

July 13, 2007

Leslie Norwalk, Esq.
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-FC) Final Rule - Medicaid Program; Cost Limit for Providers
Operated by Units of Government (Vol. 72, No. 102), May 29, 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) submits the following comments on the Centers for Medicare & Medicaid Services' (CMS) final rule restricting how states fund their Medicaid programs and pay public hospitals.

Congress' one-year moratorium on the final rule, we believe, precludes CMS from taking action regarding this rule. As a result, the agency should withdraw the rule. However, CMS has chosen to publish the final rule and is soliciting comments on the definition of units of government while noting that it cannot move forward until May 2008. The AHA opposes CMS' policy changes set forth in the rule.

CMS' new definition of "unit of government" will determine which government hospitals and other providers are eligible to participate in funding states' non-federal share of their Medicaid programs. The new definition also will determine which providers will be subject to further restrictions on the Medicaid payments they receive.

The final rule makes the following changes from the proposed rule in the definition of "unit of government":

- **Providers with direct access to revenue.** The final rule allows providers that do not have taxing authority, but have direct access to tax revenue, to be defined as "units of government."



- **State university teaching hospitals.** The final rule recognizes state teaching hospitals with direct appropriations from the state as a “unit of government.” The rule also recognizes that state university teaching hospitals that are receiving appropriated funding and provide supervised teaching experiences to graduate medical school interns and residents enrolled in a state university as providers that are operated by a unit of government.

Through these changes from the proposed rule, CMS has slightly broadened the definition of “unit of government,” which may allow a few more providers to qualify as governmental. However, the underlying rationale upon which CMS has based its change to the definition of “unit of government” remains flawed. CMS continues to ignore the principles of federalism that afford states discretion in structuring their political subdivisions, and will impose substantial harm on our public hospitals.

ANALYSIS OF AND RESPONSES TO PUBLIC COMMENTS – “UNIT OF GOVERNMENT” DEFINITION SECTION 433.50

CMS continues to base its definition of “unit of government” on a subsection of the Medicaid statute regarding provider donations and taxes, which, in fact, define the distinct and more narrow term “unit of *local* government.” The AHA, in this letter, reiterates the arguments outlined in our March 15 comment letter on the proposed rule regarding the definition of “unit of government.”

CMS defines 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 this final 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 “taxing authority or direct access to tax revenues.” There is no basis for this restriction in the Medicaid statute.

In fact, CMS acknowledges in the final rule that the term “unit of government” is not specifically defined in the statute. CMS uses the definition of a different term, “unit of local government,” in section 1903(w)(7)(G) of the *Social Security Act* as the basis for its proposed definition of the term “unit of government.” CMS’ rationale for this approach is the agency’s consideration of the “characteristics generally shared by the entities specifically referenced in the statute” and the statute’s “underlying intent.”

CMS uses circular reasoning to justify its decision. Without explanation or support, the agency concludes that taxing authority is the “shared” characteristic of the entities in section 1903(w)(7)(G) of the Act as well as the “underlying intent” of Congress in section 1903(w)(6)(A) of the Act. CMS then explains in the final rule that, in order for the statute to be implemented consistently, it must read a link to taxing authority in both the definition of “unit of government” and “unit of local government.”

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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."¹ 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 intergovernmental transfers (IGT), 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 final rule on the wrong statutory definition, but 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." CMS is proposing to limit the definition of a "unit of government" to entities that have taxing authority or direct access to tax revenues. This approach appears to be the agency's interpretation of the "overall statutory rationale" and its reading of "the statutory definition of governmental entities to require certain common qualities, such as taxing authority, or the ability to directly access tax funding." The AHA respectfully disagrees with this characterization of the statute's plain language.

The definition of "unit of government" in section 1903(w)(7)(G) does not include the words "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 "taxing authority."

¹ *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).

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CMS' restrictive definition will have significant practical implications for our nation's public hospitals. 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 final 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