Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC SUBMISSION

January 23, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments to CMS-2393-P
Proposed Rule: Medicaid Program; Medicaid Fiscal Accountability Regulation

Dear Sir or Madam:

The Center for Children and Families (CCF), part of the Health Policy Institute at the McCourt School of Public Policy at Georgetown University, is an independent, nonpartisan policy and research center that conducts research, develops strategies and offers policy solutions to improve the health of America's children and families, particularly those with low- and moderate-incomes. Thank you for this opportunity to make the following comments to the CMS proposed rule.

More than 30 million low-income children rely on Medicaid for their health coverage, accounting for well over 40 percent of all Medicaid beneficiaries. We therefore believe that any proposed rule related to Medicaid should be evaluated not only for its likely effects on all beneficiaries and their access to needed care but also particularly for its effects on children and their families. As discussed further below, we strongly oppose nearly all provisions of the proposed rule because the rule would likely result in serious harm to state budgets, health care providers and low-income Medicaid beneficiaries including children and families.

The rule would have a significant harmful impact because the proposed rule would establish new broad, ill-defined standards for review and approval and make substantive technical changes to federal requirements for state financing and supplemental payment arrangements that would likely result in states eliminating or scaling back such arrangements over time. If, as is likely, states are unable to identify other financing sources, such as higher taxes or cuts to other parts of their budget, states would have no choice but to institute overall cuts to their Medicaid program in the areas of eligibility, benefits and provider payments. Similarly, if states are unable to increase payments to

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health care providers in other ways to substitute for current supplemental payments, such as raising base payments, providers could experience significant financial instability. Millions of children and families, as well as seniors, people with disabilities and other adults, could thus experience reduced access to needed care if states make damaging programmatic cuts and if providers are unable to provide their existing array of services to Medicaid beneficiaries.

Instead, any final rule should only include some new limited public reporting and data collection requirements related to current state financing and supplemental payments that are designed to assess whether the development of any new regulations or policies is necessary, minimize administrative burden and allow for a reasonable implementation and compliance timeframe for states and providers. Once such data is reported reliably and accurately, it would allow for comprehensive CMS analysis and for CMS to work collaboratively with states, providers, beneficiaries and other stakeholders to develop far more reasonable, narrowly-targeted and well-defined changes to state financing and supplemental payment regulations that could address potential violations of the current statutory and regulatory requirements but without risking indiscriminate, widespread harm to state Medicaid programs. Moreover, unlike the case with this proposed rule, such an information and data collection-first approach would allow CMS to conduct a sufficient Regulatory Impact Analysis of, and stakeholders to make meaningful, substantive comments to, subsequent policy changes included in any future proposed CMS rulemaking.

1. Proposed Rule Would Make Major Changes to Existing Requirements for State Financing and Supplemental Payments

The proposed rule would establish new broad, ill-defined standards of review and approval of financing and supplemental payment arrangements that give excessive discretion to CMS. These standards would apply not only to new arrangements but also to existing arrangements that have already been approved by CMS and have been in place for many years. Examples include:

- States may now raise funds through provider taxes operating under waivers of the federal uniform and broad-based requirements if the taxes meet certain CMS-mandated mathematical tests. But under the proposed changes to 42 C.F.R. § 433.68, such provider tax waivers must not only continue to meet the tests but must also satisfy a new "undue burden" standard under which CMS would find whether the tax applies disproportionately to Medicaid providers using, among others, a consideration of the "net effect," "totality of the circumstances," "reasonable expectations" of participating entities and a reasonable determination by CMS.

- In determining the governmental status of a provider for purposes of calculating the upper payment level for supplemental payments, a "totality of the circumstances" test would be used under the proposed changes to 42 C.F.R. § 447.286.

- Under the proposed changes to 42 C.F.R. § 447.252 and 42 C.F.R. § 447.302, states would also have to indicate how supplemental payments are consistent with "economy, efficiency, quality of care and access," which are longstanding general federal requirements for state Medicaid programs, but CMS does not establish specific criteria for how these state justifications of supplemental payments would be evaluated.

Moreover, the proposed rule would newly require that all existing provider tax waivers and supplemental payment arrangements be limited to a three-year duration. While states could subsequently renew these provider tax waivers and supplemental payments, these renewals would be subject again to these new standards of review and approval. As a result, the proposed rule would likely inject significant uncertainty into state Medicaid programs for states and health care providers. Because the proposed standards of review are so vague and give CMS so much discretion — as the proposed rule does not sufficiently spell out what would constitute an undue burden, what an examination of the totality of circumstances or net effect would entail or how supplemental payments must be consistent with economy, efficiency, quality of care and access — and because reviews would occur at least every three years, the proposed rule could have a large chilling effect.

The proposed rule would also impose numerous substantive technical changes to longstanding requirements governing state financing and supplemental payment arrangements that could explicitly bar or restrict current arrangements. Examples include:

- Under current law, public providers may make intergovernmental transfers (IGTs) derived from any public funds. In contrast, under the proposed changes to 42 C.F.R. § 433.51, the proposed rule would limit IGTs to funding derived from state and local taxes or appropriations to teaching hospitals. That would effectively bar IGTs composed of private insurance revenues and charitable donations, even though many public hospitals rely on tax revenues to a much lesser extent than in the past. As a result, this could reduce the amount of IGTs available to finance state Medicaid programs and if states are unable to replace that funding with other sources such as general revenues, this could lead to states cutting their Medicaid programs.

- Under the proposed changes adding 42 C.F.R. § 447.406, the proposed rule would set a new upper limit on supplemental payments to physicians and other practitioners equal to 50 percent of base payments (and 75 percent for services in a Health Professional Shortage Area) that is lower than current federal requirements. Supplemental payments to practitioners may not now exceed the Average Commercial Rate, which is higher than the proposed limit.

As a result, under not only the provisions cited above but other provisions of the proposed rule, the rule could significantly prohibit or limit existing financing for Medicaid derived from provider taxes, IGTs and/or certified public expenditures (CPEs) and existing supplemental payments state Medicaid programs are making to health care providers. States could also end up eliminating or significantly scaling back current financing and

payment arrangements in their Medicaid programs out of fear and confusion due to the new overly broad and ill-defined review and approval standards and excessive discretion that would be provided to CMS.[1]

2. Proposed Rule Includes Virtually No Analysis of the Likely Harmful Impact on the Medicaid Program

Wholly inconsistent with both Executive Order 12866 and the requirements of the Administrative Procedure Act, the proposed rule includes virtually no Regulatory Impact Analysis of the likely harmful effects of the proposed rule on the Medicaid program. It states that the "fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is *unknown*" [italics added]. The rule further notes that "we do not have sufficient data to predict or quantify the impact of the proposed provisions on health-care related taxes…."

The only estimates of the fiscal effects on state Medicaid programs that CMS provides are for the administrative costs associated with compliance with new proposed reporting and data collection requirements and the single proposed provision establishing the new, lower limit on Medicaid supplemental payments to physicians and other health practitioners. CMS estimates that were such a supplemental limit provision in effect in fiscal year 2017, it would have reduced total Medicaid expenditures anywhere from $0 to $222 million. Notably, even with this estimate of the single provision, which suffers from a high degree of uncertainty, CMS does not include any analysis of the resulting impact on beneficiaries or their access to care.

The proposed rule also does not specify any benefits of the proposed rule, only claiming that the rule would ensure states are complying with the general federal "efficiency, economy and quality of care" requirements for Medicaid programs overall. Similarly, in discussing how the proposed rule is better than the regulatory alternative of not proposing the rule at all, CMS only mentions the benefits of greater data reporting to support more adequate analysis and oversight of supplemental payments to providers. But there is no discussion of the benefits of the major elements of the rule making changes to the review and approval standards or making substantive technical modifications to the federal requirements for state financing and supplemental payment arrangements.

Even though it is CMS' obligation to assess and estimate the impact of the proposed rule on the Medicaid program including on states, providers and beneficiaries — especially in the absence of any new statutory changes necessitating this rule — the proposed rule instead merely invites "comments from states, providers and other stakeholders on the estimates and potential state responses to these provisions." However, as is likely the case with other

[1] See Edwin Park, "Administration Fails to Assess Impact of Major Changes Proposed for State Medicaid Financing and Supplemental Provider Payments," *Health Affairs Blog*, January 16, 2020, available at https://www.healthaffairs.org/do/10.1377/hblog20200116.391921/full/ and Cindy Mann and Anne O'Hagen Karl, "Proposed Rules on Medicaid Financing Miss Mark And Threaten Access," *Health Affairs Blog*, January 8, 2020, available at https://www.healthaffairs.org/do/10.1377/hblog20200108.392104/full/.

stakeholders, we are unable to conduct a detailed assessment of the proposed rule, comment meaningfully on the specific impact of the new review standards and agency discretion and substantive changes on individual state financing and supplemental payment arrangements, and/or estimate the specific impact on individual states' Medicaid budgets, health care providers and beneficiaries. This is due, in part, to the complexity of existing financing approaches and supplemental payments across the states, the lack of publicly available information about existing arrangements and the absence of reliable, accurate outside analysis of how the proposed rule would affect Medicaid programs on a state-by-state or provider-specific basis. It is also the result of significant uncertainty from the new vague and ill-defined standards financing and supplemental payment arrangements that would provide undue discretion to CMS in reviewing and approving both existing and new state practices which would make it difficult for stakeholders to assess how such standards would be applied in individual cases.

Nevertheless, it is highly likely that the proposed rule could have a significant, widespread and harmful effect on most state Medicaid programs. For example, the Kaiser Family Foundation found that in state fiscal year 2019, 49 states plus the District of Columbia used one or more provider taxes to finance their share of the cost of Medicaid programs (42 states plus the District of Columbia had hospital provider taxes, 44 states plus the District of Columbia had nursing home provider taxes, 34 states plus the District of Columbia had provider taxes on intermediate care facilities for those with intellectual disabilities and 14 states had taxes on managed care organizations.)[2] Moreover, the preamble to the proposed rule states that about 35 states currently have provider tax waivers, although it does not specify which states have such waivers. Moreover, while more recent data do not appear to be available, GAO found that in fiscal year 2012, 31 states used IGT funding and 28 states plus the District of Columbia used CPEs.[3] In fact, in 2012, 26 percent of the non-federal

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[2] Kaiser Family Foundation, "States With At Least One Provider Tax In Place," available at https://www.kff.org/medicaid/state-indicator/states-with-at-least-one-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Kaiser Family Foundation, "States With a Hospital Provider Tax in Place," available at https://www.kff.org/medicaid/state-indicator/states-with-a-hospital-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Kaiser Family Foundation, "State With a Nursing Facility Provider Tax in Place," available at https://www.kff.org/medicaid/state-indicator/states-with-a-nursing-facility-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Kaiser Family Foundation, "States With an Intermediate Care Facility for Those With Intellectual Disabilities (ICF-IDs) Provider Tax in Place," available at https://www.kff.org/medicaid/state-indicator/states-with-an-intermediate-care-facility-for-those-with-intellectual-disabilities-icf-ids-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; and Kathleen Gifford et al., "A View from the States: Key Medicaid Policy Changes," Kaiser Family Foundation, October 2019, available at https://www.kff.org/medicaid/report/a-view-from-the-states-key-medicaid-policy-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2019-and-2020/.

[3] Government Accountability Office, Table B#2 in "Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 to 2012 (GAO-15-227SP, March 2015), an E-Supplement to GAO-14-627," available at https://www.gao.gov/special.pubs/gao-15-227sp/index.htm.

share of Medicaid costs, on average, were financed from provider taxes (10.4%) and IGTs and CPEs (15.5%), with those percentages likely higher today especially with more states now relying on provider taxes.[4] If states are unable to replace funding derived from providers and IGTs/CPEs with other financing sources — such as general revenues generated from higher taxes or from cuts to other parts of their budgets — states would have no choice but to reduce their spending on their Medicaid programs. Under the federal-state Medicaid financial partnership, fewer state dollars spent on Medicaid means fewer federal Medicaid matching funds and much larger total cuts to Medicaid overall, including cuts in the areas of eligibility and benefits that adversely affect children and families and their access to needed care.

In addition, according to the Congressional Research Service, with the exception of Alaska, Delaware and Vermont, all states and the District of Columbia provide supplemental fee-for-service payments to health care providers outside of the Disproportionate Share Hospital program, although the magnitude of those payments varies considerably by state.[5] MACPAC estimates that total federal and state non-DSH payments equaled $28.4 billion in fiscal year 2018 (with another $14.3 billion in various payments to hospitals provided through section 1115 waivers).[6] While only a portion of these existing payments may ultimately be affected by the rule, this gives a sense of the potentially large fiscal impact if states were to reduce their existing supplemental payments and were unable to increase their base provider payments. This could destabilize hospitals, nursing homes and other health care providers, causing them to reduce the availability of services to low-income Medicaid beneficiaries. Children, families and other beneficiaries like seniors, people with disabilities and other adults could face highly inadequate provider networks and be unable to access needed care on a timely basis.

3. Final Rule Should Include Only New Limited Reporting and Data Collection Requirements

With one exception, discussed below, CMS should withdraw all provisions of the proposed rule. That includes withdrawal, among others, of new standards for review and approval of state financing and supplemental payment arrangements, periodic renewal of provider tax waivers and supplemental payments, and substantive modification of existing federal requirements related to financing and supplemental payments.

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[4] Government Accountability Office, "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection," Reissued March 13, 2015, available at https://www.gao.gov/products/GAO-14-627.

[5] Congressional Research Service, "Medicaid Supplemental Payments," Updated December 17, 2018, available at https://fas.org/sgp/crs/misc/R45432.pdf.

[6] Georgetown University Center for Children and Families calculations based on Medicaid and CHIP Payment and Access Commission, MACStats Exhibit 24: Medicaid Supplemental Payments to Hospital Providers by State and Exhibit 25: Medicaid Supplemental Payments to Non-Hospital Providers by State, December 2019, available at https://www.macpac.gov/macstats/medicaid-benefits/.

Instead, if there is any final rule, it should only include limited public reporting and data collection requirements related to supplemental payments and state financing that would improve transparency and oversight and would facilitate any future rulemaking, as described further below. Such public reporting and data collection requirements could be similar to the reporting related to supplemental payments and state financing in proposed 42 C.F.R. § 447.288(c) and to prior supplemental payment reporting recommendations of the Medicaid and CHIP Payment and Access Commission (MACPAC).[7] CMS, however, should ensure such requirements are designed to be usable and actually help assess whether any new policies or regulations are necessary to address issues that cannot be remedied with existing statutory and regulatory authority. It should also limit such reporting and data requirements in ways that minimize the administrative burden on states and providers. CMS should also establish a far more reasonable multi-year timeframe to allow for adequate planning and implementation by states. Otherwise the reported data is likely not to be reliable, accurate and meaningful. Finally, CMS should make the information publicly available in an accessible format for stakeholders.

This data, along with detailed, comprehensive CMS analysis of such information and necessary collaboration with states, providers, and beneficiary advocates, would then allow for the later development of more reasonable, narrowly-targeted and well-defined approaches that could address violations of the current statutory and regulatory requirements related to financing and supplemental payments — to the extent that they are necessary because current federal regulations do not already address them — but without risking indiscriminate, widespread harm to state Medicaid programs. Importantly, unlike under the proposed rule, it would also allow CMS to conduct a sufficient, comprehensive Regulatory Impact Analysis to determine the likely effect on Medicaid of any proposals included in future CMS rulemaking related to state financing and supplemental payments (including the impact on states, providers and beneficiaries including children and families) that fully complies with Executive Order 12866 and the requirements of the Administrative Procedure Act. Moreover, unlike under the proposed rule, such a data collection-first approach would also allow stakeholders, including those representing low-income children and families and other Medicaid beneficiaries, to evaluate the reported data independently and later make meaningful, substantive comments to any proposed policy changes.

[7] Medicaid and CHIP Payment and Access Commission, "Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments," March 2014, available at https://www.macpac.gov/publication/ch-6-examining-the-policy-implications-of-medicaid-non-disproportionate-share-hospital-supplemental-payments/.

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Thank you again for the opportunity to make the above comments to the proposed rule. Please contact me at Edwin.Park@georgetown.edu if you have any questions or if we can be of further assistance.

Respectfully submitted,

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