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Association**

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March 15, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, No. 11), January 18, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The AHA opposes this proposed rule and would like to highlight the harm it would cause to our nation's hospitals and the patients they serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

CMS estimates the rule will cut \$3.9 billion in federal funds over five years. This amounts to a budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year, 300 representatives and 55 senators signed letters to Health and Human Services (HHS) Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. Recently, Congress restated its position with 226 representatives and 43



senators having signed letters to the House and Senate leadership urging them to stop this proposed rule from moving forward.

Policy changes of this magnitude must be made in a way that will ensure the health care needs of Medicaid recipients are met. Historically, whenever there has been a substantial change to Medicaid funding policy – such as prohibiting provider-related taxes and donations, modifying disproportionate share (DSH) hospital allotments, or modifying application of Medicaid upper payment limits (UPLs) – those changes have been made, or at the very least, supported by Congress. If CMS intends to make further sweeping changes to Medicaid, they should first be made by legislation, not regulation. Indeed, the Administration recognized this in its fiscal year 2006 budget submissions to Congress, where it proposed that Congress pass legislation to implement the very policy changes contained in this rule.

The AHA also is concerned that in several places in the preamble discussion, CMS describes its proposed changes as “clarifications” of existing policy, suggesting that these policies have always applied, when in fact, CMS is articulating them for the first time. By describing many changes as clarifications, CMS appears to be trying to do an “end run” around the notice-and-comment process. Any attempt to implement these proposals in a retrospective nature would violate the *Administrative Procedures Act*.

Attached to this letter is a detailed discussion of our concerns relating to:

- The cost-based reimbursement limitation and the individual provider-based UPL to be applied to government-operated providers;
- The proposed narrowing of the definition of “unit of government;”
- The proposed restrictions on intergovernmental transfers and certified public expenditures and the characterization of CMS’ proposed changes as “clarifications” rather than changes in policy; and
- The absence of data or other factual support for CMS’ estimate of savings under the proposed rule.

If these policy changes are implemented, the nation’s health care safety net will unravel, and health care services for millions of our nation’s most vulnerable people will be jeopardized. We urge CMS to permanently withdraw its proposed rule.

If you have any questions, please feel free to contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

**The American Hospital Association's
Detailed Comments on CMS-2258-P**

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Cost LIMIT FOR PUBLIC HOSPITALS

The rule proposes to limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule restricts states' ability to make supplemental payments to providers with financial need by setting the Medicaid UPL for government-operated hospitals at the individual facility's cost. This proposal is effectively a cut in funding for those public hospitals¹ and safety-net providers that – as CMS has recognized – are in stressed financial circumstances and are most in need of enhanced payments. These cuts will undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote HHS' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventative care.

As explained below, the AHA believes that it is arbitrary and capricious to impose a cost-based limitation on hospital reimbursement and to deny states the flexibility to reward hospitals – both public and private – whose costs for services are less than the rates states might pay, for example, under a prospective payment system. Further, imposing a hospital-based UPL is contrary to the requirement of the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA) that CMS establish an aggregate UPL, and it will create an unwarranted burden on providers and states.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. The AHA is very concerned that in CMS' zeal to reduce federal Medicaid spending, important costs, such as graduate medical education, physician on-call services or clinic services, would not be recognized and therefore would no longer be reimbursed. The AHA is further concerned that the Administration plans to eliminate all federal funding for Medicaid graduate medical education as outlined in the president's fiscal year 2008 proposed budget. Congress should have the opportunity to review any change to the Medicaid program's support for graduate medical education, and we urge CMS not to move forward with any proposed rule that would implement the president's budget proposal.

COST LIMIT

In the preamble to the proposed rule, CMS says that it does not find Medicaid payments in excess of cost to government-operated health care providers to be consistent “with the statutory principles of economy and efficiency as required by section 1902(a)(30)(A)” of the *Social Security Act* (the “Act”). If CMS' goal is to assure that Medicaid payments are consistent with economy and efficiency, then there is no basis for imposing a cost-based reimbursement system to only government-operated hospitals. The AHA, however, opposes limiting any individual hospital's reimbursement to 100 percent of costs.

In the Regulatory Impact Analysis of its January 2001 final rule modifying the Medicaid UPL, CMS concluded:

¹ Although the AHA confines its comments to hospitals, it recognizes the broader implications of the proposed rule for non-hospital providers of Medicaid services.

While a facility-specific limitation may be the most effective method to ensure state service payments are consistent with economy and efficiency, when balanced against the additional administrative requirements on states and HCFA, coupled with congressional intent for states to have flexibility in rate setting, *we are not sure that the increased amount of cost efficiency, if any, justifies this approach as a viable option.*

66 Fed. Reg. 3148, 3174 (Jan. 12, 2001) (emphasis added).

In the preamble to its January 18, 2002 final rule removing the 150 percent UPL for hospital services furnished by non-state, government-owned or -operated hospitals, CMS stated that the revised UPL of 100 percent for non-state government providers “will assure that payments will be consistent with ‘efficiency, economy and quality of care’ as required by section 1902(a)(30)(A) of the *Social Security Act.*” 67 Fed. Reg. 2602, 2608 (Jan. 18, 2002).

CMS does not provide any explanation in the proposed rule why the 100 percent aggregate UPL is now insufficient to meet the efficiency and economy requirements of section 1902(a)(30)(A) and must be replaced with a UPL based on each individual provider’s costs and a cost-based reimbursement limit. As CMS is aware, Congress moved away from cost-based reimbursement under Medicaid when it adopted the so-called “Boren Amendment” in 1980. Since then, hospital reimbursement systems have evolved following the model of the Medicare program and its use of prospective payment systems. These reimbursement systems are intended to improve efficiency by rewarding hospitals that can keep costs below the amount paid. Many state Medicaid programs have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit.

CMS says that it has examined state Medicaid financing arrangements and found that “many” states are making supplemental payments to government-operated providers in excess of cost, and that this excess payment is used to subsidize health care operations unrelated to Medicaid, or is returned to the state as a source of revenue. The agency provides no data or factual support for how many states are making such “excess payments” nor any specific information regarding how providers in these states are using these excess payments. Moreover, as CMS has repeatedly recognized, the aggregate UPL system affords states the flexibility to tailor reimbursement policy to meet local needs by making supplemental payments to particular hospitals in financial stress.

In a brief filed in federal court litigation over the 2002 UPL rule² (the “UPL Brief”), CMS described the “concept” behind the UPL as being able “to set aggregate payment amounts for specifically-defined categories of health care providers and specifically-defined groups of providers, but leave the states considerable flexibility to allocate payment rates within those categories and groupings.” UPL Brief, page 9. In the preamble to the 2002 final rule, CMS stated that, under the 100 percent UPL, “states also retain some flexibility to make enhanced payments to selected public hospitals under the aggregate limit.” 67 Fed. Reg. at 2603. CMS

² Defendant’s Memorandum in Support of His Motion for Summary Judgment and in Opposition to Plaintiffs’ Motion for a Permanent Injunction, *Ashley County Medical Center v. Thompson*, 205 F. Supp. 2d 1026 (E.D. Ark.) (No. 4:02CV00127).

reiterated this position on pages 3-4 of the UPL Brief, stating that “[t]he new rules leave states considerable flexibility to direct higher Medicaid payments to particular hospitals that may be in stressed financial circumstances.”

CMS also has expressly recognized the potential financial implications of limiting reimbursement to an individual provider’s costs, and the importance of the aggregate UPL system for preserving access to Medicaid services, particularly with regard to safety-net hospitals. In the UPL Brief on page 39, CMS pointed out that “the upper payment limit is an aggregate limit for all institutions in the category of non-state public hospitals, not an individual limit for each hospital.” Responding to the allegation that several public hospitals in Arkansas would be jeopardized by the 100 percent UPL, CMS reasoned that

the state could increase payments for those particular hospitals and decrease payment levels at other county and local hospitals (perhaps in more affluent parts of the state) where the low-income patient load was less heavy. . . There is no reason to merely suppose that state governments will be indifferent to the special needs of particular urban or rural hospitals in deciding how aggregate Medicaid payments will be allocated among non-state public hospitals. An equal and across-the-board reduction in Medicaid payments for county and local hospitals – the assumption on which all of plaintiffs’ fiscal speculations are apparently premised – is neither mandated nor even contemplated by the 100 percent rule.

Id. at 39-40 (emphasis in original).

CMS is now mandating just such an “across-the-board reduction,” disregarding without explanation its prior statements regarding the importance of the flexibility allowed states under the UPL system to make enhanced payments to hospitals in special need. This policy change will penalize states and providers that have never utilized abusive or inappropriate funding mechanisms by denying those states the ability to pay public hospitals more than 100 percent of costs. Moreover, CMS has not provided clear direction in the proposed rule as to which costs CMS will permit states to reimburse.

CMS’ proposal will directly harm the ability of states to meet their statutory obligation to ensure access to care for Medicaid beneficiaries. Under section 1902(a)(30)(A) of the Act, states must assure that Medicaid payments “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” By prohibiting states from reimbursing a provider for more than costs, and restricting states from making enhanced payments to providers in financial need, CMS is imposing a funding restriction that will ultimately be passed on from the states to government providers. To the extent that these cuts in funding will lead to a curtailment in beneficiary care and services, it is the states – and not CMS – that will be subject to challenge or complaint by beneficiary advocates and to witnessing their citizens’ care compromised.

DIFFERENTIAL TREATMENT OF PUBLIC AND PRIVATE HOSPITALS

Under CMS' proposal, the cost-based limit on reimbursement and the individual provider-based UPL, will apply only to government-operated providers. States will continue to be able to make Medicaid payments to private hospitals that exceed costs, and private hospitals will continue to be reimbursed under an aggregated UPL. If, as CMS suggests, its policy is consistent with the requirements of economy and efficiency under section 1902(a)(30)(A) of the Act, there is no rational basis for distinguishing between public and private hospitals. Requiring differential treatment of public and private Medicaid hospitals also is inconsistent with the equal protection clause of the Constitution, as well as CMS' own repeated statements regarding the importance of payment equality for all categories of Medicaid hospitals.

As discussed above, CMS' rationale for proposing a cost limitation on reimbursement for government-operated providers is the requirement of economy and efficiency in section 1902(a)(30)(A) of the Act. CMS does not provide any explanation of why subjecting public, but not private, hospitals to a cost limitation is economic and efficient. To the contrary, CMS has repeatedly emphasized the importance of payment equality among categories of Medicaid providers. Restoring such "payment equity" was one of the Secretary's stated rationales for implementing the 100 percent UPL in the 2002 final rule. CMS agreed with the statement of commenters to the 2002 final rule that "one group of providers should not have a financial benefit over another group of providers who provide the same type of services." 67 Fed. Reg. at 2604. CMS went on to explain that its intent in the rule was "to treat all facilities equally, and apply the same aggregate UPL to each group of facilities, regardless of who owns or operates the facilities." *Id.* This notion of payment equity across groups of Medicaid providers is repeated throughout the preamble to the 2002 final rule,³ and the "equity rationale" was highlighted in CMS' 2002 UPL Brief as "standing alone . . . sufficient to sustain the 100 percent rule against a claim that it is arbitrary and capricious, in violation of the Administrative Procedures Act." CMS provides no explanation for how it is now consistent with economy and efficiency to reverse its stance on the importance of payment equity by imposing a discriminatory and unfair reimbursement limit on government-operated providers. There is no rational basis for a policy that prevents public Medicaid providers from availing themselves of the same benefits afforded private Medicaid providers, and it is contrary to the equal protection afforded under the Constitution. Moreover, the AHA opposes limiting any individual hospital's Medicaid reimbursement to 100 percent of costs.

REQUIREMENTS OF THE MEDICARE, MEDICAID AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000

Section 705(a) of BIPA required CMS to issue a final regulation modifying the UPL test applied to state Medicaid spending "by applying an *aggregate* upper payment limit to

³ See, e.g., 67 Fed. Reg. at 2604 ("this rule is critical for maintaining the fiscal integrity of the Medicaid program and ensuring that all facilities are treated equally under Federal Medicaid UPL regulations"); *id.* at 2605 ("We believe the reduction of the UPL from 150 percent to 100 percent will be sufficient to maintain the fiscal integrity of the Medicaid program and ensure that all facilities are treated equally under the Federal Medicaid UPL regulations").

payments made to government facilities that are not state-owned or -operated facilities.” (Emphasis added.) Section 701(a)(3) of BIPA, which addressed modifications to DSH payments, used the same language in describing the final regulation required under section 705(a), as “relating to the application of an *aggregate* upper payment limit test for state Medicaid spending . . . [for services] provided by government facilities that are not state-owned or -operated facilities.” (Emphasis added.) Congress explicitly contemplated that CMS’ final regulation regarding UPLs would apply an aggregate limit. CMS’ proposed rule, which removes the aggregate UPL and imposes a limit based on the individual provider’s costs, is precluded by the clear statement in BIPA that UPLs be based on an aggregate limit for each provider class.

PROPOSED DEFINITION OF “UNIT OF GOVERNMENT”

CMS proposes to define the term “unit of government” by reference to a provision of the Medicaid statute that defines the distinct and more narrow term “unit of *local* government.” Both of these terms are used in the subsection of the statute regarding provider donations and taxes, but by picking and choosing which provisions it will apply, CMS has ignored both the statutory framework and purposes of these distinct terms. Moreover, even if the statutory definition of “unit of local government” were applicable to CMS’ proposal, it cannot reasonably be read to have the narrow meaning that CMS sets forth in the proposed rule.

CMS proposes to add new language to its rules governing state financial participation in Medicaid. Specifically, CMS proposes to define a unit of government to “conform” with the definition of “unit of local government” in the provider tax and donations provisions of the Medicaid statute (1903(w)(7)(G)). Under the proposed rule, only those entities that meet CMS’ new definition of “unit of government” will be permitted to fund the state’s share of Medicaid expenditures. CMS inappropriately limits its definition of “unit of local government” to entities with “generally applicable taxing authority.” There is no basis for this restriction in the Medicaid statute. CMS’ proposed definition ignores the principles of federalism that afford states discretion in structuring their political subdivisions and will impose substantial harm on public hospitals. We urge CMS not to finalize this proposal.

In the rule, CMS proposes to use Congress’ definition for a unit of *local* government as the basis for its proposed definition of the broader term “unit of government.” Section 1903(w)(7)(G) of the Act defines the term “unit of local government.” This term is used in subsection 1903(w)(1)(A) of the Act, which reduces the federal contribution to Medicaid by revenues received by states or units of local government from certain provider donations or health care-related taxes. The proposed rule has no connection to this subsection. Rather, CMS is using the definition of unit of local government to define a different, broader term – “unit of government” – which is the term used in the subsection 1903(w)(6)(A) of the Act restricting CMS’ authority to regulate intergovernmental transfers (IGTs).

CMS’ reliance on the definition of unit of local government is misplaced. “Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the

disparate inclusion or exclusion.”⁴ Congress used the narrower term “unit of *local* government” to define those government entities subject to the prohibition on provider donations and taxes (1903(w)(1)(A)), but recognized that other government entities may permissibly make IGTs, and thus purposely used the broader and different term “unit of government” in the IGT section of the statute (1903(w)(6)(A)).

Not only is CMS basing its proposal on the wrong statutory definition, it has narrowed the definition in a way that is incompatible with the terms of the statute. Section 1903(w)(7) (G) defines a unit of local government to mean, “a city, county, special purpose district, or other governmental unit in the state.” The proposed rule, by comparison, limits the definition of a unit of government to those entities that have “generally applicable taxing authority.” It further states that a health care provider may be considered a unit of government,

only when it is operated by a unit of government as demonstrated by a showing of the following:

- The health care provider has generally applicable taxing authority; or
- The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider’s expenses, liabilities, and deficits, so that a contractual arrangement with the state or local government is not the primary or sole basis for the health care provider to receive tax revenues.

CMS states in its preamble discussion that the proposed provisions are modified “to be consistent” with the statute. The AHA respectfully disagrees with this characterization. The definition of “unit of government” in section 1903(w)(7)(G) does not include the words “generally applicable taxing authority” nor any of the other restrictive language that CMS proposes. Instead, Congress defined the term in a way that affords deference to the states’ right to structure their own governmental subdivisions, in accordance with the constitutional principles of federalism. Rather than “conforming” the regulation to this statutory definition, CMS narrows it in a manner that is not authorized by the plain text of the statute and intrudes upon the traditional authority of the states.

The deference that Congress provided to states under its definition of unit of local government is reinforced by section 1903(d)(1) of the Act, which requires the Secretary to estimate the amount of the federal Medicaid payment based on the state’s reported estimate of Medicaid expenditures for the quarter and the amount “appropriated or made available by the state and its political subdivisions for such expenditures in such quarter.” There is no limitation in section 1903(d)(1) on which political subdivisions may make funding available for Medicaid expenditures, and certainly no requirement that such subdivisions have “generally applicable taxing authority.”

⁴ *Russello v. United States*, 464 U.S. 16, 23 (1983) (quoting *United States v. Wong Kim Bo*, 472 F. 2d 720, 722 (5th Cir. 1972). “[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there.” *Connecticut Nat’l Bank v. Germain*, 503 U.S. 249, 253-54 (1992).

CMS' restrictive definition will have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. For example, the University of Colorado Hospital Authority was established as a quasi-governmental and corporate entity based on a finding by the Colorado General Assembly that the University of Colorado University Hospital Authority was "unable to become and remain economically viable due to constraints imposed by being subject to various kinds of government policy and regulation." Colo. Rev. Stat. § 23-21-501(1)(d). In a February 20 letter to Colorado Gov. Bill Ritter, University of Colorado Hospital President and CEO Bruce Schroffel stated that the University of Colorado Hospital could lose \$30 million in funding a year because it would not meet CMS' restrictive new definition of "unit of government" and would be unable to generate certified public expenditures (CPEs). Similarly, in a March 14 letter to CMS Acting Administrator Leslie Norwalk, the California Hospital Association Disproportionate Share Task Force noted that the University of California's medical centers and Alameda County (CA) Medical Center may be at risk of losing essential funding because they would appear not to meet CMS' stringent proposed definition.

LIMITATIONS ON INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES

CMS' proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs and CPEs, including limiting the source of IGTs to funds generated from tax revenue. The AHA believes these proposed restrictions directly conflict with the purpose and plain language of the Medicaid statute. In 1991, Congress identified certain provider donations and provider-related taxes as an inappropriate means of funding the non-federal share of Medicaid payments and restricted the use of these financing mechanisms. In doing so, however, Congress included a specific provision in section 1903(w)(6)(A) of the Act to make clear that these restrictions would not affect the use of IGTs. CMS is now using this provision, which was intended to limit the Secretary's authority to regulate IGTs derived from state or local taxes, as the basis for a new requirement that *all* IGTs must be made from state or local taxes.

In the proposed rule's preamble, CMS states that it has systematically eliminated inappropriate financing arrangements, such as recycling mechanisms, through the state plan amendment process. If these abusive practices have been addressed, it is unclear why CMS is proposing an unauthorized restriction on the source of IGTs. This proposal is inconsistent with Medicaid law and historic CMS policy.

RESTRICTIONS ON IGTs

Under the proposed rule, only entities that meet CMS' restrictive new definition of "unit of government" are permitted to make IGTs. As discussed above, CMS says that it has based this definition on section 1903(w)(7)(G) of the Act, which defines a unit of *local* government, not a "unit of government." Additionally, in the preamble to the proposed rule, CMS claims that, "generally," for the state to receive the federal match where a government-operated health care provider has transferred the non-federal share, the state must demonstrate "(1)

[t]hat the source of the transferred funds is state or local tax revenue (which must be supported by consistent treatment on the provider's financial records); and (2) that the provider retains the full Medicaid payment and is not required to repay, or in fact does not repay, all or any portion of the Medicaid payment to the state or local tax revenue account." This fundamental change in IGT policy appears to be discussed only in the preamble and is not addressed in the text of the proposed regulations. The use of the term "clarify" suggests that CMS views the fundamental changes it is proposing as merely clarifications of existing Medicaid funding policy. However, CMS is articulating for the first time a substantial shift in Medicaid policy. The proposed changes go far beyond mere clarifications and, as a result, any attempt to implement them on a retrospective basis would be contrary to the notice and comment requirements of the *Administrative Procedure Act*.

As noted above, CMS claims that the basis for these new limitations on the use of IGTs is the agency's intent "to conform" its regulatory language to section 1903(w)(6)(A) of the Act, which sets forth an exception from restrictions on provider-related donations and taxes. Rather than "conforming" the proposed rule to this statutory exception, CMS does the opposite. Congress included this statutory exception to permit states to continue using state or local taxes to make IGTs. It did not authorize CMS to require states to only use state or local taxes to make IGTs, nor did it preclude the use of other sources of funds, such as patient care revenues.

Section 1903(w)(6)(A) is not the only place where Congress made clear that the state share of Medicaid payments could come from local sources other than local tax revenue. Section 1902(a)(2) of the Act permits up to 60 percent of the state's share of financial participation to come from "local sources," without restriction. If Congress had wanted to limit state financial participation to funding from state or local tax revenue, it would have included that requirement explicitly.

CMS itself has acknowledged that it has limited authority to regulate IGTs. In the 2002 final rule, CMS stated that, "[u]nder section 1903(w)(6)(A) of the Social Security Act, the Congress limited [CMS'] authority to regulate states' certain uses of IGTs." 67 Fed. Reg. at 2606. CMS stated further, in response to a comment that public hospitals be required to have a net gain of at least two-thirds of additional federal funds collected under hospital-based UPL plans, "[i]t is not clear what the commenter believes would be the legal authority for CMS to limit a hospital's use of its own funds." *Id.* at 2605. Moreover, although CMS "gave consideration to formulating a policy with respect to" IGTs in the Regulatory Impact Analysis of its 2001 final rule, CMS said that it "did not pursue this alternative because we recognize that states, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs. Furthermore, there are statutory limitations placed on the Secretary which limit the authority to place restrictions on IGTs." 66 Fed. Reg. at 3175. Now, contrary to these prior statements, CMS is inappropriately construing the same statutory terms to impose restrictions on states that Congress did not authorize or intend.

RESTRICTIONS ON CPEs

The AHA is troubled by CMS' new standards for generating and documenting CPEs and is concerned about the administrative burden on both hospitals and states. CMS proposes new standards for the documentation of CPEs that are used to fund the non-federal share of

expenditures. The government entity will be required to submit to the state Medicaid agency a certification statement including an attestation regarding compliance with the Medicaid state plan and the Medicaid regulations. The certification must be submitted by the state to CMS as the basis for the state claim for federal funds within two years of the date of the expenditure. In addition, CMS states that a public provider may generate a CPE from its own costs only if the state plan contains an actual cost reimbursement methodology.

Under the proposed rule, in order for the states to develop interim payment rates for providers that are paid using a cost reimbursement methodology funded by CPEs, the state must undertake two separate reconciliations. Additionally, while generating little real benefit, the new documentation standards are likely to result in substantial administrative burden on hospitals and may even subject Medicaid providers to unwarranted allegations of *False Claims Act* violations. AHA members take seriously their obligations to report Medicaid expenditures properly, and CMS can ensure the accuracy of Medicaid claims without imposing this burdensome certification requirement.

INSUFFICIENT DATA TO SUPPORT CMS' ESTIMATE OF SPENDING CUTS

The proposed rule is subject to the arbitrary and capricious standard of review under the *Administrative Procedure Act*. Before a rule is finalized, an agency “must examine the relevant data and articulate a satisfactory explanation for its action including ‘a rational connection between the facts found and the choice made.’”⁵ CMS says that the proposed rule is estimated to result in \$3.87 billion in savings over five years, but does not provide any relevant data or facts to support this conclusion. The basis for this estimate appears to be that CMS has “examined Medicaid state financing arrangements across the country” and, in doing so, has “identified numerous instances in which state financing practices do not comport with the Medicaid statute.” CMS does not indicate what these financing practices might be or how many states are currently employing them. Moreover, CMS expressly says that it has systematically required states to eliminate problematic financing arrangements through the state plan amendment process. This raises further questions about the estimated savings and casts doubt on the rational upon which CMS has based these sweeping policy changes to how states finance their share of Medicaid and how states reimburse their public providers.

⁵ *Ashley County Medical Center v. Thompson*, 205 F. Supp. 2d 1026, 1048 (E.D. Ark. 2002)