No. 04-74204

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U.S. COURT OF APPEALS

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES,

Petitioner,

v.

CENTERS FOR MEDICARE AND MEDICAID SERVICES; MARK B. MCCLELLAN, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; TOMMY G. THOMPSON, in his official capacity as Secretary of the U.S. Department of Health and Human Services,

Respondents.

PETITION FOR REVIEW OF THE FINAL DETERMINATION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

BRIEF OF RESPONDENTS

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December 23, 2004

STATEMENT CONCERNING ORAL ARGUMENT

Respondent does not request oral argument. This is a straightforward case of interpretation of the Medicaid statute and regulations which Respondent believes can be resolved by reference to the applicable statute, regulations, legislative history and case law. Respondent will be pleased to provide oral argument if the Court believes that oral argument will aid the Court in resolving the questions presented herein.

STATEMENT OF RELATED CASES

Respondent states that there are no related cases in this Court as described in Ninth Circuit Rule 28-2.6.

TABLE OF CONTENTS

STATEMENT OF JURISDICTION....1

STATEMENT OF THE ISSUE....2

STATEMENT OF THE CASE....2

STATEMENT OF FACTS....4

I. Statutory and Regulatory Framework....4

A. The Medicaid Program....4

1. Payment for Tribal Facilities....7

2. Statutory and Regulatory Limitations on Payment....10

a. Modification of Upper Payment Limitation Rule....12

II. Factual Background....13

A. The Proposed Alaska State Plan Amendment....14

B. Procedural History....15

SUMMARY OF THE ARGUMENT....19

STANDARD OF REVIEW....21

ARGUMENT....22

I. The Secretary's decision to deny proposed Alaska SPA 01-009 must be upheld because it was based on a permissible construction of the Medicaid statute....22

A. The scope of review of the Secretary's construction Of the Medicaid statute is limited....22

B. The Secretary properly found that the proposed State Plan Amendment is inconsistent with 42 U.S.C. §1396(a)(30)(A)....24

1. Departure from the HHS rates must meet the statutory standard for efficiency and economy....29

2. The repeal of the Boren Amendment does not implicate the Secretary's authority under (A)(30)(A)....32

C. The proposed amendment does not meet the standards of 42 C.F.R. § 447.325....37

1. The IHS rate must be considered in assessing compliance with the regulatory limit in this case....37

2. The State's proposed methodology does not meet the regulatory standard....41

CONCLUSION....43

ADDENDUM

42 U.S.C. § 1396a(a)(30)(A)

42 C.F.R. § 447.325

TABLE OF AUTHORITIES

CASES

Apache Co. v. U.S., 429 U.S. 876 (1976)....7

Atkins v. Rivera, 477 U.S. 154, 156 (1986)....4, 5

Chevron, U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)....22, 23, 24, 28

Community Hosp. Of Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 1993)....24

Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000)....34

Georgia v. Shalala, 8 F.3d 1565 (11th Cir. 1993)....23

Independent Acceptance Co. v. State of California, 204 F.3d 1247 (9th Cir. 2000)....5

Irvine Med. Ctr. V. Thompson, 275 F.3d 823 (9th Cir. 2002)....22

McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987)....7

Orthopaedic Hosp. V. Belshe, 103 F.3d 1491 (9th Cir. 1997)....28, 32

Pennsylvania Pharmacists Ass'n. V. Houston, 283 F.3d 531 (3rd Cir. 2002) (*en banc*)....10, 11, 33, 36

Queen of Angels/Hollywood Presbyterian Med. Ctr. V. Shalala, 65 F.3d 1472 (9th Cir. 1995)....23

Pharmaceutical Research and Mfrs. Of America v. Thompson, 362 F.3d 817 (D.C. Cir. 2004)....22, 24, 27

Rust v. Sullivan, 500 U.S. 173 (1991)....37

Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87 (1995).... 24

State of Louisiana v. U.S. Dept. of Health and Human Servs,
905 F. 2d 877 (5th Cir. 1990)....23

State of Texas v. U.S. Dep't of Health and Human Servs.,
61 F.3d 438 (5th Cir 1995)....23

Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502 (1990)....4, 5, 34

STATUTES AND RULES

25 U.S.C. § 1642.... 8, 31

42 U.S.C. § 1396....1

42 U.S.C. § 1396a....5

42 U.S.C. § 1396a(a)....5

42 U.S.C. § 1396a(b)....5, 26

42 U.S.C. § 1396(a)(3)....2, 4

42 U.S.C. § 1396a(a)(13)(A)(1980)....35

42 U.S.C. § 1396a(a)(13)(A) (1992)....33

42 U.S.C. § 1396(a)(30)(A).... *passim*

42 U.S.C. § 1396b(a)(1).... 6

42 U.S.C. § 1396b(w)(6)(A)....31

42 U.S.C. § 1396(d)(b)....3, 8, 9, 14

42 U.S.C. 1396(j)....8, 31

REGULATIONS

42 C.F.R. § 405.503....38

42 C.F.R. § 405.504....39

42 C.F.R. § 413.13....38

42 C.F.R. § 413.13(a)....38

42 C.F.R. § 413.13(b)....38

42 C.F.R. § 413.13(e)....38

42 C.F.R. § 430 Subpart D....6

42 C.F.R. § 430.14....5

42 C.F.R. § 430.15....5

42 C.F.R. § 430.18....4, 6

42 C.F.R. § 430.102....4

42 C.F.R. § 430.102(c)....1

42 C.F.R. § 447.200....12

42 C.F.R. § 447.253(a)....6

42 C.F.R. § 447.253(b)(1)....6

42 C.F.R. § 447.272(c)(2)....13, 14, 39

42 C.F.R. § 447.321(c)(2) 13, 14, 39

42 C.F.R. § 447.325 .... *passim*

43 Fed. Reg. 45,253 (Sept. 29, 1978) 11

48 Fed. Reg. 56,046 (Dec. 19, 1983) 27, 28

66 Fed. Reg. 3148 (Jan. 12, 2001) 12, 30

66 Fed. Reg. 3159 (Jan. 12, 2001) 8, 13

67 Fed. Reg. 15,214 (Mar. 29, 2002) 39

67 Fed. Reg. 65,127 (Oct. 23, 2002) 17

67 Fed. Reg. 69,223 (Nov. 15, 2002) 6

LEGISLATIVE MATERIALS

H.R. Rep. No. 94-1026, 1976 U.S.C.C.A.N. 2562 .... 7, 8, 31

Pub. L. No. 96-499, Section 962(a) 34

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PETITION FOR REVIEW OF THE FINAL DETERMINATION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

STATEMENT OF JURISDICTION

This case is presented for review of a final agency action of the Secretary of the United States Department of Health and Human Services ("the Secretary") issued by the Administrator of the Centers for Medicare & Medicaid Services ("CMS") pursuant to 42 U.S.C. § 1316 and 42 C.F.R. § 430.102(c).[1] The

[1]The decision was issued by Acting Deputy Administrator Leslie Norwalk, acting as Administrator on June 22, 2004.

Administrator's decision was entered on June 22, 2004. Petitioner filed its Petition for Review on August 16, 2004. The appeal from this decision is timely and is within this Court's appellate jurisdiction under section 1116(a)(3) of the Social Security Act, 42 U.S.C. § 1316(a)(3).

STATEMENT OF THE ISSUE

Whether the Secretary's decision to disapprove a proposed amendment to the Alaska State Medicaid Plan, SPA 01-009, because it did not comply with the statutory mandate of efficiency and economy set forth in 42 U.S.C. § 1396a(a)(30)(A) was a reasonable interpretation of the Medicaid provisions of the Social Security Act.

STATEMENT OF THE CASE

In this action, the State of Alaska ("State" or "Alaska") has requested review of a final decision of the Secretary denying approval of a proposed amendment to the Alaska State Medicaid Plan, SPA 01-009, under Title XIX of the Social Security Act (the "Act"), 42 U.S.C. §§ 1396 et seq. Excerpts of Record ("ER") 55-67.

In SPA 01-009, the State of Alaska proposed to alter its Medicaid payment methodology for State tribal health facilities. Such payments would, in turn, be fully reimbursed by the federal government under a limited exception to ordinary

Medicaid federal matching payments in section 1905(b) of the Social Security Act, 42 U.S.C. § 1396d(b). These facilities had long been paid for services provided to Native Americans in accordance with rates established by the Indian Health Service ("IHS") in Alaska's State Medicaid plan. The State plan amendment at issue proposed that these facilities be paid under a wholly different payment methodology based upon what it terms "the customary charges of the provider, but . . . not more than the prevailing charges in the locality for comparable services under comparable circumstances." ER 24. The State proposed to calculate the upper limit of these charges not based on the charges of these facilities, but on the charges for one private hospital in Anchorage. Subject to this limitation the State proposed to accept the charge on the bill as the customary charge for the facility. ER 26. The State acknowledged that these increased rates will result in a substantial increase in Federal Medicaid funds paid to the State, only 10% of which would actually be retained by the tribal facilities. ER 27. The State would have no net Medicaid expenditures under this amendment, and the majority of the additional funds received would go to the State's Medicaid fund. Id.

CMS disapproved the amendment on July 11, 2002. ER 33. The disapproval was based upon the finding that the increased rates were not consistent with efficiency, economy and quality of care. 42 U.S.C.

§ 1396a(a)(30)(A).

The State filed a timely request for administrative reconsideration pursuant to 42 C.F.R. § 430.18 on August 30, 2002. See Tr. 94-108. On April 15, 2003, an administrative hearing was held before an agency Hearing Officer, and on April 23, 2004, the Hearing Officer issued a proposed decision upholding the disapproval. ER 38-54. On June 22, 2004, Acting Deputy CMS Administrator Leslie Norwalk issued a final determination upholding the Hearing Officer's decision. ER 55-66. The June 22, 2004 decision is the final agency action in accordance with 42 C.F.R. § 430.102. Alaska has appealed that decision to this Court pursuant to 42 U.S.C. § 1316(a)(3).

STATEMENT OF FACTS

I. Statutory and Regulatory Framework

A. The Medicaid Program

The Medicaid program is a cooperative federal-state program established in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." Harris v. McRae, 448 U.S. 297, 301 (1980). See Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502 (1990); Atkins v. Rivera, 477 U.S. 154, 156 (1986); see also 42

U.S.C. § 1396. Although participation in the Medicaid program is voluntary, states electing to participate must comply with the requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services. See 42 U.S.C. § 1396a; Wilder, 496 U.S. at 502; Rivera, 477 U.S. at 157; Independent Acceptance Co. v. State of California, 204 F.3d 1247, 1249 (9th Cir. 2000).

To qualify for federal assistance, participating states must submit to the Secretary, and have approved, a "plan for medical assistance" that complies with certain statutory requirements. 42 U.S.C. § 1396a(a). The Secretary must approve any State plan or State plan amendment ("SPA") that complies with these statutory requirements. 42 U.S.C. § 1396a(b). Among other things, such a plan must provide "such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care . . .." 42 U.S.C. § 1396a(a)(30)(A).

The Secretary has delegated responsibility for approving state plans and plan amendments to the Centers For Medicare & Medicaid Services ("CMS"), a component of the U.S. Department of Health and Human Services. See 42 C.F.R. §§ 430.14, 430.15. Echoing the requirement of the statute, under CMS regulations

a participating State is required to provide certain assurances before the State's Medicaid plan or plan amendments may be approved. 42 C.F.R. § 447.253(a). Among other things, a State must assure CMS that the State has found its payment rates to be "reasonable and adequate to meet the costs incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards." 42 C.F.R. § 447.253(b)(1). If CMS disapproves a State plan or plan amendment, the State is entitled to pursue an administrative review process that includes discovery and a public evidentiary hearing. See 42 C.F.R. §§ 430.18 and 430 Subpart D.

Under traditional Medicaid, once a State has an approved plan, the Secretary pays to the State a percentage of the "total amount expended . . . as medical assistance under the State plan." Section 1903(a)(1) of the Act, 42 U.S.C. § 1396b(a)(1). That portion of the state's medical assistance costs paid by the Secretary is referred to as the Federal Medical Assistance Percentage ("FMAP"). Id. The FMAP for each state is set forth in the Federal Register. See, e.g., 67 Fed. Reg. 69223 (Nov. 15, 2002). For 2004, the FMAP for Alaska is 57.58%. Id. Accordingly, the Federal fisc pays 57.58% of the costs expended by Alaska for medical assistance under the State plan. The remaining 42.42% is paid by Alaska.

However, as discussed below, Medicaid services provided to Native Americans through Indian Health Service and tribal facilities are not subject to the standard Alaska FMAP rate. The FMAP rate for such services is 100%. Thus, the federal government reimburses the State in full for medical assistance provided to Native Americans through IHS and tribal facilities. Id.

1. Payment for Tribal Facilities

As noted above, federal payments for the Medicaid services provided to Native Americans in tribal health care facilities at issue in this case are not restricted to Alaska's ordinary 57.58% FMAP. Id. These services are wholly funded by the federal government under a scheme unique to certain facilities serving Native Americans. As citizens of the United States and residents of the individual states in which they reside, Native Americans are eligible for Medicaid on the same basis as all other American citizens. H.R. Rep. No. 94-1026 at 107 (1976), reprinted in 1976 U.S.C.C.A.N. 2652, 2745. See also McNabb v. Bowen, 829 F.2d 787, 793 n.5 (9th Cir. 1987) (citing Apache Co. v. U.S., 429 U.S. 876 (1976)). Prior to 1976, however, Indian Health Service ("IHS") facilities did not generally receive reimbursement from the Medicare and Medicaid programs for services provided to eligible Native Americans. H.R. Rep. No. 94-1026 at 107, 1976 U.S.C.C.A.N. at 2745. In order to broaden access to, and improve the

quality of, health care services for Native Americans, Congress enacted the Indian Health Care Improvement Act, Pub. L. No. 94-437 ("IHCIA"). This legislation added a provision to section 1905(b) of the Social Security Act to provide for 100 percent FMAP to states for "amounts expended as medical assistance for services that are received through an Indian Health Service facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization . . . 42 U.S.C. § 1396d(b). The provision for 100 percent FMAP was meant to avoid the perceived unfairness and inequity to states that would otherwise have resulted if states were suddenly made responsible for payment of costs under their Medicaid programs that had previously been fully underwritten by the federal government through the IHS's direct funding of its facilities and services. H.R. Rep. No. 94-1026 at 108, 1976 U.S.C.C.A.N. 2746. The statute provided that payments at the special rate would be used to make necessary improvements to facilities serving Native Americans. IHCIA § 402(c) (codified at 25 U.S.C. § 1642 and 42 U.S.C §§ 1396d(b), 1396(j)). Congress intended that the Medicaid funding "be used to expand and improve current IHS health care services and not to substitute for present expenditures." H.R. Rep. No. 94-1026 at 108, 1976 U.S.C.C.A.N. at 2746.

The IHS publishes annually the rates that it authorizes its facilities to charge for inpatient and outpatient services to Medicare and Medicaid beneficiaries. See,

e.g., 66 Fed. Reg. 3159 (Jan. 12, 2001). With respect to Medicaid, "[t]hese rates are calculated as the full cost of providing Medicaid services under Medicare payment principles." Id. The rates for the state of Alaska are set separately from those in the lower 48 states in recognition of higher costs in Alaska. Id.

In 1996, CMS expanded its definition of the term "Indian Health Service Facility" in section 1905(b) to include not only IHS facilities, but also health care facilities owned and operated by Native American tribes and tribal organizations but funded by IHS under a contract or compact with the tribe or tribal organization, as authorized under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended ("tribal facilities"). See 42 U.S.C. § 1396d(b) (2001). On December 19, 1996, CMS and the IHS entered into a Memorandum of Agreement ("MOA") which permitted any state to claim 100 percent FMAP for "amount[s] it pays to any [tribal] facility for services provided to Medicaid eligible" Native Americans. ER 10-14.

Under the MOA, the IHS periodically develops a list of facilities eligible for 100 percent FMAP, both IHS operated facilities and tribal facilities, and CMS provides the list to the states. ER 15-21. CMS distributed the 1996 MOA to all state Medicaid directors by letter dated January 3, 1997. ER 9. That letter notes that "The revised policy expands our definition of 'a facility of the Indian Health

Service' to include tribally owned facilities . . ." Id. The facilities at issue in this dispute are tribal facilities, and services provided to Medicaid-eligible Native Americans through these facilities are subject to the 100% FMAP.[2]

2. Statutory and Regulatory Limitations on Payment

In amending the Social Security Act in January, 1968, Congress added § 1902(a)(30), 42 U.S.C. § 1396a(a)(30)(A), which stated that a State Medicaid Plan should "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." Social Security Act Amendments of 1967, Pub. L. No. 90-248, § 237, 81 Stat. 821, 911 (1968). The amendment was designed both to provide free choice of medical services and to contain costs. See generally Pennsylvania Pharmacists Ass'n v. Houston, 283 F.3d 531 (3d Cir. 2002) (*en banc*). While the section was amended several times, the language requiring "efficiency, economy and quality of care" contained in subsection

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[2]The state argues that tribal facilities are not IHS facilities, Petitioner's brief at 33, but it does not contest that they are tribal facilities, and therefore that Medicaid expenditures for the facilities are fully funded by the federal government under the 100% FMAP.

(a)(30)(A) is unchanged from the original.[3]

In addition to the general statutory requirements for economy and efficiency, the Secretary has promulgated regulations under the authority of 42 U.S.C. § 1396a(a)(30(A) setting upper payment limitations ("UPLs") for the amount a State may pay for a specific service or facility. The UPL at issue in this case, 42 C.F.R. § 447.325, was promulgated in 1978. 43 Fed. Reg. 45253 (Sept. 29, 1978). The regulation states that:

> The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

42 C.F.R. § 447.325. As was noted at the hearing,[4] the terms "customary charges" and "prevailing charges" are not further defined with regard to this section, and are not further defined within the Medicaid regulations. The assessment of whether proposed payments are within these limits is an interpretive determination that is made on a case-by-case basis taking into account the locality, the services, the circumstances, and the historical charges for the services.

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[3]The legislative history of the section is reviewed in Pennsylvania Pharmacists Ass'n v. Houston, 283 F.3d at 540-41.

[4]Testimony of Robert Labbe, Supplemental Excerpts of Record ("Supp. ER.") 18.

a. Modification of Upper Payment Limitation Rule

In 2001 CMS published a final rule modifying the Medicaid UPLs for inpatient hospital services and other services. 66 Fed. Reg. 3148 et seq. (Jan. 12, 2001). The manner in which UPLs are complied with is complex, and CMS found that the upper payment regulations then in effect created a mechanism by which States could receive additional federal matching payments while lowering State expenditures for covered services, in contravention of the statutory intent. Id. at 3149. The final rule amended 42 C.F.R. Part 447.200 et seq., to, among other things, establish an aggregate upper payment limit that applies to payments made to government facilities that are not State government-owned or operated and a separate aggregate UPL on payments made to privately-owned facilities. The new regulations allowed a higher upper limit for payment to non-State public hospitals to "recognize the higher costs of inpatient and outpatient services in public hospitals." 66 Fed. Reg. at 3148.

These regulations do not apply to the facilities at issue in this case. With regard to IHS and tribal facilities, the new regulations state only that:

> The limitation in paragraph (b) of this section does not apply to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

66 Fed. Reg. at 3176; 42 C.F.R. §§ 447.272(c)(2), 447.321(c)(2).

The effect of the new regulations on tribal facilities such as those at issue here is to remove them from the UPLs applicable to other inpatient hospital facilities. The preamble to the new rule states that:

> We have restructured paragraph (c) of §§ 447.272 and 447.321 to exclude IHS and tribal facilities that are funded under Pub. L. 93-638 from the UPLs. Instead, these facilities will be subject to the payment limits at § 447.325.

66 Fed. Reg. at 3159.

The Secretary explained that because the new UPLs are aggregate limitations rather than limitations for each facility, including the tribal facilities within the UPLs might empower the States to set lower payment limits for the tribal facilities, while setting payments for its own facilities at higher levels, and still be in compliance with the aggregate UPLs. Id.

II. Factual Background

A. The Proposed Alaska State Plan Amendment

The current Alaska state plan pays for services provided to Medicaid-eligible Native Americans through tribal inpatient hospital facilities in accordance with the IHS published rate. See Prehearing brief of Petitioner at 11, Tr. 175. As we have stated above, those rates are reimbursed in full by the federal government

through the 100% FMAP provision, 42 U.S.C. § 1396d(b). These services are billed to the State Medicaid agency by the tribal facilities and the State claims reimbursement for those charges from the federal government. The federal government ultimately pays for the services under the narrow exception to the statutorily-established standard FMAP rates. The charges submitted to Medicaid by the tribal facilities have traditionally been based upon the published IHS rates, which are derived by the IHS from the costs of operating the facilities at issue.[5] Alaska has proposed to radically alter that payment structure.

Alaska submitted proposed State plan amendment 01-009 to CMS for approval on December 24, 2001. The proposed state plan amendment states:

> Under agreement with a Tribal Health Facility provider the Department may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances. Such a payment is not subject to the provisions of 42 CFR 447.272 and 42 CFR 447.321, but is subject to the payment limits at 42 CFR 447.325.

ER 24.

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[5]The State purports to find it significant that these are tribal-operated, not IHS-operated, inpatient facilities. Appellant's brief at 33. But the IHS rates for Alaska were derived from the costs of operating these very facilities, not IHS-operated inpatient facilities and in fact are higher than those of IHS-operated inpatient facilities in the lower 48 states due to the higher costs of operating in Alaska. [cite] The State does not contest that the facilities at issue are tribal facilities that receive 100% of their funding from the federal government.

B. Procedural History

After reviewing the language of the proposed State plan amendment, on February 28, 2002, CMS sent a letter requesting further clarification and asking specific questions concerning how the funding mechanism would work. Tr. 158-59. On May 3, 2002, after withdrawing its initial response of March 8, the state submitted its final response to those questions. ER 25-32. With regard to determining the customary and prevailing charges for a facility, the response revealed that as the "customary charge," the state would "accept the charge shown on the claim as the applicable charge for that claim." For determining the "prevailing charge," the State's representative testified that Alaska plans to set its proposed payment rates by using the charges it determines for one private hospital located in Anchorage, Alaska. Supp. ER 9, 11 (Testimony of Nancy Weller) .

The State acknowledged that it did not have any information on the actual charges of the providers for the facilities in question, but would merely accept the amount on the bill as the customary charge of the provider, and pay it in full. Id. at 9. The State projected that this amendment would cost the federal government nearly $50 million per year in additional payments to the State of Alaska, but that only 10% of that additional revenue would be retained by the tribal facilities. ER 27. In exchange for this nominal payment increase, the tribes would "be expected

to enter into an intergovernmental agreement with the State in order to receive the additional revenue available through the [State Plan Amendment]." Id. Under that agreement, the tribes would retain 10% more than what they would be paid under the IHS rate, and the remaining 90% of the additional $50 million received from the federal government through the 100% FMAP provisions would be returned to the state "to help assure that health care services funded by Medicaid remain accessible to eligible Alaskans including Alaska Natives." Id. In other words, 90% of the additional funds received from the federal government would go not to the tribal facilities who provided the services being billed, but into the State's general Medicaid fund.

In a letter from the former Administrator of CMS, Thomas A. Scully, dated July 11, 2002, CMS informed the State that it was disapproving SPA 01-001 as inconsistent with section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A). ER 33. It noted that at present those facilities were being paid at the IHS rates, which were based on an analysis of statewide costs of the Alaska IHS facilities. Id. It went on to note that

> Alaska's proposed rate would substantially exceed the IHS published rates. While we might consider a request for a higher rate if supported by data showing costs that were not considered by IHS in setting the published rates, Alaska provided no such data to substantiate its proposed rates. Absent any such data we find that the

> proposed rates are not consistent with efficiency, economy and quality of care, as required under section 1902(a)(30)(A).

Id.

The State requested reconsideration of this decision, and, on October 23, 2002, the Administrator published a notice in the Federal Register responding to Alaska's request and announcing an administrative hearing. 67 Fed. Reg. 65,127 (Oct. 23, 2002) .

An evidentiary hearing was held on April 15, 2003. Alaska presented testimony from Nancy Weller, formerly the manager of State, Federal and Tribal Relations for the Division of Medical Assistance and Robert Labbe, Deputy Commissioner, of the Alaska Department of Health and Social Services, explaining how the proposed SPA would operate. Supp. ER 1-10. On April 7, 2004, a hearing officer issued a recommended decision upholding the Administrator's disapproval of SPA 01-009. Er 39-54. The hearing officer found that the rates proposed by the State violate § 1902(a)(30)(A) of the Social Security Act and that the State proposal did not set customary or prevailing charges in a proper manner. Id.

After reviewing the recommended decision, on June 22, 2004 the Administrator issued a decision affirming the disapproval of the SPA. ER 55-66.

The Administrator found that the hearing officer reasonably concluded that SPA-01-009 must conform to the criteria set forth in § 1902(a)(30)(A) of the Act that the SPA be consistent with efficiency and economy, and that the question of conformance is not limited to whether the proposed SPA complies with the upper payment regulation at 42 C.F.R. § 447.325. ER. 64. The Administrator noted that the record contains no cost data justifying the increase beyond the IHS rates, nor does it even contain an assertion from the State that the published IHS rates that had been in longstanding use were not adequate payment for the services provided by tribal facilities. Id. In support of this conclusion, the Administrator thought it significant that the State proposed to require the tribal facilities to refund all but 10 percent of the proposed payment amount.[6] ER. 64-65.

The Administrator also found that even if the inquiry were independent of the statutory mandate and confined to the question of whether the SPA is in compliance with the applicable UPL, it would be rejected. The proposed SPA fails to comply with the regulation at § 447.325, because the IHS published rates

[6]The State's brief incorrectly characterizes the Administrator's decision as *requiring* the submission of cost data. The Administrator's rationale for disapproving the proposed amendment was not the absence of cost data, but the lack of justification that the proposed rates were consistent with the statutory standard of 42 U.S.C. § 1396a(a)(30)(A). The absence of cost data justifying the increase was merely illustrative.

are a more accurate measure of the prevailing charge of the communities where the tribal facilities are located than the charges of a single private facility in the largest city in Alaska, which the State offered as the comparison for prevailing charges. The facilities at issue are not private, but are tribal facilities historically paid the IHS rate under a unique scheme applicable only to facilities serving the Native American population. Thus, the method proposed by the State would not result in an accurate measure of "prevailing charges in the locality for *comparable services under comparable circumstances*," as required by § 447.325. Id. at 65 (emphasis in the original).

SUMMARY OF THE ARGUMENT

Under the terms of the Social Security Act, Congress has provided the Secretary of HHS final authority to approve or disapprove any amendment to a State Medicaid plan. Since 1968, States have been required as a condition of approval to make assurances to the Secretary that those plans fulfill the statutory mandate for efficiency and economy contained in 42 U.S.C. § 1396a(a)(30).

The amendment Alaska has proffered would pay for services provided to Medicaid-eligible individuals in tribal facilities at a rate more than three times the rate currently in place for such services. Under a limited exception to the ordinary Medicaid funding provisions applicable only to facilities serving Native

Americans, the additional monies generated would be fully reimbursed by the federal government, while the State will have no additional net expenditures. Further, the State has acknowledged that 90% of the additional funds received from the federal government would not stay with the tribal facilities whose services are being reimbursed and for whom the federal funds were intended, but would be diverted to the State's general Medicaid fund. The Secretary reasonably found that this proposal did not meet the statutory mandate because Alaska made no showing that the additional payments to the facilities were consistent with efficiency and economy.

Although Alaska has challenged the decision to disapprove the amendment through the agency's established administrative process and up to this Court, it has refused to make any substantive attempt to show that its proposal comports with the statutory mandate of efficiency and economy. Eschewing any discussion of the reasonableness of its rate, Alaska focuses its argument on the theory that the agency's longstanding practice of determining a SPA's compliance with the statutory mandate through case-by-case adjudication is limited to ensuring State compliance with the terms of specific upper payment limitations promulgated under that statute. Thus, the State endeavors to read the broad proscriptions mandating efficiency and economy out of the statute. Its argument flies in the face

of the law, common sense and past practice.

Even assuming arguendo that Alaska is correct in its remarkable assertion that the Secretary has no authority to determine whether a State plan amendment complies with the statutory standard other than through promulgation of regulations setting forth upper payment limitations, the Secretary reasonably found that the State has failed to show that the proposed amendment complies with the applicable regulatory limitation. That limitation allows payment up to the level of "prevailing charges in the locality for comparable services under comparable circumstances." 42 C.F.R. § 447.325. The State's proposed amendment, which would determine this limitation by looking at the charge list for one private hospital located in Anchorage, does not take into account the prevailing charges of the tribal hospitals in question nor the circumstances under which they are funded. Thus, even under the State's own theory that upper payment limitations are the only restrictions on payment rates, the proposed State plan amendment must fail.

The Secretary's decision that the proposed State plan amendment does not comport with the Medicaid statute and regulations is based on a reasonable interpretation of the statutory and regulatory standards. That decision is entitled to deference and should be upheld.

STANDARD OF REVIEW

The Secretary's decision is reviewed under the standard of review set forth in the Administrative Procedure Act and must be upheld unless it is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law. 5 U.S.C. § 706(2)(A). The decision to disapprove a proposed amendment to a state Medicaid plan must be upheld if it was based upon a permissible construction of the relevant Medicaid statute. Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843 (1984); Pharmaceutical Research and Mfrs. of America v. Thompson, 362 F.3d 817, 821-22 (D.C. Circuit 2004); Irvine Med. Ctr. v. Thompson, 275 F.3d 823, 830 (9th Cir. 2002).

ARGUMENT

I. The Secretary's decision to deny proposed Alaska SPA 01-009 must be upheld because it was based on a permissible construction of the Medicaid statute.

A. The scope of review of the Secretary's construction of the Medicaid statute is limited.

Where a party claims that an agency has erred in construing a statute that Congress has entrusted the agency with implementing, the claim is reviewed under the now-familiar framework of the Supreme Court's decision in Chevron, U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837 (1984). Queen of

Angels/Hollywood Presbyterian Med. Ctr. v. Shalala, 65 F.3d 1472, 1477 (9th Cir. 1995). Under this framework, the Court's only task is to determine "whether the agency's answer is based on a permissible construction of the statute." Id., citing Chevron U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. at 843.

The principles established in Chevron have been well-recognized in the context presented here: the Secretary's denial of a proposed State Medicaid plan amendment. State of Texas v. U.S. Dep't of Health and Human Svcs., 61 F. 3d 438 (5th Cir. 1995); Georgia v. Shalala, 8 F.3d 1565, 1573 (11th Cir. 1993). Where the propriety of the Secretary's denial of a proposed SPA centers around an issue of statutory construction, as here, the Court's only "task is to determine whether the statutory construction proffered by HHS is valid." State of Texas v. U.S. Dep't. of Health and Human Servs., 61 F.3d at 440. If the agency's ruling meets these standards, the Court's inquiry is ended. State of Louisiana v. U.S. Dep't. of Health and Human Servs., 905 F. 2d 877, 880 (5th Cir. 1990).

This deference is owed regardless of whether the agency proceeds by rulemaking or by adjudication. The Supreme Court has made it clear that the Secretary is not obliged to promulgate regulations to address "every conceivable question in the process of determining reimbursement," but may decide such issues by case-by-case adjudication. Shalala v. Guernsey Mem'l Hosp., 514 U.S.

87, 97 (1995); accord, Community Hosp. of Monterey Peninsula v. Thompson, 323 F.3d 782, 789 (9th Cir. 1993).[7] Congress has expressly delegated to the Secretary the authority to approve Medicaid state plan amendments, and the Secretary's understanding of that authority controls unless it is contrary to the statute's plain language or is unreasonable. See Pharmaceutical Research and Mfrs. of America v. Thompson, 362 F.3d at 821-22. For the reasons set forth below, the Secretary's determination is reasonable and entitled to deference under the second prong of Chevron.

B. The Secretary properly found that the proposed State Plan Amendment is inconsistent with 42 U.S.C. § 1396a(a)(30)(A).

The Secretary's decision to disapprove Alaska SPA 01-009 must be upheld because the Secretary reasonably determined that the proposed amendment does not meet the requirement for "efficiency, economy and quality of care" set forth in 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid statute. Alaska's proposed amendment to its State Medicaid plan would pay tribal health facilities at rates over three times the current rate. However, the State makes no effort to demonstrate that such rates are necessary to compensate these facilities or

[7]The State's argument distinguishing this line of cases presupposes the assumption that the UPLs define the only limit on the exercise of the State's discretion. As we discuss *infra*, this assumption is without foundation.

otherwise meet the statutory standard.

Alaska itself concedes that the proposed payments will greatly exceed the costs in the area for operating these facilities. The tribal facilities for whom these funds were intended will be allowed to keep only 10% of this money, while the additional 90% will be returned to the State's Medicaid fund. ER 27. This request for increased payment rates is little more than a means to obtain additional federal funds for the State through a program designed solely to assist Native Americans. Clearly, such payments are not steeped in concerns for "economy" or "efficiency" in the tribal facilities.

The State's answer is not that these additional monies are needed to fund the tribal facilities. Completely absent from the State's brief is any substantive defense as to why the disapproved SPA comports with the statute's facial requirements for efficiency and economy. Alaska instead argues that the Secretary should be deemed legally powerless to stop this inappropriate siphoning of federal funds absent a specific upper payment limitation aimed at these particular tribal facilities. It argues that the broad powers conferred by Congress upon the Secretary to demand that Medicaid payment rates be consistent with "efficiency and economy" must be narrowly construed and cannot provide a basis for the disapproval of the State's proposal. However, the State's theory derives little

support from the statute, regulations, or common sense. The Secreatry's obligations under the Medicaid statute to protect the federal fisc, in particular § 1902(a)(30)(A), demand that the federal government ensure that its health care funds are used in a cost-effective manner.

In order to accept the State's theory, this Court would have to accept the proposition that the case-by-case review given every proposed SPA for compliance with the Medicaid statute and regulations does not embrace the "efficiency" and "economy" portions of this core provision. But this statutory provision has been in effect consistently through many iterations of the federal government's changing role in overseeing State Medicaid payments. States have long been obliged to make assurances to the Secretary that whatever methodology is employed in setting payment rates is cost-effective and in conformity with applicable statutes and regulations, including § 1396a(a)(30(A). See 42 U.S.C. § 1396a(b). As the Deputy Administrator noted in her decision, section 1902(b) of the Social Security Act expressly states that the Secretary will approve state plans when they meet the conditions set forth in subsection (a), which includes the efficiency and economy provisions of § 1902(a)(30)(A). CMS is required to review the methodologies proposed in SPAs to ensure conformance with the principles established in § 1902(a)(30)(A), as well as any applicable regulations.

ER 64.

As the D.C. Circuit recently stated in reviewing the Secretary's authority to construe the Medicaid statute:

> This is not a case of implicit delegation of authority through the grant of general implementation authority. In the case of the Medicaid payment statute, the Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments. See 42 U.S.C. § 1396 ("The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance."). In carrying out this duty, the Secretary is charged with ensuring that each state plan complies with a vast network of specific statutory requirements, see generally 42 U.S.C. 1396a . . .. Through this "express delegation of specific interpretive authority," Mead, 533 U.S. at 229, 121 S. Ct. at 2172, the Congress manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law.

Pharmaceutical Research and Mfrs. of America v. Thompson, 362 F.3d at 821-22.

The only support offered by the State for the proposition that case-by-case review to determine compliance with (a)(30)(A) is inappropriate is a sentence from the Statement of Considerations to a regulation setting UPLs for long-term care facilities. See Petitioner's brief at 8, *citing* 48 Fed. Reg. 56,046, 56,049 (Dec. 19, 1983). This sentence responded to suggestions that either the regulations or the State plan should be required to define the term "efficiently and economically operated facility." While the discussion acknowledges that States

should have considerable discretion in determining what is efficient and economical in structuring their Medicaid programs, nothing in the statement of considerations or anywhere else suggests an intent that the Secretary abrogate his responsibility to make a case-by-case finding of compliance with (a)(30(A) when reviewing a State plan amendment. Indeed, the very statement of considerations cited by the State provides that "[a]ssurances and related information are required when States are proposing to make significant changes in their payment methods and standards." 48 Fed. Reg. 56,047.

Further, the State's suggestion that it is the role of the State, rather than the federal government, to determine compliance with the Medicaid statute, ignores the statutory mandate and has been rejected by this Court. See Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1495 (9th Cir. 1997) (rejecting the State of California's contention that its interpretation of the Medicaid statute is entitled to Chevron deference, citing the "familiarity and expertise of the federal agency with the subject matter of its mandate and the need for coherent and uniform construction of federal law nationwide"). While the State is vested with broad authority to establish Medicaid provider payment rates, those rates must advance efficiency and economy, and the Social Security Act mandates that the Secretary not approve a SPA unless the Secretary is assured that those conditions have been met. 42

U.S.C. § 1396a(a)(30)(A). The final determination on that issue rests with the Secretary, not the State. Id.

1. Departure from the IHS rates must meet the statutory standard of efficiency and economy.

Contrary to the State's contention, the Secretary has never asserted that there is a statutory requirement that a state use the rates set by the IHS for its Medicaid rates for tribal facilities. Although most states do use those rates, as does Alaska in its current state plan, they may adopt other payment schemes that comport with the statutory standard. Indeed, the disapproval notice spelled out the Secretary's views:

> While we might consider a request for a higher rate if supported by data showing costs that were not considered by IHS in setting the published rates, Alaska provided no such data to substantiate its proposed rates. Absent any such data we find that the proposed rates are not consistent with efficiency, economy and quality of care, as required under section 1902(a)(30)(A).

ER 33.

While the use of IHS rates is not mandatory, such rates are those customarily and historically utilized and provide an effective baseline for consideration. Deviation from these rates should be justified by some evidence to show why the departure is consistent with §1902(a)(30)(A). This statutory "rule of reason" is applied on a case-by-case basis. Throughout the administrative

litigation Alaska has made no showing that the deviation it proposes meets the statutory standard, other than making the assertion (which we dispute) that it comports with the upper payment limitation of 42 C.F.R. § 447.325.

IHS rates are based on the average costs of operating the very tribal facilities at issue here. Indeed, the IHS rates for Alaska are higher than those in other states in recognition of the higher costs of operating these facilities. See 66 Fed. Reg. 3159 (Jan. 12, 2001). Alaska's payment scheme implicitly recognizes that these rates are sufficient to ensure efficiency, economy and quality of care, because Alaska would permit the facilities to retain only 10% of the amounts above that rate. Specifically, Alaska has stated that the tribe "will be expected to enter into an intergovernmental agreement with the state in order to receive the additional revenue available through the State Plan Amendment." ER 27. That agreement would require the tribe to refund all but 10% of the additional amounts received from the federal government above the IHS rate to the state through an intergovernmental transfer. Id. In other words, 90% of the increased revenues will be given back to the State for its general Medicaid fund. ER 24-25. Thus, as the State admits, the reimbursement the State seeks is far in excess of that necessary to meet the cost of efficiently and economically operating the facilities.

The State's scheme is especially problematic given the specific statutory

mandate that the funds made available through the 100% FMAP for tribal facilities were intended by Congress to go specifically to the facilities served through the IHS system. IHCIA § 402(c) (codified at 25 U.S.C. § 1642 and 42 U.S.C §§ 1396d(b), 1396(j). Congress intended that the Medicaid funding "be used to expand and improve current IHS health care services and not to substitute for present expenditures." H.R. Rep. No. 94-1026 at 108, 1976 U.S.C.C.A.N. at 2746. Ninety percent of the increased funds the State seeks will not serve that purpose. To the contrary, the State's proposal flies squarely in the face of Congress' intent, seeking to use 90% of the additional money for the State's general Medicaid program.

While the State is correct in asserting that there is no blanket prohibition against intergovernmental transfers *per se*, see 42 U.S.C. § 1396b(w)(6)(A), it does not follow from this that the artificially-inflated payment rates that generate the monies to be transferred need to be approved. The discussion of the intergovernmental transfer provisions by the State is irrelevant. The Secretary has not disapproved the transfer, but has disapproved the increased payment rates under 42 U.S.C. § 1396a(a)(30)(A).

The State also challenges the government for requiring the submission of cost data to support its methodology. Petitioner's brief at 25-27. First, the

government has not "required" the State to submit cost data, it has found that the State has shown no justification for departure from the IHS rates, and suggested that a showing of higher costs might be a way to justify an increased rate. While it is true that in general "reasonable cost" reimbursement under Medicaid has been largely replaced by a charge-based system, even this charge-based system must be grounded in some concrete basis with its roots in the efficient and economical provision of care. An economically-operated system contemplates charges that bear some relationship to the cost of providing the service.

As this Court has said:

> The requirements of § 1396a(a)(30)(A) are . . . not so flexible as to allow the [State] to ignore the costs of providing services. For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs . . .

Orthopaedic Hosp. v. Belshe, 103 F.3d at 1499. The State has the burden of showing why its proposed amendment is efficient and economical, and has failed to proffer any evidence that it is so.

2. The repeal of the Boren Amendment does not implicate the Secretary's authority under (a)(30)(A).

Alaska argues that the agency's longstanding practice of determining a

proposed SPA's compliance with statutory requirements has been limited by repeal of the Boren Amendment and the promulgation of new UPLs under the authority of (a)(30)(A). Citing no authority, the State asserts that since the repeal of the Boren Amendment "there is no basis in the law for challenging the rate as being too high." But, as we have demonstrated, case-by-case scrutiny under the statute and the regulations in 42 C.F.R. § 430 Subpart D is a foundation of the State plan amendment approval process, not only for Alaska, but for all states, and the repeal of the Boren Amendment, which involves a statutory provision other than (a)(30)(A), does not alter or restrict the Secretary's role under (a)(30)(A). See generally Pennsylvania Pharmacists Ass'n v. Houstoun, 283 F.3d 531 (analyzing the difference between 42 U.S.C. § 1396a(a)(30)(A) and the Boren Amendment, § 1396a(a)(13)(A) (1992). Further, the UPL at issue here, 42 C.F.R. § 447.325, was promulgated in 1976, long before the Boren Amendment or its subsequent repeal. It does not derive its authority from the Boren amendment and the amendment's repeal has little if any effect on the regulation.

The state badly mischaracterizes the legislative history and case law in suggesting that since the repeal of the Boren Amendment the federal government is compelled to pay excessive amounts of money for Medicaid services with no role in determining whether those payments are necessary or proper as long as a

State can argue that it somehow meets a regulatory UPL. The State's argument to the contrary is particularly ironic given that one of Congress' stated reasons for repealing the Boren Amendment is that it did not fulfill its original intent of reducing Medicaid costs, including costs to the federal government. See Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 919 (5th Cir. 2000) As the Fifth Circuit said in considering the amendment's repeal:

> One of the primary purposes for passing the Boren Amendment was to provide states with flexibility in setting reimbursement rates and thereby reduce Medicaid costs . . . However, because of the litigation that was generated after the Boren Amendment's enactment, Congress recognized that the Amendment had the opposite effect on Medicaid costs than it had intended. See 141 Cong. Rec. § 18693 (1995) (statement of Sen. Roth).

Id. (citation omitted).

The Supreme Court examined the Boren Amendment in Wilder v. Virginia Hosp. Ass'n., 496 U.S. at 505-06. The amendment affected the way Medicaid reimbursement rates were set for institutional providers. Pub. L. 96-499, § 962(a), 94 Stat. 2650 (1980). The section required that a State plan for medical assistance must

> provide . . . for payment . . .through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . .

42 U.S.C. § 1396a(a)(13)(A) (1980). The statutory provision goes on to set specific proscriptions for the calculation of payments to be made to skilled nursing facilities and hospitals that serve a disproportionate number of low income patients with special needs. Id. As the State noted in its brief, under the Boren Amendment the State was required to make annual assurances to the Secretary that its rates were in compliance with that provision. Petitioner's brief at 8. While the repeal of the amendment eliminated the requirement that the States present their rates to the Secretary for approval, it left unaffected the requirement that the States comply with the more general requirement that their plans comply with efficiency and economy under (a)(30)(A).

The Third Circuit has spoken to the distinction between the two sections in light of the repeal of the Boren Amendment in a way that directly contradicts the State's assertions. In construing (a)(30)(A)'s requirement for "efficiency, economy, quality of care and adequate access to providers by Medicaid beneficiaries," the Court said that :

> It seems clear to us that the first two required outcomes – "efficiency" and "economy" – relate to the state program, not providers, i.e., Section 30(A) requires that a state program set payments at levels that make the program efficient and economical. What sort of payments would make a program inefficient and uneconomical? Payments that are *too high.*

Pennsylvania Pharmacists Ass'n v. Houstoun, 283 F.3d at 537 (footnote omitted) (emphasis in the original).[8] The Court went on to note that the Secretary is responsible for ensuring that state plans are administered in accordance with the requirements of (a)(30)(A). Id. at 543-44 (citing 42 U.S.C. § 1396c).

Nowhere in any of the cases cited by the State, nor in the legislative history, is there a suggestion that the repeal of the Boren amendment alters the Secretary's responsibilities under (a)(30)(A) to ensure that a state's Medicaid rates are consistent with efficiency and economy and quality of care (i.e., the rates are neither too high nor too low), nor that the only means to restrain unsupported rate increases is through the UPL regulations. This is particularly true where, as here, there are no net State Medicaid expenditures, the proposed amendment increases federal Medicaid costs threefold, and the recipients of the rate increases do not actually see most of the money.

B. The proposed amendment does not meet the standards of 42 C.F.R. § 447.325

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[8]The language cited by the State, footnote 12, notes only that the National Governors' Association unanimously recommended repeal of the Boren Amendment. That is hardly surprising, as the repeal was designed to limit provider lawsuits, give States more discretion over their Medicaid funds, and to reduce Medicaid costs. It does absolutely nothing to support the assertion that a State can force the federal government to pay more than is efficient and economical, particularly in a situation where there is no concomitant State expenditure.

1. The IHS rate must be considered in assessing compliance with the regulatory limit in this case.

Even assuming arguendo the State's assertion that the only proper inquiry is into the State's compliance with the UPL contained in 42 C.F.R. § 447.325, the Secretary has found that standard has not been satisfied and that the plan amendment was reasonably denied. This decision should be upheld under the deferential standard of review applied to the Secretary's construction of his agency's regulations. Irvine Med. Ctr. v. Thompson, 275 F.3d 823, 830 (9th Cir. 2002) ("An agency . . . must be given ample latitude to adapt its rules and policies to the demands of changing circumstances," citing Rust v. Sullivan, 500 U.S. 173, 187 (1991) (internal quotations and citations omitted.))

The regulation in question provides:

> The agency may pay the customary charges of the provider but must not pay more than the prevailing charges *in the locality* for comparable services *under comparable circumstances*.

42 C.F.R. § 447.325 (Emphases added).

As was noted at the administrative hearing in this matter, the terms "customary charges" and "prevailing charges" are not further defined with regard to this section, and are not further defined within the Medicaid regulations. Supp. ER 18. The assessment of whether proposed payments are within these limits is

an interpretive determination that is made on a case-by-case basis taking into account the locality, the services, the circumstances, and the historical charges for the services.[9]

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[9]Under traditional Medicare, facilities are paid according to costs, not charges. The terms "customary charges" and "prevailing charges" continue to be used under Medicare in reference to payments to physicians and suppliers, as well as certain other services such as certain hospital outpatient procedures. For these purposes, the terms are specifically defined in regulations at 42 C.F.R. §§ 405.503 ("customary charges") and 405.504 ("prevailing charges"). The term "customary charges" for these purposes is defined in the regulation as "the uniform amount which the individual physician or other persons charges in the majority of cases for a specific medical procedure or service." 42 C.F.R. 405.503(a). Unlike the term "prevailing charges," "customary charges" are specific to the individual provider.

The term "customary charges" is also referenced under Medicare with regard to certain inpatient procedures, and is defined in 42 C.F.R. § 413.13. According to § 413.13(b), CMS will pay "the lesser of reasonable costs or customary charges." Section 413.13(a) defines the term "customary charges" as "the regular rates that providers charge both beneficiaries and other paying patients for services furnished to them." But these charges are not determined merely by looking at the charges listed on the charge schedule, as the State would have it. The definition is further explained in § 413(e), which provides that customary charges actually reflect the amounts actually collected from charge-paying non-Medicare patients, not just the amount on the charge sheet. See PRM 2604.3, attached as Appendix A. Thus, even accepting arguendo the totality of the State's argument, the State has failed to show that the charges it proffers for the hospital it is using to establish its upper payment limit are charges that are actually paid by paying patients. Thus, they do not meet the State's own definition of "customary charges."

The term "prevailing charges" with respect to physician services paid under Medicare is defined at § 405.504. The term refers to those charges that fall within the range of charges most frequently and most widely used in a locality for

While other Medicaid UPLs such as §§ 447.272 and 321 are aggregate limits (i.e., based on a sum total of a wide-ranging group of facilities), § 447.325 is not: it is a specific limitation that requires looking at the particular facilities and specific community involved. For the facilities at issue here, the services are recognized under CMS' interpretation of the statute as members of the unique statutory class of facilities which receive 100% of their funding from the federal government. For facilities of this type, the IHS published rates, authorized by the Commissioner of IHS, are anappropriate comparison of prevailing charges. Indeed, those published rates make special provision for facilities in the State of Alaska in recognition of the higher costs incurred in Alaska. See 67 Fed. Reg. 15214 (Mar. 29, 2002).

Alaska plans to set the UPL for these facilities by comparing the charges of

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particular medical procedures or services. The top of this range establishes an overall limitation on the charges that the carrier will accept as reasonable for a given service, except where unusual circumstances or medical complications warrant an additional charge. Prevailing charges are derived from the overall pattern existing within a locality, and are determined according to the formula prescribed by the regulations in § 405.504 et seq.

These principles have limited applicability to this case. The hospitals at issue are a unique class of hospitals that furnish services that are not comparable to those of other hospitals, and the State has admitted that its proposed payment system will take into account the unique status of these facilities by reimbursing them in accordance with the rates ordinarily applicable to such facilities.

the tribal facilities to those of a hospital which receives its Medicaid funding through the State and federal governments through a system that measures costs, not charges.[10] But as we have demonstrated and the State recognized in its testimony,[11] tribal facilities are not private hospitals, they are facilities which receive virtually all of their funding through the federal government (IHS and Medicaid), and the State recovers 100% payment for Medicaid services provided through these facilities. Thus, for the term in § 447.325 to have any meaning, "comparable services under comparable circumstances" should not mean a private hospital in Anchorage, but similar IHS and tribal facilities receiving services through the IHS scheme. The IHS rate, which represents what tribal hospitals in Alaska actually receive under both Medicare and Medicaid, is a far more accurate measure of the prevailing charges. In the system through which these payments are funded, the IHS, as charged by the federal government, has determined prevailing rates for Indian Health Facilities. Although, as we have noted, use of these rates is not mandatory, Alaska has given no sound economic reason for departing from them. To the contrary, the State is itself relying on those rates by

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[10]Alaska admits that it does not factor in these charges in reimbursing this hospital under Medicaid, but reimburses on a cost basis. Supp. ER 19.

[11]Supp. ER 20.

allowing the tribal facilities to retain only 10% of the amounts they will receive above those rates.[12]

2. The State's proposed methodology does not meet the regulatory standard.

Even if we were to overlook the unique situation through which these facilities are funded, as Alaska would have us do, the regulation allows the State to pay the customary charge of the provider, but no more than the prevailing charges for comparable services under comparable circumstance. 42 C.F.R. § 447.325. Alaska further admits that it does not have any charge data from the tribal facilities, except for the Norton Sound Health Corporation, which although eligible for the IHS rate, has chosen to opt out of the system. Id. at 8-9.[13] The State contends that the tribal hospitals do not have data sufficient to allow Alaska to determine customary charges. Id. at 9. The only charge information that the State receives from the Tribal Facilities is the bill which has the payment specified under the Indian Healthcare Improvement Act, which is based on the IHS payment

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[12]The State argues that there is some significance to the fact that there are no IHS-operated inpatient facilities in Alaska. It bears repeating that the facilities at issue receive the same 100% FMAP as do IHS facilities, and the rates they receive are determined in reference to the IHS system. This would continue to be true under the State's proposed amendment: all but 10% of the additional federal funds received would not be returned to the facilities.

rate. Testimony of Robert Labbe, Supp. ER 13.

Thus, as the State admitted in its testimony before the hearing officer, Id., Alaska simply does not have any information other than the rates received through the IHS system by which it could determine customary and prevailing charges for these facilities. To the extent that it admits that it has information on one hospital, it has not included this information in its calculation, but instead is using as its reimbursement rate 100% of the charges at one large private hospital in Anchorage where by its own admission the upper payment limit is "pretty high." Testimony of Nancy Weller, Supp. ER 11. Indeed, Alaska estimates that accepting these charges would effectively triple the federal Medicaid payments currently received by the tribal facilities.

The State admits that it plans to set its proposed payment rates by using the charges it determines for one private hospital. Testimony of Nancy Weller, Supp. ER. 9, 11. It also concedes that under its proposed amendment the State would not have any information on the specific charges of the providers, and would merely accept the amount on the bill as the customary charge of the provider, and pay it in full. ER 26. Of course, the State would have no incentive to scrutinize that amount, as the federal government would reimburse the State 100% of those charges under the 100% FMAP for tribal facilities contemplated by 42 U.S.C. §

1396d(b).

It is clear from the record that the State's goal in ascertaining charges is not to discover the actual charges of these facilities but to maximize the State's receipt of federal funds without any concomitant State expenditure. This is an effort that makes a mockery of any attempt to ensure the efficient and economical operation of the facilities and similarly violates the requirement in 42 C.F.R .§ 447.325 that the payment limits be based upon "prevailing charges in the locality for comparable services under comparable circumstances."

CONCLUSION

For the foregoing reasons, the Court should uphold the final agency decision disapproving proposed Alaska State Plan Amendment 01-009.

Respectfully submitted,

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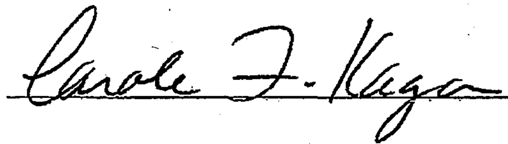
CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7), the undersigned counsel certifies that this brief complies with the type-volume limitations and typeface requirements of those rules.

1. Exclusive of the exempted portions specified by Fed. R. App. P. 32(a)(7)(B)(iii), according to Corel WordPerfect 9 word processing software, the brief contains 9,915 words.

2. The brief has been prepared in proportionally spaced typeface using Corel WordPerfect 9 word processing software. The typeface of the brief is Times New Roman 14-point font, in compliance with Fed. R. App. P. 32(a)(5) and (6).



Carole F. Kagan

ADDENDUM

42 U.S.C.A. § 1396a

United States Code Annotated Currentness
Title 42. The Public Health and Welfare

Chapter 7. Social Security (Refs & Annos)
Subchapter XIX. Grants to States for Medical Assistance Programs (Refs & Annos)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must--

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

42 C.F.R. § 447.325

CODE OF FEDERAL REGULATIONS
TITLE 42--PUBLIC HEALTH
CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH
AND HUMAN SERVICES
SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS
PART 447--PAYMENTS FOR SERVICES
SUBPART F--PAYMENT METHODS FOR OTHER INSTITUTIONAL AND NONINSTITUTIONAL
SERVICES
OTHER INPATIENT AND OUTPATIENT FACILITIES
Current through December 16, 2004; 69 FR 75406

§ 447.325 Other inpatient and outpatient facility services: Upper limits of payment.

The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 447.325
42 CFR § 447.325
END OF DOCUMENT

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 23th day of December, 2004, I caused a copy of the foregoing Brief of Respondents to be sent via Federal Express to:

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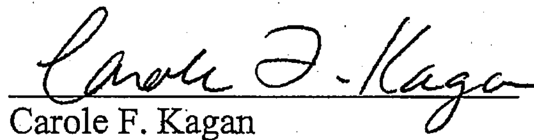

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