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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Proposed Rule: CMS–2393–P, Medicaid Program: Medicaid Fiscal Accountability Regulation (Vol. 84, No. 222), November 18, 2019 and CMS-2393-N (Vol. 84, No. 249) December 30, 2019

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation related to Medicaid program financing and supplemental payments**. Given that the proposal would severely curtail the availability of health care services to millions of individuals and because many of its provisions are not legally permissible, the AHA requests that the agency withdraw the proposed rule in its entirety**.

If finalized, the rule would significantly change hospital supplemental payments and cripple state Medicaid program financing. On state Medicaid financing, CMS claims to be clarifying policies regarding providers' role in funding the non-federal share of Medicaid, but the rule goes far beyond clarification and introduces vague standards for determining compliance that are unenforceable and inconsistent with CMS's statutory authority. The rule contains significant changes to health care-related taxes (provider taxes), "bona fide" provider donations, intergovernmental transfers (IGTs) and certified

public expenditures (CPE).[1] The rule includes definitional changes to supplemental hospital categories and public funds. The agency also proposes to change the review process for supplemental payment programs and provider tax waivers. In addition, the agency would grant itself unfettered discretion in evaluating permitted state financing arrangements through vague concepts such as "totality of circumstances," "net effect," and "undue burden." These vague standards for determining compliance are contrary to the legal requirements of administrative law because they will make it impossible for a state to know whether its program complies with the Medicaid statute.

Despite not having access to the data available to the federal government, Manatt Health (Manatt), in collaboration with the AHA, analyzed the potential financial impact of the proposed rule under different scenarios, applying conservative (minimum impact), midrange, and aggressive (maximum impact) assumptions, based on public data and other private sources.

Manatt's analysis found that the proposed changes could have devastating consequences. Nationally, the Medicaid program could face total funding reductions between $37 billion and $49 billion annually or 5.8% to 7.6% of total program spending.[2] Hospitals specifically could see reductions in Medicaid payments of $23 billion to $31 billion annually, representing 12.8% to 16.9% of total hospital program payments.[3] Moreover, the impact at the individual state level would vary significantly. In nearly all states, the reductions that would result from this rule could unquestionably mean cuts in program enrollment and covered services. The impact in some states could be catastrophic.

While the AHA understands CMS's interest in enhancing its stewardship of the Medicaid program through greater transparency of Medicaid financing and supplemental payments, the regulations proposed by the agency go far beyond increasing transparency. The proposed regulations would restrict state access to important funding streams, limit the use of supplemental payments (payments to offset base payments set below the cost of providing care), and introduce significant uncertainty with respect to how the agency would evaluate state approaches. The proposed changes are numerous and varied, and the agency would give states virtually no time to make policy and budgetary adjustments to offset the loss of federal funds, assuming they could mitigate them at all.

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[1] IGTs are funds that government providers transfer to the state for the state to use for federal matching purposes. CPEs are expenditures government providers certify as qualifying expenditures to the state for the state to use for federal matching purposes.

[2] Based on a scenario analysis developed by Manatt Health and discussed in more detail in the Financial Impact Estimate section below

[3] Estimates represent the unmitigated impact of the proposed policies meaning that they do not account for strategies that states and providers may adopt to lessen the impact of the proposed rule's provisions, which are discussed in more detail in the financial impact analysis section.

The biggest losers of these policy changes would be the 75 million individuals who rely on the Medicaid program as their primary source of health coverage. This is a diverse group of people, but they have in common some form of vulnerability. Medicaid pays for approximately half of the births in the country, as well as care for almost half of all children and adults with special health care needs, such as physical and developmental disabilities, dementia and serious mental illness. Medicaid also is the primary source of coverage for individuals living in nursing homes and individuals with other long-term care needs.[4] In most instances, there is no other form of health coverage available to these individuals – either because they are too young, too old or too disabled to work – or because they work in part-time or low-wage jobs that do not offer health care coverage.[5]

The magnitude of financial loss to the program as a result of this rule would force states to make untenable choices regarding eligibility, benefits and provider reimbursement. Each of these choices is fraught with negative consequences:

- Cuts to eligibility would remove a key lever that states have to implement population health efforts, including public health interventions, and would result in widespread and compounding economic losses that would be felt well beyond the health care sector.

- Benefit cuts, such as to optional services like substance use disorder treatment, opioid treatment and prescription drug coverage, would reduce states' abilities to provide high quality care, which in turn would likely increase spending on other services to treat unmanaged conditions.

- Provider payment cuts would exacerbate access challenges when providers can no longer sustain the losses and decline to participate in the program or are forced to close their doors.

Optional eligibility groups and benefits likely would be the first targets for cuts. The expansion population would be an obvious first place states may look to reduce enrollment. Through expansion, many states cover homeless individuals, low-income parents and working adults who cannot access health coverage through their employers. Coverage for this population has been shown to have a number of individual and societal benefits, including increased access to care, improved health outcomes, better ability by states to mitigate the opioid overdose epidemic and increased economic activity.[6]

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[4] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/
[5] https://www.macpac.gov/wp-content/uploads/2016/01/Employer-Sponsored-Insurance-for-Low-and-Moderate-Income-Children.pdf
[6] Association of Medicaid Expansion With Opioid Overdose Mortality in the United States; *JAMA Network Open*:(1)3;2020 .e1919066. doi:10.1001/jamanetworkopen.2019.19066 and AHA *The Importance of Coverage* Oct. 2019, https://www.aha.org/system/files/media/file/2019/10/report-importance-of-health-coverage_1.pdf, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00929

However, other eligibility groups and benefits may not be spared. Provider taxes and IGTs fund much more than just supplemental payments to providers.[7] They are core sources of funding for states and often are applied to managed care capitation rates, fee-for-service base payments and other Medicaid payments. Funding losses this severe likely would force states to reexamine their core programs, especially as some of the most costly care is for mandatory groups of disabled children and adults and the low-income elderly.

Reductions in Medicaid enrollment or provider payments would put access to care at risk for both Medicaid beneficiaries and entire communities. Medicaid payments, including disproportionate share hospital (DSH) and non-DSH supplemental payments, historically have been lower than the cost of providing care to Medicaid patients,[8] and many providers would be unable to sustain further payment cuts. A number of studies have shown that lower Medicaid reimbursement rates reduce Medicaid beneficiaries' access to care. One study comparing physician acceptance of different types of insured patients found that physicians accepted 70% of new Medicaid patients, compared to 82% of new privately insured patients and 83% of new Medicare patients.[9] A more recent report found that increasing the Medicaid-to-Medicare fee ratio by one percentage point increased the Medicaid patient acceptance rate by almost one percentage point (0.78).[10]

Entire communities also could lose access to care if such payment or enrollment reductions were realized. This is especially true in rural communities with hospitals and health systems already teetering on the financial brink. Since 2010, 120 rural hospital have closed, with 19 of those in 2019 alone – the largest number of closures in a single year since at least 2005. The relationship between rural hospital sustainability and Medicaid is unequivocal. Roughly, 15% of rural hospital revenue is based on Medicaid, making it a key factor in supporting health care access in rural communities.[11] In addition, at least 80% of rural hospitals that have closed since 2014 occurred in non-expansion states, a finding that was echoed in a recent Government Accountability Office (GAO) report showing that states that expanded their Medicaid program saw fewer rural hospital closures.[12] Decreasing Medicaid enrollment or further payment reductions would further strain such vulnerable hospitals and could ultimately result in more hospital closures – a devastating consequence for the entire community.

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[7] Analysis provided by Manatt Health and discussed in more detail in the Financial Impact Estimate section below.
[8] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid`
[9] Decker, S. 2012. In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Affairs 31, no. 8: 1673–1679.
[10] https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full/
[11] 2018 AHA Annual Survey
[12] https://www.gao.gov/products/GAO-18-634#summary

Despite the potential for such significant negative consequences, CMS has provided little to no analysis to justify these policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. Many of the changes would violate the Medicaid law or are arbitrary and capricious in violation of the Administrative Procedure Act. They also violate due process protections in the Constitution. Moreover, at the same time the agency proposes these changes, it plans to rescind rules that require states to demonstrate that Medicaid beneficiaries have sufficient access to care, thus weakening CMS's ability to ensure adequate oversight of the program.[13] For all these reasons, the AHA strongly urges CMS to withdraw this rule.

Our comments are organized into two sections. **Section 1** provides a more detailed discussion of our key policy and legal concerns, focusing primarily on CMS's policies regarding state financing arrangements, hospital supplemental payments, and the implementation timeline and effective dates. **Section 2** provides a financial impact estimate of these key provisions.

I. POLICY AND LEGAL CONCERNS REGARDING KEY PROVISIONS OF THE RULE

State Financing Arrangements

The Medicaid program is jointly financed with state and federal funds. While states have some latitude in how they finance their share of program expenditures, federal law requires that at least 40% of the state's portion be financed by the state; up to 60% of the state share may come from local government sources.[14] The most recent public reporting on state financing arrangements found that, in state fiscal year (FY) 2012, 69% of funds came from state general revenues; 16% from local governments (including IGTs and CPEs); 10% from health care-related taxes; and 5% from other sources.[15] As such, states are well within the statutory requirements that govern their sources of funding.

For nearly 30 years, states have relied on public and private providers to help finance their share of Medicaid program dollars as Congress intended. A Department of Health and Human Services Office of Inspector General (OIG) review of seven states' hospital assessment programs found that provider financing arrangements were used to increase low Medicaid reimbursement rates, as well as fund children's health care coverage, support public hospitals, finance psychiatric services and increase managed care organization value-based payment incentives, among other uses.[16] CMS, Congress and other government agencies have raised concerns over certain state

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[13] www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission
[14] Section 1902 (a) of the Social Security Act
[15] https://www.gao.gov/products/GAO-14-627
[16] https://oig.hhs.gov/oas/reports/region3/31600202.pdf

financing arrangements that they claim artificially inflate state Medicaid spending. But rather than simply targeting problematic financing arrangements, CMS's proposed rule sweeps much more broadly, casting doubt on a wide range of legitimate financing arrangements that CMS and Congress have long endorsed.

Moreover, the proposed rule suggests that CMS has not seriously considered the consequences of limiting such arrangements or the challenges states would face in attempts to mitigate these consequences. The Congressional Budget Office's (CBO) own analysis on the impact of limiting Medicaid provider tax programs notes that most states would not be able to replace all revenue lost and that access to health care services may be reduced along with reductions in provider payments.[17]

In this proposed rule, CMS claims to clarify policies regarding providers' role in funding the non-federal share of Medicaid, such as IGTs, CPEs, provider taxes, and bona fide provider donations. In many cases, however, the agency has proposed new and significant changes to current policy – well beyond the goal of clarification. In addition, the agency has granted itself considerable discretion in evaluating permitted state financing arrangements through new concepts, such as "totality of circumstances," "net effect," and "undue burden." The following is a discussion of AHA's policy concerns regarding key provisions of the proposed rule, including a discussion of legal issues identified.

IGTs, CPEs, and Bona Fide Provider Donations *(42 CFR Sec. 433.51, 433.51 (b), 433.52, 433.54, 447.251, 447.286)*

Narrow Definition of "Non-State Government" Provider (42 CFR Sec. 433.51, 433.52, 447.251, 447.286)

For purpose of Medicaid financing and payment, current rules define providers by ownership categories, such as non-state government owned, state government owned and private. These provider categories determine how the Upper Payment Limit (UPL) applicable to most non-DSH supplemental payments is calculated.[18] CMS also has indicated that it seeks to align the "non-state government provider" and "state governmental provider" UPL categories with the category of entities that are eligible to make IGTs and CPEs.[19] Public hospitals (non-state government and state government) are currently defined as those owned or operated by a public entity. Variations exist across states in terms of what constitutes a public entity. One example used in the proposed rule is that some states consider as "public" hospitals owned by a local government but operated by a private entity under a long-term management agreement.

[17] https://www.cbo.gov/budget-options/2018/54727
[18] Non-DSH supplemental payments or UPL payments are payment limits tied to a reasonable estimate of what Medicare would have paid for the same service and is calculated based on the ownership category of the provider: state government owned; non-state government owned; and private.
[19] 84 Fed. Reg. 63722, 63752 (Nov. 18, 2019).

Under current policy, these hospitals would qualify as "public" for the purposes of making IGTs and calculating the UPL.[20]

CMS proposes to redefine what is a "non-state government provider" (such as a hospital or nursing home), and the agency would reserve for itself considerable discretion when assessing what arrangements meet the new definitions. The agency proposes to redefine the governmental providers as a unit of local or state government or a state university teaching hospital with administrative control over funds appropriated by the state legislature or local tax revenue. CMS further proposes that, beyond the new definition, the agency would have discretion to judge whether, "in the totality of the circumstances," the entity qualifies as a governmental provider. The ill-defined discretion CMS has reserved for itself will create confusion and uncertainty for states in determining which governmental providers can transfer local funds for purposes of funding the states' non-federal share. The agency also has failed to account for the substantial reliance by states on the prior policy and the harm that this policy change would cause.

Legal Analysis: If finalized, CMS's proposal to change the definition of public provider would be arbitrary and capricious because CMS's stated concerns easily could be addressed through specific prohibitions on discrete types of non-bona fide transactions. The vague proposed language, which focuses on "the totality of the circumstances," fails to give adequate guidance to states and Medicaid providers and to constrain CMS's discretion. It is arbitrary and capricious for that reason as well. The proposed language would "restrict states' use of funds" in violation of section 1903(w)(6)(A) of the Social Security Act.

Restrictions on Sources of IGTs (42 CFR Sec. 433.51 (b))

Under current federal law, states may put IGTs toward the state share of Medicaid payments if the IGTs come from "public funds," with an exception for most federal funds.[21] As discussed above, CMS proposes to replace "public funds" with "state or local funds" and require that such funds be "derived from state or local taxes (or funds appropriated to state university teaching hospitals)." This proposal would limit the amount of IGTs to the amount of the provider's state or local tax revenue (or funds appropriated to a state university teaching hospital). Many public hospitals, as well as state teaching hospitals, receive little in terms of state or local tax revenue or appropriations. They appropriately look to other revenue sources such as commercial insurance payments or fund balances to enable them to make IGTs because once commercial insurance revenue and fund balances are in the possession of the public agency, they constitute "public funds." Some states continue to use the tobacco tax settlement funds, which are not appropriated funds or derived from state or local taxes, to support public hospitals.

[20] 84 Fed. Reg. 63722, 63777 (Nov. 18, 2019).
[21] 42 USC 1396b(w)(6)(A).

CMS also proposes to change the regulatory language regarding which entities are eligible to make IGTs and CPEs from "public agencies" to "units of government within a state." CMS's proposal would specifically allow IGTs from "funds appropriated to state university teaching hospitals," but it leaves unclear whether public hospitals that are not state university teaching hospitals could ever make IGTs. For example, it is unclear whether a local county hospital could use funds appropriated by the county that are derived from local tax revenue as an IGT.

The rule, if implemented, could limit the number public hospitals able to make IGTs, as well as effectively cap the IGT amount eligible public hospitals can use to fund the state's non-federal share.

Legal Analysis: If finalized this proposal would not be permissible because CMS has failed to recognize that, in the past, it has approved IGTs and CPEs derived from "public funds" that may not qualify as "state and local funds" under the proposed regulation, and it has approved IGTs and CPEs from "public agencies" that may not qualify as "units of government within a State." This is an unacknowledged change from a prior policy that has engendered substantial reliance by state and non-state government providers, in violation of the Administrative Procedure Act.

Payments Funded by Certified Public Expenditures (CPEs) Made to Providers that are Units of Government (42 CFR Sec. 447.206)[22]

CMS proposes new requirements for CPE-related payments. These new requirements would include limiting the Medicaid payment to the cost incurred for treating Medicaid beneficiaries, specifying the methods for determining allowable cost, and requiring that a retrospective reconciliation be performed after the provider's fiscal year ends to ensure that the CPE did not exceed actual cost. These proposed requirements would add administrative burden and greater uncertainty regarding funding for government providers.

Legal Analysis: The proposed language would require a burdensome auditing regime for CPEs with no basis in the statute. The proposal to limit CPEs to "the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries" is more restrictive than and inconsistent with the statute, which only limits CPEs to "the non-Federal share of expenditures."[23]

Increased Agency Discretion to Prohibit Provider Donations (42 CFR Sec. 433.52, 433.54)

States and local governments have long collaborated with providers to ensure access to health care services for their Medicaid population, as well as to improve the health of the overall community. Health care providers are permitted, under federal law and

[22] CPEs are expenditures government providers certify as qualifying expenditures to the state for the state to use for federal matching purposes

[23] Social Security Act § 1903(w)(6)(A).

regulation, to make "bona fide" donations to governmental entities with certain restrictions as long as the donation does not have a "direct or indirect relationship" to Medicaid payments. (In other words, the state cannot promise that any donation is returned to the provider making the payment, providers furnishing the same class of services, or any related entity.[24]) While such financial arrangements are not uncommon, CMS expresses concern that some state and provider arrangements do not meet the test of bona fide donations. The agency proposes to address these concerns by introducing a new "net effect" standard related to provider donations. This standard would allow CMS to determine whether the provider donation results "in a reasonable expectation that the provider, provider class, or related entity will receive a return of all or a portion of the donation either directly or indirectly." CMS again would use the "totality of the circumstances" concept to determine when to apply the "net effect" standard, discretion that would create confusion and uncertainty for states.

Legal Analysis: If finalized, this proposal would not be permissible because in describing a hold harmless "practice" in the absence of any express hold-harmless provision in a provider donation agreement, the proposal is inconsistent with existing regulatory language that refers to a hold-harmless "provision."[25]

The proposal includes vague language that will create uncertainty and unnecessary burdens for states and providers. This violates the statute, which authorizes CMS to issue regulations that "specify types of provider-related donations ... that will be considered to be bona fide provider-related donations." [26]

PROVIDER TAXES (42 CFR SECS, 433.52, 433.55, 433.56, 433.68, 433.72)

***Prohibition on Certain Provider Tax Hold Harmless Arrangements* (Sec. 433.68)**
Current federal law prohibits a provider tax arrangement that directly or indirectly holds the provider harmless for the tax paid. CMS proposes to change the current regulations implementing the hold harmless provision by incorporating the "net effect" standard previously discussed. This new standard would give CMS considerable discretion to look at the "totality of circumstances" that the "net effect" of a tax arrangement would have. Specifically, CMS would assess – using undefined criteria – whether in the totality of circumstances the taxpayer could have a reasonable expectation of receiving a certain return of the tax paid. Thus, it is granting itself unfettered discretion.

CMS states that it wants to specifically address state financing arrangements that: 1) impose a provider tax and use the tax as the non-federal share to make Medicaid provider payments; and 2) enable providers receiving more in Medicaid payment than their tax contribution to transfer funds to providers that received less in Medicaid payment than their tax contribution. CMS notes that the "net effect" standard would

24 § 433.54 Bona fide donations
25 42 C.F.R. § 433.54(e).
26 Social Security Act § 1903(w)(2)(B).

allow it to look at arrangements where the provider serves as an intermediary, regardless of whether CMS has previously approved such arrangements. These new, vague terms without defined criteria would impermissibly create confusion and uncertainty for states.

Legal Analysis: If finalized this proposal would violate the statute because the new definition of "direct guarantee" is not consistent with statutory language[27]. First, CMS's proposed definition would classify arrangements as "guarantees" when there is merely a "reasonable expectation" that the taxpayer may be held harmless, and where the net effect of an arrangement "may result" in the taxpayer receiving a return of some or all of the tax. Such arrangements are not "guarantees." Second, CMS's proposed definition would classify arrangements as "direct" guarantees based on the "net effects," considering "the totality of the circumstances." This language does not describe "direct" guarantees within the meaning of the statute.

The proposal is arbitrary and capricious because it includes vague language that will create uncertainty and unnecessary burdens for states and providers. Moreover, CMS has failed to acknowledge that it is changing course from a prior policy that has engendered substantial reliance interests, as required under the Administrative Procedure Act.

Provider Tax Waivers and Taxing Medicaid Utilization at a Higher Rate (Sec. 433.68)

Federal law permits states to impose provider taxes on defined classes of health care services that are broad-based (all services within the class are taxed), uniform (all providers in the class pay the same tax rate) and do not hold providers harmless for the cost of the tax. States can request tax waivers from the broad-based and uniformity requirements. The tax waivers require that states meet specific statistical tests to demonstrate that the tax is generally redistributive in nature.

CMS proposes additional tests or conditions provider taxes would have to meet to assure the agency that the tax is redistributive. Specifically, CMS would evaluate whether the tax rate for any given taxpayer group is based on their level of Medicaid activity or non-activity. CMS outlines four conditions that it will evaluate. For example, CMS will consider whether the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity. CMS again reserves significant discretion to consider the "totality of circumstances" when determining how a state determines groupings of providers for particular tax rates.

The AHA challenges CMS on its introduction of a new standard above and beyond the statistical tests already required to ensure that a tax is generally redistributive and not directly correlated to Medicaid provider payments. In fact, the 1993 final rule implementing the law noted that the agency designed the existing statistical tests

[27] Social Security Act § 1903(w)(4)(C)(i).

(known as the B1, B2 and P1, P2) to reduce ambiguity and that a more subjective standard would be "administratively burdensome and virtually impossible to apply fairly throughout the nation."[28] CMS's application of the "net effect" standard and the concept of "totality of circumstances" does have the unfortunate consequence of introducing ambiguity into the process. These new standards would create a greater degree of uncertainty for state governments and providers in terms of what CMS would or would not determine as permissible provider tax programs. Many of these tax programs support base payments, DSH and non-DSH supplemental hospital payments, and, in some states, hospital directed payments through managed care arrangements. In addition, these tax programs would need legislative approval before the state could submit them to CMS for a waiver. If the waiver is denied, the state would need to go back to the legislature to amend the tax statute (which may not even be possible until the legislature is back in session). States and providers would be left with little certainty that their tax programs would be acceptable. In other words, state Medicaid budgets and hospital payment programs would be in a precarious place, putting care for vulnerable Medicaid patients at risk.

Legal Analysis: If finalized this proposal would violate the statute because it would be an impermissible interpretation of the requirement that a tax be "generally redistributive in nature."[29] The existing regulation in 42 C.F.R. § 433.68(e)(1)–(2) captures the requirement that a tax be generally redistributive. The new proposed language would broaden the "generally redistributive" standard to forbid any type of correlation, direct or indirect, between the amount of the tax and Medicaid payments to the taxpayer. Moreover, the proposal is arbitrary and capricious because it includes vague language that will create uncertainty and unnecessary burdens for states and providers.

***Time Period for Provider Tax Waivers* (Sec. 433.72)**

CMS proposes greater oversight and monitoring of provider tax waivers. Specifically, the agency would grant waivers for a three-year period, after which the state would need to seek a renewal. Existing waivers approved by CMS would require renewal three years from the effective date of the final rule. The three-year period for provider tax waivers is new policy in CMS's own administrative process to oversee state Medicaid programs. For many states, a three-year period may not be enough time to get a waiver renewal through the state approval process, including review by the state legislature, before the current waiver expires. The Medicaid and CHIP Payment and Access Commission (MACPAC) cited these factors explicitly in its March 2018 recommendation to Congress to extend the approval period for 1915(b) waivers.[30] CMS should take into account the additional burden this process places on states. Instead of an arbitrary three-year limit on waivers, CMS should work with each state to determine appropriate timelines based on the unique circumstances of their waivers.

28 58 Fed. Reg. at 43164. http://cdn.loc.gov/service/ll/fedreg/fr058/fr058155/fr058155.pdf
29 Social Security Act § 1903(w)(3)(E)(ii)(I).
30 https://www.macpac.gov/publication/streamlining-medicaid-managed-care-authority-2/

Restrictions on States Embedding Provider Taxes in Broader Taxes on Non-healthcare Related Services (Sec. 433.55(c))

The federal Medicaid statute defines a "health care-related tax," to include a tax that "provides for treatment of [health care services] that is different from the treatment provided to [other services].[31] CMS has proposed to expand the definition of "different" "treatment" to encompass scenarios where a tax on a set of health care related services is conjoined with a tax on unrelated services.[32]

In the preamble to the 1992 interim final rule implementing the health care related policy, CMS endorsed the types of combined taxes that it now proposes to define as "health care related taxes" [33] and prohibit in certain circumstances. This is arbitrary and capricious since CMS is clearly changing policy while purporting to be merely "clarifying" prior policy. In addition, for states that have these embedded taxing arrangements, this change could be challenging to address in a timely fashion. This is another example of CMS's indifference to the challenges states face in developing state financing policy, seeking state level approval and securing CMS approval.

Legal Analysis: If finalized, this proposal would not be permissible because CMS would be changing course from a prior policy that has engendered substantial reliance interests and fails to acknowledge or justify the change. CMS previously stated that a tax does not provide for "different treatment" of health care services if it involves "a flat rate based on gross receipts."[34]

This proposal relies on an unreasonable and unlawful interpretation of "different treatment" within the meaning of § 1903(w)(3)(A)(ii) of the Social Security Act. If differential treatment encompasses taxes like the example offered in the preamble, then it would swallow the category of taxes that are "related to health care items or services," undermining the purpose of the statutory provision. For taxes whose burden falls partly on health care providers and partly on others, Congress has set an 85% threshold for when such taxes will be deemed "health care related." CMS's proposal could be read to mean that *any* tax that falls partly on health care providers will be deemed "health care related," irrespective of the 85% threshold that Congress has mandated in the statute.

Medicaid Supplemental Payments

States have considerable flexibility in designing their fee-for-service (FFS) payment rates. Base payments for providers are tied to claims for specific services. States, however, can provide add-on payments in the form of supplemental payments that can be paid on a periodic basis and not be tied to a specific Medicaid beneficiary or service. Base payments are typically set significantly below the cost of care, and, historically, supplemental payments have served to improve provider payment rates. However, even

31 Social Security Act Sec.1903(w)(3)(A)
32 84 Fed. Reg. at 63,733; 42 C.F.R. § 433.55(c).
33 57 Fed. Reg. at 55122. (Nov. 24, 1992)
34 Ibid pages. 55,118,and 55,127

the use of supplemental payments does not make providers whole. Even after accounting for supplemental payments, hospitals receive, on average, only 89 cents on every dollar spent caring for Medicaid patients.[35]

Supplemental payments take two forms: DSH payments, which are statutorily required, and non-DSH payments. Non-DSH supplemental payments include UPL payments, as well as payments made through Section 1115 waivers, such as uncompensated care pools or Delivery System Reform Incentive Payments (DSRIP) programs. Some states make graduate medical education (GME) payments as well to support training of medical professionals, and these are typically considered non-DSH supplemental payments. MACPAC's recent report to Congress notes that UPL hospital payments in FY 2017 surpassed Medicaid DSH payments.[36] It also is important to note that states and CMS have looked to supplemental payment to promote broader delivery system reforms such as value-based purchasing arrangements. The 2016 Medicaid managed care rule is one such example where supplemental funds provided through managed care arrangements are tied to quality performance measures.[37]

CMS proposes significant changes to the policies for non-DSH supplemental payments. The agency cites concerns over the growth in non-DSH supplemental payments for hospitals and other providers as justification for the following proposed policy changes, which also include increased reporting requirements. The agency seems to ignore the potential impact these payment changes may have for state strategies to promote value-base purchasing of health care services for this vulnerable population.

Definitions: Base vs. Supplemental **Sec. 447.286**
CMS proposes to define supplemental payments as any payment that is not tied to a specific service (therefore not a base payment) or a DSH payment. The agency proposes to define base payments as the fee for a service plus any payment adjustments, add-ons, or other additional payments received by the provider and attributable to a specific service provided to a beneficiary, including those payments made to account for a higher level of care or complexity of services. CMS does not address GME payments, and it is not clear how they would be treated.

New Definitions for UPL Ownership Categories for Inpatient and Outpatient Services **Sec. 447.272, 447.321 (new) 447.288 (a)-(b)**
As discussed previously, CMS proposes to redefine the existing three UPL ownership categories to state government provider, non-state government provider and private provider. The redefinition would eliminate the terms "state or non-state government owned or operated." In this redefinition, a state government provider would include a state government provider that is a unit of the state government or state university

[35] AHA January 2020 https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid
[36] https://www.macpac.gov/wp-content/uploads/2019/03/Oversight-of-Upper-Payment-Limit-Supplemental-Payments-to-Hospitals.pdf
[37] Mann, C, and Karl, A; Health Affairs Blog Jan. 8, 2020.

teaching hospital. The non-government provider definition would include a health care provider that is a unit of local government in a state that has access to and administers state appropriated funds. The unit of local government could be a city, county, special district, or other government non-state unit. CMS again proposes to reserve for itself considerable discretion through examining the "totality of circumstances" when determining which hospitals should be in which ownership category for purposes of determining their UPL limit and ultimately their supplemental payments. The definitional changes in the UPL ownership categories could result in a change in the distribution of UPL payments, including resulting in fewer hospitals receiving UPL payments.

CMS also introduces a level of uncertainty for states and government providers in calculating the UPL aggregate pools based on ownership category when it reserves for itself discretion in determining which public hospitals would fit into which government provider ownership category. The legal concerns regarding these definitional changes are the same as reflected above in the section on *Narrow Definition of "Non-State Government" Providers (Sec.447.288).*

CMS proposes to codify current guidance on the calculation of UPL. UPL is currently set at the aggregate amount, within the UPL ownership category, based on what Medicare would have paid for the same services using Medicare payment and cost principles. CMS proposes to move away from the current standard of a reasonable estimate of what Medicare would have paid for the comparable services. The agency purports to clarify sub-regulatory guidance that states may estimate the UPL based on either Medicare or Medicaid cost principles and spells out the data elements and parameters for the methodology. For example, the data elements must be no more than two years old and be either from the Medicare cost report or a state cost report using Medicare cost principles. The methodology would need to include projected changes in Medicaid enrollment and utilization, as well as Medicare trend factors. In addition, CMS proposes to require that states use templates approved by the Office of Management and Budget when submitting their UPL calculations for review.

Many of these new requirements will be challenging for states to meet, in particular ensuring data elements can be no more than two years old. In addition, CMS provides no guidance on how states are to project changes in utilizations and enrollment or what Medicare trend factors should be used. We urge the agency to do so.

Limitations on Practitioner Supplemental Payments to a Percentage of Base Payments (Sec. 447.406)

The proposed rule would set new limits on Medicaid supplemental payments to physicians and other practitioners at 50% of Medicaid base payments or 75% for practitioners in underserved areas designated as health professional shortage areas. Medicaid physician payment rates have historically been lower than Medicare payment rates. For example, Rhode Island and New Jersey pay less than 50% of what Medicare

pays physicians for the same service.[38] Some states have used these supplemental payment programs to improve payment for physicians and practitioners with the objective of improving access to services for vulnerable communities. These supplemental payment programs often support physicians and other practitioners at public academic teaching hospitals and rural hospitals serving vulnerable communities. As such, changes in UPL payments for physicians and practitioners could particularly limit beneficiary access to tertiary and quaternary services, as well as all hospital services in rural communities.

Legal Analysis: CMS's proposal is arbitrary and capricious because CMS has failed to consider whether supplemental payments based on the average commercial rate (ACR) should be retained because they are needed "to assure that payments ... 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."[39]

The percentage caps that CMS has chosen are inadequately explained and arbitrary. Moreover, CMS's proposal is arbitrary and capricious because it is based on the stated concern that supplemental payments are being driven by the availability of local financing, but CMS has failed to consider the alternative – proposed in a 2016 GAO report – of simply enacting a rule that supplemental payments cannot be conditioned on the availability of local financing.

***UPL Reporting Requirements* (Sec. 447.288)**

CMS proposes new UPL reporting requirements. Specifically, states would need to report provider-level payment details as part of the already-required aggregate reporting for UPL supplemental payments. They also would need to submit provider-specific payment information for payments received for the services that are identified in the state plan and through any Section 1115 waiver demonstration program. In addition, states would be required to identify the non-federal source of Medicaid funding that supports the UPL payments. In their reporting, states would have to explain how such supplemental payments meet the statutory equal access standard of "efficiency, economy and quality of care to ensure access." The provider-level report would include: identification (legal name, address, national provider number); payment (supplemental payments, DSH, donations, Medicaid cost-sharing, other third-party Medicaid payments); provider type (e.g., critical access hospital, teaching, children's hospitals); and provider category (public or private). States would need to ensure that the data used to conduct the UPL calculation are no more than two years old and drawn from either the Medicare cost report or a state cost report using Medicare cost principles. In addition, states would need to project changes in Medicaid enrollment and utilization, as well as Medicare trend factors, to be used in the UPL methodology. States could be penalized for failure to submit timely and accurate data.

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[38] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/
[39] Social Security Act § 1902(a)(30)(A)

While some enhanced data reporting could be useful for CMS and other policymakers to understand and evaluate Medicaid supplemental payments, the new provider-level reporting requirements is a blunt instrument and would generate largely unusable data while increasing burden on states and providers. Especially problematic is the lack of adequate guidance from the agency on some of the proposed reporting requirements, such as projecting enrollment and utilization, as well as Medicare trend factors. In addition, the data reported would be unaudited, raising the possibility of inaccurate and misleading submissions. Unaudited data would be of limited value to CMS in its efforts to improve transparency of the program. Finally, as a condition of approval, states would be required to ensure that the supplemental payments were consistent with the current statutory equal access standard of "economy, efficiency, quality of care, and access."[40] Yet, CMS provides states no guidance or criteria to evaluate if provider payments meet the access standard. As noted earlier, CMS is planning to rescind current rules that requires states demonstrate beneficiary access to care and that CMS monitor access to care and provider payment. Therefore, this proposed approach appears inconsistent with other actions by the agency.

Limited Approval Period **(Sec. 447.406)**
The proposed rule limits approval for the practitioner and physician supplemental payments to a three-year period. The supplemental payment methodologies would sunset after three years and require states to submit for new approval. While the proposed rule is clear that the new practitioner supplemental payment is time limited, the regulatory text is not clear on whether the three-year limited approval period applies to all UPL supplemental payment programs. Nevertheless, the three-year approval period may not be sufficient time for states to secure approval from state agencies and legislatures, and we refer the agency to our earlier comments on an alternative approach.

Effective Dates and Transition Periods

The proposed rule has virtually no transition timeline for states to make changes to their financing and supplemental payment programs. These financing and payment programs are complex and states would need considerable time to work with their state legislatures and affected stakeholders to implement any mitigation strategies. In its 2016 Medicaid managed care rule, CMS gave states a 10-year transition period to comply with the new rules. This proposed rule only sets forth a transition period for approved provider tax waivers and UPL payment programs. Some of the proposed rule's most significant provisions affecting IGTs and provider tax policies would be effective upon finalization of the rule, giving states no opportunity to make any necessary policy and legislative changes. **If it finalizes this proposal, AHA urges CMS to provide reasonable effective dates and timelines.**

[40] Section 1902 (a)(30)(A) of the Social Security Act

II. FINANCIAL IMPACT ESTIMATE

A financial impact analysis is critical to understanding how the proposed rule could affect state governments' ability to finance their Medicaid programs and, in turn, the impact on patients and providers. As CMS notes in the proposed rule (84 Fed. Reg. at 63772), Executive Order 12866 On Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011) direct agencies to provide a cost/benefit analysis of economically significant regulatory actions. As part of this, CMS is required to assess all costs and benefits of available regulatory alternatives and if regulation is necessary, to select regulatory approaches that maximize net benefits. Despite proposing policy changes with the potential for significant economic consequences, with the exception of one provision, CMS failed to conduct such an analysis and thus failed to comply with the Executive Orders.

Despite not having access to the data available to the federal government, Manatt, in collaboration with the AHA, reviewed public data and other private sources. Manatt analyzed the potential financial impact of the proposed rule under different scenarios, applying conservative (minimum impact), midrange, and aggressive (maximum impact) assumptions. The following estimates represent the unmitigated impact of the proposed policies and do not account for strategies that states and providers may adopt to lessen the impact of the proposed rule's provisions, which are discussed in more detail below. Based on data limitations, the estimates do not account for all potential changes in the proposed rule (e.g. changes to CPEs).

Findings

Manatt's findings underscore the AHA's deep concerns about the impact of the proposed regulation. Specifically, Manatt found:

- **The proposed rule is likely to substantially reduce funding for the Medicaid program.** The estimated impact of the proposed rule on total computable Medicaid program spending (state and federal) ranges from **$37 billion to $49 billion** in spending reductions annually, or **5.8% to 7.6%** of total Medicaid program spending (*see Table 1*). The estimated impact on total computable Medicaid payments to hospitals ranges from **$23 billion to $31 billion** in annual reductions, or **12.8% to 16.9%** of total Medicaid payments to hospitals (*see Table 2*).

Table 1. Estimated MFAR Impact on Total Medicaid Spending

Impact	Scenario *(all dollars in millions; based on 2019 values)*		
	Conservative *(Minimum Impact)*	**Midrange**	**Aggressive** *(Maximum Impact)*
Reductions in Total Computable Medicaid Spending	-$37,271	-$44,006	-$48,916
Reductions in Federal Share of Medicaid Spending	-$23,954	-$28,306	-$31,449
Reductions in Non-Federal Share Financing	-$13,317	-$15,700	-$17,467
Reductions as a Percentage of Total Medicaid Spending	**-5.82%**	**-6.87%**	**-7.64%**

Table 2. Estimated Reductions on Medicaid Payments to Hospitals

Impact	Scenario *(all dollars in millions; based on 2019 values)*		
	Conservative *(Minimum Impact)*	**Midrange**	**Aggressive** *(Maximum Impact)*
Reductions in Total Computable Medicaid Spending	-$23,070	-$27,389	-$30,532
Reductions as a Percentage of Total Estimated Medicaid Payments to Hospitals	**-12.76%**	**-15.15%**	**-16.89%**

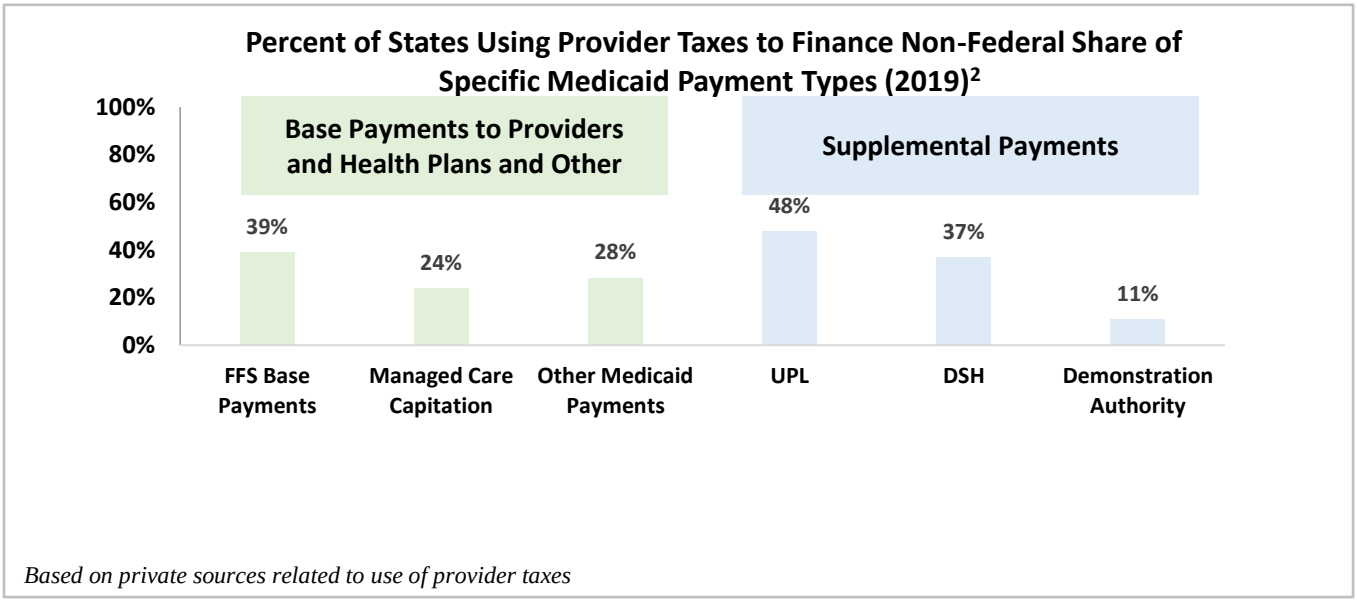
- **Provider taxes and IGTs – the sources of non-federal share financing most impacted by the proposed rule – have increased substantially since 2012, representing an important and growing non-federal share financing source for state Medicaid programs.** The increases are most significant for provider taxes – in 2012, provider taxes represented 10% of the total state share of Medicaid program spending; in 2019, such taxes represented 16% of the state share.[41] During this same period, nearly a dozen states have looked to some form of provider taxes to help fund their Medicaid expansion.[42]

- **Provider taxes and IGTs serve as critical financing mechanisms for the Medicaid program at large, not just for supplemental payments.[43] Thirty-nine percent** of states use a portion provider taxes to support Medicaid fee-for service

[41] 2012 data based on 2012 GAO Survey. 2019 data based on private sources related to use of provider taxes.
[42] https://www.governing.com/topics/health-human-services/gov-medicaid-expansion-funding-states.html
[43] Data based on private sources related to use of provider taxes.

base payments, **24%** use a portion to support managed care capitation payments other than directed payments or pass-through payments, and **28%** use a portion to support general Medicaid program costs *(see Figure 1)*. Trends are similar related to IGTs. While IGTs and provider taxes finance a large amount of supplemental payments, they also have become integral to financing of the entire Medicaid program in many states.

Figure 1. Percent of States Using Provider Taxes to Fund Specific Payment Types



Based on private sources related to use of provider taxes

Limitations

Manatt Health developed these estimates as a scenario analysis rather than a precise estimate due to data limitations, lack of information of all relevant circumstances in each state and the vagueness of the proposed rule itself. As such, Manatt applied assumptions to define a range of potential impacts of the proposed rule.

As previously noted, these results also do not incorporate potential mitigation strategies that could reduce losses related to the proposed rule, but which are highly speculative. States and providers may use a variety of approaches to mitigate the impact of the proposed rule. Most mitigation strategies would require states and providers to restructure current Medicaid financing arrangements, often requiring both political support among affected stakeholders and state administrative or legislative action to implement new approaches. As a result, mitigation strategies will be highly dependent on the context in each state. Because it is difficult to quantify how the losses could be mitigated, the estimated financial impacts displayed represent the impact of the proposed rule absent any mitigation strategies states and providers may use to

preserve financing and payments. The actual impact of the proposed rule, however, is likely less after accounting for state and provider mitigation strategies. The estimates represent the "unmitigated impact."[44]

CONCLUSION

The proposed rule falls far short of striking a balance between government accountability and protecting the Medicaid program's core mission of providing access to health care services to Medicaid beneficiaries. **Given the proposed rule undermines the state Medicaid programs, adversely impacts those who rely on the program, suffers from numerous legal infirmities, and requires considerable time for mitigation (if it is even possible), the AHA requests that the agency withdraw the proposed rule in its entirety.** Protecting access to health services for the more than 75 million Medicaid beneficiaries is our utmost priority. We look forward to working with the agency to explore reasonable transparency measures that ensure accountability in Medicaid state financing and payment policies without risking access to care for Medicaid beneficiaries and their broader communities.

Please contact me if you have questions, or feel free to have a member of your team contact Molly Collins, director of policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

[44] In the regulatory impact analysis in the proposed rule relating to practitioner payments (the only portion of the rule where CMS provided an estimate of impact), CMS notes that the loss of revenue for practitioners might be affected by mitigations but, similar to the analysis here, CMS did not attempt to quantify the mitigations.

FOR IMMEDIATE RELEASE

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HEALTH CARE LEADERS VOICE CONCERNS OVER PROPOSED CMS MEDICAID REGULATIONS

WASHINGTON (January 30, 2020) — Rick Pollack, President and CEO at the American Hospital Association (AHA), and Mark Parkinson, President and CEO at the American Health Care Association (AHCA), issued the following joint statement in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Medicaid Fiscal Accountability Regulation.

"We appreciate CMS' responsibility to oversee appropriate Medicaid financing and service delivery. However, the bleak reality is that Medicaid funding is already inadequate. Enacting this proposed rule would cut up to $50 billion nationally from the Medicaid program annually, further crippling Medicaid financing in many states and jeopardizing access to care for the 75 million Americans who rely on the program as their primary source of health coverage.

"Entire communities could lose access to care under this proposal, especially in rural areas where 15 percent of hospital revenue and nearly two-thirds of nursing facility revenue nationwide depend on Medicaid funding. The supplemental payment programs targeted in this rule are also a critical lifeline at hospitals, health systems and nursing facilities that serve some of the most vulnerable Americans.

"CMS has provided little to no analysis to justify these policy changes, nor has the agency assessed the impact on providers and the patients they serve. Many of the proposed changes would also violate federal laws, including the current Medicaid statute. The AHA and AHCA request that the agency withdraw the proposed rule in its entirety."

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About the American Hospital Association
The American Hospital Association (AHA) is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA advocates on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups. Founded in 1898, the AHA provides insight and education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org.

About the American Health Care Association and National Center for Assisted Living
The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents 14,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-

acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day. For more information, please visit www.ahca.org or www.ncal.org.