

Date: June 8, 2004

MEMORANDUM

To: National Association of Public Hospitals and Health Systems

From: Powell, Goldstein, Frazer & Murphy, LLP

Re: New CMS Policy on States' Use of Public Funds to Finance Medicaid

You have asked for an analysis of the legal underpinnings of new policies and procedures unofficially adopted by the Centers for Medicare and Medicaid Services (CMS) with respect to states' use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs) to fund the non-federal share of Medicaid expenditures. These new policies and procedures were partially outlined in a letter from CMS Administrator Mark McClellan to Senator Charles Grassley dated April 28, 2004, and represent a sharp break from the past. CMS has not undertaken notice and comment rulemaking procedures in establishing the new policies. Many members of the National Association of Public Hospitals and Health Systems (NAPH) have reported disruption and delay in crucial Medicaid funding streams as a result of CMS pressure on their states in this regard. This memorandum reviews the legal basis for IGTs and CPEs, and examines whether CMS has overstepped the bounds of its legal authority in adopting its new policies and procedures.

In brief, IGTs and CPEs are clearly authorized through both the Medicaid statute and implementing regulations. Neither the statute nor the regulation is restrictive with regards to the source of the IGTs or CPEs, requiring only that they be from "public funds." CMS's apparent reliance on 1991 legislation as authority for its new restrictive policy is misplaced. That law did not directly restrict the scope of permissible transfers or certifications; rather, it limited the Secretary's authority to restrict them. CMS itself has explicitly acknowledged that the 1991 statute does not narrow the scope of permissible IGTs and that the agency would have to adopt a new regulation in order to do so. The Administrative Procedure Act clearly requires formal notice and comment rulemaking for the kind of policy change suggested in Dr. McClellan's letter. To the extent that CMS is obtaining voluntary "cooperation" by states with its new policy through threatened denials of state plan amendments and/or threatened retroactive disallowances of legal IGTs/CPEs, its threats are not based on any legal authority and undermine the federal-state-local partnership underlying the Medicaid statute.

Local Funding of Medicaid is Well-Founded in the Medicaid Statute

Since its inception, Medicaid has always permitted states to rely on local government funds as a source of financing for the program. Indeed, in the Medicaid statute Congress refers only to the federal share and the “non-federal share” of Medicaid expenditures; nowhere does the term “state share” appear. The statute explicitly permits states to derive up to 60 percent of the non-federal share from “local sources” other than state general revenues.¹ Based on this statutory authority, CMS has had regulations in place (dating back at least to 1977²) allowing states to use “public funds” as a source of Medicaid financing:

- (a) Public funds may be considered as the State’s share in claiming FFP [Federal Financial Participation] if they meet the conditions specified in paragraphs (b) and (c) of this section.
- (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
- (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.³

Public funds “transferred from other public agencies” have come to be known as “intergovernmental transfers” and public funds “certified by the contributing public agency” have come to be referred to as “certified public expenditures.”

Neither the underlying statute nor the governing regulation includes any explicit or implicit restrictions on the types of “public funds” that may be used to claim FFP under Medicaid, or on the types of “public agencies” which may contribute such funds. Indeed, even the term “public” is not defined in the statute or regulations.⁴ Standing on their own, these provisions do not give CMS the authority to change its policy unilaterally and narrow the types of public funds that may be used as the non-federal share.

¹ 42 U.S.C. § 1396a(a)(2).

² See 42 Fed. Reg. 60564 (November 28, 1977).

³ 42 C.F.R. §433.51.

⁴ CMS has established categories of “government-owned or operated” facilities for purposes of defining upper payment limits on Medicaid reimbursement. In that context, governmental facilities include “all facilities that are either owned or operated by the State” and “all government facilities that are neither owned nor operated by the State.” 42 C.F.R. §447.272(a). CMS has explained that this definition includes “county or city owned and operated facilities, quasi-independent hospital districts, and hospitals that are owned by local governments but operated by private companies through contractual arrangements with those local governments as long as the hospital retains the ability to make an IGT to the State.” 66 Fed.Reg. 3154 (Jan. 12 2001). If there is a distinction between a “public agency” and a “government-owned or operated” facility, CMS has not made such distinction clear, and it would be logical for a state to conclude that the funds held by a governmental facility are public funds and are therefore eligible sources for the non-federal share of Medicaid expenditures under 42 C.F.R. §433.51.

Congress Has Not Restricted the Types of Public Funds Eligible for Federal Medicaid Match

In the April 28 letter CMS appears to rely on section 1903(w)(6) of the Social Security Act for authority for its new policy. A careful reading of that provision and of the letter, however, demonstrate both that the provision provides insufficient authority to CMS and that CMS apparently is aware of its lack of such authority.

Section 1903(w)(6) was enacted as part of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.⁵ That law placed a number of restrictions on states' use of funds derived from provider taxes and donations as the non-federal share of Medicaid expenditures. In the course of enacting these restrictions, however, Congress specifically protected states' use of certain public funds in financing Medicaid:

The Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government with a State as the non-Federal share of expenditures . . . regardless of whether the unit of government is also a health care provider . . .”⁶

These provisions are directed to the Secretary of Health and Human Services, preventing him from restricting the use of certain types of IGTs and CPEs (those derived from state or local taxes or appropriations to state university teaching hospitals). They do not directly place any limitations on states' use of public funds. Any implications in the April 28 letter that Congress itself has restricted the use of public funding for Medicaid are completely unfounded.

CMS Would Have to Undergo Notice and Comment Rulemaking to Restrict States' Use of Public Funds in the Medicaid Program

CMS itself has acknowledged that the 1991 law does not independently narrow the types of public funds that may be used as the non-federal share, and that in order to do so CMS would have to go through notice and comment rulemaking. In the preamble to the regulations implementing the 1991 provider tax and donation law, CMS (then the Health Care Financing Administration) asserted:

Funds transferred from another unit of State or local government which are not restricted by the statute *are not considered a provider-related donation or health care related tax*. Consequently, until the Secretary adopts regulations changing the treatment of

⁵ Pub. L. No. 102-234, 105 Stat. 1793, codified at 42 U.S.C. §1396b(w).

⁶ 42 U.S.C. §1396b(w)(6)(A).

intergovernmental transfers, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds *from any governmental source . . .*⁷

CMS knew that it would have to revise the regulation, through formal rulemaking procedures, in order to narrow the scope of permissible IGTs in the wake of the 1991 legislation. Yet the regulation has been retained in essentially the same substantive form since at least 1977.⁸ It has not been narrowed and in order to do so now, CMS must go through rulemaking procedures.

The wording of Dr. McClellan's letter to Senator Grassley subtly acknowledges this point. It attempts to describe a category of "protected" IGTs which it distinguishes from "recycling mechanisms." *The letter conspicuously does not say that any IGT that does not meet CMS's definition of "protected" is impermissible.* Rather, it simply says that such IGTs are not protected by the statute. In other words, such IGTs are not subject to the congressional prohibition on regulatory restrictions. Yet *as CMS itself has acknowledged, "until the Secretary adopts regulations changing the treatment of intergovernmental transfers," IGTs from "any governmental source" are permissible.*

Federal law (in particular, the Administrative Procedure Act (APA)) requires federal agencies to subject new interpretations of federal law to notice and comment rulemaking procedures.⁹ In this case, CMS's new restrictive policy on IGTs is having a substantial impact on states, safety net providers and patients who rely on such providers for care. Yet none of these interested parties have had an opportunity for input into the CMS policymaking process and the process is suffering because of it. We believe that CMS is in violation of the APA in effectively adopting new rules applicable to IGTs and CPEs without following proper rulemaking procedures.

We have our doubts whether, even if it were to subject its new policy to proper rulemaking procedures, CMS could establish a new restrictive definition of permissible sources of public funds that would not interfere with traditional and legitimate financing arrangements between states and local governments. Nor do we believe that restricting IGTs and CPEs to appropriated taxpayer dollars would be advisable from a public policy perspective in that it would penalize governmental providers who have attained self-sufficiency, funding operations out of patient care revenues rather than taxpayer subsidies. We also believe that such a policy would raise a whole host of practical and accounting issues related to the tracking of funds through an organization and within a state. Yet none of these concerns have yet been fleshed out because of

⁷ 57 Fed. Reg. 55119 (November 24, 1992) (emphasis added). Note that in this preamble, CMS appears to use the term "governmental" and "public" as interchangeable, further strengthening the reasonable conclusion by states that entities that are "government owned or operated" under Medicaid regulations are capable of contributing IGTs or CPEs. See footnote 4, *supra*.

⁸ Although its placement in the Code of Federal Regulations has changed several times, the regulation has remained substantially unchanged since 1977 (*see* 42 Fed. Reg. 60564 (November 28, 1977)).

⁹ See 5 U.S.C. § 551 *et seq.*

the failure of CMS to issue its new policy in writing in a manner in which states, providers, patients, Members of Congress and other interested parties can review and comment upon.

States' Compliance with CMS's New Policy is Not Required by Law

Finally, we understand that NAPH is concerned about the "chilling effect" that CMS's new policies are having with respect to states' legitimate uses of local funds as the non-federal share of Medicaid expenditures. For example, you have informed us that some NAPH members are reporting an unwillingness of their states to draw down newly appropriated federal Disproportionate Share Hospital (DSH) funding out of the mistaken belief that they cannot use IGTs or CPEs to finance new DSH payments. Other states are reluctant to propose legal modifications to their state plans because of the arduous approval process and resources required to respond to a seemingly endless array of CMS questions and requests for information.

The April 28 letter itself reports that CMS has obtained the "cooperation" of several states in terminating their use of IGTs and states that the agency "does not currently intend to pursue issues related to funding sources in connection with such financing practices for periods prior to the date of termination." These statements suggest that CMS may be obtaining such cooperation by explicitly or implicitly threatening retroactive disallowances if states fail to cooperate. Given that intergovernmental transfers of public funds – whether "protected" under the 1991 statute or not – are permissible under current laws and regulations, such threats of retroactive action are not grounded in any statutory or regulatory authority. Nevertheless, the mere suggestion of such action – and the prohibitive legal and practical costs it would entail for the state – may be sufficient to obtain the "cooperation" of states anxious to avoid such costs, particularly when the costs of terminating the use of IGTs are borne primarily by safety net providers losing access to Medicaid funding rather than by the state itself.

Similarly, NAPH members report that CMS has held up approval of several state plan amendments pending resolution of unrelated financing issues and has in some cases threatened disapproval if the amendment is to be financed through IGTs. This tactic too is unauthorized by statute. Federal Medicaid law requires the Secretary to "approve any plan which fulfills the conditions specified" in the federal statute relating to the requirements of state Medicaid plans.¹⁰ If the plan amendment itself is lawful, CMS cannot withhold approval simply because it does not like the financing source. If it believes the financing source is *illegal* (as opposed to "unprotected" under the 1991 statute), then its remedy would be to defer and/or disallow FFP for payments under the plan amendment. By holding amendments hostage to its evolving policies on IGTs, CMS is preventing states from making and receiving FFP for provider payments that are legal under federal law.

¹⁰ 42 U.S.C. §1396a(a); 42 U.S.C. §1396a(b).

Conclusion

In summary, current law permits states to use public funds – *any* public funds – as the source of the non-federal share of Medicaid expenditures, and CMS has not undertaken any notice and comment rulemaking under the APA to restrict their use. CMS's recent letter to Senator Grassley implies that its new restrictive policy on IGTs is based on current statutory authority, but stops short of saying so directly. Instead, it appears that CMS may be imposing its new policy more through coercive pressure tactics on states rather than through legal rulemaking procedures. Such action violates both the spirit and the letter of the APA and the federal-state-local partnership established under the Medicaid statute.

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