February 1, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: **Medicaid Program; Medicaid Fiscal Accountability Regulation, RIN 0938–AT50/CMS–2393–P**

Dear Administrator Verma,

The National Health Law Program appreciates the opportunity to submit comments regarding the proposed Medicaid Fiscal Accountability Regulation. We strongly oppose the proposed changes to the existing regulations that impose vaguely defined new restrictions jeopardizing States' ability to fund the nonfederal portion of Medicaid payments. The new rules, if finalized, could invalidate or require changes to many existing financial arrangements without a clear mechanism to adhere to the proposed standard, which would inject uncertainty into state Medicaid funding and destabilize state Medicaid programs. By extension, the proposed changes may cause unintended consequences that ultimately limit coverage and access to needed care for millions of people who rely on Medicaid – children, pregnant women, people with disabilities, older individuals and other underserved populations.

The subject matter of the proposed rule is extremely complex and the lack of specifics makes it difficult for us to respond to the rule's potential impact on access to care. We are, however, very concerned that the proposed rule will directly affect all individuals on whose behalf our organization works.

Impact of the Proposed Rule

The proposed rule would have a significant detrimental impact on how states finance their Medicaid programs and pay providers like hospitals, nursing homes and clinicians. It could lead states to cut benefits and eligibility as well as provider payments, jeopardizing access to care for over 70 million Medicaid beneficiaries. HHS says it 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 rather than seek to obtain that better understanding, HHS would severely restrict states' ability to use these mechanisms to finance their share of Medicaid expenditures and reimburse providers.

The proposed rule would make a number of highly technical policy changes that could prohibit or limit ways that states finance their share of Medicaid expenditures or provide supplemental payments to providers. For example, under current law, public providers may make "Intergovernmental Transfers" (IGTs) using any public funds. The proposed rule would limit the source of IGTs to funds from state and local taxes or funds appropriated to teaching hospitals. That would effectively prohibit public providers from using private insurance revenues or charitable donations to fund IGTs. As a result, the proposed rule would likely reduce the amount of IGTs if states are unable to replace IGT funding with other sources such as general revenue. In many states, this likely could lead to cuts in their Medicaid programs. Because fewer state funds for Medicaid results in fewer federal Medicaid matching funds, the cuts would be much larger than the shortfall in state funding. The proposed rule also seeks to limit the use of provider taxes and other existing, legal funding mechanisms states utilize to pay their share of Medicaid costs. It also would restrict the use of supplemental payments.

Discretionary Standards

We are also concerned that the proposed rule would establish discretionary standards of review for states' Medicaid financing arrangements and supplemental payments that would create uncertainty about what is allowable. These standards would apply to both new and current financing and payment arrangements that HHS approved and have been in place for many years.

Effectively, HHS seeks to adopt a broad, "we know it when we see it" approach to defining key standards for approving provider taxes, certified public expenditures, and intergovernmental transfers. HHS relies on poorly explained terms like the "totality of circumstances" or "net effect" that leave tremendous discretion to the agency and may make it difficult for states to know what is permissible and what is not.

The proposed standards of review give HHS too much discretion and fail to explain how HHS would apply them, which could lead to geographic, or other unexplained differences between states. Further, because HHS would conduct reviews at least every three years for certain provider taxes and all supplemental payments, states could end up eliminating or significantly scaling back existing financing and payment arrangements in their Medicaid programs out of fear and confusion.

Provider Taxes

We are concerned that the proposed changes would simply make it harder for states to use provider taxes in any circumstance. In the preamble, HHS describes several specific examples where it argues that some currently approved taxes that meet the regulatory statistical tests to show that they are redistributive actually violate the spirit of the statute. The GAO and Office of the Inspector General have made recommendations in prior years that HHS reevaluate the effectiveness of these tests.

However, it appears that rather than address these specific cases with targeted regulatory fixes, the proposed rules impose extremely broad new tests for both showing that a provider tax is "generally redistributive" and proving that the tax does not include any agreement that providers will be held harmless for any portion of the test. In both cases, HHS proposes that on top of the existing specific statistical tests to determine waiver compliance, HHS will consider "the totality of circumstances" regarding whether a tax puts an "undue burden" on services paid

for by Medicaid, such as by excluding or charging a lower rate on taxpayers groups defined by their level of Medicaid activity. This includes any arrangement whereby HHS determines the taxpayer group parameters to be a proxy for Medicaid activity.[1] A second "direct guarantee" test would add new language that would invalidate any tax if, based on the "totality of circumstances," its "net effect…results in reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party."[2]

This leaves states with no clarity on whether an existing or proposed new tax will satisfy the regulation, and will likely chill participation in these funding mechanisms. Currently, the "guarantee test" prohibits direct (explicit) guarantees of reimbursement for taxes paid, and applies a second test of an "indirect" guarantee. The indirect guarantee test includes a safe harbor provision that deems tax structures compliant if the revenue from the tax does not exceed six percent of the taxpayers' patient revenues. To date, every approved provider tax has stayed below this six percent cap to meet the indirect guarantee test.

The breadth of the proposed language for a direct guarantee may render the direct/indirect distinction meaningless, effectively subsuming the indirect guarantee test and the 6 percent cap. For example, the second prong of the indirect guarantee test would allow a provider tax exceeding six percent of total patient revenues provided that fewer than 75 percent of the taxpayers in the class receive back at least 75 percent of their tax costs back through Medicaid or other state payments.[3] Depending on how HHS interprets the proposed direct guarantee test language, it could find that some or most providers in the taxpayer class had a "reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount." Even if that return was due an increase in payments for Medicaid services, HHS might interpret it as a reasonable expectation of return and invalidate the tax. Without clarity about the difference between a direct and indirect guarantee, it appears the proposed language could endanger almost any provider tax.

It may be that HHS has allowed itself more discretion in an attempt to forestall novel financial arrangements that it has not yet imagined. But proposing such broad discretion increases confusion and the chance for arbitrary, inconsistent decisions from the agency. It even opens the door for discriminatory action against certain states. A better approach would be to first

[1] 84 Fed. Reg. 63778. Proposed amendment to 42 C.F.R. § 435.68(e)(3)(iv).
[2] 84 Fed. Reg. 63778 (Nov. 18, 2019). Proposed amendment to 42 C.F.R. § 433.68(f)(3).
[3] 42 C.F.R. §433.68(f)(3)(i)(B)

collect more information on the mechanisms in use and then propose specific language that address the flaws in those approaches without creating a blanket ban on potentially all existing provider taxes that could put state Medicaid financing in chaos. As one example that could result from the proposed rule, Arizona predicts that several of its currently approved taxes would be no longer permissible under the proposed changes. Further, both approved and proposed taxes in California, Ohio, Michigan, and Illinois appear to potentially match scenarios that HHS describes as inconsistent with its proposed rules.

Intergovernmental Transfers (IGTs)

In addition to placing new limits on provider taxes, the proposed rules include substantial changes to the rules governing IGTs that would unnecessarily limit states flexibility to finance the nonfederal share of Medicaid. We have similar concerns about these changes.

The rules propose to limit IGTs to public funds derived from state and local taxes.[4] The NPRM claims that this is just following the statute, but the statute sets state and local taxes as a floor, not a upper limit, on funds the Secretary could allow for IGTs.[5] The statute certainly allows HHS the discretion to be more generous in revenue sourcing, and it is not clear what is gained by limiting IGTs so strictly.

Certified Public Expenditures

Adding to the confusion and concern for unintended consequences around this proposed rule, school superintendents have written that the proposed changes for Certified Public Expenditures (CPE) – another mechanism states us to general nonfederal match – might interfere with school Medicaid funding because the proposed rule restricts CPEs by limiting them to only claims that have been processed through MMIS. This despite the fact that HHS has worked with some states for many years to create and allow CPEs in some school-based Medicaid initiatives that do not require reporting through MMIS. The proposed rule could disrupt these arrangements.

[4] 42 C.F.R. § 433.51(b).
[5] 42 U.S.C. § 1396b(w)(6).

Approval time limits

The time limit on approvals for supplemental payment SPAs, provider taxes, IGTs and CPEs will add administrative burden to state Medicaid agencies. HHS has to find a better balance between the tendency for provider classes or ownership to change over time with the added burden on state governments to reapply for waiver approvals every 3 years.

The NPRM does not justify the three year length of time between renewals, save comparing it with the length of Section 1115 waiver initial approvals. Yet Section 1115 waivers are intended as testable, temporary experiments. These Medicaid financing arrangements are not time-limited experiments and so are not comparable. It may be reasonable to ask a state to amend its SPA if the terms of the SPA change materially, but requiring a periodic renewal over an arbitrary length of time is bad policy.

Fiscal Impact and Administrative Requirements for Proposing a Rule

Despite all the potential disruption from this proposed regulation, HHS punted on evaluating the potential financial impact of this rule, declaring it "unknown." This is unacceptable and leaves the public unable to provide effective comments, effectively nullifying the required notice-and-comment opportunity because the public does not know the impact on which to base its comments. We recommend that HHS first collect more data on how the proposed rule might affect existing provider taxes and supplemental payments before implementing sweeping changes that could throw Medicaid financing into chaos. With more data reporting, it could be possible for HHS to identify whether limited changes could help ensure program integrity without unnecessarily restricting statutory financing mechanisms that states depend on to fund Medicaid and ensure access to care for all Medicaid recipients.

Given the unknown fiscal impact, we believe HHS has failed to comply with Executive Order (E.O.) 12,866 in proposing this rule. E.O. 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action. An agency should propose a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs, and after considering all costs and benefits of available regulatory alternatives, including the alternative of not proposing a rule. HHS acknowledges that "[t]he fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is *unknown* [italics added]." The only estimate of the fiscal effects on state Medicaid programs

that HHS provides is for the single provision establishing the new, lower limit on Medicaid supplemental payments to physicians and other practitioners.

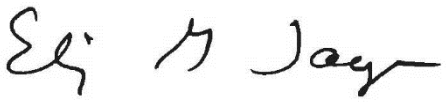
Separate from the requirements of E.O. 12,866, under the Administrative Procedure Act, courts have held that when an agency relies on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the rule unreasonable. Because HHS' cost-benefit analysis for the Proposed Rule fails to adequately quantify or to explain why HHS could not quantify those costs, HHS does not adequately assess the economic effects of the Proposed Rule. Thus finalizing the Proposed Rule is unreasonable.

Conclusion

Despite acknowledging that more information is needed, HHS proposes making immediate, significant changes in the current rules regarding supplemental payments and the use of provider taxes, intergovernmental transfers (IGTs) and certified public expenditures (CPEs) to finance the state share of Medicaid costs. 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 and reimburse providers. It is likely that most states would not increase the amount of general revenue they devote to Medicaid, forcing them to make cuts in provider payments, benefits and even eligibility. Similarly, states are unlikely to increase base payments to providers or increase payments in other ways to offset the reduction or elimination of supplemental payments.

We urge HHS 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. If you have any questions please contact David Machledt (machledt@healthlaw.org) or Mara Youdelman (youdelman@healthlaw.org).

Sincerely,



Elizabeth G. Taylor
Executive Director

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