January 31, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via: http://www.regulations.gov/

RE: Proposed Rule: CMS 2393-P/RIN 0938-AT50 Medicaid Program: Medicaid Fiscal Accountability Regulation

Dear Administrator Verma:

The Children's Hospital Association of Texas (CHAT) appreciates the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation (MFAR), CMS 2393-P/RIN 0938-AT50. CHAT represents eight free-standing, not-for-profit children's hospitals located in Texas. Its mission is to advance children's health and well-being by advocating for policies and funding that promote children's access to high-quality, comprehensive health care. On behalf of our members, CHAT respectfully requests that the Centers for Medicare and Medicaid Services withdraw the proposed regulation because it will severely impair the Texas Medicaid program, on which our member hospitals are heavily dependent. While CHAT understands and supports CMS's goal of gaining a better understanding of how supplemental payments are used by states, CHAT believes that the proposed regulation will substantially harm children's hospitals in Texas for a number of reasons.

Medicaid is the primary payor for care provided by children's hospitals in Texas.

Children's hospitals in Texas rely heavily on Medicaid funding due to a confluence of factors, including:

- The number of children in Texas;
- The poverty rate for children in Texas; and
- The limited number of payors for children (*i.e.*, no Medicare payments).

According to the Texas State Demographer, 7.4 million children under the age of 18 lived in Texas in 2019. About half of those children are enrolled in Medicaid or the Children's Health Insurance Program (CHIP). To put this number in perspective, the number of children under 18 in Texas exceeds the **total population of 38 US states and territories,**[1] **and one of every 10 children in the country lives in Texas**.[2] With the large number of children in Texas and the poverty rate for children in the state, Medicaid is the payor for between 50% and 80% of all inpatient days at children's hospitals.

According to the Annie E. Casey Foundation's 2019 Kids Count Book,[3] 21% of children, more than 1.5 million kids, live in poverty in Texas. Texas has a very lean Medicaid program, and most of the enrollees are children. In fact, Texas has only two eligibility categories that exceed the federally-mandated minimums: pregnant women and the aged, blind, and disabled.[4]

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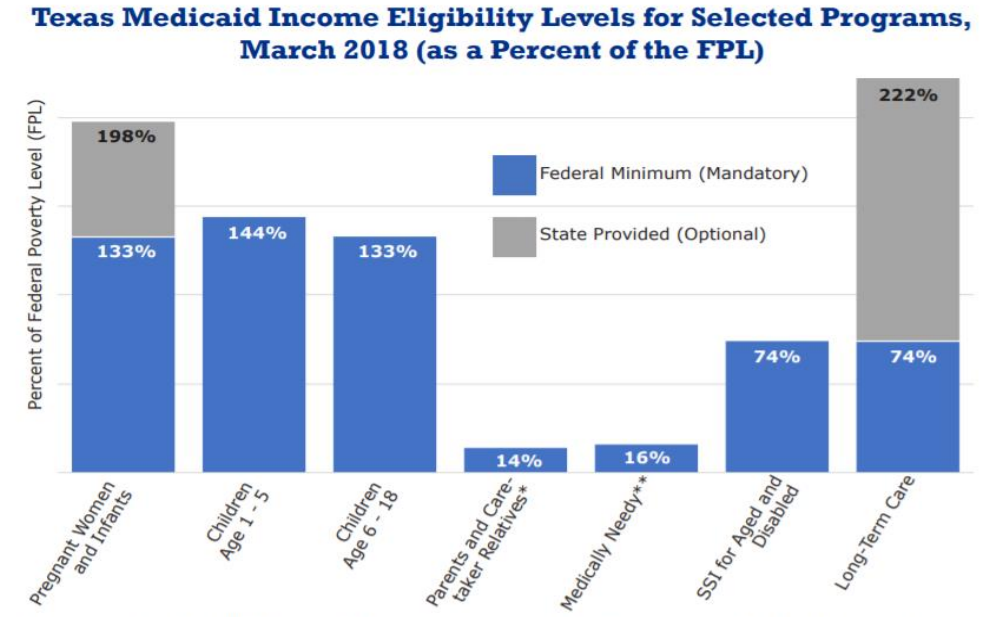
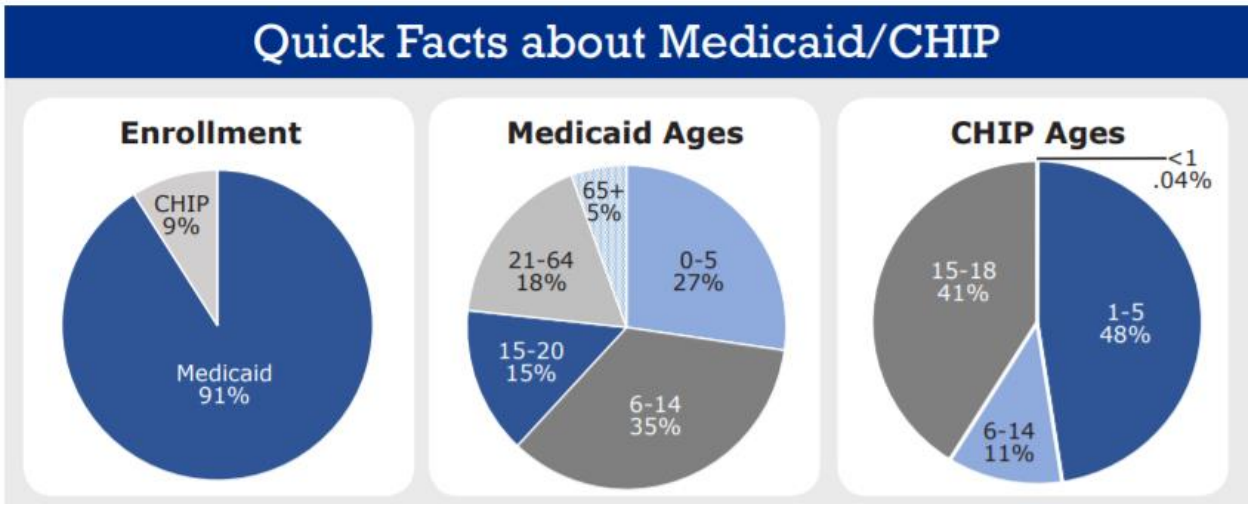
[1] World Population Review, last accessed on 1/29/20.
[2] https://www.childstats.gov/americaschildren/tables/pop1.asp, last accessed on 1/29/20.
[3] https://www.aecf.org/resources/2019-kids-count-data-book/, last accessed 1/29/20.
[4] https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/reference-guide, p. 12, last accessed 1/29/20.



This figure reflects eligibility levels as of March 2018. In 2014, the Affordable Care Act (ACA) required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for Modified Adjusted Gross Income (MAGI) changes.

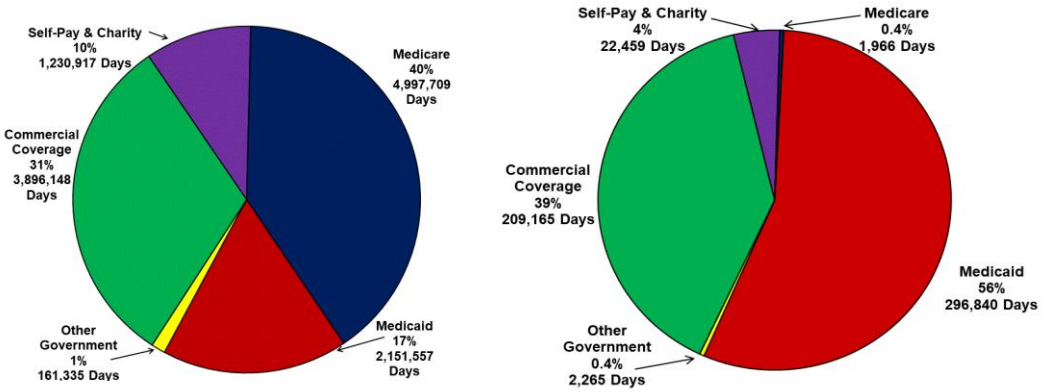
*For Parents and Caretaker Relatives, maximum monthly income limit in SFY 2018 was $230 for a family of three, which is approximately 14 percent of the FPL. **For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2018 was $275 for a family of three, which is approximately 16 percent of the FPL.

As is demonstrated by the chart below, 77% of the Medicaid enrollees are under age 21:[5]



Children's hospitals also have a limited number of payor sources, as they receive almost no Medicare funding. Thus, as is shown below, children's hospitals are heavily dependent on Medicaid funding:

[5] https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/reference-guide, p. 3, last accessed 1/29/20.



All Other Texas Hospitals
No. of Hospitals = 403
Total Patient Days = 12.44 Million

CHAT Hospitals
No. of Hospitals = 8
Total Patient Days = 532,695

Source: Texas Hospital Inpatient Discharge Public Use Data File, 2016; Center for Health Statistics, DSHS.

Disruption to or reduction in this vital funding will limit the availability of life-saving and life-sustaining services for all children. Children's hospitals serve as the safety net for all children, not only in the state but often across the region, nation, and world. El Paso Children's Hospital, for example, is the only free-standing children's hospital between San Antonio, Texas, and Phoenix, Arizona. These hospitals do not differentiate care based on a patient's payor. In fact, children's hospitals often subsidize specialists' and sub-specialists' payments to ensure that these providers are accessible to **all** children. Any disruption in Medicaid funding threatens the availability of specialized pediatric services to every child who needs medical care.

MFAR would devastate Medicaid programs that are critical to the financial support of children's hospitals in Texas.

MFAR would have a devastating impact on the Texas Medicaid program upon which children's and other safety net hospitals rely to defray some of the uncompensated cost of treating Medicaid and uninsured patients. The Uncompensated Care ("UC") program under Texas's section 1115(a) Medicaid demonstration waiver has been a critical source of funding for children's hospitals in our State to meet the healthcare needs of children who rely solely on Medicaid for coverage or who are under- or un-insured and depend on charity care. The same holds true for the state's Medicaid Disproportionate Share Hospital ("DSH") program. UC and DSH payments help make up some, but far from all, of the uncompensated costs that children's hospitals incur in treating children who must look to the Medicaid program to pay their hospital and medical bills.

There is already enormous pressure on governmental entities to use scarce public funds to support the provision of care to the Medicaid and uninsured populations in the state. UC and DSH payments cover only a portion of the uncompensated cost incurred by hospitals like children's hospitals that bear the highest burden in treating Medicaid and uninsured patients, many of whom are infants or children with serious or life-threatening conditions. MFAR as proposed would add significant and unnecessary disruption to Medicaid program funding that already faces steep challenges.

The proposed changes at 42 C.F.R. § 433.68(f)(3) will unduly burden states, local governmental entities, and providers when participating in otherwise valid health care-related taxes.

Replacing the current objective tests used to determine whether an impermissible hold-harmless arrangement exists in the context of health care-related taxes with a subjective "net effect" test will make it more difficult for states and local governmental entities to institute health care-related taxes—even when entirely compliant—that are vital for bringing federal Medicaid funds to children's hospitals and other parts of the healthcare safety net. State and local governmental entities will need to be concerned about whether differing business relationships or transactions among independent taxpayers have the net effect of reducing or offsetting tax burdens. Public resources will need to be expended to consider "all relevant financial transactions or transfers of value" and the "totality of the circumstances"—including but not necessarily limited to—the "reasonable expectations of the participating entities" and their "reciprocal actions." These changes will put administrative burdens on governmental entities and additional financial strain on the Medicaid program, including Medicaid supplemental payment programs and the DSH program, which are already under severe strain.

The proposed changes at section 433.68(f)(3) would also have financial ramifications for healthcare providers even if they continue to receive some level of Medicaid payments that are funded by health care-related taxes. The proposed section 433.68(f)(3) is so ambiguous that providers will be unable to record these Medicaid payments as revenue without establishing significant reserves in case CMS decides that the payments are impermissible. This will result in material decreases to provider net revenue, which could in turn reduce access to care for all patients. As in the case of market uncertainty, when there is Medicaid finance uncertainty, providers like children's hospitals that rely substantially on Medicaid to meet their obligations, will contract, meaning that they will begin to limit growth, cut back services, and reduce outlay. Providers will be unable to seek the financing necessary to fund healthcare services or to meet their financial obligations to employees and creditors. This will result in life-sustaining and life-saving care not be available to children as well as a large economic contraction, as hospitals are large employers and economic drivers in their community. No one wants to move to a state that does not have high-quality healthcare.

The proposed rules changes to 42 C.F.R. § 433.68(f)(3) are unconstitutionally vague and cannot be squared with the Social Security Act.

In addition to putting excessive strain on the ability of children's hospitals to serve Medicaid patients, CHAT believes that the proposed changes to 42 C.F.R. § 433.68(f)(3) are legally invalid.

First, nothing in these provisions articulates a specific and clear test so that the regulated entities can identify permissible or impermissible activity; instead, the proposed provisions allow CMS to make *ad hoc* decisions on a case-by-case basis. When enacting the initial health care-related tax regulations, the Healthcare Financing Administration (HCFA) (CMS's predecessor) emphasized the importance of applying "clear and specific rules" for identifying a hold harmless arrangement, and HCFA acknowledged that "subjective [tests] would be administratively burdensome and virtually impossible to apply fairly throughout the nation."[6]

Section 433.68(f)(3) falls far short of implementing HCFA's position. It also runs afoul of core, due process protections provided by the U.S. Constitution. It is widely accepted that laws must "provide explicit standards for those who apply

[6] Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156, 43,167 (Aug. 13, 1993) ("We believe that subjective analysis does not allow for a reasonable test of the hold harmless provisions. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured.").

them" in order to prevent arbitrary and discriminatory enforcement.[7] Any rule that permits such a high degree of subjectivity would authorize CMS to approve or deny similar programs in different States and still be within the scope of the regulation because the regulation does not articulate a clear test for identifying a direct guarantee. Federal courts have acknowledged that this "unfettered discretion is patently offensive to the notion of due process,"[8] and the Supreme Court has warned against rules that create a "trap for the wary as well as unwary."[9]

By moving away from a standardized test to determine whether a health care-related tax involves an impermissible guarantee and substituting vague and over-broad language like "totality of the circumstances" and "net effect," CMS is injecting vague and subjective standards into Medicaid funding structures that will likely cause large and unpredictable swings in program funding. This unpredictability will potentially result in reductions in current services children's hospitals can provide to Medicaid patients and limitations in making long-term investments to meet the growing needs of patients.

Second, CMS lacks authority to apply 42 C.F.R. § 433.68(f) in the ways articulated in the preamble. Based on language in the preamble, CMS is attempting to regulate wholly private transactions in identifying a prohibited hold harmless arrangement in 42 C.F.R. § 433.68(f)(3). CHAT believes that CMS lacks the authority to regulate this activity under the Social Security Act (the Act). The guarantee hold harmless test Congress adopted in 1991 clearly requires the "*State or other unit of government imposing the tax*" to be the entity holding a taxpayer harmless.[10] Nothing in the Act delegates authority to the Secretary to expand this test to include purely private transactions that allegedly hold taxpayers harmless.. With agency rulemaking, it is a "basic tenet" that the regulations "must be consistent with the statute under which they are promulgated." [11] CMS does not have the authority here to broaden the scope of Congress's guarantee hold harmless test to regulate transactions that occur exclusively between private entities with no governmental direction or participation. Not only does the Act disallow CMS's argument in the preamble that transactions solely between private parties can really be transactions holding taxpayers harmless, this argument is also inconsistent with decades of guidance that concluded that CMS does not have authority to regulate private transactions in this manner.

If this rule takes effect, it will require CMS or the States to police each and every transaction a Medicaid provider makes. Nothing in the Act or its legislative history indicates Congress intended to allow CMS to have that level of regulatory power over a private entity's transactions. CMS has not identified any statutory authority that imposes this duty or even permissive authority for this type of oppressive oversight. Once a provider receives its Medicaid payment, the provider has discretion in how to use that funding. In fact, the Departmental Appeals Board within the U.S. Department of Health & Human Services previously acknowledged that Medicaid providers may use funds "for whatever purposes are consistent with [their] governing polices."[12] CMS's proposed rule directly contradicts the agency's longstanding policy and the Act.

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[7] *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).
[8] *Bullfrog Films, Inc. v. Wick*, 847 F.2d 502, 513-15 (9th Cir. 1988).
[9] *Gentile v. State Bar of Nevada*, 501 U.S. 1030, 1051 (1991).
[10] 42 U.S.C. § 1396b(w)(4) (emphasis added).
[11] *Decker v. Northwest Envtl. Defense Ctr.*, 568 U.S. 597, 608 (2013).
[12] Alaska Dep't of Health and Social Servs., DAB No. 2103 at 23 (2007).

Similar deficiencies exist with other MFAR provisions.

The problems that beset 42 C.F.R. § 433.68(f)(3) are far from isolated:

- 42 C.F.R. § 433.54(c)(3): The proposed rule adds a similar "totality of the circumstances"/"net effects" rubric to determine whether a guarantee hold harmless exists in the context of provider-related donations. As with the additions to 42 C.F.R. § 433.68(f)(3), these changes would make it more difficult for governmental entities to support the provision of care to the neediest individuals, including children covered by Medicaid who suffer from the most complex medical conditions. These proposed changes also suffer from the same infirmity of being unconstitutionally vague.

- 42 C.F.R. § 433.51: In a dramatic shift from what CMS currently allows, this proposed change would prohibit governmental entities, including local public hospitals, from making intergovernmental transfers ("IGTs") for Medicaid payments using their net operating revenue or other sources of public funds such as public bonds, publicly-financed loans, or disbursements from tobacco settlement funds. CMS justifies this change by claiming that the Act allows IGTs to be made only when the source of funding is tax revenue or appropriations to State university teaching hospitals.

  This position is belied by both the governing statute and decades of past practice. The federal statute clearly creates a safe harbor for IGTs that are derived from tax revenue such that CMS cannot limit or interfere with these funding sources.[13] But the statute in no way prohibits states from relying on other sources of local government funds such as bonds, publicly financed loans, tobacco settlement funds, and the like. For decades, CMS and its predecessor agencies have allowed operating revenue of public hospitals and other sources of public funds comprise IGTs.

For the above reasons, CHAT respectfully requests CMS to consider how these regulations will unduly harm children's hospitals and other safety net providers and constrain legitimate state and local funding arrangements. We believe that these harms—which are real—are not outweighed by the benefit of eliminating and deterring those select arrangements that may be truly abusive or improper. CHAT therefore respectfully urges CMS to withdraw this proposed rule and instead work with interested stakeholders to address legitimate concerns raised by the agency regarding the need for more transparency and accountability on state supplemental Medicaid payments.

Sincerely,

Stacy E. Wilson

Stacy E. Wilson, J.D.
President

[13] *See* 42 U.S.C. § 1396b(w)(6)(A).