Center on Budget and Policy Priorities

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2392-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2393, Proposed Medicaid Fiscal Accountability Regulation

Dear Sir or Madam:

Thank you for the opportunity to comment on the proposed "Medicaid Fiscal Accountability Regulation" published in the Federal Register on November 18, 2019. The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

The proposed rule would have a significant impact on how states finance their Medicaid programs, and could lead states to cut benefits and eligibility as well as provider payments, jeopardizing access to care for millions of Medicaid beneficiaries. The preamble states that CMS wants to "better understand the relationship between and among the following: Supplemental provider payments, costs incurred by providers, current UPL requirements, state financing of the non-federal share of supplemental payments, and the impact of supplemental payments on the Medicaid program (such as improvements in the quality of, or access to, care.)" Yet even before CMS takes steps to gain that better understanding, the rule would severely restrict states' ability to use these mechanisms to finance their share of Medicaid expenditures.

We agree that additional information is needed to better understand whether state financing arrangements advance the objectives of Medicaid, and support CMS' proposal to require additional reporting. Payments made through these financing arrangements represent a large share of Medicaid reimbursement to hospitals. As the rule notes, supplemental payments, Disproportionate Share Hospital (DSH) payments, and uncompensated care payments made under section 1115 demonstration authority were 27 percent of Medicaid payments to hospitals in 2016. Every state except Alaska uses provider taxes as a financing mechanism, according to the Kaiser Family

Foundation. Understanding how these arrangements work is important for all stakeholders. We urge CMS to make information collected on these arrangements available to the public.

Despite the acknowledgment that more information is needed, the rule "puts the cart before the horse" by making immediate, significant changes in the rules on the financing of supplemental payments, provider taxes, and the use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs). It also subjects provider taxes and other financing arrangements to new, vague tests that give CMS substantial discretion whether to approve them, thereby leaving states with tremendous uncertainty. Yet the required regulatory impact analysis says the "fiscal impact on the Medicaid program from the implementation of the policies is unknown."

Before changing the rules on how states finance their share of Medicaid expenditures, CMS should get the information it needs to determine whether supplemental payments, provider assessments, and other financing arrangements are consistent with statutory requirements, whether they advance the objectives of Medicaid, whether changes in the rules governing these arrangements are necessary, and what the impact of any such changes would be. While the proposed rule significantly increases state reporting requirements, it's not clear that information that would be collected would ensure that CMS can properly regulate state financing arrangements nor is it clear whether the information would be in a format accessible to stakeholders.

Making changes without solid, usable information could have a detrimental impact on Medicaid beneficiaries by upsetting longstanding, legitimate financing arrangements. States would have to substitute general or other revenue for the revenue they now receive through provider taxes or through IGTs or CPEs, which would be difficult in many states. If they couldn't adequately finance their share of Medicaid expenditures, they would have to make harmful cuts in provider payments, benefits or eligibility.

We urge CMS to withdraw this rule and instead establish a transparent process to (1) determine what information is essential to better understand state financing arrangements; (2) develop and implement a plan for obtaining that information; and (3) disseminate the information CMS gathers during this process in a public and accessible format. Changes in policy shouldn't be made without a full understanding of their impact when the impact of the changes could limit access to health care for low-income and vulnerable people.

**Major Changes in State Financing Rules Could Force States to Cut Benefits and Eligibility**

We agree that the financial integrity of the Medicaid program is important as is adherence to the statutory requirement in section 1902(a)(30)(A) that states have methods and procedures to assure Medicaid payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." While CMS relies on this provision as the basis for the proposed rule, it's worth noting that it recently rescinded a rule designed to ensure that beneficiaries have access consistent with the statutory requirement without putting anything in its place. CMS rescinded the "equal access" rule based on a claim that it was burdensome for states to collect information on whether provider payments were sufficient to ensure equal access.

The subject matter of the proposed Medicaid Fiscal Accountability Regulation is extremely complex, making it difficult for stakeholders, especially beneficiaries and their advocates, to develop comments that are based on a full analysis and understanding of the rule's impact on access to care. On top of the complexity, the lack of information, which CMS cites as one of its rationales for proposing the rule, makes it difficult to analyze the differential impact it will have on states and localities and across different groups of providers. Moreover, the rule would institute new and vague standards for judging state financing arrangements, such as "net effect" and "totality of the circumstances" tests, that would give CMS broad discretion in deciding whether these arrangements are acceptable, causing significant uncertainty and potential disruption for state budgets.

The challenge of determining the impact of this proposed rule is clear from its totally inadequate regulatory impact analysis (RIA), which provides an analysis of only one of the many changes the rule would make despite finding that the rule is economically significant. The RIA states that the fiscal impact on the Medicaid program from the implementation of the policies in the rule is "unknown." CMS should not be making significant changes in state financing arrangements that could have a significant impact on beneficiaries' access to care without a better understanding of the consequences.

While the vague nature of the new standards the rule would impose on provider taxes and other arrangements contributes to the "unknown" impact, it is clear that several policy changes, including the one provision the RIA does analyze, would have a significant impact and could significantly curtail the ability of states to finance their Medicaid programs and thereby impede beneficiaries' access to care.

*Limits on the Use of Intergovernmental Transfers Likely to Decrease Access to Care*

The rule would limit the use of IGTs as the state share of Medicaid expenditures by narrowing the definition of entities that can make IGTs and limiting the types of funds those entities can transfer. CMS would have discretion under a new "totality of the circumstances" test to decide whether entities qualify as state or non-state governmental providers able to make IGTs. Those that do qualify would only be able to use funds "derived from state or local taxes (or funds appropriated to a state university teaching hospital)" as the source of their IGTs. This would eliminate the ability of governmental providers to use commercial revenue or other non-federal funds as the source of an IGT, and significantly restrict funding available to use as IGTs, leaving big gaps in states' ability to fund their Medicaid programs. Most states would be unable to fill the gap with other revenue, making it likely they would have to cut provider payments, benefits or even eligible individuals from their programs.

States rely heavily on IGTs to fund the state share of supplemental payments to hospitals and other providers, including DSH payments. While it's true, as the preamble notes, that section 1903(w)(6) refers only to state and local taxes in prohibiting the Secretary from *restricting* states' use of IGTs, that provision does not prohibit a broader use of other revenue as IGTs, which has been longstanding CMS policy.

The proposed rule fails to analyze the impact of this change on the Medicaid program, but the impact is likely to be significant and harmful. CMS' main justification for the change is that state and non-state governmental providers may be using funds received from private providers as the source of their IGTs. Once the state receives the IGT from the state or non-state governmental providers,

the state then makes a supplemental payment to the private provider in violation of provisions prohibiting provider donations as a source of the state share. We agree such arrangements should be prohibited to the extent they are facilitating unlawful provider donations, but anecdotal reports of such arrangements don't legitimize the far-reaching change CMS proposes. CMS should instead use its existing authority to enforce limits on provider donations until it collects the information it needs to prohibit unlawful arrangements without sweeping in those that are legitimate.

The proposed rule would invalidate longstanding and legitimate use of IGTs to fund the state share of Medicaid expenditures, putting payments to hospitals and other providers and ultimately services for beneficiaries, at risk. Moreover, the changes on allowable IGTs would take effect immediately, giving states little time to figure out alternative financing arrangements to avoid Medicaid cuts.

*Limiting Supplemental Payments to Practitioners Likely to Decrease Access to Care*

Some states make supplemental payments to physicians and other practitioners to augment inadequate base payments. According to CMS, supplemental payments are most often directed to practitioners affiliated with academic medical centers and safety net hospitals. Currently, the upper payment limit for such payments is based on average commercial payment rates. The rule would limit the supplemental payments to 50 percent of base payments except for providers in Health Professional Shortage Areas, where the limit would be 75 percent of base payments.

CMS claims that states could address any problems the new limits cause by increasing base payments, which would allow for higher supplemental payments. But increasing base payments across-the-board would require increased general revenue that states may not have. Many of the providers receiving these payments are specialists in academic medical centers, including sub-specialists in children's hospitals. While the regulatory impact analysis does include a fiscal estimate for this provision, stating that it could reduce Medicaid expenditures from $0 to $222 million depending on state actions, it does not analyze how reductions would affect beneficiaries. Moreover, it does not account for other fiscal pressures states would experience from the rule, which would make it less likely that they would increase base payments to providers in order to mitigate the rule's impact.

*Requiring that Providers' Retain the Full Amount of Payments Could Limit Provider Participation*

The rule would require that state and non-state government providers receive and retain the full payment when the payment is based on a CPE. It would specifically prohibit the state from retaining any part of the payment as a processing or administrative fee if the fee is related to the amount a provider receives through a Medicaid payment or the amount a unit of government contributes through an IGT. We generally agree that those providing the service should receive the full payment for the services they provide. However, we are concerned that this may disrupt some arrangements local education agencies have with states that make it possible for school-based health providers to

participate in the Medicaid program, particularly small districts that rely on the state for processing their claims.[1]

*The Rule Substitutes Vague Standards for Budgetary Certainty*

States need certainty in determining how they finance their share of Medicaid expenditures, including the structure of their provider taxes, how they finance supplemental and DSH payments, and how much general revenue they need. Decisions on general revenue have a ripple effect in state budgets, affecting funding for other state priorities including education and transportation. The proposed rule would create significant uncertainty for states as to their financing arrangements, in large part because of the substantial discretion CMS would have in deciding whether to approve them based on new, vague standards.

As noted, CMS would use a "totality of the circumstances" test to determine whether entities qualify as non-state government providers. The rule also would:

- Institute a broad "net effect" standard that would be used to evaluate (1) whether a transfer of value is a provider-related donation, (2) whether a provider-related donation is bona fide, and (3) whether a health care-related tax contains an impermissible hold harmless provision. According to the proposed definition, the net effect of an arrangement would be determined "in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities, and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity."

- Require that states seeking waivers of the "broad-based" and "uniform" requirements for provider taxes show that the taxes don't place an "undue burden" on the Medicaid program, even if states show their proposals meet current statistical tests used to determine whether waivers should be granted.

- Require that states seeking authority to make, or continue to make, supplemental payments specify how the payments to individual providers promote "efficiency, economy, quality of care and access" without specifying the criteria that CMS will use in approving supplemental payments.

These standards and tests inject new uncertainty into state financing arrangements, making it harder for states to ensure they can adequately finance their Medicaid programs. The uncertainty and discretion afforded to CMS to disapprove longstanding arrangements could have a chilling effect on states, making it more likely that they make cuts to their Medicaid programs rather than risk disapproval of their provider taxes, IGTs and other financing arrangements. Importantly, the uncertainty regarding approval of provider taxes could discourage additional states from expanding Medicaid and possibly threaten the financing of existing expansions given that many states have

[1] See Arizona Health Care Cost Containment System, "Summary of AHCCCS Response to the Proposed Medicaid Fiscal Accountability Regulation," https://www.azahcccs.gov/shared/Downloads/News/2019/AHCCCSMFARSummary_200117.pdf.

financed their share of expansion expenditures through provider taxes. And of course, this chilling effect would be on top of the likelihood that cuts would be necessary due to disapproval of current financing arrangements.

**Reporting Requirements Should Provide Transparent Information Needed to Assure Financial and Program Integrity**

The rule responds to concerns about the lack of provider-specific information on supplemental payments that have been raised by the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Government Accountability Office by instituting new reporting requirements. We agree that reliable and specific information is needed to judge whether supplemental payments are promoting access and consistent with relevant requirements. Reporting requirements should be carefully designed to obtain information that is usable and transparent to the public, striking a balance between obtaining what's necessary while not being overly burdensome to states and other government entities.

The new requirements are extensive and potentially burdensome, but it's not clear they would provide CMS with information they would need to compare Medicaid payments with costs at the provider level, because of the absence of information on MCO payments. Moreover, the large amounts of data being collected may end up being unusable, because of an inability to reconcile information from different sources and time periods. Given the rule is purportedly intended to strengthen the fiscal integrity of the Medicaid program by better understanding state financing arrangements, it's important that reporting requirements be calibrated to obtain the needed information in a useable form.

**Conclusion**

If adopted in its current form, the proposed rule would force many states to make rapid changes in the way they finance their share of Medicaid expenditures. It's likely that most states would be unable to increase the amount of general revenue they devote to Medicaid to maintain spending at current levels, forcing them to make cuts in provider payments, benefits and even eligibility. But the lack of data and vagueness of many provisions of the rule make it impossible to fully understand its impact. We urge CMS to withdraw the rule in its entirety, and instead establish a process to obtain a full understanding of various financing arrangements, their impact on the program, and necessity for any potential changes.

Thank you for your attention to our comments. If you need further information, please contact Judith Solomon (solomon@cbpp.org) or Jessica Schubel (jschubel@cbpp.org).

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