DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

IN THE MATTER OF:	*	
	*	
South Carolina	*	**Review of CMS Presiding Officer**
State Plan Amendments 16-0012A, 17-0006A	*	**Recommended Decision:**
and 18-0011A	*	**Docket No. 2020-01**
	*	
	*	
	*	

****

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for the final agency review pursuant to 42 C.F.R. §430.102. The CMS Presiding Officer presented his recommended findings and proposed decision to the Administrator. The South Carolina Department of Human Services (the State) submitted exceptions to the CMS Presiding Officer's recommended decision. All exceptions to the CMS Presiding Officer's recommended decision have been made part of the administrative record and reviewed.

Issues

The issue is whether the South Carolina State Plan Amendments (SPAs) 16-0012-A, 17-0006-A and 18-0011-A are inconsistent with the requirements of:

1. Section 1902(a)(2) of the Social Security Act, which provides that the State plan must assure adequate funding for the non-Federal share of expenditures from State or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

2. Sections 1903(a) and 1905(b) of the Act, which provide that States receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable State expenditures on medical assistance.

3. Section 1903(w)(6)(A) of the Act, which allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-Federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903 of the Act.

CMS Presiding Officer's Proposed Decision

The Presiding Officer recommended that the CMS Administrator uphold the July 9, 2019 disapproval of the State SPAs 16-0012-A, 17-0006-A and 18-0011-A. Based upon review of the administrative record, Presiding Officer found that the State failed to prove that the SPAs conform with Federal requirements. *See* 42 C.F.R. § 430.3.

Procedurally, the CMS Presiding Officer rejected the State's view that the scope of the proceeding may not include CMS' arguments related to impermissible donations. The CMS Presiding Officer found that the third listed issue in this reconsideration proceeding includes whether the SPAs are inconsistent with:

> Section 1903(w)(6)(A) of the Act, which allows states to use funds derived from state or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-Federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903 of the Act.

The Presiding Officer found that section 1903(w)(6)(A) of the Act contains a restriction relating to taxes and other qualified appropriations. The section also discusses, and was intended to cover, the concerns relating to intergovernmental transfers (IGT) as a whole. Notably, the provision expressly discusses "donations," which is covered within section 1903(w) of the Act.

Furthermore, the Presiding Officer found that the State was on notice of CMS' concern with regard to whether the IGTs were provider-related donations as early as 2017, when Greenville Health System's Chief Financial Officer briefed Jeff Saxon (staff of SCDHHS) on the issue, noting that a "CMS Email attempt[ed] to characterize the IGT Funds made by the Greenville Health Authority as 'donations that would not otherwise be recognized as the non-Federal share. . . ." In addition, the Presiding Officer took notice of section 1903(w)(6) which states that the funds are not protected if the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

With regard to the substantive arguments made by CMS, the Presiding Officer found that CMS' position was supportable. Section 1903(w)(1)(A) reduces provider related donations (other than bona fide donations) for purposes of determining the amount to be paid to a State. In this case, as the funds are derived from non-bona fide donations, 42 C.F.R. § 433.51(b) would not permit the funds in question, (regardless of whether they qualify as public funds), to be considered for the non-Federal share.

Applying the statutory definition, the Presiding Officer found Greenville Hospital Authority (GHA) and the two hospitals are closely related. After a review of the law and facts with respect to the phrase "provider related donation" defined in section 1903(w)(2)(A) and the terms "related" and "health care provider" defined under section 1903(w)(7), the Presiding Officer found that CMS was justified in classifying the transfer of funds at issue as a "donation" in accordance with the controlling statutory definition.

The Presiding Officer also recognized that section 1903(w)(1)(A)(i)(I) of the Act contains an exception regarding the treatment of bona fide donations, which do not reduce the amount to be paid to a State, unlike provider donations. Section 1903(w)(1)(B) defines a bona fide donation. The Presiding Officer found, however, that the transfer of funds would not expressly qualify as a bona fide donation as the transfer has a relationship to (uncollected) payment for services. Additionally, as noted above, GHA and the two hospitals at issue are related entities. Further, the Presiding Officer found that the statute provides that the Secretary retains a high level of discretion over whether the donation is determined to be bona fide.

The State argued that the regulations at 42 C.F.R §§ 433.51(b) and 433.57 permit "public funds" that are transferred from other public agencies to be considered as the non-Federal share in claiming Federal Financial Participation (FFP), as long as those funds do not come from impermissible provider taxes or non-bona fide donations. However, the Presiding Officer found that, while the regulations address when public funds "may" be considered the State share, they do not overcome the Social Security Act's restriction in section 1902(w) of the use of non-bona fide donations as a permissible source of the non-Federal share of payments for State expenditures. In this case, however, as noted, the Presiding Officer found that, as the funds are derived from non-bona fide donations, 42 C.F.R. § 433.51(b) would not permit the funds in question, regardless of whether they qualify as "public funds", to be considered for the non-Federal share of payments for State expenditures. In this case, as the funds are derived from non-bona fide donations, the Presiding Officer found that 42 C.F.R. § 433.51(b) would not permit the funds in question, regardless of whether they qualify as public funds, to be considered for the non-Federal share

The CMS Presiding Officer found that CMS correctly determined that the SPAs should be denied because the State failed to provide an adequate source of funding for the State share of the proposed Medicaid plans. Based upon the relationship between Greenville Health Authority (GHA) and the hospitals at issue, (Prisma Health Greenville Memorial Hospital (PHGMH) and Prisma Health Richland Hospital (PHRH)), the CMS Presiding Officer found that the funds meet the statutory definition of non-bona fide donations, which are not a permissible funding source for the non-Federal share of Medicaid payments citing to section 1903(a)(1), (2), and (6) of the Act and section 1902. Without a permissible funding source for the non-Federal share of Medicaid payments, a State's expenditures do not qualify to be matched with Federal funds in accordance with sections 1903(a) and 1905(b) of the Act. Under such circumstances, the State would not receive any statutorily determined Federal Medical Assistance Percentage (FMAP). The non-Federal share of the payments proposed in SPAs 16-0012-A, 17-0006-A and 18-0011-A would not originate from a permissible source.[1]

[1] The CMS Presiding Officer determined that Prisma Health and Greenville Health Authority met the criteria set forth in 42 CFR 430.76© to participate as an *amicus curiae*, which CMS did not oppose.

State's Exceptions to Proposed Decision

The State submitted exceptions to the Proposed Decision stating that the Presiding Officer's decision was erroneous and urged the Administrator to reject the Proposed Decision and approve the plan amendments in question.

The State did not take exception to the Presiding Officer's Findings of Fact that the Greenville Health Authority or GHA, the transferring entity, is a governmental entity with a close relationship to two private hospitals that lease facilities previously operated by GHA. Nor did the State take exception to the Presiding Officer's finding that the transferred funds were payments collected through a State-run "Setoff Debt Collection Program" to garnish individual income tax refunds to satisfy medical bills owed to GHA related to medical services provided before the private hospitals began operation of the facilities. There is no dispute that the transferred funds are to come from patient revenue earned during the time that the hospitals were publicly operated hospitals; nor is there any dispute that the funds will be used as the non-Federal share of payments to physicians affiliated with the now-privately operated hospitals.

The State took exception to the CMS Presiding Officer's conclusion of law that this transfer of funds from a public entity consisting entirely of revenue earned by a public entity is a non bona-fide "donation" that cannot be used to support a private provider with which the public entity has a "close relationship." The State contends that the issue of what constitutes "public funds" eligible for transfer to a State Medicaid Agency for use as the non-federal share is of nationwide importance, with implications far beyond the three State plan amendments at issue here. Referring to 42 C.F.R. §433.51(a)-(c), the State argued that CMS regulations provide that "[p]ublic funds may be considered as the State's share in claiming FFP" if they meet two conditions: first, they must be "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;" and second, "[t]he public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds."

The State claimed that, in accordance with these regulations, public entities across the country -- including Indian tribes, counties, hospital districts, local health authorities, and public providers -- routinely transfer funds for use as the non-Federal share in State Medicaid payments. Overwhelmingly, if not exclusively, these transfers are made by the public providers themselves or by a public entity that has a close relationship with the provider. In accordance with previous CMS guidance, sometimes these funds are derived from State and local tax revenue, however, the State contends that they often are sourced from non-tax funds. The State alleged that the Proposed Decision threatens to upend these longstanding and critical sources of Medicaid funding by treating these transfers as invalid provider-related "donations."

Specifically, the State addressed its exceptions as follows:

Exception #1: The Proposed Decision Misreads Section 1903(w)(6)

The Proposed Decision recommended that the Administrator conclude that "regardless of whether" funds are "public funds" within the meaning of 42 C.F.R. §433.51(b), a transfer from a public entity closely related to a provider is a donation. The Presiding Officer bases this recommendation on section 1903(w)(6)(A) of the Social Security Act.

In its briefs before the Presiding Officer, CMS took the position that intergovernmental transfers derived from State and local taxes were "protected" under section 1903(w)(6) but that all other transfers were "unprotected" donations that could not be considered as "public funds." In the Proposed Decision, the Presiding Officer appears to go even further, recommending that the Administrator hold that any transfer of funds (presumably, even one derived from State and local taxes) that comes from a public entity with a "close relationship" to a provider is a donation.

The State argued that CMS' brief and the proposed decision's position are contrary to the plain statutory language. By its terms, section 1903(w)(6) in and of itself does not restrict the public funds that may be used as a valid source of non-Federal share through an intergovernmental transfer. Rather, the statute provides that if the Secretary limits use of public funds, he "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 within a State[.]" CMS itself confirmed this reading of the statute when it promulgated regulations implementing its provisions in 1992. At that time, CMS informed States: "until the Secretary adopts regulations changing the treatment of intergovernmental transfers, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level)." *See* State Ex. P, 57 Fed. Reg. 55043, 55119 (Nov. 24, 1992) (emphasis added). Since that time, the Secretary has proposed, but not adopted, regulations changing the treatment of intergovernmental transfers to limit the sources of revenue that can be used as the non-federal share. *See* State Ex. R, 72 Fed. Reg. 29748, 29766 (May 29, 2007) (withdrawn); SC Ex. U, 84 Fed. Reg. 63722, 63766 (Nov. 18, 2019)(withdrawn).

The State argued that, while not entirely clear, it appeared that the Presiding Officer has not only misread the introductory clause in Section 1903(w)(6) regarding the limitations on the Secretary's authority, but has also misconstrued the subsequent clause which provides that this limitation (which CMS refers to as "protection") does not apply if "the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section." The Proposed Decision appears to take the position that any transfer of funds from a public entity with a "close relationship" to a provider is a provider-related "donation" that falls outside the protections of Section 1903(w)(6). Because this clause of the provision is modifying the "protected" transfers derived from State and local taxes, the Presiding Officer apparently concludes that any transfer from a public provider or public provider-related entity would be a "donation." That extreme position goes beyond even CMS (tenuous) arguments and would permit only those intergovernmental transfers that bear no direct or indirect relationship to provider payments and are therefore "bona fide."

Exception #2: The Proposed Decision Violates A Core Principle of Administrative Law By Ignoring Prior Agency Statements and Actions.

The State also argued that the Recommended Decision is inconsistent with decades of CMS practice and public statements, on which South Carolina and other States have relied, which permit a variety of "public funds" to be used as the non-Federal share of State Medicaid payments, as long as the transferring entity is public (which is not disputed here).

As noted above, in 1992, CMS informed States that unless and until "the Secretary adopts regulations changing the treatment of intergovernmental transfers," which he has not done, States may use transferred funds "derived from any governmental source." *See* State Ex. P, 57 Fed. Reg. 55043, 55119 (Nov. 24, 1992). In 2007, CMS similarly told States that transfers from units of government were permissible "from a variety of sources (including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds)." See State Ex. R, 72 Fed. Reg. 29748, 29766 (May 29, 2007). CMS also explained that "patient care revenues from other third-party payers … would also be acceptable sources of financing the non-Federal share of Medicaid payments." *Id*. The State emphasized that lest there be any doubt on the issue, CMS expressly confirmed that "governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues." *Id*. (Emphasis added).

In this case, the State asserted that the administrative record makes abundantly clear that CMS had told States and public entities that unless and until CMS changed its regulations regarding intergovernmental transfers, it would allow a wide variety of "public funds" as the source of the non-federal share. There has been no change in the governing regulation. The Proposed Decision should be rejected, because neither CMS in its disapproval, nor the Presiding Officer in his recommended decision, explain or justify the departure from the agency's previous statements.

Exception #3: The Proposed Decision Inappropriately Attempts to Enforce an Agency Policy That the Agency Abandoned in Rulemaking.

The States also challenged that the decision attempts to enforce an agency policy abandoned in rulemaking. As explained above, in 1992, CMS informed States that they could continue to use funds "derived from any governmental source" unless and until the agency adopted a more limited definition. That statement was consistent both with the text of Section 1903(w)(6) and with an uncodified statutory provision prohibiting CMS from "chang[ing] the treatment . . . of public funds" except through notice-and-comment rulemaking. See Pub. L. 102-234. 105 Stat. 1793 (1991). Any such regulatory limitation would need to be consistent with the restrictions on the Secretary's authority in Section 1903(w)(6) which, in CMS's words, "protects" transfers derived from state and local taxes.

In 2019, the State contended that CMS proposed to adopt a more limited definition of "public funds" in its regulations, expressly limiting those funds to the "protected" sources identified in Section 1903(w)(6). See State Ex. U, 84 Fed. Reg. 63722, 63737 (Nov. 18, 2019). The administrative record includes numerous comments submitted in response to the rule, noting that the proposal represented a significant, and deleterious, change from past policy and practice. See State Exs. 26-40. Ultimately, CMS withdrew that proposed regulation. See 86 Fed. Reg. 5105 (Jan. 19, 2021).

The State concluded that the approval of a State plan amendment must be based on "relevant Federal statutes and regulations." 42 C.F.R. § 430.15(a)(1). As set forth above, CMS' existing regulation regarding the use of "public funds" as the non-Federal share does not limit the sources of funds for intergovernmental transfers to those derived from state or local taxes, and CMS has abandoned its attempt to modify that regulation to contain such a limitation. Because CMS is bound by regulation, the State maintained that the Administrator cannot, and should not, adopt or enforce policies through the State plan amendment disapproval process that CMS has decided not to pursue through regulation.

Discussion

The Administrator finds that the Centers for Medicare & Medicaid Services' (CMS') properly determined that State Plan Amendments (SPAs) 16-0012-A, 17-0006-A and 18-0011-A are inconsistent with the requirements of Section 1902(a)(2), Section 1903(a), Section 1905(b) and Section 1903(w)(6)(A) of the Act.

The Law

The Medicaid Program was enacted in 1965 as Title XIX, Grants to States for Medical Assistance Programs, of the Act. Section 1901 of the Social Security Act authorizes the Secretary of Health and Human Services to make Federal funds available to assist States in providing medical assistance to persons whose income and resources are insufficient to meet the costs of necessary medical services or to persons who are poor, blind, aged, and disabled. Medicaid is jointly financed by the Federal and state governments and is administered by the states. The Secretary has the authority to issue regulations and has delegated the responsibility for approving State Plans and SPAs to CMS.[2] Participation in the Medicaid program is voluntary, but once a state elects to participate, it must operate its program in compliance with federal law.

Although a State has some flexibility in designing its plan to consider the State's unique circumstances, the plan must comply with all statutory and regulatory requirements .Section 1902(a) requires that States that choose to participate in the Medicaid program must submit to the Secretary a comprehensive State Plan for medical assistance that describes the program and contains assurances that it satisfies all requirements of the Act. Consistent with the statute, the regulations at 42 C.F.R. Part 430 set forth the requirements, standards, procedures, and conditions for obtaining and continuing to receive federal financial participation.[3] Program regulations state that, "[w]ithin broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures." 42 C.F.R. § 430.0.

Section 1902(a)(2) establishes the required level that a State must contribute toward medical assistance and administration to obtain the Federal share of expenditures, otherwise known as Federal Financial Participation (FFP). Specifically, section 1902(a)(2) requires that a State plan must:

> (2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis *which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan*….(Emphasis added.)

[2] 42 C.F.R. §§ 430.1, 430.14, 430.15.
[3] 42 C.F.R. §§ 430.1, 430.3, 430.14, 430.15, 430.18.

To qualify for the State share certain statutory requirements are set forth. Section 1903(a) of the Act provides that from the sums appropriated, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title as provided by law.

In 1991, Congress amended the Social Security Act to address the problem of Medicaid funding schemes.[4] The amendments in section 1903(w) of the Act that resulted from compromises[5], required that certain funds defined as "provider donations and taxes" be omitted from the total amount of expenditures eligible for FFP. but protected intergovernmental transfers or IGTs that are "derived from state or local taxes" and transferred by "units of government" within a state. Section 1903(w) of the Act provides:

> (1)(A) . . . for purposes of determining the amount to be paid to a State . . . the total amount expended during such fiscal year as medical assistance under the State plan . . . shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—
>
> (i) from provider-related donations (as defined in paragraph (2)(A)), other than—
>
> I) bona fide provider-related donations (as defined in paragraph (2)(B)) . ..

Further, section 1903(w)(1), (2) addresses the definition of "provider-related donations", stating:

> (2)(A) In this subsection (except as provided in paragraph (6)), the term "provider-related donation" means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—
>
> (i) a health care provider (as defined in paragraph (7)(B)),
>
> (ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or
>
> (iii) an entity providing goods or services under the State plan for which payment is made to the State . . . .

A "bona fide provider-related donation" is defined at section 1903(w)(2)(B) of the Act stating:

> (B) For purposes of paragraph (1)(A)(i)(I), the term "bona fide provider-related donation" means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

---

[4] *See* Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law No. 102-234, 105 Stat. 1793 (Dec. 12, 1991).

[5] *See also* Debate Regarding Conference Report on H.R. 3595, Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, 137 Cong. Rec. H11865, H11871 (November 26, 1991) (CMS Ex. 1).

Relevant to this case, section 1903(w)(6) provides that:

> (6)(A) Notwithstanding the provisions of this subsection, 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 within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.
> (B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

Finally, section 1902(w)(7) defines "health care provider" and their "related organizations." Section 1903(w)(7) states:

> (7) For purposes of this subsection:
>
> . . . .
>
> (B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.
> (C) An entity is considered to be "related" to a health care provider if the entity—
> a. is an organization, association, corporation or partnership formed by or on behalf of health care providers;
> b. is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;
> c. is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or
> d. has a similar, close relationship (as defined in regulations) to the provider.

CMS implemented these provisions in an interim final rule, dated November 24, 1992,[6] and the subsequent final rule published in the August 13, 1993 *Federal Register*, stating: [7]

> Section 1902(a)(2) of the Act requires States to share in the cost of medical assistance expenditures, and permits both State and local governments to participate in the financing of the non-Federal portion of expenditures under the Medicaid program. This section specifies the minimum percentage of the State's share of the non-Federal costs, and requires that the State share be sufficient to assure that the lack of adequate funds from local government sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State. Section 1903 of the Act requires the Secretary to pay each State an amount-equal to the Federal medical

[6] *See* 57 Fed. Reg. 55118 (November 24, 1992) ("Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share").
[7] *See* 58 Fed. Reg. 43156.

assistance percentage of the total amount expended as medical assistance under the State's plan.

Public Law 102-234 amended section 1903 of the Act by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in FFP will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstationed eligibility worker donation requirements, as specified in the law. The law also specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. Such taxes are broad-based taxes which apply in a uniform manner to all health care providers in a class, and which do not hold providers harmless for their tax costs. However, the law permits States which have received, by specific date prior to the enactment of this law, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

Public Law 102-234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.

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 intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

Prior to the enactment of Public Law 102-234, regulations at 42 C.F.R. §433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The provisions of Public Law 102-234 apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act. The exemption is currently limited to Arizona. The provisions apply to donations to State or local governments from providers and related entities and to revenues generated by health care-related taxes,

> regardless of whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government, and regardless of whether the State uses these funds as the State share of medical assistance expenditures for FFP purposes. However, the provisions do not apply to the treatment of donations from entities not related to providers or the receipt of revenues generated by generally applicable taxes or other non-health care-related taxes.[8]

With respect to provider related donations CMS stated that:

> General Rule
>
> Section 1903(w)(1) of the Act provides that, effective January 1, 1992, before calculating the amount of FFP, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are as follows:
>
> Donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers);
>
> Impermissible health care-related taxes; and until October 1, 1995, permissible health care-related taxes that exceed a specified limit.
>
> It is important to note that the new statutory requirements apply to all impermissible provider-related donations and health care-related tax revenues received by State or local governments, without consideration of the use of the funds. If a State levies a tax on hospitals that is impermissible under section 1903(w) of the Act, and deposits the revenues in an account designated for some purpose other than Medicaid funding, the statute requires that the funds be offset from Medicaid expenditures even though the State is not using the revenues as its share of Medicaid expenditures for FFP purposes. For this purpose, the statute treats the State, and units of local government within the State, as a single entity. The fact that the funds were not received directly by the Medicaid agency does not alter the statute's requirements that the funds be reduced from the State's claimed expenditures.
>
> Section 1903(w)(2)(A) of the Act defines "provider-related donations" as any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses. Section 1903(w)(2)(B) defines "bona fide provider-related donations" as provider-related donations that have no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established to the satisfaction of the Secretary. The statute also gives the Secretary the authority to specify, by regulation, types of provider-related donations

[8] *Id*. 57 Fed. Reg. at 5518-5519.

that will be considered to be bona fide provider-related donations. [9]

CMS specifically stated that:

> We are revising subpart B in 42 CFR part 433 to incorporate the statutory provisions of section 1903(w) of the Act relating to States' receipt of provider-related donations and health care-related taxes. Under revised subpart B, we are adding §§ 433.50 through 433.74. Section 433.50, entitled Basis, scope, and applicability, includes a provision that this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act (section 1903(w)(7)(D) of the Act).[10]
>
> ….
>
> Additionally, provider-related donations are defined under this section as a donation made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan. Under this definition, donations made by a health care provider to an organization, which in turn donates money to the State, will be considered to be an indirect donation to the State by the health care provider. Thus, the statutory requirements pertaining to provider-related donations would apply.[11]

The regulation, now designated at 42 C.F.R. § 433.51, describes the State share of financial participation which provides:

> (a) Public Funds may be considered as the State's share in claiming FFP 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 are 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.

In implementing section 1902(w) of the Act, 42 CFR § 433.52 sets forth general definitions:

> As used in this subpart—

---

[9] *Id*. 57 Fed. Reg. at 55119.
[10] *Id.* at 55119-55120.

[11] *Id*. at 55120.

to such a health care provider, or an entity providing goods or services to the State for Entity related to a health care provider means—

(1) An organization, association, corporation, or partnership formed by or on behalf of a health care provider;

(2) An individual with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act;

(3) An employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or

(4) A supplier of health care items or services or a supplier to providers of health care items or services.

Health care provider means the individual or entity that receives any payment or payments for health care items or services provided.

Provider-related donation means a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related administration of the State's Medicaid plan.

(1) Donations made by a health care provider to an organization, which in turn donates money to the State, may be considered to be a donation made indirectly to the State by a health care provider.

The regulation at 42 C.F.R.§ 433.54 describes bona fide donations.

(a) A bona fide donation means a provider-related donation, as defined in § 433.52, made to the State or unit of local government, that has no direct or indirect relationship, as described in paragraph (b) of this section, to Medicaid payments made to—

(1) The health care provider;

(2) Any related entity providing health care items and services; or

(3) Other providers furnishing the same class of items or services as the provider or entity.

(b) Provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in paragraph (c) of this section.

The regulation at 42 C.F.R. § 433.57 provides:

Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues

> generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—
>
> (a) Permissible provider-related donations, as specified in § 433.66(b); or
> (b) Health care-related taxes, as specified in § 433.68(b).[12]

As noted by CMS in its briefs, the foregoing requirements in excluding non-bona fide provider donations does not distinguish between private and public health care entities. The general principles are subsumed in §433.51 as specifically restricted by § 433.57 consistent with the Act.

Background

The South Carolina Medicaid program provides a supplemental payment to physician practitioners who are employed by or under contract with State university teaching programs that train medical residents and interns. These payments are used to support State training programs with the intent to ensure participation from specialists and primary care physicians in serving Medicaid patients.

---

[12] The 1991 amendments to the Medicaid Act were implemented 1991 at 52 Fed. Reg. 5514 (November 11, 1992) and stated:

> § 433.57 General rules regarding revenues from provider-related donations and health care-related taxes.
> Effective January 1,1992, HCFA will deduct from a State's expenditures from medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—
> (a) Donations and taxes that meet the requirements specified in § 433.58, except for certain revenue received during a specified transition period;
> (b) Permissible provider-related donations, as specified in § 433.66(b): or
> (c) Health care-related taxes, as specified in § 433.68(b).

Subsequently, §433.57 was amended by— A. Removing paragraph (a). and B. Redesignating existing paragraphs (b) and (c) as paragraphs (a) and (b), respectively. (73 Fed, Reg. 9698) (February 22, 2008). (" Section 1903(w) of the Act, as added by the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, became effective January 1, 1992. However, section 1903(w)(1)(C)(ii) of the Act provided for transition periods during which, under certain circumstances, States could receive, without a reduction in FFP, revenues from provider-related donations and impermissible health care-related tax programs in effect before the enactment of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991. The requirements related to these transition periods are currently located in various sections of the current regulation from § 433.58 through § 433.68. The last transition period expired in 1993. We are proposing to remove from within the regulatory text all references to collection of provider-related donations and health care-related taxes during the transition periods since all transition periods have expired. We believe this would create a more streamlined regulation that is easier to read *See* 72, Fed Reg 13726 13731 (March 23, 2007) (Proposed Rules)).

In March 2016, the South Carolina Department of Health and Human Services (DHHS) submitted a State plan amendment (SPA 16-0004) to change the calculation of the supplemental payments from a percentage of Medicaid charges, to a payment based on the average commercial rate. The original SPA 16-0004 identified eight institutions whose teaching physician would qualify for supplemental payments. The institutions included physicians employed by or under contract with Greenville Memorial Hospital, which at the time of submission was still operated by Greenville Hospital Authority (or GHA). The State informed CMS that the source of the non-Federal share of the supplemental payments described in SPA 16-0004 would come from intergovernmental transfers (IGTs) from public entities. CMS approved the SPA, with a "sunset" date of September 30, 2016.

The State then submitted SPA 16-0012 to extend the supplemental payment program for the period beginning October 1, 2016. The SPA provided that the State share of the physician supplemental payments for the hospital(s) comes from what the State characterized as IGTs from GHA to the State, funded primarily from the Setoff Debt Collection Program. The SPAs proposed that CMS would pay the corresponding FFP for the physician payments.

In 1995, the South Carolina legislature established the Setoff Debt Collection Program at South Carolina CODE § 12-56-10 *et seq*. Under the program, when a claimant agency (considered to be a State agency, board, political subdivision or other governmental or quasi-governmental entity) is owed a delinquent debt, a governmental entity may request that the South Carolina Department of Revenue setoff payment of that debt from any tax refund that the debtor would otherwise be entitled to receive.[13]

Greenville Health Authority (GHA) was formerly known as Greenville Health System and was established by the South Carolina Legislature in 1947. The authority was established to ensure the establishment and maintenance of adequate health care facilities in the community it serves. Prior to 2016, GHA owned and operated Greenville Memorial Hospital (now Prisma Health Greenville Memorial Hospital (PHGMH)). In 2016, GHA entered into a long-term lease with a private operator Upstate Affiliate Organization. (Prisma Exhibit 3, *2019 Report to the Greenville Hospital Authority*, "Memorandum of Lease" at p 36.) Due to a merger. the latter was later established as Prisma Health (Prisma). Prisma Health currently operates both Prisma Health Greenville Memorial Hospital or PHGMH (formerly Greenville Memorial Hospital) and Prisma Health Richland Hospital (PHRH) (formerly known as Palmetto Health Richland). *See*, December 2, 2019 Prisma Health Petition to participate as a party for a general recitation of history of entities.

The GHA owned the hospital, but as of October 1, 2016, GHA leased its assets to a private non-profit (now called Prisma Health), which assumed substantially all of the obligations of GHA, including operation of Greenville Memorial Hospital. The change in the relationship raised CMS' concern relating to the transfers of funds from GHA as the non-Federal share of supplemental payments. CMS and the State agreed that payments to physicians associated with Greenville Memorial Hospital would be submitted as a separate SPA so as not to affect approval for the remaining hospitals. At CMS' request, the State separated SPA 16-0012 into two SPAs. SPA 16-0012 included all participating hospitals with the exception of Greenville Memorial Hospital and SPA 16-0012-A included only Greenville Memorial

[13] SC CODE § 12-56-50.

Hospital.[14] CMS approved SPA 16-0012, and issued a "request for additional information" with respect to SPA 16-0012-A.

Subsequently, SPAs 17-0006 and 18-0011 were submitted. However, in the interim, Upstate had merged with Palmetto Health (the parent corporation of Palmetto Health Richland Hospital or PHRH), forming Prisma Health. CMS raised similar concerns with respect to transfers from GHA being used as the non-Federal share of payments to what would now be PHRH. Consequently, the SPAs were again split with the supplemental payments for these two hospitals (Prisma Health Greenville Memorial Hospital or PHGMH (formerly Greenville Memorial Hospital and Prisma Health Richland Hospital (PHRH) (formerly known as Palmetto Health Richland) set out in SPA 17-0006-A and 18-0011-A.

During this period of the submissions, the State provided information to CMS regarding the funding source for the payments to physicians affiliated with the hospitals, Greenville Memorial Hospital and Palmetto Health Richland for the three SPAs.

The record shows significant correspondence between the State and CMS. In a February 7, 2018 electronic mail from CMS to Jeff Saxon, CMS responded that it did not have an issue with the entity transferring the funds but believed that section 1903(w)(6)(A) of the statute requires that Inter-government Transfers (IGT) must be derived from State or local tax revenue for the funds to be protected.[15]

In January 2019**,** the Director of SCDHHS sent a memo to CMS explaining the public status of GHA, describing the legal authorities supporting the State's position that IGTs did not have to come from State or local taxes. The State contended that GHA will not have any financial gain as result of the transfers. The State contended that there are no provider-related donations between the two hospitals and GHA.

CMS requested additional information to which the State responded in April 2019, for SPA 16-0012-A. The State indicated that GHA was a public entity and explained that the Setoff Debt Collection funds were funds collected by the South Carolina Department of Revenue for debts owed to Greenville Memorial Hospital from the time period when it was owned and operated by GHA, and therefore a valid source of public funds.[16] Subsequently, in May 2019, SCDHHS provided similar responses with respect to the requests for additional information for SPAs 17-0006-A and 18-0011-A.

---

[14] The Amica noted that 16-0012-A only isolated Greenville Memorial Hospital, and that Palmetto Health Richland was included with all other hospitals in 16-0012. October 25, 2016 Prisma Health Petition, n. 1. Greenville Memorial Hospital was leased to a non-profit organization, which eventually merged with Palmetto Health in 2017 to form Prisma Health. Palmetto Health Richland became incorporated into the SPA 17-006 A and 18-0011-A. Its origins traces from 1892 as Columbus Hospital, when it was eventually renamed Richland Memorial Hospital. Richland Memorial Hospital merged with Baptist Hospital (formerly South Carolina Hospital) in the late 1990s to form Palmetto Health. Palmetto Health became Prisma Health.

[15] Exhibit 9 p.1.

[16] SCDHHS Exhibits 14, 15.

CMS Disapproval

On July 9, 2019, CMS disapproved the three SPAs, concluding that GHA's revenue transfer to the State Medicaid Agency violated sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act. CMS stated:

> These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).
>
> The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the other State Medicaid Agency as the non- federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.
>
> The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs. In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.
>
> Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that States received a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-Federal share of

> the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

In summary, CMS stated it did not determine whether the GHA was a unit of government eligible to make an IGT, however, CMS determined that the ultimate source of the revenue was not derived from State or local tax revenue, but rather, from uncollected patient revenues which were directly garnished from State individual income tax refunds. CMS found that GHA does not have taxing authority, nor does it receive appropriated funds that could be used as the source of the non-federal share for an allowable intergovernmental transfer. CMS disapproved the SPAs because the non-Federal share of the payments proposed would not originate from a permissible source.

The State sought reconsideration of the disapproval by letter dated September 5, 2019. The CMS Administrator issued a notice, which was published in the *Federal Register* on October 11, 2019, announcing a hearing to reconsider CMS' decision to disapprove the State plan amendments. The *Federal Register* notice set forth the issues to be considered at the hearing.

Holding

The Administrator upholds the July 9, 2019 disapproval of South Carolina SPAs 16-0012-A, 17-0006-A and 18-0011-A. The State has failed to prove that the SPAs conform with Federal requirements. The State has proposed to fund the non-Federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act.

The payments proposed under the SPAs would be funded though amounts transferred from GHA to the State Medicaid Agency. The State contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity-Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an IGT derived from State or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While the status of GHA as a unit of government was not examined by CMS or assessed as to whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, CMS did find that the source of GHA's transfers were in fact derived from a "Setoff Debt Collection Program" whose funds are derived from patient revenue.

Section 1906(w)(6)(A) of the Act provides that only IGTs which are derived from State and local taxes or certain appropriations are protected sources of the State's share. The "Set off Debt Collection Program" garnishes State individual income tax refunds to satisfy outstanding medical debt owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from State or local taxes as required by the statute to support a protected IGT, but instead from previously uncollected patient revenue which are to be used to fund the amount of physician payments the provider hospitals expect to receive. As such, the revenue is not a protected source for use as an IGTs to serve as the non-Federal share of the supplemental payments under the proposed SPAs. Furthermore,

GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

The statute provides that the Secretary retains a high level of discretion over whether a donation is bona fide and under the definition established by the Secretary, the designated funds fail to meet that definition. Section 1903(w)(1)(A) of the Act provides that provider donations must be deducted from the total amount of Medicaid expenditures eligible for FFP unless they qualify as bona fide donations. Under section 1902(w)(7)(B) of the Act and 42 C.F.R. §433.54, a "bona fide" donation is a provider related donation that has no direct or indirect relationship to Medicaid payments to that provider, a related entity, or other providers furnishing the same class of items or services as the provider. A health care provider is an individual or person that receives payment for the provision of health care services as explained at section 1396(w)(7)(B) of the Act. The debt set-off that provides the source of the funds involves collected debt from the medical services of the health care provider and are directly related to the amount these same entities are to receive for physician payments and thus, comprising non-bona fide provider donations.

Section 1902(a)(2) of the Act provides that the State plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that States receive a statutorily determined FMAP for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for State expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a State's expenditures does not qualify to be matched with federal funds. Under such circumstances, the State cannot receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18- 0011-A would not originate from a permissible source, and the State has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS appropriately disapproved the SPAs since they were not consistent with the foregoing provisions of the Act.

The State argues that the funds at issue are "public funds" as it contends the GHA qualifies as a government entity and, therefore, the revenues from the debt collection of patient accounts for rendered medical services may be qualified as the State's share as intergovernmental transfers or IGTs. As CMS noted, the term "public funds" is not defined in the statute or regulation. The language in the regulation at 42 C.F.R. § 433.51, upon which the State relies, was established long before the 1991 enactments at issue. (*See* Appendix.)[17] The State's reading would ignore the clear statutory language enacted in 1991 and

[17] Similar regulatory language was used for programs under HEW and later HHS and Medicaid as early as the 1970s surrounding administrative training costs and donations. (See Appendix.) The issue that gave rise to the 1991 legislation appears to have originated from revisions in 1984 to a narrow provision on calculating FFP for administrative training costs under Medicaid set forth in the "Medicaid Program; Third Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation" at 49 Fed. Reg. 23078 (June 4, 1984). ('Section 432.60 is in Part 432—State Personnel Administration. Because the revised requirements would no longer be limited to training costs, we would redesignate them as § 433.45 of Part 433—Fiscal Administration. " 433.45 was redesignated as 433.51.) The early preamble language from 1984 suggests

negate its lawful establishment in the regulation at 42 C.F.R. § 443.57(a) which requires amounts to be deducted from the State's expenditures for medical assistance, before calculating FFP if the donations are not—permissible provider-related donations, as specified in 42 C.F.R. § 433.66(b). Moreover, the nature of these funds, as provider related donations that are explicitly derived from medical debts from patient care services of the specified hospitals and tied to the amount of physician payments the specified hospitals expect to receive, is supported by the record and law. The regulation clearly requires, consistent with the statute, that these amounts are to be deducted from the State's expenditures as a step that is mandated to be taken before calculating FFP. CMS has appropriately determined that such amounts are not protected under section 1902(w) of the Act.[18] When that required action is taken, there is no State expenditure to fund the State's share of Medicaid expenditures, and the SPAs are correctly denied as inconsistent with the Act.[19]

The State also claims the preamble to 2007 regulations, that were ultimately invalidated, showed CMS was inconsistently applying the policy in this disapproval. The State incorrectly asserted that, in that same 2007 preamble, "CMS confirmed that '[g]overnmentally-operated health care providers are not required to demonstrate that the funds transferred or certified are, in fact, tax revenues." But that statement must be understood in context. The full response reads:

> Governmentally-operated health care providers may use appropriated tax revenues to fund the non-Federal share of Medicaid expenditures through IGTs or CPEs. Governmentally-operated health care providers are not required to demonstrate that the funds transferred or certified are, in fact, tax revenues. A governmentally-operated health care provider is always able to access tax revenue, a characteristic of which reflects a health care provider's governmental status, and helps to define eligibility to participate in IGTs and/or CPEs.[20]

---

an expectation that: "The definition of "State funds" generally used by States means funds over which the State legislature has an unrestricted power of appropriations." 49 Fed. Reg. 23078. The use of the term "public funds' in the regulation, would appear to be the result of the origin of the regulatory language having been developed from other programs in the 1970s and brought forward. The computation of the FFP is done after a final step required under 42 C.F.R. §433.57, as required by section 1903(w)(6) of the Act.

[18] Despite the State's allegations, the preamble of the 1992 final rule is not contradicted in this holding. The State quotes that CMS informed States: "until the Secretary adopts regulations changing the treatment of intergovernmental transfers, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level)." *See* State Ex. P, 57 Fed. Reg. 55043, 55119 (November 24, 1992). The State ignores the phrase inseparable from the underlined emphasis "other than impermissible taxes or donations derived at various parts of the State government or at the local level." Here the funds are an impermissible donation. The SPA disapprovals do not require for support a regulation changing the treatment of intergovernmental transfers, rather, the support is in the plain meaning of the statute.

[19] *See also* "Brief of Respondent Centers for Medicare & Medicaid Services", dated May 19, 2020, pp.6-10 discussing the extensive history of this legislation supporting the disapproval in this case.

[20] 72 Fed. Reg. 29748, 29760.

The text quoted by the State only addresses the evidentiary accounting the State must make with respect to governmentally-operated health care provider to establish that the IGTs are protected under a new (invalidated) proposed definition of governmentally owned. By definition, these entities would have to have taxing authority or direct access to tax revenues. The Agency went on to explain that providers qualifying as "governmentally-owned" under the proposed regulation would not have to demonstrate that the funds transferred or certified were, in fact, tax revenues, in recognition of the fact that dollars are fungible and "funds from different sources can be commingled in health care provider accounts."[21] For that reason, the Agency explained, it was "not requiring that governmentally-operated health care providers trace funding precisely," though such providers would need to have either "taxing authority or direct access to State or local tax funds in at least the amount of the IGT or CPE …."[22] Notably, even in the context of this invalidated rule, CMS had consistently explained since the law's 1991 enactment, that, under section 1902(w) of the Act, IGTs must be funded with State or local tax dollars in order to be protected, the plain meaning of the statute that is not disrupted or rebutted by any statements in this preamble. Therefore, the State's argument is not persuasive here.

Moreover, as CMS explained in its brief, the more appropriate portions of the preamble to the 2007 regulations are those describing the *existing* statutory requirements for protected IGTs, implemented pursuant to section 1903(w) of the Act, which was not touched by the invalidated policy. The preamble explained that: "Section 1903(w)(6)(A) of the Act protects IGTs and CPEs only when 'derived from State or local taxes (or funds appropriated to a State university teaching hospital)."[23] Further, CMS stated "[t]his statutory clause would not be necessary if any governmental entity revenues could be used for protected transactions."[24]. The preamble goes on to explain that operating revenues would not satisfy this statutory requirement for protection:

> When funds are received by a health care provider in the course of its normal operations, those funds are not "derived from State or local taxes" unless they are tax funds or are funds appropriated by a government entity from tax revenues and paid for Medicaid services at the health care provider. Funds appropriated from tax revenues and paid for non-Medicaid services at the health care provider lose their characteristic as "derived from State or local taxes" and, to the extent unexpended on the designated non-Medicaid services, would be profits derived from the provision of those services. Such funds could not be used to contribute the non-Federal share of Medicaid expenditures because they are derived from the operations of the health care provider, rather than from State or local tax revenues.[25]

Therefore, the State incorrectly asserts that the disapproval of the SPAs is contrary to prior statements relating to successfully promulgated rules. Rather, the State's referenced quotes can only be accurately understood within the context of policies that were invalidated and not allowed to stand.

---

[21] 72 Fed. Reg. 29763.
[22] 72 Fed. Reg. 29763.
[23] 72 Fed. Reg. 29762.
[24] 72 Fed. Reg. 29762.
[25] 72 Fed. Reg. 29748, 29762–63.

In disapproving these SPAs, CMS also has not violated the provision prohibiting the Secretary from issuing any "interim final regulations" which change the treatment of "public funds" as a source of the State share "except as may be necessary to permit the Secretary to deny Federal financial participation for public funds … that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act." The Secretary has not issued any relevant interim final regulations. The statute does not, by its terms, prevent the Secretary from denying FFP for public funds "derived from donations," pursuant to review of a SPA. which would include the funds offered by GHA in this case. The disapproval applies the plain meaning of the statute as properly promulgated in the regulations and is case specific and limited to these proposed SPAs.

In sum, the funds transferred from GHA which is derived from the debt collections of patient revenues of the respective hospitals, is not a permissible source. Under these specific circumstances, in these SPAs, the decision to disapprove the contested State Plan Amendments was proper.

Decision

The Administrator affirms the disapproval of South Carolina SPAs 16-0012-A, 17-0006-A and 18-0011-A.

THIS CONSTITUTES THE FINAL ADMINISTRATIVIE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: November 25, 2024

Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services

Appendix:

1970s

The language for the now designated 42 CFR 443.51 appeared to originate from early regulatory language used in Titles I, X , XIV and XVI and later IV and finally similar language was adopted in Title XIX of the Social Security Act. *See*, 35 Fed Reg 6628, 6633 (April 24, 1970); 35 Fed. Reg, 18170 (November 26, 1970). *See e,g*, 45 C.F.R. Part 222. [26] In addition similar language was used when various amendments were combined and transferred to new Part 221, from Parts 220 and 222,[27] and established 45 CFR 221.61 (38 Fed. Reg. 10782, 10788 (May 1, 1973))(Part 221-Service Programs for Families and Children and for Aged blind and disabled individuals: Title I, IV (Parts A and B), X, XIV, and XVI of the Social Security Act).[28]

.

Separate "training" regulations were proposed for financial assistance, medical assistance and social services at 42 Fed. Reg. 2440 (January 11, 1977). 45 CFR Part 207.1 explained that the scope of the rule was for requirements and the conditions for Federal financial participation (FFP) which are applicable to training costs incurred for the financial and medical assistance and services programs under titles I, IVA, X, XIV, XVI (AIM), XIX and XX of the Social Security Act.[29] Further, 45 C.F.R. Part 207.16 stated:

---

[26] *Id.* at 30036.

[27] See *e g*, 38 Fed. Reg. 4608, 4613 (February 16, 1973))

[28] *See also* Final rule at 38 Fed Reg. 30072 (Oct 31, 1973)(final rule) ("Notice of proposed rulemaking was Published in the FEDERAL REGISTER on September 10, 1973 (38 FR 24872) to modify the social services regulations which had previously been published in the FEDERAL REGISTER on May 1, 1973 (38 FR 10782), effective July 1, 1973. On July 9, 1973; Public Law 93-66 postponed the effective date of the social services regulations until November 1, 1973. Notice of this postponement was published in the FEDERAL REGISTER on July 25, 1973 (38 FR 19911). The final regulations published herewith incorporate the regulations that were published on May 1, 1973, together with a clarifying amendment published in the FEDERAL REGISTER on June 1, 1973' (38 FR 14375) and the proposed rulemaking of September 10, 1973".*Id*. at 30072.)

[29] 42 Fed, Reg, 2440 ("The regulations for programs currently administered by the Social and Rehabilitation Service, published beginning in 1969, are organized in four groups: 1. Parts 201 through 213•Policies applicable to several or all of the programs administered by the Social and Rehabilitation Service. 2. Parts 220 through 228—Policies applicable to social service programs, Including the Work Incentive Program (WIN). 3. Parts 232 through 237—Policies applicable to the income maintenance program. 4. Parts 246 through 252—Policies applicable to the Medicaid program, The Department wishes to make its regulations as clear, concise and usable as possible. Already underway ix a pilot Project for total revision of the Medicaid regulations. Overall structure is a major consideration on which the Service wishes the advice of the users of its regulations. The current organizational pattern means that the total body of policies applicable to any one of the three major programs are obtainable only by referring to group 1 and to group 2, 3, or 4, as described above.")

> § 207.16 Sources of State funds. (a) Public funds. Public funds including funds from Indian Tribes may be considered as the State's share in claiming Federal reimbursement where such funds:
> (1) Are appropriated directly to the State or local agency, or transferred from another public agency to the State or local agency and under its administrative control;
> (2) Are certified by the contributing public agency as representing expenditures eligible for FFP under this section;
> (3) Represent value, as determined in accordance with 45 CFR 74.53 (b) and (c), and Appendix C. Part II, B. 11 of 45 CFR 74, of goods or property provided by a public agency even if the agency does not incur any current expenditures for such goods or property during the period of their use in the program; or
> (4) Are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

In the subsequent rule promulgated at 42 Fed. Reg. 60561 (November 29, 1977), the separate training regulations addressing Medicaid rules for financing training were published.[30] The regulation at 42 C.F.R. 446.150 explained:

> This subpart contains the State plan requirements for personnel administration and the conditions for, and rate of, Federal financial participation in staff and training costs incurred for medical assistance programs under title XIX of the Social Security Act. These regulations bring together, clarify, and recodify, with few substantive changes, current policies on staffing and training, including training and use of subprofessional staff and volunteers, as they apply to the Medicaid program (Title XIX of the Social Security Act) The basis is HCFA's desire to make its regulations clearer and simpler. The purpose is to contribute to more effective operation of the Medicaid programs.

The final rule provided that: "42 CFR Chapter IV is amended as set forth below: 1. Part 446 is amended by adding new §§ 446.150, 446.151, 446.165, 446.166, 446.170, 446,175, 446.180, *and 446.185*, and by providing Subpart titles." (Emphasis added.)[31] The language promulgated for Title XIX at 42 C.F.R. 446.185, stated that:

> § 446.185 Sources of State share and cost allocation.
> (a) Public funds as the State's share.
> (1) Public funds may be considered as the State's share in claiming Federal reimbursement if they meet the conditions specified in paragraph (a) (1) and (3) of this section.
> (2) The public funds are appropriated directly to the State or local 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.

---

[30] Concurrently, 42 Fed, Reg, 60566 (November 28, 1977) was published that: "This rule revises § 205.202 and Part 225 to make them inapplicable to the Medicaid programs under title XIX of the Social Security Act. The Pertinent content has been transferred to 42 CFR Part 446 in regulations published today at 42 FR 60564."

[31] 42 Fed. Reg. 60561.

> (3) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

In 1978, pursuant to the reorganization and rewriting of Subchapter C- Medical Assistance Program, 42 CFR Part 446 was redesignated. In particular, 42 C.F.R. 446.185 was redesignated to 42 CFR 432.60.[32] The authority for this subpart was specifically referenced at § 432.1, to implement "sec. 1902(a)(4) of the Act, which relates to a merit system of State personnel administration and training and use of subprofessional staff and volunteers in State Medicaid programs, and sec. 1903(a), rates of FFP for Medicaid staffing and training costs. It also prescribes regulations, based on the general administrative authority in sec. 1902(a)(4), for State training programs for all staff."[33] The regulation at 42 CFR 443.60 provided:

> Sources of State share of training expenditures and cost allocation. –
> (a) Public funds as the State's share.
> (1) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraph (a) (2) and (3) of this section.
> (2) 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.
> (3) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.
> (b) Private donated funds as the State's share. (1) Funds donated from private sources may be considered as the State's share in claiming FFP only if they meet the conditions specified in paragraph (b) (2) through (4) of this section.
> (2) The private funds are transferred to the State or local Medicaid agency and are under its administrative control.
> (3) The private funds are donated without any restriction which would require their use for the training of particular individuals or at particular facilities or institutions.
> (4) The private funds do not revert to the donor's facility or use unless the donor is a non-profit organization. and the Medicaid agency, of its own volition, decides to use the donor's facility.[34]

1984

This language was set forth in the 1984 proposed rule in "Medicaid Program; Third Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation" at 49 Fed. Reg. 23078 (June 4, 1984). The Health Care Financing Administration or HCFA, (the former CMS) removed § 432.60 [Removed and Reserved] and explained its content would be revised and redesignated as a new § 433.45 under Part 433.[35](which

[32] 43 Fed. Reg. 45176 (Sept. 29, 1978).
[33] *See* 43 Fed. Reg. 45199.
[34] *See* 43 Fed. Reg. 45201.

[35] "Medicaid Program; Third Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation" *see* 49

eventually was redesignated as §433.451. The agency explained that, *inter alia*, State funds are generally understood to be defined as "funds over which the state legislature has an unrestricted power of appropriation" stating that:

> General Background
>
> Section 1902(a)(2) of the Social Security Act requires States to share in the cost of medical assistance expenditures but permits both State and local governments to participate in the financing of the non-Federal portion of the Medicaid program. This section specifies the percentage of the State's share of these costs and requires that this share be sufficient to assure that lack of adequate funds from local sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State.
>
> As State fiscal budgets have become more austere, State legislatures have looked increasingly to alternative sources for funding a larger portion of the Medicaid program. Questions have arisen regarding the use of public and private donations as sources of the State's share of financial participation.
>
> *The definition of "State funds" generally used by States means funds over which the State legislature has an unrestricted power of appropriations.* Therefore, in order for donations from public or private sources to be considered as the State's share of financial participation in Medicaid, we issued regulations (§ 432.60) for determining when donations ceased being local or private funds and became State funds for purposes of a Federal program. In developing the regulations, *we wanted to ensure that the Medicaid agency maintained administrative control and unrestricted power of allocation of all donated funds.* Section 432.60 outlines the conditions under which public and private funds may be considered as the State's share of Medicaid expenditures.
>
> At the time the regulations were formulated, there was some concern about potential for abuse. We wanted to prevent donations that could be made conditional on some benefit to the donor. For example, we were particularly concerned that a "kick-back" situation could result from private donations made by a proprietary organization, such as a long-term care facility or data processing company, in return for Medicaid business. Therefore, the regulations permitted use of public and private funds as the sources of the State's share of financial participation only for one category of costs, that is, training expenditures.
>
> Experience has shown no abuse of public and private funds through conditional donations or kick-backs. Generally, donated funds are commingled with all other Medicaid funds under the State agency's administrative control. By limiting the use of donations as State funds only to expenditures for training purposes, the regulations have placed an administrative burden on the States in terms of cost allocation. Furthermore,

Fed. Reg. 23078 (June 4, 1984).

> if a State were to receive donations in an amount greater than its total training expenditures, the excess funds could not be used as the State share of other Medicaid expenditures.
>
> Proposed Changes
>
> We propose to revise the requirements in § 432.60 so that public and private donations can be used as a State's share of financial participation in the entire Medicaid program rather than just training expenditures. The revision would permit States more flexibility in administering their program and reduce the recordkeeping necessary to relate donated funds exclusively to training expenditures. Section 432.60 is in Part 432—State Personnel Administration. Because the revised requirements would no longer be limited to training costs, we would redesignate them as §433.45 of Part 433—Fiscal Administration.

1985

These changes were adopted in final in 1985,[36] where the agency again stated that: "The definition of 'State funds' generally used by States means funds over which the State legislature has an unrestricted power of appropriations."[37] One focus of the revision was to reduce the recordkeeping required, but not changing the underlying policy and requirements. A new § 433.45 was added to read as follows:

> § 433.45 Sources of State share of financial participation.
> (a) Public funds as the State's share. (1) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (a)(2) and (3) of this section.
> (2) 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.
> (3) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.
> (b) Private donated funds as the State's share. (1) Funds donated from private sources

[36] 50 Fed. Reg. 46652 (November 12, 1985) ("Medicaid Program; Third Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation") ("On June 4, 1984, we published in the Federal Register (49 FR 23078) a notice of proposed rulemaking that addressed most of the amendments of the Medicaid regulations included in this document. We received 42 comments on the proposed regulations from State welfare and health agencies, a State Medicaid directors' association, medical and health care associations, a hospital, private welfare agencies, citizens' groups, and private citizens. We also held meetings with two State Medicaid advisory groups to obtain comments. A summary of these public comments, our responses, and an explanation of any changes made in these final regulations as a result of the comments are discussed under the section "Summary of Public Comments on Proposed Rules and Department Responses" presented later in this document." *Id.)*

[37] 50 Fed Reg 46657.

> may be considered as the State's share in claiming FFP only if they meet the conditions specified in paragraphs (b)(2) and (3) of this section.
> (2) The private funds are transferred to the State or local Medicaid agency and are under its administrative control.
> (3) The private funds do not revert to the donor's facility or use unless the donor is a non-profit organization, and the Medicaid agency, of its own volition, decides to use the donor's facility.

1990

CMS subsequently issued a proposed rule in February 9, 1990 at 55 Fed. Reg 4626 ("Medicaid Program; State Share of Financial Participation")(February 9, 1990). CMS explained that:

> This proposed rule would: Clarify that entities involved in the financing of the non-Federal share of Medicaid payments must be a unit of government; clarify the documentation required to support a certified public expenditure; limit reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost; require providers to receive and retain the full amount of total computable payments for services furnished under the approved State plan…[38]

The agency explained that "[c]urrently States are allowed to use, under certain circumstances, public and private donations and all State taxes as sources of the State share of financial participation in Medicaid. Due to recent program experience indicating potential for use of these revenues to affect unfairly the Federal share of Medicaid expenditures, we are proposing to clarify the existing policy on the use of donated funds by requiring the offset of revenues received from donations from expenditures used to calculate the Federal share of Medicaid payments. We also are proposing a new policy providing for similar treatment of revenues derived from taxes applied uniquely to providers." The agency further explained that:

> *A. Objectives*
> The Medicaid statute authorizes Federal matching for State expenditures for medical assistance. The fundamental premise of this regulation is that certain revenues received by States from providers of services effectively reduce the nominal expenditures made by the States as payments to those providers. We believe that Federal matching payments in these situations should not be based upon the nominal or cash expenditures made, but should be based on the "net" expenditure. This policy is designed to ensure that Federal matching payments are not unfairly affected by devices such as "donations" or provider-specific taxes. These devices would, without an offset mechanism, unfairly increase the Federal share of Medicaid payments, in relation to the appropriate State share determined by section 1903 of the Act.
>
> The objectives of this proposed rule are to clarify the current policy concerning donations, to incorporate a provision in the regulations that permits HCFA to base FFP on the "net expenditures" made by a State (consistent with the earlier GAB decision (No. 956)), and

[38] 55 Fed. Reg 4626.

to provide a new policy providing for similar treatment of tax revenues derived from taxes levied on providers.

This regulation would require the offset of nominal expenditures by the revenues received from provider donations and from taxes applied uniquely to providers. This offset is the vehicle we propose to use to ensure that Federal funding is not unfairly affected by donation and tax devices.

Current regulations prohibit States from using donations made by providers or those affiliated with providers as the State share of Medicaid expenditures. This regulation would continue the policy and provide that the revenues from all provider donations would be subtracted from nominal expenditures to determine net expenditures eligible for Federal matching. Providers are not routinely engaged in donating funds to State governments. Our view is that all provider donations have the same effect, that is, an effective reduction in State Medicaid expenditures Since this new regulation would revise the current regulation governing the use of donated funds, it would supersede the recent GAB decision (No. 1047). It would apply to all provider donations to States, not merely those shown to be "coercive".

Similarly, this regulation would also apply to revenues produced by State taxes that are uniquely applied to providers. These taxes, which might be described as coerced donations, have the same outcome of effectively reducing States' expenditures for Medicaid payments.

Finally, this regulation would apply to State payments of taxes. In some cases, States have attempted to include taxes paid by the Medicaid agency in Medical Assistance expenditures. These taxes typically have been sales taxes paid by the Medicaid agency on behalf of Medicaid recipients who would have otherwise been liable for the tax if they were not Medicaid patients. In these cases, since the State's payment of the tax is exactly offset by the receipt of revenue, there is no basis for a claim for FFP.

This regulation would supersede the current State Medicaid Manual (SMM) instruction on taxes. This provision (section 2493) of the SMM states that FFP is unavailable for payments to providers for reimbursement of taxes applied uniquely to providers. This section also precludes FFP in tax payments made directly by the State. This proposed regulation would apply to the same types of taxes, but would, instead of precluding FFP, simply use the revenues derived from such taxes to offset nominal expenditures.

States would be permitted to reimburse providers for tax payments. In the case of inpatient hospital and long-term care facility payments, the State is, in fact, obligated to pay efficiently and economically operated facilities for the costs that must be incurred in furnishing services. In these situations, Medicaid payment rates must reflect all of the costs, including taxes, that providers must incur. . It is not our intent to limit State taxing authority, but simply to set forth the consequences of certain types of taxes with respect to FFP. In developing this regulation, we sought to satisfy several objectives, including the following:

> 1. Our intent is to assure that FFP is based on "net expenditures" and is not unfairly affected by donation and tax devices.
> 2. Consistent with our policy encouraging State flexibility in administering the Medicaid program, we do not want to dictate to States the permissible uses of particular dollars.
> 3. We would continue to discourage States from using tax or donation devices to evade their legal responsibility to set reasonable payment rates for health care providers.
> 4. We would treat taxes and donations comparably because both may be used in essentially similar ways by the State to reduce nominal expenditures.

CMS further explained that:

> The fundamental premise underlying this proposal is that the Federal government is authorized under section 1903 of the Act to match only State expenditures for medical assistance. To the extent that State revenues are derived from provider donations, provider-specific taxes, or State tax payments, the State's actual expenditures are effectively reduced by the amount of that revenue. To determine the State's net expenditures, the nominal or cash expenditures for medical services must first be determined and then the donations and revenues received from provider-specific and State-paid taxes must be subtracted. However, we do not propose to offset revenues derived from taxes paid by providers when those taxes are of general applicability to all businesses in the State. In this case, general taxes would not be considered to have the same explicit effect on Medicaid expenditures.
>
> In summary, although a State may not be precluded from using donations or taxes from health care providers as sources of funds, it would be required to offset the amount of the donation or tax against legitimate expenditures, unless the tax was paid pursuant to a law of general applicability. The offset would determine the net amount the State has expended on medical assistance, for the purpose of determining the level of FFP.[39]

The February 9, 1990 proposed rule was subsequently followed on September 12, 1991, with an Interim final rule with comment. at 56 Fed. Reg. 46380, 4380-46381, where the agency observed that:

> Under certain circumstances, States are currently permitted to use voluntary contributions (donated funds) from providers and all revenues from State-imposed taxes, as the State share of the costs of the Medicaid program. There is now widespread use of State donations or other voluntary provider payment programs that unfairly affect the Federal share of Federal Financial Participation (FFP). This practice circumvents the States' statutory obligation to expend funds for medical assistance. Therefore, effective January 1, 1992, this interim final rule requires that the amount of funds donated from Medicaid providers be offset from Medicaid expenditures incurred on or after this date before calculating the amount of FFP in Medicaid expenditures. On November 12, 1985, we published in the Federal Register a final rule (50 FR 46652) that established regulations at 42 C.F.R. §433.45 relating to sources of State financial participation. The major provision of that rule was that public and private donations could be used as

[39] 55 Fed. Reg. 4626, 4630 (February 9, 1990) (Proposed rule.)

.

> State's share of financial participation in the entire Medicaid program, instead of only for training expenditures, to which they had been limited by the previous regulation found at § 432.60.
>
> Our intent in eliminating the prior restriction was to permit the States additional flexibility in administering their programs and to reduce the recordkeeping necessary to relate donated funds exclusively to training expenditures. We had not encountered any funding issues concerning the use of donations or other voluntary payments in the limited area of Medicaid training. [40]

Pursuant to the September 1991 rule at 56 Fed. Reg. 46380-021991 ("Medicaid Program; State Share of Financial Participation" (Sept. 12, 1991)), the agency explained that:

> The current § 433.45 defines the conditions under which public funds and private donated funds may be used as the State's share in claiming FFP. We permit the use of public funds as the State share if the funds are—
>
> - Appropriated directly to the State or local Medicaid agency;
>
> - Transferred from other public agencies to the State or local agency and under its administrative control; or
>
> - Certified by the contributing public agency as representing expenditures eligible for FFP.
>
> We permit the use of private donations or other voluntary payments as the State share if the funds—
>
> - Are transferred to the Medicaid agency and under its administrative control; and
>
> - Do not revert to the donor's facility or use unless the donor is a non-profit organization, and the Medicaid agency, of its own volition, decides to use the donor's facility.
>
> The regulations do not address the remedy that would be used if a donation or other voluntary payment which did not meet the conditions of the regulation were received from providers.
>
> There are no regulations limiting the State's use of any tax revenue for its share in the costs of the Medicaid program.

However, subsequently, at 56 Fed. Reg. 56132 (Medicaid Program; State Share of Financial Participation) (October 31, 1991) another interim final rule with comment was published, which explained that:

> The agency on September 12, 1991, published in the *Federal Register* an interim final rule with comment entitled "Medicaid Program; State Share of Financial Participation" (56 FR 46380). It dealt with the use of State taxes and provider donations as the State share of the costs of the Medicaid program. Because of misunderstanding created by certain portions of that rule, we are publishing this interim final rule to withdraw and

[40] 56 Fed. Reg. 46380-81.

> cancel it and to set forth a clearer interim final rule on donations and taxes." The agency stated that: "Even though many portions of this rule are the same as those published on September 12, 1991, we are reprinting the entire rule, including the following changes and clarifications which included that: We are making clear that this rule does not invalidate the longstanding practice of using intergovernmental transfers for financing a portion of the State's Medicaid program as long as such transfers are not derived from State or local revenue sources precluded by this rule. The rule leaves intact the current policy at 42 CFR 433.45(a), which we are redesignating as § 433.45(c).

In December 1991 the agency withdrew the October 1, 1991 interim final rule.[41] 56 Fed. Reg. Reg. 64195-(Medicaid Program; State Share of Financial Participation")(December 9, 1991) (Withdrawal of interim final rule with comment.)

1992

Finally, in 1992, the agency issued an interim final rule with comment period at 57 Fed. Reg. 55118 ("Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals") (November 24, 1992). The interim final rule established in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The rule also added provisions that establish limits on the aggregate amount of payments a State may make to disproportionate share hospitals for which FFP is available. Notably, this interim final rule implemented provisions of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, which was enacted December 12, 1991.

> Public Law 102-234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.
>
> 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 intergovernmental transfer, States may continue to use, as the State share of medical

---

[41] 56 Fed. Reg. Reg. 64195("Medicaid Program; State Share of Financial Participation")(December 9, 1991) (Withdrawal of interim final rule with comment.)("On September 12, 1991, we published in the Federal Register an interim final rule with comment entitled "Medicaid Program; State Share of Financial Participation" (56 FR 46380). It dealt with the use of State taxes and provider donations as the State share of the costs of the Medicaid program. On October 31, 1991, we published a clarifying interim final rule with comment (56 FR 56132), which withdrew and cancelled the September 12, 1991, interim final rule. After further consideration, the Secretary has also decided to withdraw the October 31, 1991 interim final rule." *Id.* at 64195.)

> assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).
>
> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.[42]

Per this publication, the regulation was redesignated at 42 C.F.R. §433.51 and stated:

> § 433.51 Public funds as the State share of financial participation.
>
> (a) Public funds may be considered as the State's share in claiming FFP 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.[43]

2007

CMS published a proposed rule January 18, 2007. This proposed rule would: "Clarify that entities involved in the financing of the non-Federal share of Medicaid payments must be a unit of government; clarify the documentation required to support a certified public expenditure; limit reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost; require providers to receive and retain the full amount of total computable payments for services furnished under the approved State plan…."[44] CMS explained at 72 Fed. Reg. at 2238-2239 that:

---

[42] 57 Fed. Reg. 55118, 55119.

[43] The final rule was published at 58 Fed. Reg. 43156 ("Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes: Limitations on Payments to Disproportionate Share Hospitals")(August 13, 1993)(Final rule). *See also* 58 Fed. Reg. 6095 "Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals"; (Correction Notice.) (January 26, 1993) (Section 433.45 is redesignated as § 433.51 under subpart B.)

[44] 72 Fed. Reg. 2236 ("Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership")(January 18, 2007).

At section 1903(w)(6)(A) of the Act, the Medicaid statute provides that units of government within a State may transfer State and/or local tax revenue to the Medicaid agency for use as the non-Federal share of Medicaid payments. Because this provision does not override the definition of an expenditure as a net outlay, as discussed below, claimed expenditures must be net of any redirection or assignment from a health care provider to any State or local governmental entity that makes IGTs to the Medicaid agency. Generally, for the State to receive Federal matching on a claimed Medicaid payment where a governmentally operated health care provider has transferred the non-Federal share, the State must be able to demonstrate: (1) That 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.

….

Defining a Unit of Government (§ 433.50)
We are proposing to add new language to § 433.50 to define a unit of government to conform to the provisions of section 1903(w)(7)(G) of the Act. As discussed earlier, section 1903(w)(7)(G) of the Act identifies the five types of units of government that may participate in the non-Federal share of Medicaid payments: A State, a city, a county, a special purpose district, or other governmental units within the State. The proposed provisions at § 433.50 are modified to be consistent with this statutory reference. The newly proposed regulatory definition of unit of government includes:

• Any State or local government entity (including Indian tribes) that can demonstrate it has generally applicable taxing authority, and

• Any State-operated, city-operated, county-operated, or tribally-operated health care provider.

Under the proposed rule, health care providers that assert status to make IGTs or CPEs as a "special purpose district" or some form of "other" local government must demonstrate they are operated by a unit of government by showing that:

• 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 governmental unit with taxing authority (that is legally obligated to fund the governmental 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.[45]

[45] 42 C.F.R. § 433.51 was revised at 72 Fed. Reg. 2236, 2246 ("Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership"(January 18, 2007)) and the proposed rule set forth at stated:

In May 2007 CMS published a final rule with comment period at 72 Fed. Reg. 29748 ("Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership") (May 29, 2007). CMS proposed to (1) clarify that only units of government are able to participate in the financing of the non-Federal share of Medicaid expenditures. The agency explained that this final rule with comment period clarifies that entities involved in the financing of the non-Federal share of Medicaid payments must be a unit of government. In particular, CMS explained that:

> Under Pub. L. 102-234, which inserted significant restrictions on States' use of provider related taxes and donations at section 1903(w) of the Act, the Congress made clear that participation by local sources was limited to: (1) Permissible taxes or donations and (2) intergovernmental transfers (IGTs) and certified public expenditures (CPEs) from units of government. Specifically, units of government were permitted to participate in the funding of the non-Federal share of Medicaid payments through an exemption from provider tax or donation restrictions at section 1903(w)(6)(A) of the Act that reads:
>
> Notwithstanding the provisions of this subsection, 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 within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as

---

* * * * *42 CFR § 433.51

3. Section 433.51 is revised to read as follows:

42 CFR § 433.51

§ 433.51 Funds from units of government as the State share of financial participation.

(a) Funds from units of government may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum —

(1) Identifies the relevant category of expenditures under the State plan;

(2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;

(3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and

(4) Is subject to periodic State audit and review.

(c) The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

Subsequent regulations implementing Pub. L. 102-234 give effect to this statutory language. Amendments made to the regulations at 42 CFR part 433, at 47 FR 55119 (November 24, 1992) explained:

> 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 intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

The above statutory and regulatory authorities clearly specify that in order for an intergovernmental transfer (IGT) or certified public expenditure (CPE) from a health care provider or other entity to be exempt from analysis as a provider-related tax or donation, it must be from a unit of State or local government. Section 1903(w)(7)(G) of the Act identifies the four types of local entities that, in addition to the State, are considered a unit of government: A city, a county, a special purpose district, or other governmental units in the State. The provisions of this final regulation conform our regulations to the aforementioned statutory language and further define the characteristics of a unit of government for purposes of Medicaid financing.

Consequently, 42 C.F.R. §433.51 was proposed to be revised to read as follows:

42 CFR § 433.51

§ 433.51 Funds from units of government as the State share of financial participation**.**
(a) Funds from units of government may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
(b) The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum—
(1) Identifies the relevant category of expenditures under the State plan;
(2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;
(3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and

> (4) Is subject to periodic State audit and review.
> (c) The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.
> (i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended [25 U.S.C. 450b].

2010

However, a final rule to implement court orders, published 75 Fed. Reg. 73972, ("Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership") (November 30, 2010), amended the Medicaid regulations to conform with the decision by the United States District Court for the District of Columbia on May 23, 2008 in *Alameda County Medical Center, et al. v. Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, et al*., 559 F. Supp. 2d (2008) that vacated a final rule with comment period published in the *Federal Register* in May 29, 2007. The regulatory action took the ministerial steps to remove the vacated provisions from the Code of Federal Regulations and reinstate the prior regulatory language impacted by the May 29, 2007 final rule with comment period and was effective immediately on date of publication on November 30, 2010.

The rule explained that The U.S. Troop Readiness, Veterans Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007 prohibited the Secretary of Health and Human Services from finalizing or otherwise implement the provisions contained in a proposed rule published on January 18, 2007, titled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership".[46] Consequently, 42 C.F.R. §433.51 was revised to its pre-2007 version, and as presently written.

2019

On November 18, 2019, the agency published a proposed rule at 84 Fed.Reg. 63722 ("Medicaid Program; Medicaid Fiscal Accountability" (November 18, 2019) (Proposed rule.) The purpose of the rule was intended to promote transparency by establishing new reporting requirements for States to provide CMS with certain information on supplemental payments to Medicaid providers, including supplemental payments approved under either Medicaid state plan or demonstration authority, and applicable upper payment limits. Additionally, the proposed rule would establish requirements to ensure that State plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan and with efficiency, economy, and quality of care. This proposed rule addressed the financing of supplemental and base Medicaid payments through the non-federal share, including States' uses of health care-related taxes and bona fide provider-related donations, as well as the requirements on the non-federal share of any Medicaid payment. The agency explained that:

> While some of the proposed policies are new, there are policies within the proposed rule

[46] 72 Fed. Reg. 2236 – 2248.

> that CMS has operationalized through our work with states and interpretations of the statute in subregulatory guidance and federal regulations. We have implemented this subset of policies using existing legal authority. Some of the proposed policies in the proposed rule, such as the non-bona fide provider related donations provisions, have been reviewed and upheld by the Departmental Appeals Board (DAB) and the courts. Therefore, we are clarifying the regulatory language in this proposed rule that may have been subject to misinterpretation by states and other stakeholders, or that otherwise could benefit from additional specificity. In these cases, as discussed below, we are not proposing new statutory interpretations, but are merely proposing to codify existing policies into the Code of Federal Regulations (CFR) to improve guidance to states and other stakeholders and, to the extent possible, help prevent states from implementing policies that do not comport with applicable statutory requirements. [47]

The Agency further explained that:

> 3. Medicaid Program Financing
>
> a. Background
> Medicaid expenditures are jointly funded by the federal and state governments. Section 1903(a)(1) of the Act provides for payments to states of a percentage of medical assistance expenditures authorized under the approved state plan. FFP is available when there is a covered Medicaid service provided to a Medicaid beneficiary, which results in a federally matchable expenditure that is funded in part through non-federal funds from the state or a non-state governmental entity (except when the statute provides a 100 percent federal match rate for specified expenditures). The percentage of federal funding is the federal medical assistance percentage (FMAP) that is determined for each state using a formula set forth in section 1905(b) of the Act, or other applicable federal matching rates specified by the statute.
>
> The foundation of federal-state shared responsibility for the Medicaid program is that the state must participate in the financial burdens and risks of the program, which provides the state with an interest in operating and monitoring its Medicaid program in a manner that results in receiving the best value for the funds expended. Sections 1902(a), 1903(a), and 1905(b) of the Act require states to share in the cost of medical assistance and in the cost of administering the state plan. Section 1902(a)(2) of the Act and its implementing regulation in part 433, subpart B require states to share in the cost of medical assistance expenditures and permit other units of state or local government to contribute to the financing of the non-federal share of medical assistance expenditures. These provisions are intended to safeguard the federal-state partnership, irrespective of the Medicaid delivery system or authority (for example, FFS, managed care, and demonstration authorities), by ensuring that states are meaningfully engaged in identifying, assessing, mitigating, and sharing in the risks and responsibilities inherent in a program as complex and economically significant as Medicaid and are accordingly motivated to administer their programs economically and efficiently.

[47] 84 Fed. Reg. 63722, 63722-63723.

> Of the permissible means for financing the non-federal share of Medicaid expenditures, the most common is through state general funds, typically derived from tax revenue appropriated directly to the Medicaid agency. Revenue derived from health care-related taxes can be used to finance the non-federal share only when consistent with federal statutory requirements at section 1903(w) of the Act and implementing regulations at part 433, subpart B. The non-federal share may also be funded in part from provider-related donations to the state, but these donations must be "bona fide" in accordance with section 1903(w) of the Act and implementing regulations, which means truly voluntary and not part of a hold harmless arrangement that effectively repays the donation to the provider (or to providers furnishing the same class of items and services).
>
> Non-federal share financing sources can also come from IGTs or certified public expenditures (CPEs) from local units of government or other units of state government in which non-state governmental entities contribute funding of the non-federal share for Medicaid either by transferring their own funds to and for the unrestricted use of the Medicaid agency or by certifying to the state Medicaid agency the amount of allowed expenditures incurred. In each instance, allowable IGTs and CPEs, as with funds appropriated to the state Medicaid Agency, must be derived from state or local tax revenue or from funds appropriated to state university teaching hospitals. IGTs may not be derived from impermissible health care-related taxes or provider-related donations (discussed below); they are subject to all applicable federal statutory and regulatory restrictions. Even when using funds contributed by local governmental entities, the state must meet the requirements at section 1902(a)(2) of the Act and § 433.53 that obligate the state to fund at least 40 percent of the non-federal share of total Medicaid expenditures (both service related and administrative expenditures) with state funds. Additionally, these authorities require states to assure that a lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the state.
>
> The extent to which private providers may participate in the funding of any Medicaid payment (for example, managed care, FFS base, or supplemental payments) is essentially restricted to the state's authority to levy limited health care-related taxes and to rely on bona fide provider-related donation in accordance with statutory and regulatory requirements. Since the use of IGTs and CPEs are restricted to governmental entities, states and providers increasingly have turned to the use of health care-related taxes to enable the maintenance of, or increases to, Medicaid payments to providers. In addition, several states have explored the use of provider-related donation arrangements to further leverage private provider funding.[48]

The Preamble further explained at 84 Fed. Reg 63737-63738 that**:**

> 2. State Share of Financial Participation (§ 433.51)
> We are proposing to amend § 433.51to more clearly define the allowable sources of the

[48] 84 Fed. Reg at 63722-63723.

non-federal share to more closely align with the provisions in section 1903(w) of the Act. In § 433.51(a) and (c), we are proposing to replace the current reference to "public funds" with "state or local funds" which is consistent with statutory language as in section 1903(w)(6)(A) of the Act. Public funds is not a phrase used in section 1903(w) of the Act, and the use of this phrase in regulation has caused confusion with respect to permissible sources of non-federal share. We are proposing to revise § 433.51(b) by similarly replacing the current reference to public funds and by specifying more precisely the funds that states may use as state share. Although we have applied the statutory language to our review and approval of state financing mechanisms, the term public funds in the regulatory text has created confusion among states, and has led to state requests to derive IGTs from sources other than state or local tax revenue (or funds appropriated to state university teaching hospitals), which is not permitted under the statute in section 1903(w)(6)(A) of the Act. The proposed amendment to paragraph (b) would clearly limit permissible state or local funds that may be considered as the state share to state general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency; IGTs from units of government (including Indian tribes), derived from state or local taxes (or funds appropriated to state university teaching hospitals), and transferred to the state Medicaid Agency and under its administrative control, except as provided in proposed §433.51(d); or CPEs, which are certified by the contributing unit of government as representing expenditures eligible for FFP and reported to the state as provided in proposed § 447.206.

We are proposing these revisions to specifically align the allowable sources of the non-federal share with the statute. The proposed provisions would make clear that allowable state general fund appropriations under § 433.51(b)(1) are those made directly to the state or local Medicaid agency, and are differentiated from appropriations made to other units of government that otherwise may be tangentially involved in financing Medicaid payments through IGTs or CPEs. We would describe allowable IGTs and CPEs in proposed § 433.51 (b)(2) and (3), respectively. The statute clearly differentiates between these sources of funds. Specifically, section 1903(w)(6)(A) of the Act provides that states generally may finance the state share using funds derived from state or local taxes (or funds appropriated to state university teaching hospitals) transferred from or certified by units of government within a state as the non-federal share of Medicaid expenditures. The phrase "transferred from or certified by" refers to the IGT and CPE, respectively, and the statute clearly indicates that those funding mechanisms must be derived from state or local taxes (or funds appropriated to state university teaching hospitals). The inclusion of the above reference to "funds appropriated to state university teaching hospitals" in §433.51(b)(2) is a direct reference to language in section 1903(w)(6)(A) of the Act to more precisely implement the Act in this regulatory provision.

….

Lastly, we are proposing to add paragraph (d) to this section to clearly indicate that state funds provided as an IGT from a unit of government but that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation that is non-bona fide under §§ 433.52 and 433.54. This language is intended to implement the preclusion under section 1903(w)(6)(A) of the

> Act on the use of IGTs where the IGT is derived from a non-bona fide provider-related donation by making it abundantly clear that, as indicated in the statute, the IGT must come from state or local tax revenue (or funds appropriated to state university teaching hospitals), and any IGTs that are derived from, or are related to, non-bona fide provider-related donations would be prohibited. [49]

The proposed rule language provided:

> 433.51 State share of financial participation.
> (a) State or local funds may be considered as the State's share in claiming Federal financial participation (FFP) if they meet the conditions specified in paragraphs (b) and (c) of this section.
> (b) State or local funds that may be considered as the State's share are any of the following:
> (1) State General Fund dollars appropriated by the State legislature directly to the State or local Medicaid agency.
> (2) Intergovernmental transfer of funds from units of government within a State (including Indian tribes), derived from State or local taxes (or funds appropriated to State university teaching hospitals), to the State Medicaid Agency and under its administrative control, except as provided in paragraph (d) of this section.
> (3) Certified Public Expenditures, which are certified by a unit of government within a State as representing expenditures eligible for FFP under this section, and which meet the requirements of § 447.206 of this chapter.
> (c) The State or local funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.
> (d) State funds that are provided as an intergovernmental transfer from a unit of government within a State that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation that is non-bona fide under §§ 433.52 and 433.54.

2021

However, by notice published January 19, 2021, at 86 Fed. Reg. 5105-5106 ("Medicaid Program; Medicaid Fiscal Accountability") the agency withdrew the proposed rule stating that:

> On November 18, 2019, we published a proposed rule that proposed to amend our regulations dealing with grants to states for medical assistance programs, state fiscal administration, payments for services, Medicaid program integrity, and allotments to states and grants. (84 FR 63722). After an internal review of the proposed rule, CMS has decided to withdraw the proposed rule.

> The proposed rule sought to promote accountability and transparency for Medicaid payments by establishing new reporting requirements for states to provide CMS with certain information on supplemental payments to Medicaid providers, including supplemental payments approved under either Medicaid state plan or demonstration

[49] 84 Fed. Reg at 63737-38.

authority, codification of parameters for Medicaid upper payment limit calculations, provider definitions associated with data reporting and Medicaid financing, Medicaid disproportionate share hospital audit requirements and changes to some existing operational processes to better align with technology improvements. This proposed rule also sought to establish additional requirements to ensure that state plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan and with efficiency, economy, and quality of care. Finally, this proposed rule sought to address the non-federal share financing of supplemental and base Medicaid payments, including states' uses of health care-related taxes and provider-related donations, and other requirements for sources of the non-federal share.

We received approximately 10,188 individual comments (4,225 unduplicated comment submissions) through the extended comment period.[FN1] We received significant comments on the proposed rule regarding its potential impact on states and their budgets, Medicaid providers and Medicaid beneficiary access to needed services. Many commenters stated their belief that the proposed rule did not include adequate analysis of these matters. Numerous commenters indicated that CMS, in some instances, lacked statutory authority for its proposals and was creating regulatory provisions that were ambiguous or unclear and subject to excessive Agency discretion.

While we continue to support the intent and purpose of the rule to increase fiscal accountability and improve transparency in the Medicaid program, based on the considerable feedback we received through the public comment process, we have determined it appropriate to withdraw the proposed provisions at this time. Moving forward, we want to ensure agency flexibility in re-examining these important issues and exploring options and possible alternative approaches that best implement the requirements of the Medicaid statute. We also believe it is important to re-examine and fully analyze the proposed Medicaid reporting requirements in consideration of the recent Congressional action through the Consolidated Appropriations Act of 2021 (H.R. 116-133, Pub. L. 116-260) which establishes new statutory requirements for Medicaid supplemental payment reporting. This withdrawal action does not limit our prerogative to make new regulatory proposals in the areas addressed by the withdrawn proposed rule, including new proposals that may be substantially identical or similar to those described therein.

Finally, the withdrawal of this proposed rule does not affect existing federal legal requirements or policy that were merely proposed to be codified in regulation, including certain provisions related to Medicaid financing and Medicaid Upper Payment Limit (UPL) requirements. For example, without limitation, this includes guidance in State Medicaid Director Letter (SMDL) #13-003, which discussed a submission process to comply with the UPL requirements; SMDL #14-004, which discussed Medicaid financing and provider-related donations; as well as State Health Officials (SHO) Letter #14-001, which addressed health care-related taxes. This withdrawal action does not affect CMS' ongoing application of existing statutory and regulatory requirements or its responsibility to faithfully administer the Medicaid program. (Emphasis added.)

2023/2024

CMS summarized the history of this issue at 88 Fed. Reg. 28092, 28127-28129 (May 3, 2023) ("Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality") (Proposed rule), stating:[50]

> *Background on Medicaid Non-Federal Share Financing*. Medicaid expenditures are jointly funded by the Federal and State governments. Section 1903(a)(1) of the Act provides for Federal payments to States of the Federal share of authorized Medicaid expenditures. The foundation of Federal-State shared responsibility for the Medicaid program is that the State must participate in the financial burdens and risks of the program, which provides the State with an interest in operating and monitoring its Medicaid program in the best interest of beneficiaries (see section 1902(a)(19) of the Act) and in a manner that results in receiving the best value for taxpayers for the funds expended. Sections 1902(a)(2), 1903(a), and 1905(b) of the Act require States to share in the cost of medical assistance and in the cost of administering the Medicaid program. FFP is not available for expenditures for services and activities that are not medical assistance authorized under a Medicaid authority or allowable State administrative activities. Additionally, FFP is not available to States for expenditures that do not conform to approved State plans, waiver, demonstration projects, or contracts, as applicable.
>
> Section 1902(a)(2) of the Act and its implementing regulation in 42 CFR part 433, subpart B require States to share in the cost of medical assistance expenditures and permit other units of State or local government to contribute to the financing of the non-Federal share of medical assistance expenditures. These provisions are intended to safeguard the Federal-State partnership, irrespective of the Medicaid delivery system or authority (for example, FFS or managed care delivery system, and State plan, waiver, or demonstration authority), by ensuring that States are meaningfully engaged in identifying, assessing, mitigating, and sharing in the risks and responsibilities inherent in operating a program as complex and economically significant as Medicaid, and that States are accordingly motivated to administer their programs economically and efficiently (see, for example, section 1902(a)(4) of the Act).
>
> There are several types of permissible means for financing the non-Federal share of Medicaid expenditures, including, but not limited to: (1) State general funds, typically derived from tax revenue appropriated directly to the Medicaid agency; (2) revenue derived from health care-related taxes when consistent with Federal statutory requirements at section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; (3) provider-related donations to the State which must be "bona fide" in accordance with section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; [FN88] and (4) intergovernmental transfers (IGTs) from units of State or local government that contribute funding for the non-Federal share of Medicaid expenditures by transferring their own funds to and for the unrestricted use of

[50] *See also* Final rule published at 89 Fed. Reg. 41002, 41072-41074 (May 10, 2024) ("Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality").

the Medicaid agency.[FN89] Regardless of the source or sources of financing used, the State must meet the requirements at section 1902(a)(2) of the Act and § 433.53 that obligate the State to fund at least 40 percent of the non-Federal share of total Medicaid expenditures (both medical assistance and administrative expenditures) with State funds.

Health care-related taxes and IGTs are a critical source of funding for many States' Medicaid programs, including for supporting the non-Federal share of many payments to safety net providers. Health care-related taxes made up approximately 17 percent ($37 billion) of all States' non-Federal share in 2018, the latest year for which data are available.[FN90] IGTs accounted for approximately 10 percent of all States' non-Federal share for that year. The Medicaid statute clearly permits certain health care-related taxes and IGTs to be used to support the non-Federal share of Medicaid expenditures, and CMS supports States' adoption of these non-Federal financing strategies where consistent with applicable Federal requirements. CMS approves hundreds of State payment proposals annually that are funded by health care-related taxes that appear to meet statutory requirements. The statute and regulations afford States flexibility to tailor health care-related taxes within certain parameters to suit their provider community, broader State tax policies, and the needs of State programs. However, all health care-related taxes must be imposed in a manner consistent with applicable Federal statutes and regulations, which prohibit direct or indirect "hold harmless" arrangements (see section 1903(w)(4) of the Act; 42 CFR 433.68(f)).

States first began to use health care-related taxes and provider-related donations in the mid-1980s as a way to finance the non-Federal share of Medicaid payments (Congressional Research Service, "Medicaid Provider Taxes," August 5, 2016, page 2). Providers would agree to make a donation or would support (or not oppose) a tax on their activities or revenues, and these mechanisms (donations or taxes) would generate funds that could then be used to raise Medicaid payment rates to the providers. Frequently, these programs were designed to hold Medicaid providers "harmless" for the cost of their donation or tax payment. As a result, Federal expenditures rapidly increased without any corresponding increase in State expenditures, since the funds used to increase provider payments came from the providers themselves and were matched with Federal funds. In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (Pub. L. 102-234, enacted December 12, 1991) to establish limits for the use of provider-related donations and health care-related taxes to finance the non-Federal share of Medicaid expenditures. Statutory provisions relating to health care-related taxes and donations are in section 1903(w) of the Act.

Section 1903(w)(1)(A)(i)(II) requires that health care-related taxes be broad-based as defined in section 1903(w)(3)(B), which specifies that the tax must be imposed with respect to a permissible class of health care items or services (as described in section 1903(w)(7)(A)) or with respect to providers of such items or services and generally imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers or with respect to all non-Federal, nonpublic providers; additionally, the tax must be imposed uniformly in accordance with section

1903(w)(3)(C) of the Act. However section 1903(w)(1)(A)(iii) of the Act disallows the use of revenues from a broad-based health care related tax if there is in effect a hold harmless arrangement described in section 1903(w)(4) of the Act with respect to the tax. Section 1903(w)(4) of the Act specifies that, for purposes of section 1903(w)(1)(A)(iii) of the Act, there is in effect a hold harmless provision with respect to a broad-based health care related tax if the Secretary determines that any of the following applies: (A) the State or other unit of government imposing the tax provides (directly or indirectly) for a non-Medicaid payment to taxpayers and the amount of such payment is positively correlated either to the amount of the tax or to the difference between the amount of the tax and the amount of the Medicaid payment; (B) all or any portion of the Medicaid payment to the taxpayer varies based only upon the amount of the total tax paid; or (C) the State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax. Section 1903(w)(1)(A) of the Act specifies that, for purposes of determining the Federal matching funds to be paid to a State, the total amount of the State's Medicaid expenditures must be reduced by the amount of revenue received the State (or by a unit of local government in the State) from impermissible health care-related taxes, including, as specified in section 1903(w)(1)(A)(iii) of the Act, from a broad-based health care related tax for which there is in effect a hold harmless provision described in section 1903(w)(4) of the Act.

In response to the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, we published the "Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals" interim final rule with comment period in the November 24, 1992 *Federal Register* (57 FR 55118) (November 1992 interim final rule) and the subsequent final rule published in the August 13, 1993 *Federal Register* (58 FR 43156) (August 1993 final rule) establishing when States may receive funds from provider-related donations and health care-related taxes without a reduction in medical assistance expenditures for the purposes of calculating FFP.

After the publication of the August 1993 final rule, we revisited the issue of health care-related taxes and provider-related donations in the "Medicaid Program; Health-Care Related Taxes" final rule (73 FR 9685) which published in the February 22, 2008 Federal Register (February 2008 final rule). The February 2008 final rule, in part, made explicit that certain practices would constitute a hold harmless arrangement, in response to certain State tax programs that we believed contained hold harmless provisions. For example, five States had imposed a tax on nursing homes and simultaneously created programs that awarded grants or tax credits to private pay residents of nursing facilities that enabled these residents to pay increased charges imposed by the facilities, which thereby recouped their own tax costs. We believed that these payments held the taxpayers (the nursing facilities) harmless for the cost of the tax, as the tax program repaid the facilities indirectly, through the intermediary of the nursing facility residents. However, in 2005, the Department of Health and Human (HHS) Departmental Appeals Board (the Board) (Decision No. 1981) ruled that such an arrangement did not constitute a hold harmless arrangement under the regulations then in place (73 FR 9686-9687).

Accordingly, in discussing revisions to the hold harmless guarantee test in § 433.68(f)(3), the February 2008 final rule preamble explained that a State can provide a direct or indirect guarantee through a direct or indirect payment. We stated that a direct guarantee will be found when, "a payment is made available to a taxpayer or party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax" as a result of the payment (73 FR 9694). We noted parenthetically that such a direct guarantee can be made by the State through direct or indirect payments. *Id*. As an example of a party related to the taxpayer, the preamble cited the example of, "as a nursing home resident is related to a nursing home" (73 FR 9694). As discussed in this preamble to the February 2008 final rule, whenever there exists a "reasonable expectation" that the taxpayer will be held harmless for the cost of the tax by direct or indirect payments from the State, a hold harmless situation exists and the tax is impermissible for use to support the non-Federal share of Medicaid expenditures.

Non-Federal Share Financing and State Directed Payments. The statutory requirements in sections 1902(a)(2), 1903(a), 1903(w), and 1905(b) of the Act concerning the non-Federal share contribution and financing requirements, including those implemented in 42 CFR part 433, subpart B concerning health care-related taxes, bona fide provider related donations, and IGTs, apply to all Medicaid expenditures regardless of delivery system (fee-for-service or managed care). We employ various mechanisms for reviewing State methods for financing the non-Federal share of Medicaid expenditures. This includes, but is not limited to, reviews of fee-for-service SPAs, reviews of managed care SDPs, quarterly financial reviews of State expenditures reported on the Form CMS-64, focused financial management reviews, and reviews of State health care-related tax and provider-related donation proposals and waiver requests.[51]

[51] *See also* Final rule at 89 Fed. Reg. 41002 at 41073 (Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality)(May 10, 2024), again discussing the "Background on Medicaid Non-Federal Share Financing".