the Spending Clause set forth in Article I, Section 8 of the United States Constitution. Accordingly, as the only rights afforded under the Medicaid Act are to state governments, the Medicaid Act does not provide individual health care providers with any rights for which they might make a claim. As the United States Supreme Court recently explained, "the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements—for the State's 'breach' of the Spending Clause Contract—is the withholding of Medicaid funds" by CMS. Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378, 1385 (2015).

In Armstrong v. Exceptional Child Ctr., Inc., the United States Supreme Court determined there is no private right of action to enforce Medicaid reimbursement rules in 42 U.S.C. § 1396a(a)(30)(A) because the statute did not provide any right of action, instead giving enforcement powers only to the federal government. See id. The Supreme Court declined to imply any right of action due to the "judicially unadministrable nature" of that statute. Id. Specifically:

> Explicitly conferring enforcement of this judgment-laden standard upon the Secretary alone establishes, we think, that Congress wanted to make the agency remedy that it provided exclusive, thereby achieving the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking, and avoiding the comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action…. The sheer complexity associated with enforcing § 30(A), coupled with the express provision of

> an administrative remedy, § 1396c, shows that the Medicaid Act precludes private enforcement of § 30(A) in the courts.

Id. (citation and internal quotation marks omitted). This logic applies with even more force to the provider tax requirements set forth in section 1396b(w) of the Medicaid Act. The statute at issue in Armstrong v. Exceptional Child Ctr., Inc., section 1396a(a)(30)(A), requires states to reimburse health care providers in a certain manner. As such, it is conceivable that an individual health care provider might have a private right of action under said provision. However, the United States Supreme Court declined to find such a right of action. Under the statute at issue in the present matter, section 1396b(w), the federal government's exclusive enforcement authority in section 1396b(w) is even clearer than in section 1396a(a)(30)(A). To that end, section 1396b(w) is framed solely in terms of how the federal government may impose penalties upon states that have provider taxes that do not comply with all of the applicable requirements. Accordingly, given that the United States Supreme Court has declined to find a private right action under the Medicaid Act to a provision that applies to individual health care providers, there can be no dispute that said Court would similarly decline to find a private right of action under a provision under which no mention is made of individual health care providers.

Moreover, the United States Supreme Court has generally declined to infer private rights of action from Spending Clause statutes (such as the Medicaid Act) because those statutes "conferred no specific, individually enforceable rights, even by a class of the statute's principle beneficiaries." Gonzaga Univ. v. Doe, 536 U.S. 273, 281, 122 S.Ct. 2268, 2274 (2002) (citing Suter v. Artist M., 503 U.S. 347, 357 (1992)). The United States Supreme Court noted that this is because "the provisions entirely lack the sort of 'rights-creating' language critical to showing the requisite congressional intent to create new rights." Id. at 287 (citations omitted). In line with this policy, section 1396b(w) simply sets forth requirements for states to comply with in order to fund their state share of the Medicaid program with provider taxes.[123] All of the provisions in this statute pertain to how CMS may reduce a state's FFP if it determines that a provider tax does not meet federal requirements. No provision in section 1396b(w) affords health care providers with any individually enforceable rights. Therefore, if a state violates section 1396b(w), only the federal government has the authority to enforce these requirements.[124]

[123] By way of example, section 1396b(w) begins by stating "… for purposes of determining the amount to be paid to a State … the total amount expended … as medical assistance under the State plan … shall be reduced by the sum of any revenues received by the state… from health care related taxes…other than broad-based health care related taxes…; or from a broad-based health care related tax, if there is in effect a hold harmless provision…." 42 U.S.C. § 1396b(w)(1)(A).

[124] The underlying purpose for which section 1396b(w) was enacted further confirms there is no private right of action to enforce the provider tax requirements. Congress established the rules to prevent states from using provider taxes as a "'loophole' in the Medicaid program that allowed states to gain extra federal matching funds without spending more state money." Protestant Memorial Medical Ctr., Inc. v. Maram, 471 F.3d 724, 726 (7th Cir. 2006). This context is clear from the text of the statute, which, as described above, relates only to CMS reducing FFP for states with non-compliant provider taxes. The legislative history also shows that Congress enacted section 1396b(w) as a compromise to replace a CMS regulation that would have eliminated all federal Medicaid matching funds for provider-specific taxes. See id.; see also Medicaid Moratorium Amendments Act of 1991, Conf. Report 102-409, to Accompany H.R. 3595, pp. 15-18 (Nov. 27, 1991). The statute that resulted, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments Act of 1991, is similar to the current provisions in section 1396b(w) and was based on a compromise negotiated between CMS and states (acting through the National Governors' Association). See State Financing of Medicaid, U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the

Because there is no private right of action, the Petitioners' claim that the Hospital User Fee has been implemented in a manner not permitted under the Federal Medicaid Act is not properly before the Departments. CMS, on the other hand, can and does enforce federal provider tax requirements. Federal regulations set forth specific procedures that enable state Medicaid agencies to challenge CMS decisions, including hearing and appeal rights. See 42 C.F.R. § 430.42. Those proceedings are between the federal and state governments.[125] As such, the Petitioners' claim that the Hospital User Fee has been implemented in a manner not permitted under the Federal Medicaid Act is properly addressed by CMS, rather than the Departments.

Given the foregoing, the Departments have no authority to find that the Hospital User Fee, as implemented, is not permitted under the Medicaid Act and that the states should be penalized by CMS as a result thereof. That being said, as set forth extensively above, Chapter 211a incorporates by reference, and makes a part of Chapter 211a, certain provisions of the Medicaid Act. Accordingly, the Departments will address below whether the Hospital User Fee has been implemented in a manner consistent with those provisions that have been made part of the Fee.

C. The Petitioners must prove by clear and convincing evidence that the Departments implementation of the Hospital User Fee is inconsistent with Chapter 211a of the Connecticut General Statutes.

As referenced above, the Petitioners allege that the Hospital User Fee, as applied to them, is contrary to the statutory provisions governing said Fee and the Medicaid Act. The Connecticut Supreme Court has long recognized that the burden of proof in tax cases lies with the taxpayer challenging the state's application of a tax to said taxpayer. By way of example, the Connecticut Supreme Court has stated that "[i]t is well established that the burden of proving an error in a deficiency assessment is on the plaintiff . . . ." Leonard v. Comm'r of Revenue Svcs, 264 Conn. 286, 302 (2003) (internal quotation marks and citations omitted). The Connecticut Supreme Court

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Committee on Energy and Commerce, No. 102-79, Nov. 25, 1991, pp. 355-356 (statement of Rep. Waxman, chairman); see also R.I. Dep't of Human Svcs, DAB Decision No. 1682, 1999 WL 985362 (Apr. 13, 1999), at *2.

As the CMS administrator explained at a 1991 Senate hearing about the proposed legislation that resulted in the provider tax requirements, the purpose of those requirements is so that "those responsible for the States' direct fiscal management [] have a reasonable stake in costs. This is what the whole program is premised on. State matching requirements have always acted as a critical restraint on the otherwise open-ended Medicaid program." HCFA [CMS] Regulation Restricting Use of Medicaid Provider Donations and Taxes, U.S. Senate, Hearing before the Committee on Finance, S. Hrg. 102-580, Nov. 19, 1991, p. 25 (statement of Gail Wilensky, CMS Administrator). The provider tax rules are thus intended to ensure that FFP is limited based on states' ability to provide state share funds from genuine sources, which solely regulates the relationship between states and the federal government.

This context further demonstrates that only the federal government has the authority to enforce the federal Medicaid provider tax requirements.

[125] CMS has issued penalties of FFP for states' provider taxes that it determines have not complied with all of the provider tax requirements. A number of states have taken advantage of their formal appeal rights to challenge those disallowances to the U.S. Department of Health and Human Services Departmental Appeals Board (DAB). See, e.g., Ga. Dep't of Cmty Health, DAB Decision No. 1973, 2005 WL 1164058 (Apr. 28, 2005); Ky. Dep't for Medicaid Svc, DAB Decision No. 1524, 1996 WL 34480051 (Jan. 29, 1996); R.I. Dep't of Human Svcs, DAB Decision No. 1682, 1999 WL 985362 (Apr. 13, 1999).

further stated that "[t]he plaintiff must present clear and convincing evidence that the assessment is incorrect or that the method of audit or amount of tax assessed was erroneous or unreasonable." Id. (Internal quotations and citations omitted). Thus, the Petitioners, in challenging the Departments' application of the Hospital User Fee to them, must provide clear and convincing evidence of the invalidity of the Departments' imposition of said Fee upon them.

D. The Hospital User Fee complies with the provider tax requirements set forth in the Medicaid Act.

As a preliminary matter, the Departments find that the Hospital User Fee meets all of the requirements for a provider tax set forth in 42 U.S.C. § 1396b(w)(3)(A) that are incorporated by reference in Chapter 211a.

First, the Hospital User Fee is broad-based because it applies to inpatient and outpatient net revenue from all hospitals in Connecticut, except for the exempted categories of hospitals as approved by CMS waiver. R. at 632-52. As referenced above, the Medicaid Act requires that provider taxes be broad-based, meaning that the taxes must apply to all items or services within a class and all providers providing said items or services. 42 U.S.C. §§ 1396b(w)(1)(A)(ii) and (w)(3)(B). A state must obtain a waiver from CMS if it wishes to exempt any services or providers. 42 U.S.C. § 1396b(w)(3)(E). The Departments find that the Hospital User Fee complies with these requirements.

To that end, Conn. Gen. Stat. § 12-263b provides, in pertinent part that "there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter." Conn. Gen. Stat. § 12-263b(a). As such, the Hospital User Fee is applied to all taxpayers who fall within the definition of "hospital." Conn. Gen. Stat. § 12-263a provides that the term "hospital" means

> any health care facility or institution, as defined in section 19a-630, which is licensed as a short-term general hospital by the Department of Public Health but does not include (A) any hospital which, on October 1, 1997, is within the class of hospitals licensed by the department as children's general hospitals, or (B) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant to chapter 920.

Conn. Gen. Stat. § 12-263a(1). Consistent with the definition set forth above, only licensed short-term general hospitals are subject to the tax.[126] Additionally, the definition specifically excludes children's hospitals and government run hospitals. Finally, Conn. Gen. Stat. § 12-263b provides that

> The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship.

[126] The definition of short term general hospitals excludes psychiatric and specialty hospitals. As such, psychiatric and specialty hospitals were not subject to the Fee. See Conn. Agencies Regs. § 19-13-D1(b).

Conn. Gen. Stat. § 12-263b(a). Accordingly, the Hospital User Fee applies to all short-term general hospitals, other than those that are financially distressed, children's hospitals and government run hospitals. As certain providers were exempt, DSS was required to, and did, obtain a waiver from CMS.[127]

[127] CMS waiver approvals of the Hospital User Fee and CMS approvals of Medicaid State Plan Amendments describing the Hospital User Fee show that the Hospital User Fee complies with the Medicaid Act.

CMS approved two waivers for the Hospital User Fee, one waiver for the structure of the Hospital User Fee from SFY 2012 through 2015 and another waiver for the current structure of the Hospital User Fee, which began in SFY 2016. R. at 632-52. Both waivers approve the structure of the Hospital User Fee, which exempts public, psychiatric, specialty, children's and financially distressed hospitals. Those exemptions are necessary to implement the Hospital User Fee statute, which defines "hospital" to include only an entity "licensed as a short-term general hospital by the Connecticut Department of Public Health" and the statute further excludes hospitals licensed as a children's general hospital or a state-operated hospital. Conn. Gen. Stat. § 12-263(1). Both waivers also approve the Hospital User Fee as complying with the requirements that in order to obtain a waiver of the broad-based requirement, the tax must be generally redistributive and not directly correlated with Medicaid payments. For both waiver applications, DSS presented detailed statistical analyses, which CMS approved and which demonstrate that the taxes are generally redistributive. R. at 632-52.

In addition, in reviewing certain Medicaid State Plan Amendments (SPAs) that changed the reimbursement methodology for Medicaid providers, CMS requires DSS to describe the sources of state share Medicaid funding. As part of those questions, known as standard funding questions, CMS requires DSS to describe the Hospital User Fee, including the exemptions, the tax rates, and the overall tax structure. CMS informed all states that it would not approve a payment methodology if it "identifies a possibly unacceptable provider [tax] assessment" as the funding source for that payment. CMS, State Medicaid Director Letter, SMD # 10-020, Revised State Plan Amendment Review Process, October 1, 2010, p. 6, R. at 968.

In their letter dated August 29, 2016, the Petitioners object to this CMS guidance document on the grounds that it is not "formal guidance" because it is not a regulation. R. at 1366. That argument fails because it inappropriately conflates the terms "formal guidance" with regulations, but courts have long recognized that an agency can issue formal guidance short of a regulation, which reflects agency intention and is entitled to varying degrees of deference. See, e.g., United States v. Mead Corp., 533 U.S. 218, 121 S.Ct. 2164 (2001). Specifically, CMS interpretations of Medicaid statutes, even "relatively informal CMS interpretations of the Medicaid Act, such as the State Medicaid Manual, are entitled to respectful consideration in light of the agency's significant expertise, the technical complexity of the Medicaid program, and the exceptionally broad authority conferred upon the Secretary under the Act." Wong v. Doar, 571 F.3d 247, 259 (2d Cir. 2009) (citation omitted); see also Lopes v. Department of Social Services, 696 F.3d 180, 187-188 (2d Cir. 2012) (deference to CMS amicus curiae brief); Estate of Landers v. Leavitt, 545 F.3d 98, 107-108 (2d Cir. 2008) (deference for CMS interpretations of Medicaid or Medicare statutes and regulations, especially long-standing and consistent interpretations). In addition, the Petitioners argue that this document is not relevant because it does not show that CMS specifically approves provider taxes as part of the SPA approval process. However, the letter indicates that CMS reviews the description of provider taxes as part of the SPA review process. Specifically, standard CMS procedures require the state to answer standard funding questions in order for the SPA to be reviewed. Moreover, as explained in this guidance letter, CMS only approves a SPA after it has reviewed and approved all related documents, including the responses to the standard funding questions.

For example, in SPA 13-029, which sets forth the reimbursement methodology for Medicaid inpatient hospital supplemental payments under Medicaid for SFY 2014 and 2015, DSS described the Hospital User Fee on the responses to the mandatory standard funding questions. R. at 679. CMS approved SPA 13-029 on December 20, 2013, which means that CMS determined that the SPA and all of the associated components of the submission package complies with federal Medicaid requirements, including the description of the Hospital User Fee in the responses to the standard funding questions. Id., R. at 653-655; see also 42 C.F.R. §§ 430.10 and 430.15(a). As another example, on May 26, 2016, CMS approved SPA 16-013, which sets forth the reimbursement methodology for inpatient hospital supplemental payments for SFY 2016. R. at 3015-17. That SPA approval similarly shows that CMS approved the state share funding sources, including the description of the Hospital User Fee on the responses to the standard funding

Second, the Hospital User Fee is uniform because each hospital is taxed at the same rate for inpatient hospital services and the same rate for outpatient hospital services. As referenced above, in order to be considered uniform, revenue from all items and services within a class must be taxed at the same rate. 42 U.S.C. §§ 1396b(w)(1)(A)(i) and (w)(3)(C)(III). If the state wishes to provide credits, exclusions, or deductions, the state must get a waiver from CMS. 42 U.S.C. § 1396b(w)(3)(E). The Hospital User Fee applies to two classes of services, inpatient hospital services and outpatient hospital services. For the period SFY 2012 through SFY 2015, using the formulaic tax rate set forth in statute, DSS calculated a uniform fee on inpatient hospital services at a rate of 5.5%. For the period SFY 2012 through SFY 2015, using the formulaic tax rate set forth in statute, DSS calculated a uniform fee on outpatient hospital services at a rate of 3.83%. For the period SFY 2016 through present, using the formulaic tax rate set forth in statute, DSS calculated a uniform fee on inpatient hospital services at a rate of 6%. For the period SFY 2016 through present, using the formulaic tax rate set forth in statute, DSS calculated a uniform fee on outpatient hospital services at a rate of 6%. As the fee imposed on each class of service was uniform for all periods in which the Hospital User Fee has been in effect, the Hospital User Fee clearly complies with the uniformity requirement

Finally, the Hospital User Fee complies with the hold harmless provisions because the tax is not directly correlated to Medicaid payments to hospitals, as demonstrated by DSS in its waiver applications to CMS, which waivers were approved by CMS. Similarly, the Hospital User Fee does not violate any of the other types of hold harmless provisions enumerated in the federal statute and regulations. See 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f).

Consistent with the above, the Departments find that the Hospital User Fee itself complies with the provider tax requirements set forth in the Medicaid Act. The Departments will next examine whether the services upon which DSS calculated the Hospital User Fee complies with the Chapter 211a and the provisions of the Medicaid Act incorporated therein.

E. The Departments find that DSS's implementation of the Hospital User Fee complies with the requirements set forth in Chapter 211a and the provisions of the Medicaid Act incorporated therein.

As set forth above, the Petitioners allege that DSS calculated the Hospital User Fee in a manner inconsistent with the provisions of Chapter 211a and the Medicaid Act. More specifically, the Petitioners allege that the net revenue upon which DSS calculated the Hospital User Fee contained revenue from services other than those subject to the Hospital User Fee (inpatient and outpatient hospital services). As set forth more fully herein, the Departments find that DSS's implementation of the Hospital User Fee complies with the requirements set forth in Chapter 211a and the provisions of the Medicaid Act incorporated therein.

questions as complying with applicable federal Medicaid requirements. For all these reasons, as detailed in the approved waivers from CMS, the structure of the Hospital User Fee complies with the federal Medicaid provider tax requirements.

i. Under Chapter 211a, the Hospital User Fee is applied to accrued payments from the provision of inpatient and outpatient hospital services, as said services are defined by the Medicaid Act and regulations promulgated thereunder.

In order to determine whether the Departments' implementation of the Hospital User Fee complied with Chapter 211a and the provisions of the Medicaid Act incorporated therein, it is necessary to first set forth the scope of the Hospital User Fee. Stated another way, in order to determine whether DSS's application of the Hospital User Fee to the Petitioner Hospitals complies with Chapter 211a and the Medicaid Act, it is necessary to first understand what is subject to tax under the Hospital User Fee. To that end, as set forth more fully above, the Hospital User Fee is "a tax on the net patient revenue of each hospital in this state." Conn. Gen. Stat. § 12-263b. Net patient revenue is further defined to mean "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." Conn. Gen. Stat. § 12-263a(2). Accordingly, the Hospital User Fee is applied to accrued payments from inpatient and outpatient hospital services.

Inpatient hospital services and outpatient hospital services are two specific classes of services upon which states may impose provider taxes. 42 C.F.R. § 433.56(a). Accordingly, as a provider tax, the Hospital User Fee is required to comply with the definition of "inpatient hospital services" and "outpatient hospital services" set forth in the Medicaid Act. While the classes of services upon which states may impose a provider tax are set forth in 42 CFR § 433.56(a), said regulation does not contain definitions of inpatient and outpatient hospital services. Rather, federal Medicaid regulations at 42 C.F.R. §§ 440.10 and 440.20 provide additional details regarding the federal provider tax classes of inpatient and outpatient hospital services, respectively, as well as the specific scope of net revenue that is subject to the Hospital User Fee.[128]

Recently adopted state legislation also confirms that "the definition of net patient revenue set forth in section 12-263a of the general statutes complies with and is consistent with subsection (w) of 42 USC 1396b, 42 CFR 440.10 and 42 CFR 440. 20." Conn. Public Act 16-3, May spec. sess., § 121. As the West Virginia Supreme Court determined: "[t]he definitions that govern Section 1903(w)[129] [of the Social Security Act] are set forth in 42 U.S.C. § 1396d." Wheeling Hospital, Inc. v. Lorensen, 230 W. Va. 670, 675-676, 742 S.E.2d 86, 91-92 (2013). The West Virginia Supreme Court further explained that the federal Medicaid regulations that were "adopted for the purpose of interpreting and implementing the definitions of services that are covered by Medicaid" also need to be used to define the federal provider tax classes. Id., 230 W. Va. at 676, 742 S.E.2d at 92.

The federal Medicaid benefit category definitions of inpatient hospital services and outpatient hospital services are very broad and provide, respectively, as follows:

[128] In addition, the Medicaid payment definitions also govern state Medicaid programs' ability to obtain FFP. See 42 C.F.R. § 440.2(b).

[129] Section 1903(w) refers to section 1903(w) of the Social Security Act, which is codified in the U.S. Code as 42 U.S.C. § 1396b(w), which is the statutory subsection of the Medicaid statute regarding provider tax requirements. In turn, the federal Medicaid benefit categories are listed in 42 U.S.C. § 1396d(a), which is also section 1905(a) of the Social Security Act.

(a) Inpatient hospital services means services that—

(1) Are ordinarily furnished in a hospital for the care and treatment of inpatients;

(2) Are furnished under the direction of a physician or dentist; and

(3) Are furnished in an institution that—

(i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
(ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
(iii) Meets the requirements for participation in Medicare as a hospital; and
(iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of §482.30 of this chapter, unless a waiver has been granted by the Secretary…..

(a) Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that—

(1) Are furnished to outpatients;

(2) Are furnished by or under the direction of a physician or dentist; and

(3) Are furnished by an institution that—

(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) Meets the requirements for participation in Medicare as a hospital….

42 C.F.R. §§ 440.10(a) and 440.20(a).[130] Consistent with the above-quoted regulations, in order to be subject to the Hospital User Fee, the services must be (1) those ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a hospital that meets the above-listed criteria. Accordingly, it is clear that these two categories of services are extremely broad, since they include virtually all services provided in the inpatient or outpatient hospital setting.

ii. CMS has provided further context regarding the scope of the "inpatient hospital" and "outpatient hospital" classes that may be subject to provider taxes, which confirms that these are very broad classes.

As referenced above, the inpatient and outpatient hospital classes of services are exceedingly broad, including virtually all services provided in the inpatient or outpatient setting. As they are so broad, these provider tax classes can potentially overlap with the other provider tax classes,

[130] Embedded within those two regulatory definitions are the terms inpatient, outpatient, and patient, which are defined in 42 C.F.R. § 440.2(a).

such as physicians' services, outpatient prescription drug services, ambulatory surgical center services, dental services, etc.[131] To that end, CMS has provided guidance regarding the scope of states' ability to impose taxes on services that could fall within multiple provider tax classes. More specifically, CMS has confirmed that those services that overlap classes with "inpatient hospital services" and "outpatient hospital services" remain subject to taxation as "inpatient hospital services" and "outpatient hospital services," even with the overlap.

By way of brief background, hospitals are required to provide an extensive array of services. To that end, hospitals are organized and licensed for the purpose of providing diagnosis, care, and treatment for a wide variety of conditions. See Conn. Agencies Regs. § 19-13-D1(b)(4). DPH regulations specifically require all acute care general hospitals to "have, at a minimum, the following departments: medicine, pathology and radiology. Hospitals may operate other departments. If surgery or obstetrics is performed in the hospital, there shall be a department of anesthesia. If a hospital operates departments in surgery, obstetrics, psychiatry, or anesthesia, each such department shall have a chief." Conn. Agencies Regs. § 19-13-D3(c)(4). Those regulations also require that "The hospital shall maintain or have available facilities, equipment and qualified personnel, under competent medical supervision, appropriate to the needs of the hospital in serving its patients. These shall include, as a minimum, a clinical laboratory, blood bank, pathological services, a radiology department and an operating room." Conn. Agencies Regs. § 19-13-D3(f). In addition, "[e]ach general hospital shall be organized in such a way as to provide adequate care for persons with acute emergencies at all hours." Conn. Agencies Regs. § 19-13-D3(j)(2).

Similarly, the conditions of participation in Medicare and Medicaid, which each of the Petitioners have affirmed that they follow, likewise require hospitals to provide a broad variety of inpatient and outpatient hospital services. These requirements provide that hospitals must have an organized medical staff with doctors, dentists, and/or podiatrists that oversee the services provided by the hospital, which means that all services provided by a hospital are ultimately provided under the direction of a physician. See 42 C.F.R. § 482.22(b). Specifically, the regulation requires that the "hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital." Id. Hospitals must also provide pharmaceutical services, radiologic services, and laboratory services. 42 C.F.R. §§ 482.25, 482.26, and 482.27. Accordingly, hospitals are required to provide a wide variety of inpatient and outpatient hospital services.[132]

As referenced above, the provisions of the Medicaid Act governing provider taxes (42 U.S.C. §§ 1396b(w)(7)(A)(i) and (ii) and 42 C.F.R. §§ 433.56(a)(1) and (2)) include a listing of provider tax classes that may be taxed by states, but do not include specific definitions of the tax classes

[131] It is important to note that the Departments do not find that inpatient and outpatient hospitals services are the same as those services provided in other settings. Rather, the unique services that hospitals provide may fall within other federal provider tax classes, in addition to also falling within the provider tax classes of inpatient hospital services and outpatient hospital services, due to the broad nature of all of the different classes of services that may be subject to provider taxes. See Ruling 3 for a more detailed analysis of the differences between services provided in a hospital as compared to services provided by non-hospital providers.

[132] As noted above in Ruling 3, while the services provided in a hospital setting may seem similar to those provided in other settings, due to the fact that the services are provided in a hospital setting, the services are fundamentally different than other services. This is because of the enhanced level of care hospitals provide. See Ruling 3 for a more detailed analysis of the differences between services provided in a hospital as compared to other settings.

themselves. Nevertheless, the CMS preamble[133] to the regulation governing the listing of provider tax classes confirms that inpatient hospital services and outpatient hospital services are broad categories of provider taxes that overlap with other categories, and that the services that overlap must be included within said classes, regardless of any potential overlap.

Specifically, as part of CMS's preamble to the regulation that established those classes in 42 C.F.R. § 433.56(a), CMS explained that "We believe **inpatient hospital services encompass all services provided in an inpatient hospital setting**, including psychiatric services. Consequently, we believe psychiatric hospital services need not be listed as a specific inpatient hospital service." CMS, Final Rule, Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43156, 43162 (Aug. 13, 1993) (emphasis added). The same reasoning means that the provider tax class of outpatient hospital services similarly encompasses all services provided in an outpatient hospital setting.

The legislative history of the federal provider tax statute, 42 U.S.C. § 1396b(w), further confirms the broad nature of the federal provider tax classes of inpatient hospital services and outpatient hospital services. Congress enacted section 1396b(w) as a compromise to replace a CMS regulation that would have eliminated all federal Medicaid matching funds for provider-specific taxes. See Medicaid Moratorium Amendments Act of 1991, Conf. Report 102-409, to Accompany H.R. 3595, pp. 15-18 (Nov. 27, 1991). The statute that resulted, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments Act of 1991, is similar to the current provisions in section 1396b(w) and was based on compromise language negotiated between CMS and states (acting through the National Governors' Association). See State Financing of Medicaid, U.S. House of Representatives, Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, No. 102-79, Nov. 25, 1991, pp. 355-356 (statement of Rep. Waxman, chairman). Providing additional detail about this compromise that resulted in the federal provider tax statute, the National Governors' Association (NGA) submitted a summary of this compromise with CMS as part of its testimony to the House Subcommittee on Health and the Environment in support of the proposed legislation that was ultimately adopted as section 1396b(w). Notably, the NGA summary explains that "A 'class' of providers refers to, for example, all hospitals…in the state." Id. at 430 (statement of Raymond Scheppach, Executive Director, NGA). The NGA summary also stipulates that "[s]ervices could not be unbundled from what is normally considered to be part of a provider's business." Id. Thus, Congress' understanding of

[133] As the Second Circuit Court of Appeals explained, "When issuing regulations, the [federal] Administrative Procedure Act requires agencies to 'incorporate in the rules adopted a concise general statement of their basis and purpose,' 5 U.S.C. § 553(c), a statement that is commonly known as the regulation's preamble." Halo v. Yale Health Plan, 819 F. 3d 42, 52 (2d Cir. 2016). The preamble generally refers to the federal agency's entire explanation and related materials that precede the regulation text being adopted, amended or repealed, including the agency's explanations and responses to public comments.

The Second Circuit further explained that because federal agencies are required to include a preamble, the interpretation of a regulation "requires us to examine the regulation's text in light of its purpose, as stated in the regulation's preamble." Id. (citations omitted). Relatedly, the Ninth Circuit Court of Appeals specifically noted that CMS statements in a preamble to a different regulation "are entitled to deference because they represent the agency's interpretation of its own regulation." United States v. United Healthcare Ins. Co., __ F.3d __, 2016 WL 4205941, at *11 n. 9 (9th Cir. Aug. 10, 2016) (citations omitted).

the provider tax classes when it adopted section 1396b(w) was that the classes of both inpatient and outpatient hospital services included all services provided by the hospitals in the inpatient and outpatient settings, respectively. See id.

Additional discussion in the legislative history to Congress's adoption of section 1396b(w) further confirms the broad nature of the provider tax classes of inpatient and outpatient hospital. Specifically, in describing the CMS position on how broad-based tax requirements would protect the Medicaid program to the Senate Finance Committee, the CMS Administrator explained that: "We are less concerned with a broad-based provider-specific tax—that is, a tax on all the hospitals in a class, on all their revenue—because we think that, by its nature, will result in redistribution from some institutions [that provide fewer services to individuals with Medicaid] to others than happen to be providing [greater amounts of] services to the Medicaid population."[134] HCFA[135] Regulation Restricting Use of Medicaid Provider Donations and Taxes, Hearing Before the Committee on Finance, U.S. Senate, S. Hrg. 102-580, Nov. 19, 1991, p. 39 (statement of Gail Wilensky, CMS Administrator). This statement confirms that CMS interpreted the provider tax classes of inpatient hospital services and outpatient hospital services as a broad "tax on all the hospitals in a class, on all their revenue."

Because these two provider tax classes are so broad, it is inevitable that provider tax classes overlap with the provider tax classes of inpatient and outpatient hospital services. In other words, certain services will simultaneously fall into the provider tax class of inpatient or outpatient hospital services and also one or more additional provider tax classes. For example, physical therapy services provided in an outpatient hospital therapy department fall within the provider tax class of outpatient hospital services and also likely fall within the provider tax class of therapist services.[136] CMS described this overlap in the preamble to the federal provider tax regulations:

> While the regulations specify classes that can be taxed, the regulations cannot interfere with the State's authority to impose taxes on one or more of the providers or prohibit a

[134] The CMS Administrator continued on to say that the reason for her concern is that "The nature of Medicaid is that relatively smaller numbers of providers provide services to significant populations [on Medicaid]. Typically, substantial numbers of hospitals or other providers provide very little, or no services [to individuals on Medicaid]. It is the return to the people who put the money up, with an enhancement, that tends to give you a distorted financial picture" if a state structures its provider taxes in a manner that generates federal matching funds based on taxes targeted towards providers that receive much of their revenue from providing services to individuals on Medicaid. HCFA [CMS] Regulation Restricting Use of Medicaid Provider Donations and Taxes, Hearing Before the Committee on Finance, U.S. Senate, S. Hrg. 102-580, Nov. 19, 1991, p. 39 (statement of Gail Wilensky, CMS Administrator).

[135] Prior to 2001, CMS was called the Health Care Financing Administration (HCFA). For clarity, throughout this Declaratory Ruling, the Departments use the term CMS, regardless of whether the relevant document was produced before or after 2001.

[136] The Departments wish to make clear that just because a service provided by a hospital can be taxed in multiple provider classes does not mean that said service is the same as that provided by another health care provider. As explained in more detail in Ruling 3, services provided by a hospital differ on many levels from a service provided by a non-hospital provider. Specific to the example of physical therapy outpatient hospital services, the fact that they are provided by a hospital means that a much wider variety of other services are available and also provided by the same entity, likely improving the potential for coordinated care compared to a free-standing therapy provider; the hospital therapy department is likely to have longer hours, more support services, more staff, and more rigorous certification standards compared to a free-standing therapy provider; and given the hospital's greater market size and power, the hospital therapy department is likely to have a broader referral network and receive higher reimbursement than a free-standing therapy provider.

> State from taxing a provider that would fall under two classes. However, we will consider a tax to be broad based when the tax is imposed on all inpatient hospital services, with the exclusion for HMO owned and operated hospitals if the HMO services are also being taxed. However, if HMO services are not being taxed, the tax on inpatient hospital services would not be broad based unless it is imposed on all hospital services, including HMO inpatient hospital services.

58 Fed. Reg. 43156, 43161. Consistent with the above, CMS specifically requires that a tax must apply to all inpatient (or outpatient) hospital services, even if the services could fall within another class when there is no tax on that other class. The only circumstances under which overlapping services could be exempt from a tax would be if there are taxes on both classes of services. This rule enables states to avoid double-taxing providers, while ensuring that all services within a class are subject to tax, even those services that may fall into more than one provider tax class.

In formal guidance to states, CMS similarly explained that "[i]f a State does not impose a separate tax on physician services, the inpatient hospital services performed by the physician should be subject to the tax. If, however, the State has a separate tax on physicians[']services, the State may include the inpatient hospital services performed by the physician under either inpatient hospital services or under physician services." CMS State Medicaid Director Letter, Questions and Answers – Taxes and Donations, June 21, 1995, p. 7, R. at 972, 979.[137] Accordingly, states are required to tax all services within a class, even those services that could fall into more than one provider tax class.

[137] As explained above, the Petitioners objected to this document on the grounds that it is not formal guidance. R. at 1367. As discussed above, however, that argument fails because it inappropriately conflates the terms "formal guidance" with regulations, but courts have long recognized that an agency can issue formal guidance short of a regulation, which reflects agency intention and is entitled to varying degrees of deference. See, e.g., United States v. Mead Corp., 533 U.S. 218, 121 S.Ct. 2164 (2001). Specifically, CMS interpretations of Medicaid statutes, even "relatively informal CMS interpretations of the Medicaid Act, such as the State Medicaid Manual, are entitled to respectful consideration in light of the agency's significant expertise, the technical complexity of the Medicaid program, and the exceptionally broad authority conferred upon the Secretary under the Act." Wong v. Doar, 571 F.3d 247, 259 (2d Cir. 2009) (citation omitted); see also Lopes v. Department of Social Services, 696 F.3d 180, 187-188 (2d Cir. 2012) (deference to CMS amicus curiae brief); Estate of Landers v. Leavitt, 545 F.3d 98, 107-108 (2d Cir. 2008) (deference for CMS interpretations of Medicaid or Medicare statutes and regulations, especially long-standing and consistent interpretations).

In addition, the Petitioners attempt to narrow this 1995 CMS guidance letter into an artificially narrow factual context regarding public hospitals. That interpretation belies the context of the CMS letter, which reflects the general proposition discussed above that the provider tax classes of inpatient and outpatient hospital services are extremely broad and may, in some contexts, overlap with other provider tax classes. That proposition is the same regardless of the ownership status of the hospital. In addition, the Petitioners argue that the CMS guidance was somehow disavowed by an unrelated U.S. Department of Health and Human Services, Office of Inspector General (OIG) Report regarding an audit of Missouri's provider tax. However, that OIG audit made no such finding. Rather, in the Missouri audit, the OIG found that Missouri "incorrectly taxed items or services (such as office rental income, interest earned, and cafeteria revenue) that are not included in the classes of health care items or services enumerated in the regulation." OIG, Review of Missouri Provider Tax, March 2007, p. 4, R. at 1412. Similarly, the OIG noted that "[t]o be permissible, the tax must be limited in its scope to only those classes of health care items and services enumerated in the Federal regulations" but found that Missouri "taxed items that are not included in [any] of the permissible classes of health care items and services." Id. at 10, 6, R. at 1418, 1414. The Petitioners have not made any allegations that they reported such non-patient service items as inpatient or outpatient accrued payments on the OHCA Report 550, nor is there any evidence that any non-patient service items were subject to the Hospital User Fee.

Consistent with the above, under Chapter 211a and the provisions of the Medicaid Act incorporated therein, "inpatient hospital services" and "outpatient hospital services" subject to the Hospital User Fee are all services that are (1) those ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a hospital that meets the criteria set forth in 42 C.F.R. §§ 440.10(a) and 440.20(a). Additionally, all services that fall within the provider tax classes of "inpatient hospital services" and "outpatient hospital services" are subject to the Hospital User Fee, regardless of whether said services could potentially also fall into another provider tax class. As the Petitioner Hospitals have challenged DSS's application of Chapter 211a to their net patient revenue, the Departments next examine the manner in which DSS implemented the Hospital User Fee to determine whether the Hospital User Fee was imposed on services that meet the criteria set forth in 42 C.F.R. §§ 440.10(a) and 440.20(a).

iii. As a preliminary matter, the Departments note that the Petitioner Hospitals upon which the Hospital User Fee was imposed met each of the criteria set forth in 42 C.F.R. §§ 440.10 and 440.20.

The Departments find that documents in the record establish that each Petitioner Hospital meets the criteria set forth in the Medicaid definitions of inpatient and outpatient hospital services at 42 C.F.R. §§ 440.10 and 440.20. Said criteria provides that each hospital be "maintained primarily for the care and treatment of patients with disorders other than mental diseases;" "licensed or formally approved as a hospital by an officially designated authority for State standard-setting;" "Meet[] the requirements for participation in Medicare as a hospital;" and "Ha[ve] in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of §482.30 of this chapter, unless a waiver has been granted by the Secretary….." 42 C.F.R. §§ 440.10 and 440.20.

First, in documents filed with the Departments in connection with the proceedings for these Petitions, each Petitioner Hospital affirmed under oath that each such Petitioner Hospital meets the requirements for participation in Medicare. Second, the Petitioners produced documents to confirm that they met those requirements, including a copy of the relevant accreditation certificate for each hospital from the appropriate accrediting institution. Third, the Petitioners produced copies of their hospital licenses from the Department of Public Health, which is the official state licensing and standard-setting authority for hospitals, as an acute care general hospital for the relevant time periods. See Conn. Gen. Stat. § 19a-490. DPH regulations define short-term general hospital as a "short term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries." Conn. Agencies Regs. § 19-13-D1(b)(1)(A). Thus, each of the Petitioners is licensed to provide "diagnosis, care and treatment of a wide range of acute conditions." Id. Finally, the hospitals also produced copies of the utilization review plans.

Accordingly, each Petitioner Hospital subject to the Hospital User Fee met the criteria of an institution set forth in 42 C.F.R. §§ 440.10 and 440.20. The question to which the Departments must turn is whether the services upon which the Hospital User Fee was imposed meet the other parts of the definitions of inpatient or outpatient hospital services set forth in Medicaid regulations,

including whether the services were (1) those ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital.

iv. In implementing the Hospital User Fee, DSS uses each Petitioner Hospital's net patient revenue as reported to OHCA in order to calculate the amount of tax due.

DSS uses each Petitioner Hospital's net patient revenue as reported to OHCA in their twelve month actual filings in order to determine the amounts of revenue the Petitioner Hospitals accrued through the provision of inpatient and outpatient hospital services that are subject to the tax.

The Hospital User Fee statute defines "net patient revenue" as "the amount of accrued payments earned by a hospital for provision of inpatient and outpatient services." Conn. Gen. Stat. § 12-263a(2). In order to obtain these amounts in conformance with that definition and to be able to calculate specific amount of tax due from each hospital, DSS used the figures reported by each hospital as inpatient net revenue and outpatient net revenue to OHCA. R. at 586-608. Specifically, DSS used the total of "Inpatient Accrued Payments" and "Outpatient Accrued Payments" as reported by each hospital to OHCA on Report 550 in order to determine the base amounts subject to the tax for each Petitioner Hospital.

As stated in the OHCA FFY 2009 and 2013 Twelve Months Actual Filing General Instructions,[138] OHCA Report 550 is a reconfiguration of data from Report 500 and there is no direct input of data into Report 550, which means that the definitions and instructions for Report 500 also apply to Report 550. OHCA FFY 2009 Twelve Months Annual Filing Instructions, pp. 9, 39; OHCA FFY 2013 Twelve Months Annual Filing Instructions, pp. 10, 38. The instructions define "inpatient accrued payments" as "the total inpatient accrued charges less accrued inpatient contractual allowances." FFY 2009 Instructions, p. 37; FFY 2013 Instructions, p. 36. The instructions define "inpatient accrued charges" as "the total inpatient accrued gross patient revenue for hospital inpatient services consistent with Medicare principles of reimbursement." FFY 2009 Instructions, p. 37; FFY 2013 Instructions, p. 36; see also Conn. Agencies Regs. §§ 19a-643-201 and 19a-643-206(c). Similarly, the instructions use comparable language for the outpatient definitions; they define "outpatient accrued payments" as "the total outpatient accrued charges less accrued outpatient contractual allowances." FFY 2009 Instructions, p. 37; FFY 2013 Instructions, p. 36. The instructions define "outpatient accrued charges" as "the total accrued gross patient revenue for hospital outpatient services consistent with Medicare principles of reimbursement." FFY 2009 Instructions, p. 37; FFY 2013 Instructions, p. 36.[139] In sum, the OHCA filing instructions, which

[138] In their letter dated August 29, 2016, the Petitioners objected to any characterization that the Departments indicate that the Petitioners acquiesced to OHCA's definitions. R. at 1358-61. However, that line of argument is not valid because as shown in the text above, the Departments are relying on said documents to describe the scope and definition of items that hospitals were required to report to OHCA, regardless of whether they agreed with said definitions. The Petitioners also objected to the OHCA FFY 2009 instructions because they were developed before the Hospital User Fee was implemented and because the FFY 2013 instructions were developed before the 2015 update to the Hospital User Fee was implemented. However, those objections are also not valid because the revenue figures reported to OHCA as net revenue were used by DSS to calculate the amount that each hospital owed under the Hospital User Fee regardless of when the instructions were crafted.

[139] OHCA regulations further define the categories described in the filing instructions. The regulations specifically provide that those "definitions shall apply to the review by the office of all matters concerning hospital financial

the Petitioner Hospitals were required to follow, show that the sums reported on the relevant lines of the OHCA Report 550 reflect accrued payments for inpatient hospital services and outpatient hospital services.[140]

The question before the Departments is whether the "inpatient hospital services" and "outpatient hospital services" for which the Petitioner Hospitals were required to report accrued payments to OHCA are the same services as those subject to tax under Chapter 211a.

v. The Departments find that the inpatient and outpatient hospital services that the Petitioner Hospitals were required to report to OHCA are the same inpatient and outpatient hospital services subject to tax under Chapter 211a. As such, DSS reliance upon the OHCA reports to calculate the Hospital User Fee imposed on the Petitioner Hospitals was proper.

Both the OHCA filing instructions and regulations require each Petitioner Hospital to report its accrued payments for "hospital inpatient services" and "hospital outpatient services." Those terms align with the federal Medicaid provider tax classes of "inpatient hospital services" and "outpatient hospital services" in 42 U.S.C. §§ 1396b(w)(7)(A)(i) and (ii) and 42 C.F.R. §§ 433.56(a)(1) and (2).

Specifically, as referenced above, the Petitioner Hospitals were required to report accrued payments pertaining to hospital inpatient services and hospital outpatient services consistent with the Medicare principles of reimbursement. See Conn. Agencies Regs. §§ 19a-643-201 and 19a-643-206(c). OHCA regulations define Medicare principles of reimbursement as "the reimbursement principles provided in 42 CFR 413…." Conn. Agencies Regs. § 19a-643-201(b)(39). Under Title XVIII of the Social Security Act, which governs Medicare ("Medicare Act"), inpatient hospital services are reimbursed under Part A of said Act. The Medicare Act includes a definition of "hospital inpatient services," which is set forth in 42 U.S.C. § 1395x, and which provides, in pertinent part, that

information or statistical data reporting requirements, as applicable." Conn. Agencies Regs. § 19a-643-201. The regulations include definitions of gross inpatient revenue and gross outpatient revenue, both of which correspond to the filing instruction definitions of inpatient accrued charges and outpatient accrued charges. Specifically, "gross inpatient revenue" is defined as "the total gross patient charges for hospital inpatient services consistent with Medicare principles of reimbursement and "gross outpatient revenue" is defined as "the total gross patient charges for hospital outpatient services consistent with Medicare principles of reimbursement." Id. In turn, those regulations define "net revenue," which the regulations cross-reference to the definition of net revenue in Conn. Gen. Stat. § 19a-659. Id. That statute, defines net revenue as "total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care and other allowances." Conn. Gen. Stat. 19a-659.

[140] In completing the OHCA reports, the Petitioner Hospitals were required to comply with the statutes, regulations, and filing instructions relevant to those reports. Hospitals filed affidavits with OHCA, including an affidavit specific to the Twelve Months Actual Filing, in which each hospital affirms that the information submitted to OHCA "that is contained in the Hospital's FY 2009 Twelve Months Actual Filing concerning its actual results from operations, is true, accurate and consistent with the FY 2009 Twelve Months Actual Filing General Instructions provided to the Hospital by" OHCA. R. at 2167-2448. The hospitals filed virtually identical affidavits with OHCA for FFY 2013. Id.

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K),[141] certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau

[141] 42 U.S.C. § 1395x(s)(2)(K) pertains to services performed by physicians assistants and nurse practitioners:

> (K)(i) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,
>
> (ii) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

42 U.S.C. § 1395x(s)(2)(K).

> of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
>
> (7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

42 U.S.C. § 1395x(b). Upon review of the above-quoted statute, although framed somewhat differently, the Medicare definitions of inpatient hospital services comport with the Medicaid definitions of said services. To that end, as referenced above, for purposes of Chapter 211a and the Medicaid Act, the term inpatient hospital services is defined broadly to include services (1) ordinarily furnished to inpatients, (2) furnished under the direction of a physician, and (3) furnished in a hospital that meet certain criteria.

First, in the Medicare Act, as quoted above, the term inpatient hospital services includes only services ordinarily furnished to inpatients, as the definition directs that the services have to be "furnished to an inpatient of a hospital" and enumerates those services ordinarily furnished to inpatients repeating the phrase "as are ordinarily furnished to inpatients." Second, in the Medicare Act, as quoted above, inpatient hospital services must by furnished under the direction of a physician. Finally, inpatient hospital services have to be performed in a hospital setting, as said services must be furnished "by a hospital" and such services can only be performed in a hospital.[142]

Accordingly, the Departments find that the Medicare and Medicaid definitions of "inpatient hospital services" comport with each other. If anything, the Medicare definition is more restrictive than the Medicaid definition.

The Medicare and Medicaid definitions of "outpatient hospital services" are also similar. Under the Medicare Act, outpatient hospital services are reimbursed under Part B of said Act in sections 1861(s)(2)(B) and (s)(2)(C) which provide as follows:

> (B) hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;
>
> (C) diagnostic services which are—

[142] As set forth above, the Departments have found that all of the Petitioner Hospitals subject to the Hospital User Fee meet the criteria set forth in the Medicaid definition of inpatient hospital services.

> (i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and
>
> (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

42 U.S.C. § 1395x(s)(2). Upon review of the above-quoted statute, although framed somewhat differently, the Medicare and Medicaid definitions of outpatient hospital services comport with each other. To that end, as referenced above, for purposes of Chapter 211 and the Medicaid Act, the term outpatient hospital services is defined broadly to include services (1) those ordinarily furnished to outpatients, (2) furnished under the direction of a physician, and (3) furnished by a hospital that meet certain criteria.

Similar to the Medicare definition of "inpatient hospital services," the Medicare definition of "outpatient hospital services" includes that the services must be those ordinarily furnished to outpatients, only references services which would be provided under the direction of a physician, and states that the services must be furnished by the hospital.[143] Accordingly, the Departments find that the Medicare and Medicaid definitions of "outpatient hospital services" comport with each other. If anything, the Medicare definition is more restrictive than the Medicaid definition.[144]

The Petitioner Hospitals, in filing their twelve month actual filings with OHCA, were required to report accrued payments from inpatient and outpatient hospital services consistent with Medicare principles of reimbursement.

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[143] As set forth above, the Departments have found that all of the Petitioner Hospitals subject to the Hospital User Fee meet the criteria set forth in the Medicaid definition of outpatient hospital services.

[144] Further confirming that these revenues fall within the federal provider tax classes, each of the hospitals complies with the applicable requirements for the revenue they received for inpatient and outpatient hospital services to fall within those provider tax classes. It is undisputed that throughout the relevant time periods until present, the Petitioners participate in Connecticut's Medicaid program as both inpatient and outpatient hospital providers. In order to participate in Medicaid as inpatient and outpatient hospital providers, each hospital demonstrated to DSS that they met these requirements, including "applicable licensing, accreditation and certification requirements." See Conn. Agencies Regs. § 17b-262-524. As part of the provider enrollment process, DSS verified that each hospital was licensed as a hospital and was certified for participation in Medicare, which are key requirements within the inpatient and outpatient hospital definitions in 42 C.F.R. §§ 440.10 and 440.20. Each hospital also signed a provider enrollment agreement with DSS, in which the hospital agreed, in this or similar language:

> 2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.
>
> 3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable. . . .
>
> 5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.

See R. at 2450-2984; see also R. at 3007-13.

As referenced above, as a provider tax, the Hospital User Fee is required to comply with the definition of "inpatient hospital service" and "outpatient hospital service" set forth in the Medicaid Act. Accordingly, the inpatient and outpatient hospital services subject to the Hospital User Fee under Chapter 211 must be those services that fall within the definitions set forth in the Medicaid Act of said services. As discussed above, the OHCA instructions and regulations require the Petitioners to report net revenue for inpatient hospital services and outpatient hospital services to OHCA consistent with the Medicare principles of reimbursement. As such, if the Petitioner Hospitals complied with the instructions and regulations governing the twelve month actual filling they reported to OHCA, said Petitioner Hospitals would only be subject to tax on services that fall within the scope of the Hospital User Fee under Chapter 211a and also within the scope of the federal provider tax classes of inpatient and outpatient hospital services.

Accordingly, the Departments, in the specified proceedings, requested that the Petitioner Hospitals provide evidence of the services for which the Petitioner Hospitals reported inpatient and outpatient accrued payments on the OHCA twelve month actual filling. The Departments find that the types of services for which the Petitioner Hospitals reported accrued payments on twelve month actual filling they filed with OHCA fall within the definitions of inpatient and outpatient hospital services set forth in the Medicaid Act and therefore also fall within federal provider tax classes of inpatient and outpatient hospital services in 42 C.F.R. §§ 433.56(a)(1) and (a)(2).

vi. The Departments find that the services for which that the Petitioner Hospitals reported accrued payments on their twelve month actual filing to OHCA all fall within the definitions of inpatient and outpatient hospital services incorporated into Chapter 211a and set forth in the Medicaid Act.

As referenced above, in order to be considered inpatient and outpatient hospital services, the services must by (1) those ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). Upon review of the information that the Petitioner Hospital provided in response to the Departments requests for information, it is apparent that all services reported on the Petitioners' twelve month actual filings meet these criteria.

a. All services reported on the Petitioners' twelve month actual filings were furnished in or by a Petitioner Hospital.

In order for amounts to be reported on the OHCA Report 550 (and its related reports 165 and 500), those revenues must have been billed by the hospital, not any affiliate entities. See OHCA 2013 Instructions, p. 4 ("The…net revenue…to be entered must be for the hospital only and must exclude all financial and statistical activity for hospital affiliates and subsidiaries." See also OHCA 2009 Instructions, p. 4. As noted above, the Petitioner Hospitals filed affidavits with OHCA attesting to compliance with all instructions. See R. at 2167-2448. In addition, the Petitioner Hospitals specifically filed affirmations with the Departments in this proceeding confirming that they did not report revenues from affiliates or subsidiaries on the OHCA reports 165, 500, or 550. See id. Accordingly, the Departments find that the amounts reported to OHCA were billed by the Petitioner Hospitals themselves, not to any affiliate or subsidiary of the hospital.

In addition to the OHCA instructions, more generally, a provider is only authorized to bill for services actually performed by the provider, which, for providers that are entities, such as hospitals, inherently includes services provided by individuals employed, under contract to, or closely affiliated with the entity. See, e.g., 45 C.F.R. § 162.1101 (Health Insurance Portability and Accountability Act or HIPAA regulation that a claim is a request for payment and related information "from a health care provider to a health plan, for health care"); 42 C.F.R. § 447.10 (Medicaid requirement to pay the provider who performed the services); 42 C.F.R. §§ 424.5, 424.33, 424.51, 424.73 (Medicare requirements that the provider must bill for services performed by the provider). There are civil and criminal penalties for false billing, such as if a provider improperly submitted claims for services not performed by the provider (including by individuals employed by, under contract to, or closely affiliated with the provider). See, e.g., 18 U.S.C. §§ 287 and 1347; 31 U.S.C. § 3729; and 42 U.S.C. §§ 1307, 1320a-7a, and 1320a-7b.[145]

The record demonstrates that the hospitals billed for the services included in the amounts they reported as net inpatient and outpatient revenue to OHCA using the hospital's national provider identifier (NPI). Under federal regulations implementing HIPAA, various types of providers, including hospitals, are required to use an NPI when submitting claims for payment for providing health care services. See 45 C.F.R. 162, Subpart D. Accordingly, the NPI the provider uses to bill for its services serves to identify the provider that furnished the services. The Petitioner Hospitals provided the NPIs that they used to bill for all of the services for which they reported payments on their twelve month actual filings. Each NPI reported by each Petitioner Hospital was an NPI associated with each said Petitioner Hospital. As such, the Departments find sufficient evidence to demonstrate that the Petitioner Hospitals were the entities that billed for, and as such furnished, the services subject to the Hospital User Fee.

Consistent with the above, all services reported on the Petitioners' twelve month actual filings were furnished in or by a Petitioner Hospital.

b. All services reported on the Petitioners' twelve month actual filings fall within the provider tax classes of inpatient or outpatient hospital services because those services were of a type ordinarily furnished to inpatients or outpatients and were provided under the direction of a physician.

As referenced in the background section of this Declaratory Ruling, the Departments determined it was necessary to conduct specified proceedings pursuant to Conn. Gen. Stat. § 4-176(e)(2) for a variety of reasons, especially to be able to find facts in order to evaluate the factual basis of the Petitioners' allegation that revenue outside the scope of the federal provider tax classes of inpatient and outpatient hospital services was subject to the Hospital User Fee. Pursuant to those proceedings, the Departments requested a variety of information and documents in order to determine information about the revenues reported by hospitals on the OHCA report 550, which is the basis for the Hospital User Fee. The Petitioners provided the Departments with various

[145] Under the provider-based status regulation, in specified circumstances, hospitals are authorized to bill for services provided at specified provider entities controlled by the hospital as if the service were provided in the hospital itself. 42 C.F.R. § 413.65. The significance of the provider-based status rule and any comparable policy is that a hospital can choose to establish or acquire various other provider types and bill and receive revenue in the same manner as if the service were literally performed at the hospital. See id.

information and documents in response to those requests. Additionally, the Plaintiffs have had an opportunity to present any additional evidence to support their claims.

Specifically, in questions 8, 19, 30, and 41 of their Request for Information dated March 3, 2016, the Departments asked the Petitioner Hospitals to "describe the types of services the hospital provided in connection with" the accrued payments reported by the petitioner to OHCA as net patient revenue (separately for inpatient and outpatient hospital services for FFY 2009 and FFY 2013). Rather than listing out specific types of services that the Petitioner Hospitals performed and billed for, such as hospital laboratory services or outpatient hospital behavioral health services, the Petitioner Hospitals simply set forth the nineteen classes of provider taxes and ascribed dollar amounts to each such class.

When the Departments again asked for information regarding the specific types of services for which the Petitioner Hospitals reported payments on their twelve month actual filings, the Petitioner Hospitals responded that their response to questions 8, 19, 30, and 41 was in fact answered by their responses to questions 9, 20, 31, and 42. In questions 9, 20, 31, and 42, the Departments asked the Petitioner Hospitals to "describe the specific method of billing for such services used by the hospital, including all specific billing codes and any other specific identifiers or codes used for billing services." In response to these questions, the Petitioner Hospitals listed out various ranges of billing codes that they claim are associated with each of the nineteen classes of provider taxes. The Petitioners further indicated that, in general, they used the categories within the UB-04 billing code standards to categorize the services. Billing codes have definitions that roughly correspond to certain services. Those definitions have significant limits, however, because many billing code definitions are terse, vague, and sometimes overlapping. As noted above, in the interest of finalizing the Declaratory Ruling as expeditiously as possible, the Departments took those responses under consideration even though those responses are still not descriptions of actual services provided, as requested. In any case, the Departments received no evidence that any of services associated with the codes were actually taxed.

Regardless, all of the codes listed by the Petitioner Hospitals are for services that fall within the provider tax classes of inpatient hospital services or outpatient hospital services. By way of example, the Petitioners claim that revenue codes 360-369 (operating room services) fall within ambulatory surgical center services when performed in the outpatient setting, but not outpatient hospital services. However, the definition of this category of codes reads: "The charges for services provided to patients by specifically trained nursing personnel who assist physicians in the performance of surgical and related procedures during and immediately following surgery." UB-04 Description of those Codes. Such services are clearly inpatient or outpatient hospital services because they must be (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). The same analysis applies to the other codes listed by Petitioners throughout their responses, which are either inpatient hospital services, outpatient hospital services, or are services that could either be inpatient or outpatient hospital services, which the Departments analyze more fully below. As such, assuming the Petitioner Hospitals included payments associated with these billing codes in their twelve month actual filings, the revenue that hospitals received for performing services associated with said codes were properly subject to the Hospital User Fee.

As referenced above, the Petitioners attempted to categorize these codes by provider tax class, claiming that the codes fall within another provider tax class rather than inpatient or outpatient hospital services. As established above, services may fall into more than one provider tax class, especially for a broad provider tax classes such as inpatient hospital services and outpatient hospital services. See 58 Fed. Reg. 43156, 43161-43162. In any case, the Petitioners' categorization of hospital billing codes by provider tax class is misleading, not only because all of the codes listed by the Petitioners fall within the provider tax classes of inpatient hospital services or outpatient hospital services, but also because some of the services which the Petitioners attempt to categorize as falling within classes other than inpatient and outpatient hospital services can only fall within inpatient and outpatient hospital services.

In particular, the codes the Petitioners listed as inpatient and outpatient hospital services omit the very large number of revenue center codes for services that can be provided in both the inpatient and outpatient hospital setting. For inpatient hospital services, this list omitted all of the various ancillary codes, including omitting the following categories, which can be performed in the inpatient or outpatient setting:[146] 250 to 259 (pharmacy), 260 to 269 (IV [intravenous] therapy), 270 to 279 (medical/surgical supplies), 280 to 289 (oncology), 300 to 309 (laboratory), 310 to 319 (laboratory pathology), 320 to 329 (radiology diagnostic), 330 to 339 (radiology therapeutic), 340 to 349 (nuclear medicine), 350 to 359 (computed tomographic [CT] scan), 370 to 379 (anesthesia), 380 to 389 (blood [components]), 400 to 409 (other imaging services), 420 to 429 (physical therapy), 430 to 439 (occupational therapy), 440 to 449 (speech-language pathology), 470 to 479 (audiology), codes 610 to 619 (magnetic resonance technology), codes 631 to 639 (pharmacy, extension of codes 250 to 259), code 750 (gastro-intestinal services), codes 960 to 969 (professional fees), codes 970 to 979 (professional fees), and codes 980 to 989 (professional fees).

The Petitioners similarly omitted all of the above-listed codes for outpatient hospital services. In addition, the Petitioners also omitted codes 510 to 519 (clinic), code 762 (outpatient hours), codes 820 to 829 (hemodialysis – outpatient / home), codes 830 to 839 (peritoneal OPD [outpatient department] / home), 840 to 849 (CAPD [continuous ambulatory peritoneal dialysis] OPD [outpatient department] / home), codes 850 to 859 (CCPD [continuous cycling peritoneal dialysis] OPD [outpatient department] / home), codes 900 to 909 (behavioral health treatment / services), and codes 910 to 919 (behavioral health treatment), and codes 920 to 929 (other diagnostic services).[147] For example, this list omits revenue code 510 (general classification – clinic), within the category of the hospital outpatient clinic revenue codes, which describe "clinic visit charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients." This code is a broad code that describes outpatient hospital services provided in the outpatient hospital clinic. The services described by that code are outpatient hospital services because they are ordinarily furnished to outpatients, furnished under the direction of a physician, and furnished in or by a Petitioner Hospital. See 42 C.F.R. § 440.20(a).

[146] For most of these categories, the services included in the category of billing codes can be provided in both the inpatient and outpatient hospital setting. In a few circumstances, certain individual codes can only be provided in the outpatient setting, such as revenue code 303 (renal patient [home]) within the laboratory category of codes.

[147] Although a number of the codes within several of these categories are more typically performed in the outpatient hospital setting, some of these codes can also be performed in the inpatient hospital setting.

As described above, the DPH license requirements and the conditions of participation for Medicare and Medicaid require that hospitals provide a wide variety of services, including many of the ancillary services that are provided in the inpatient and outpatient hospital setting. Accordingly, because these are key outpatient hospital services, it is not appropriate to exclude them from the broad scope of the inpatient and outpatient hospital services provider tax classes. For example, as noted above the Petitioners omitted from inpatient and outpatient hospital services the CT scan revenue code series, which is described as relating to "charges for computed tomographic scans of the head and other parts of the body." These services are a common component of both inpatient and outpatient hospital services, as CT scans are performed in conjunction with other inpatient and outpatient hospital services. As another example, the Petitioners omitted from inpatient and outpatient hospital services the cardiology revenue code series, which is "charges for cardiac procedures" and are described as being "provided by staff from the cardiology department of the hospital or under arrangement." A specific code within this series revenue code 483 (echocardiology), which is a service that is provided in both the inpatient and outpatient hospital settings. The services described by that code are inpatient or outpatient hospital services because they are ordinarily furnished to inpatients or outpatients, furnished under the direction of a physician, and furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a).

For all of these reasons, based on a review of the documents in the record, the Departments find that the revenues reported by the Petitioners to OHCA on the twelve month actual filing as inpatient accrued payments and outpatient accrued payments were for services that fall within the scope of the federal provider tax classes of inpatient and outpatient hospital services. In their Brief, the Petitioners assert that various types of services fall outside those federal provider tax classes. The Departments address each of those arguments below.

F. The Departments find that the Petitioners' allegations are without foundation in and contrary to well-established law governing provider taxes.

The Departments note that the Petitioner Hospitals have alleged that certain of these services for which the reported accrued payments on their twelve month actual filings to OHCA are not subject to the Hospital User Fee. Accordingly, as the Petitioners are contesting the imposition of said Fee to their net patient revenue the Petitioners are required to demonstrate, by clear and convincing evidence that the services upon which the tax has been imposed are not subject to the tax. See Leonard v. Comm'r of Revenue Svcs, 264 Conn. 286, 302 (2003). Rather than providing concrete evidence of services that were improperly subject to the tax, the Petitioner Hospitals have posited the legal theory that certain services that could overlap with other provider tax classes, such as psychological services or therapist services, should not be taxed as inpatient hospital services and outpatient hospital services. As this theory has been categorically rejected by CMS, the Departments find that the Petitioners' allegations are without basis.

As an initial matter, the Departments note that the Petitioners have failed to provide any evidence that any of the services subject to the Hospital User Fee were not properly subject to the Fee within the provider tax classes of inpatient and outpatient hospital services. The Petitioners did not provide a list of the services upon which the Hospital User Fee was imposed, instead choosing to

provide a list of the nineteen classes of provider taxes and a list of billing codes.[148] Those billing codes were listed in response to the Departments' request for information numbers 9, 20, 31, and 42, which asked the Petitioners to "describe the specific method for billing" for services included in the amounts reported as inpatient and accrued payments to OHCA. As discussed above in the Facts section, in their letter dated July 28, 2016, the Petitioners asserted that those responses, in conjunction with the billing code standards manual, constituted their responses to the Departments' request for information questions 8, 19, 30, and 41, which ask the Petitioners to "identify and describe the type or types of services the hospital provided in connection with" the amounts reported as inpatient and outpatient accrued payments to OHCA. Accordingly, the Petitioner Hospitals' sole evidence for their position appears to be their allegations that certain hospital billing codes do not fall within the provider tax classes of inpatient and outpatient hospital services. However, as described more fully below, all of the billing codes that the Petitioner Hospitals claim are not inpatient and outpatient hospital services do, in fact, fall within the provider tax classes of inpatient and outpatient hospital services, even if some of those services also potentially fall within one or more additional provider tax classes.[149] As CMS has indicated that services that overlap with inpatient and outpatient hospital services remain inpatient and outpatient hospital services, the Departments' find that the Petitioners' allegations are without any foundation in law.

The Petitioners allege that the Hospital User Fee "impermissibly taxes many other categories of health care services" in addition to inpatient and outpatient hospital services. R. at 12, 33. More specifically, the Petitioners allege that the figures on OHCA Report 550 for inpatient and outpatient accrued payments "include revenue received by hospitals for the delivery of classes of services other than inpatient and outpatient hospital services which are separate and distinct categories for purposes of a qualified federal health care-related tax…" R. at 16, 37. The Petitioners further allege that "revenue from at least the following classes of services, separate and distinct from inpatient and outpatient hospital services, has been and is subject to the tax: physician services; home health care services, outpatient prescription drugs; ambulatory surgical centers; dental services; podiatric services; psychological services; therapist services; laboratory and x-ray services; and emergency ambulance services." Id. However, all of the services that the Petitioners allege are not inpatient and outpatient hospital services, do, in fact, fall within the provider tax classes of inpatient and outpatient hospital services.

The premise of the Petitioners' primary arguments in their Brief is in stark contrast to CMS guidance, which, as detailed above, confirms that inpatient and outpatient hospital services are very broad categories of service that that may fall into multiple federal provider tax classes in addition to the provider tax classes of inpatient and outpatient hospital services. As described above, based on CMS regulatory history, CMS guidance, legislative history, and regulatory

[148] Those billing codes were listed in response to the Departments' request for information numbers 9, 20, 31, and 42, which asked the Petitioners to "describe the specific method for billing" for services included in the amounts reported as inpatient and accrued payments to OHCA. As discussed above in the Facts section, in their letter dated July 28, 2016, the Petitioners asserted that those responses, in conjunction with the billing code standards manual, constituted their responses to the Departments' request for information questions 8, 19, 30, and 41, which ask the Petitioners to "identify and describe the type or types of services the hospital provided in connection with" the amounts reported as inpatient and outpatient accrued payments to OHCA.

[149] As noted above, even if a service provided by a hospital may fall into more than one provider tax class, as explained in Ruling 3, services provided by hospitals are fundamentally different from services provided by non-hospital providers. This just means that the service provided by the hospital may be subject to different taxes.

context, the provider tax classes of inpatient and outpatient hospital services include virtually all services provided in an inpatient or outpatient hospital setting, respectively, and therefore some of those services may also overlap with various other provider tax classes. See, e.g., 58 Fed. Reg. 43156, 43161-43162.

In their Brief, the Petitioners repeatedly point to various payers having multiple—or separate reimbursement methodologies for various types of services, ostensibly in support of the proposition that the existence of a separate payment methodology for a service means that it could not also be an inpatient or outpatient hospital service. The existence of different reimbursement methodologies for a service depending on the setting does not mean that a service provided by a hospital does not fall within both inpatient or outpatient hospital services and also one or more additional provider tax classes.[150] Related to different payers' specific reimbursement methodologies, the Petitioners also point to specific payers' definitions of service categories as support for their arguments regarding the ostensibly narrow scope of the provider tax classes of inpatient and outpatient hospital services.[151] Similarly, the Petitioners also point to various DPH and other descriptions of service categories as ostensible evidence in support of their position that the provider tax classes of inpatient and outpatient hospital services are narrow and ostensibly exclude a broad variety of services that are commonly provided by hospitals.[152] As discussed above, however, the CMS preamble to the provider tax class regulation, as well as the legislative

[150] As explained in detail in Ruling 3, the services provided by a hospital are fundamentally different from services provided by a non-hospital provider. Because the provider tax classes of inpatient and outpatient hospital services are so broad, some hospital services may simultaneously fall within both those classes and also one or more additional provider tax classes. Even if a hospital service may fall into the same provider tax class (in addition to inpatient or outpatient hospital service) as a service provided by a non-hospital service, that simply means that they are both subject to a tax, but it does not mean that those services are the same. Specifically, the various differences between services provided by a hospital compared to services provided by a non-hospital provider remain significant, as outlined in Ruling 3.

[151] For example, in their Brief, the Petitioners point to Medicare's specific definitions for payment purposes for various categories, the specific listing in Connecticut's Medicaid state plan of how Connecticut's Medicaid program defines and pays for certain services. Similarly, in the Petitioners' explanation of their counter-designated documents for the record dated September 8, 2016, the Petitioners point to definitions from Medicare, Medicaid Disproportionate Share Hospital (DSH) payment definitions of services, Connecticut's Medicaid State Plan and proposed Medicaid State Plan Amendment, and DSS operational policies with the force of regulation pursuant to Conn. Gen. Stat. § 17b-239. As explained by CMS, DSH relates to the state Medicaid program's specific definitions of service categories, which means that it, too, represents a specific payer's reimbursement methodology, not a source that describes the scope of the provider tax classes. See 81 Fed. Reg. 53982. Moreover, DSH audits and related documents are used only in the specific context of calculating a hospital's provision of uncompensated care and are designed to ensure that a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients ('uncompensated care costs')." CMS, Medicaid Program; Disproportionate Share Hospital Payments; Final Rule; 73 Fed. Reg. 77904 (Dec. 19, 2008). Thus, DSH definitions and related documents are narrowly focused on that purpose, which is completely unrelated to determining the scope of the federal provider tax classes. All of those definitions only indicate each payer's description, however, and are not relevant for determining the scope of the provider tax classes.

[152] For example, in their Brief, the Petitioners point to the services listed in the DPH Statewide Health Care Facilities and Services Plan. Relatedly, in the Petitioners' explanation of their counter-designated documents for the record dated September 8, 2016, they point to the same DPH plan. In addition, the Petitioners counter-designated a variety of other documents, including hospital price masters, which simply include a list of codes and the DPH acute care hospital and outpatient surgical facility data report, which is simply a listing a various types of surgeries provided in different settings. Contrary to the Petitioners' arguments, however, those documents are simply descriptions of services, but are not relevant for determining the scope of the provider tax classes.

history and various other sources, confirms provider tax classes of inpatient and outpatient hospital services are very broad and CMS has indicated that some services will fall within both inpatient or outpatient hospital services and also one or more additional provider tax classes.

In any case, any payer's reimbursement methodology is not relevant for determining the federal provider tax classes, which are governed by the CMS regulatory history and guidance, regulatory context, and legislative history, all as described above. Moreover, relying on any specific payer's payment methodology would make the scope of the provider tax classes vary throughout the country, which is contrary to the purpose of uniform federal provider tax classes.[153,154] The West Virginia Supreme Court concurred that the scope of the federal provider tax classes is determined by looking at the overall federal regulatory definitions of the federal Medicaid benefit category in 42 C.F.R. Part 440, not by any particular billing codes and, by extension, any particular payer's reimbursement methodology. See Wheeling Hosp. Inc., 742 S.E.2d at 93. This rationale is consistent with Congress's intent in enacting the provider tax classes and CMS's intent in enforcing the provider tax requirements to ensure that taxes are broad-based and are not used as a loophole by states. CMS confirmed in the CMS preamble to the provider tax class regulation that the provider tax classes are broad and that states have substantial flexibility in constructing their taxes, all of which further shows that the provider tax classes are separate from any particular payer's reimbursement methodology. See 58 Fed. Reg. at 43161-43162.

As another line of argument in their Brief, the Petitioners also allege that the amounts reported to OHCA as inpatient and outpatient accrued payments "collectively include all patient charges. As a result, the OHCA reports include revenues for categories of services that are not classified as inpatient and outpatient hospital services under the Medicaid Act." R. at 745. The Petitioners then detail similar arguments for several Medicaid provider tax classes. Throughout their Brief, the Petitioners ignore the fundamental principle described above that the provider tax classes of inpatient and outpatient hospital services are so broad that various services will fall within one of those classes and also one or more additional provider tax classes.

In support of this argument, the Petitioners repeatedly point out that specific services can only be performed by an individual or entity with a license other than a hospital, implying that the hospital

[153] In a footnote in the Petitions, R. at 17, 38, and as a document counter-designated by the Petitioners for inclusion in the record attached to their letter dated August 29, 2016, R. at 1376, the Petitioners reference an OIG audit of Missouri's provider tax, which resulted in a recommended disallowance because the OIG found that Missouri "incorrectly taxed items or services (such as office rental income, interest earned, and cafeteria revenue) that are not included in the classes of health care items or services enumerated in the regulation." OIG, Review of Missouri Provider Tax, March 2007, p. 4, R. at 1412. The Petitioners have not made any allegations that they reported such non-patient service items as inpatient or outpatient accrued payments on the OHCA Report 550. Moreover, the OHCA reports require hospitals to report such types of income—unrelated to providing inpatient or outpatient hospital services—under the **separate** category of "other operating revenue," which is a completely separate line of the relevant OHCA reports from the lines for inpatient accrued payments and outpatient accrued payments. OHCA 2009 Instructions, pp. 8, 37; OHCA 2013 Instructions, pp. 8, 35. Accordingly, any such items should not have been reported by the hospitals as inpatient or outpatient accrued payments on the OHCA Report 550 and would therefore not be taxed by the Hospital User Fee.

[154] As noted in the text, looking at any particular payer's specific reimbursement methodology is not relevant in analyzing the scope of each provider tax class. Thus, the specific reimbursement methodology for Connecticut's Medicaid program, as described in Connecticut's Medicaid State Plan, is not relevant to this inquiry, since Connecticut's Medicaid program has chosen merely one set of options within the broad federal Medicaid framework.

therefore cannot provide those services because two licenses are required, rather than one. However, a single entity can have multiple licenses simultaneously and an entity such as a hospital can also bill for services provided by individuals with practitioner licenses employed by or under contract to the hospital. Based on a review of the record, all of the Petitioners have hospital and laboratory licenses; individual clinicians employed by or under contract to the hospital have various types of individual clinical licenses; a small number of Petitioners also have home health agency licenses; and a small number of Petitioners may have additional licenses. Thus, the hospital as a single entity, and as a billing provider on behalf of individual clinicians employed by or under contract to the hospital, simultaneously has multiple licenses. Simply because it serves the hospital's purpose in this particular context to ignore that it can simultaneously operate under both license does not make the other license somehow disappear.

As detailed below, the Departments have reviewed the Petitioners' claims that specific services are not inpatient or outpatient hospital services, but find that all of those services meet the definitions of inpatient and outpatient hospital services in 42 C.F.R. §§ 440.10 and 440.20(a). The Departments therefore find that all of the services subject to the Hospital User Fee fall within the provider tax classes of inpatient and outpatient hospital services.

i. The services that the Petitioners claim are physicians' services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are physicians' services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are physician services, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of "revenue center codes," Current Procedural Terminology (CPT) and Health Care Common Procedural Coding System (HCPCS)[155] codes the Petitioners claim are physician services, not inpatient or outpatient hospital services. Revenue center codes are codes that only hospitals are permitted to use. As such, all of the services associated with revenue center codes must be furnished in or by a Petitioner Hospital. Moreover, those services that that Petitioners claim are physician services are ordinarily furnished to

[155] Revenue center codes, also known as revenue codes, are developed by the American Hospital Association and are used only by hospitals to bill for specified services. In general, revenue center codes are much fewer in number and much broader than CPT or HCPCS codes. CPT codes are developed by the American Medical Association and are billing codes that describe procedures and professional services, typically with far more specificity and detail than revenue center codes. HCPCS codes are billing codes that identify various types of procedures, services, products, and supplies, typically with a similar level of detail to CPT codes.

outpatients and are furnished by or under the direction of a physician. For example, the Petitioners claim that codes 980-989 are not inpatient or outpatient hospital services. These codes pertain to fees charged for the following: Emergency Room, Outpatient Services, Clinic, Medical Social Services, EKG, EEG, Hospital Visit, Consultation, and Private Duty Nurse. It is self-evident that each of these codes are for services ordinarily furnished to inpatients or outpatients, as applicable, as each of the charges are for hospital departments and procedures typically used by or furnished to outpatients or inpatients, as applicable. Moreover each of these units and procedures are required to operate under the direction of a physician under Connecticut law. Accordingly, all of the services associated with codes 980-989 are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital thereby meeting the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a).

As another example, among the codes listed by the Petitioners as falling only within physicians' services, is revenue code 975 (operating room). As explained above, revenue codes may only be used by hospitals. As such, services associated with this code must be furnished in or by a Petitioner hospital. Moreover, operating rooms are ordinarily utilized by inpatients or outpatients and must operate under the direction of a physician. Accordingly, services associated with revenue code 975 are ordinarily furnished to inpatient and outpatients, furnished by or under the direction of a physician, and furnished in or by a Petitioner hospital. The service therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. Relatedly, as an example of the CPT codes listed by the Petitioners as falling only within physicians' services is CPT code 77371 ("radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session…"). SRS is a non-surgical radiation therapy to treat brain abnormalities and small tumors. The services associated with this code must be furnished at the direction of a physician and can only be performed in a hospital. Accordingly, such services are ordinarily furnished to inpatients and outpatients, furnished by or under the direction of a physician, and furnished in or by a Petitioner hospital. The service therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. The Departments find that the other billing codes that the Petitioners claim are for physician services are similar to these examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and/or outpatient hospital services.

Regardless of whether these services may also fall into the provider tax class of physicians' services, these services still fall within the provider tax classes of inpatient and outpatient hospital services. Accordingly, consistent with CMS guidance, such services are properly subject to the Hospital User Fee.

As further support for this position, the regulations discussed above at 42 C.F.R. §§ 440.10, 440.20(a), and 440.50 demonstrate that the provider tax classes of physicians' services and inpatient and outpatient hospital services can overlap, which means that a service could potentially fall within both provider tax classes.[156] In particular, as explained above, the CMS regulatory

[156] As noted above, even though a service provided by a hospital may fall within more than one provider tax class, as explained in detail in Ruling 3, services provided by a hospital differ significantly in various ways from services provided by a non-hospital provider.

history indicates that all services provided in the inpatient hospital setting fall within that provider class and that the provider classes overlap with each other. See 58 Fed. Reg. 43156, 43161-43162. In addition, CMS specifically understood that the class of physicians' services overlaps with the classes of inpatient and outpatient hospital services because it informed states that "[i]f a State does not impose a separate tax on physician services, the inpatient hospital services performed by the physician should be subject to the tax. If, however, the State has a separate tax on physicians[']services, the State may include the inpatient hospital services performed by the physician under either inpatient hospital services or under physician services." CMS State Medicaid Director Letter, Questions and Answers – Taxes and Donations, June 21, 1995, p. 7, R. at 979. Thus, because there is no separate tax on physicians' services in Connecticut, any service that may fall within both physicians' services and also inpatient or outpatient hospital services must be subject to the Hospital User Fee.

Further demonstrating this overlap, the federal Medicaid benefit category regulation definition of physicians' services in 42 C.F.R. § 440.50 overlaps to a substantial extent with the definitions of inpatient and outpatient hospital services in 42 C.F.R. §§ 440.10 and 440.20(a). CMS regulatory history regarding various regulations described above (nurse-midwife, nurse practitioner, and home health) and confirms that physicians' services overlaps with the federal Medicaid benefit category definition of physicians' services is as follows:

> (a) … whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician—
>
> > (1) Within the scope of practice of medicine or osteopathy as defined by State law; and
> >
> > (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy….

42 C.F.R. § 440.50(a). So long as the service is provided by or under the personal supervision of a physician employed by, under contract to, or affiliated with a hospital, this category overlaps with inpatient or outpatient hospital services, depending on whether the service was provided in the inpatient or outpatient hospital setting.

The definition of inpatient hospital service specifies that the service must be "furnished under the direction of a physician or dentist," which overlaps substantially with the physicians' services definition, which must be performed "by or under the personal supervision" of the physician. Compare 42 C.F.R. § 440.10 with 440.50(a). Certainly any service personally provided by the physician is also provided under that person's direction. Similarly, any service provided under the personal supervision of a physician is likewise simultaneously provided under that physician's direction. The outpatient hospital definition likewise includes a condition that the service must be "furnished by or under the direction of a physician or dentist," which similarly overlaps with physician services. Compare 42 C.F.R. § 440.20(a) with 440.50(a). CMS specifically recognized that when physicians' services are provided by a hospital, those services also fall within the definition of inpatient or outpatient hospital services. See 60 Fed. Reg. 61483, 61484-61485. Thus, it is clear that there is overlap between the classes of physician services and inpatient and

outpatient hospital services. As such, in accordance with CMS guidance, such services are properly considered inpatient and outpatient hospital services since Connecticut does not have a provider tax on physician services.

In their Brief, the Petitioners ignore this overlap and instead claim that physicians' services should not be subject to the Hospital User Fee both because individual physicians must be licensed and various health care payers pay separately for physicians' services. See Petitioners' Brief, pp. 9-11, R. at 748-50. As noted above, any specific payer's reimbursement methodology is not relevant for determining the scope of the provider tax classes. Moreover, while physicians have an individual license, so must a variety of the other practitioners employed by, under contract to, or affiliated with the hospital who provide inpatient and outpatient hospital services on behalf of the hospital, including nurses. See Conn. Gen. Stat. ch. 378. Hospitals routinely employ, contract with, and affiliate with physicians in order for the physician to perform inpatient or outpatient hospital services on behalf of the hospital, within the broad definition applicable for the federal provider tax classes.[157]

The services that the Petitioners' claim are physicians' services are services that meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are physicians' services were not properly subject to the Hospital User Fee.

ii. The services that the Petitioners claim are dental services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are dental services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are dental services, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee. See 42 C.F.R. §§ 440.10 and 440.20(a).

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of CPT codes beginning with D and CPT

[157] The Petitioners own categorization of billing codes presents further evidence services typically fall within more than one provider tax class. To that end, the Petitioners have indicated that all CPT codes are physicians' services. Moreover, the Petitioners have alleged that some of these same CPT codes are outpatient prescription drugs, ambulatory surgical center services, therapist services, laboratory and x-ray services, and various services identified by the Petitioners as allegedly falling within the provider tax class they identified as 42 C.F.R. § 433.56(a)(19). As such, the Petitioners are claiming that the same CPT codes fall within multiple provider tax classes. The only classes that they claim cannot overlap are inpatient and outpatient hospital services.

code 41899, which the Petitioners claim are dental services but not inpatient or outpatient hospital services. When these services are provided in the inpatient or outpatient hospital setting, they are inpatient or outpatient hospital services. For example, CPT code D2330 is for "resin-based composite, 1 surface, anterior." This is simply a tooth colored cavity filling. Dentists will perform fillings in a hospital setting if the patient needs to be put under anesthesia for the procedure to be performed. Accordingly, CPT code D2330 is ordinarily furnished to inpatient and outpatients, furnished by or under the direction of a physician (or dentist),[158] and furnished in or by a Petitioner hospital. The service therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. The Departments find that the other billing codes that the Petitioners claim are for dental services are similar to these two examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and/or outpatient hospital services.

Regardless of whether these services may also fall into dental services, these services still fall within the provider tax classes of inpatient and outpatient hospital services. Accordingly, consistent with CMS guidance described above, such services are properly subject to the Hospital User Fee. Specifically, the federal Medicaid benefit category regulation definition of dental services overlaps to a substantial extent with inpatient and outpatient hospital services. Dental services:

> (a) … means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of—
>
> (1) The teeth and associated structures of the oral cavity; and
>
> (2) Disease, injury, or impairment that may affect the oral or general health of the beneficiary.
>
> (b) "Dentist" means an individual licensed to practice dentistry or dental surgery.

42 C.F.R. § 440.100. The definition of inpatient hospital service, among other conditions, specifies that the service must be "furnished under the direction of a physician or dentist," which overlaps substantially with the dental services definition, which must be performed "by or under the supervision" of the dentist. Compare 42 C.F.R. § 440.10 with 440.100. Certainly any service personally provided by the dentist is also provided under that person's direction. Similarly, any service provided under the supervision of a dentist is likewise simultaneously provided under that dentist's direction. The outpatient hospital definition likewise includes a condition that the service must be "furnished by or under the direction of a physician or dentist," which similarly overlaps with dental services. Compare 42 C.F.R. § 440.20(a) with 440.100. The Departments, therefore, determine that any dental services billed by and paid to the hospital (and therefore provided by or under the supervision of a dentist furnishing services on behalf of the hospital) are inpatient hospital services or outpatient hospital services, even if they may also fall within the provider tax class of dental services. Such services are therefore properly taxed under the Hospital User Fee.

[158] Note, the definition of inpatient and outpatient hospital services provides that said services must be "furnished by or under the direction of a physician **or dentist.**" 42 C.F.R. §§ 440.10 or 440.20(a) (emphasis supplied).

In their Brief, similar to their argument regarding physicians' services, the Petitioners claim that dental services should not be subject to the Hospital User Fee both because dentists have a separate license and that Connecticut's Medicaid State Plan lists a reimbursement methodology under the benefit category of dental services.[159] Petitioners' Brief, p. 15, R. at 754. However, as explained above, a service may fall within multiple federal provider tax classes and any payer's individual payment methodology is not relevant to determine the scope of these classes. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are dental services do not also fall within the provider tax classes of inpatient and outpatient hospital services.

The services that the Petitioners' claim are dental services are services that meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are dental services were not properly subject to the Hospital User Fee.

iii. The services that the Petitioners claim are podiatric services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are podiatric services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are podiatric services, but not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services, as said services are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue center codes and CPT codes they claim are associated with podiatric services rather than hospital services. Revenue center codes are codes that only hospitals are permitted to use. As such, all of the services associated with revenue service codes must be furnished in or by a Petitioner Hospital. Moreover, those services that that Petitioners claim are podiatric services are ordinarily furnished to outpatients and are furnished by or under the direction of a physician. For example, 510 (outpatient hospital clinic) and 761 (specialty services in treatment room), both of which are codes that only hospitals are permitted to use. It is self-evident that each of these fees are for services ordinarily furnished to inpatients or outpatients, as each of the charges are for hospital departments and procedures typically used by or furnished to outpatients. Moreover each of these units and procedures are required to operate under the direction of a physician under Connecticut law. Accordingly, all of the services associated with codes 510 and 761 are (1) furnished to inpatients or outpatients, (2)

[159] As noted above, even if a service can fall within more than one provider tax class, as detailed in Ruling 3, services provided by a hospital differ in many ways from services provided by a non-hospital provider.

furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital thereby meeting the definition of outpatient hospital services in 42 C.F.R. § 440.20(a).

In addition, the Petitioners also claim that the following are podiatric services rather than inpatient and outpatient hospital services: "the CPT codes that identify podiatric services fall in the evaluation and management and surgery ranges," which presumably refers to any CPT code in those ranges that relates to the ankle and/or foot. For example, among the CPT codes listed includes CPT code 28001 (incision and drainage bursa – foot), which is a procedure whereby a physician directs that a fluid filled sack in a foot is drained. Such a procedure often occurs in an outpatient hospital setting. As such, this service is ordinarily furnished to inpatient and outpatients, furnished under the direction of a physician, and furnished in or by a Petitioner hospital. The service therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. The Departments find that the other billing codes that the Petitioners claim are for podiatric services are similar to these examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and/or outpatient hospital services.

Regardless of whether these services may also fall into the provider tax class of podiatric services, these services still fall within the provider tax classes of inpatient and outpatient hospital services.[160] Accordingly, consistent with CMS guidance, such services are properly subject to the Hospital User Fee.

The services that the Petitioners' claim are podiatric services are services that meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are podiatric services were not properly subject to the Hospital User Fee.

iv. The services that the Petitioners claim are therapist services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are therapist services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are therapist services, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

[160] As noted above and as explained in detail in Ruling 3, even though a service may fall within multiple provider tax classes, services provided by a hospital are fundamentally different from services provided by a non-hospital provider.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes. For example, among the codes listed by the Petitioners in this category the Petitioners list revenue code 424 (physical therapy evaluation or reevaluation). This service is routinely provided in both the inpatient and outpatient hospital settings and is necessary to determine the types of physical therapy that will be necessary for a patient. As another example, revenue code 413 (hyperbaric oxygen therapy) is a procedure that involves enclosing a patient in a chamber and providing the patient with oxygenated air. This procedure is commonly provided in the hospital setting under the direction of a doctor. Accordingly, it is self-evident that each of these two services is ordinarily furnished to inpatient and outpatients, furnished under the direction of a physician, and furnished in or by a Petitioner hospital. Each of these two services therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. An example of CPT codes that the Petitioners listed as being only within the provider tax class of therapist services is CPT code 94010 (spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation). Spirometry is a diagnostic procedure used by physicians to measure breathing effectiveness and is used by said physicians to diagnose various conditions related to breathing, including asthma and chronic obstructive pulmonary disease. Accordingly, these services are ordinarily furnished or inpatients or outpatients and are performed under the direction of a physician. Accordingly, this service also meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. The Departments find that the other billing codes that the Petitioners claim are for therapist services are similar to these two examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and/or outpatient hospital services.

In their Brief, similar to their argument regarding physicians' services, the Petitioners claim that these services should not be subject to the Hospital User Fee because physical therapists, occupational therapists, speech and language pathologists, and respiratory therapists must have a separate license and that Connecticut's Medicaid State Plan lists a reimbursement methodology for services provided by therapists in independent practice. R. at 758. However, as explained above, services provided by a hospital using licensed practitioners employed by, under contract to, or affiliated with the hospital are inpatient or outpatient hospital services so long as they meet the criteria in 42 C.F.R. §§ 440.10 or 440.20(a), as applicable. Moreover, any payer's individual payment methodology is not relevant to determine the scope of the provider tax classes.

The services that the Petitioners' claim are therapist services are services that meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, within the provider tax classes of inpatient and outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are therapist services were not properly subject to the Hospital User Fee.

v. The services that the Petitioners' claim are psychological services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are psychological services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are psychological services, but not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes they claim are psychological services rather than inpatient or outpatient hospital services. For example, in the inpatient hospital context, the Petitioners claim that revenue code 114 (psychiatric), falls within the provider tax class of psychological services rather than inpatient hospital services. This service refers to the psychiatric inpatient hospital room and board provided to a patient who is in a private hospital room and includes the various routine inpatient hospital services provided for individuals admitted as an inpatient to a psychiatric unit of the hospital. As with all inpatient hospital services, the entire psychiatric unit is operated under the direction of one or more physicians, including the chief psychiatrist overseeing the unit, as well as other attending physicians. Accordingly, this service is ordinarily furnished to inpatients, furnished under the direction of a physician, and furnished in or by a Petitioner hospital. This service therefore meets the definition of inpatient hospital services in 42 C.F.R. §§ 440.10.

As an example in the outpatient hospital context, the Petitioners claim that revenue code 913 (partial hospitalization – intensive) falls within the provider tax class of psychological services rather than outpatient hospital services. Intensive partial hospitalization services are intensive, structured behavioral health treatment services provided by hospitals that do not require an overnight hospital stay. As with all services provided by a hospital's psychiatric unit, the chief psychiatrist and other attending physicians oversees the services, which means that they are provided under the direction of a physician. Thus, this service inherently involves intensive outpatient hospital services designed to treat behavioral health conditions. Accordingly, this service is ordinarily furnished to outpatients, furnished by or under the direction of a physician, and furnished in or by a Petitioner hospital. This service therefore meets the definition of outpatient hospital services in 42 C.F.R. § 440.20(a). The Departments find that the other billing codes that the Petitioners claim are for psychological services are similar to these two examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and/or outpatient hospital services.

As set forth above, regardless of the scope of the provider tax class of psychological services, so long as the services meet the definitions of either inpatient or outpatient hospital services, those services fall into those provider tax classes. Significantly, in the preamble to the provider tax class regulation, CMS specifically stated that "[w]e believe inpatient hospital services encompass all services provided in an inpatient hospital setting, including psychiatric services. Consequently, we believe psychiatric hospital services need not be listed as a specific inpatient hospital service." 58 Fed. Reg. 43156, 43162. The same reasoning applies to outpatient hospital services. Accordingly, based on that statement, psychological services provided by a hospital also fall within the definition of inpatient or outpatient hospital services, so long as those services also meet the various conditions for inpatient and outpatient hospital services.

In more practical terms, behavioral health services are one of several important categories of service almost universally provided, at least to some extent, by acute care general hospitals. While it may be possible to isolate the billing categories for these services, in practice, they are one of several key types of inpatient and outpatient hospital services for most hospitals. In their Brief, the Petitioners' claim that these services should not be subject to the Hospital User Fee because of the separate licenses required for various individual practitioners who perform behavioral health services and the distinct billing methodology used by various payers that is separate from non-psychological hospital services. See R. at 756. Similar to other categories, this argument ignores that the provider tax classes may overlap with each other. That assumption is particularly inappropriate for psychological services because, as quoted above, CMS specifically stated that inpatient hospital services includes psychiatric services provided in the inpatient setting. Moreover, for the reasons described above, any particular payer's payment methodology is not relevant for determining the scope of the provider tax class.

The services that the Petitioners claim are psychological services are services that meet the Medicaid definition of inpatient and outpatient hospital services and therefore fall within the provider tax classes of inpatient and outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are psychological services were not properly subject to the Hospital User Fee.

vi. The services that the Petitioners' claim are outpatient prescription drugs meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are outpatient prescription drugs. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are outpatient prescription drug services, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner

Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes they claim are outpatient prescription drugs rather than inpatient or outpatient hospital services. For example, the Petitioners claim revenue code 255 (pharmacy services incident to radiology) is not an inpatient or outpatient hospital service. Said code pertains to drugs provided as part of a hospital's provision of radiology services. Said drugs can only be prescribed by or under the direction of a physician, which physicians routinely do when the hospital provides radiology services. As such, this service is ordinarily furnished to inpatients and outpatients, furnished by or under the direction of a physician, and furnished in or by a Petitioner hospital. This service therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 and 440.20(a). Among the CPT/HCPCS codes listed by the Petitioners as falling only within the provider tax class of outpatient prescription drugs are the entire C series (as well as other series). Notably, the C series is entitled the "CMS Hospital Outpatient Payment System" and can only be used by hospitals. For example, code C1820 (generator, neurostimulator (implantable)…) relates to the provision of a neurostimulator that is implanted in a patient's body by a physician during surgery to deliver electrical signals near the spine and is intended to treat chronic pain. Accordingly, such services are ordinarily furnished or inpatients or outpatients and such services are provided by or under the direction of a physician. This service therefore meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 and 440.20(a). The Departments find that the other billing codes that the Petitioners claim are for outpatient prescription drugs are similar to these examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and/or outpatient hospital services.

Regardless of whether these services may also fall into the provider tax class of outpatient prescription drugs, these services still fall within the provider tax classes of inpatient and outpatient hospital services. Accordingly, consistent with CMS guidance, such services are properly subject to the Hospital User Fee.

In their Brief, the Petitioners claim that these services should not be subject to the Hospital User Fee because Connecticut's Medicaid State Plan lists a reimbursement methodology for drugs provided by pharmacies as well as prosthetic devices and eyeglasses provided by medical equipment and vision providers, respectively. See R. at 752. As explained above, any particular payer's reimbursement methodology is not relevant to determine the scope of the federal provider tax class.

The services that the Petitioners claim are outpatient prescription drugs are services that meet the Medicaid definition of outpatient hospital services (and possibly also inpatient hospital services in certain circumstances) and therefore fall within the provider tax classes of (inpatient and) outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are outpatient prescription drugs were not properly subject to the Hospital User Fee.

vii. The services that the Petitioners' claim are laboratory and x-ray services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are laboratory and x-ray services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are laboratory and x-ray services, but not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services fall within the provider tax classes of inpatient or outpatient hospital services and are therefore properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes they claim are laboratory and x-ray services rather than inpatient or outpatient hospital services. For example, the Petitioners claim certain "diagnostic and routine clinical laboratory tests" are not inpatient or outpatient hospital services such as revenue code 301 (chemistry). Revenue code 301 is the billing code that hospitals use in order to get reimbursed for performing a blood chemistry test, which is essentially testing the patient's blood. Revenue center codes are codes that only hospitals are permitted to use. As such, all of the services associated with revenue center codes, including revenue code 301, must be furnished in or by a Petitioner Hospital. Moreover, as is self-evident, blood tests are commonly performed in hospitals in both the inpatient and outpatient setting as routine diagnostic procedures that are ordered under the direction of a physician. Accordingly, it is clear that the blood tests performed by hospitals in connection with revenue code 301 meet the definitions of inpatient and outpatient hospital services as they are services that are (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee. Accordingly, such services are ordinarily furnished to inpatients or outpatients and they are provided by or under the direction of a physician. Accordingly, this service meets the definition of inpatient or outpatient hospital services in 42 C.F.R. §§ 440.10 and 440.20(a).

The Petitioners also claim certain x-ray services are not inpatient or outpatient hospital services, including revenue code 331 (chemotherapy – injected). As its name suggests, revenue code 331 is the billing code that hospitals use in order to get reimbursed for providing chemotherapy to patients by injection. This particular revenue code refers to chemotherapy provided in the outpatient context. Revenue center codes are codes that only hospitals are permitted to use. As such, all of the services associated with revenue center codes, including revenue code 331, must be furnished in or by a Petitioner Hospital. Moreover, as is self-evident, chemotherapy treatment is ordinarily provided by hospitals in both the inpatient and outpatient setting and must be performed under the direction of a physician. Accordingly, it is clear that the chemotherapy

treatment performed by hospitals in connection with revenue code 331 meet the definition of outpatient hospital services as they are services that are (1) ordinarily furnished to outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee.

The Departments find that the other billing codes that the Petitioners claim are for laboratory and x-ray services are similar to these two examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definitions of inpatient and outpatient hospital services. Consistent with CMS guidance, such services are properly subject to the Hospital User Fee.

The Petitioners, however, claim that laboratory and x-ray services provided by a hospital are not inpatient and outpatient hospital services because they fall within the provider class of laboratory and x-ray services. However, the federal definition of the provider class of laboratory and x-ray services specifically excludes laboratory and x-ray services provided by a hospital. To that end, laboratory and x-ray services are "defined as services provided in a licensed, free-standing laboratory or x-ray facility. **This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department**." 42 C.F.R. § 433.56(a)(17) (emphasis added). By its very terms, this provider tax class does not include services provided in a hospital inpatient department or hospital outpatient department. Therefore, the only services that could potentially fall within the provider class of laboratory and x-ray services are services that are those provided by free-standing, non-hospital providers. The Departments did not impose the Hospital User Fee on any services provided by free-standing, non-hospital providers, but rather imposed the tax only on services provided by the hospital.

A hospital can only bill for services provided by the hospital, not through an independent, free-standing, non-hospital provider. Further, as explained above, the OHCA instructions specifically require the figures on the relevant OHCA reports to include only the hospital's revenue, not any affiliate or subsidiary revenue. The hospitals should not have reported any revenue from affiliates or subsidiaries on the OCHA Reports 165, 500, or 550, and each Petitioner Hospital affirmed that no such revenue was included on those reports. For all of these reasons, the Departments determine that the Hospital User Fee did not apply to any services that fall within the provider tax class of laboratory and x-ray services defined in 42 C.F.R. § 433.56(a)(17).

In arguing that the hospitals were subject to tax on services that fall within the provider tax class of laboratory and x-ray services, the Petitioners thus imply that the hospitals erroneously reported revenue for non-hospital entities that provided laboratory and x-ray services, in violation of the OHCA instructions and in contrast to the Petitioners' affirmations to the Departments in this proceeding. In their Brief, the Petitioners claim that these services should not be subject to the Hospital User Fee because hospital laboratories are required to have separate laboratory licenses. R. at 758-60. As discussed above, however, each hospital in fact holds multiple licenses simultaneously and is in fact required to provide laboratory services.[161]

[161] In their Brief, the Petitioners assert that "in certain circumstances, the services are provided under arrangement with other third parties such as nursing homes, physician groups, municipalities, etc., which pay the hospital for the lab service and then bill payers for the service. This net revenue is included on the Report 165 and is subject to the

The services that the Petitioners claim are laboratory and x-ray services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore within the provider tax classes of inpatient and outpatient hospital services. Moreover, services that the Petitioners claim are laboratory and x-ray services can never fall into the provider tax class of laboratory and x-ray services because said provider tax class specifically excludes services provided by a hospital. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are laboratory and x-ray services were not properly subject to the Hospital User Fee.

viii. The services that the Petitioners' claim are ambulatory surgical center services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are ambulatory surgical center services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are ambulatory surgical center services, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee. See 42 C.F.R. §§ 440.10 and 440.20(a).

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes they claim are ambulatory surgical center services rather than inpatient or outpatient hospital services. For example, the Petitioners claim that revenue codes 360 to 369 (operating room services) are not inpatient or outpatient hospital services. Said codes are "for services provided to patients by specifically trained nursing personnel who assist physicians in the performance of surgical and related procedures during and immediately following surgery." Within that section, for example, revenue code 360 is the general code for operating room services. Revenue center codes are codes that only hospitals are permitted to use. As such, all of the services associated with revenue center codes, including revenue codes 360-369, must be furnished in or by a Petitioner Hospital. Moreover, as is self-evident, hospitals routinely provide care to patients before, during, and after surgery, which care is performed under the direction of a physician. Accordingly, there can be no dispute that these services are (1) ordinarily furnished to outpatients, (2) furnished under

Hospital User Fee. This revenue has also been subject to the Connecticut Unrelated Business Income Tax, resulting in unconstitutional double taxation." R. at 760. That excerpt from the Brief raises a completely different legal issue that was not included in the statement of questions in the Petitions and was not referenced in the Petitions. Accordingly, because the Departments can only issue a Declaratory Ruling in response to questions in the Petitions, this question is not properly before the Departments in this proceeding and the Departments therefore cannot address it here.

the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

The Petitioners claim that CPT code 42809 is not an inpatient or outpatient hospital service. Said code pertains to the "removal of foreign body from pharynx." Stated simply, hospitals use this CPT code in order to receive payment for removing objects from a patient's throat. This often occurs in an emergency context at hospitals and should only be performed by or under the direction of a doctor. Accordingly, services performed by hospitals in connection with CPT code 42809 meet the definition of outpatient hospital services as they are services that are (1) ordinarily furnished to outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee. The Departments find that the other billing codes that the Petitioners claim are for ambulatory surgical center services are similar to these two examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definition of outpatient hospital services.

The Petitioners, however, claim that ambulatory surgery services provided by a hospital are not inpatient and outpatient hospital services because they ostensibly fall only within the provider class of ambulatory surgical center (ASC) services. However, as explained below, the Departments find that none of the services the Petitioners have identified as ASC services fall within the provider tax class of ASC services. The definition of this provider tax class is "Ambulatory surgical center services, **as described for purposes of the Medicare program** in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures." 42 C.F.R. § 433.56(a)(9) (emphasis added). Thus, unlike any of the other provider tax classes, the ASC services tax class solely includes ASC facility services as defined by Medicare. Medicare defines ASC "facility services" as "services that are furnished in connection with covered surgical procedures performed in an ASC as provided in §416.164(a) for which payment is included in the ASC payment established under §416.171 for the covered surgical procedure." 42 C.F.R. § 416.2. Medicare defines as ASC as:

> any **distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization** and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part.

Id. (emphasis added). Accordingly, the provider tax class of ASC services includes only services provided by a "distinct entity" that operates "exclusively" for providing ambulatory surgical services, unlike hospitals, which are authorized to provide a wide variety of services. As such, no services provided by a hospital can fall within the provider tax class of ASC services.[162] Given

[162] The Medicare Claims Processing Manual elaborates upon this point. Specifically, said Manual provides that an ASC "operated by a hospital (i.e., under the common ownership, licensure or control of a hospital" must meet several criteria in order to provide and be reimbursed for providing ASC services. Medicare Claims Processing Manual, Chapter 14, § 10.1. Specifically, the manual requires that:

> To participate in Medicare as an ASC operated by a hospital, a facility:

that all of the services at issue were provided by Petitioner Hospitals, none of said services fall within the provider tax class of ASC services.[163]

The services that the Petitioners claim are ASC services meet the Medicaid definition of inpatient and outpatient hospital and therefore fall within the provider tax classes of (inpatient and) outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are ASC services were not properly subject to the Hospital User Fee.

ix. The services that the Petitioners' claim are ambulance services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are ambulance services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are ambulance, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) ordinarily furnished to inpatients or outpatients, (2)

- Elects to do so.
- Is a **separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital** with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
- Meets all the requirements with regard to health and safety, and **agrees to the assignment, coverage and payment rules applied to independent ASCs**; and
- Is surveyed and approved as complying with the conditions for coverage for ASCs in 42 CFR 416.25-49.

Id. (emphasis added). In addition, a hospital-operated ASC must agree that it "participates [in Medicare] and is paid only as an ASC." 42 C.F.R. § 416.30(f)(3). Separately, if a hospital-operated ASC decides to participate in Medicare as a department of the hospital, then "the hospital must comply with CMS requirements to certify the hospital-operated facility as a provider-based department of the hospital as described in 42 CFR 413.65, including meeting all of the hospital conditions of participation specified in 42 CFR 482." Medicare Claims Processing Manual, Chapter 14, § 10.1. In that situation, all of the hospital-operated ASC's services would fall within the provider tax class of outpatient hospital services, not ASC services. As described above, all of the Petitioners affirmed to OHCA and the Departments that they reported only revenues to OHCA that are from the hospital itself, not any subsidiaries or affiliate entities. Therefore, the Departments find that all the services reported by the Petitioners as falling with the ASC services provider tax class instead fall only within the outpatient hospital services provider tax class (or if the services were provided in the inpatient hospital setting, then such services fall within the inpatient hospital services provider tax class).

[163] In their letter dated August 29, 2016, the Petitioners counter-designated the DRS ASC Gross Receipts Tax Registration Notice for inclusion in the record. R. at 1376. Said notice is not relevant to this appeal. DRS has determined that hospital departments are not subject to Connecticut's provider tax on ASCs, which further confirms that ambulatory surgical services provided by a hospital fall only within the outpatient hospital services provider tax class, not the ASC provider tax class.

furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list HCPCS codes they claim are ambulance services rather than inpatient or outpatient hospital services. For example, the Petitioners claim that HCPCS code S0208, which pertains to "paramedic intercept, hospital-based ALS service (non-voluntary, non-transport)," is not an inpatient or outpatient hospital service. Essentially, hospitals use this billing code in order to receive reimbursement for providing advanced life support services to patients at the scene of an incident. The charge is for the advanced life support services, not the transportation. However, the very definition of this billing code suggests that this service can only be provided by hospitals. That service is ordinarily furnished to outpatients, is furnished under the direction of a physician (because the entire hospital is required to be under the direction of a medical staff directed by physicians, as discussed above), and is furnished by a Petitioner hospital. This service therefore meets the definition of outpatient hospital services in 42 C.F.R. § 440.20(a). The Departments find that the other billing codes that the Petitioners claim are for ambulance services are similar to this example. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definition of outpatient hospital services.

Regardless of whether these services may also fall into emergency ambulance services, these services still fall within the provider tax class of outpatient hospital services. Accordingly, consistent with CMS guidance, such services are properly subject to the Hospital User Fee. As further support for this position, the regulations in 42 C.F.R. §§ 440.20(a) and 42 C.F.R. § 440.170(a)(1) demonstrate that the provider tax classes of emergency ambulance services and outpatient hospital services overlap. The federal tax class regulation in 42 C.F.R. § 433.56(a)(18) simply includes the phrase "emergency ambulance services" without any further definition. 42 C.F.R. § 433.56. The only potentially applicable Medicaid service category definition is simply that "'Transportation' includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary." 42 C.F.R. § 440.170(a)(1). For outpatient hospital services, as discussed above, they must simply provided by the hospital, not necessarily in the hospital. In order to operate an ambulance in Connecticut, a provider must have a license from DPH, but there is nothing to preclude a hospital from simultaneously having both a hospital license and an ambulance license. As explained above, the provider tax class of outpatient hospital services is extremely broad. So long as the ambulance service otherwise meets the requirements of outpatient hospital services, it can simultaneously fall within both categories.

The services that the Petitioners claim are ambulance services meet the Medicaid definition of inpatient and outpatient hospital and therefore fall within the provider tax classes of outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are ambulance service were not properly subject to the Hospital User Fee.

x. The services that the Petitioners' claim are home health services meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather are home health services. The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services and are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that are home health services, not inpatient or outpatient hospital services. As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee. See 42 C.F.R. §§ 440.10 and 440.20(a).

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes they claim are home health services rather than inpatient or outpatient hospital services. For example, the Petitioners claim that revenue code 570 (home health aide), is not an inpatient or outpatient hospital service. However, home health aides are only assigned to patients as part of a treatment plan developed by a physician. Physicians in hospitals commonly develop these plans in order to discharge patients from hospitals. Moreover, as revenue codes are only used by hospitals, it will only ever be a hospital that provides the service associated with this revenue code. Accordingly, if a Petitioner Hospital charged using revenue code 570, said service was (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee.

As another example, the Petitioners claim that CPT code G0151 which is the code for a "[s]ervice performed by a qualified physical therapist in the home health or hospital setting, each 15 minutes," is not an inpatient or outpatient hospital service. As with home health aides, physical therapy is prescribed by a physician as part of an overall treatment plan. Accordingly, if a Petitioner Hospital charged using CPT code G0151, said service was (1) ordinarily furnished to inpatients or outpatients,[164] (2) furnished under the direction of a physician, and (3) furnished in

[164] Federal Medicaid regulations define "outpatient" as "a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight." 42 C.F.R. § 440.2(a). Because all of these services were inherently provided by a Petitioner Hospital (otherwise the hospital would not be reporting revenues associated with said services), the individual receiving the services is a patient of the hospital, which is an organized medical facility, even if the services themselves were provided at a setting other than the hospital, such as the patient's home or other community setting. In addition, as noted above, the definitions of some of the codes listed by the Petitioners as falling within home health are broad and some of those codes are services that could be provided either in the hospital or in the patient's home or other community setting. For all of those reasons, therefore, individuals who receive the services listed by the Petitioners as being home health services are patients of the hospital and therefore meet the definition of "outpatient" in 42 C.F.R.

or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee. The Departments find that the other billing codes that the Petitioners claim are for home health services are similar to this example. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definition of outpatient hospital services.

Additionally, the Petitioners claim certain hospice services are home health services rather than inpatient hospital services or outpatient hospital services. In particular, one Petitioner identified revenue codes 115 and 125 as pertaining to home health services rather than inpatient or outpatient hospital services. Hospitals use those two revenue codes to charge for private and semi-private room and board for patients receiving hospice care. Hospice care is generally palliative care provided under the direction of a doctor. Moreover, as revenue codes are only used by hospitals, it will only ever be a hospital that provides the service associated with these revenue codes. Accordingly, if a Petitioner Hospital charged using revenue codes 115 and 125, said service was (1) ordinarily furnished to inpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. As such, these services are properly subject to the Hospital User Fee.

Regardless of whether these services may also fall into home health services, these services fall within the provider tax class of outpatient hospital services (and for inpatient hospice services and perhaps other services as well, also inpatient hospital services). Accordingly, consistent with CMS guidance, such services are properly subject to the Hospital User Fee. As further support for this position, the regulations demonstrate that the provider tax classes of home health services and outpatient hospital services overlap. As described above, the federal provider tax class of outpatient hospital services is very broad and overlaps with many other categories. The relevant portions of the federal Medicaid benefit category definition of home health services include:

> (a) … services … provided to a beneficiary—
> (1) At his place of residence, as specified in paragraph (c) …; and
> (2) On his or her physician's orders as part of a written plan of care….
>
> (b) Home health services include the following ….
> (1) Nursing service …,
> (2) Home health aide service provided by a home health agency,
> (3) Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place….
> (4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency….
>
> (c) A beneficiary's place of residence, for home health services, does not include a hospital …. (1) Nothing in this section should be read to prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place, other than a hospital ….

§ 440.2(a), which is incorporated by reference into the definition of outpatient hospital services in 42 C.F.R. § 440.20(a).

42 C.F.R. § 440.70. Home health agency, in turn, is defined as "a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare." Id. For outpatient hospital services, there is potential overlap between the service categories to the extent that the service meets the various conditions both for outpatient hospital services and home health services.

There is no overlap between home health services and inpatient hospital services because home health services cannot be provided in a hospital but inpatient hospital services are required to be performed in a hospital. It appears, however, that the Petitioners claim that hospice services are home health services. The Departments do not believe that they are, regardless, as set forth above, inpatient hospice services provided in or by a hospital meet the definition of inpatient hospital services, and, similarly, outpatient hospice services provided in or by a hospital meet the definition of outpatient hospital services. Thus, hospice services reported by one or more Petitioners also fall within the provider tax classes of inpatient or outpatient hospital services, as applicable.

The services that the Petitioners claim are home health services meet the Medicaid definition of inpatient and outpatient hospital and therefore fall within the provider tax classes of inpatient and outpatient hospital services. For all of these reasons, the Departments determine that the Petitioners have failed to prove by clear and convincing evidence that the services they claim are home health services were not properly subject to the Hospital User Fee.

xi. The services that the Petitioners' claim fall within the provider tax class of 42 C.F.R. § 433.56(a)(19) meet the Medicaid definition of inpatient and outpatient hospital services and are, therefore, properly considered inpatient and outpatient hospital services.

The Petitioners alleged that the Departments have taxed them on certain services, which they claim are not inpatient or outpatient hospital services, but rather fall within the provider tax class of 42 C.F.R. § 433.56(a)(19).[165] The Petitioners claim that such services fall outside the provider tax classes of inpatient or outpatient hospital services are not properly subject to the Hospital User Fee. As evidence, the Petitioners have provided the Departments with a list of hospital billing codes that they claim represent services that fall within the provider tax class of 42 C.F.R. § 433.56(a)(19). As set forth below, all of the services identified by the Petitioners meet the Medicaid definitions of inpatient or outpatient hospital services as said services are (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). As such, these services are properly subject to the Hospital User Fee.

More specifically, in the Petitioners' responses to the Departments' Request for Information questions 9, 20, 31, and 42, the Petitioners list a variety of revenue service codes and CPT codes they claim fall within the provider tax class of 42 C.F.R. § 433.56(a)(19) rather than inpatient or

[165] The federal regulations describe this category as follows: "Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following: (i) The fee must be broad based and uniform or the State must receive a waiver of these requirements; (ii) The payer of the fee cannot be held harmless; and (iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program." 42 C.F.R. § 433.56(a)(19).

outpatient hospital services. For example, the Petitioners claim that revenue code 943, which is for "cardiac rehabilitation" is not an inpatient or outpatient hospital service. Cardiac rehabilitation refers to an outpatient treatment plan put in place by a patient's doctor to assist a patient in recovering from heart conditions. Such plans are routinely put in place in order to discharge patients from hospitals. Physicians in hospitals commonly develop these plans in order to discharge patients from hospitals. Moreover, as revenue codes are only used by hospitals, it will only ever be a hospital that provides the service associated with this revenue code. Accordingly, if a Petitioner Hospital charged using revenue code 570, said service was (1) ordinarily furnished to inpatients or outpatients, (2) furnished under the direction of a physician, and (3) furnished in or by a Petitioner Hospital.

As another example, the Petitioners claim that CPT code 77470 which is for radiation therapy is not an inpatient or outpatient hospital service. Radiation therapy is a "special treatment procedure (e.g., total body irradiation, hemibody radiation per oral or endocavitary irradiation)." Such therapy is commonly prescribed by doctors to treat cancer and treatment is typically performed at a hospital. Accordingly, it is clear that this service is an inpatient or outpatient hospital service because it is routinely provided to inpatients or outpatients, as applicable, is furnished by or under the direction of a physician, and is furnished in or by a Petitioner Hospital. See 42 C.F.R. §§ 440.10 and 440.20(a). The Departments find that the other billing codes that the Petitioners claim fall within the provider tax class of 42 C.F.R. § 433.56(a)(19) are similar to these examples. Accordingly, this same analysis applies to all such codes and all such codes similarly meet the definition of inpatient or outpatient hospital services, as applicable. Therefore, all of these services fall within the provider tax classes of inpatient or outpatient hospital services and were properly subject to the Hospital User Fee.[166]

F. Conclusion

Given the foregoing, the Departments find that Petitioners have not established by clear and convincing evidence that any of the services subject to tax under the Hospital User Fee do not fall within the provider tax classes of inpatient and outpatient hospital services pursuant to 42 C.F.R. §§ 433.56(a)(1) and (2). Accordingly, the Departments hold that the Hospital User Fee has not been implemented in a manner inconsistent with Chapter 211a of the Connecticut General Statutes or Title XIX of the Social Security Act, which governs the Medicaid program (specifically 42 U.S.C. § 1396b(w), which details federal Medicaid requirements for provider taxes).

[166] In their Petitions, the Petitioners allege that revenue from "at least the following classes of services…physician services; home health care services, outpatient prescription drugs; ambulatory surgical centers; dental services; podiatric services; psychological services; therapist services; laboratory and x-ray services; and emergency ambulance services" was improperly taxed. R. at 16-17, 37. In their Brief, the Petitioners addressed each of these provider tax classes but did not address any other provider tax classes listed in 42 C.F.R. § 433.56(a). Because neither the Petitions nor the Brief addressed any other provider tax class, the Departments determine that the Petitioners have waived any arguments regarding any of those provider tax classes and decline to address any arguments regarding those provider tax classes in this Declaratory Ruling.

5. The Departments have not administered the Hospital User Fee in an arbitrary and capricious manner, nor have they abused the discretion afforded to them under Chapter 211a of the Connecticut General Statutes.

The Petitioners have alleged that the Departments' "overall administration, collection, and enforcement of the [Hospital User Fee] is arbitrary and capricious and therefore unenforceable." R. at 17, 39. As support for this claim, the Petitioners largely restate the arguments made in support of their first, second, and fourth questions claiming that the Departments' administration of the Hospital User Fee is arbitrary and capricious because (1) the Departments administered the Hospital User Fee despite the fact that it includes an unconstitutional delegation of authority, (2) the Departments' administration violated the UAPA, and (3) the Departments imposed the Hospital User Fee on services not properly subject to the tax. See R. at 18, 39-40. Additionally, the Petitioners alleged that "DSS's action in obliterating the supplemental pool fundamentally alters the legislative intent of the Act and therefore constitutes an arbitrary decision by the state." R. at 18. As set forth more fully below, the Departments find that neither DRS nor DSS acted beyond the scope of their statutory mandate. As such, neither Department acted in an arbitrary or capricious manner.

A. It is the Petitioners' burden to demonstrate that the Departments have acted in an arbitrary or capricious manner or abused their discretion in implementing the Hospital User Fee.

The Petitioners' challenge appears to be raised using the legal standard provided in Conn. Gen. Stat. § 4-183, which is the statute that authorizes appeals from state agency final decisions to Superior Court. In particular, subsection (j) of that statute provides as follows:

> The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The court shall affirm the decision of the agency unless the court finds that substantial rights of the person appealing have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: (1) In violation of constitutional or statutory provisions; (2) in excess of the statutory authority of the agency; (3) made upon unlawful procedure; (4) affected by other error of law; (5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or **(6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.** If the court finds such prejudice, it shall sustain the appeal and, if appropriate, may render a judgment under subsection (k) of this section or remand the case for further proceedings. For purposes of this section, a remand is a final judgment.

Conn. Gen. Stat. § 4-183(j) (emphasis added).[167]

[167] As referenced in Conn. Gen. Stat. § 4-183(j), an agency's actions are entitled to deference. To that end, the Connecticut Supreme Court has explained that the courts "must uphold the [agency's] decision if any of those reasons [for its actions] are sufficient to justify the action taken." Griffin Hosp. v. Comm'n on Hosp. & Health Care, 200 Conn. 489, 498 (1986) (citations omitted). Further, "the substantial evidence rule governs judicial review of administrative fact-finding under the UAPA…An administrative finding is supported by substantial evidence if the

The burden of proof in such a challenge falls on the Petitioners: "[i]t is fundamental that a plaintiff has the burden of proving that the commissioner, on the facts before him, acted contrary to law and in abuse of his discretion. . .. The law is also well established that if the decision of the commissioner is reasonably supported by the evidence it must be sustained. . .." Demma v. Comm'r of Motor Vehicles, 165 Conn. 15, 16–17, 327 A.2d 569, 570 (1973). Accordingly, it is the Petitioners' burden to demonstrate that the Departments have acted in an arbitrary or capricious manner or abuse their discretion in implementing the Hospital User Fee.

B. The Departments are required to act within the scope of their statutory mandates.

In order to determine whether the Departments have acted in an arbitrary or capricious manner or abused their discretion, it is first necessary to review the scope of each Department's authority to act under the Hospital User Fee.

The Departments are state agencies; see Conn. Gen. Stat. §§ 12-1a and 17b-1; and, "therefore, [are] bod[ies] of limited authority that can act only pursuant to specific statutory grants of power. . .. 'It is well established that an administrative agency possesses no inherent power. Its authority is found in a legislative grant, beyond the terms and necessary implications of which it cannot lawfully function.' . . . In the absence of a grant of authority from the legislature, any action taken by an agency is 'void.'" Pereira v. State Bd. of Educ., 304 Conn. 1, 40–41, 37 A.3d 625, 649–50 (2012) (internal citations omitted).[168]

As a corollary to this principle, state agencies must perform all functions statutorily mandated. Failure to do so would be to act contrary to statute. For example, the Commissioner of Revenue

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record affords a substantial basis of fact from which the fact in issue can be reasonably inferred." Cadelrock Properties Joint Venture, L.P. v. Comm'r of Envtl. Protection, 253 Conn. 661, 676 (2000) (internal citations and quotation marks omitted). Moreover, "Even as to questions of law, [t]he court's ultimate duty is only to decide whether, *in light of the evidence*, the [agency] has acted unreasonably, arbitrarily, illegally or in abuse of its discretion." Rocque v. Freedom of Information Comm'n, 255 Conn. 651, 658 (2001) (emphasis in original; citations omitted). As noted above, the individual challenging an agency's decision bears the burden of proving that it is arbitrary, capricious, illegal, or an abuse of discretion. See O'Sullivan v. DelPonte, 27 Conn. App. 377, 382 (1992) (citations omitted).

[168] The Connecticut Supreme Court has long held that state agencies

> "'must act strictly within [their] statutory authority, within constitutional limitations, and in a lawful manner.' " . . .. In like manner, " '[n]o administrative or regulatory body can modify, abridge or otherwise change the statutory provisions under which it acquires authority unless the statute specifically grants it that power.' " . . ..

Lundy Elecs. & Sys., Inc. v. Connecticut State Tax Com'r, 189 Conn. 690, 694–95, 458 A.2d 387, 390 (1983) (citations omitted); see also Tilcon Connecticut, Inc. v. Comm'r of Envtl. Prot., 317 Conn. 628, 648, 119 A.3d 1158, 1170 (2015) ("'Administrative agencies ... are tribunals of limited jurisdiction and their jurisdiction is dependent entirely upon ... the statutes vesting them with power and they cannot confer jurisdiction upon themselves.... We have recognized that [i]t is clear that an administrative body must act strictly within its statutory authority, within constitutional limitations and in a lawful manner.... It cannot modify, abridge or otherwise change the statutory provisions ... under which it acquires authority unless the statutes expressly grant it that power.' . . .We must therefore interpret the statutory provisions under which the department acquires its authority.").

Services cannot simply refuse to collect income tax properly due. Similarly, nor can the Commissioner of Social Services refuse to pay a physician for providing a covered service to a Medicaid member, so long as the physician, the service, and the member comply with applicable requirements. To that end, in the performance of their statutory duties, the Departments are required to presume that the statutes which they are charged with administering are constitutional. See Rayhall v. Akim Co., 263 Conn. 328, 337, 819 A.2d 803, 810 (2003) ("It is well settled under the common law that adjudication of the constitutionality of legislative enactments is beyond the jurisdiction of administrative agencies."); Giaimo v. City of New Haven, 257 Conn. 481, 494, 778 A.2d 33, 43 (2001) ("Finally, in seeking to ascertain the intent of the legislature ... we are guided by the golden rule of statutory interpretation ... that the legislature is presumed to have intended a reasonable, just and constitutional result.").

In order to determine whether the Departments acted beyond the scope of their statutory authority, it is necessary to understand the scope of each Departments' authority under the Hospital User Fee. To that end, under Conn. Gen. Stat. § 12-263b, as described more fully in Ruling 1, DSS was statutorily required to calculate the amount of user fee each hospital was obligated to pay based on the net patient revenue of each of the hospitals. Additionally, as set forth above, the General Assembly required DSS to calculate the Hospital User Fee to ensure that it generated sufficient funds to meet the revenue estimates set forth in each state budget. Finally, DSS had to ensure that governmental, psychiatric, specialty, and children's hospitals were exempt from the Hospital User Fee and financially distressed hospitals were exempt from paying user fee on accrued payments earned by a hospital for the provision of outpatient hospital services. DSS's calculations were required to comply with federal Medicaid requirements.[169]

[169] Conn. Gen. Stat. § 12-263a provides, in pertinent part, that:

> (a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. **The rate of such tax shall be up to the maximum rate allowed under federal law and in conformance with the state budget adopted by the General Assembly. Each hospital shall be promptly notified of the amount of tax due by the Commissioner of Social Services. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed in order to ensure conformance with the state budget adopted by the General Assembly. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship**. Effective July 1, 2012, and for the succeeding fifteen months, the rates of such tax, the base year on which such tax shall be assessed, and the hospitals exempt from the outpatient portion of the tax based on financial hardship shall be the same tax rates, base year and outpatient exemption for hardship in effect on January 1, 2012.
>
> (b) Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue as determined by the Commissioner of Social Services. Payment shall be made with such return. Each hospital shall file such return electronically with the department and make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether the hospital would otherwise have been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

Conn. Gen. Stat. § 12-263b (emphasis supplied). Additionally, Conn. Gen. Stat. § 12-263a provides as follows:

Additionally, by statute, DRS had a limited role in the implementation of the Hospital User Fee. Specifically, DRS was charged with the collection of the Hospital User Fee from the hospitals. See Conn. Gen. Stat. § 12-263b ("Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue as determined by the Commissioner of Social Services. Payment shall be made with such return. Each hospital shall file such return electronically with the department.").

With the above as background, the Departments address each of the Petitioners' charges that the Departments acted arbitrarily or capriciously.

C. The Departments did not act beyond the scope of authority set forth in Chapter 211a to implement the Hospital User Fee.

First, the Petitioners assert that DSS "lacks the authority to set the tax rate for [the] Hospitals Tax" and that "[i]ts decision to do so without the proper authority is arbitrary and capricious and an abuse of discretion." R. at 18. The Petitioners further assert that "DRS collected and enforced the Hospitals Tax despite DSS lacking the proper authority to set the tax rate and tax base year of the Hospitals Tax. . .. DRS, which is charged by statute to administer and interpret all taxes under Title 12, has an obligation to confirm that DSS's authority is legitimate."[170] R. at 39. As explained more fully in Ruling 1 and as summarized below, DSS did not set the tax rate for the Hospital User Fee.

> As used in sections 12-263a to 12-263e, inclusive:
>
> (1) "Hospital" means any health care facility or institution, as defined in section 19a-630, which is licensed as a short-term general hospital by the Department of Public Health but does not include (A) any hospital which, on October 1, 1997, is within the class of hospitals licensed by the department as children's general hospitals, or (B) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant to chapter 920;
>
> (2) "Net patient revenue" means the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services;
>
> (3) "Commissioner" means the Commissioner of Revenue Services;
>
> (4) "Department" means the Department of Revenue Services.

Conn. Gen. Stat. § 12-263a.

[170] The Departments note that the Petitioners' statement here is inaccurate and attempts to imbue the Commissioner of Revenue Services with powers that he simply does not have. First, the Commissioner of Revenue Services does not have authority to administer and interpret all taxes under Title 12. The Commissioner of Revenue Services does not implement Chapters 203, 203a, 204, 204a, 205, 206, 226, 226a, 226b, 229a of Title 12. Additionally, the Commissioner of Revenue Services is not charged with certain aspects of the administration of certain tax credits under Chapter 208. Second, nowhere in the Connecticut General Statutes is the Commissioner of Revenue Services charged with policing the actions of other state agencies or municipalities that are charged with implementing taxes under the Connecticut General Statutes. For example, the Commissioner of Revenue Services has no role in ensuring that municipalities appropriately levy the property taxes set forth in Chapter 203. The suggestion that other state agencies are required to report to the Commissioner of Revenue Services regarding the implementation of taxes said state agencies are charged with implementing conflicts with the proper role and function of state agencies in implementing the statutes that they are charged to implement.

DSS merely calculated the amount of user fee due from each taxpayer. As such, DSS could not have acted arbitrarily or capriciously by setting the tax rate. Accordingly, DRS did not act arbitrarily or capriciously in collecting and enforcing the Hospital User Fee.

i. DSS did not set a tax rate for the Hospital User Fee and, therefore could not have acted arbitrarily and capriciously by doing so.

The Petitioners have claimed that DSS acted arbitrarily and capriciously by setting the tax rate of the Hospital User Fee when it lacked authority to do so. DSS did not set the tax rate of the Hospital User Fee. Rather, DSS acted within the scope of its statutory mandate and calculated the amount of user fee due from each taxpayer.

As explained in Ruling 1, DSS did not set the tax rate for the Hospital User Fee. The General Assembly set the tax rate by setting forth in statute a formula by which the Hospital User Fee would be calculated. Specifically, through the statutory language in Chapter 211a of the Connecticut General Statutes, the state budget (including the revenue estimates), as well as incorporating federal Medicaid requirements by reference, the General Assembly set up a tightly defined framework for the Hospital User Fee. Because DSS was required to implement the Hospital User Fee within that framework, DSS simply needed to calculate the specific amount of user fee owed by each hospital. As explained above, the General Assembly confirmed this intention in the recently adopted clarifying legislation. 2016 Conn. Pub. Acts 3, May spec. sess., §§ 119-121.

Thus, the language of Chapter 211a of the Connecticut General Statutes, as amended, gives DSS statutory authorization to implement the Hospital User Fee. Additionally, DSS is also "authorized to do all things necessary to…qualify for and accept any federal funds…" Conn. Gen. Stat. § 17b-3(b). Relatedly, as Connecticut's state Medicaid agency, DSS is "authorized to take advantage of [the Medicaid program]… and may administer the same in accordance with all the requirements provided therein…" Conn. Gen. Stat. § 17b-260. In order to ensure the Hospital User Fee was implemented in compliance with federal Medicaid requirements—and to ensure that the state's Medicaid FFP would not be penalized by CMS for non-compliance with those requirements—these statutes also give DSS the authority to implement the Hospital User Fee. In particular, it was necessary for DSS calculate the specific amount of tax that each hospital would be required to pay in order to ensure that the Hospital User Fee complied with federal Medicaid provider tax requirements and to prepare the necessary package for requesting the waivers from CMS in 2011 and 2015 to approve the exemptions of the categories of hospitals specifically exempted from the tax. See R. at 632-52. As a necessary component of those actions, DSS also needed to calculate the tax rate that was required by the General Assembly in order to conform to the tight specifications for the tax described above. In addition, as discussed above, DSS needed to calculate the specific tax amounts in order to perform the required P1/P2 statistical test to show that the tax is generally redistributive and also to demonstrate to CMS that there is no direct correlation between tax amounts and supplemental payments and increased DSH payment amounts to the hospitals. Although already authorized by Chapter 211a as discussed above, DSS also had separate statutory authority to perform those functions from Conn. Gen. Stat. §§ 17b-3(b) and 17b-

260 in order to preserve federal Medicaid funding and avoid having the state's FFP penalized by CMS.[171]

Because DSS's authority was limited only to implementing the Hospital User Fee as dictated by the General Assembly through the various factors described above, DSS simply performed the necessary actions to implement the tax in the manner prescribed by the General Assembly. To that end, as set forth more fully in the Facts, DSS acted as charged by the General Assembly in Chapter 211a and calculated the amount of user fee due from the taxpayers consistent with its statutory mandate.[172]

Furthermore, the Petitioners have not provided any evidence that DSS went beyond the scope of its statutory mandate and arbitrarily or capriciously set the tax rate. For example, as set forth extensively above, the General Assembly charged DSS with calculating the tax due from each hospital such that the total would equal $349.1 million annually for SFY 2012-2015 and $556 million annually for SFY 2016-2017. DSS complied with this obligation and calculated the amount of fee due from each hospital to equal $349.1 million annually for SFY 2012-2015 and

[171] In addition to Conn. Gen. Stat. §§ 17b-3(b) and 17b-260, even if Chapter 211a did not explicitly give DSS the limited authority necessary to implement the Hospital User Fee in accordance with the detailed parameters as set forth by the General Assembly, other statutes also confer this authority on DSS. Specifically, DSS also has general statutory authority to "administer services to achieve the purposes of the department as established by statute." Conn. Gen. Stat. § 17b-3(a)(4). Thus, DSS had the authority to calculate the amount of tax due within the parameters set forth by the General Assembly because those actions amount to administration of services necessary to achieve the purposes set forth in Chapter 211a to raise revenue while complying with federal Medicaid requirements.

[172] By way of example, in 2011, consistent with DSS's obligation to calculate the amount of user fee due by determining the amount of net patient revenue each taxpayer had in each year, DSS reviewed the twelve month actual reports of the hospitals for FFY 2009. Under Conn. Gen. Stat. § 12-263b, net patient revenue is defined to be "the amount of accrued payments earned by a hospital for the provision of inpatient and outpatient services." As the twelve month actual reports included certified disclosures by the hospitals of their net patient revenue including "inpatient and outpatient accrued payments," DSS used the information set forth therein to determine how much net patient revenue a hospital had in a given year.

As certain hospitals were specifically exempt from the Hospital User Fee under Conn. Gen. Stat. §§ 12-263a and 12-263b, DSS was required to calculate the amount of Hospital User Fee to both exempt the categories of hospitals as set forth in Chapter 211a and comply with the broad-based requirements of the federal Medicaid provider tax statute and regulations. DSS was also required to request a waiver of the broad-based requirements from CMS. Accordingly, using the data from the twelve month actual filings submitted to OHCA, DSS conducted several calculations in order to apply for a waiver from CMS. As part of the waiver application process DSS performed the P1/P2 test, which showed that the user fee was generally redistributive despite exempting certain hospitals. R. at 632-39. The results of said test were set forth in a waiver application DSS submitted to CMS on June 7, 2011.

Additionally, as part of the waiver application process, DSS was required to demonstrate that the Hospital User Fee and associated Medicaid payments did not hold the taxpayers harmless for the tax either directly or indirectly. Accordingly, DSS included in the waiver application the use of the proceeds of the user fee and payments made to the hospitals in order to demonstrate that those payments did not hold harmless any taxpayer directly or indirectly as payments were not directly correlated to the tax. R. at 632-39.

CMS approved DSS's waiver application effective July 1, 2011. R. at 640-41. Accordingly, DSS calculated the amount of Hospital User Fee due from each of the hospitals subject to the user fee in a manner consistent with CMS's waiver approval. Specifically, DSS apportioned the total revenue that need to be raised from the Hospital User Fee consistent with each hospitals' net patient revenue for FFY 2009 and the distribution that the user fee had to comply with (when also considering the supplemental payments and increased DSH payments) in order to avoid containing a hold harmless provision. On September 30, 2011, DSS notified the hospitals by email of their required tax amounts for SFY 2012-2013. R. at 586-89.

$556 million annually for SFY 2016-2017. The Petitioners have not provided any evidence to demonstrate that DSS substituted its own authority for that of the General Assembly and calculated the tax due to achieve a figure higher or lower than what the General Assembly set forth in the revenue estimates. Stated another way, DSS did not calculate the Hospital User Fee so that it would generate no revenue or so that it would generate billions of dollars. Rather, DSS calculated the Hospital User Fee so that it would generate the amount of revenue dictated by the General Assembly.

Finally, the Petitioners assert that DSS exercised its limited authority in a manner that violates the separation of powers in the Connecticut Constitution. As described in Ruling 1 of this Declaratory Ruling, the Departments find that the General Assembly did not unconstitutionally delegate to DSS the authority to set the tax rate. The Departments reached that finding after examining the relevant facts and determined that the General Assembly prescribed all of the parameters of the Hospital User Fee through a formulaic tax rate for the reasons described above. Thus, the General Assembly did not delegate this authority to DSS at all. Rather, it set a series of tight parameters that DSS was required to follow in order to implement the Hospital User Fee. Therefore, the Departments similarly find that DSS did not exercise its authority in violation of separation of powers in the Connecticut Constitution because the General Assembly retained its legislative authority and DSS was implementing the parameters set forth by the General Assembly. This role is consistent with the constitutional role of the executive branch to implement policies established by the legislative branch.

Irrespective of whether the General Assembly properly or improperly delegated authority to DSS, DSS as a state agency is required to presume that the statutes that it is charged with enforcing are constitutional unless told otherwise by the Attorney General or a court. As such, DSS is required to perform those functions it is charged with performing under statute. To do otherwise would be to act arbitrarily and capriciously beyond the scope of DSS's statutory mandate. Accordingly, the Departments find that DSS implemented the Hospital User Fee in a manner that is neither arbitrary, nor capricious, nor did DSS abuse its discretion.

ii. DRS did not act arbitrarily or capriciously or abuse its discretion in collecting the Hospital User Fee DSS calculated.

The Petitioners claim that DRS should not have collected or enforced the Hospital User Fee because DSS did not have authority to set the tax rate and base claiming "DRS, which is charged by statute to administer and interpret all taxes under Title 12, has an obligation to confirm that DSS's authority is legitimate."[173] R. at 39. As set forth above, DSS did not set the tax rate or base of the Hospital User Fee, so the basis upon which the Petitioners' claim is predicated is faulty. Moreover, the Commissioner of Revenue Services acted appropriately within the scope of his statutory mandate as set forth in Conn. Gen. Stat. §§ 12-263b, 12-263c, and 12-263d.

As set forth above, DRS had a limited role in the implementation of the Hospital User Fee. Specifically, DRS's role was as follows:

[173] Irrespective of whether DSS acted properly, which the Departments believe it did, the Departments are unclear as to how DRS could be deemed to have acted arbitrarily or capriciously based on actions taken by another state agency.

> Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue as determined by the Commissioner of Social Services. Payment shall be made with such return. Each hospital shall file such return electronically with the department.

Conn. Gen. Stat. § 12-263b(b). Conn. Gen. Stat. §§ 12-263c[174] and 12-263d[175] further prescribe that DRS is responsible for issuing assessments in circumstances were taxpayers fail to file returns

[174] Conn. Gen. Stat. § 12-263c provides as follows:

> (a) If any hospital fails to pay the amount of tax reported to be due on its return within the time specified under the provisions of section 12-263b, there shall be imposed a penalty equal to ten per cent of such amount due and unpaid, or fifty dollars, whichever is greater. The tax shall bear interest at the rate of one per cent per month or fraction thereof, from the due date of such tax until the date of payment.
>
> (b) If any hospital has not made its return within one month after the time specified in section 12-263b, the Commissioner of Revenue Services may make such return at any time thereafter, according to the best information obtainable and according to the form prescribed. To the tax imposed upon the basis of such return, there shall be added an amount equal to ten per cent of such tax, or fifty dollars, whichever is greater. The tax shall bear interest at the rate of one per cent per month or fraction thereof, from the due date of such tax until the date of payment.
>
> (c) Subject to the provisions of section 12-3a, the commissioner may waive all or part of the penalties provided under this section when it is proven to his satisfaction that the failure to pay any tax on time was due to reasonable cause and was not intentional or due to neglect.
>
> (d) The commissioner shall notify the Commissioner of Social Services of any amount delinquent under sections 12-263a to 12-263e, inclusive, and, upon receipt of such notice, the Commissioner of Social Services shall deduct and withhold such amount from amounts otherwise payable by the Department of Social Services to the delinquent hospital.

Conn. Gen. Stat. § 12-263c.

[175] Conn. Gen Stat. § 12-263d provides as follows:

> (a) The Commissioner of Revenue Services may examine the records of any hospital subject to a tax imposed under the provisions of sections 12-263a to 12-263e, inclusive, as he may deem necessary. If he shall determine therefrom that there is a deficiency with respect to the payment of any such tax due under the provisions of said sections 12-263a to 12-263e, inclusive, he shall assess the deficiency in tax, give notice of such deficiency assessment to the hospital and make demand thereupon for payment. Such amount shall bear interest at the rate of one per cent per month or fraction thereof from the date when the original tax was due and payable. When it appears that any part of the deficiency for which a deficiency assessment is made is due to negligence or intentional disregard of the provisions of said sections 12-263a to 12-263e, inclusive, or regulations adopted thereunder, there shall be imposed a penalty equal to ten per cent of the amount of such deficiency assessment, or fifty dollars, whichever is greater. When it appears that any part of the deficiency for which a deficiency assessment is made is due to fraud or intent to evade the provisions of sections 12-263a to 12-263e, inclusive, or regulations adopted thereunder, there shall be imposed a penalty equal to twenty-five per cent of the amount of such deficiency assessment. No hospital shall be subject to more than one penalty under this subsection in relation to the same tax period. Within thirty days of the mailing of such notice, the hospital shall pay to the commissioner, in cash, or by check, draft or money order drawn to the

or file deficient returns. Essentially, DRS is charged with the collection and enforcement of the Hospital User Fee. DRS complied with these obligations by promulgating guidance regarding how the Hospital User Fee was to be collected and issuing an electronic tax return. Accordingly, DRS has complied with its statutory mandate.

The Petitioners have not provided any evidence that DRS acted outside the scope of its statutory mandate. Rather, the Petitioners have alleged, without support, that DRS should not have collected the Hospital User Fee as it is charged with doing in Conn. Gen. Stat. §§ 12-263b, 12-263c, and 12-263d because the Petitioners believe that the Hospital User Fee violates Article Second of the Connecticut Constitution. The Departments have already ruled that the Hospital User Fee does not violate Article Second of the Connecticut Constitution. Irrespective of this ruling, DRS as a state agency is required to act as if statutes are constitutional unless told otherwise by the Attorney General or a court. Moreover, DRS, as a state agency, is obligated to perform all actions the actions it is charged with by the General Assembly. As such, had DRS acted as the Petitioners urge it should and refused to collect and enforce the Hospital User Fee, DRS would have acted contrary to its statutory mandate and would have acted arbitrarily and capriciously. Accordingly, the Commissioner was precluded from taking the actions that the Petitioners urge it should have taken.

Consistent with the above, the Departments find that neither DSS nor DRS acted arbitrarily or capriciously as DSS did not set the rate of the Hospital User Fee. Rather, each Department acted appropriately within the scope of their statutory mandates.

> order of the Commissioner of Revenue Services, any additional amount of tax, penalty and interest shown to be due.
>
> (b) Except in the case of a wilfully false or fraudulent return with intent to evade the tax, no assessment of additional tax shall be made after the expiration of more than three years from the date of the filing of a return or from the original due date of a return, whichever is later. If no return has been filed as provided under the provisions of section 12-263b, the commissioner may make such return at any time thereafter, according to the best information obtainable and according to the form prescribed. Where, before the expiration of the period prescribed herein for the assessment of an additional tax, a hospital has consented in writing that such period may be extended, the amount of such additional tax due may be determined at any time within such extended period. The period so extended may be further extended by subsequent consents in writing before the expiration of the extended period.
>
> (c) The commissioner may enter into an agreement with the Commissioner of Social Services delegating to the Commissioner of Social Services the authority to examine the records and returns of any hospital subject to the tax imposed under section 12-263b and to determine whether such tax has been underpaid or overpaid. If such authority is so delegated, examinations of such records and returns by the Commissioner of Social Services and determinations by the Commissioner of Social Services that such tax has been underpaid or overpaid shall have the same effect as similar examinations or determinations made by the Commissioner of Revenue Services.

Conn. Gen. Stat. § 12-263d.

D. DSS did not act arbitrarily and capriciously or abuse its discretion in implementing the Hospital User Fee by violating the UAPA as DSS did not violate the UAPA. Accordingly, DRS did not act arbitrarily and capriciously or abuse its discretion by collecting the Hospital User Fee in spite of DSS's alleged violation of the UAPA.

In their second argument within this section, the Petitioners allege that DSS "arbitrarily established the rate of the Hospitals Tax at 6% and the base year to 2013 in violation of the UAPA. Conn. Gen. Stat. § 4-167."[176] The Petitioners also allege that "DRS arbitrarily administered and collected the Hospitals Tax even though the tax rate and base year were impermissible established." As explained in Ruling 2, the Departments find that DSS's actions regarding the implementation of the Hospital User Fee in 2015 did not violate the UAPA. Consequently, there is no basis for the Petitioners' allegations that DSS acted arbitrarily or capriciously by violating the UAPA or that DRS acted arbitrarily or capriciously in collecting the tax in spite of DSS's alleged violation of the UAPA.

In brief, DSS was not required to enact a regulation setting the tax rate and base because the tax rate and base were already set forth in statute. DSS was simply charged with calculating the amount of hospital user fee due from each taxpayer within parameters as set forth by the General Assembly in the language of Chapter 211a of the Connecticut General Statutes, as well as the state budget adopted by the General Assembly for SFY 2016-2017, and the federal Medicaid requirements incorporated by reference by the General Assembly. Such actions do not constitute a regulation, but rather are simply applying a statute to a set of facts. To that end, the General Assembly confirmed in clarifying legislation that calculations and notifications regarding the amount of tax due and setting the base year "do not constitute regulations for purposes of chapter 54 of the general statutes." 2016 Conn. Pub. Acts 3, May spec. sess., § 119.

Therefore, for all of these reasons, DSS was merely following requirements of the General Assembly and, as such, did not need to adopt a regulation. Accordingly, DSS was not required to promulgate a regulation and "provide notice" or "grounds" for its "decision." As DSS did not violate the UAPA in implementing the Hospital User Fee, it did not act arbitrarily or capriciously by doing so. Furthermore, as DSS did not violate the UAPA, the Petitioners have not provided a basis for their allegations that DRS acted arbitrarily or capriciously or abused their discretion in collecting the Hospital User Fee.

E. DSS's prior "actions" regarding the inpatient hospital supplemental payment pools do not affect the validity of the Hospital User Fee. In any case, those actions did not constitute an arbitrary or capricious decision.

In the third argument in this section, the Petitioners assert that "DSS's actions in obliterating the [Medicaid inpatient hospital] supplemental pool fundamentally alters the legislative intent of [chapter 211a of the Connecticut General Statutes] and therefore constitutes an arbitrary decision

[176] The Petitioners only raise this challenge regarding the actions taken by DSS in 2015. Accordingly, the Departments only consider that particular challenge. In any case, if the Petitioners had made similar arguments regarding earlier actions taken by DSS, based on similar reasoning, the Departments find that the earlier actions would also not have been arbitrary, capricious, or a violation of the UAPA.

by the State." R. at 18. The basis for this allegation appears to be that at the time the Petitioners filed the Petitions, they had not received certain supplemental payments.

As a preliminary matter, changes in the supplemental payments are not relevant for determining whether DSS's actions in implementing the Hospital User Fee are lawful. As the General Assembly confirmed in the clarifying legislation, "the primary purpose of the [Hospital User Fee] was to raise revenue from uniquely situated health care providers that receive certain benefits from the state." 2016 Conn. Pub. Acts 3, May spec. sess., § 121. Thus, the primary purpose was to "raise revenue," not, as alleged in the Petitions, "securing federal funds without onerously burdening hospitals." Indeed, as discussed above, federal Medicaid provider tax requirements specifically prohibit the Hospital User Fee from having any direct correlation between amounts that hospitals pay in taxes compared to amounts received in supplemental and other payments nor any other prohibited hold harmless provision. See 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f). Although at the time the Hospital User Fee was first implemented in SFY 2012, as part of the state budget adopted by the General Assembly, the supplemental payments and additional DSH payments exceeded the total amount of tax paid, the General Assembly changed the supplemental payment and DSH amounts. DSS simply implemented the supplemental payments within the scope of the state budget as adopted by the General Assembly, including modifications adopted by the General Assembly. For the Hospital User Fee, on the other hand, as discussed above, the General Assembly kept the structure and amount the same for SFY 2012 through 2015 and only changed the structure beginning in SFY 2016.

Moreover, in addition to not being relevant to the legality of the implementation of the Hospital User Fee, this argument in the DSS Petition is moot because later in SFY 2016 (after the Petitioners filed the Petitions), DSS made inpatient hospital supplemental payments to the hospitals totaling approximately $163 million. See DSS, Medicaid Category of Service Expenditure Report (2016), R. at 1100, 1106; see also SPA 16-013, R. at 3015-17 and SPA 15-042, R. at 1297-1299. Accordingly, the Petitioners' allegation about "DSS's action in obliterating the supplemental pool" is now inaccurate, as the Petitioner Hospitals have already received all supplemental payments to which they are entitled (although they had not yet received those payments at the time the petition was filed). See, e.g., Burbank v. Board of Educ. of Canton, 299 Conn. 833, 838-841 (2011).

To that end, the reduced amount of the supplemental payments for SFY 2016 was adopted by the General Assembly in the December 2015 special session, which confirms that DSS was implementing the direction from the General Assembly.[177] Specifically in section 1 of Public Act 15-1 of the December special session, the General Assembly authorized OPM to "make reductions in allotments…in the following accounts," including a reduction of the DSS Medicaid line item by $34,161,186 each for SFY 2016 and 2017. 2015 Conn. Pub. Acts 1, Dec. spec. sess., § 1.[178]

[177] The issues posed by the Petitioners for the Departments to address relate only to the legality of the Hospital User Fee and do not make any direct challenge to the inpatient hospital supplemental payments or any other payments.

[178] The legislative history confirms the General Assembly's intent in making that reduction. In the House floor debate for that budget adjustment statute, the House Co-Chair of the Appropriations Committee, Rep. Toni Walker, noted that "Some of the expenditures in this bill are the common ground reductions that were… hospital reductions of 30 million…." Conn. House Session Transcript, 12/08/2015. In response to questions from Rep. Srinivasan asking to clarify the total amount of funding reductions, after taking into account federal Medicaid matching funds, Rep. Walker confirmed that: "…at the budget that we passed out in June, the total amount to the hospitals was $ 255 million. In the budget after this year, after the 30 million going back in plus the small hospital pool that we are paying

Thus, the actions that DSS took in making the supplemental payments later in SFY 2016 were explicitly authorized by the General Assembly as part of the budget adjustments made during the December 2015 special session. Accordingly, DSS was simply following the directives of the General Assembly and therefore any DSS decision was neither arbitrary, nor capricious, nor an abuse of discretion.

For all of these reasons, the Departments find that DSS did not "fundamentally alter the purpose" of Chapter 211a of the Connecticut General Statutes because the amount of the supplemental payments is not relevant to determine whether DSS's actions in implementing the Hospital User Fee were lawful. In any case, because DSS was simply implementing the state budget as adopted and later adjusted by the General Assembly, DSS did not act in an arbitrary or capricious manner.

F. The Departments did not act arbitrarily or capriciously or abuse their discretion by imposing the Hospital User Fee on services not subject to the tax.

In their fourth and last argument in this section of the Petitions, the Petitioners essentially repeated their argument in issue 4 of the Petitions by asserting that the Departments acted arbitrarily and capriciously because the Departments collected, enforced, and imposed the Hospital User Fee "on impermissible services that may not be taxed under the federal regulations." R. at 18, 39-40. As set forth in Ruling 4, there is no evidence that the Hospital User Fee was imposed on any services not properly subject to tax. Accordingly, there is no basis for the Petitioners' allegations that the Departments collected, enforced, and imposed the Hospital User Fee "on impermissible services that may not be taxed under the federal regulations."

Specifically, the definition of net patient revenue in Conn. Gen. Stat. § 12-263a incorporates the federal Medicaid definitions of inpatient hospital services and outpatient hospital services in 42 C.F.R. §§ 440.10 and 440.20(a). Said definitions comport with definitions of inpatient hospital services and outpatient hospital services for which the hospitals were required to report accrued payments on the twelve month actual filings they filed with OHCA, which were used to calculate the tax amounts. As such, to the extent that the Petitioner Hospitals properly filled out the OHCA reports, no services should have been taxed impermissibly. Furthermore, the Petitioner Hospitals were granted the opportunity to offer evidence that services were taxed impermissibly. All evidence the Petitioner Hospitals supplied of services potentially subject to the tax demonstrated that said services were inpatient or outpatient hospital services.

Consistent with the above, there is no evidence that the Hospital User Fee was imposed on any services not properly subject to tax. Accordingly, there is no basis for the Petitioners' allegations that the Departments arbitrarily or capriciously collected, enforced, and imposed the Hospital User Fee "on impermissible services that may not be taxed under the federal regulations."

approximately $ 164 million out to the hospitals, it is a reduction of almost $ 100 million." Id. Likewise, the Senate Co-Chair of the Appropriations Committee, Sen. Beth Bye, also referenced the same "hospital reduction of $30 million." Conn. Sen. Session Transcript, 12/08/2015. As noted elsewhere in the legislative history, the approximately $30 million reduction refers to the state share of Medicaid funds, not counting the federal matching funds or FFP.

G. The Petitioners have not provided any evidence that the Departments acted in an arbitrary or capricious manner or abused their discretion. Rather, all evidence demonstrates that the Departments acted within the scope of their statutory mandate.

For all of the reasons discussed above, the Departments find that the Departments' administration of the Hospital User Fee was neither arbitrary, nor capricious, nor an abuse of discretion—and not subject to being overturned pursuant to Conn. Gen. Stat. § 4-183.

OVERALL CONCLUSION

For all of the reasons explained above, the Departments rule in the negative regarding all of the questions presented by the Petitioners in their Petitions for declaratory ruling regarding the Hospital User Fee.

Respectfully submitted,

DEPARTMENT OF REVENUE SERVICES

By: _____
Kevin B. Sullivan
Commissioner

September 22, 2016

DEPARTMENT OF SOCIAL SERVICES

By: _____
Roderick L. Bremby
Commissioner

September 22, 2016

CERTIFICATION

I, Erica C. McKenzie, certify that a copy of the Department of Revenue Services and Department of Social Services Declaratory Ruling regarding the Hospital User Fee was sent on September 22, 2016, to all of the following:

- By electronic mail to Ron.Zdrojeski@sutherland.com, the email address of the Petitioners' counsel and the individual who signed the Petition;

- By certified mail, return-receipt requested, and first class mail to the Petitioners' counsel and the individual who signed the Petition:

  Ronald W. Zrojeski, Esq.
  Sutherland Asbill & Brennan LLP
  1114 Avenue of the Americas, 40th Floor
  New York, New York 10036-7703; and

- By certified mail, return-receipt requested, to each of the individual Petitioners as listed on the attached Service List without Appendices.

Erica C. McKenzie
Commissioner of the Superior Court