IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Plaintiff-Petitioner*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SECRETARY ROBERT F. KENNEDY, JR., IN OFFICIAL CAPACITY, *Defendant-Respondent*.	No. 25-1075

UNOPPOSED MOTION OF AMERICA'S ESSENTIAL HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, CHILDREN'S HOSPITAL ASSOCIATION, AND NORTH CAROLINA HEALTHCARE ASSOCIATION TO FILE AN *AMICI CURIAE* BRIEF WITH ADDENDUM IN SUPPORT OF PLAINTIFF-PETITIONER AND REVERSAL

America's Essential Hospitals, Association of American Medical Colleges, National Association of Children's Hospitals, Inc., d/b/a Children's Hospital Association, and North Carolina Healthcare Association (collectively, the Proposed *Amici*) respectfully move for leave to file the attached brief in support of Plaintiff-Petitioner including a regulatory addendum pursuant to Federal Rule of Appellate Procedure 29(a)(3), both of which are appended to this motion.

Pursuant to Federal Rule of Appellate Procedure 29(a)(2), undersigned counsel contacted counsel for the parties concerning the proposed *amici* brief. Plaintiff-Petitioner and Defendant-Respondent consent to the filing of this *amici* brief.

AMICI'S INTEREST

Amici are four associations representing hospitals and health care systems in the United States that serve Medicaid patients, including in this Court's jurisdiction. CMS' decision if upheld will threaten certain forms of non-federal share funding that have long been permitted and on which *Amici's* members have relied to obtain critical Medicaid payments. Elimination of those payments would gravely harm providers and their patients, who will lose access to care. *Amici* therefore have a strong interest in preserving states' ability to fund their Medicaid programs through the sources at issue in this case.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. America's Essential Hospitals supports more than 350 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce

training, research, public health, and other services. Supported by the Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value. Medicaid and dually-eligible Medicaid/Medicare patients comprise on average 46% of essential hospitals' inpatient services and 32.5% of outpatient services. Essential hospitals report margins of -14% without Medicaid supplemental payments often financed under the authority at issue in this case.

The Association of American Medical Colleges is dedicated to improving the health of people everywhere through medical education, healthcare, medical research, and community collaborations. Its members include all 160 LCME-accredited medical schools; nearly 500 academic health systems and teaching hospitals; and more than 70 academic societies. Nationally, despite comprising only 40% of hospitals, teaching hospitals provide 78% of all Medicaid hospital services. Teaching hospitals report a significant Medicaid shortfall of $28.2 billion nationally and typically expect to treat patients at a financial loss due to mission-based reasons.

The National Association of Children's Hospitals, Inc., d/b/a Children's Hospital Association, is the national voice of more than 220 children's hospitals. It advances child health through innovation in the quality, cost, and delivery of care in children's hospitals. Children's hospitals are major Medicaid providers, with, on average, 55% of their payments coming from Medicaid.

The North Carolina Healthcare Association (NCHA) represents over 130 individual and multi-hospital systems across North Carolina. Since 1918, NCHA has advocated for hospitals, health systems, and care providers to ensure they can offer high-quality health care that is equitable and accessible within the state. In North Carolina, one in four residents are covered by Medicaid.

AMICI'S INPUT IS HIGHLY RELEVANT AND UNIQUE

As set forth in the brief, *Amici* actively participated in the development and evolution of the legislative and regulatory structure at issue in this case. An understanding of that history is critical to correctly interpreting the laws governing non-federal share funding. *Amici* will provide helpful analysis of this history for the Court's consideration and are well positioned to demonstrate that the reasoning articulated by the Defendant-Respondent is inconsistent with the relevant Medicaid statute and regulations.

Furthermore, through experience over decades in federal and state policy discussions and insight from individual member hospitals involved in the structuring of related programs with states, *Amici* are uniquely suited to present examples of how the Defendant-Respondent's position in this case conflicts with actual agency practice over time, including in very recent program approvals.

Amici are deeply concerned that the Defendant-Respondent's decision will (1) upend a bedrock principle embedded in the Medicaid statute since its enactment and

(2) sow confusion about longstanding rules on which *Amici's* hospital members and their states have relied in structuring their Medicaid programs. The decision if upheld by this Court could threaten crucial payments that support the missions of essential hospitals, academic medical centers, and children's hospitals nationwide, as well as the approximately 80 million Americans who rely on Medicaid for coverage. *Amici* have invaluable input for the Court because the potential impact of this decision is not limited to the disapproval of a single program in a single state. *Amici* represent hospitals in this Court's jurisdiction and nationwide and can provide valuable insight on the scope of potential impact on hospitals and health systems similar to and different from the facts of this case.

For these reasons, in compliance with Federal Rule of Appellate Procedure 29(a)(3)(B), *Amici's* brief is desirable and relevant to the disposition of the case.

CONCLUSION

For the foregoing reasons, *Amici* respectfully request the Court grant leave to file the attached *amici curiae* brief with addendum.

Date: April 21, 2025

Respectfully submitted,

s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC
300 New Jersey Avenue NW
Suite 300
Washington, DC 20001
(202) 567-6202
beyman@eymanlaw.com

s/ Eva Johnson
Eva Johnson
Eyman Partners, LLC
300 New Jersey Avenue NW
Suite 300
Washington, DC 20001
(202) 567-6205
ejohnson@eymanlaw.com

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE
WITH TYPE-VOLUME LIMITATIONS

The Motion for Leave to File Amicus Brief complies with the type-volume limitation contained in FRAP 27(d)(2) because it contains 896 total words. It also complies with the typeface and type style requirements of FRAP 32(a)(5)-(6) because it was prepared using Microsoft Word in Times New Roman 14-point font and is double-spaced.

Dated: April 21, 2025

Respectfully submitted,

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC

Counsel for Amici Curiae

CERTIFICATE OF FILING AND SERVICE

I certify that a copy of the foregoing motion was filed electronically with the Court via the CM/ECF system and further certify that a copy was served on all parties or their counsel of record through the CM/ECF system.

Dated: April 21, 2025

Respectfully submitted,

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC

Counsel for Amici Curiae

No. 25-1075

In the United States Court of Appeals for the Fourth Circuit

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Plaintiff-Petitioner,

-v-

DEPARTMENT OF HEALTH AND HUMAN SERVICES, SECRETARY ROBERT F. KENNEDY, JR., in Official Capacity,

Defendant-Respondent.

On Petition for Review of Final Decision of the United States Department of Health and Human Services

BRIEF OF AMICI CURIAE AMERICA'S ESSENTIAL HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, CHILDREN'S HOSPITAL ASSOCIATION, AND NORTH CAROLINA HEALTHCARE ASSOCIATION IN SUPPORT OF PLAINTIFF-PETITIONER AND REVERSAL

Barbara D.A. Eyman
Eva Johnson
Eyman Partners, LLC
300 New Jersey Avenue NW
Suite 300
Washington, DC 20001
(202) 567-6202
beyman@eymanlaw.com
ejohnson@eymanlaw.com

Counsel for Amici Curiae

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, counsel to Amici Curiae certifies that America's Essential Hospitals, the Association of American Medical Colleges, Children's Hospital Association, and North Carolina Healthcare Association have no parent companies, subsidiaries, or affiliates that have issued shares to the public, and no publicly traded corporation owns 10% or more of any of these entities.

Dated: April 21, 2025

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

TABLE OF AUTHORITIES (Cont.)

FEDERAL REGISTER

CONGRESSIONAL RECORD

TABLE OF AUTHORITIES (Cont.)

OTHER AUTHORITIES

STATEMENT REQUIRED UNDER
FEDERAL RULE OF APPELLATE PROCEDURE 29(a)(4)(E)

No party's counsel authored this brief in whole or in part. No party, party's counsel, or person – other than the amici curiae – contributed money intended to fund the preparation or submission of this brief.

Dated: April 21, 2025

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC

Counsel for Amici Curiae

IDENTITY AND STATEMENT OF INTEREST OF AMICI CURIAE

Amici are four associations representing hospitals and health care systems in the United States. CMS' decision if upheld will threaten certain forms of non-federal share funding that have long been permitted and that Amici's members have relied on to obtain critical Medicaid payments. Elimination of those payments would gravely harm providers and their patients, who will lose access to care. Amici therefore have a strong interest in preserving states' ability to fund their Medicaid programs through the sources at issue in this case.

America's Essential Hospitals is dedicated to high-quality care for all, including those who face social and financial barriers to care. The association's more than 350 members provide a disproportionate share of the nation's uncompensated care, with three-quarters of their patients uninsured or covered by Medicare or Medicaid.

The Association of American Medical Colleges (AAMC) is dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members include all 160 LCME-accredited medical schools; nearly 500 academic health systems and teaching hospitals; and more than 70 academic societies.

The National Association of Children's Hospitals, Inc., d/b/a Children's Hospital Association, is the national voice of more than 220 children's hospitals. It

advances child health through innovation in the quality, cost, and delivery of care in children's hospitals. Children's hospitals are major Medicaid providers, with, on average, 55% of their payments coming from Medicaid.

The North Carolina Healthcare Association (NCHA) represents over 130 individual and multi-hospital systems across North Carolina. Since 1918, NCHA has advocated for hospitals, health systems, and care providers to ensure they can offer high-quality health care that is equitable and accessible within the state.

INTRODUCTION

Throughout the history of the Medicaid program, the authorizing statute and regulations have permitted states to fund the non-federal share of Medicaid payments with public funds transferred by local governments, known as intergovernmental transfers (IGTs). As units of government, public providers can and do routinely fund IGTs. Private providers, by contrast, cannot fund the non-federal share except in circumstances carefully prescribed by Congress in Pub. L. No. 102-234 (1991), which authorized certain health care provider taxes and "bona fide" donations. At various times, CMS has attempted to exceed its statutory authority by restricting the sources from which IGTs can be funded. However, CMS has withdrawn all such attempts after receiving widespread criticism that its misguided proposals would gut the Medicaid program with devastating and far-reaching impacts. The Administrator's decision revives these abandoned proposals that have never become law, concluding that (1) IGTs must be derived from taxes and appropriations; and (2) IGTs by public providers are provider-related donations. Both conclusions are unsupported by law and legislative history as well as inconsistent with longstanding and current agency practice.

If allowed to stand uncorrected, the Administrator's decision will sow confusion about the rules for IGT-funded Medicaid payments across the country. In 2018, local governments (predominantly through IGTs) supported an estimated 12 percent of

Medicaid spending nationally, including tens of billions of dollars of payments for care provided at essential hospitals, academic medical centers, and children's hospitals. *Medicaid Base and Supplemental Payments to Hospitals*, Medicaid & CHIP Payment & Access Comm'n (MACPAC) 3 (April 2024), https://bit.ly/4iuk7So [hereinafter "April 2024 MACPAC Report"]. The Administrator's decision jeopardizes these essential payments to the severe detriment of the U.S. health care system and patients nationwide.

ARGUMENT

I. Petitioners Are Correct That Federal Law Does Not Require IGTs to Be Derived Only from State and Local Taxes or Appropriations

A. The Administrator's Decision Conflicts with Federal Statute

The Administrator incorrectly identifies Section 1903(w)(6)(A) of the Social Security Act, codified at 42 U.S.C. § 1396b(w)(6)(A), as the instrumental legal authority in this case. Specifically, the Administrator's interpretation that "Section 1903(w)(6)(A) of the Act *allows units of government to participate in Medicaid funding*," JA 71 (emphasis added), conflicts with the statute's plain text and is historically and factually incorrect. Funding from "local sources," including IGTs, has been authorized by a different statute at 42 U.S.C. § 1396a(a)(2) since Medicaid's inception.[1] CMS regulations affirm that this provision permits "local governments" to fund the non-Federal share. 42 C.F.R. § 433.50(a) ("This subpart interprets and implements [42 U.S.C. § 1396a(a)(2)] which . . . *permit both State and local governments to participate in the financing of the non-Federal portion* of medical assistance expenditures.") (emphasis added). Public hospitals, public health care districts and authorities, and state universities are among the "local

[1] Notably, the legislation originally introduced in the House of Representatives would have required 100% of the non-federal share to be funded by States without the use of local funds. *See* 111 Cong. Reg. 15791 (July 7, 1965); H.R. Cong. Rep. No. 682, 89th Cong. 1st Sess. 50 (1965).

governments" that have long been permitted to make IGTs and "can derive the funds that they use for IGTs . . . from any public funds, including local tax revenue or patient revenue." *Report to Congress on Medicaid and CHIP*, MACPAC 5 (June 2024), https://bit.ly/3Ri0Ic9 [hereinafter "June 2024 MACPAC Report"]. Their IGTs support payments to both public and private hospitals across the country.

42 U.S.C. § 1396b(w)(6)(A), cited by the Administrator, was added to the statute in 1991, long after IGTs became a permissible non-federal share funding source. This provision does not change states' authority to use IGTs under 42 U.S.C. § 1396a(a)(2). It instead governs the conduct of CMS, prohibiting the agency from ever taking steps to limit IGTs from certain protected sources—taxes and certain appropriations. 42 U.S.C. § 1396b(w)(6)(A) ("*[T]he Secretary may not restrict* States' use of funds" where derived from identified sources) (emphasis added). The Administrator should not be permitted to twist a statutory provision designed to limit *agency* authority into one that severely restricts *state* authority to use IGTs.

B. The Administrator's Decision Conflicts with Federal Regulations

42 C.F.R. § 433.51 is the regulatory source of authority for IGTs. The regulation provides that "[p]ublic funds may be considered as the State's share" as long as specified conditions are satisfied: (1) "[t]he public funds . . . *are transferred from other public agencies* . . . to the State"; and (2) "[t]he public funds are not Federal funds. . . ." (emphasis added). The transfers from GHA satisfy all § 433.51

conditions; the parties do not dispute that the funds were transferred from a public agency and are not Federal funds.

The Administrator impermissibly reads new restrictions into the text of § 433.51 and dismisses the State's reliance on it, appearing to assert that the provider-related donation legislation enacted by Congress in 1991 had the effect of superseding or amending § 433.51 without any changes to the regulatory text. In fact, the legislative history makes clear that the donation provisions were not intended to narrow the scope of § 433.51. And Congress expressly required CMS to go through formal notice-and-comment rulemaking with State consultation to make any future changes to § 433.51, Petitioner's Br. at 30, which CMS has never done. Every attempt to do so has been formally withdrawn. *See* 75 Fed. Reg. 73975 (Nov. 30, 2010) (2007 rule withdrawal); 86 Fed. Reg. 5105 (Jan. 19, 2021) (withdrawal of proposed rule); *see also* Petitioner's Br. at 12–15.

C. The Administrator's Decision Conflicts with CMS Practice Permitting IGTs from Sources Other than Taxes and Appropriations

Consistent with Amici's and Petitioner's understanding of the relevant laws (and at odds with the Administrator's decision), CMS frequently approves Medicaid payment programs funded by IGTs derived from sources other than taxes and appropriations. In 2022, CMS began making publicly available some of the financing data it routinely collects in connection with payment approvals, including

the governmental nature of the entity making IGTs, the total amount of IGTs, and information on the taxing authority and appropriations received by the transferring entity. *Table 4*, *Section 438.6(c) Preprint*, Ctrs. for Medicare & Medicaid Servs. (2021), https://bit.ly/4lBBRh6. A review of publicly available preprint approvals shows that over roughly the last three years, CMS approved 102 preprints for IGT entities that report no taxing authority and no or insufficient appropriations to cover the IGT amount.[2] *Approved State Directed Payment Preprints*, Medicaid.gov, https://bit.ly/3Y0NioB (last visited Apr. 18, 2025). CMS cannot now base disapproval of South Carolina's SPAs on a legal theory that is plainly inconsistent with CMS' every day, real world practices.

II. Petitioners Are Correct That IGTs of Public Funds by Public Authorities and Providers Are Not Provider-Related Donations

Petitioners correctly identify § 433.51 and its predecessor regulations containing the same "public funds" language at 42 C.F.R. § 432.60 (1978) and 42 C.F.R. § 433.45 (1985) (collectively, the "public funds regulation") as the key legal authority in this case. Petitioner's Br. at 29. The administrative opinions below reflect a fundamental misunderstanding of this regulation, collapsing the laws governing IGTs by public providers on the one hand and laws governing provider-

[2] This number is an undercount, as many states include details on IGT sources in attachments that are not available through CMS' website.

related donations by private providers on the other. *See* June 2024 MACPAC Report, at 4–5 (identifying IGTs and bona fide provider donations as distinct non-federal share funding sources and stating, "Each permissible source of funding is subject to different rules"). An understanding of the legislative and regulatory structure and history, in which Amici actively participated,[3] is critical to correctly interpreting the laws governing non-federal share funding. The evolution of the regulatory text over time, as described herein, is included in the Addendum.

Prior to 1990, the public funds regulation distinguished between two different sources of funding: "public funds" and "*private donated* funds," both of which CMS permitted for a time as sources of non-federal share funding.[4] *See* regulations at Add. (emphasis added). In 1990 and 1991, CMS twice proposed rules that would have eliminated the public funds regulation in its entirety and replaced it with language requiring the subtraction of amounts donated by health care providers from states' claims for federal matching funds. *See* 55 Fed. Reg. 4626, 4628–31 (Feb. 9, 1990) (proposed rule); 56 Fed. Reg. 46380, 46380–46387 (Sept. 12, 1991) (proposed rule).

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[3] *See* Statement of Larry S. Gage for AEH (then National Association of Public Hospitals) and Robert Sweeney for CHA, Broad-Based Provider Taxes and Disproportionate Share Hospital Limits in the Medicaid Program: Hearing Before the H. Subcomm. on Health and the Environment of the H. Comm. on Energy and Commerce, 102nd Congress 458–479 (Nov. 25, 1991).

[4] References to "CMS" prior to June 14, 2001 should be read to refer to the agency's prior name, the Health Care Financing Administration or "HCFA."

Neither rule became law. Concerned about the potentially devastating impact to state Medicaid programs, Congress imposed a series of moratoria on CMS' attempted regulations. Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8431; Omnibus Budget Reconciliation Act (OBRA) of 1989, Pub. L. No. 101-239, § 6411(b); OBRA of 1990, Pub. L. No. 101-508, § 4701(a).

During the many Congressional hearings that followed, members of Congress specifically expressed concern that CMS' confusing proposals could eliminate IGTs by public providers. *See, e.g., State Financing of Medicaid: Financing Medicaid Through Provider Taxes and Intergovernmental Transfers: Hearing Before the H. Subcomm. on Health and the Environment of the H. Comm. on Energy and Commerce*, 102nd Congress 189 (Oct. 16, 1991) (quoting analysis of the Congressional Research Service: "[S]ome critics of [the September 1991] rule believe that it may interfere with routine transfers of funds between State and local agencies, [which] often operate or own health facilities, including public hospitals. . . . Because the agencies transferring the funds are Medicaid providers, it is conceivable that [IGTs] might be treated by HCFA [now CMS] as provider donations, and hence prohibited"). The Administrator at the time acknowledged this confusion, telling Congress: "The September 12 rule could be read to eliminate [IGTs], including longstanding State practices. It was not our intent to do this." *Id.* at 275. Given Congressional pressure, CMS then issued an October 1991

"clarifying" rule (which also never took effect), proposing to reinstate the public funds regulation as part of its donation regulation. 56 Fed. Reg. 56132, 56132–56140 (Oct. 31, 1991) (proposed rule).

But confusion remained as to whether transfers by public providers should be treated as IGTs of public funds, or as donations of a provider. Congress insisted on the former, adding language to the final legislation requiring that IGTs by public providers be treated the same as IGTs by other public entities—that is, as IGTs rather than donations. 42 U.S.C. § 1396b(w)(6)(A) ("*Notwithstanding the provisions of this subsection* [governing provider-related donations], the Secretary may not restrict States' use of funds where such funds are derived from [taxes and certain appropriations] transferred from . . . units of government within a State . . . *regardless of whether the unit of government is also a health care provider*. . . . ") (emphasis added). The Conference Report explained that "current transfers from *county or other local teaching hospitals* continue to be permissible if not derived from sources of revenue prohibited under this act." H.R. Conf. Rep. No. 409, at 17 (Nov. 27, 1991) (emphasis added); *see also State Financing of Medicaid: Broad-Based Provider Taxes and Disproportionate Share Hospital Limits in the Medicaid Program: Hearing Before the H. Subcomm. on Health and the Environment of the H. Comm. on Energy and Commerce*, 102nd Cong. 355, 432 (Nov. 25, 1991) (statement of the National Governors Association, which played a critical role in

negotiating the final legislative language: "HCFA will reinstate its pre-existing regulation on the use of public funds, and provide therein that transferred . . . funds do not lose their character merely because the transferring . . . entity is also a Medicaid provider"). In the final legislation, Congress also took steps to make it harder for CMS to restrict sources of public funds going forward. Congress required CMS to withdraw its October 1991 rule and prohibited the Secretary from "chang[ing] current treatment of intergovernmental transfers except through the formal APA regulatory process. . . . " H.R. Conf. Rep. No. 409, at 17 (Nov. 27, 1991); *see also* Petitioner's Br. at 9–10.

In November 1992, CMS issued regulations implementing the 1991 legislation, restoring the structure distinguishing between "public funds" and "private donations" that had been in place prior to this period of regulatory upheaval. CMS retained the public funds regulation governing IGTs and redesignated it as its own provision at 42 C.F.R. § 433.51 "for consistency in the organization of the regulations." 57 Fed. Reg. 55118, 55119 (Nov. 24, 1992). Then, in a series of separate regulations, 42 C.F.R. § 433.57 and related definitional provisions, CMS addressed impermissible provider-related donations.

Though written in legalese, the overarching purpose of the provider-related donation laws is simple: to prohibit private providers from funding the non-federal share of Medicaid expenditures, whether directly or indirectly. *United States ex rel.*

Rose v. E. Tex. Med. Ctr. Reg'l Healthcare Sys., 2008 U.S. Dist. LEXIS 65660, at *4 (E.D. Tex. Aug. 25, 2008) (describing the addition of 42 U.S.C. § 1396b(w) in 1991 as a "response[] to a perceived abuse of the system, which allowed states to obtain funds *from private entities* . . . without actually having to contribute to any of the funding") (emphasis added). The donation rules do not restrict in any way the ability of public entities—including public providers—to use their public funds to make IGTs, other than to prohibit pass-through donations from private entities through public entities, which did not occur in this case. *See* June 2024 MACPAC Report, at 6 (explaining the application of the donation rules to local governments as follows: "[P]ublic agencies that provide IGTs for payments to a *non-governmental provider* cannot receive impermissible donations *from these [private] providers*") (emphasis added).[5]

In sum, the legal flaws in the Administrator's decision require reversal. If upheld, the Administrator's decision would upend a bedrock principle embedded in the Medicaid statute since its enactment. Local governments, including public providers,

[5] Beyond this fatal legal flaw in the Administrator's application of the donation rules, there are other flaws of note. CMS admittedly did not examine whether GHA is a unit of government, JA 71–72, even though the character of a provider and its funds as public or private is a central legal issue and a prerequisite to finding an impermissible donation. In addition, though CMS emphasized that the Medicaid statute grants the Secretary a "high level of discretion" to determine whether a donation is "bona fide," JA 73, 127, the "bona fide" provisions are an exception that only becomes relevant if there is a provider-related donation in the first place, and there is not here.

are permitted to fund the state's share of Medicaid payments, and their funds are "considered as the State's share" in claiming federal matching funds. 42 C.F.R. § 433.51. Many public providers lack access to tax revenues and rely on patient care and other revenues to fund IGTs instead. If, as the Administrator concludes, all public provider transfers are necessarily provider-related donations, and only taxes and certain appropriations are permissible sources of IGTs, public providers would rarely be permitted to participate in non-federal share funding. There is no basis for this result under current law.

III. Upholding the Administrator's Aberrant Decision Would Have Nationwide Impact with Devastating Consequences for the Medicaid Program and Beneficiaries

Medicaid and the Children's Health Insurance Program cover nearly 80 million Americans, 37 million of whom are children. *November 2024 Medicaid & CHIP Enrollment Data Highlights*, Medicaid.gov, https://bit.ly/4ioZmr5 (last visited Apr. 18, 2025). In North Carolina, one in four residents are covered by Medicaid. *NC Medicaid Expansion Reaches 650,000 North Carolinians Enrolled Fewer Than 18 Months After Launch*, N.C. Dep't Health & Hum. Servs. (Apr. 9, 2025), https://bit.ly/3Geek5Q. Restricting longstanding sources of IGTs would result in cuts to Medicaid funding used by Amici's members to sustain services for these low-income and vulnerable children and adults. Medicaid providers depend on this funding. Medicaid rates from states and Medicaid plans are notoriously low, in part

due to limits on allocated state general revenue, resulting in substantial uncompensated costs and threatening providers' ability to serve beneficiaries. Providers rely on targeted Medicaid payment programs to supplement these inadequate base rates—payments that are more often funded by IGTs. In 2018, funds from local governments (*i.e.*, IGTs) represented 12 percent of Medicaid spending nationally, 40% of the non-federal share for disproportionate share hospital (DSH) payments, and 25% of the non-federal share for other supplemental payments (such as graduate medical education payments). April 2024 MACPAC Report, at 3.

The importance of IGT-funded enhanced payments cannot be overstated, particularly for Amici's members who care for the underserved, train the nation's health care workforce, and provide specialized, lifesaving services. The payments often make the difference in the financial viability of safety net providers. In 2022, essential hospitals would have had -14 percent operating margins without DSH and other Medicaid supplemental payments. *Essential Data*, Am.'s Essential Hosps. 14 (2024), https://bit.ly/4j91mVz. In South Carolina alone, an AAMC analysis of 2022 Medicare cost reports found that a cut of $25 million in Medicaid payments would reduce teaching hospitals' already negative margins (-9 percent) to -11 percent. And for children's hospitals, even with supplemental payments, Medicaid reimburses only 80 percent of the cost of care provided.

IGT-funded Medicaid payments also have supported a wide array of essential services that ensure broad and equal access for the Medicaid population. Among other examples, Amici's members use Medicaid payments to fund high-cost, negative-margin services (e.g., trauma care, advanced neonatal intensive care, burn care, transplants); expand access to behavioral health care and substance use disorder services; improve maternal health outcomes; address chronic conditions such as cancer, heart disease, diabetes, and obesity; expand residency training programs (as Medicare support is frozen at 1996 levels); fuel biomedical research to develop lifesaving medical innovations; and increase access in rural areas. If the Administrator's decision is upheld, Amici's members will be forced to curtail services that are critical to keeping Americans healthy.

Upholding the decision would also undermine the diligent efforts of public providers around the country over many years to reduce their dependence on local taxes and to provide tax relief to their residents, relying on CMS' longstanding practice of approving a wide variety of public funding sources. In doing so, many have undertaken significant organizational restructuring to strengthen their finances. *See* Larry S. Gage, *Transformational Governance: Best Practices for Public and Nonprofit Hospitals and Health Systems*, Ctr. for Healthcare Governance 45–64 (2012), https://bit.ly/3EpDo9o. Many public providers have thus funded IGTs with patient care revenues. States too have relied on a variety of public funding sources,

including state tobacco and opioid settlements, state university tuition revenue, collected fees and fines, earned interest, and more. All of these arrangements would be jeopardized if the Administrator's decision becomes precedent. States and localities would be left with two choices: raise taxes or cut Medicaid payments, both of which are undesirable and unnecessary policy outcomes.

CONCLUSION

For the foregoing reasons, this Court should reverse the Administrator's decision and remand to the agency with instructions to approve Petitioner's state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A.

Dated: April 21, 2025

Respectfully submitted,

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC
300 New Jersey Avenue NW, Suite 300
Washington, DC 20001
(202) 567-6202
beyman@eymanlaw.com

/s/ Eva Johnson
Eva Johnson
Eyman Partners, LLC
300 New Jersey Avenue NW, Suite 300
Washington, DC 20001
(202) 567-6205
ejohnson@eymanlaw.com

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE
WITH TYPE-VOLUME LIMITATION

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Dated: April 21, 2025

Respectfully submitted,

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC

Counsel for Amici Curiae

CERTIFICATE OF FILING AND SERVICE

I certify that a copy of the foregoing brief was filed electronically with the Court via the CM/ECF system and further certify that a copy was served on all parties or their counsel of record through the CM/ECF system.

Dated: April 21, 2025

Respectfully submitted,

/s/ Barbara D.A. Eyman
Barbara D.A. Eyman
Eyman Partners, LLC

Counsel for Amici Curiae

REGULATORY ADDENDUM

1978 Final Rule	1985 Final Rule	1990 Proposed Rule (never effective)	Oct. 1991 Interim Final Rule (never effective)	1992 and Current Rule (In Effect Since 1992, Formally Reinstated in 2010)	2007 Rule (never effective)	2019 Proposed Rule (never effective)
42 CFR §432.6 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	**42 CFR §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	**42 CFR §433.45 Determining the level of State expenditures for FFP purposes.** (a) *Purpose*. This section describes how a State's net expenditure for medical assistance is calculated in the presence of donations, tax revenues or other transfers to the State from those who receive Medicaid payments from the State…. (c) *General rule.* When calculating	**42 CFR §433.45 Determining the level of State expenditures for FFP purposes.** (a) *Purpose*. This section describes how a State's net expenditure for medical assistance is calculated in the presence of donations, tax revenues or other transfers to the State from those who receive Medicaid payments from the State….	**42 CFR §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	**42 CFR §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	**42 CFR §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:

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(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	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	State expenditures that are claimable for Federal matching as medical assistance, HCFA subtracts from nominal State expenditures the amount of any revenue to the State generated by health care providers when that revenue results from donations made to the State by the providers or results from taxes applied uniquely to providers. . . .	(b)(4) *Donation* means any voluntary payment, including, but not limited to, a gift, contribution, presentation or award. (c) *Public funds as the State's share.* Public funds may be considered as the State's share in claiming FFP if they are not generated through a provider-specific tax or donation as described in paragraph (d) or	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	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	(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,

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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	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 paragraphs (b)(2) and (3) of this section.	(d) *Donations*. When a health care provider makes donations to the State, the revenue from the donated amount is offset and subtracted from the State's nominal expenditures…. (g) *Other transfers.* The general rule set forth in paragraph (c) of this section applies to any transfer of funds. These transfers are either from a health care provider or from a	(e) respectively of this section and if they meet the following conditions: (1) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies to the State or local agency and under its administrative control… (2) The funds are not Federal funds, or are Federal funds authorized	are Federal funds authorized by Federal law to be used to match other Federal funds. **42 CFR §433.57 General rules regarding revenues from provider-related donations and health care-related taxes.** Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assist-	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	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

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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 restrictions which would require their use	(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 nonprofit organization, and the Medicaid agency, of its own volition, decides to use the donor's facility.	related organization to the State government or to any fund or instrumentality to which the State government has access.	by Federal law to be used to match other Federal funds…. (e) *Donations*. When calculating State expenditures that are claimable for Federal matching as medical assistance, HCFA subtracts from nominal State expenditures the amount of any donations made to the State, county, or any other governmental instrumentality,	ance, 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	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.	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-

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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 organi-zation and the Medicaid agency of its own volition, decides to use the donor's facility…			by or on behalf of health care providers. [(g) deleted]	donations, as specified in § 433.66(b); or (b) Health care-related taxes, as specified in § 433.68(b).	(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 govern-mental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university	bona fide under §§ 433.52 and 433.54.

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					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].	