Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

February 1, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: REF CMS-2393-P

Re: Medicaid Program; Medicaid Fiscal Accountability Regulation; Proposed Rule (84 *Federal Register* 63722, November 18, 2019)

Dear Ms. Verma:

The Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, appreciates the opportunity to comment on Centers for Medicare and Medicaid Services' (CMS) proposed Medicaid Fiscal Accountability Regulation (MFAR) to promote transparency and to establish new, and clarify existing, requirements applicable to states' financing of Medicaid payments.

CHA supports CMS' goals of ensuring that Medicaid payments to health care providers are consistent with the proper, efficient operation of the program and improving program transparency. However, we are deeply concerned that the proposed rule will constrain the ability of states to adequately finance their Medicaid programs and jeopardize Medicaid beneficiaries' access to care. Many of the proposals lack clarity and precision, which could create significant uncertainty for state Medicaid programs, state budgets, Medicaid providers and Medicaid beneficiaries. Furthermore, CMS does not currently have sufficient information about supplemental payments, the financing arrangements that underlie those payments, or the impact of this proposed rule on the Medicaid program and access to care to proceed.

If finalized, the proposed rule could force states to reduce the size of their Medicaid programs by covering fewer beneficiaries, restricting health care services or reducing provider payment rates. A recent analysis suggests the proposed rule could reduce Medicaid program by $37 billion to $49 billion in annual funding, with $23 to $31 billion of those losses falling on hospitals and

health systems.[1] But the real loss will be to Medicaid beneficiaries, who include our nation's most vulnerable seniors, individuals with disabilities, children and adults and who would face reduced access to health coverage and consequently to medical care. **We urge CMS not to finalize the proposed MFAR.**

Section 1902(a) (30) (A) of the Social Security Act (the Act) requires that states pay Medicaid providers an amount "consistent with efficiency, economy, and quality of care and… sufficient to enlist enough providers so that care and services are available… at least to the extent that such care and services are available to the general population in the geographic area." Under Medicaid's federal-state partnership model, states seek to uphold these statutory requirements by employing a broad range of statutorily authorized approaches for financing the non-federal share of Medicaid payments, including provider taxes, intergovernmental transfers (IGTs) and certified public expenditures (CPEs). These sources of funding help states finance the basic workings of the program (e.g., base payments) as well as supplemental payments, including disproportionate share hospital (DSH) payments, fee-for-service payments made under the upper payment limit (UPL) and Section 1115 waiver payments. Since Medicaid often reimburses providers at well below the cost of care, supplemental payments have evolved into a critical component of the Medicaid payment ecosystem and help ensure that providers are able to continue to care for Medicaid's most vulnerable beneficiaries.

Proposed limits on financing the non-federal share of Medicaid payments will jeopardize access for beneficiaries.

The proposed rule would establish new limits on provider taxes, IGTs, and CPEs - legitimate and commonly used sources of non-federal share financing - that would make it difficult for states to adequately finance their Medicaid programs. It would unravel or create uncertainty related to many of these statutorily permitted sources of financing, disrupting major elements of how states finance the non-federal share of Medicaid. Faced with underfunded Medicaid programs, states would be forced to consider cutting provider rates, raising taxes or jeopardizing coverage and access to care for beneficiaries.

States' use of health-care related taxes to finance their Medicaid programs would be subject to new, expansive and poorly defined rules that could result in more of those arrangements being determined to be impermissible. In the proposed rule, CMS seeks to amend regulations governing health care related taxes, including:

- Introducing a "net effect" standard to supplement current regulations prohibiting "any direct or indirect payment, offset, or waiver" that directly or indirectly holds harmless the entity paying the tax. Under the proposed rule, CMS could judge whether, "considering the totality of circumstances, the net effect of an arrangement between the State (or other unit of government) and the taxpayer (i.e., provider) results in a

[1] Manatt Health analysis January 2020.

reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount." It is not clear how CMS will determine whether a "reasonable expectation" of a hold harmless exists, nor is any process laid out for states to contest CMS's findings. Providers enter into myriad arrangements with each other for various legitimate business reasons; under the proposed rule, any agreement between two providers could be subject to scrutiny and put the State's entire provider tax at risk.

- Introducing a new "undue burden" standard that would allow CMS to override the mathematical tests in current regulation used to approve waivers of broad-based and uniform tax requirements. State policymakers could never be certain whether a tax is approvable based on this standard. CMS also proposes such waivers be renewed every three years, which may not be feasible or appropriate for every state waiver and could be an obstacle to state's ability to adequately fund their programs.

In addition, the proposed rule would limit states' ability to generate the non-federal share in a number of other ways, with potential implications for beneficiary access to care. Proposed changes to the standards for IGTs would limit the entities that can make IGTs and give discretion to CMS to use an undefined "totality of the circumstances" test to rule on whether an entity that is a public entity under state law and rules is in CMS's view a public entity eligible to make an IGT. This introduces more uncertainty for state Medicaid programs and represents undue federal interference in matters appropriately left to states. In addition, the types of funds that could be used as IGTs would be limited to those "derived from state or local taxes" or appropriated to a state university teaching hospital. There is no sound policy or legal basis for limiting state teaching hospitals and other clearly public entities from using any of their funds – other than federally derived dollars – for IGTs. The distinctions made by the proposed regulations are inconsistent with state laws and budgeting and would produce arbitrary results across similarly situated public entities.

The effect of the above proposals would be to limit the funding that states could use to pay for their share of costs of the Medicaid program. If states were unable to replace those amounts with alternative funds —from general revenues, new taxes, or from other state budget resources — Medicaid programs would need to be cut. Cuts to Medicaid mean that fewer people receive Medicaid coverage, that their coverage provides fewer services, and/or that reimbursement reductions limit provider access. Any and all of these outcomes would have significant implications for access to medical care for the poorest and most vulnerable among us.[2]

[2] A large body of literature ties provider payment rates to access to Medicaid beneficiaries. For example, see D. Alexander and M. Schnell, *Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health* at https://economics.stanford.edu/sites/g/files/sbiybj9386/f/alexander_schnell_2018.pdf; Y. Shen and S. Zuckerman, The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries; *Health Services Research*, June 2005, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361165/; S. Decker, Changes in Medicaid Physician Fees and Patterns of Ambulatory Care, *Inquiry*, 2009, 46, 291–304.

Undefined terms will permit too much discretion, leading to substantial uncertainty for states and providers.

The proposed rule would introduce a number of highly subjective, undefined terms into the regulations that would give CMS substantial and broad discretion to approve or disapprove non-federal share financing mechanisms. States would be unable to predict with any certainty their ability to finance Medicaid at given levels, potentially harming beneficiary access to care.

For example, health care related tax programs determined to impose an "undue burden" on the Medicaid program would be prohibited, even if such taxes technically meet the statutory broad-based and uniform waiver requirements. The level of burden that is considered "undue" is not defined. The "totality of circumstances" and the "net effect" of health care related taxes would be examined when determining if they are permissible arrangements. The "net effect" is loosely defined to include the "totality of circumstances." The term "totality of circumstances," however, is not defined at all.

If finalized such unclear and undefined standards of review would provide CMS with wide latitude to prohibit non-federal share financing and supplemental payment arrangements it deems inconsistent with Medicaid statute and regulation. This would make it difficult for states to know which arrangements are permissible, how to come into compliance, and whether CMS will maintain a consistent view of compliance over time, both within and across administrations. Moreover, the requirement that supplemental payments and certain tax programs be reapproved every three years introduces a further degree of uncertainty. A state would have no assurance that subsequent CMS reviewers would permit the continuation of previously approved financing and/or payment provisions. The cumulative effect of the uncertainty could lead states to eliminate or scale back existing lawful arrangements and hesitate to establish new approaches to financing Medicaid improvements, such as new opioid treatments, expanded coverage, or optional benefits. CHA is concerned that these proposed changes, also, could result in limiting access to health care for people who rely on Medicaid.

Supplemental payments to make up for inadequate base payments will be undermined.

The Medicaid statute requires payment rates that are sufficient enough to ensure that Medicaid beneficiaries have the same access to care that other individuals in the area have.[3] Base payments, however, have historically been well below providers' costs and below the amounts that Medicare pays for the same services.[4] In response states have relied on supplemental payments to ensure continued sufficient access to care. For example, states began making

[3] 42 U.S.C. 1396a (a)(30) (A).
[4] MACPAC, wrestling with the impact of low provider payments on access to care for beneficiaries found that in 2011 FFS base payment rates were below hospitals' costs of providing services to Medicaid beneficiaries and below Medicare rates for comparable services. MACPAC Issue Brief, *Medicaid Base and Supplemental Payments to Hospitals*, March 2019, https://www.macpac.gov/wp-content/uploads/2018/06/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

supplemental payments following the recession of 2008 to ensure access to Medicaid could be maintained.[5] They continue to be one of the tools states use to make providers whole and to ensure that enrollees continue to be able to access a reasonable network of providers.

As discussed above, the proposed regulation attempts to constrain supplemental payments through the regulation of nonfederal sources of financing applicable to the Medicaid program writ large. However, in addition CMS proposes a new standard to its review of supplemental payment submissions and requires that supplemental payment state plan amendments must be renewed every three years. The new standard for review, however, is vague and open-ended, leaving states with no guidance on how to meet program requirements, putting all of these payments at risk.

CMS has also proposed capping supplemental payments for physicians and other practitioners at 50% of fee-for-service base payments or 75% of such payments for services in designated health professional shortage areas. CMS does not provide data or evidence to indicate that supplemental payments in excess of those thresholds are excessive and does not evaluate the impact that those ceilings would have on access to services for Medicaid beneficiaries. Moreover, the proposed changes would have a particularly negative effect on physicians in states with the lowest base payments. Hospitals, health care systems, long-term care facilities and Medicaid beneficiaries all rely on there being sufficient access to physicians and to primary health care providers. A provision that impacts access to those providers will have reverberations on all of our providers' ability to care for Medicaid beneficiaries.

These restrictions on states' use of supplemental payments could threaten Medicaid beneficiaries' access to providers and practitioners. While the statute requires that Medicaid base rates be adequate to ensure sufficient provider access, CMS' earlier proposal to rescind requirements on states to monitor the impact of provider payment rates on access suggests the requirement will not be adequately enforced.

CMS proposed the rule without an adequate regulatory impact analysis.

While CHA is supportive of CMS's commitment to fiscal stewardship and transparency, implementing a rule with such far-reaching implications is premature without further analysis and deliberation. CMS provided a regulatory impact analysis for only one of the many provisions included in the proposed MFAR. Despite the well-known connection between payment rates and access to care, CMS did not examine the impact of any of the provisions on access to medical care for beneficiaries. Nor did CMS adequately consider potential provider burden resulting from the proposed rule's new reporting provisions as states will undoubtedly require additional

[5] Mann, C. and Bachrach, D. Integrating Medicaid Supplemental Payments into Value-Based Purchasing, November 22, 2016, https://www.commonwealthfund.org/publications/fund-reports/2016/nov/integrating-medicaid-supplemental-payments-value-based.

reporting from providers as they comply with CMS' new requirements. A financial impact estimate was provided for only the one provision.

A rule that could potentially jeopardize many of the funding streams that states have put in place to address chronic underfunding and ensure that an adequate number of providers are available demands greater understanding of its impact than we now have. This position is shared by the Medicaid and CHIP Payment and Access Commission, which concluded in a recent public meeting that there is currently insufficient publicly available data to analyze key provisions of the rule and recommended that CMS take a more cautious approach to implementing these reforms. Indeed, the regulatory impact analysis in the proposed rule itself makes clear that CMS does not have the information needed to quantify the anticipated impact of the proposed rule or even to design an audit for reporting purposes (proposed rule at 63,773-74).

Because of our deep concerns that this proposal will deprive the states of the ability to adequately fund their Medicaid program and therefore will cause children, families, the elderly and people with disabilities to be denied access to health care, CHA urges CMS to withdraw this rule in its entirety. If CMS believes changes are necessary, it should work states, providers, and other stakeholders in a deliberative process to ensure the sustainability, transparency, and integrity of the Medicaid program without jeopardizing beneficiaries' access to care.

Thank you for the opportunity to comment on the Medicaid fiscal accountability proposed rule. We look forward to a continued partnership to strengthen and improve Medicaid for the people it serves. If you have any questions about these comments, please do not hesitate to contact me or Kathy Curran, CHA senior director, public policy, at 202-721-6300.

Sincerely,

Lisa A. Smith
Vice President
Advocacy and Public Policy