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File Code CMS-2393-P: Comments on the Medicaid Financial Accountability Regulation (MFAR)

The Texas Association of Voluntary Hospitals is comprised of 14 health systems operating more than 150 hospitals in Texas. These not for profit hospitals form a significant portion of the safety net for Medicaid and uninsured patients. Texas leads the nation in the percent of the population without health insurance, and like many states, the rates paid for Medicaid services are well below the cost of providing those services. Therefore, we rely heavily on the availability of Medicaid supplemental payments to partially offset the cost of care for these low-income populations. We appreciate the opportunity to comment on the proposed MFAR rule.

The summary of the proposed rule indicates that MFAR would accomplish the following objectives:

1. promote transparency;
2. establish requirements to ensure that state plan amendments proposing new supplemental payments are consistent with proper and efficient operation of the state plan and with efficiency, economy, and quality of care; and
3. address issues related to the financing of the non-federal share of supplemental and base payments including the requirements pertaining to the non-federal share of any Medicaid payment.

While CMS states that much of the proposed rule merely codifies or clarifies existing policies, to the contrary, we find that the rule redefines the policies and historical positions held by CMS in a way that threatens the ongoing viability of the health care safety net. We submit that the proposed rule's departure from the CMS policies that have enabled states to finance their portion of supplemental payments would force state governments to increase taxes in order to salvage these critical programs or watch as the health care infrastructures that support rural communities and inner-cities collapse. This document will point out the specific provisions in the proposed rule that would create this dilemma.

We respectfully ask that CMS withdraw the proposed rule, and work collaboratively with states to achieve the shared goals of transparency and accountability in Medicaid while protecting the fragile safety net that supports Medicaid and uninsured patients.

I. PROVIDER TAXES

1. The proposed rule's "reasonable expectation" standard for identifying a direct guarantee violates the Social Security Act.

TAVH opposes the proposed use of the "reasonable expectation" standard for identifying a direct guarantee in 42 C.F.R. § 433.68(f)(3) because it violates the Social Security Act (the Act). The proposed "reasonable expectation" standard effectively bans States from using health care-related taxes for Medicaid financing because, by definition, providers will expect that if they are taxed to support the Medicaid program, some of those Medicaid funds will flow to the taxpaying providers. Specifically, CMS explains a "direct guarantee" will exist any time a taxpayer has a "reasonable expectation" that it will receive a return of "any portion" of its tax. Therefore, CMS's position ignores Congress's mandate that States may use health care-related taxes for Medicaid payments. When addressing health care-related taxes, Congress specified that States could use them for Medicaid financing and clarified that nothing in the Act would "preclude States from relying on [Medicaid] reimbursement to justify or explain the [purpose of the] tax."[1] Consequently, CMS cannot argue the proposed rule complies with Congressional intent while also saying that providers may not have any expectation that a tax to support the Medicaid program will result in any benefit to the providers that are subject to the tax.

In 1991, when Congress passed these health care-related tax provisions, Congress laid out three clear hold harmless tests, which the Secretary enforces, but Congress did not delegate any legislative authority to the Secretary to expand these tests in any way. With agency rulemaking, it is a "basic tenet" that the regulations "must be consistent with the statute under which they are promulgated."[2] CMS's proposed "reasonable expectation" standard is entirely inconsistent with the statute and the explicit legislative history surrounding the Act's health care-related tax provisions.

The proposed changes to 42 C.F.R. § 433.68(f)(3) would capture far more regulated activity than Congress intended, effectively invalidating any tax used to fund Medicaid payments to the taxpayers. One motivation Congress had for passing these provisions in 1991 was to clarify to the Secretary that CMS could not prohibit the use of health care-related taxes as a source of Medicaid financing. CMS's predecessor agency proposed a rule in 1991 that prohibited health care-related taxes if there was any "linkage" between payments to the provider and the tax.[3] In response to this proposal, a 1991 House report noted, "In short, it appears that the Secretary has attempted by regulation to convert the statutory provision

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1 42 U.S.C. § 1396b(w)(4).
2 Decker v. Northwest Envtl. Defense Ctr., 568 U.S. 597, 608 (2013).
3 Medicaid Program; State Share of Financial Participation, 56 Fed. Reg. 46,380 (Sept. 12, 1991).

enacted in OBRA 90 from a general authorization for States to use the revenues from provider-specific taxes into a broad prohibition against the use of provider-tax revenues." [4] The report further called the agency's attempts to subvert the statute "an illogical and patently impractical result."[5] Through this proposed rule, CMS is once again attempting to do what Congress explicitly rejected in 1991. Therefore, CMS must remove this proposed provision.

2. The proposed rule's "totality of the circumstances" and "net effect" tests violate the Social Security Act, provide CMS with unfettered discretion, and are impermissibly vague.

TAVH opposes the imposition of new subjective tests, such as "totality of the circumstances" and "net effects," for identifying a direct guarantee in 42 C.F.R. § 433.68(f)(3) because these subjective tests are impermissibly vague. Nothing in these tests articulates a specific standard so that the regulated entities can identify permissible or impermissible activity; instead, the proposed rule allows CMS to make ad hoc decisions on a case-by-case basis. It is widely accepted that laws must "provide explicit standards for those who apply them" in order to prevent arbitrary and discriminatory enforcement.[6] 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. Moreover, the subjectivity provided by this level of discretion would lead to erratic swings in the determination of permissible funding by subsequent administrations. Federal courts have acknowledged that this "unfettered discretion is patently offensive to the notion of due process,"[7] and the Supreme Court has warned against rules that create a "trap for the wary as well as unwary."[8]

When enacting the initial provider tax regulations, 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."[9] CMS did not have authority to utilize broad, subjective tests in 1993, and CMS lacks the authority now. This provision must be struck from the proposed rule.

3. The proposed rule's "totality of the circumstances" test for determining whether a health care-related tax is generally redistributive is subjective and impermissibly vague.

TAVH opposes the imposition of a subjective test like "totality of the circumstances" for determining whether a health care-related tax is generally redistributive in 42 C.F.R.

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4 H.R. Rep. No. 102-310, at 25 (1991)

5 H.R. Rep. No. 102-310, at 25 (1991).

6 *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).

7 *Bullfrog Films, Inc. v. Wick*, 847 F.2d 502, 513-15 (9th Cir. 1988).

8 *Gentile v. State Bar of Nevada*, 501 U.S. 1030, 1051 (1991).

9 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.").

§ 433.68(e)(3)(iv) because such a subjective test is impermissibly vague. Including a catch-all standard does not provide sufficient guidance to States on which classes would or would not be permissible groupings. Instead, the proposed rule allows CMS to make ad hoc decisions on a case-by-case basis. It is widely accepted that laws must "provide explicit standards for those who apply them" in order to prevent arbitrary and discriminatory enforcement.[10] 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. Without a clear standard, CMS can completely disregard a State's appropriate and justifiable policy reasons for excluding certain classes. For example, if a State determines that rural hospitals or critical access hospitals should be excluded from the tax to prevent a disruption of services, CMS could second-guess the State's rationale based on the "totality of the circumstances." Federal courts have acknowledged that this "unfettered discretion is patently offensive to the notion of due process,"[11] and the Supreme Court has warned against rules that create a "trap for the wary as well as unwary."[12]

The Social Security Act directs CMS to ensure the "net impact" of the tax is "generally redistributive,"[13] and CMS established clear, numerical tests to address that directive. To the extent CMS now believes the tests require additional refinement, CMS should develop and explain a new calculation. Establishing a broad and subjective catch-all standard bereft of clear rules will lend itself to inconsistent and potentially discriminatory enforcement, particularly between different administrations.

4. CMS has no authority to apply the Social Security Act's hold harmless tests to private transactions absent state participation.

TAVH opposes attempts to regulate private transactions in identifying a prohibited hold harmless arrangement in 42 C.F.R. § 433.68(f)(3)—which is CMS's clear intent from this provision as discussed in the preamble—because CMS lacks authority to regulate this activity under the Social Security Act (the Act). Since Congress adopted the hold harmless tests in 1991, the tests have clearly required the "***State or other unit of government imposing the tax***" to be the entity holding a taxpayer harmless in order to violate the Act.[14] Nothing in the Act delegates legislative authority to the Secretary to expand these tests in any way. With agency rulemaking, it is a "basic tenet" that the regulations "must be consistent with the statute under which they are promulgated."[15] CMS does not have the authority to broaden the scope of Congress's hold harmless tests to regulate transactions that occur exclusively between private entities with no governmental direction or participation. Moreover, CMS's argument in the preamble that a Medicaid payment retains that characteristic after a provider receives the payment, such that transactions solely between private parties are really hold harmless transactions with the governmental taxing entity,

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[10] *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).
[11] *Bullfrog Films, Inc. v. Wick*, 847 F.2d 502, 513-15 (9th Cir. 1988).
[12] *Gentile v. State Bar of Nevada*, 501 U.S. 1030, 1051 (1991).
[13] 42 U.S.C. 1396b(w)(3)(E).
[14] 42 U.S.C. § 1396b(w)(4) (emphasis added).
[15] *Decker v. Northwest Envtl. Defense Ctr.*, 568 U.S. 597, 608 (2013).

violates the plain language of the Act and decades of prior CMS and other regulatory agency guidance that concluded 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 due to the fungible nature of money. 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 intrusive 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 Department of Health & Human Services previously acknowledged that Medicaid providers may use funds "for whatever purposes are consistent with [their] governing polices."[16] CMS's proposed rule directly contradicts the agency's longstanding policy and the Act, and stands in stark contrast to the good work that the Trump Administration has done in reducing government regulations on business.

In addition to the legal consequences of this change, the rule would have financial ramifications for all healthcare providers that receive Medicaid payments. Even though Medicaid payments are reimbursement for costs healthcare providers already incurred, MFAR's regulations are so ambiguous in terms of what is permissible that providers will be unable to record these Medicaid payments as revenue without significant reserves for potential write-offs. This will result in a material decrease to provider net revenue, cause significant job loss and reduce access to care for all patients. Providers will be unable to seek the financing necessary to fund health care services or to meet their financial obligations to employees and creditors.

It is clear from the preamble that CMS is challenging a perceived impermissible effect of private arrangements regardless of whether statutory authority provides a credible avenue for CMS to regulate that private activity. For these reasons, CMS should tailor the proposed rule changes and correct the overreaching discussions in the preamble to clarify that purely private transactions are outside of CMS's regulatory authority for purposes of identifying a hold harmless arrangement.

5. CMS's characterization that states have taken advantage of a "loophole" in federal law when designing their health care-related taxes ignores prior CMS approvals of financing sources other than general revenue.

TAVH opposes the characterization in the preamble that States have taken advantage of a "loophole" in federal law when designing their health care-related taxes. This framing gives the perception that States are actively attempting to evade federal requirements when they actually worked in conjunction with CMS to design their tax programs. During the 2008-2009 recession, CMS worked with States and used CMS's flexibility under federal law to identify permissible financing sources other than State general revenue. States particularly relied on these flexibilities once the federal government ended its stimulus funding in 2012,

[16] Alaska Dep't of Health and Social Servs., DAB No. 2103 at 23 (2007).

and they have continued to rely on these financing sources for their Medicaid programs ever since. Health care-provider taxes often support numerous Medicaid payment programs, including base rates for rural hospitals, nursing homes, and physicians.

While there may be isolated incidences where States or providers abuse certain financing or payment structures, the scope of this proposed rule threatens to have a much broader impact. Under prior administrations, CMS made conscious policy decisions to allow States a degree of flexibility within the parameters of the Social Security Act and helped States design their health care-related taxes to ensure the sustainability of the Medicaid program. In a complete reversal, CMS now contends the States are taking advantage of a "loophole" and attempting to defraud the federal government. CMS provided clear guidelines for states to follow in designing their health care-related taxes, and the States abided by those guidelines.

Many States have legitimate policy justifications supporting any exclusions in their health care-related tax and the specific programs the taxes fund. The States worked with CMS to ensure the design was appropriate and consistent with the federal requirements. Several changes in the proposed rule now threaten to effectively prohibit States from using health care-related taxes to finance part of their Medicaid programs. Without health care-related taxes as a source of financing, many States may be forced to reduce their level of participation in the Medicaid program. This will likely result in escalating the rate of rural hospital closures, reducing access to care in both the rural and urban setting, reducing service lines that are high in Medicaid volume (e.g. obstetrics), and increasing the rates commercial plans must pay to subsidize hospitals' losses on treating Medicaid and indigent patients.

The proposed rules will have the opposite effect of their stated intention. They will result in decreasing the sufficiency of States' Medicaid provider networks, in direct contradiction to the mandate of the Social Security Act.

II. STATE FLEXIBILITY

1. The proposed rule exceeds CMS's statutory authority by interfering with state discretion to administer state Medicaid programs and set reimbursement rates.

The Social Security Act ("the Act") affords states great flexibility in designing their Medicaid programs.

Minimum Reimbursement Required

The Act requires states to set ***minimum*** reimbursement rates that are "sufficient to enlist enough providers so that care and services are available [to Medicaid beneficiaries] to the extent such care and services are available to the general population" (referred to as the "Equal Access Provision").[17]

Maximum CAP on Individual Hospitals

The Act likewise sets a ***maximum*** reimbursement rate for individual Medicaid providers—the hospital-specific charge limit.[18] Within this range of maximum and minimum reimbursement rates, Congress has granted states the discretion to design tailored reimbursement programs that conform to individual state circumstances and policy goals.

The proposed rule violates the Act by undermining that congressionally granted deference. CMS now asserts that a state violates the Act if it makes supplemental payments to only a subgroup of providers within a class because the providers' reimbursement may exceed their costs.[19] CMS' relies on the Act's requirement that states ensure payments are consistent with "economy, efficiency, and quality of care" as the authority for CMS to regulate and reduce the rates states set for their individual providers.[20] But Congress already explicitly specified the maximum rate states may pay their individual provider ***in the Act***—the charge limit[21]—and the Act does not provide CMS the discretion to implement caps on individual providers below that limit or to undermine Congress' unambiguous intent.

Maximum CAP on Groups of Hospitals

Though the Act already creates a provider-specific reimbursement ceiling, Congress has authorized other, additional reimbursement ceilings ***in the aggregate***, i.e., on a group of providers. In 1981, for example, Congress directed that "the amount paid [consistent with the Act] cannot, ***in the aggregate***, exceed the amount determined to be reasonable under Medicare."[22] But Congress rejected CMS' attempt to impose similar Medicare-based ceilings on *individual* providers in a 1986 House Budget Committee statement entitled "Clarification of flexibility for State Medicaid payment systems for inpatient services."[23] There, the Committee clarified that Congress' intent in replacing the "reasonable cost" standard of 1965

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17 42 U.S.C. § 1396a(a)(30)(A).
18 42 U.S.C. § 1396b(i)(3) (effective date Oct. 30, 1971).
19 *Medicaid Program; Medicaid Fiscal Accountability Regulation* 84 Fed. Reg. 63,722, 63,724 (Nov. 18, 2019) [hereinafter "MFAR"].
20 *Id.*
21 42 U.S.C. § 1396b(i)(3) (effective date Oct. 30, 1971).
22 *See* H.R. CONF. REP. 97-208, 962, 1981 U.S.C.C.A.N. 1010, 1324 (emphasis added).
23 Statement by the House Budget Committee, H.R. REP. 99-727, 121-22, 1986 U.S.C.C.A.N. 3607, 3711-12.

was to provide states with more—not less—flexibility when setting rates.[24] The Committee stated that "the Secretary has ***no authority whatsoever*** … to impose Medicare-related limits of any kind on [states'] payment rates."[25] The Committee continued:

> "[N]othing in the Medicaid statute shall be construed as authorizing the Secretary to limit the amount of payment that may be made with respect to inpatient hospital, SNF, ICF, or ICF/MR services. This includes any limitations, including [those based on Medicare reimbursement principles]."[26]

Read together, the 1981 and 1986 statements illustrate that CMS may only impose ***aggregate*** reimbursement caps on Medicaid providers' reimbursement because Congress has already explicitly created a provider-specific one. This conclusion is bolstered by CMS' own admission in 2001 that Congress intended a recent amendment to the Act to provide states ***more flexibility*** to "target rate increases to particular types of facilities."[27] Yet the proposed rule now attacks state reimbursement programs that direct more favorable rates to some providers over others (for example, to providers who can finance their own payments through IGTs or CPEs) and attempts to dictate state payments at the provider level—contrary to the Act and to Congress' intent.[28]

Congress' intent, as revealed through the Act's legislative history, neither precludes states from directing favorable rates to one provider over another nor prevents them from considering available financing sources when making those determinations—so long as they remain within the Act's minimum reimbursement floor and its provider-specific charge-limit ceiling.[29] This statutory framework leaves little room for CMS to interfere with states' Medicaid program design and payment structures at the provider level.

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[24] *See id*.

[25] *Id*. (emphasis added).

[26] *Id*.

[27] *See* H.R. Rep. 105-149, 547 (1997) ("The provisions in this chapter would give states **increased** flexibility to implement managed care programs, set payment rates, expand eligibility, implement programs of all-inclusive care for the elderly (PACE), change benefit requirements; and meet federal requirements for administrative activities.") (emphasis added); *Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations*, HEALTH CARE FIN. ADMIN. (Dec. 10, 1997), *available at* https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD121097.pdf ("The intent of [the Boren Amendment's replacement] is to provide states with **maximum possible flexibility**, as well as to minimize HCFA's role in reviewing inpatient hospital and long-term care state plan amendments involving payment rate changes.") (emphasis added).

[28] MFAR at 63,724.

[29] 42 U.S.C. § 1396a(a)(13)(A).

III. INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES

1. CMS lacks the authority to limit funds that public bodies may use for intergovernmental transfers to only tax revenue or state appropriations.

TAVH opposes proposed Section 433.51, which would impermissibly prohibit the use of "public funds" for intergovernmental transfers ("IGTs") by state and local government entities, including hospital districts, that finance the nonfederal share of Medicaid payments. Proposed Section 433.51 replaces the definition of IGT-eligible public funds with one that permits IGTs comprised solely of tax revenue dollars or, for state university teaching hospitals, state appropriations.[30] In its Preamble, CMS urges that "IGTs from sources other than state or local tax revenue [or state appropriations are] not permitted under" Section 1903(w)(6)(A) of the Social Security Act (the "Act"). But that argument ignores both the plain meaning of Section 1903(w)(6)(A) and Congress' unambiguous intent regarding the agency's treatment of public funds.

In 1991, Congress enacted Section 1903(w)(6)(A) of the Act, which provides that CMS "may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to state university teaching hospitals) transferred from units of government within a State as the non-Federal share of expenditures, regardless of whether the unit of government is also a health care provider."[31] Congress explained that its amendments implemented a "moratorium" that was "permanent" on changes in CMS policy regarding a state's use of IGTs and that it intended the amendments to allow state entities to use more than solely tax revenue or state appropriations for IGT.[32] Congress specifically intended the 1991 amendments to protect IGTs from "***any public funds … from public entities***," including hospital district revenues from "services rendered."[33]

CMS acknowledged this congressional mandate in 1992,[34] and again in its 2007 Final Rule,[35] where CMS explained that IGTs may come from "public funds" including a governmental entity's or state university teaching hospital's "fees, grants, earned interest, fines, sale or

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30 Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,737–38 (Nov. 18, 2019) [hereinafter "*MFAR*"].

31 Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, Pub. L. 102-234, 105 Stat. 1793 (Dec. 12, 1991) (codified at 42 U.S.C. 1396b(w)(6)(A)).

32 H.R. CONF. REP. 102-310, 1991 U.S.C.C.A.N. 1413, 1414 (Nov. 26, 1991) ("With respect to intergovernmental transfers, this moratorium would be permanent.").

33 *See id.* at 1426 ("A hospital district may transfer or certify to the State Medicaid agency a portion of its revenues, which may be collected by the district's facilities as payment for services rendered, or through its special taxing authority.").

34 Medicaid Program: Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55,118, 55,119 (Nov. 24, 1992) ("Public Law 102-234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes transferred from or certified by units of governments within a State [unless derived from provider-related donations] …. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.").

35 Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29,748 (May 29, 2007).

lease of public resources, legal settlements and judgments, revenue from bond issuances or tobacco settlement funds."[36] For governmentally operated healthcare providers, CMS similarly acknowledged that "patient care revenues from third-party payers … would [also] be acceptable sources of financing."[37]

MFAR violates the permanent moratorium Congress expressly imposed on CMS in the Act. MFAR erases current rules that allow IGTs "derived from public funds …. transferred from" a public agency and prohibits all IGTs other than those "derived from State or local taxes" or, for state university teaching hospitals, "derived from state appropriations."[38] These changes appear innocuous because MFAR uses the Act's "derived from" language.[39] But upon reading MFAR's preamble, CMS' true intent becomes clear: the new regulatory language applies "derived from" to mean *solely* tax revenue. These changes contradict the Act's safe harbor for transfers of any **funds** that originate in and are derivative of tax revenue or appropriations, such as the "service revenues" that Congress explicitly identified as a protected source.[40] MFAR's attempt to prohibit the use of service revenues and other funds derived from these sources for IGT purposes violates the explicit language of the Act's safe harbor, which embodies the stated intent of Congress.

CMS' sudden departure from longstanding policy (i) will jeopardize the very economy, efficiency and quality of care the agency seeks to enforce, (ii) is inconsistent with congressional direction, and (iii) arbitrarily departs from sound policymaking. This departure will acutely harm providers that comprise states' healthcare safety nets and that educate the next generation of physicians. These providers require the discretion to invest tax revenue and appropriations in operations, like patient services, and cannot afford to set aside these funds exclusively for IGT. TAVH therefore asks that CMS fulfill its administrative obligation to honor Congress' clearly expressed intent and preserve Section 433.51's definition of "public funds" that recognizes funds "derived from" either tax revenue or state appropriations as a permissible source of IGTs.

2. CMS lacks the authority to prohibit one state agency from transferring its state appropriations to the state Medicaid agency to finance the non-federal share.

TAVH opposes attempts to drastically reduce the use of State general revenue for the nonfederal share of Medicaid payments, as proposed by the changes to 42 C.F.R. Section 433.51 ("Section 433.51"). Proposed Section 433.51 provides that State general revenue is ineligible for federal financial participation ("FFP") if the State Legislature allocates it to any other unit of the State besides the Medicaid agency or a State university teaching hospital.[41] But that limitation violates Sections 1902(a)(2) and 1903(w) of the Social Security Act (the "Act") and deviates significantly from longstanding CMS policy.

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[36] *See id.* at 29,766.
[37] *Id.*
[38] *See MFAR*, *supra* note 1, at 63,737–38.
[39] *See* 42 U.S.C. § 1396b(w)(6)(A).
[40] *See* H.R. CONF. REP. 102-310, *supra* note 4, 1426.
[41] Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722, 63738 (Nov. 18, 2019).

Through Sections 1902(a)(2) and 1903(w) of the Act, Congress intended to permanently[42] protect States' broad use of general revenue appropriations for IGT purposes: "So long as the transfer of public funds (for either covered services or administrative activities) is made by or through a general or special purpose unit of State or local government, **the transfer is protected under the current regulation and under the moratorium on changes in that regulation, regardless of whether the unit of government is also a health care provider**."[43] Any attempt by CMS to prohibit States' use of general revenue—whether derived from State appropriations, taxes, or operating revenue—from State entities other than the Medicaid agency or State university teaching hospitals therefore plainly contradicts the Act. CMS itself has acknowledged this congressionally mandated restriction on its authority: "Congress included an exception to a general prohibition on the receipt of voluntary contributions from health care providers by allowing units of government, including governmentally-operated health care providers, to participate in the intergovernmental transfer process."[44] Indeed, CMS has historically approved state plan amendments that clearly contemplate the "transfer of funds between agencies" as an "acceptable appropriation."[45]

MFAR's proposed change makes an arbitrary distinction where one does not exist in law and serves only to restrict already strained State resources that support healthcare services for patients in need. Many units of State government—including medical schools, physician groups, clinical healthcare providers, and health departments—receive State appropriations and their State dollars are indistinguishable from those appropriated to a state teaching hospital. Therefore, there is no distinction between an IGT of a State university teaching hospital and an IGT of another State entity for purposes of FFP eligibility.

Accordingly, TAVH requests that CMS preserve Section 433.51's definition of public funds and allow States the flexibility to use State general revenue—whether appropriated directly to the State Medicaid agency or to another unit of State government—as eligible for FFP.[46] This course of action is consistent with both the plain language and legislative intent of Sections 1902(a) and 1903(w) of the Act, as well as CMS' own practice for the past 30 years.

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42 H.R. CONF. REP. 102-409, 1991 U.S.C.C.A.N. 1413, 1426 (Nov. 12, 1991) (emphasis added).

43 *Id.*

44 *See* Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership; Final Rule, 72 Fed. Reg. 29,748, 29, 760 (May 29, 2007) (emphasis added); *see id*. at 29,762 (citing transferred funds from other state or local government entities as consistent with Section 1903(w)(6)(A) of the Act).

45 *Letter to the Virginia Department of Medical Services re: Approval of State Plan Amendment 11-018*, CMS (Mar. 15, 2016); *see also Letter to the Nevada Division of Health Care Financing and Policy re: Non-Federal Share Financing*, CMS (July 19, 2006) ("[One option for non-Federal share financing] involves the sister division [(*e.g.*, a related state agency)] using an intergovernmental transfer …. consistent with the Federal regulations.").

46 CMS could still review financing mechanisms for possible non-bona fide provider-related donations without the proposed change to Section 433.51.

3. The proposed rule's limitations on certified public expenditures exceeds CMS's statutory authority.

TAVH opposes the creation of new requirements regarding a state's use of Medicaid funds obtained through certified public expenditures (CPEs).[47] When a state certifies or makes a legitimate Medicaid expenditure, CMS' proposed rule dictates how the State must allocate the federal matching reimbursement the State receives. CMS' proposed rule thus violates the Social Security Act (the Act) and contradicts CMS' longstanding policy and guidance.

CMS does not have the authority to limit a state's use of Medicaid funding attributable to CPEs. The Act unequivocally guarantees that CMS "may not restrict States' use of funds where such funds are . . . certified by units of government within a State as the non-Federal share of expenditures under this title."[48] Congress specifically contemplated local governments supporting the Medicaid program[49] and permanently prohibited CMS from interfering with states' use of these funds absent a congressional change to the Act.[50] The proposed rule violates Congress' explicit permanent Moratorium both by dictating how and when the State must allocate funds to and among its state and local public healthcare providers. CMS's proposed rule thus interferes with states' statutorily guaranteed flexibility to utilize public funds under the Act from units of state or local government.[51]

Fundamentally, CPEs represent federal financial participation-eligible costs *already incurred* by the State, either directly or through local governments. The State is entitled to reimbursement for legitimate costs it already incurred. Like any other claim for federal financial participation, the State is the only entity that may submit a claim for federal matching funds attributable to the CPE.[52] When the state submits its claim for federal matching funds for a CPE, it does so with the recognition that the unit of government effectively stepped into the State's shoes for providing covered Medicaid services,[53] which means the unit of government has already covered both the state share and the federal share

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47 42 C.F.R. § 447.206(b)(4) (providing that "the certifying entity of the certified public expenditure must receive and retain the full amount of Federal financial participation associated with the payment"). The proposed rules also require that states expend the received funds through an interim payment process to the certifying entity. 42 C.F.R. § 447.206(b)(4).

48 42 U.S.C. § 1396b(w)(6)(A).

49 H.R. REP. 102-310, 15, 1991 U.S.C.C.A.N. 1413, 1426 (CPEs and IGTs "include any public funds received by the State Medicaid agency from public entities or local units of government that function as health care providers.")

50 H.R. CONF. REP. 102-409, 18, 1991 U.S.C.C.A.N. 1441, 1444; *see also* H.R. CONF. REP. 102-409, 18, 1991 U.S.C.C.A.N. at 1426-27 ("[T]he moratorium in the Committee bill is permanent and applies to all public funds used as a source of the State share of Medicaid expenditures, including those from public entities or units of government that are also health care providers that participate in Medicaid. If the Secretary believes that any change in current statutory policy is warranted, he should present his legislative recommendations to this Committee and to the Congress. Under current law, he is without authority to make any changes in current policy or practice through regulation or administrative procedures.").

51 42 C.F.R. § 447.207 (specifying that CPEs may only be used so long as they are consistent with the proposed limits in Section 447.206); 42 C.F.R. § 447.206(b)(4),(d) (directing how states may expend federal funds attributable to a CPE).

52 42 C.F.R. § 433.30.

53 Congress explicitly did not delineate between expenditures by the state and local governments when setting CPE policy. Specifically, Congress considers CPEs "public funds received by the State Medicaid agency from public entities or local units of government" for purposes of federal financial participation. *See* H.R. REP. 102-310, 15, 1991 U.S.C.C.A.N. 1413, 1415–1418, 1426 (defining intergovernmental transfers to include CPEs when discussing the "public funds [that] may be considered as the State's share in claiming FFP").

of the cost of such services. The proposed rule, therefore, should not direct how states use the federal share that is attributable to the expenditures the State already incurred. Once the state provides Medicaid services, any funds it receives may be used for any purpose the state desires. The proposed rule encumbers how the state uses the federal share it already earned and essentially requires states to spend the federal share twice on the Medicaid program.

CMS' proposed restrictions on a state's use of Medicaid funding attributable to CPEs is inconsistent with CMS' prior policy. CMS' proposed rule implementing 42 C.F.R Section 447.206 is inconsistent with CMS' longstanding policy regarding CPEs. That policy was reflected in the preamble to CMS' 2007 final rule, in which CMS explains that because "State or local tax dollars were used to satisfy the costs of providing services to Medicaid individuals . . . Federal matching funds are available as a percentage of such costs . . . in recognition that a unit of government has satisfied the Medicaid payment in full (that is, both State and Federal share) for services provided to Medicaid individuals."[54] The proposed rule disregards the recognition that, under a CPE, the Medicaid payment was made in full.

CMS further reiterated in the preamble to the retracted 2007 final rule that states are free to use the federal funds claimed through CPEs however they like. In the preamble, CMS confirmed that states are not required to make payments to the certifying units of government:

> "Federal matching funds are effectively repayment of the Federal share of the total computable expenditure initially satisfied at a State or local government level . . .. To the extent a State agency chooses to distribute those Federal funds in a manner that is not proportional to the costs incurred by other governmental units within the State, CMS does not plan to interfere with such decisions between States, local governments and/ or governmentally-operated health care providers."[55]

CMS' proposed rule is a significant departure from this explicit and statutorily-based policy.

Consequently, TAVH respectfully requests that CMS eliminates the unnecessary requirements of 42 C.F.R Section 447.206 that violate the Act and inappropriately reverse longstanding and informed federal policy. The proposed rule eliminates state flexibility and shifts control from states to CMS to decide how Medicaid funds should be allocated to the State's own units of government, effectively altering the State's authority to budget state revenue amongst its own state agencies.

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[54] 72 Fed. Reg. at 29,789 (CMS subsequently retracted the rules, but the guidance reflects CMS' acknowledgment that CMS is reimbursing the state from the federal portion of an already incurred cost).

[55] 72 Fed. Reg. at 29,799.

IV. PHYSICIAN REIMBURSEMENT AND ACCESS TO CARE

1. The proposed rule places arbitrary and insufficient limits on physician supplemental payment rates in violation of the Social Security Act.

TAVH opposes the imposition of an arbitrary and insufficient limit on physician supplemental payments. Locating physicians available and willing to treat Medicaid patients in communities with high Medicaid volumes is a struggle throughout the United States. Nationwide, 30% of physicians refuse to take Medicaid patients.[56] In states like Texas without significant physician supplemental payments, 55% of physicians are unwilling to take Medicaid managed care patients.[57] When asked why, Texas physicians indicated that payment was too low to cover the cost of providing services.[58] To alleviate this type of challenge, many states created supplemental payment programs that make enrolling as a Medicaid provider a more palatable option for physicians. CMS historically permitted states to reimburse physicians through those programs at an amount comparable to the provider's average commercial rates to ensure access to care as required by the Social Security Act by incentivizing physicians to be willing to treat Medicaid patients.[59] In the proposed rule, CMS now seeks to limit supplemental payments to physicians to 50-75% of the physicians' base Medicaid rates, even while CMS acknowledges in other regulations that physicians sometimes need to be paid more in order to ensure access to underserved populations.[60]

Congress explicitly recognized in the Equal Access Provision of the Social Security Act that there is a meaningful relationship between provider rates and access to care.[61] The Act requires that states set Medicaid rates to ensure that Medicaid patients' access to care equals that of a non-Medicaid patient. Eliminating the option of an actuarially sound average commercial rate standard removes states' abilities to make the treatment of Medicaid patients competitive with providing services to non-Medicaid patients. Indeed, CMS recently encouraged states to optimize Medicaid provider services in their markets through actuarially sound standards, including commercial rates:

> "To encourage states to continue developing payment models that produce *optimal results* for their local markets and to clarify how the regulatory standards apply in such cases, we are also proposing to add a new paragraph § 438.6(c)(1)(iii)(E) that would allow states to require managed care plans to adopt

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[56] Health Affairs, "Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn't." Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full/.

[57] Texas Medical Association, "Survey of Texas Physicians 2016." Retrieved from https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2016_Physician_Survey_Findings.pdf.

[58] Texas Medical Association, "Survey of Texas Physicians 2016." Retrieved from https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2016_Physician_Survey_Findings.pdf.

[59] *See, e.g.*, Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care, 83 Fed. Reg. 57,264-01, 57,270 (Nov. 14, 2018). CMS defines fair market value as "the price at which *bona fide* sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition." *See* 42 C.F.R. § 411.351.

[60] 42 C.F.R. § 411.357(t).

[61] 42 U.S.C. § 1396a(a)(30)(A) (emphasis added) ("A State plan for medical assistance must … *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 … are available to the general population in the geographic area.").

> … a *commercial rate*, or other market-based rate for network providers that provide a particular service under the contract."[62]

In order to ensure adequate access to physician care for Medicaid beneficiaries, physicians need to be willing to care for Medicaid patients. When physicians are not paid an amount commensurate with what they are paid for treating other patients (i.e. commercial rates), the physicians will choose to treat non-Medicaid patients. Physicians are not required to accept patients or provide services at below-market rates. If rates are much lower than commercial rates, physicians can easily decide to opt out of the Medicaid program. Unless Congress statutorily mandates that physicians treat Medicaid patients, supplemental payments to physicians that bring total Medicaid payments closer to average commercial rates are necessary to keep physicians in the Medicaid program.

2. The proposed rule imposes arbitrary and insufficient limits on physician supplemental payments that will harm rural communities.

TAVH opposes an arbitrary limit on physician supplemental payments. Such limits especially jeopardize care in rural communities. Nationwide, 15% of Medicaid beneficiaries live in rural communities.[63] In rural areas, 45% of children are enrolled in Medicaid or Children's Health Insurance Program coverage.[64] The physician supplemental payment rate limits CMS proposes would critically harm these already medically disadvantaged communities and their patients. Hospitals in rural communities rely on current levels of supplemental payments to incentivize physicians to practice in otherwise financially undesirable service areas with relatively large Medicaid and Medicare populations. Without paying these physicians fair market value rates, rural hospitals' continued ability to recruit enough physicians to operate the facilities becomes an open question—risking not just rural Medicaid but all rural patients' access to physician care.

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[62] Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care, 83 Fed. Reg. 57,264-01, 57,270 (Nov. 14, 2018) (emphasis added). CMS's recognition of commercial rates as an actuarially sound standard for Medicaid provider rates is hardly limited to last year's proposed rule. *See, e.g.*, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,576-01 (Nov. 2, 2015) (as part of federal oversight ensuring access to care consistent with the Equal Access Provision, CMS required states to submit data comparing their provider rates with, among others, average commercial rates for comparable services); *see id.* at ("The flexibility in designing service delivery systems and provider payment methodologies … is consistent with the requirement of [The Equal Access Provision]."); Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program, 77 Fed. Reg. 66,670-01, 66,691 (Nov. 6, 2012) (explicitly including volume-based payments made up to average commercial rates in the Medicaid base rate calculation). *See also* Letter re: Medicaid Access to Care Implementation Guidance SMD #17-004, Ctrs. for Medicaid & CHIP Servs. (Nov. 16, 2017) (acknowledging that a decrease in rates, so long as it is still comparable with average commercial rates, would be unlikely to harm Medicaid patients' access to care).

[63] Center on Budget and Policy Priorities, "How Medicaid Work Requirements Will Harm Rural Residents – And Communities." Retrieved from: https://www.cbpp.org/research/health/how-medicaid-work-requirements-will-harm-rural-residents-and-communities.

[64] Center on Budget and Policy Priorities, "Medicaid Works for People in Rural Communities." Retrieved from: https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities

3. CMS falsely asserts that commercial payments do not constitute fair market value and are not efficient for Medicaid services.

TAVH disagrees with CMS that commercial payments do not consider patient access and quality of care. In the proposed rule, CMS asserts that paying fair market value rates is not efficient for Medicaid.[65] This comment fails to appreciate the fact that commercial payors are just as interested, if not more so, in efficiency and economy as CMS because they stand to profit from paying lower rates. Commercial payors are incentivized to only pay physicians the minimum necessary to entice the physician to see the payor's patients. Thus, if a physician is offering services that are so valuable that commercial payors must pay higher rates to secure the provider's services, those higher rates are fair market value for that service and there is no reason a physician should accept less than that.

[65] Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. at 63764 (Nov. 18, 2019).

V. ADMINISTRATIVE RULEMAKING REQUIREMENTS

1. CMS has not fulfilled its duty to conduct a Regulatory Impact Analysis for economically significant rulemakings under Executive Order 12866.

TAVH opposes the proposed rule because it fails to satisfy Executive Order 12866, which requires CMS to: (a) perform a Regulatory Impact Analysis for the rule, based on the best information obtainable, and (b) present the information to the public in an "accurate, clear, complete, and unbiased manner."[66] Instead, CMS only says the rule is "economically significant" [67] but the fiscal impact "is unknown."[68] This fails to meet either of CMS' obligations because it did not analyze the impact of the many substantive changes in the rule and has not given the public information that is accurate, clear, and complete.

CMS also fails to meet the requirement, for any rule where the data is too ambiguous to analyze the fiscal impact, to conduct an "uncertainty analysis" to give stakeholders a range of economic impact with a probability assessment.[69] CMS instead provides no range of impact and no probability assessment. CMS also fails to follow the recommendation of the Office of Management and Budget that agencies postpone regulation where an "uncertainty analysis" isn't practical, rather than subject stakeholders to the unknown.[70]

TAVH identified numerous states in which more than $1 billion in Medicaid payments are jeopardized by the proposed rule (these payments comply with current rules and often have explicit CMS approval). This economic impact will occur immediately, not after a transition period as suggested by the proposed rules, because CMS incorrectly characterizes many of the rule's changes to longstanding CMS policy as "clarifications," which will have immediate effect. For the remaining changes in the rule, CMS suggests an incremental transition, but the way CMS drafted the rule, the instant a state makes even a minor change to its Medicaid program, the state is vulnerable to CMS' immediate enforcement of the new rule.

CMS' Regulatory Impact Analysis leaves states, providers, and other stakeholders unable to prepare for the effects of the proposed rule. A proposed rule of this magnitude merits a more thorough analysis than CMS has provided. Given the economic significance—and CMS' stated uncertainty of the rule's impact—we respectfully request that CMS withdraw the rule until the agency can produce a Regulatory Impact Analysis that complies with Executive Order 12866.

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66 *See* Agency Checklist: Regulatory Impact Analysis, OIRA, https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/inforeg/inforeg/regpol/RIA_Checklist.pdf (last visited Jan. 3, 2019). The Executive Order applies to any rule that has "an annual effect on the economy of at least $100 million *or* adversely affect in a material way" a sector of the economy, jobs, public health, or State or local governments. *See* Exec. Order No. 12,866, 58 Fed. Reg. 51, 735 (Sept. 30 1993).

67 Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,772 (Nov. 18, 2019).

68 *Proposed Rule* at 63,773.

69 *See* Circular A-4, OMB, at 38–42 (Sept. 17, 2003), https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf.

70 *See id*.

2. CMS must perform an economic impact analysis of the proposed rule's impact on small and rural providers under the Regulatory Flexibility Act.

TAVH opposes the Secretary's certification that the proposed rule would not have a "significant economic impact on a substantial number of small entities" because that certification ignores the proposed rule's impact on private and governmental rural and small hospitals, as well as rural physician practices, who must disproportionately rely on supplemental Medicaid financing to attract practitioners, maintain operations, and provide necessary healthcare services to their community.

Federal law requires that rulemaking agencies conduct economic impact analyses.[71] Through the Regulatory Flexibility Act ("RFA"), Congress expressly instructed agencies to assess the economic impact of a proposed rule on "small entities," which include small business entities, small nonprofit organizations, and small governmental entities.[72] CMS contends that the requirements of its proposed rule "are the sole *responsibility*"[73] of state Medicaid agencies, which are not small entities. Therefore, CMS asserts the proposed rule does not "impact" small entities. This summary dismissal is legally defective and fails to meet the RFA's requirements.[74]

CMS attempts to narrow the rule's "impact" to only state Medicaid agencies, who must implement changes in federal policy at the state level. CMS has historically recognized its RFA obligation and has never applied such a constrained interpretation of the RFA in previous, similar rulemakings. For example, in CMS's 2007 Final Rule establishing Medicaid cost limits ("Cost Rule"), [75] which contains some provisions identical to the proposed rule, the agency concluded the Cost Rule would impose a significant economic impact on governmentally operated, small rural hospitals:

> "We expect this regulation to have a significant economic impact on a substantial number of small entities, specifically health care providers that are operated by units of government, including governmentally-operated small rural hospitals, as they will be *subject to* the new Medicaid cost limit imposed by this regulation …."[76]

CMS's 2019 stance is irreconcilable with its 2007 conclusion that an RFA analysis was warranted. The Cost Rule, like this proposed rule, imposed a new cap on Medicaid reimbursement for certain providers (specifically, governmentally operated providers). CMS acknowledged that the Cost Rule would significantly harm hospitals currently receiving payments above that cap and performed an appropriate RFA analysis analyzing the impact

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71 *See, e.g.*, Regulatory Flexibility Act, 5 U.S.C. §§ 601–612; Exec. Order No. 12,866, 58 Fed. Reg. 51,735 (Oct. 4, 1993). Section 605 of the Regulatory Flexibility Act says no analysis is required if so certified by the Secretary. *See* 5 U.S.C. § 605. That certification is incorrect and should be withdrawn.

72 *See id.* at § 601(6)

73 *See* Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,773 (Nov. 18, 2019).

74 *See* Alfa Int'l Seafood v. Ross, 264 F. Supp. 3d 23 (D.D.C. 2017) (final RFA analyses subject to arbitrary and capricious analysis under the Administrative Procedures Act); U.S. Cellular Corp. v. FCC, 254 F.3d 78 (D.C. Cir. 2001) (initial RFA analyses contained in proposed rulemakings are subject to a procedural, good faith analysis).

75 *See* Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29,748 (May 29, 2007).

76 *Id.* at 29,831 (emphasis added).

of that cap on small entities.[77] The changes CMS now proposes, like the Cost Rule, explicitly cap reimbursement for small physician practices. And CMS's new constraints on public hospital revenue eligible for intergovernmental transfers ("IGTs") will substantially diminish those hospitals' Medicaid payments. These providers, like the small governmental entities under the Cost Rule, will be "subject to" CMS's proposed changes. But CMS now avoids its statutory responsibility to conduct an RFA analysis because enforcement of its proposed regulations is "the sole responsibility of" state Medicaid agencies. To contend that an RFA analysis is excused each time CMS directs its administrative requirements to state Medicaid agencies effectively eliminates the requirements of the RFA in any future Medicaid rulemaking—a result plainly contrary to Congress's intent in enacting the RFA. [78]

Because the proposed changes would devastate state Medicaid programs and providers across the country, TAVH respectfully requests that CMS perform its statutorily required analysis of the rule's economic impact on rural and small governmental providers so that stakeholders and Congress are afforded an opportunity to consider and prepare for the impact of the proposed rule.

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[77] *Id.*

[78] Agencies are owed no level of deference for the interpretation of statutes they do not administer; therefore, CMS and the Secretary will receive no level of deference for their interpretation of the RFA's requirements. *See* Am. Trucking Ass'n v. EPA, 175 F.3d 1027 (D.C. Cir. 1997), *modified in other respect*, 195 F.3d 4 (D.C. Cir. 1999), *reversed in other respect*, Whitman v. Am. Trucking Ass'n, 531 U.S. 457 (2001).