TORCH
Texas Organization of Rural & Community Hospitals

January 29, 2020

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

RE: MFAR – CMS-2393-P

To whom it may concern:

Despite supplemental payments and an 1115 waiver, Texas leads the nation with 26 rural hospital closures since 2010. On behalf of the remaining rural hospitals, clinics and health care organizations serving rural Texans, the Texas Organization of Rural and Community Hospitals (TORCH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Medicaid Fiscal Accountability Regulation (MFAR – CMS-2393-P) proposed rule (84 Fed. Reg. 63722 dated Nov. 18, 2019). Rural providers meet the needs of 11 percent[1] of rural Texans across 163 rural counties, including 184 whole county Medically Underserved Areas (MUAs)[2].

MFAR puts safety-net providers, Medicaid beneficiaries, and all employees, employers and patients in rural Texas at risk. The rule summary notes a goal to "promote transparency," which we support, but the remaining ~200 pages are very problematic for rural healthcare, the Texas Medicaid program, and state flexibility authorized by the Social Security Act.[3] This letter focuses on implications in Texas, though almost every other state is also impacted. We believe there is no state more adversely impacted than Texas and no class of healthcare providers more acutely harmed than rural. Research repeatedly affirms that the closure of rural hospitals is a major contributing factor to rural infrastructure loss, rural employment loss, a decline in preventative care and a decline in access to primary and emergency services. Three things to consider:

1. Texas has not expanded Medicaid and is now being forced under MFAR to reconsider. The Texas Legislature has taken active steps to prevent Texas from expanding Medicaid, a position afforded by the Supreme Court's ruling which protects states from the Medicaid expansion mandate.
2. Texas, under an 1115 waiver, transitioned from traditional Upper Payment Limits (UPL) and fully into managed care. Initially this transition included Inpatient Services and has expanded to include skilled nursing services. Texas is also now looking to transition additional long-term care services and support into Medicaid managed care.

[1] USDA-ERS https://www.ruralhealthinfo.org/states/texas
[2] U.S. Health Resources and Services Administration Data Warehouse[3] 42 U.S. Code § 1396b. Payment to States
[3] 42 U.S. Code § 1396b. Payment to States

3. Under the 1115 Waiver, Texas has transformed delivery of healthcare services, including telemedicine, integration and improved access to primary care in rural Texas. We have done this while never encumbering the full amount of funds available under our budget neutrality limit, saving the federal government money. This savings hasn't come without a cost. Texas has been unable to stop the closure of rural hospitals, but through the diligent efforts of the provider community, has in limited circumstances found ways to transition hospitals to rural, safety-net Emergency Departments and clinics where patient access and choice can remain intact. This preserves jobs, industry, and transportation in rural Texas while ensuring emergency services are available.

Under this Administration which seems to be moving away from a "one size fits all" and "Washington knows best" approach, the MFAR rule is an unexpected return to those philosophies and an attempt to dictate state tax policy. Rather than objective tests of existing programs that allow flexibility and collaboration between state and federal partners to improve care, states are being required to 1) regulate on behalf of the federal government, 2) increase state funding in lieu of local funding, and/or 3) significantly shrink their Medicaid program. Rural Providers across 262,000 square miles present our following conundrum:

1. The proposed rule will have a material impact on hospital authorities and lower tax-collecting public entities. There are a hospital authorities in Texas that are the only access to care for their region. They would be excluded from participation under the proposed rule. Current law allows a unit of local government including a special purpose district or other governmental unit in the State to participate in funding the non-federal share and leaves the matter to States. The new definition of public funds in the proposed rule by CMS is a killer because it precludes other governmental units based on their ability to tax. Further, Texas public policy strongly favors low taxes, which means a significant volume of public revenue is raised from fees or other sources. While some states may favor high taxes and low fees, Texas favors low taxes and multiple high service fees. Any limitation or restriction of intergovernmental transfers to tax revenue will disproportionately burden low tax states like Texas.
2. Any current program or transition program will be unlikely to survive. Texas Medicaid is transitioning the current Texas Delivery System Reform Incentive Payments (DSRIP) to a sustainable Rural Transformation Program aimed at creating efficiencies in local networks while also allowing providers to risk share with the managed care organizations and the state. Texas has a historical precedent of being innovative and willing to transition. The UPL transition was hard, but we have improved access and made huge strides to track and to improve patient outcomes. The proposed MFAR rule ignores both the long-standing and recently informed CMS policy decisions to transition Texas Medicaid, and instead characterizes the flexibility CMS previously afforded states in partnership with their managed care organizations and local governments as "schemes."[5] Although CMS's stated intent is to provide clear guidance to

[5] https://www.cms.gov/newsroom/press-releases/cms-administrator-seema-vermas-speech-national-association-medicaid-directors-washington-dc

states, the proposed rule makes it less clear to us whether a given program approach complies with the requirements, specifically under the state directed payment programs which fall under managed care. Over the course of DSRIP, 26 rural hospitals have closed even with the participation in DSRIP transformation The MFAR effects on all Texans (not just Medicaid recipients) will be felt first - and most severely - in rural Texas based on a report to CMS highlighting risk factors in rural areas.[6] The report noted, "Texas is the state with highest number of vulnerable hospitals, with 75 rural hospitals (50 percent) identified at risk of closure." Further network adequacy under Medicaid was highlighted as problematic as Texas Medicaid plans struggle in rural areas and is a growing threat under this proposed rule.

3. MFAR aims to take states and providers to a place where there is no equivalence, scale, flexibility or innovation. Our view is the Medicaid program has been a program that allows room for flexibility, new ideas, and innovation. If states like Texas maintain current Medicaid payment and coverage, the proposed rule will force us to choose between massive tax increases or cuts to fill budget shortfalls. This will create a larger divide in rural Texas between the "haves" and the "have nots" and between urban and rural communities. The blue-collar hourly worker who likely doesn't have insurance coverage will be left without local access. The small businesses will have to pay more for care in suburban or urban areas and absorb the losses associated with lost time at work due to travel time to and from clinics or go without preventive care services.
4. MFAR is being forced 1) with a very aggressive timeframe, 2) at a time when Congress is divided and distracted, and 3) with adversely and disproportionately impact on states like Texas who have held fast under the ruling of the Supreme Court protecting the state from the Medicaid expansion mandate. If adopted, the rule will certainly draw challenges, in and out of court, due to inconsistencies with federal statutes and regulations aimed at programs Congress has allowed for decades. The rule hinders the ability of providers to plan for the future by creating material economic uncertainty.
5. Executive Order 12866, Regulatory Planning and Review (September 30, 1993) and Executive Order 13563, Improving Regulation and Regulatory Review (February 2, 2011) direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year). CMS has failed to undertake the required regulatory impact analysis (RIA).
6. CMS currently faces significant challenges in maintaining a sufficient number of physicians to treat the Medicaid population. A lack of Medicaid participating primary care providers, results in a lack of access to care at the first tier and ultimately to Medicaid recipients seeking higher cost emergency room care and requiring hospital care. Much of this problem rests with inadequate Medicaid physician fee reimbursement and has a disproportionate impact in rural

[6] Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas' Uncompensated Care Pool, As prepared by Health Management Associates August 26, 2016.

areas, which already suffer from a physician shortage and limited access to care. Supplemental payments have helped rural hospitals to both recruit and maintain rural physicians and ensured the physicians participation in the Medicaid program. Any degradation in Medicaid supplemental payments will have a direct impact on the availability of and access to physician care in rural communities.

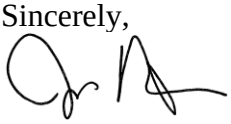
MFAR puts safety-net providers, Medicaid beneficiaries, and all employees, employers and patients in rural Texas at risk. However, if the goal as stated in the rule is to "promote transparency," CMS should work with states to report or update reports to ensure CMS has the data necessary to comply with 42 U.S.C. 1396a, regarding the financial participation by the state for the non-federal share not being less than 40 percent. Proceeding with this MFAR rule in a way that pulls the rug out from under states like Texas makes waste of the work already done to fundamentally reshape our Medicaid program from UPL. Additionally, the proposed narrowing of what are allowable state matching dollars, which appears to limit them to state appropriated budget dollars, is especially challenging in Texas. Article VIII, Section 22, of the Texas Constitution limits spending of state tax revenue not dedicated by the Constitution to the estimated rate of growth of the state economy. In recent years that equates to an increase of 6 to 8% for each two-year budget cycle to the next biennium. Historically, much of the allowable increase is consumed by inflation, state employee/retiree insurance, hurricanes, and other budget factors. So even if the Texas Legislature were amenable to increasing Medicaid match dollars (which is highly unlikely politically in a strong Republican state), they would not have a legal avenue to raise the state budget by an additional $4 to $5 billion a year to replace state match.

Our view from rural Texas is MFAR, if adopted as proposed, would result in one of three outcomes:

1. Medicaid Expansion (not likely in Texas),
2. Mandated massive tax increases (not likely in Texas), and
3. An acceleration of rural closures.

MFAR's sweeping changes critically harm already medically disadvantaged communities and threatens rural hospitals' ability to care for the people in their communities. As you are aware, safety net providers in rural areas anchor the local economy, so when the hospital fails, the entire community - employers, schools, and churches – fails, too. In sum, pending further demonstration of the need for the most harmful provisions in the Proposed Rule, we recommend and urge CMS to amend the rule and remove the new definition of public funds until such time as it is prepared to offer a firm alternative funding vehicle or pathway which maintains the rural safety net and guarantees a continued and consistent revenue stream to rural facilities that is sufficient to allow them a future.

Sincerely,



John Henderson
President/CEO