No. _____, Original

In The
Supreme Court of the United States

STATES OF TEXAS, KENTUCKY, MAINE, MISSOURI, AND NEW JERSEY,

Plaintiffs,

v.

MICHAEL O. LEAVITT, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant.

MOTION FOR LEAVE TO FILE BILL OF COMPLAINT, SUPPORTING BRIEF, AND BILL OF COMPLAINT

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MOTION FOR LEAVE TO FILE BILL OF COMPLAINT AND SUPPORTING BRIEF

The Plaintiff States of Texas, Kentucky, Maine, Missouri, and New Jersey, pursuant to Rule 17 of the Rules of the Court, move for leave to file their Complaint against Michael O. Leavitt, Secretary, United States Department of Health and Human Services, for the reasons stated therein and in the accompanying Brief in Support.

QUESTIONS PRESENTED

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"), which amended the Social Security Act to add Medicare Part D, the prescription drug program. 42 U.S.C. §§1395w-101 to -152. The MMA requires States to pay a portion of the costs associated with providing federal Medicare drug coverage to persons eligible for both Medicare and Medicaid. 42 U.S.C. §1396u-5(c)(1)(A), (B). If a State fails to make the required payments, commonly referred to as "clawback" payments, the federal government will offset that amount, plus interest, against Medicaid payments that it otherwise would have made to the State. *Id.* §1396u-5(c)(1)(C).

1. Is the "clawback," an unconstitutional tax against the States in their sovereign capacities?

2. Does the clawback impermissibly commandeer state legislatures to fund the federal Medicare program?

3. Does the clawback violate the Constitution's Guarantee Clause by improperly usurping control of essential functions of state government?

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JURISDICTION

The Plaintiff States invoke the Court's original jurisdiction under Article III, §2 of the United States Constitution and 28 U.S.C. §1251(b)(3) because this is an action between a State and a citizen of another State. The Plaintiff States are sovereign States of the United States, and Defendant Michael O. Leavitt, the Secretary of the United States Department of Health and Human Services, is a resident and citizen of the State of Utah.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Tenth Amendment to the United States Constitution provides:

> The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively or to the people. U.S. CONST. amend. X.

The Guarantee Clause provides in relevant part:

> The United States shall guarantee to every State in this Union a Republican Form of Government. U.S. CONST. art. IV, §4.

The relevant statutory provisions are reproduced in the appendix.

STATEMENT OF THE CASE

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"). Pub. L. No. 108-173, 117 Stat. 2066. Title I of the MMA creates a new outpatient prescription drug coverage program under Medicare ("Medicare Part D" or "Part D"). The program went into effect on January 1, 2006, and is administered by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS").

Under Medicare Part D, the federal government will offer optional outpatient prescription drug coverage to all Medicare beneficiaries, including individuals (known as

"dual eligibles") who were previously already covered for prescription drugs under the States' Medicaid programs. 42 U.S.C. §1395w-101.

The federal government has shifted a large portion of the expense of this new federal program to the States. The MMA requires that States contribute to financing the new prescription drug benefit for dual eligibles by remitting to the federal government annual payments in compensation for most of the savings that Congress anticipates States will realize from no longer providing prescription drug coverage for these individuals under their Medicaid programs. 42 U.S.C. §1396u-5(c)(1)(A), (B). The payment has become known as the "clawback."

The clawback payments are calculated according to a statutory formula. A State's monthly payment is 1/12 the product of multiplying the following three factors: (1) the amount the State spent, per capita, on dual eligibles in 2003 for Medicaid prescription drugs covered under Part D, trended forward based on factors specified in the statute;[1] (2) the number of dual eligibles enrolled in Part D plans in that State; and (3) the "phase-down percentage" applicable to the year in which the payment is calculated. In 2006, States must pay 90 percent of their anticipated savings to the federal government; that amount gradually declines to 75 percent in 2015 and years after. *See* 42 U.S.C. §1396u-5(c)(1)(A); *see also* 42 C.F.R. §423.910.

CMS makes these calculations and sends letters to each State advising it of the payment amounts that must be made to the federal government. *See generally* Exhibits to Bill of Complaint. The Secretary is required to notify each State of the amount of its clawback payment not later than October 15 before the beginning of each year (beginning in 2006). 42 U.S.C. §1396u-5(c)(2)(B).

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[1] For 2006, the growth factor is based on published National Health Expenditure ("NHE") statistics. For 2007 and beyond the trend is the annual increase in Part D per capita spending as determined solely by the Secretary. *See* 42 U.S.C. §1395u-5(c)(2)(A)(ii) to -5(c)(4)(B).

In October 2005, CMS sent letters to the States specifying the amounts of their 2006 clawback payments. *See* Exhibits TX1, KY1, ME1, MO1, and NJ1. Six weeks later, in December 2005, CMS sent a second group of letters altering some States' 2006 clawback payments. *See* Exhibits TX2, ME2, and NJ2. In February 2006, CMS sent a third set of letters, changing yet again the amounts due from the States in 2006. *See* TX3, KY2, ME3, MO2, and NJ3.

The Plaintiff States still have not received written confirmation of the exact amounts of their clawback payments (including payments for the months of January and February of 2006), which remain subject to further alteration by the Secretary. If a State fails to make its designated payment at whatever time the Secretary finally advises the States of the exact amounts due and demands payment, the federal government will offset that amount, plus interest, against the Medicaid funds it otherwise would have provided to the State. 42 U.S.C. §1396u-5(c)(1)(C).

SUMMARY OF THE ARGUMENT

The Constitution establishes "an indestructible Union, composed of indestructible States," in which both the States and the federal government retain a "separate and independent existence." *Texas v. White*, 74 U.S. (7 Wall.) 700, 725 (1869). That independence, inherent in our republican form of government, ensures that each State as a sovereign entity remains responsible for and accountable to its citizens.

The clawback payment erodes the States' sovereignty and threatens their rightful place in our federal structure. Through the unambiguous language of the clawback, Congress demands that the States shall remit a monthly check to fund a purely federal benefit program. The clawback is assessed against States *because* they are States, in direct contravention of the States' longstanding right not to be taxed by the federal government.

The clawback's infringement on the States' sovereignty is not merely theoretical. It interferes with the most fundamental state function – command and control of the state fisc. It eliminates all control over a significant portion of each State's available resources. There can be no debate among the State's legislators about the best way to spend the funds. There can be no compromise among competing interests. Instead, the States must hand over to the federal government a specified dollar amount for the support and operation of an entirely federal program.

For these reasons, the clawback also violates the anticommandeering principle that is inherent in our constitutional structure, as well as the constitutional guarantee that the States will have a republican form of government. The clawback commands the States to legislate – not just to pass substantive law, but to appropriate money – to enable Congress to provide the national electorate with a federal benefit. In so doing, the clawback undermines democratic accountability by allowing Congress to take credit for providing federal prescription drug coverage through Part D without having to ask its constituents to pay for that benefit through higher taxes or reductions in federal spending. Instead, Congress has passed much of the bill onto the States, thereby frustrating the ability of voters to allocate credit and blame for the benefits and additional taxation that Congress has mandated.

Congress has entered uncharted territory, imposing, for the first time in modern history, a direct tax on the States. No other federal statute conscripts state governments directly to fund a federal program as does the MMA's clawback provision. The clawback thus works a fundamental change in our constitutional structure, whereby Congress may now interfere with, and even usurp, essential functions of state government. The Court should exercise its original jurisdiction to ensure that the core functions of self-government, which the Constitution reserves to the States as independent sovereigns, are not compromised.

ARGUMENT

The MMA's clawback provision is unconstitutional. It transgresses constitutional doctrines that prohibit direct taxation of the States and the conscription of state legislatures to appropriate funds for exclusively federal programs. Thus, the clawback raises structural concerns regarding congressional erosion of state sovereignty – concerns that are aptly described as follows:

> "[T]he erosion of state sovereignty is likely to occur a step at a time. 'If there is any danger, it lies in the tyranny of small decisions – in the prospect that Congress will nibble away at state sovereignty, bit by bit, until someday essentially nothing is left but a gutted shell.'" *South Carolina v. Baker*, 485 U.S. 505, 533 (1988) (O'Connor, J., dissenting) (quoting L. TRIBE, AMERICAN CONSTITUTIONAL LAW §5-20, at 381 (2d ed. 1988)).

Allowing the clawback provision to operate will require the States, as part of their annual budgeting process, to collect and remit state funds to the federal government for the operation of a federal program. That Congress could have this power over the States is antithetical to the structure of the Constitution, as well as to the Tenth Amendment and the Guarantee Clause. The Court should exercise its original jurisdiction to review the MMA's clawback provision and decide the important constitutional questions it raises.

I. THE CLAWBACK CONSTITUTES AN UNCONSTITUTIONAL FEDERAL TAX AGAINST THE STATES IN THEIR SOVEREIGN CAPACITIES.

The clawback operates as a discriminatory tax upon each of the States "as States" to fund the federal Medicare program and substantially interferes with essential functions of state government. As such, the clawback constitutes a significant attack on state sovereignty and is unconstitutional. No federal statute has ever required state legislatures to raise, allocate, and remit to the

federal government state monies to fund an exclusively federal program. That is, until now. And this novel attempt to conscript the States' treasuries exceeds Congress's authority.

A. The Longstanding Doctrine of Intergovernmental Tax Immunity Prohibits Federal Taxation of the States "as States."

For over 130 years, the Court has recognized that our constitutional structure forbids federal taxation of the States *qua* States:

> "[T]he very nature of our constitutional system of dual sovereign governments is such as impliedly to prohibit the federal government from taxing the instrumentalities of a state government, and in a similar manner to limit the power of the states to tax the instrumentalities of the federal government." *Metcalf & Eddy v. Mitchell*, 269 U.S. 514, 521 (1926).

Although the parameters of the States' immunity from federal taxation have changed over the years, the proposition that the federal government may not impose taxes that infringe on States' sovereignty remains a core principle of constitutional law.

1. The origins and development of the doctrine of intergovernmental tax immunity.

In *McCulloch v. Maryland*, 17 U.S. 316 (1819), Chief Justice John Marshall warned that "the power to tax involves the power to destroy." *Id.*, at 431. *McCulloch* both recognized the destructive power of taxation and gave birth to what has become known as the doctrine of intergovernmental tax immunity. Specifically, the Supremacy Clause prohibited Maryland from taxing a branch of the Bank of the United States because any state tax on federal instrumentalities would be repugnant to the Constitution. *Id.*, at 436-37.

The doctrine of tax immunity as between the federal government and the States gained reciprocity in *Collector v. Day*, 78 U.S. (11 Wall.) 113 (1871), *overruled in part by Graves v. New York ex rel. O'Keefe*, 306 U.S. 466 (1939). *Collector* determined that instrumentalities of the States should enjoy the same immunity from federal taxation that the instrumentalities of the federal government enjoy from state taxation. *Id.*, at 127. The Court recognized that the Tenth Amendment reserved to the States the powers not delegated to the United States and immunized from federal interference the exercise of those reserved powers.[2] *Id.*, at 124. In the half-century following *Collector*, the Court expanded the States' tax immunity to insulate not only direct state government functions, but also secondary or derivative transactions relating to the performance of governmental functions.[3]

In the 1930s, this expansive view of state immunity from federal taxation was narrowed to some degree. For example, *Ohio v. Helvering*, 292 U.S. 360 (1934), introduced a distinction between traditional governmental functions and proprietary state functions, concluding that the former were immune from federal taxes while the latter were not. *Id.*, at 369-70 (upholding a federal license tax on the sale of liquor within a State where the State had a monopoly on liquor trade). Under this distinction, the Court upheld federal taxes on proprietary state functions, such as state-operated railroads and sporting events, in a number of cases.[4]

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[2] The Court then applied this constitutional principle broadly, concluding that a state judicial officer was not subject to the federal income tax because he was an instrumentality of the State – and therefore shared the State's immunity from federal taxation. *Id.*

[3] *See, e.g.*, *United States v. Baltimore & O.R. Co.*, 84 U.S. (17 Wall.) 322 (1873) (private railroad company exempt from federal tax on money owed a municipality); *Indian Motorcycle Co. v. United States*, 283 U.S. 570 (1931) (private company may not be taxed by the United States on sale of motorcycles to a city for use in the city's police force).

[4] *See, e.g., Helvering v. Powers*, 293 U.S. 214 (1934) (upholding application of federal income tax to persons employed by state-owned

(Continued on following page)

In *Helvering v. Gerhardt*, 304 U.S. 405 (1938), the Court retreated from its views that state employees should enjoy derivative immunity from federal taxation, concluding that the imposition of federal income taxes on state workers' salaries placed only a speculative or remote burden on States, and not the direct, palpable burdens on the States with which the doctrine was properly concerned. *See id.*, at 421-22. The Court eventually applied this rationale to overrule *Collector v. Day* itself in *Graves v. New York ex rel. O'Keefe*, 306 U.S. 466 (1939).

2. *New York v. United States* sets forth the current formulation of the intergovernmental-tax-immunity doctrine.

The Court's struggle in the first half of the twentieth century to define the parameters of the intergovernmental-tax-immunity doctrine culminated with *New York v. United States*, 326 U.S. 572 (1946). In *New York*, the Court rejected its recently formulated distinction between state governmental and proprietary functions as unworkable and overly protective of state governmental functions, but could not agree on the precise scope of States' immunity from federal taxation. *Id.*, at 580-84.

The entire Court, however, unquestionably agreed that the States still enjoyed *some* immunity from federal taxation, particularly taxation that was discriminatory or that interfered with the essential functions of state government and state sovereignty. Justices Frankfurter and Rutledge concluded that the doctrine should protect States only from those federal taxes that would discriminate against state functions in favor of private activities. *Id.*, at 581-84 (Frankfurter, J., joined by Rutledge, J.). Justice Frankfurter's nondiscrimination standard would preclude federal taxation of state functions with attributes of

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railway); *Allen v. Regents of the Univ. Sys. of Ga.*, 304 U.S. 439 (1938) (upholding federal tax on admissions to intercollegiate football games by state-owned schools).

sovereignty, including sources of revenue "uniquely capable of being earned only by a State." *Id.*, at 582.

Chief Justice Stone, joined by Justices Reed, Murphy, and Burton, agreed that a discriminatory tax against States would be unconstitutional, but went even further, concluding that even if a tax did not discriminate, it would violate the tax-immunity doctrine if it "unduly interfere[d] with the performance of the State's functions of government." *Id.*, at 588 (Stone, C.J., concurring). If it did, then the fact that it was nondiscriminatory would not save it. *Id.*

The dissenters (Justice Douglas, joined by Justice Black) agreed with the principle that the federal government may not tax a State "as a State." They also believed, however, that any activity that was within the limits of a State's police power was a legitimate governmental activity that the federal government could not tax, and they would have struck down the tax at issue. *Id.*, at 591 (Douglas, J., dissenting).

Thus, although a majority of the *New York* Court did not agree on the precise contours of the tax-immunity doctrine, every Justice on the Court agreed with the core principle that – at a minimum – the federal government may not tax a State "as a State." *Id.*, at 582; *see also id.*, at 587-88, 590-97. Under Justice Frankfurter's formulation, a federal tax is discriminatory – and therefore unconstitutional – if it is aimed at sources of revenue uniquely earned by a State or if it infringes upon the States' functions as sovereigns. *Id.*, at 582. Under Chief Justice Stone's formulation, even a nondiscriminatory tax upon the States cannot survive constitutional scrutiny if it unduly interferes with the performance of the State's functions of government. *Id.*, at 588 (Stone, C.J., concurring).

3. The clawback presents important questions concerning the parameters of State immunity from federal taxation that the Court has not considered since *New York*.

The Court has not squarely addressed the extent of the States' immunity from direct federal taxation since

New York. Notably, however, the most recent discussion of the issue sparked a heated debate between a plurality authored by Justice Brennan and a dissent by then-Justice Rehnquist – precisely the fertile fields from which have sprung much of the modern so-called Federalist revival.

In *Massachusetts v. United States*, 435 U.S. 444 (1978), Justice Brennan, writing for a plurality of the Court, discussed the remaining scope of the intergovernmental-tax-immunity doctrine, framing in dicta the doctrine quite narrowly. Justice Brennan's dicta earned a dissent from then-Justice Rehnquist, disagreeing with the plurality's effort to narrow the doctrine, and specifically noting that Justice Brennan's discussion of the tax immunity doctrine "reflects the views of only four Justices." *Id.*, at 472 (Rehnquist, J., dissenting).

In *Massachusetts*, the Court was presented with the question whether the federal government could impose a tax on all civil aircraft flying in the navigable airspace of the United States, including those owned by the States. The Court did not decide the case under the tax-immunity doctrine because it concluded that the "tax" was actually a permissible "user fee." *Id.*, at 460-63.

Nonetheless, Justice Brennan discussed in dicta what he concluded was the limited continuing viability of the tax-immunity doctrine. He reasoned that, "Congress, composed as it is of members chosen by state constituencies, constitutes an inherent check against the possibility of abusive taxing of the States by the National Government." *Id.*, at 456.

Even if Justice Brennan's formulation of the doctrine were not dicta, the clawback highlights why Congress may not always be relied upon to check abusive taxation of the States, and why the continued viability of the tax-immunity doctrine is important. The clawback itself is a product of Congress's incentive to take credit for providing prescription drug coverage for seniors while at the same time avoiding accountability for the program's cost. By substantially shifting the costs of Medicare Part D to the States, Congress enjoys the benefit of the public's

perception that it has expanded medical services available to the elderly without imposing the corresponding cost on its constituents.

The clawback raises an issue that goes to the heart of the tax-immunity doctrine: whether the federal government may, consistent with constitutional principles, impose a direct tax upon the States *qua* States – requiring the States' legislatures to collect, allocate, and remit state funds to the federal government to operate the federal Medicare program. It also presents the Court with the opportunity to clarify the scope of this important constitutional doctrine. The Court should exercise its original jurisdiction to confirm that the States, as sovereigns, remain free from the very type of federal taxation that *New York* prohibits.

B. The Clawback Provision Taxes the States "as States" Because It Interferes With the States' Ability to Govern.

The operation of the clawback demonstrates that it is an unconstitutional federal tax on the States *qua* States. It requires that all States "*shall provide*" for paying the Secretary a portion of the costs (as set by the statutory formula) of providing drugs under Part D to individuals who are dually eligible for Medicare and Medicaid. 42 U.S.C. §1396u-5(c) (emphasis added). Thus, the clawback turns the States into a direct funding source for a federal program.

The clawback also substantially impairs the States' ability to govern. It interferes with the States' budgetary processes and eliminates the States' control over a substantial portion of their budgets by tying their payments to the costs incurred by a federal agency over which the States have no control.

1. The clawback substantially interferes with the States' budgetary processes.

The clawback interferes with the most basic function of each State's legislature – the allocation of scarce

resources among competing, legitimate state interests – by eliminating their control over a significant portion of their budgets. A federal agency tells the States the amount, and the States' legislatures must remit a check in that amount.

If allowed to stand, the clawback will cause significant uncertainty in the States' budget-making processes because the statutory payment schedule operates on a calendar-year basis, while the Plaintiff States budget on a fiscal-year basis.[5] The statute requires CMS to notify the States of the clawback amounts that are due for the upcoming year just two months before that year begins – in October. 42 U.S.C. §1396u-5(c)(2)(B). But the States will have long since passed the budgets that would encompass all expenditures for, at a minimum, the early months of that year. If the Court upholds the clawback, the States will be forced, every year, to guess the amount of this mandatory appropriation calculated solely by the Secretary.

The grave uncertainty that the clawback injects into the States' budgeting processes is already evident. Since October 2005, CMS and the Secretary have sent up to three different notices to the States, repeatedly altering the clawback amounts the States must pay in 2006. And the States have still not received their final clawback "invoices" from the federal government specifying the exact amounts to be paid this year. The most recent and substantial change that the Secretary made to the States' payments came in early February,[6] following the publication of a number of media stories about the impending filing of this suit.[7]

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[5] *See* TEX. CONST. art. III, §49a; N.J. CONST. art. VIII, §2, para. 2; KY. CONST. §169; MO. CONST. art. 4, §23; 5 M.R.S.A. §1663.

[6] On February 9, the Secretary significantly altered a variable in the clawback formula to substantially lower the States' clawback payments. *See* Exhibits TX3, KY2, ME3, MO2, and NJ3.

[7] *See, e.g.,* Juliet Williams, *State to Sue Feds Over Medicare*, L.A. DAILY NEWS, Feb. 2, 2006, at N10 (reporting that California will sue over the clawback along with Texas, Kentucky, and Missouri); Tim

(Continued on following page)

But the Secretary and CMS's actions – reducing the current liability of a number of States that had been actively contemplating litigation – although apparently calculated to undermine this suit, only further highlight the fundamental problems with the clawback. The Secretary can arbitrarily raise or lower the States' clawback payments when and how he likes. In this instance, he has lowered the payments several times as the threat of this litigation grew. But there is nothing to prevent him from similarly raising the amounts that the States owe in the future by manipulating the same variables used recently to lower the States' clawback payments. Because the States will be forced to complete their budget processes without knowing the amount of their clawback appropriations, appropriations subject to significant change at the sole discretion of a federal agency, the clawback mechanism substantially impairs the States' ability to govern.

2. The clawback eliminates the States' control over a large portion of their budgets.

The clawback also unduly interferes with the States' budgetary processes by placing control over a substantial portion of their budgets in the hands of a federal instrumentality – CMS.[8] Although a State may use its budget process to control costs and spending associated with state agencies, the States have no control whatsoever over the structure, financing, or scope of Medicare Part D, even though federal law now mandates that they help finance the benefit. Because the clawback effectively puts control

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O'Neil, *Missouri Fights to Hold on to Medicaid Savings*, ST. LOUIS POST-DISPATCH, Feb. 7, 2006, at B4 (reporting that Missouri, working with California, Texas, and possibly other States, would file suit in February challenging the clawback).

[8] After 2006, the amount States must pay will be dictated by the amount the federal government spends for prescription drugs under Medicare Part D, as determined by the Secretary. 42 U.S.C. §§1396u-5(c)(4)(B), 1395w-102(b)(6).

of a substantial portion of each State's fisc in the hands of a federal agency, the clawback unduly interferes with the States' most basic function – the efficient and proper allocation of scarce state resources. Accordingly, under the principles of intergovernmental tax immunity set forth in *New York*, the clawback is an unconstitutional tax on the States.

C. The Clawback Is Not a Condition on the Receipt of Federal Funds.

The Court has recognized that Congress may exercise its Spending Clause power to require States to take certain actions – indeed, to legislate according to Congress's instructions – as a condition of receiving federal funds. For example, in *South Dakota v. Dole*, 483 U.S. 203, 206-08 (1987), the Court upheld, under Congress's Spending Clause power, the constitutionality of a federal statute that conditioned the States' receipt of federal highway funds on the States' adoption of Congress's choice of a minimum drinking age.

The clawback provision, however, is fundamentally different from the statute in *Dole*. It does not require States to pass certain legislation as a precondition to receiving related federal funds. Rather, it commands the States to *pay* a certain amount of funds, and if they do not pay that amount, the federal government will offset the amount owed against the share of federal Medicaid funding, plus interest, that they would otherwise have received. 42 U.S.C. §1396u-5(c)(1)(A), (C).

The clawback provision's plain language demonstrates that it is not a condition on the receipt of federal funds. Congress knows how to designate conditions – indeed, it did so in another subsection of the statute, §1396u-5(a). There, Congress listed several requirements with which States must comply, and it expressly stated that compliance was a condition of the States' participation in the Medicaid program and their receipt of Medicaid funding. 42 U.S.C. §1396u-5(a).

By contrast, the clawback provision, §1396u-5(c), contains no such language. It simply commands the States to pay according to the formula.[9] The clawback's mandate that the States make payments to the federal government to fund *Medicare* cannot be fairly characterized as a "condition" on the States' receipt of *Medicaid* funds.[10]

Nor was the failure of Congress to design the provision as a condition on the receipt of federal funds – or,

[9] The clawback – in effect – rescinds the States' option under Medicaid to choose whether they will cover the cost of prescription drugs for dual eligibles. Medicaid classifies prescription drugs as "optional services," 42 U.S.C. §1396d(a), allowing the States at any time to opt out of providing prescription drug coverage. The clawback transforms what was an optional coverage under Medicaid into a perpetual requirement to fund, in part, that coverage through the federal Medicare program.

[10] Even if the Court determines that the clawback is a condition rather than a tax, it remains unconstitutional. Although the Spending Clause empowers Congress to attach conditions to the receipt of federal funds, that power "is of course not unlimited." *Dole*, 483 U.S., at 207. The Court has recognized four general restrictions. Conditions that Congress places on the receipt of federal funds must: (1) be "in pursuit of the general welfare"; (2) be "unambiguous[ ], enabling the States to exercise their choice knowingly, cognizant of the consequences of their participation"; (3) be in relation "to the federal interest in particular national projects or programs"; and (4) not contravene other constitutional provisions. *Id.* (citations and internal quotation marks omitted). The clawback fails the second restriction: it is ambiguous. As the Plaintiff States have demonstrated, *see supra* Part I.B., the clawback introduces a substantial element of uncertainty into each State's budget-making process. The annual growth in Part D spending is solely within the control of Congress and the Secretary, not the States. *See* 42 U.S.C. §§1396u-5(4)(B), 1395w-102(b)(6). States have no control over, nor any way to accurately predict the year-to-year increase in, future Part D spending, yet they are compelled to fund it. State legislatures will have to make their budgeting decisions (including whether to continue participation in the Medicaid program) without knowing their final financial obligations to Part D. Thus, while the clawback's language is unambiguous, the effect of its provisions is to impose a monetary burden on the States each year of uncertain dimensions. The clawback is therefore not sufficiently unambiguous to enable the States "to exercise their choice knowingly, cognizant of the consequences of their participation." *Dole*, 483 U.S., at 207.

even more directly, simply to reduce the amount of federal funds by the desired amount – mere oversight or scrivener's error. Doing so would have required Congress to bear the political consequence of reducing Medicaid funds; by ordering the States to pay the clawback tax, elected Members of Congress have "reduced" nothing, and state legislatures are left to reduce spending or raise taxes to foot the bill.

The clawback cannot be rendered constitutional just because a State may refuse to pay the tax, resulting in the federal government subsequently reducing the State's Medicaid funding plus interest under 42 U.S.C. §1396u-5(c)(1)(C). The Court specifically rejected this reasoning in *South Carolina v. Baker*:

> "The United States cannot convert an unconstitutional tax into a constitutional one simply by making the tax conditional. Whether Congress could have imposed the condition by direct regulation is irrelevant; *Congress cannot employ unconstitutional means to reach a constitutional end.*" 485 U.S., at 516 (emphasis added).

The Court should conclude that the clawback is a direct and unconstitutional tax upon the States.

II. THE CLAWBACK IS AN UNCONSTITUTIONAL ATTEMPT BY THE FEDERAL GOVERNMENT TO COMMANDEER THE APPROPRIATIONS POWERS AND PROCESSES OF STATE LEGISLATURES TO FUND THE FEDERAL MEDICARE PROGRAM.

"It is incontestible that the Constitution established a system of 'dual sovereignty,'" *Printz v. United States*, 521 U.S. 898, 918 (1997) (quoting *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991)), under which the States retained "'a residuary and inviolable sovereignty,'" *id.*, at 919 (quoting THE FEDERALIST NO. 39, at 245 (James Madison)). To protect that sovereignty, the Framers rejected a system under which the States would have operated as the instruments of the federal government in favor of "'a Constitution that confers upon Congress the power to regulate

individuals, not States.'" *Id.*, at 920 (quoting *New York v. United States*, 505 U.S. 144, 166 (1992)). Accordingly, it is beyond cavil that the Constitution does not permit Congress to require States to pass legislation according to Congress's instructions. *New York*, 505 U.S., at 162. Rather, "[i]t is an essential attribute of the States' retained sovereignty that they remain independent and autonomous within their proper sphere of authority." *Printz*, 521 U.S., at 928.

These principles animate the anticommandeering doctrine that the Court recognized in *New York* and *Printz*. *Id.*, at 925-26; *New York*, 505 U.S., at 175-77. Under this doctrine, the clawback provision is an impermissible invasion of the States' residual sovereignty that cannot stand.

A. The Clawback Commandeers the States' Legislatures by Requiring Them to Appropriate State Funds for the Federal Medicare Program.

The anticommandeering doctrine prohibits Congress from conscripting state governments as its agents. *New York*, 505 U.S., at 178. In *New York*, for example, the Court struck down a provision of the Low-Level Radioactive Waste Policy Amendments Act of 1985 that required state legislatures either to take title to waste in their States or to implement state laws mandating the disposal of waste according to Congress's instructions.[11] *Id.*, at 177. The Court held that both options would unconstitutionally commandeer the state legislatures because both would force States into the service of a federal regulatory program. *Id.*, at 175-76.

[11] The Court also considered two other provisions of the Act, the monetary and the access incentive provisions, and upheld both under Congress's Commerce Clause and Spending Clause powers. *New York*, 505 U.S., at 171-74.

Similarly, in *Printz*, the Court invalidated a provision of the Brady Handgun Violence Prevention Act on the ground that it commandeered state executive officials, albeit on an interim basis, to implement background checks on persons attempting to buy guns. 521 U.S., at 933. The Court concluded that the anticommandeering principles applied equally to attempts by Congress to force state executive officers to enforce federal law as to congressional attempts to force States, in their legislative capacities, to promulgate laws. *Id.*

The anticommandeering doctrine of *New York* and *Printz* is a logical corollary to the system of dual-sovereignty that the Constitution established. As a bedrock principle, the States are independent of the federal government and are not subject to congressional commands to legislate.

For these reasons, the clawback provision, which commands States' legislatures to appropriate funds for implementing a federal program, runs afoul of the anti-commandeering doctrine. It does not regulate the behavior of individuals, but commands action by States in their sovereign capacities.

The clawback provision orders States to appropriate millions of dollars to be paid to the federal government each year to support the federal Medicare program. In so doing, it strikes at the heart of the States' ability to govern – their budgets. State government is centered around nothing so much as the allocation of scarce state dollars. Because the clawback conscripts state legislatures to appropriate and remit funds to support a purely federal program, it contravenes the anticommandeering doctrine.

B. The Clawback Undermines Accountability in Our Constitutional System.

The Court has noted that the "great innovation" of the Constitution's design is that the people have two separate political capacities, "each [of which is] protected from incursion by the other." *Printz*, 521 U.S., at 920 (citation omitted). This separation ensures that "a State's

government will represent and remain accountable to its own citizens." *Id.* But for our representative form of government to work, citizens must be aware of who has made the decisions that affect them.

The Court has recognized the accountability issues that would be present if the federal government were permitted to create a program, but require the States to pay for its implementation. In *Printz*, the Court noted that the federal government could "take credit for 'solving' problems without having to ask [its] constituents to pay for the solutions with higher federal taxes." *Id.*, at 930. Allowing the federal government to reap the benefit of "providing" services to the public, while forcing the States to bear the financial burdens for those services, undermines the accountability that our system of dual sovereignty requires.

The clawback presents just such a scenario. It represents Congress's affirmative decision to avoid political accountability for the expense of Part D by substantially shifting the program's costs from itself to the States. Congress's sleight of hand allows it to take the credit for providing senior citizens with prescription drug coverage, while requiring the States to absorb much of the financial burden of implementing the program. In this way, Congress avoids political fallout by not having to impose unpopular additional tax burdens on its constituents and by shifting that burden to the States and their constituents.

III. THE CLAWBACK VIOLATES THE STATES' RIGHT TO A REPUBLICAN FORM OF GOVERNMENT.

The Constitution directs the United States to "guarantee to every State in this Union a Republican Form of Government." U.S. CONST. art. IV, §4. That guarantee operates in tandem with the basic principles of federalism that the rest of the Constitution embodies to preserve the States' sovereignty and independence from the federal government. *See Baker*, 485 U.S., at 533-34 (O'Connor, J., dissenting); *see also supra* Parts I, II.

The Court has always recognized the importance of maintaining independent state governments. Long ago, the Court stated that "the preservation of the States, and the maintenance of their governments, are as much within the design and care of the Constitution as the preservation of the Union and the maintenance of the National Government." *White*, 74 U.S., at 725. Each of the States, the Court noted, is "'endowed with all the functions essential to separate and independent existence.'" *Id.* (quoting *County of Lane v. Oregon*, 74 U.S. (7 Wall.) 71, 76 (1869)).

The Court has also acknowledged that each State "is entitled to order the processes of its own governance." *Alden v. Maine*, 527 U.S. 706, 752 (1999). The "power to make decisions and to set policy," is an authority that "gives the State[s their] sovereign nature." *Fed. Energy Regulatory Comm'n v. Mississippi*, 456 U.S. 742, 761 (1982). The Constitution grants States control over their internal governmental machinery, and the federal government may not usurp control of the most fundamental processes of state government.

The clawback violates this basic constitutional principle by essentially hijacking the States' budgetary processes to require that a substantial portion of each State's budget be dictated not by the policy decisions of state officials, but by the federal agency charged with administering Medicare. The clawback simultaneously reduces the authority that the State legislatures have over their budgets and delivers that authority into the hands of agents of the federal government. Because the Guarantee Clause protects the States from precisely this kind of substantial federal incursion, the clawback cannot be upheld.

REASONS THE COURT SHOULD TAKE JURISDICTION

I. THE COMPLAINT RAISES ISSUES THAT ARE APPROPRIATE FOR THE COURT'S EXERCISE OF ORIGINAL JURISDICTION.

The Court applies two principal considerations in determining whether to exercise its original jurisdiction

under Article III, §2. First, the Court examines the nature of the complaining State's interest, particularly the "seriousness and dignity of the claim." *Illinois v. City of Milwaukee*, 406 U.S. 91, 93 (1972); *see also Mississippi v. Louisiana*, 506 U.S. 73, 77 (1992). Second, the Court considers the availability of an adequate alternative forum in which the claim can be resolved. *See United States v. Nevada*, 412 U.S. 534, 538 (1973).

The Plaintiff States' Complaint merits consideration by this Court in the first instance, even under the Court's strict discretionary standard, because: (1) it raises issues of great constitutional magnitude and (2) no adequate alternative forum for timely and finally resolving the dispute is available. Certainly the substantial intrusion of the federal government into one of the essential functions of state government – the budgetary process – and the unprecedented imposition of a direct tax on the States *qua* States, raise serious constitutional questions. And because the clawback has already taken effect, dramatically impacting the operations of state governments, this Court's timely and final resolution of its constitutional validity is of paramount importance to the States.

A. The Plaintiff States' Claims Are of Great Constitutional Importance Because They Are Aimed at Preserving the States' Rights as Independent Sovereigns.

The clawback constitutes a novel, direct tax that the federal government has imposed upon States "as States." It substantially and unduly interferes with a core function of state government – the process of developing and implementing state budgets and allocating the States' limited financial resources. Thus, the clawback significantly erodes the States' continued status as independent sovereigns within our constitutional structure. The seriousness and dignity of the claims made in this case, both in terms of the clawback's actual impact upon the States and the core constitutional questions its enactment raises, merit the exercise of the Court's original jurisdiction.

The Court has exercised its original jurisdiction in circumstances that involved far less intrusion into state governmental functions, and that only arguably concerned an indirect tax upon a State. For example, in *South Carolina v. Regan*, 465 U.S. 367 (1984), South Carolina challenged the constitutionality of an Internal Revenue Code provision that limited the federal income tax exemption for interest earned on state bonds to those issued in registered form and excluded most of those issued in bearer form. *See id.*, at 370-71. The State filed suit against the Secretary of the Treasury and invoked the Court's original jurisdiction, maintaining that the statute was constitutionally invalid because it violated the Tenth Amendment and the doctrine of intergovernmental tax immunity. *Id.*, at 370. The Court held that the case raised issues of substantial concern to the States, and was appropriate for the exercise of its original jurisdiction.[12]

The constitutional questions presented by the Plaintiff States' Complaint rise to at least the same level of magnitude and dignity as the claims South Carolina made in *Regan*. Indeed, the Court based its ultimate decision against South Carolina in large part on the fact that the challenged Internal Revenue Code provision did *not* constitute a direct, discriminatory tax upon the State and did *not* substantially interfere with South Carolina's governmental functions. *See Baker*, 485 U.S., at 526-27. Here, the clawback's plain language imposes a direct and discriminatory tax upon the States and directly infringes

[12] Justice Brennan's plurality opinion concluded that the Court should exercise its jurisdiction because South Carolina had alleged that the federal statute would materially interfere with and infringe upon its authority to borrow funds and because the submission of an amicus brief by a number of States supporting South Carolina established that the issue raised was "of vital importance to all fifty States." *Id.*, at 382. Justice Blackmun's concurrence agreed that the Court should grant South Carolina leave to file its complaint because "the issue presented is a substantial one, and of concern to a number of States," and he was "satisfied that prompt resolution of the issue [in the Court] will benefit all concerned." *Id.*, at 384.

upon the States' budgetary processes. Finally, as in *Regan*, an *amicus* brief joined by an additional ten States supports the Plaintiff States' Complaint and urges the Court to exercise its original jurisdiction to resolve the constitutional issues that the clawback presents. The *amicus* brief, together with the Plaintiff States' Complaint and Brief, establish that the clawback raises issues of no less vital importance than the issues raised in *Regan*. The Court should therefore exercise its original jurisdiction in this case as well.

B. There Is No Adequate Alternative Forum to Timely and Finally Resolve the Plaintiff States' Claims.

The clawback provision went into effect on January 1, 2006, imposing a direct tax upon the States that is projected to result in payments of billions of dollars of state funds to the federal government over just the next two years. *See* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE "CLAWBACK:" STATE FINANCING OF MEDICARE DRUG COVERAGE (June 2004), http://www.kff.org/medicaid/upload/The-Clawback-State-Financing-of-Medicare-Drug-Coverage.pdf (last visited March 1, 2006). Thus, the federal government's substantial interference in the States' budgetary processes has already begun, usurping the States' constitutional right as independent sovereigns to make their own policy decisions concerning the allocation of their scarce resources.

The clawback's constitutionality is an issue of great and *immediate* importance to the States. For this reason, the Plaintiff States request that the Court exercise its original jurisdiction and enjoin the clawback's operation. If the Court does not hear this case, the Secretary faces the prospect of litigation in courts throughout the United States, conflicting trial court decisions concerning the constitutionality of the clawback, and resulting confusion among the States as to whether the clawback tax should be paid. Where, as here, constitutional questions presented in an original complaint are of serious concern

across the country – and call for a definitive resolution by this Court in the first instance – the Court may properly exercise its original jurisdiction. *E.g.*, *South Carolina v. Katzenbach*, 383 U.S. 301, 307 (1966).

If the States were to pursue a remedy first in the district courts, they would face several years of litigation there and in the courts of appeals before the case could be presented to this Court for final resolution by a petition for writ of certiorari. Even assuming a best-case scenario, under which a lower court would enjoin the clawback's operation until the States could present the issues to this Court and have them resolved, the States' legislatures would not know in the interim whether they would ultimately owe tremendous sums of money to the federal government under the clawback.

Alternatively, if the lower courts would not enjoin the clawback's operation, the States would be subjected to years and years of unconstitutional interference with essential functions of state government while awaiting the lower courts' decisions and, ultimately, this Court's decision, and likely without the ability to recoup unconstitutional clawback payments in light of sovereign immunity. For these reasons, there is no adequate alternative forum in which to timely and *finally* resolve the significant constitutional issues raised by the Complaint.

Last, because the issues presented focus on the Court's interpretation of the constitutional validity of a federal statute, the case can be tried on stipulated facts. They concern a long-dormant doctrine – perhaps because direct taxes on States are heretofore so rarely attempted – that this Court is uniquely situated to revive. The Plaintiff States' lawsuit turns upon the Court's determination whether the clawback violates the tax-immunity doctrine, the anticommandeering doctrine, and the Guarantee Clause, all of which are purely legal questions. Thus, in order to resolve the issues that the Complaint raises, the Court will not be required to engage in substantial fact-finding tasks for which it has acknowledged it is

"ill-equipped." *Ohio v. Wyandotte Chems. Corp.*, 401 U.S. 493, 498 (1971).

II. THERE ARE NO IMPEDIMENTS TO THE COURT'S EXERCISE OF ITS ORIGINAL JURISDICTION.

There are no impediments to the Court's exercise of its original jurisdiction in this case. The Court has made clear that it will not exercise its original jurisdiction where a complaint does not present a justiciable controversy, *see California v. Texas*, 437 U.S. 601 (1978); where the State is not the real party in interest, *see Puerto Rico v. Iowa*, 464 U.S. 1034 (1984); or where the State lacks standing, *see Pennsylvania v. New Jersey*, 426 U.S. 660 (1976). As demonstrated below, the Complaint in this case raises a justiciable controversy for which the Plaintiff States are both the real parties in interest and have standing to make the claims asserted. Likewise, federal sovereign immunity is inapplicable here and does not bar the Plaintiff States' Complaint.

A. The Plaintiff States Present Justiciable Claims for the Court's Review.

Whether the clawback unduly intrudes on the States' core sovereignty and thus violates the Constitution under any of the bases the Plaintiff States assert is a justiciable question uniquely suited for this Court's review. In *Baker v. Carr*, 369 U.S. 186 (1962), the Court identified six factors that determine whether a particular question is justiciable or whether it is a political question that is ill-suited for the judiciary to resolve.[13] Because the Plaintiff

[13] The Court identified six independent definitions of a non-justiciable political question:

> "[1] a textually demonstrable constitutional commitment of the issue to a coordinate political department; or [2] a lack of judicially discoverable and manageable standards for

(Continued on following page)

States' claims all arise from the federal government's interference with the States' constitutionally guaranteed autonomy, none of the *Baker* factors preclude the Court's jurisdiction in this case.

The States' tax and anticommandeering claims are firmly established as being within the Court's power to adjudicate. *See New York*, 326 U.S., at 573-84 (considering claim that Congress imposed unconstitutional tax on the State of New York); 584-86 (Rutledge, J., concurring) (same); 586-90 (Stone, C.J., concurring) (same); 590-97 (Douglas, J., dissenting) (same); *see also New York*, 505 U.S., at 174-77 (invalidating law under anticommandeering principles); *Printz*, 521 U.S., at 932 (same).

Although the Court has left the justiciability of the Guarantee Clause unresolved, *see New York*, 505 U.S., at 183-86, the circumstances of this case demonstrate exactly why the Court cannot leave the Guarantee Clause's promise to Congress alone. The Constitution forbids federal interference with state autonomy, and it is the courts' responsibility to enforce that prohibition. The federal political process cannot guard against the sort of affront to States' sovereignty that the clawback causes. National politics will not keep Congress from using the clawback as a model for funding new federal programs because, if allowed to stand, it will undoubtably prove an attractive way for Congress to further its own goals with

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> resolving it; or [3] the impossibility of deciding without an initial policy determination of a kind clearly for nonjudicial discretion; or [4] the impossibility of a court's undertaking independent resolution without expressing lack of the respect due coordinate branches of the government; or [5] an unusual need for unquestioning adherence to a political decision already made; or [6] the potentiality of embarrassment from multifarious pronouncements by various departments on one question." *Baker*, 369 U.S. at 217.

These tests are "probably listed in descending order of both importance and certainty." *Vieth v. Jubelirer*, 541 U.S. 267, 278 (2004) (plurality op.).

the least federal cost and risk of political consequence. Even if other Guarantee Clause complaints may present justiciability problems, the Plaintiff States' claims, which are rooted in the very structure of our government, should not.

B. The Plaintiff States Are the Real Parties in Interest and Have Standing to Assert Their Claims.

The Plaintiff States are the real parties in interest and have standing to bring the claims that the Complaint raises. Each of the Plaintiff States has and will sustain "an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (citations and internal quotation marks omitted). The clawback by its very terms is directed at the States as sovereigns, interfering with the essential functions of state government and taxing the States *qua* States to fund a federal program. Under the circumstances, each Plaintiff State has standing to bring this action.

C. Sovereign Immunity Does Not Bar the Plaintiff States' Claims.

The Plaintiff States seek a declaration that the clawback violates the Constitution for the reasons stated in this brief. Accordingly, this suit against the Secretary falls within the well-recognized category of complaints for which the federal government does not maintain sovereign immunity – those seeking to invalidate unconstitutional statutes. *See Dugan v. Rank*, 372 U.S. 609, 621-22 (1963); *Malone v. Bowdoin*, 369 U.S. 643, 647 (1962); *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 689-90 (1949). The Court has expressly recognized that a suit to enjoin a federal officer from enforcing an

allegedly unconstitutional statute does not constitute a suit against the sovereign because "the conduct against which specific relief is sought is beyond the officer's powers and is, therefore, not the conduct of the sovereign." *Larson*, 337 U.S., at 690.

CONCLUSION

For these reasons, the Court should grant the Plaintiff States' motion for leave to file the complaint.

Respectfully submitted,

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APPENDIX

CONSTITUTIONAL PROVISIONS INVOLVED

Article IV, §4 to the United States Constitution provides:

> The United States shall guarantee to every State in this Union a Republican Form of Government, and shall protect each of them against Invasion; and on Application of the Legislature, or of the Executive (when the Legislature cannot be convened) against domestic Violence. U.S. CONST. art. IV, §4.

The Tenth Amendment to the United States Constitution provides:

> The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively or to the people. U.S. CONST. amend. X.

STATUTORY PROVISION INVOLVED

§1396u-5. Special provisions relating to medicare prescription drug benefit

(a) Requirements relating to medicare prescription drug low-income subsidies and medicare transitional prescription drug assistance

As a condition of its State plan under this subchapter under section 1396a(a)(66) of this title and receipt of any Federal financial assistance under section 1396b(a) of this title subject to subsection (e) of this section, a State shall do the following:

(1) Information for transitional prescription drug assistance verification

The State shall provide the Secretary with information to carry out section 1395w-141 of this title.

(2) Eligibility determinations for low-income subsidies

The State shall –

(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 139w-114 of this title;

(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

(C) otherwise provide the secretary with such information as may be required to carry out part D, other than subpart 4 of part D, of subchapter XVIII of this chapter (including section 139w-114 of this title).

(3) Screening for eligibility, and enrollment of, beneficiaries for medicare cost-sharing

As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual's eligibility for medical assistance for any medicare cost-sharing described in section 1396d(p)(3) of this title, and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

(b) Regular federal subsidy of administrative costs

The amounts expended by a State in carrying out subsection (a) of this section are expenditures reimbursable under the appropriate paragraph of section 1396b of this title.

(c) Federal assumption of medicaid prescription drug costs for dually eligible individuals

(1) Phased-down State contribution

(A) In general

Each of the 50 States and the District of Columbia for each month beginning with January 2006 shall provide for payment under this subsection to the Secretary of the product of –

(i) the amount computed under paragraph (2)(A) for the State and month;

(ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6) for such State and month; and

(iii) the factor for the month specified in paragraph (5).

(B) Form and manner of payment

Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under section 1395v of this title, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(C) Compliance

If a State fails to pay to the Secretary an amount required under subparagraph (A), interest shall accrue on such amount at the rate provided under section 1396b(d)(5) of this title. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section 1396b(a) of this title subject to subsection (e) of this title, in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

(D) Data Match

The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

(2) Amount

(A) In General

The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to –

(i) 1/12 of the product of –

(I) the base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1396d(b)) of this title applicable to the State for the fiscal year in which the month occurs; and

(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph ___ for that year.

(B) Notice

The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

(3) Base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals

(A) In general

For purposes of paragraph (2)(A), the "base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals" for a State is equal to the weighted average (as weighted under subchapter (c)) of –

(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

(B) Gross per capita medicaid expenditures for prescription drugs

(i) In general

The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this subchapter during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid care plan.

(ii) Determination

In determining the amount under clause (i), the Secretary shall –

(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

(II) exclude expenditures attributable to covered outpatient prescription drugs that are not covered part D drugs (as defined in section 1395w-102(e) of this title); and

(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

(iii) Adjustment factor

The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of –

(I) aggregate payments under agreements under section 1396r-8 of this title; to

(II) the gross expenditures under this subchapter for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS-64) for the 4 quarters

of calendar year 2003 and such other data as the Secretary may require.

(C) Weighted average

The weighted average under subparagraph (A) shall be determined taking into account –

(i) with respect to subparagraph (A)(i), the average number of ful-benefit dual eligible individuals in 2003 who are not described in clause (iii); and

(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for covered outpatient drugs through a medicaid managed care plan.

(4) Applicable growth factor

The applicable growth factor under this paragraph for –

(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections from the years involved); and

(B) a succeeding year, is the annual percentage increase specified in section 1395w-102(b)(6) of this title for the year.

(5) Factor

The factor under this paragraph for a month –

(A) in 2006 is 90 percent;

(B) in 2007 is 88⅓ a percent;

(C) in 2008 is 86⅔ percent;

(D) in 2009 is 85 percent;

(E) in 2010 is 83⅓ percent;

(F) in 2011 is 81⅔ percent;

(G) in 2012 is 80 percent;

(H) in 2013 is 78⅓ percent;

(I) in 2014 is 76⅔ percent; or

(J) after December 2014, is 75 percent.

(6) Full-benefit dual eligible individual defined

(A) In general

For purposes of this section, the term "full-benefit dual eligible individual" means for a State for a month an individual who –

(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of subchapter XVIII, or under an MA-PD plan under part C of subchapter XVIII; and

(ii) is determined eligible by the State for medical assistance for full benefits under this subchapter for such month under section 1396a(a)(10)(A) of this title or 1396a(a)(10)(C) of this title, by reason of section 1396a(f) of this title, or under any other category of eligibility

for medical assistance for full benefits under this subchapter, as determined by the Secretary.

(B) Treatment of medically needy and other individuals required to spend down

In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under section 1396a(a)(10)(C) of this title or by reason of section 1396a(f) of this title, the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.

(d) Coordination of prescription drug benefits

(1) Medicare as primary payor

In the case of a part D eligible individual (as defined in section 1395w-101(a)(3)(A) of this title) who is described in subsection (c)(6)(A)(ii) of this section, notwithstanding any other provision of this subchapter, medical assistance is not available under this subchapter for such drugs (or for any cost-sharing respecting such drugs), and the rules under this subchapter relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this Subchapter. No payment may be made under section 1396b(a) of this title for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

(2) Coverage of certain excludable drugs

In the case of medical assistance under this subchapter with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of subchapter XVIII or an MA-PD plan under part C of such subchapter, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.

(e) Treatment of territories

(1) In general

In the case of a State, other than the 50 States and the District of Columbia –

(A) the previous provisions of this section shall not apply to residents of such State; and

(B) if the State establishes and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under section 1308(f) (as increased under section 1308(g) for the State shall be increased by the amount for the fiscal period specified in paragraph (3)

(2) Plan

The Secretary shall determine that a plan is described in this paragraph if the plan –

(A) provides medical assistance with respect to the provisions of covered part D drugs (as defined in section 1395w-102(e) of this title) to low-income part D eligible individuals;

(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

(C) meets such other criteria as the Secretary may establish.

(3) Increased amount

(A) In general

The amount specified in this paragraph for a State for a year is equal to the product of –

(i) the aggregate amount specified in subparagraph (B); and

(ii) the ration (as estimated by the Secretary) of –

(I) the number of individuals who are entitled to benefits under part A of subchapter XVIII or enrolled under part B of subchapter XVIII and who reside in the State (as determined by the Secretary based on the most recent available

data before the beginning of the year); to

(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

(B) Aggregate amount

The aggregate amount specified in this subparagraph for –

(i) the last 3 quarters of fiscal year 2006, is equal to $28,125,000;

(ii) fiscal year 2007, is equal to $37,500,000; or

(iii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1395w-102(b)(6) of this title for the year involved.

(4) Report

The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

(Aug. 14, 1935, c. 531, Title XIX, § 1935, as added Dec. 8, 2003, Pub.L. 108-173, Title I, § 103(a)(2) to (d)(1), 117 Stat. 2154.)

No. _____, Original

In The
Supreme Court of the United States

STATES OF TEXAS, KENTUCKY, MAINE, MISSOURI, AND NEW JERSEY,

Plaintiffs,

v.

MICHAEL O. LEAVITT, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant.

BILL OF COMPLAINT

The Plaintiff States of Texas, Kentucky, Maine, Missouri, and New Jersey (the "Plaintiff States") bring this action against Michael O. Leavitt, Secretary, United States Department of Health and Human Services, and for their cause of action state as follows:

PARTIES

1. The Plaintiff States are sovereign States of the United States.

2. The Defendant is a resident and citizen of Utah, and is the duly appointed, qualified and acting Secretary

of the United States Department of Health and Human Services (the "Secretary").

JURISDICTION

3. The Plaintiff States invoke the Court's original jurisdiction under Article III, Section 2 of the Constitution of the United States, as well as 28 U.S.C. §1251(b)(3).

FACTUAL BACKGROUND

4. Congress established the Medicare program under Title XVIII, and Medicaid under Title XIX, of the Social Security Act of 1965.

5. Medicare is the federal health insurance program for seniors and certain disabled individuals. Most people 65 and older are entitled to receive Medicare benefits if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for ten years. People under 65 who receive Social Security Disability Insurance payments generally become eligible for Medicare after a two-year waiting period.

6. Medicaid, the nation's major public health program for low-income Americans, is a means-tested entitlement program. To qualify for Medicaid, an individual must meet financial criteria and also be part of a group that is "categorically eligible" for the program, such as low-income children, pregnant women, the elderly, people with disabilities, and parents.

7. The federal and state governments jointly finance Medicaid, and the States administer it within broad federal guidelines. Federal law mandates coverage of some

groups below specified minimum income levels, but allows States broad optional authority to extend Medicaid beyond these minimum standards. For example, the provision of prescription drug coverage is an optional Medicaid service that States can elect to provide. This flexibility has produced wide State-to-State variation in Medicaid coverage.

8. Traditionally, a large portion of Medicaid spending has been attributable to "dual eligibles" – low-income seniors and persons with disabilities enrolled in both the Medicare and Medicaid programs. For these individuals, the Medicare program covered basic health care services (*e.g.*, hospital care, physician services) and the Medicaid program paid for Medicare premiums and cost-sharing requirements.

9. Prior to January 2006, all fifty States and the District of Columbia covered prescription drugs for at least some Medicaid enrollees. *See* A. GRADY & C. SCOTT, CONGRESSIONAL RESEARCH SERVICE, IMPLICATIONS OF THE MEDICARE PRESCRIPTION DRUG BENEFIT FOR STATE BUDGETS, CRS-1 (2004) ("Grady and Scott"). It is estimated that almost 7.5 million Medicaid beneficiaries are dual eligibles. *See* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUNDATION, DUAL ELIGIBLES: MEDICAID'S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES (February 2006), http://www.kaiserfamilyfoundation.org/medicaid/upload/Dual-Eligibles-Medicaid-s-Role-for-Low-Income-Medicare-Beneficiaries-Feb-2006.pdf (last visited March 1, 2006). Although dual eligibles constituted only 14 percent of all Medicaid beneficiaries, they have accounted for approximately 40 percent of all Medicaid spending. *See id.*

10. On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act

of 2003 (the "MMA"). Pub. L. No. 108-173, 117 Stat. 2066. The MMA significantly altered the operation of the Medicare and Medicaid program. Effective January 1, 2006, the federal government, through the new Medicare Part D, will offer outpatient prescription drug coverage to all Medicare recipients. *See* P.L. 108-173, §101(a), 117 Stat. 2066, 2071-2150 (adding new sections 1860D-1 to -42 to the Social Security Act) (codified at 42 U.S.C. §§1395w-101 to -152). Those covered will include the dual eligibles who had previously been provided prescription drug coverage by the States through their Medicaid programs. Thus, Congress has effectively federalized prescription drug coverage by taking a benefit that was once provided by the States and making it available instead through a federal program.

11. Although the new prescription drug coverage will be provided by the Medicare program, the federal government will not bear the entire expense of the Part D coverage. Rather, the Part D benefit is funded in two ways: (1) by traditional Medicare funding through enrollee payments and the Health Insurance Trust Fund; and (2) by phased-down state payments made directly to the federal government (commonly referred to as the "clawback"). Grady and Scott, at CRS-1,2.

12. The States' clawback "contribution" to the funding of Medicare Part D is a monthly payment each of the 50 States is required to make to the federal government under the MMA. Under the statutory formula, a State's monthly payment is 1/12 the product of multiplying the following three factors: (1) the amount the State spent, per capita, on dual eligibles in 2003 for Medicaid prescription drugs covered under Part D, trended forward based on factors specified in the statute. For 2006, the growth

factor is based on published National Health Expenditure ("NHE") statistics, which are assumed national averages that do not necessarily reflect actual costs in any given State. For 2007 and beyond, the trend is the annual increase in Part D per capita spending as determined solely by the Secretary; (2) the number of dual eligibles enrolled in Part D plans in that State; and (3) the "phase-down percentage" applicable to the year in which the payment is calculated. *See* 42 U.S.C. §1396u-5(c)(1)(A); *see also* 42 C.F.R. §423.910.

13. In 2006, the phase-down is 90 percent, meaning that States must pay 90 percent of their anticipated savings to the federal government. *See* 42 U.S.C. §1396u-5(c)(1)(A); *see also* 42 C.F.R. §423.910. The amount gradually declines to 75 percent in 2015. *See id.* The United States Department of Health and Human Services, Centers for Medicare and Medicaid ("CMS") makes these calculations and sends letters to each State advising the payment amounts that must be made to the federal government. *See* Exhibits TX1-3, KY1-2, ME1-3, MO1-2, and NJ1-3. If a State fails to make its designated payment, the federal government will offset that amount, plus interest, against the Medicaid funds it otherwise would have provided to the State. 42 U.S.C. §1396u-5(c)(1)(C).

14. The clawback substantially interferes with an essential function of state government – the budgetary process. The statute requires that each year, CMS – a federal agency over which the States have no control – will issue monetary demands to state legislatures specifying the amounts of the States' clawback payments to the federal government for the following year. The States cannot and will not know what precise amounts of money CMS will demand that they pay in each succeeding fiscal

year to fund Medicare, nor will they have any authority to determine if these state funds directly assessed and collected by the federal government are being properly used by CMS. As a result, the clawback turns over a significant aspect of the States' budgeting process to a federal agency, creating uncertainty in the States' allocation of their scarce resources.

15. The initial actions of CMS and the Secretary applying the statute's mandate exemplify the uncertainty created by the clawback and the States' loss of control over their own budgets. In October 2005, CMS notified the States by letter of the amounts of their clawback payments for 2006. *See* Exhibits TX1, KY1, ME1, MO1, and NJ1. Six weeks later, CMS sent letters altering the amount of some of the States' clawback payments. *See* Exhibits TX2, ME2, and NJ2. In February 2006, the Secretary once again changed the calculations and the amounts owed by the States. *See* Exhibits TX3, KY2, ME3, MO2, and NJ3. The final clawback "invoices" have still not been delivered to the States. It remains unclear what further changes, if any, will be made to the calculation of the States payments, when the States will be advised of the exact amounts owed, and when payment will be demanded by the federal government.

16. Thus, to the extent, if any, that the States were able to plan their budgets based upon the federal government's October 2005 notification, such planning was rendered obsolete based upon decisions made at the sole discretion of a federal official.

17. The Defendant, as Secretary of the United States Department of Health and Human Services, is charged

with calculation and collection of the clawback payments from the States. *See* 42 U.S.C. §1396u-5(c).

CONSTITUTIONAL CLAIMS

18. The clawback payments required by 42 U.S.C. §1396u-5(c) are an unconstitutional tax upon the States in violation of the intergovernmental-tax-immunity doctrine. This doctrine, grounded in the Tenth Amendment to the United States Constitution, provides a constitutional barrier to direct and discriminatory taxation of sovereign States by the federal government. *See New York v. United States*, 326 U.S. 572 (1946).

19. The clawback violates the intergovernmental-tax-immunity doctrine because it is a discriminatory tax imposed directly upon the States "as States" that substantially and unduly interferes with essential functions of state government and impermissibly infringes on state sovereignty.

20. The clawback also violates the anticommandeering doctrine recognized by the Court in *New York v. United States*, 505 U.S. 144 (1992), and *Printz v. United States*, 521 U.S. 898 (1997). This doctrine ensures the preservation of the system of "dual sovereignty" established in the Constitution, under which the States are not meant to operate as instruments of the federal government – but as separate sovereigns in their own right. *See Printz*, 521 U.S., at 925-26; *New York*, 505 U.S., at 175-77.

21. The clawback violates the anticommandeering doctrine because it impermissibly commands the States' legislatures to appropriate funds for the implementation of a federal program. The States may not, consistent with the

anticommandeering doctrine, be commanded by Congress to collect, allocate, and remit state funds to the federal government in order to finance Medicare.

22. Further, because it improperly infringes upon essential functions of state government, and the autonomy of state government, the clawback also contravenes the Guarantee Clause of the United States Constitution. The Guarantee Clause requires the United States to "guarantee to every State in this Union a Republican Form of Government." U.S. CONST. art. IV, §4. Along with the basic principles of federalism embodied in the Constitution, the Guarantee Clause preserves the States' sovereignty and independence from the federal government.

23. The clawback mandates that a substantial portion of each State's budget will now be dictated not by the policy decisions of state officials, but rather by a federal agency charged with administering Medicare. The clawback's simultaneous reduction of the authority of state legislatures over their budgets and delivery of such authority into the hands of agents of the federal government violates the Guarantee Clause.

PRAYER FOR RELIEF

The Plaintiff States of Texas, Kentucky, Maine, Missouri, and New Jersey pray that the Court:

1. Grant the Plaintiff States' motion for leave to file their complaint and assume original jurisdiction of this cause.

2. Enter a decree adjudging that 42 U.S.C. §1396u-5(c) is in violation of the Constitution of the United States.

3. Enter a decree permanently enjoining and restraining the Defendant from enforcing or attempting to enforce 42 U.S.C. §1396u-5(c) against the Plaintiff States; and

4. Grant the Plaintiff States such other and further relief as the Court deems just and proper.

Respectfully submitted,

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Attorney General of Texas

BARRY R. MCBEE
First Assistant Attorney General

EDWARD D. BURBACH
Deputy Attorney General
for Litigation

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March 2, 2006

No. _____, Original

In The
Supreme Court of the United States

STATES OF TEXAS, KENTUCKY, MAINE, MISSOURI, AND NEW JERSEY,

Plaintiffs,

v.

MICHAEL O. LEAVITT, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant.

On Motion for Leave to File
Bill of Complaint

EXHIBITS TO BILL OF COMPLAINT

TX 1

OCT-14-2005 16:41

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Mr. David Balland
Associate Commissioner for
Medicaid and CHIP
Health and Human Services Commission
Mail Code: H100
P.O. Box 85200
Austin, TX 78708-5200

OCT 14 2005
[DATE STAMP]

Dear Mr. Balland:

The purpose of this letter is to notify you of your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full dual-eligible per-capita Medicaid drug payment amount for 2006. The Federal statute explicitly establishes the phased-down State contribution formula. The information in this letter, which reflects our dialogue with you about your Medicaid drug costs, will be the basis for your monthly phased-down State contribution payments. These State contributions are one component of a package of MMA provisions that are expected to provide a significant new savings to States as well as comprehensive Medicare drug coverage for your dual-eligible beneficiaries.

As you know the phased-down contribution for 2006 reflects 90 percent of the expected state costs of Medicaid drug coverage for your dual-eligible beneficiaries, as determined by the MMA. Please note that the percentage

in the phase-down contribution formula declines for all of the States from 90 percent in 2006 to 75 percent over the next 10 years. This decline significantly reduces the State contribution payment each year. In particular, in 2006, the expected cost is determined by multiplying a measure of your 2003 per-capita Medicaid drug costs by an update factor specified in the statute to be the 2003-2006 National Health Expenditure (NHE) inflation factor for prescription drug expenditures.

The MMA requires that CMS notify each State no later than October 15 before each calendar year, beginning October 15, 2005, of its annual per capita drug payment expenditure amount for next year. Throughout this implementation phase we have made every effort to involve the States. We have conducted numerous all-State calls to share a dialogue regarding the implementation methodology, and have worked individually with each State to ensure that the baseline data submitted are accurate and consistent with the statutory requirements.

Payments for the phased-down State contribution begin in January 2006, and are made on a monthly basis for each subsequent month. These payments are defined by MMA to be the product of the annual per-capital full dual-eligible drug payments and the monthly State enrollment of full dual-eligibles. The phased-down State contribution data for your State is included in the enclosure to this letter.

We very much appreciate, the State's cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual-eligible population well, and will result in overall benefits to our State partners who have worked so

hard to help us put this program in place. States will have additional savings in 2006, derived from new subsidies from Medicare to help pay for drug coverage for State retirees. States with prescription assistance programs (SPAP) will see additional savings from Medicare coverage for beneficiaries who previously received coverage through the SPAP. In addition, because the phased-down contribution does not begin until February and the Medicare coverage begins in January, your State will only make 11 monthly phased-down contribution payments in 2006, further enhancing state savings next year.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification regarding the data or calculations.

Sincerely

/s/
Dennis G. Smith
Director

Enclosure

cc: Regional Administrator
Associate Regional Administrator, Medicaid

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The phased-down State contribution payments are defined by MMA to be the product of the annual per-capita full dual eligible drug payments and the monthly state enrollment of full dual eligibles. The methodology for this calculation is described in more detail in this attachment. The calculation involves establishing a fee-for service per-capita drug cost, adjusting that cost by the Medicaid

rebate percentage, and weighing in any full-dual eligible managed care drug costs. The State share of this result is then projected forward for 2006 using the National Health Expenditures drug cost, and reduced by 10 percent for the phase-down factor.

The baseline free-for-service per-capita costs are established using information reported by the State in calendar year 2003 through the Medicaid Statistical Information System (MSIS). For States which cover full dual eligibles in comprehensive HMO or PACE programs, the per-capita dual eligible drug payment is defined by MMA to be the weighted combination of the fee-for service (FFS) drug payments and comprehensive capitated drug payments. The capitated per capita dual eligible drug cost was provided by your State in response to a template developed by CMS. The weights used to combine the FFS and capitated per-capita drug costs were derived from the MSIS-reported enrollment numbers.

We recently shared with States the full-dual-eligible enrollment for the 2003 calendar year. This is the denominator of the baseline per-capita dual eligible drug cost. Based on follow up discussions with States regarding those enrollment numbers, we have adopted a revised methodology to establish monthly dual eligibility status from the quarterly MSIS dual eligibility coding. The final methodology assigns full dual status to each month of eligibility in a quarter for eligible MSIS enrollees having a full dual eligible code for that quarter. This methodology is applied consistently to determinations of monthly dual status for both payments and enrollment. In addition, we have worked extensively with each State over the last year to ensure that the baseline MSIS data accurately reflect the State Medicaid program.

The fee-for-service per-capita payment amounts are developed using the State-submitted MSIS drug claim files reported the months of January-December 2003 (MSIS fiscal year 2003 quarters 2-4 and fiscal year 2004 quarter 1). The final payment amount includes the amount paid on all drug claims with the following exclusions:

1. claims associated with individuals who were not a full dual eligible in the prescription fill month,
2. claims for Part D excluded drugs,
3. claims for individuals in pharmacy-plus or other 1115 drug-only demonstrations,
4. claims for Indian Health Service or Family Planning services,
5. claims with an invalid National Drug Code (NDC) including an alpha character, and
6. claims with an invalid prescription fill date.

This coding for the fields used to determine these exclusions is defined in the MSIS data dictionary available at:

http://www.cms.hhs.gov/medicaid/msis/default.asp

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final pear [sic]-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	3,903,272	0	
Total FFS Drug Payments	$798,314,005		
Drug Rebate Factor	20.08%		
Baseline Per-capita Drug Cost	$163.46	$0	$163.46
2003-2006 NHE Inflation Factor			35.54% ($605 to $820)
2006 Total Per-capita Drug Cost			$221.54
2006 State Share Percentage			39.34%
2006 State Per-capita Drug Cost			$87.16
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phasedown Payment (January-September/ October-December)*			$78.44/$78.20

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

TX 2

DEC-29-2005 THU 09:15 AM FAX NO. 4911978

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Mr. David Balland
Associate Commissioner for Medicaid and CHIP
Health and Human Services Commission
Mail Code H100
P.O. Box 85200
Austin, TX 78708-5200
Fax: 512-491-1977

Dear Mr. Balland:

The purpose of this letter [sic] to notify you of an update to your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full-dual eligible per-capita Medicaid drug payment amount for 2006. This updated information supersedes the numbers sent to you on October 14th and will be the basis for your monthly phased-down State contribution payments.

This change is a slight reduction in your baseline per-capita Medicaid drug payment amount for 2006, as reflected in the attached table. The change was made to address a concern raised by the State regarding retroactive enrollment adjustments, and incorporates updated dual eligible enrollment data.

We very much appreciate the States' cooperation in implementing this process and the other provisions in the

MMA. We believe that the package of MMA provisions will serve the dual eligible population well, and will result in overall benefits to our State partners who have worked so hard to help us put this program in place.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification.

Sincerely,

/s/
Dennis G. Smith
Director

Enclosure

CC: Associate Regional Administrator, Medicaid
Regional Administrator

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final pear [sic]-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	3,925,887	0	
Total FFS Drug Payments	$802,251,520		
Drug Rebate Factor	20.08%		
Baseline Per-capita Drug Payments	$163.32	$0	$163.32
2003-2006 NHE Inflation Factor			35.54% ($605 to $820)
2006 State Share Percentage			39.34%
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phase-down Payment (January-September/October-December)*			$78.37/$78.13

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

TX 3

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB -9 2006
[DATE STAMP]

The Honorable Rick Perry
Governor of Texas Austin,
Texas 78711

Dear Governor Perry:

Thank you for your outstanding work over the past several months regarding the implementation of the Medicare Modernization Act of 2003 (MMA) and the Part D program. We are just over a month into the most significant change in Medicare since the program began 40 years ago, and for the vast majority of seniors, the new benefit is working.

As the President's Budget for 2007 has been released, there is even better news to report. The newest estimates show that the cost of the new drug benefit will be even lower than previously expected for our Medicare beneficiaries, taxpayers, and states. Our efforts to bring competition and choice into the Medicare program are yielding great dividends.

I am pleased to inform you that the newly-updated National Health Expenditures (NHE) growth rate that is used for the calculation of the phased-down state contribution in the President's Budget is even lower than last year's estimates. Nationally, we project the

state contributions will be reduced by $37 billion in the period 2006-2015 compared to these costs estimated last summer. In addition, we will apply the new index to recalculate the per capita amount used in the state contribution for CY 2006. Texas's new per capita amount will be $70.80 for the January-September period compared to the old amount of $78.37, a reduction of 9.7 percent. According to our estimates, when comparing annual payments based on December actual enrollment reported by Texas, using the new NHE will mean additional savings of $29,294,242 for the state in CY 2006.

This lower rate of growth is indeed good news for the long-term, and I am pleased to inform you of our response to lower the state contribution immediately. If you have any questions about our actions in this matter, please do not hesitate to call me.

Sincerely,

/s/ Michael O. Leavitt
Michael O. Leavitt

KY 1

OCT. 17 2005 5:26 PM NO. 1650

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Ms. Shannon Turner, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6 West
Frankfort, KY 40621

OCT 14 2005
[DATE STAMP]

Dear Ms. Turner:

The purpose of this letter is to notify you of your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full dual-eligible per-capita Medicaid drug payment amount for 2006. The Federal statute explicitly establishes the phased-down State contribution formula. The information in this letter, which reflects our dialogue with you about your Medicaid drug costs, will be the basis for your monthly phased-down State contribution payments. These State contributions are one component of a package of MMA provisions that are expected to provide a significant new savings to States as well as comprehensive Medicare drug coverage for your dual-eligible beneficiaries.

As you know the phased-down contribution for 2006 reflects 90 percent of the expected state costs of Medicaid drug coverage for your dual-eligible beneficiaries, as determined by the MMA. Please note that the percentage in the phase-down contribution formula declines for all of the States from 90 percent in 2006 to 75 percent over the

next 10 years. This decline significantly reduces the State contribution payment each year. In particular, in 2006, the expected cost is determined by multiplying a measure of your 2003 per-capita Medicaid drug costs by an update factor specified in the statute to be the 2003-2006 National Health Expenditure (NHE) inflation factor for prescription drug expenditures.

The MMA requires that CMS notify each State no later than October 15 before each calendar year, beginning October 15, 2005, of its annual per capita drug payment expenditure amount for next year. Throughout this implementation phase we have made every effort to involve the States. We have conducted numerous all-State calls to share a dialogue regarding the implementation methodology, and have worked individually with each State to ensure that the baseline data submitted are accurate and consistent with the statutory requirements.

Payments for the phased-down State contribution begin in January 2006, and are made on a monthly basis for each subsequent month. These payments are defined by MMA to be the product of the annual per-capital [sic] full dual-eligible drug payments and the monthly State enrollment of full dual-eligibles. The phased-down State contribution data for your State is included in the enclosure to this letter.

We very much appreciate, the State's cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual-eligible population well, and will result in overall benefits to our State partners who have worked so hard to help us put this program in place. States will have additional savings in 2006, derived from new subsidies

from Medicare to help pay for drug coverage for State retirees. States with prescription assistance programs (SPAP) will see additional savings from Medicare coverage for beneficiaries who previously received coverage through the SPAP. In addition, because the phased-down contribution does not begin until February and the Medicare coverage begins in January, your State will only make 11 monthly phased-down contribution payments in 2006, further enhancing state savings next year.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification regarding the data or calculations.

Sincerely

/s/
Dennis G. Smith
Director

Enclosure

cc: Regional Administrator
Associate Regional Administrator, Medicaid

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The phased-down State contribution payments are defined by MMA to be the product of the annual per-capita full dual eligible drug payments and the monthly state enrollment of full dual eligibles. The methodology for this calculation is described in more detail in this attachment. The calculation involves establishing a fee-for service per-capita drug cost, adjusting that cost by the Medicaid rebate percentage, and weighing in any full-dual eligible

managed care drug costs. The State share of this result is then projected forward for 2006 using the National Health Expenditures drug cost, and reduced by 10 percent for the phase-down factor.

The baseline free-for-service [sic] per-capita costs are established using information reported by the State in calendar year 2003 through the Medicaid Statistical Information System (MSIS). For States which cover full dual eligibles in comprehensive HMO or PACE programs, the per-capita dual eligible drug payment is defined by MMA to be the weighted combination of the fee-for service (FFS) drug payments and comprehensive capitated drug payments. The capitated per capita dual eligible drug cost was provided by your State in response to a template developed by CMS. The weights used to combine the FFS and capitated per-capita drug costs were derived from the MSIS-reported enrollment numbers.

We recently shared with States the full-dual-eligible enrollment for the 2003 calendar year. This is the denominator of the baseline per-capita dual eligible drug cost. Based on follow up discussions with States regarding those enrollment numbers, we have adopted a revised methodology to establish monthly dual eligibility status from the quarterly MSIS dual eligibility coding. The final methodology assigns full dual status to each month of eligibility in a quarter for eligible MSIS enrollees having a full dual eligible code for that quarter. This methodology is applied consistently to determinations of monthly dual status for both payments and enrollment. In addition, we have worked extensively with each State over the last year to ensure that the baseline MSIS data accurately reflect the State Medicaid program.

The fee-for-service per-capita payment amounts are developed using the State-submitted MSIS drug claim files reported the months of January-December 2003 (MSIS fiscal year 2003 quarters 2-4 and fiscal year 2004 quarter 1). The final payment amount includes the amount paid on all drug claims with the following exclusions:

1. claims associated with individuals who were not a full dual eligible in the prescription fill month,
2. claims for Part D excluded drugs,
3. claims for individuals in pharmacy-plus or other 1115 drug-only demonstrations,
4. claims for Indian Health Service or Family Planning services,
5. claims with an invalid National Drug Code (NDC) including an alpha character, and
6. claims with an invalid prescription fill date.

This coding for the fields used to determine these exclusions is defined in the MSIS data dictionary available at:

http://www.cms.hhs.gov/medicaid/msis/default.asp

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final pear [sic]-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	1,011,223	148,658	[redacted]
Total FFS Drug Payments	$272,848,106	[redacted]	[redacted]
Drug Rebate Factor	20.79%	[redacted]	[redacted]
Baseline Per-capita Drug Cost	$213.73	$163.02	$207.23
2003-2006 NHE Inflation Factor	[redacted]	[redacted]	35.54% ($605 to $820)
2006 Total Per-capita Drug Cost	[redacted]	[redacted]	$280.87
2006 State Share Percentage	[redacted]	[redacted]	30.74%
2006 State Per-capita Drug Cost	[redacted]	[redacted]	$86.34
2006 Phased-Down Percentage	[redacted]	[redacted]	90%
Final 2006 State Per-capita Phase-down Payment (January-September/ October-December)*	[redacted]	[redacted]	$77.71/$76.90

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

KY 2

THE SECRETARY OF HEALTH
AND HUMAN SERVICES
WASHINGTON, D.C. 20201
FEB -9 2006
[DATE STAMP]

The Honorable Ernie Fletcher
Governor of Kentucky
Frankfort, Kentucky 40601

Dear Governor Fletcher:

Thank you for your outstanding work over the past several months regarding the implementation of the Medicare Modernization Act of 2003 (1V MA) and the Part D program. We are just over a month into the most significant change in Medicare since the program began 40 years ago, and for the vast majority of seniors, the new benefit is working.

As the President's Budget for 2007 has been released, there is even better news to report. The newest estimates show that the cost of the new drug benefit will be even lower than previously expected for our Medicare beneficiaries, taxpayers, and states. Our *efforts* to bring competition and choice into the Medicare program are yielding great dividends.

I am pleased to inform you that the newly-updated National Health Expenditures (NHS) growth rate that is used for the calculation of the phased-down state contribution in the President's Budget is even lower than last year's estimates. Nationally, we project the state contributions

will be reduced by $37 billion in the period 2006-2015 compared to these costs estimated last summer. In addition, we will apply the new index to recalculate the per capita amount used in the state contribution for CY 2006. Kentucky's new per capita amount will be $70.20 for the January-September period compared to the old amount of $77.71, a reduction of 9.7 percent. According to our estimates, when comparing annual payments based on December actual enrollment reported by Kentucky, using the new NHE will mean additional savings of $7,833,644 for the state in CY 2006.

This lower rate of growth is indeed good news for the long-term, and I am pleased to inform you of our response to lower the state contribution immediately. If you have any questions about our actions in this matter, please do not hesitate to call me.

Sincerely,

/s/
Michael O. Leavitt

ME 1

FEB-22-2006 15:06 287 2675 287 2675

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Mr. J. Michael Hall, Director
Deputy Commissioner of Health
Bureau of Medical Services
Department of Health & Human Services
#11 Statehouse Station
442 Civic Center Drive
Augusta, ME 04333-0011

OCT 14 2005
[DATE STAMP]

Dear Mr. Hall:

The purpose of this letter is to notify you of your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full dual-eligible per-capita Medicaid drug payment amount for 2006. The Federal statute explicitly establishes the phased-down State contribution formula. The information in this letter, which reflects our dialogue with you about your Medicaid drug costs, will be the basis for your monthly phased-down State contribution payments. These State contributions are one component of a package of MMA provisions that are expected to provide a significant new savings to States as well as comprehensive Medicare drug coverage for your dual-eligible beneficiaries.

As you know the phased-down contribution for 2006 reflects 90 percent of the expected state costs of Medicaid drug coverage for your dual-eligible beneficiaries, as determined by the MMA. Please note that the percentage

in the phase-down contribution formula declines for all of the States from 90 percent in 2006 to 75 percent over the next 10 years. This decline significantly reduces the State contribution payment each year. In particular, in 2006, the expected cost is determined by multiplying a measure of your 2003 per-capita Medicaid drug costs by an update factor specified in the statute to be the 2003-2006 National Health Expenditure (NHE) inflation factor for prescription drug expenditures.

The MMA requires that CMS notify each State no later than October 15 before each calendar year, beginning October 15, 2005, of its annual per capita drug payment expenditure amount for next year. Throughout this implementation phase we have made every effort to involve the States. We have conducted numerous all-State calls to share a dialogue regarding the implementation methodology, and have worked individually with each State to ensure that the baseline data submitted are accurate and consistent with the statutory requirements.

Payments for the phased-down State contribution begin in January 2006, and are made on a monthly basis for each subsequent month. These payments are defined by MMA to be the product of the annual per-capital [sic] full dual-eligible drug payments and the monthly State enrollment of full dual-eligibles. The phased-down State contribution data for your State is included in the enclosure to this letter.

We very much appreciate, the State's cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual-eligible population well, and will result in overall benefits to our State partners who have worked so

hard to help us put this program in place. States will have additional savings in 2006, derived from new subsidies from Medicare to help pay for drug coverage for State retirees. States with prescription assistance programs (SPAP) will see additional savings from Medicare coverage for beneficiaries who previously received coverage through the SPAP. In addition, because the phased-down contribution does not begin until February and the Medicare coverage begins in January, your State will only make 11 monthly phased-down contribution payments in 2006, further enhancing state savings next year.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification regarding the data or calculations.

Sincerely

/s/
Dennis G. Smith
Director

Enclosure

cc: Regional Administrator
Associate Regional Administrator, Medicaid

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The phased-down State contribution payments are defined by MMA to be the product of the annual per-capita full dual eligible drug payments and the monthly state enrollment of full dual eligibles. The methodology for this calculation is described in more detail in this attachment.

The calculation involves establishing a fee-for service per-capita drug cost, adjusting that cost by the Medicaid rebate percentage, and weighing in any full-dual eligible managed care drug costs. The State share of this result is then projected forward for 2006 using the National Health Expenditures drug cost, and reduced by 10 percent for the phase-down factor.

The baseline free-for-service [sic] per-capita costs are established using information reported by the State in calendar year 2003 through the Medicaid Statistical Information System (MSIS). For States which cover full dual eligibles in comprehensive HMO or PACE programs, the per-capita dual eligible drug payment is defined by MMA to be the weighted combination of the fee-for service (FFS) drug payments and comprehensive capitated drug payments. The capitated per capita dual eligible drug cost was provided by your State in response to a template developed by CMS. The weights used to combine the FFS and capitated per-capita drug costs were derived from the MSIS-reported enrollment numbers.

We recently shared with States the full-dual-eligible enrollment for the 2003 calendar year. This is the denominator of the baseline per-capita dual eligible drug cost. Based on follow up discussions with States regarding those enrollment numbers, we have adopted a revised methodology to establish monthly dual eligibility status from the quarterly MSIS dual eligibility coding. The final methodology assigns full dual status to each month of eligibility in a quarter for eligible MSIS enrollees having a full dual eligible code for that quarter. This methodology is applied consistently to determinations of monthly dual status for both payments and enrollment. In addition, we have worked extensively with each State over the last year

to ensure that the baseline MSIS data accurately reflect the State Medicaid program.

The fee-for-service per-capita payment amounts are developed using the State-submitted MSIS drug claim files reported the months of January-December 2003 (MSIS fiscal year 2003 quarters 2-4 and fiscal year 2004 quarter 1). The final payment amount includes the amount paid on all drug claims with the following exclusions:

1. claims associated with individuals who were not a full dual eligible in the prescription fill month,
2. claims for Part D excluded drugs,
3. claims for individuals in pharmacy-plus or other 1115 drug-only demonstrations,
4. claims for Indian Health Service or Family Planning services,
5. claims with an invalid National Drug Code (NDC) including an alpha character, and
6. claims with an invalid prescription fill date.

This coding for the fields used to determine these exclusions is defined in the MSIS data dictionary available at:

http://www.cms.hhs.gov/medicaid/msis/default.asp

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations

up to the final pear [sic]-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	523,631	0	
Total FFS Drug Payments	$128,374,559		
Drug Rebate Factor	25.47%		
Baseline Per-capita Drug Cost	$182.73	$0	$182.73
2003-2006 NHE Inflation Factor			35.54% ($605 to $820)
2006 Total Per-capita Drug Cost			$247.66
2006 State Share Percentage			37.10%
2006 State Per-capita Drug Cost			$91.88
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phase-down Payment (January-September/ October-December)*			$82.70/$81.87

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

ME 2

FEB-22-2006 15:08 287 2675 287 2675

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

DEC 27 2005
[DATE STAMP]

Mr. J. Michael Hall, Director
Deputy Commissioner of Health
Bureau of Medical Services
Department of Health & Human Services
#11 Statehouse Station
442 Civic Center Drive
Augusta, ME 04333-0011

Dear Mr. Hall:

The purpose of this letter to notify you of an update to your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full-dual eligible per-capita Medicaid drug payment amount for 2006. This updated information supersedes the numbers sent to you on October 14th and will be the basis for your monthly phased-down State contribution payments.

This change is a slight reduction in your baseline per-capita Medicaid drug payment amount for 2006, as reflected in the attached table. The change was made to address a concern raised by States which did not originally provide Medicaid Statistical Information System baseline file coding necessary to support exclusion of Indian Health Services drug costs.

We very much appreciate the States' cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual eligible population well, and will result in overall benefits to our State partners who have worked so hard to help us put this program in place.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification.

Sincerely,

/s/
Dennis G. Smith
Director

Enclosure

CC: Associate Regional Administrator, Medicaid
Regional Administrator

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final pear [sic]-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	523,631	0	
Total FFS Drug Payments	$128,168,897		
Drug Rebate Factor	25.47%		
Baseline Per-capita Drug Payments	$182.44	$0	$182.44
2003-2006 NHE Inflation Factor			35.54% ($605 to $820)
2006 State Share Percentage			37.10%
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phasedown Payment (January-September/ October-December)*			$82.56/$81.74

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each

month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

ME 3

**THE SECRETARY OF HEALTH
AND HUMAN SERVICES
WASHINGTON, D.C. 20201**

FEB -9 2006
[DATE STAMP]

The Honorable John Baldacci
Governor of Maine
Augusta, Maine 04333-0001

Dear Governor Baldacci:

Thank you for your outstanding work over the past several months regarding the implementation of the Medicare Modernization Act of 2003 (MMA) and the Part D program. We are just over a month into the most significant change in Medicare since the program began 40 years ago, and for the vast majority of seniors, the new benefit is working.

As the President's Budget for 2007 has been released, there is even better news to report. The newest estimates show that the cost of the new drug benefit will be even lower than previously expected for our Medicare beneficiaries, taxpayers, and states. Our efforts to bring competition and choice into the Medicare program are yielding great dividends.

I am pleased to inform you that the newly-updated National Health Expenditures (NHE) growth rate that is used for the calculation of the phased-down state contribution in the President's Budget is even lower than last year's estimates. Nationally, we project the

state contributions will be reduced by $37 billion in the period 2006-2015 compared to these costs estimated last summer. In addition, we will apply the new index to recalculate the per capita amount used in the state contribution for CY 2006. Maine's new per capita amount will be $74.59 for the January-September period compared to the old amount of $82.56, a reduction of 9.7 percent. According to our estimates, when comparing annual payments based on December actual enrollment reported by Maine, using the new NHE will mean additional savings of $4,370,589 for the state in CY 2006.

This lower rate of growth is indeed good news for the long-term, and I am pleased to inform you of our response to lower the state contribution immediately. If you have any questions about our actions in this matter, please do not hesitate to call me.

Sincerely

/s/
Michael O. Leavitt

MO 1

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Mr. Q. Michael Ditmore, MD., Interim Director
Division of Medical Services
Department of Social Services
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102

Dear Dr. Ditmore:

The purpose of this letter is to notify you of your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full dual-eligible per-capita Medicaid drug payment amount for 2006. The Federal statute explicitly establishes the phased-down State contribution formula. The information in this letter, which reflects our dialogue with you about your Medicaid drug costs, will be the basis for your monthly phased-down State contribution payments. These State contributions are one component of a package of MMA provisions that are expected to provide a significant new savings to States, as well as comprehensive Medicare drug coverage for your dual-eligible beneficiaries.

As you know, the phased-down contribution for 2006 reflects 90 percent of the expected state costs of Medicaid drug coverage for your dual-eligible beneficiaries, as determined by the MMA. Please note that the percentage in the phase-down contribution formula declines for all of the States from 90 percent in 2006 to 75 percent over the

next 10 years. This decline significantly reduces the State contribution payment each year. In particular, in 2006, the expected cost is determined by multiplying a measure of your 2003 per-capita Medicaid drug costs by an update factor, specified in the statute to be the 2003-2006 National Health Expenditure (NHE) inflation factor for prescription drug expenditures.

The MMA requires that CMS notify each State no later than October 15 before each calendar year, beginning October 15, 2005, of its annual per capita drug payment expenditure amount for the next year. Throughout this implementation phase we have made every effort to involve the States. We have conducted numerous all-State calls to share a dialogue regarding the implementation methodology, and have worked individually with each State to ensure that the baseline data submitted are accurate and consistent with the statutory requirements.

Payments for the phased-down State contribution begin in January 2006, and are made on a monthly basis for each subsequent month. These payments are defined by MMA to be the product of the annual per-capita full dual-eligible drug payments and the monthly State enrollment of full dual-eligibles. The phased-down State contribution data for your State is included in the enclosure to this letter.

We very much appreciate the State's cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual-eligible population well, and will result in overall benefits to our State partners who have worked so hard to help us put this program in place. States will have additional savings in 2006, derived from new subsidies from Medicare to help pay for drug coverage for State

retirees. States with prescription assistance programs (SPAP) will see additional savings from Medicare coverage for beneficiaries who previously received coverage through the SPAP. In addition, because the phased-down contribution does not begin until February and the Medicare coverage begins in January, your State will make only 11 monthly phased-down contribution payments in 2006, further enhancing state savings next year.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification regarding the data or calculations.

Sincerely,

/s/
Dennis G. Smith
Director

Enclosure

cc: Regional Administrator
Associate Regional Administrator, Medicaid

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The phased-down State contribution payments are defined by MMA to be the product of the annual per-capita full dual eligible drug payments and the monthly state enrollment of full dual eligibles. The methodology for this calculation is described in more detail in this attachment. The calculation involves establishing a fee-for service per-capita drug cost, adjusting that cost by the Medicaid rebate percentage, and weighting in any full-dual eligible managed care drug costs. The State share of this result is

then projected forward for 2006 using the National Health Expenditures drug cost, and reduced by 10 percent for the phase-down factor.

The baseline fee-for-service per-capita costs are established using information reported by the State in calendar year 2003 through the Medicaid Statistical Information System (MSIS.) For States which cover full dual eligibles in comprehensive HMO or PACE programs, the per-capita dual eligible drug payment is defined by MMA to be the weighted combination of the fee-for-service (FFS) drug payments and comprehensive capitated drug payments. The capitated per-capita dual eligible drug cost was provided by your State in response to a template developed by CMS. The weights used to combine the FFS and capitated per-capita drug costs were derived from the MSIS-reported enrollment numbers.

We recently shared with States the full-dual-eligible enrollment for the 2003 calendar year. This is the denominator of the baseline per-capita dual eligible drug cost. Based on follow up discussions with States regarding those enrollment numbers, we have adopted a revised methodology to establish monthly dual eligibility status from the quarterly MSIS dual eligibility coding. The final methodology assigns full dual status to each month of eligibility in a quarter for eligible MSIS enrollees having a full dual eligible code for that quarter. This methodology is applied consistently to determinations of monthly dual status for both payments and enrollment. In addition, we have worked extensively with each State over the last year to ensure that the baseline MSIS data accurately reflect the State Medicaid program.

The fee-for-service per-capita payment amounts are developed using the State-submitted MSIS drug claim files reported the months of January-December 2003 (MSIS fiscal year 2003 quarters 2-4 and fiscal year 2004 quarter 1). The final payment amount includes the amount paid on all drug claims with the following exclusions:

claims associated with individuals who were not a full dual eligible in the prescription fill month,

claims for Part D excluded drugs,

claims for individuals in pharmacy-plus or other 1115 drug-only demonstrations,

claims for Indian Health Service or Family Planning services,

claims with an invalid National Drug Code (NDC) including an alpha character, and

claims with an invalid prescription fill date.

This coding for the fields used to determine these exclusions is defined in the MSIS data dictionary available at:

http://www.cms.hhs.gov/medicaid/msis/default.asp

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final per-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	1,612,297	0	
Total FFS Drug Payments	$511,380,946		
Drug Rebate Factor	18.55%		
Baseline Per-capita Drug Cost	$258.33	$0	$258.33
2003-2006 NHE Inflation Factor			35.54 % ($605 to $820)
2006 Total Per-capita Drug Cost			$350.13
2006 State Share Percentage			38.07%
2006 State Per-capita Drug Cost			$133.29
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phasedown Payment (January-September/ October-December)*			$119.96/$121.00

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

MO 2

**THE SECRETARY OF HEALTH
AND HUMAN SERVICES
WASHINGTON, D.C. 20201**

FEB -9 2006
[DATE STAMP]

The Honorable Matt Blunt
Governor of Missouri
Jefferson City, Missouri 65101

Dear Governor Blunt:

Thank you for your outstanding work over the past several months regarding the implementation of the Medicare Modernization Act of 2003 (MMA) and the Part D program. We are just over a month into the most significant change in Medicare since the program began 40 years ago, and for the vast majority of seniors, the new benefit is working.

As the President's Budget for 2007 has been released, there is even better news to report. The newest estimates show that the cost of the new drug benefit will be even lower than previously expected for our Medicare beneficiaries, taxpayers, and states. Our efforts to bring competition and choice into the Medicare program are yielding great dividends.

I am pleased to inform you that the newly-updated National Health Expenditures (NHE) growth rate that is used for the calculation of the phased-down state contribution in the President's Budget is even lower than last year's estimates. Nationally, we project the

state contributions will be reduced by $37 billion in the period 2006-2015 compared to these costs estimated last summer. In addition, we will apply the new index to recalculate the per capita amount used in the state contribution for CY 2006. Missouri's new per capita amount will be $108.38 for the January-September period compared to the old amount of $119.96, a reduction of 9.7 percent. According to our estimates, when comparing annual payments based on December actual enrollment reported by Missouri, using the new NHE will mean additional savings of $18,512,407 for the state in CY 2006.

This lower rate of growth is indeed good news for the long-term, and I am pleased to inform you of our response to lower the state contribution immediately. If you have any questions about our actions in this matter, please do not hesitate to call me.

Sincerely,

/s/
Michael O. Leavitt

NJ 1

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Ms. Ann C. Kohler, Director
Division of Medical Assistance
& Health Services
Department of Human Services
P.O. Box 712
Trenton, NJ 08625-0712

OCT 14 2005
[DATE STAMP]

Dear Ms. Kohler:

The purpose of this letter is to notify you of your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full dual-eligible per-capita Medicaid drug payment amount for 2006. The Federal statute explicitly establishes the phased-down State contribution formula. The information in this letter, which reflects our dialogue with you about your Medicaid drug costs, will be the basis for your monthly phased-down State contribution payments. These State contributions are one component of a package of MMA provisions that are expected to provide a significant new savings to States as well as comprehensive Medicare drug coverage for your dual-eligible beneficiaries.

As you know the phased-down contribution for 2006 reflects 90 percent of the expected state costs of Medicaid drug coverage for your dual-eligible beneficiaries, as determined by the MMA. Please note that the percentage in the phase-down contribution formula declines for all of the States from 90 percent in 2006 to 75 percent over the

next 10 years. This decline significantly reduces the State contribution payment each year. In particular, in 2006, the expected cost is determined by multiplying a measure of your 2003 per-capita Medicaid drug costs by an update factor specified in the statute to be the 2003-2006 National Health Expenditure (NHE) inflation factor for prescription drug expenditures.

The MMA requires that CMS notify each State no later than October 15 before each calendar year, beginning October 15, 2005, of its annual per capita drug payment expenditure amount for next year. Throughout this implementation phase we have made every effort to involve the States. We have conducted numerous all-State calls to share a dialogue regarding the implementation methodology, and have worked individually with each State to ensure that the baseline data submitted are accurate and consistent with the statutory requirements.

Payments for the phased-down State contribution begin in January 2006, and are made on a monthly basis for each subsequent month. These payments are defined by MMA to be the product of the annual per-capital full dual-eligible drug payments and the monthly State enrollment of full dual-eligibles. The phased-down State contribution data for your State is included in the enclosure to this letter.

We very much appreciate, the State's cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual-eligible population well, and will result in overall benefits to our State partners who have worked so hard to help us put this program in place. States will have additional savings in 2006, derived from new subsidies

from Medicare to help pay for drug coverage for State retirees. States with prescription assistance programs (SPAP) will see additional savings from Medicare coverage for beneficiaries who previously received coverage through the SPAP. In addition, because the phased-down contribution does not begin until February and the Medicare coverage begins in January, your State will only make 11 monthly phased-down contribution payments in 2006, further enhancing state savings next year.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification regarding the data or calculations.

Sincerely

/s/
Dennis G. Smith
Director

Enclosure

cc: Regional Administrator
Associate Regional Administrator, Medicaid

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The phased-down State contribution payments are defined by MMA to be the product of the annual per-capita full dual eligible drug payments and the monthly state enrollment of full dual eligibles. The methodology for this calculation is described in more detail in this attachment. The calculation involves establishing a fee-for service per-capita drug cost, adjusting that cost by the Medicaid

rebate percentage, and weighing in any full-dual eligible managed care drug costs. The State share of this result is then projected forward for 2006 using the National Health Expenditures drug cost, and reduced by 10 percent for the phase-down factor.

The baseline free-for-service per-capita costs are established using information reported by the State in calendar year 2003 through the Medicaid Statistical Information System (MSIS). For States which cover full dual eligibles in comprehensive HMO or PACE programs, the per-capita dual eligible drug payment is defined by MMA to be the weighted combination of the fee-for service (FFS) drug payments and comprehensive capitated drug payments. The capitated per capita dual eligible drug cost was provided by your State in response to a template developed by CMS. The weights used to combine the FFS and capitated per-capita drug costs were derived from the MSIS-reported enrollment numbers.

We recently shared with States the full-dual-eligible enrollment for the 2003 calendar year. This is the denominator of the baseline per-capita dual eligible drug cost. Based on follow up discussions with States regarding those enrollment numbers, we have adopted a revised methodology to establish monthly dual eligibility status from the quarterly MSIS dual eligibility coding. The final methodology assigns full dual status to each month of eligibility in a quarter for eligible MSIS enrollees having a full dual eligible code for that quarter. This methodology is applied consistently to determinations of monthly dual status for both payments and enrollment. In addition, we have worked extensively with each State over the last year to ensure that the baseline MSIS data accurately reflect the State Medicaid program.

The fee-for-service per-capita payment amounts are developed using the State-submitted MSIS drug claim files reported the months of January-December 2003 (MSIS fiscal year 2003 quarters 2-4 and fiscal year 2004 quarter 1). The final payment amount includes the amount paid on all drug claims with the following exclusions:

1. claims associated with individuals who were not a full dual eligible in the prescription fill month,
2. claims for Part D excluded drugs,
3. claims for individuals in pharmacy-plus or other 1115 drug-only demonstrations,
4. claims for Indian Health Service or Family Planning services,
5. claims with an invalid National Drug Code (NDC) including an alpha character, and
6. claims with an invalid prescription fill date.

This coding for the fields used to determine these exclusions is defined in the MSIS data dictionary available at:

http://www.cms.hhs.gov/medicaid/msis/default.asp

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final pear-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	1,499,723	89,878	
Total FFS Drug Payments	$492,161,281		
Drug Rebate Factor	18.23%		
Baseline Per-capita Drug Cost	$268.35	$150.64	$261.69
2003-2006 NHE Inflation Factor			35.54% ($605 to $820)
2006 Total Per-capita Drug Cost			$354.69
2006 State Share Percentage			50.00%
2006 State Per-capita Drug Cost			$177.35
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phasedown Payment (January-September/ October-December)*			$159.61/$159.61

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

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DEC-20-2005 14:06

DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Ms. Ann C. Kohler, Director
Division of Medical Assistance
& Health Services
Department of Human Services
P.O. Box 712
Trenton, NJ 08625-0712

Dear Ms. Kohler:

The purpose of this letter [sic] to notify you of an update to your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full-dual eligible per-capita Medicaid drug payment amount for 2006. This updated information supersedes the numbers sent to you on October 14th and will be the basis for your monthly phased-down State contribution payments.

This change is a slight reduction in your baseline per-capita Medicaid drug payment amount for 2006, as reflected in the attached table. The change was made to address a concern raised by States having an Adult SCHIP Waiver, and gives the State the benefit of the slightly higher Federal matching rate for drug costs associated with dual eligibles in your Adult SCHIP program.

We very much appreciate the States' cooperation in implementing this process and the other provisions in the

MMA. We believe that the package of MMA provisions will serve the dual eligible population well, and will result in overall benefits to our State partners who have worked so hard to help us put this program in place.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification.

Sincerely,

/s/
Dennis G. Smith
Director

Enclosure

CC: Associate Regional Administrator, Medicaid
Regional Administrator

ATTACHMENT – PHASED-DOWN STATE CONTRIBUTION DATA

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final pear [sic]-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	1,499,723	89,878	
Total FFS Drug Payments	$492,100,314		
Drug Rebate Factor	18.23%		
Baseline Per-capita Drug Payments	$268.32	$150.64	$261.66
2003-2006 NHE Inflation Factor			35.54% ($605 to $820)
2006 State Share Percentage			50.00%
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phasedown Payment (January-September/ October-December)*			$159.59/$159.59

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing

will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

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**THE SECRETARY OF HEALTH
AND HUMAN SERVICES
WASHINGTON, D.C. 20201**

FEB -9 2006
[DATE STAMP]

The Honorable Jon S. Corzine
Governor of New Jersey
Trenton, New Jersey 08625

Dear Governor Corzine:

Thank you for your outstanding work over the past several months regarding the implementation of the Medicare Modernization Act of 2003 (MMA) and the Part D program. We are just over a month into the most significant change in Medicare since the program began 40 years ago, and for the vast majority of seniors, the new benefit is working.

As the President's Budget for 2007 has been released, there is even better news to report. The newest estimates show that the cost of the new drug benefit will be even lower than previously expected for our Medicare beneficiaries, taxpayers, and states. Our efforts to bring competition and choice into the Medicare program are yielding great dividends.

I am pleased to inform you that the newly-updated National Health Expenditures (NHE) growth rate that is used for the calculation of the phased-down state contribution in the President's Budget is even lower than last year's estimates. Nationally, we project the

state contributions will be reduced by $37 billion in the period 2006-2015 compared to these costs estimated last summer. In addition, we will apply the new index to recalculate the per capita amount used in the state contribution for CY 2006. Missouri's new per capita amount will be $144.18 for the January-September period compared to the old amount of $159.59, a reduction of 9.7 percent. According to our estimates, when comparing annual payments based on December actual enrollment reported by New Jersey, using the new NHE will mean additional savings of $26,197,409 for the state in CY 2006.

This lower rate of growth is indeed good news for the long-term, and I am pleased to inform you of our response to lower the state contribution immediately. If you have any questions about our actions in this matter, please do not hesitate to call me.

Sincerely,

/s/
Michael O. Leavitt