



AMERICA'S ESSENTIAL HOSPITALS

January 31, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-2393-P: Medicaid Program; Medicaid Fiscal Accountability Regulation

Dear Administrator Verma:

America's Essential Hospitals appreciates the opportunity to submit comments on the proposed Medicaid Fiscal Accountability Regulation (MFAR). The Centers for Medicare & Medicaid Services (CMS) has been developing this regulation for years, according to the Department of Health and Human Services' (HHS') regulatory agenda, purported as an effort to increase reporting and transparency for Medicaid supplemental payments. The proposed MFAR goes far beyond a transparency initiative. The provisions would cut at the very core of the Medicaid program by introducing unprecedented restrictions on states' ability to fund their share of the Medicaid program. Prohibiting states from using traditional local sources of funding leaves them with an untenable choice between enacting painful program cuts or turning to state and local taxpayers to replace the funding this rule would prohibit. **For the reasons we outline in our comments below and attached, America's Essential Hospitals strongly urges CMS to withdraw the MFAR in its entirety, including all preamble commentary imposing regulatory standards that have not gone through notice-and-comment rulemaking.**

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including vulnerable populations. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins one-fifth that of other hospitals—1.6 percent on average compared with 7.8 percent for all hospitals nationwide.¹

¹ Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2017 Annual Member Characteristics Survey*. America's Essential Hospitals. April 2019. <https://essentialdata.info>. Accessed December 19, 2019.

In addition, as essential hospitals, our members serve as cornerstones of care in their communities, providing specialized inpatient, outpatient, and emergency services—such as trauma, burn, and inpatient psychiatric care—which often are unavailable elsewhere in their communities. In the 10 largest U.S. cities, our members operate 31 percent of all level I trauma centers, 39 percent of all burn-care beds, and 6,200 psychiatric care beds.² Members of America’s Essential Hospitals play a vital role in providing ambulatory care to their communities—operating a median of nine ambulatory care locations per hospital.³ Essential hospitals also deliver ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

Essential hospitals have a unique position in the Medicaid delivery system. Given their largely low-income, disadvantaged patient populations, they are distinctly positioned to make a real and lasting impact on the lives and well-being of the most disadvantaged individuals. Our members have the expertise, passion, and commitment to apply and adapt proven models of care to the benefit of their patients and to pioneer new models to meet patients’ specialized needs. Essential hospitals consistently find increasingly innovative and efficient strategies for providing high-quality, complex care to their patients, all while facing high costs and limited resources. Given the reality of their patient mix and margins, our members utterly depend on Medicaid funding to carry out their missions and remain viable.

Provisions in the MFAR would have a deep and devastating impact on stakeholders who rely on the Medicaid program. The rule threatens longstanding arrangements states rely on to finance their share of the Medicaid program. Its provisions are broad, sweeping, and impossibly vague, giving states no reliable standards on which to structure their financing arrangements with any level of certainty. The MFAR would subject states to massive retroactive disallowances at any time based on shifting and opaque CMS review criteria, wreaking havoc on state and local budgets and further jeopardizing access and quality of care for beneficiaries. The resulting, seemingly intentional, chilling effect would make states unable to use legitimate sources of funding Congress intended to be available to them. In addition, provisions of the MFAR would result in an overreach of federal government oversight and discretion.

Further, the preamble to the rule announces new and novel interpretations of the Medicaid statute and claims they represent clarifications of existing regulations. However, these interpretations have not previously been subject to notice-and-comment rulemaking. Many of these interpretations, if enforced, could expose states to millions—even billions—of dollars in potential retroactive disallowances.

The rule’s intrusion into states’ organization of, delegation of authority to, and relationship with their units of local government undermines bedrock principles of federalism. The specter of CMS second-guessing whether a particular entity within a state is sufficiently governmental to meet CMS’ vague idea of a “unit of government” is distressing and contradicts decades of precedent, in which CMS has deferred to states’ ordering of their internal organizational and fiscal affairs. In

² Ibid.

³ Ibid.

addition, certain provisions of the rule clearly exceed CMS' statutory authority or are otherwise unlawful.

CMS appears to have issued this rule without any meaningful analysis of its impact on states, providers, and, most important, Medicaid beneficiaries. The cursory regulatory impact analysis vastly understates the effects of the proposed rule. While we acknowledge the difficulties in precisely estimating the financial impact, that fact alone is reason enough to withdraw the MFAR. CMS attempted to promulgate a similar regulation in 2007, which ultimately was rejected by both Congress and the courts.⁴ In many ways, the current proposal is much more far-reaching than the now-withdrawn 2007 rule.

Ultimately, this proposal, if implemented, would weaken the nation's health care safety net and put access to care at risk for the nation's most vulnerable people. The MFAR would undermine the state role in Medicaid by granting the federal government broad, arbitrary discretion to limit states' ability to fund their own programs through longstanding financing arrangements. These arrangements allow states to address pressing state-level policy and public health issues, such as the ongoing opioid epidemic, and ensure beneficiaries have access to critical health services.

CMS must withdraw the MFAR in its entirety, including all preamble statements purporting to clarify existing interpretations. We urge the agency to consider the following comments on the overarching problems with the MFAR that necessitate its withdrawal.

1. The MFAR would force massive Medicaid cuts and/or state and local tax increases.

Faced with challenging state budget constraints, many states have turned to local governments and providers to shoulder a portion of the state share of the cost of Medicaid program expenditures. Intergovernmental transfers (IGTs), certified public expenditures (CPEs), and provider taxes are congressionally sanctioned and regulated sources of the nonfederal share of funding for the program, and they date back to Medicaid's inception.

Provisions in the MFAR aim to restrict—either directly or indirectly—these long-established funding arrangements, limiting the ability of states to fund Medicaid at adequate levels. Restricting how states can finance the nonfederal share would leave them with limited and politically unsavory choices: either shrinking their Medicaid programs or seeking alternative funding through state or local tax increases or rerouting other general revenue streams. Any cuts to the Medicaid program will weaken the nation's health care safety net and put access to care at risk for our most vulnerable people, including children, the disabled, and the elderly. **To protect the stability and viability of the Medicaid program, CMS must withdraw the MFAR in its entirety.**

2. The MFAR would particularly constrain states' ability to provide supplemental payments, which directly affects essential providers.

In the absence of adequate Medicaid base payment rates, states increasingly rely on various types of supplemental payments to support providers and ensure Medicaid beneficiaries have access to needed care. The proposed rule would have a particularly severe impact on such supplemental

⁴ 72 Fed. Reg. 2,236 (Jan. 18, 2007).

provider payments, which are disproportionately funded through sources other than appropriations to the state Medicaid program.⁵ While America's Essential Hospitals would prefer sufficient base rates to render supplemental payments unnecessary, that is not the reality. The federal government has not taken steps to ensure that states pay adequate base rates to avoid the need for supplemental payments. As a result, supplemental payments are a critical means of enhancing below-cost Medicaid rates that are simply unsustainable on their own. While it is not ideal that the nonfederal share of these payments often comes from local governments and providers, there is nothing inappropriate about these funding sources.

Moreover, fee-for-service (FFS) supplemental payments—including locally funded supplemental payments—are subject to clear limits, based on Medicare or commercial rates, to ensure economical and efficient payments. If locally funded supplemental payments result in provider rates at the Medicare or commercial level—levels that cannot be considered unreasonable—then the federal government's share of those costs cannot be either excessive or inappropriate. To the extent CMS policies result in the loss of such supplemental payments, the federal government would be unfairly shifting 100 percent of the burden to providers to contend with base rates not only below market and below Medicare, but also frequently below (often *well* below) the cost of care.

For America's Essential Hospitals members, for whom Medicaid is such a crucial payer, supplemental payments have made the critical difference between viability and bankruptcy. As previously noted, our members' current operating margins are 1.6 percent—including supplemental payments. Reductions in supplemental payment sources would push those tight margins into the red. Essential hospitals rely on the funding provided through these various supplemental payment programs to support their critical missions. By constraining states' ability to provide such support, the MFAR would severely reduce beneficiaries' ability to access needed care.

Among the missions of essential hospitals is responding to public health crises, including the opioid epidemic. The cuts in supplemental payments would come at a time when the country is still struggling with this epidemic—a top priority for states and the administration.⁶ The opioid epidemic has disproportionately affected Medicaid beneficiaries; the Medicaid and CHIP Payment and Access Commission (MACPAC) found Medicaid beneficiaries have a higher rate of opioid use disorder (OUD) than privately insured individuals.⁷ MACPAC also found Medicaid beneficiaries have higher OUD treatment rates than privately insured individuals, making access to care even more critical.⁸ Supplemental payments support the providers who are at the heart of states' response to this crisis. Medicaid coverage is critical to stemming the opioid epidemic—undermining the program will jeopardize the progress the nation is making to mitigate this pressing public health concern.

⁵ Medicaid and CHIP Payment and Access Commission. *Medicaid Base and Supplemental Payments to Hospitals* (Figure 3). March 2019.

⁶ *Help and Resources National Opioids Crisis*. U.S. Department of Health and Human Services. <https://www.hhs.gov/opioids/>. Accessed December 27, 2019.

⁷ MACPAC. June Report to Congress (Chapter 2: Medicaid and the Opioid Epidemic). June 2017. <https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>. Accessed December 27, 2019.

⁸ *Ibid.*

We believe provisions in the MFAR aim to limit supplemental payments to providers and the corresponding federal support critical to the sustainability of the Medicaid program. **For states to have the ability to appropriately finance the nonfederal share, CMS must withdraw the MFAR regulation.**

3. CMS has not adequately determined the impact of the MFAR, especially the effect on patient access to care.

The regulatory impact analysis for the proposed rule is cursory at best. CMS estimates a total cost to states of complying with the myriad reporting requirements at \$145,221 per year in the aggregate. In projecting the effects on the Medicaid program in general, the only estimate the agency provides is a loss of \$222 million in supplemental practitioner payments. CMS does not even attempt to determine the impact of the MFAR's sweeping restrictions on nonfederal share funding. Instead, it simply admits "[t]he fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."⁹ It is irresponsible and reckless for the agency to move forward with implementing policies of this significance without understanding the full effect on states, their budgets, providers, and Medicaid beneficiaries.

Given the magnitude and complexity of CMS' proposals, we are very concerned about the limited timeframe available to stakeholders to fully assess the impact of the policy changes and offer meaningful, data-driven comments. CMS recognized a 60-day comment period is insufficient to determine the impact of the rule by issuing a 15-day extension.¹⁰ Even with the extension, the comment period does not allow for sufficient and meaningful impact analysis. Currently, most states are fully focused on drafting and finalizing their state budgets. In addition, many state legislative sessions will not begin until early to mid-January, which limits the ability of state governments to identify and detail the impact on their states and share those findings with the agency. **CMS cannot implement regulations of this magnitude with an uncertain effect on states and, as such, must withdraw the MFAR in its entirety.**

4. As written, the MFAR applies overly broad and vague standards, making it impossible for states and providers to ensure compliance, while granting vast new oversight authority for CMS.

Throughout the proposed rule, CMS uses vague terminology to describe prohibited Medicaid financing practices it intends to terminate. In many cases, the preamble attempts to describe particular payment or financing practices, but CMS' proposed regulatory text gives the agency "catchall" authority to regulate (and prohibit) additional practices not described in the regulation, through terms such as "totality of the circumstances," "net effect," "undue burden," and "associated transactions." This sweeping new federal oversight authority leaves states and other Medicaid stakeholders without any means of ensuring a given supplemental payment or funding arrangement is permissible.

We fear the result would be a chilling effect, in which states decline to use permissible funding sources for fear CMS will decide—either now or at some future time—that considering the "totality of the circumstances" (i.e., any factor deemed relevant by CMS), the arrangement is no

⁹ 84 Fed. Reg. 63,722, 63,773 (November 18, 2019).

¹⁰ 84 Fed. Reg. 71,887 (December 30, 2019).

longer permissible. The vague language also would allow CMS to adopt arbitrary enforcement practices as the agency has not laid out any objective standards against which permissible and impermissible practices are measured. These actions do not comport with federal law. Federal administrative law, rooted in the constitutional requirement for due process, does not allow federal agencies to adopt vague and arbitrary standards of this nature, particularly where, as here, the consequences to regulated parties are so severe.¹¹ The proposed rule does not satisfy the legal requirement of giving states and providers “ascertainable certainty” of the standards to which they are subject, nor does it serve CMS’ own stated policy goal of improving transparency in the Medicaid program.¹² **Therefore, CMS does not have the legal authority to implement the ambiguous standards in this policy.**

5. The preamble to the MFAR includes new interpretations of Medicaid law that have not gone through notice-and-comment rulemaking.

In explaining several new regulatory provisions, the preamble to the proposed rule announces interpretations of the Medicaid statute that CMS claims are merely “clarifications” of existing policies rather than proposals to adopt new standards. In some cases, these clarifications are not reflected in new regulatory text, appearing only in passing in the preamble discussion. The “clarifications” include policies that have not gone through notice-and-comment rulemaking as required by the Administrative Procedure Act (e.g., policies announced in State Medicaid Director Letter (SMD 14-004)), and many have never before been articulated, even in subregulatory guidance.¹³ These “clarifications” constitute unlawful retroactive rulemaking, and run counter to recent executive branch pronouncements requiring agencies to treat guidance as nonbinding.^{14,15} **Thus, in addition to withdrawing the MFAR, CMS also must explicitly state it will not enforce any of the regulatory policies announced in the proposed rule, even if framed as “clarifications.”**

6. Provisions in the MFAR undermine principles of federalism that are foundational to the Medicaid program.

The Medicaid program was intentionally designed as a federal-state partnership. States structure their respective programs to answer the needs of their populations, within broad federal guidelines. The federal government defers to varying state fiscal and organizational structures through which the program is implemented.

¹¹ See, e.g., *Oglala Sioux Tribe of Indians v. Andrus*, 603 F.2d 707, 718 (8th Cir. 1979) (“A court need not accept an agency’s interpretation of its own regulations if that interpretation ... deprives affected parties of fair notice of the agency’s intentions.”); *Phelps Dodge Corp. v. Federal Mine Safety & Health Review Commission*, 681 F.2d 1189, 1192 (9th Cir. 1982) (“[T]he application of a regulation in a particular situation may be challenged on the ground that it does not give fair warning that the allegedly violative conduct was prohibited.”).

¹² *General Electric Co. v. EPA*, 53 F.3d 1324 (D.C. Cir. 1995).

¹³ CMS. SMD 14-004. Accountability No. 2: Financing and Donations. May 9, 2014. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-004.pdf>. Accessed December 27, 2019.

¹⁴ See, e.g., *Monmouth Medical Center v. Thompson*, 257 F.3d 807, 813-14 (D.C. Cir. 2001); *Alaska Professional Hunters Association Inc. v. FAA*, 177 F.3d 1030, 1033-34 (D.C. Cir. 1999) (prohibiting retroactive rulemaking).

¹⁵ See Executive Order No. 13892, 84 Fed. Reg. 55,239 (Oct. 15, 2019); DOJ Associate Attorney General Memo on Limiting Use of Agency Guidance Documents in Affirmative Civil Enforcement Cases (Jan. 25, 2018); HHS General Counsel Memo on Impact of Allina on Medicare Payment Rules (Oct. 31, 2019).

Certain provisions in the rule would dramatically shift the balance between federal and state governments by granting broad federal discretion to regulate the fiscal and organizational structures within states. In particular, the rule would allow CMS to second-guess states in creating and defining units of governments within the state and in determining whether a local governmental entity is in fact governmental. The rule also would allow CMS to restrict states from using certain sources of funds provided by governmental entities as the nonfederal share of Medicaid expenditures. The extraordinary degree of intrusion into matters traditionally reserved to the state reflects a disregard for the principles of federalism and a federal-state partnership of equals on which the Medicaid program is based.

This administration has signaled its recognition of the importance of the state role through other policies granting states more flexibility to administer their respective Medicaid programs. In a March 2017 letter to state governors, HHS and CMS conveyed a commitment to usher in a “new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population.”¹⁶ Subsequent guidance to states has reinforced that commitment, such as allowing states to pursue work and community engagement requirements as a condition of Medicaid eligibility.¹⁷ More recently, the administration signaled an openness to alternative Medicaid financing approaches “in exchange for greater flexibility and budget certainty.”¹⁸ However, states would be unable to design programs to meet the needs of their Medicaid beneficiaries or have budget certainty if the proposed restrictions on funding the nonfederal share are implemented. Further, provisions in the proposed rule would increase federal administrative power, running run counter to the administration’s desire to give states more flexibility. **CMS should not and cannot engage in rulemaking that intrudes on and discounts the traditional state role in Medicaid program design and administration.**

7. The MFAR violates basic tenets of federal administrative law.

As described in further detail throughout this letter, the MFAR exceeds CMS’ legal authority in numerous respects. Some provisions conflict directly with federal statute or deviate from congressional intent. Some are arbitrary because CMS failed to provide a reasoned basis for a proposed policy or failed to consider important aspects of the policy. Other provisions are capricious, with the agency changing policy without adequate—or any—explanation. The MFAR’s vague rules fail to give regulated parties adequate notice of the types of conduct that will be penalized; as such, it is an abuse of agency discretion. Further, policies identified in the preamble as “clarifications” have not been incorporated into the regulatory text; this violates notice-and-comment rulemaking requirements. Beyond the MFAR’s individual provisions, the entire rulemaking is without an adequate basis. By CMS’ own admission, the agency lacks critical data and information on supplemental payments and Medicaid financing—so much so that CMS believes new burdensome reporting requirements are necessary for CMS to properly fulfill its

¹⁶ Price T, Verma S. Letter to Governors. March 14, 2017. <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>. Accessed January 10, 2020.

¹⁷ CMS. SMD 18-002. Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. January 11, 2018. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>. Accessed January 10, 2020.

¹⁸ CMS. CMS Administrator Seema Verma’s Speech to the National Association of Medicaid Directors in Washington, D.C. November 12, 2019. <https://www.cms.gov/newsroom/press-releases/cms-administrator-seema-vermas-speech-national-association-medicaid-directors-washington-dc>. Accessed January 10, 2020.

oversight role. As such, CMS does not have a legally sufficient basis for fundamentally altering the Medicaid program's funding and financing structures as proposed in the MFAR. **The MFAR simply does not satisfy core administrative law principles and must be withdrawn.**

8. The proposed rule would impose an unacceptably high administrative burden on states and providers and an unmanageable review and oversight role for CMS.

America's Essential Hospitals supports the goals of transparency and accountability in the Medicaid program; however, the proposed rule does not achieve these goals. Rather, it overreaches, imposing an unacceptably high cost of compliance on states and providers, increasing their already overloaded administrative burden.

CMS proposes states submit and renew supplemental payment state plan amendments (SPAs) and health care-related tax waiver requests every three years, although it is not clear how CMS would manage timely review of these arrangements. CMS already struggles to keep up with a backlog in SPA (and waiver) reviews. Assuming most states have multiple supplemental payment arrangements, the addition to CMS' workload would be significant—likely slowing down its review not only of supplemental payment SPAs but also of other unrelated amendments. The delay would cause significant uncertainty for states and providers, disrupting state fiscal planning and increasing the risk associated with investing in longer-term priorities (for example, residency programs, delivery system restructuring, or population health initiatives that span multiple renewal periods).

CMS also proposes significant new quarterly and annual reporting requirements in addition to the agency's numerous existing data collection initiatives, such as those established in 2013 with its upper payment limit (UPL) accountability initiative.¹⁹ The amount, frequency and detail required in the MFAR's reporting requirements is extensive and without any clear justification. CMS has not demonstrated the ability to timely process the existing data it collects, much less any new data. For example, we are unaware of whether or how CMS uses the annual UPL demonstration data it receives, suggesting at least some of the extensive reporting proposed in the MFAR also would serve no practical purpose. Moreover, it currently takes about two years for the agency to release Medicaid disproportionate share hospital (DSH) payment audit data it receives from states three years after the payment year, resulting in a five-year data lag. These delays undercut the stated transparency goals for the data collection. **The proposed rule does not strike an appropriate balance between program integrity and administrative burden, creating unnecessary administrative costs for states and an unmanageable workload for CMS. As such, CMS must withdraw the MFAR regulation.**

9. CMS has not adequately consulted with states before proposing significant changes to the Medicaid program.

In connection with the adoption of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, on which the proposed rule is based, Congress recognized the need for

¹⁹ CMS. SMD 13-003: Federal and State Oversight of Medicaid Expenditures. March 18, 2013. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-003-02.pdf>. Accessed December 27, 2019.

state consultation before issuing and implementing regulations.²⁰ Adopted against the backdrop of a series of congressional moratoria on attempts by CMS (then called the Health Care Financing Administration [HCFA]) to regulate nonfederal share funding arrangements, Congress insisted on the state consultation to ensure meaningful consideration of the practical effects of the rulemaking.²¹ Congress recognized the federal government should not usurp states' ability to manage their program without the states having an opportunity to weigh in on potential impacts or concerns before regulatory action. Provisions in the MFAR represent significant changes to the Medicaid program and its financing. We do not believe CMS has satisfactorily consulted with states, as required by Congress, in the context of the MFAR rulemaking.

In previous rulemaking, CMS noted the standard notice-and-comment process allows for appropriate consultation with states.²² We disagree. If the notice-and-comment process was sufficient to meet Congress' requirement for consultation with states, there would have been no need for Congress to explicitly demand the additional consultation, as notice and comment periods already are required through the Administrative Procedure Act. Moreover, given the scope of the MFAR, a 75-day comment period is not enough time for CMS to adequately consult with states to determine how the proposed changes would affect their respective Medicaid programs. As detailed above, CMS acknowledges it does not know how the proposed provisions would affect states. CMS' actions to forgo proper consultation with states to determine the impact of the proposed provisions violates the congressionally mandated state consultation requirement. **As such, CMS cannot move forward with the significant changes to financing the nonfederal share as proposed in the MFAR.**

10. Several significant proposals under the MFAR are contrary to congressional intent.

In 2007, CMS engaged in similar rulemaking, attempting to narrow local funding options and restrict payments to governmental providers.²³ That rulemaking was rejected by both Congress and the courts. The finalization of the rule was blocked multiple times through congressional moratoria. In 2009, through a Sense of Congress resolution, Congress declared the 2007 rule was "improperly promulgated" and HHS "should not promulgate [it] as final regulations."²⁴ The MFAR includes many of the same proposals to narrow local funding options as the 2007 rejected rulemaking. **Implementation of provisions in the proposed rule would be contrary to clearly expressed congressional intent and action to protect the Medicaid program and, thus, the MFAR must be withdrawn in its entirety.**

In addition to the above comments, which cover the overarching problems with the MFAR that necessitate its withdrawal, we provide more detailed comments in the attached document. Our detailed comments examine these pervasive issues as they apply to particular provisions and the likely impact of those provisions on state Medicaid programs, providers, and beneficiaries.

²⁰ Sec. 5(c), Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. P.L. 102-234. 102nd Cong. (1991).

²¹ 102 H. Rpt. No. 310, at 8 (1991).

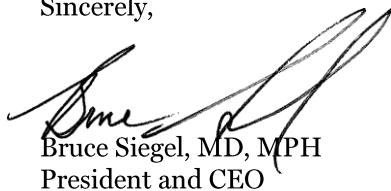
²² 73 Fed. Reg. 9,685 (February 22, 2008).

²³ 72 Fed. Reg. 2,236 (Jan. 18, 2007) and 72 Fed. Reg. 29,748 (May 29, 2007).

²⁴ American Recovery and Reinvestment Act, P.L. 111-5, 111th Cong. (2009).

America's Essential Hospitals respectfully requests thoughtful consideration of our concerns and appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Bruce Siegel', with a long, sweeping flourish extending to the right.

Bruce Siegel, MD, MPH
President and CEO

See attachment for more detailed comments on the MFAR.

Attachment

America's Essential Hospitals: Detailed Comments on the Proposed Medicaid Fiscal Accountability Regulation (MFAR)

Submitted January 31, 2020

Financing the Nonfederal Share

1. The proposed restriction on funding sources for the nonfederal share will force states to either cut the program or increase state or local taxes.

Under longstanding CMS regulations, states have been permitted to rely on the use of “public funds” from “public agencies” as the state’s share in claiming federal financial participation for Medicaid expenditures.²⁵ Congress has permitted the use of such “local sources” of funds since the inception of the program, provided the state itself funds at least 40 percent of the state share.²⁶ The tradition of allowing the use of local public funds as the state share finds its roots in the origins of Medicaid itself, as Congress intended in 1965 for the new program to draw on then-existing indigent care funding sources through local governments and public hospitals and clinics.²⁷ The public funds regulation, as it has existed for decades, reflects these roots.

The proposed rule would restrict the source of funds for both IGTs and CPEs to those “derived from State or local taxes (or funds appropriated to State university teaching hospitals).” CMS does not further define funds “derived from State or local taxes,” but presumably the rule intends to exclude public funds derived from other traditional sources, such as the earned nontax revenues of a public agency, including public hospital patient care revenues.

The change is purportedly intended to align the regulatory text with the statutory language used in the Social Security Act under section 1903(w)(6)(A), a provision adopted as part of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.²⁸ But CMS misreads the language and intent of this provision. The provision restricts HHS’ authority to *narrow* the scope of IGTs and CPEs; it does not impose a limit on permissible IGTs and CPEs as CMS now appears to assume in the proposed rule. The current public funds regulation has remained in place, unamended, both before and since the enactment of section 1903(w)(6)(A),

²⁵ 42 C.F.R. § 433.51 (2010).

²⁶ Social Security Act (SSA) § 1902(a)(2).

²⁷ MACPAC. Issue Brief: The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending. July 2017. <https://www.macpac.gov/wp-content/uploads/2017/07/The-Impact-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf>. Accessed January 3, 2020.

²⁸ Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. P.L. 102-234. 102nd Cong. (1991). Section 1903(w)(6)(A) of the SSA provides that “Notwithstanding the provisions of this subsection, the Secretary 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 or certified by units of government with a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(A)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.”

and states have continued to use these traditional nontax sources of local public funding without objection throughout that period. This confirms Congress did not intend section 1903(w)(6)(A) to enable CMS to narrow the types of allowable public funding sources.

Rather, the MFAR represents an optional policy choice by the agency to restrict states' use of these historical funding sources, without any reasonable justification for the choice and with draconian effects on the program. CMS does not explain, for example, how or why IGTs or CPEs derived from patient care revenues earned by a public hospital represent more of a threat to the fiscal integrity of the program than those derived from a local taxpayer-funded subsidy provided to a public hospital. The reality is public hospitals, as well as state university teaching hospitals, are much less reliant on taxpayer support than they once were, having worked hard to adopt efficiencies and attract more insured patients to *reduce* reliance on taxpayer funding. CMS' proposed rule threatens to undermine those gains, forcing states and localities to push more of the responsibility for funding the nonfederal share of Medicaid onto taxpayers instead of other legitimate sources of public funding. Moreover, the proposed restrictions on local funding sources surely will result in cuts to Medicaid reimbursement, shifting the burden of providing safety-net support to local taxpayers.

In short, CMS' unprecedented prohibition on the use of local public funding sources as the state share of Medicaid will hamstring states' ability to adequately fund their Medicaid programs. This will force states into the untenable position of having to choose between drastic cuts to the program (with associated impacts on access to and quality of care); significant increases in state or local taxes or reshuffling of general fund dollars to replace the traditional public funding sources; or, more likely, a combination of these politically unpopular options. All of this will occur without an articulated or discernible improvement in accountability. **Restrictions of funding sources for the nonfederal share will only serve to decrease critical dollars in state Medicaid programs.**

2. The definition of a “governmental provider” violates principles of federalism, is too vague to be implemented, and would deny states legitimate sources of funding for the nonfederal share.

In addition to restricting the sources of public funds that may be used to support the Medicaid program, CMS proposes to restrict in two ways the local governmental entities that may permissibly provide such funding. First, the proposed rule would change the regulatory language that allows “public agencies” to provide IGTs and CPEs so that only “units of government” would be able to do so. CMS does not further define a “unit of government” (although the statutory definition of a unit of *local* government appears to allow broad leeway for states to determine whether a particular governmental entity is a unit of local government).²⁹ More intrusively, however, CMS proposes new definitions of a “non-state government provider” and a “state government provider”—purportedly for purposes of determining UPLs on provider reimbursement.³⁰ However, in the preamble, CMS makes clear it intends to use these definitions

²⁹ SSA § 1903(w)(7) defines a unit of local government as “a city, county, special purpose district, or *other governmental unit in the State*” (emphasis added).

³⁰ The proposed definitions would be incorporated into 42 C.F.R. § 447.286, which by its terms contains definitions “For purposes of this subpart” (which is Subpart D-Payment for Services). The IGT and CPE regulations are contained in Part 433, Subpart B-General Administrative Requirements for State Financial Participation.

to regulate IGTs and CPEs, as well. Only those providers that meet one of the new governmental provider definitions will be permitted to participate in funding the nonfederal share.

The governmental provider definitions, in turn, are extremely intrusive, allowing CMS to second-guess a state's own determination of whether an entity it has established, through its own laws, is governmental. CMS defines a lengthy list of characteristics it will review to determine whether to uphold or reject the state's determination that an entity is governmental, including a review of operational decision-making, responsibility for financial losses, authority to dispense revenue, control over personnel decisions, payment of revenue or property taxes, and responsibility for malpractice, property, general liability, and other insurance premiums. With respect to units of government that are not providers, CMS (still in the guise of defining a governmental provider) makes clear it will examine the entity's communications with others to see if it is described as a unit of government, whether it is so characterized only for Medicaid financing purposes, and whether it has access to state appropriations or local taxes, including whether it has the ability to expend such appropriations or tax revenues.

Having painstakingly listed all of the attributes CMS decided are necessary to be a governmental provider, the agency then reserves for itself the authority to nonetheless consider the "totality of the circumstances," which may include "but would not be limited to" the listed factors. So not only would the agency intrusively review very detailed and specific characteristics of the governmental provider, but it also may consider other unspecified factors which it has yet to name.

The use of vague standards like "totality of the circumstances" is rampant throughout the MFAR, as we note in this attachment. But it is particularly inappropriate for the federal government to use it to second-guess a state's own definition of its units of government. The rule seeks to assert unprecedented federal jurisdiction over authority that quintessentially resides in states—the authority to organize themselves into sub-units of government and delegate their powers accordingly.

As noted earlier, CMS attempted a similar encroachment on state authority to define its units of government through a rule proposed and finalized in 2007.³¹ The outcry against the assault on federalism was swift, and the 2007 rule was subject to multiple congressional moratoria and ultimately thrown out by a federal court. Thereafter, Congress enacted a Sense of Congress resolution that the proposed version of the rule should not be finalized. This attempt to resurrect a CMS-imposed definition of governmental entities capable of funding Medicaid's nonfederal share violates clearly expressed congressional intent; the proposal is contrary to fundamental principles of federalism and impossible to implement and should be void for vagueness. Further, to the extent it results in a restriction on the ability of public agencies to provide IGTs and CPEs, states will be forced to raise taxes or cut their respective Medicaid programs. **CMS must not implement policies that would create vague standards, which would be difficult to implement and create uncertainty for states in funding the nonfederal share.**

3. The provider donation provisions are too vague to survive a legal challenge, violate principles of federalism, fail to advance reasonable policy objectives, and are inadequately supported.

³¹ 72 Fed. Reg. 2,236 (Jan. 18, 2007).

The proposed rule substantially and inappropriately expands the scope of arrangements that CMS can treat as impermissible non-bona fide provider-related donations. It does so in several ways, while wholly ignoring that many arrangements between public and private providers serve important and legitimate public purposes. First, CMS proposes to redefine the term “provider-related donation,” such that a donation would be found whenever a private provider assumes a prior obligation of a governmental entity, unless the private provider receives fair market value compensation. Concerningly, in determining whether an obligation has been assumed, CMS proposes to apply vague “net effect” and “totality of the circumstances” standards. In addition, CMS proposes to modify the “hold harmless” test for donations to consider the “totality of the circumstances.” In doing so, CMS would consider the “net effect” and “overall impact” of any arrangement between a unit of government and a private provider, and whether the parties have a “reasonable expectation” the provider will receive a return of some or all of the donation. These terms and provisions are so vague it appears to leave the door open for CMS to reject any arrangement on a whim and without sound cause.

The donation provisions in the proposed rule, as well as the preamble characterizing the provisions as current policy, must be withdrawn for numerous legal- and policy-based reasons. First, the “totality of the circumstances,” “net effect,” “reasonable expectations,” and “overall impact” standards CMS proposes are too vague and arbitrary to withstand legal scrutiny. Under these regulatory criteria, providers and states would have no way to determine whether a particular business arrangement between a unit of government providing IGTs and a private provider complies with the law or conforms to CMS’ expectations.³² Essentially any transfer or practice could be treated as a donation or a hold-harmless arrangement if desired by CMS. In the past, courts have struck down similarly vague regulatory standards, declaring that where regulatory standards require “the exercise of extraordinary intuition” or “the aid of a psychic,” as the proposed standards in the donation provisions of the MFAR do, they are unlawful.³³

Second, the proposed changes—in particular, characterizing the assumption of an obligation formerly held by a governmental entity as a “donation”—again violate bedrock principles of federalism (as well as CMS’ own pillar of state flexibility). The MFAR would interfere substantially in state operations, restricting state and local governments from partnering or contracting with health care providers to achieve better, more cost-effective services for local citizens, simply because the government once provided the services itself. The proposed rule also would discourage private providers from stepping up to provide needed charity care and other traditional governmental functions when governmental entities are no longer able to provide the services, for example, due to budget constraints. The modest carveout allowing for fair market value compensation is wholly inadequate. CMS appears to have given no thought to how the concept of “fair market value” can and should apply in this context. From a business and policy perspective, local governments should be encouraged to partner with private providers to achieve cost efficiencies, in which case the amounts paid for services should drop. And yet, any reduction

³² The impossibility of determining what is permissible and what is prohibited is apparent from the face of the proposed regulatory text. Take, for example, a single sentence from proposed 42 C.F.R. § 433.54(c)(3): “[A] guarantee will be found to exist where, considering the *totality of the circumstances*, the *net effect* of an arrangement between the State (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a *reasonable expectation* that the provider, provider class, or a related entity will receive a return of all or a portion of the donation.”

³³ U.S. v. Chrysler Corp., 158 F.3d 1350 (D.C. Cir. 1998) (striking down vague seat belt testing standards); see also *supra* notes [11-12].

in governmental expenditures when services shift to a private provider likely would be viewed with suspicion and presumed non-fair market value under the proposed rule. Moreover, many arrangements between local governments and providers are not susceptible to an objective fair market value assessment. For example, many longstanding arrangements between governmental entities and private providers have involved the provision of health care to the indigent, for which there is no standard for market value.

In short, the proposed rule would leave states and providers with an undesirable set of choices: (1) unwind all partnerships between public and private entities to be certain Medicaid financing arrangements continue to be viable and compliant; (2) cease the practice—long allowed by CMS—of permitting governmental entities to fund the nonfederal share of Medicaid payments to other providers; or (3) bear the significant burden of a potential retroactive disallowance. None of these options advance reasonable policy objectives. Option 1 would eliminate many legitimate, beneficial partnerships that serve the public interest without jeopardizing the integrity of the Medicaid program. Option 2 would upend many states' Medicaid programs, shifting the burden of funding the nonfederal share to taxpayers or requiring substantial cuts, harming beneficiaries and destabilizing states' health care systems. Option 3 would require states and providers to divert funding from the treatment of Medicaid beneficiaries to build substantial reserves to account for regulatory uncertainty, or risk a potentially devastating disallowance in the future.

Despite these harsh and negative effects, CMS provides a paltry explanation for its proposed changes. CMS repeatedly asserts it is seeking to codify policies articulated in a letter to state Medicaid directors, SMD 14-004, that currently is the subject of a legal challenge.^{34,35} Thus, it is premature to finalize the policies therein. Moreover, the proposed regulatory text goes well beyond SMD 14-004. As the HHS Departmental Appeals Board (DAB) recognized, “SMD 14-004 does not state that a donation occurs any time a private entity offers a service that a governmental entity has ever at any time provided.”³⁶ Yet, that is the effect of the proposed expansion to the definition of “provider-related donation” at 42 C.F.R. § 433.52. Likewise, the MFAR is so overreaching it could be interpreted by CMS to prohibit arrangements identified by the DAB as acceptable, such as a private hospital offering health screenings or mammograms to the public after a governmental hospital ceases to offer such services. CMS expresses a desire to “eliminat[e] complex financing arrangements designed to obfuscate” non-bona fide provider-related donations, but this generic and circular rationale falls far short of the agency's legal obligation to provide a well-reasoned basis for its rules.³⁷ **As such, the proposed provider donation provisions are too vague, violate principles of federalism, and fail to advance reasonable policy objectives.**

³⁴ SMD 14-004. Accountability No. 2: Financing and Donations. CMS. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-004.pdf>. Accessed December 27, 2019.

³⁵ Texas Health and Human Services Commission v. HHS, No. 3:19-cv-02857-S (N.D. Tex. Dec. 2, 2019).

³⁶ Texas Health and Human Services Commission, DAB No. 2886, at 20 (2018).

³⁷ See, e.g., Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29, 43 (1983); City of Kansas City v. Department of Housing & Urban Development, 923 F.2d 188, 189 (D.C. Cir. 1991).

4. CMS' proposed changes to the health care-related tax rules exceed statutory authority, cannot be implemented, and would destabilize state budgets.

CMS proposes several changes to provider tax regulations to greatly expand the scope of its review authority and the level of discretion afforded to the agency in exercising that authority. These changes would chill states' legitimate use of provider taxes to fund their Medicaid programs and would permit an extraordinary level of intrusion by CMS into wholly private transactions between private entities.

- a. The proposed hold-harmless provisions undermine the clarity Congress intended and mischaracterize an impermissible change in policy as a codification of current rules.

Under federal statute, provider taxes cannot hold harmless a taxpayer for the amount of the tax. When Congress adopted the 1991 provider tax provisions, it created a detailed statutory structure so states could have confidence in designing taxes that satisfy federal requirements and would not be subject to later federal challenge. Congress outlined a series of standards by which to determine if the structure of a tax is permissible or includes a hold-harmless provision. When promulgating the initial regulations implementing the hold-harmless provision, then-HCFA was careful to create clear rules following the language of the statute, acknowledging "subjective analysis would be administratively burdensome and virtually impossible to apply fairly."³⁸ That is exactly the problem with the approach proposed in the MFAR.

The proposed regulatory language at 433.68(f)(3) incorporates overly broad and vague provider donation standards, as detailed above, providing a guarantee to hold harmless a taxpayer would be found where:

"... considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and that taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount."

States and local governments have a variety of financial arrangements with taxpaying providers unrelated to Medicaid (e.g., contracts for services outside of Medicaid, a variety of grant programs related to their various missions in their communities). Given the vagueness of the proposed standards, it would be difficult for a state or local government to know whether CMS might disagree with their determination that a particular arrangement is relevant to the provider tax. Likewise, it would be difficult for states or local governments to predict whether a taxpayer might view such an arrangement as a return of a provider tax amount. More precisely, it would be impossible to interpret whether CMS would conclude a taxpayer had such expectations.

In addition, taken at face value, the scope of this language could reach any arrangement for which the state or local government is adopting a reimbursement program that compensates taxpayers for the cost of the tax at a higher rate than the tax they paid. But this is not consistent with Congress' expectation that provider taxes would be used to increase Medicaid reimbursement to taxpayers. In 1991, Congress specifically amended the statute to protect this use:

³⁸ 58 Fed. Reg. 43,166, 43,167 (August 13, 1993).

“The provisions of this paragraph ***shall not prevent*** use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.”³⁹

Taking into account the preamble discussion, the MFAR is inconsistent not only with this statutory limit on restricting the use of provider taxes, but also with Congress’ entire standard for determining a hold-harmless arrangement exists. The proposed rule would make the existence of a hold-harmless entity dependent on what is in the mind of the taxpayer, and not require involvement of the state or local government. CMS states a hold-harmless arrangement exists any time taxpayers have a “reasonable expectation” of receiving payments that will offset losses from the tax.⁴⁰ This is true “regardless of whether *the taxpayers participate voluntarily*, whether the taxpayers receive the Medicaid payments from a managed care organization, or whether taxpayers themselves make redistribution payments from funds other than Medicaid to other taxpayers.”⁴¹ Voluntary payments between private taxpayers that have the effect of offsetting some or all of a taxpayer’s tax amount—entirely separate from and even unbeknownst to the state or local government—could constitute hold-harmless arrangements.

CMS’ interpretation is contrary to the plain language of Congress’ hold-harmless standard. Under Section 1903(w)(4) of the Social Security Act, a hold-harmless provision is in effect if:

- “(A) The ***State or other unit of government*** imposing the tax provides (directly or indirectly) for a payment (other than under this title [i.e., non-Medicaid]) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.
- (B) All or any portion of the ***payment made under this title*** [i.e., Medicaid payment] to the taxpayer varies based solely on the amount of the total tax paid.
- (C) The ***State or other unit of government*** imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.”⁴²

Critically, none of these provisions incorporate notions of taxpayer intent—unsurprising given the concerns for clarity that permeated Congress’ development of the hold-harmless standard. The provisions require some involvement of the government—either that the hold-harmless payment come from the state or local government imposing the tax (in A and C), or that the hold-harmless payment is a Medicaid payment (that is, made under this title, in B). Further, the Office of Inspector General (OIG) previously concluded that agreements between taxed providers were consistent with Medicaid law “because the agreements were voluntary between the hospital providers.”⁴³

³⁹ Social Security Act § 1903(w)(4).

⁴⁰ 84 Fed. Reg. 63,722, 63,735 (November 18, 2019).

⁴¹ 84 Fed. Reg. 63,722, 63,734 (November 18, 2019).

⁴² Social Security Act § 1903(w)(4) (emphasis added).

⁴³ HHS, OIG. Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri, A-07-02-02097. April 2003. Where the state hospital association pooled Medicaid payments financed by the

The involvement of the state or other unit of government is critical to the workability of the standard; a state attempting to implement a permissible tax could examine whether other state programs exist that might violate the hold-harmless policy, but the state would have no way of knowing about private arrangements that, by definition, do not include the government. CMS' proposal would give the agency discretion to consider any and all such arrangements, as well as its subjective determination of the expectations of parties outside of the state itself, to retroactively piece together circumstances warranting a disallowance.

Unless a state is willing to take on the risk of significant financial disruption in the event of a later disallowance, it would need to seek explicit CMS approval of any provider tax. But even the concept of preapproval is unreasonably burdensome and would not protect from a later disallowance. CMS would have to review all potentially relevant transactions, and if the state were not aware of or did not think to mention an unrelated arrangement, CMS later could determine the undisclosed transaction was, in fact, a hold-harmless agreement. As a result, the proposed rule would only serve to chill the use of legitimate state or local provider tax funds to finance Medicaid payments.

Even more problematic, CMS mischaracterizes this change in policy as “merely codif[ying] currently prohibited practices.”⁴⁴ CMS implies (without directly stating) the interpretation derives from the preamble to its 2008 provider tax final rule describing as a hold-harmless provision a situation “when a *state payment* is made available to a taxpayer ... in the reasonable expectation that the payment would result in the taxpayer being held harmless ...”⁴⁵ It would require “extraordinary intuition” for a state to understand this preamble language served to extend the hold-harmless definition to *private* payments among providers. CMS also points to its statement in the preamble to the 2008 provider tax final rule that “an indirect payment” can be the basis for a hold-harmless arrangement.⁴⁶ But CMS fails to mention the additional 2008 provider tax final rule preamble description of how CMS would identify “problematic indirect payments” as payments “***controlled or directed by the state.***”⁴⁷ In explaining this language, CMS offers two additional examples:

- a nursing facility tax, in which the state Medicaid agency imposes the tax while a different state agency (the governor’s office) implements a nursing facility resident grant program (offsetting the impact of the tax); and
- that “[s]tates will not be permitted to recycle monies through third parties, by making payments to such third parties ***and requiring that the*** money be used to reimburse taxpayers for any portion of their health care related tax.”⁴⁸

assessment and distributed with explicit intent to withhold some amount from “winner” hospitals and redistribute amounts to “losers,” OIG concluded the arrangement was consistent with Medicaid law “because the agreements were voluntary between the hospital providers and the [association], and because there are no regulations precluding the arrangement.”

⁴⁴ 84 Fed. Reg. 63,722, 63,735 (November 18, 2019).

⁴⁵ Ibid (emphasis added).

⁴⁶ 84 Fed. Reg. 63,722, 63,735 (November 18, 2019), citing CMS Health Care-Related Taxes Final Rule, 73 Fed. Reg. 9,685, 9,896 (Feb. 22, 2008).

⁴⁷ 73 Fed. Reg. 9,685, 9,694 (February 22, 2008).

⁴⁸ Ibid.

Neither of these examples involve purely private, voluntary transactions between private taxpayers that do not involve the state or local government. Even under the strictest reading of the 2008 provider tax final rule preamble, the state must **require** the third party to reimburse the other taxpayers. It is unreasonable to assert the 2008 provider tax final rule provided any notice of this newly asserted interpretation. The only guidance that has addressed purely private, voluntary transactions is the 2003 HHS OIG report, which concluded “there are no regulations precluding the arrangement” between private taxpayer hospitals to redistribute the Medicaid payments funded by the tax.⁴⁹ **The hold-harmless policy discussed in the preamble, if enforced, would be a change to existing policy and thus subject to strong legal challenge. CMS should explicitly withdraw the preamble discussion purporting to clarify current law and regulations.**

Finally, CMS fails to adequately articulate the newly-proposed standard it intends to apply through the new language of the MFAR. Despite CMS’ stated goal of “clarifying” the hold-harmless standard and “solidifying a shared understanding regarding what constitutes a guarantee to hold taxpayers harmless,” CMS explores this issue only in the preamble. The text of the proposed regulation does not state CMS would look beyond “an arrangement between the State (or other unit of government) and the taxpayer.”⁵⁰

- b. CMS proposes to inject new federal discretion and uncertainty into provider tax waiver determinations.

CMS proposes to strip the current precision and predictability from the standards for approving waivers of federal requirements for a uniform, broad-based tax. Current CMS regulations provide a clear method for a state to determine whether a proposed tax structure would be considered generally redistributive, and thus permissible, through detailed statistical tests (i.e., the “P1/P2” and “B1/B2” tests).⁵¹ Now, however, CMS proposes in addition to meeting these quantifiable tests, states also must demonstrate the tax does not impose “undue burden” on Medicaid items or services, or on providers of Medicaid services. CMS would determine there is an undue burden if taxpayers are divided into groups and the tax imposes a lower rate on non-Medicaid activity or payments or a higher rate on Medicaid activity or payments. The agency also would find an undue burden if the tax excludes a group of providers based on lower Medicaid activity, as defined by CMS through conditions outlined in the regulations. Providing even greater discretion to CMS, the regulation includes a catchall category applicable to taxes defining taxpayer groups based on “any commonality” CMS “reasonably determines” to be a “proxy” for lower Medicaid activity based on the “totality of the circumstances.” States should be able to develop compliant tax waiver proposals based on the standards outlined in the regulations and have an expectation CMS will act consistently on such waiver applications. The proposed standard would inject a level of subjectivity that makes this impossible and inevitably would result in CMS enforcement that is arbitrary and capricious, in violation of federal law. Further, the proposed standard could conceivably render impermissible any existing provider tax involving a waiver. Given that such waivers often are political necessities, the rule puts all of these taxes at risk. Their loss would result in unsustainable reductions in state funding available for the Medicaid program.

⁴⁹ HHS, OIG. Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri, A-07-02-02097. April 2003; *see supra* note [41] for description of OIG conclusion.

⁵⁰ 84 Fed. Reg. 63,722, 63,739 (November 18, 2019).

⁵¹ 84 Fed. Reg. 63,722, 63,731 (November 18, 2019).

The problem created by the subjectivity of the standard is exacerbated by CMS' proposal that all waivers be limited to three years. Even if a state manages to work with CMS to develop an approvable structure, there is no guarantee of consistency for future determinations, which is critical for state planning and policymaking. Limiting states' ability to plan for long-term, sustainable sources of funding translates to CMS limiting a state's use of local sources to fund its Medicaid program.

The proposed changes to health care–related tax rules exceed statutory authority, cannot be implemented, and would destabilize state budgets.

Medicaid Payments

5. CMS' claim of authority to review providers' retention of funds and associated transactions lacks specificity and is unreasonable, and CMS has not adequately considered the potential impact.

Given the critical role of stable Medicaid revenues for essential hospitals, we appreciate the importance to providers of retaining the full amount of payment for Medicaid services. However, the proposed provisions once again include broad standards that are too vague to be fairly applied—by CMS, or by states or providers attempting to ensure the compliance of their relationships.⁵² In addition, it does not appear CMS has analyzed, let alone made public, the potential impact of the provisions on various state and local programs.

The retention provision is drafted broadly, requiring, without qualification, providers to “retain” all payments to them (or the full federal share, in the case of payments funded by CPEs). The provision also would give CMS authority to “examin[e] any associated transactions that are related to the provider's total computable Medicaid payment” to ensure compliance. It is unclear how a state or provider could know whether CMS deems a given transaction “related to” the Medicaid payment.

Taken to extremes, and as the agency notes money is fungible, CMS could claim *any* expenditure was made with a Medicaid payment, and therefore “related to” the payment. The requirement to retain payments would prohibit providers from making expenditures with Medicaid reimbursement funds. Potentially, routine payments from providers to state or local governmental entities for items or services unrelated to Medicaid payments could be deemed associated transactions. CMS attempts to allay this concern in the preamble by explaining “the use of Medicaid revenues to fund payments that are normal operating expenses of conducting business ... including ... business relationships with governments unrelated to Medicaid in which there is no connection to Medicaid payment would not be considered an associated transaction.”⁵³ But it is unclear how CMS will determine if there is a “connection to Medicaid” that would turn a payment under a normal business relationship with a government into an “associated transaction” that reduces the federal Medicaid funds available to the state.

⁵² 84 Fed. Reg. 63,722, 63,744 (November 18, 2019).

⁵³ 84 Fed. Reg. 63,722, 63,747 (November 18, 2019).

Essential hospitals have close and often historical relationships with their state and local governments that typically involve an array of financial arrangements. Through these arrangements, money flows in both directions for a variety of reasons, stemming from the evolution of how states and localities provide health care services to their citizens. We are concerned that CMS' proposed creation of new authority to examine "associated transactions" will jeopardize these arrangements, and that CMS may use its disallowance authority to pressure states, localities, and providers to dismantle such arrangements. As described above, regulations must be clear and well-articulated such that regulated entities will be able to comply.⁵⁴ The proposed retention provision does not satisfy this standard.

Further, CMS' review and audit authority is limited to payments made under the Medicaid program. Under Section 1902(a)(32) of the Social Security Act, as cited by CMS, "no payment under the [state Medicaid] plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service." CMS does not, however, have authority over providers' use of received Medicaid payments.⁵⁵

CMS' broad drafting of provisions related to provider retention of funds and associated transactions does not provide specificity and sets unreasonable standards. As such, the agency must withdraw the MFAR in its entirety.

6. The MFAR's proposed limitations on supplemental payments for practitioners are arbitrary and unnecessary.

CMS proposes to limit supplemental payments for services provided by physicians and other licensed professionals to 50 percent of Medicaid FFS base payments. For physicians providing services within geographic health professional shortage areas (as designated by the Health Resources and Services Administration) or Medicare-defined rural areas, the limit would be 75 percent of Medicaid FFS base payments. These payments typically are targeted to physicians providing services at academic medical centers and safety-net hospitals. Under current CMS policy, issued through subregulatory guidance, supplemental professional services payments are limited to no more than the average commercial rate for specific medical services.

The physician services states have chosen to target for supplemental payments are a critical component of the Medicaid delivery system, impacting not only the health of Medicaid beneficiaries, but everyone in a hospital's community. Essential hospitals, which serve as both the nation's health care safety net and teaching hospitals, would not be able to provide life-saving tertiary and quaternary care relied on by all patients without sufficient support for the qualified physicians who provide these life-saving services. Maintaining access to these professional services is especially key as provider shortages are prevalent and growing. An April 2019 study

⁵⁴ *Diamond Roofing Co. v. O.S.H.R.C.*, 528 F.2d 645, 649 (5th Cir. 1976). This case holds that the agency retains the responsibility to state with ascertainable certainty what is meant by the standards promulgated.

⁵⁵ *Englund v. Los Angeles County*, 2006 U.S. Dist. LEXIS 82034, at *26 (E.D. Cal. 2006). When analyzing supplemental Medicaid funding paid to Los Angeles County, the Court noted "once the County received the [Medicaid] payment it was not limited to how it used the money" (citing testimony of Bruce Vladeck, Administrator of Health Care Financing Administration, 1993-1997). The Court also cited Vladeck's statement, "[M]oney is fungible. Once it was paid to the hospitals, if it was paid for services that were actually being provided, at that point our [HCFA's] sort of formal jurisdiction over it and interest of what became of the funds ended."

estimates a potential shortage of up to nearly 122,000 primary and specialty physicians in 2032, as demand continues to outpace the number of practitioners.⁵⁶

CMS' proposed limit on these payments is completely arbitrary—the agency provides no explanation for why it chose 50 and 75 percent as the limits. The existing policy limiting these payments to the average commercial rate is based on market forces and is an objective standard well-grounded in the underlying statutory economy-and-efficiency standard. CMS does not explain why paying essential professional providers the same rate as they have negotiated with private payers is inappropriate or excessive. Instead, CMS cites what it admits are “outlier” payment rates recently proposed by states that are larger than it had previously seen and decides to clamp down on *all* supplemental professional services payments rather than examining the methodology by which the outliers were calculated.

CMS estimates this provision will result in a \$222 million decrease in supplemental payments to providers. We believe that number grossly underestimates the result of the proposed limit on supplemental payments to physicians. Preliminary estimates from several essential hospitals have illustrated that this provision, in fact, would have a significant, multimillion-dollar effect on their *individual* supplemental payments, with a likely nationwide impact far in excess of CMS' estimate.

Supplemental payments to physicians help safeguard access to care by ensuring adequate reimbursement and retention of Medicaid providers. The proposed limitations on supplemental payments to physicians are arbitrary, narrow access to Medicaid providers, and undervalue critical physician services. **To protect patients' access to care, CMS must not implement this policy.**

Evaluation and Renewal of State Plan Amendments

7. Proposed new standards for supplemental payment SPAs inject discretion and uncertainty into the SPA approval process, are contrary to federal statute, and inappropriately restrict state flexibility.

CMS proposes a lengthy list of burdensome new requirements supplemental payment SPAs must satisfy. Among other things, the MFAR would require states to include in SPAs an explanation of how supplemental payments are consistent with statutory requirements of efficiency, economy, quality of care, and access; criteria for determining provider eligibility; a comprehensive description of the methodology used to calculate and distribute supplemental payments to each eligible provider; provider-specific payment amounts; and monitoring and evaluation plans. Detail at this level has never before been required in SPA submissions.

The new criteria would give CMS numerous new grounds to deny or delay approval of SPA requests, injecting significant CMS discretion and uncertainty for states and providers into the SPA approval process. For example, if CMS disagreed with a state's priorities and approaches to meet pressing public health needs, CMS presumably could decide not to approve any renewal

⁵⁶ Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2017 to 2032. April 2019. https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Accessed December 27, 2019.

period. Federal statute does not contemplate this level of discretion for CMS. Rather, it requires CMS to approve “any plan” that fulfills specified statutory conditions.⁵⁷ Also of concern, the level of detail required in the proposed rule would hamstring state flexibility to make modest and reasonable changes to Medicaid payment methodologies without submitting a new SPA and awaiting CMS approval (at a time when CMS will certainly be overloaded reviewing supplemental payment SPA renewal requests, as described below).

Inexplicably, CMS proposes to significantly expand the SPA requirements for supplemental payments, when base payments—which typically pay below costs—require no similar assurances of satisfying program requirements in SPAs. In fact, CMS proposes greater documentation and justification for supplemental payments at the same time it has proposed, in a separate rulemaking, to *eliminate* existing documentation requirements intended to ensure Medicaid FFS payments are sufficient to enlist enough providers to assure beneficiary access.⁵⁸ These inconsistencies have no rational basis and highlight the extent to which CMS has overreached in the MFAR. **Further, the proposed policies, if enacted, would be contrary to federal statute. CMS must not introduce uncertainty into the SPA approval process or erode state flexibility in determining the allocation of supplemental payments to providers and, thus, must withdraw the MFAR in its entirety.**

8. The proposal to require renewal of supplemental payment SPAs every three years is unnecessary and unworkable.

Under current law, SPA approvals are not subject to any time limits, giving states and providers stability and certainty in their Medicaid funding programs. In the MFAR, CMS proposes to limit the approval period for supplemental payment SPAs to three years, thereby requiring states to submit frequent renewals and giving CMS the opportunity to “revisit” already-approved programs every third year. The proposal would cause severe disruption for states and providers, which rely on state supplemental payment programs to maintain access and quality care for beneficiaries.

CMS in the preamble suggests time limits are necessary because the current process of conducting financial reviews and issuing disallowances is too burdensome. However, CMS completely ignores the substantial new burdens the proposal would create, not just for states and providers, but for the agency itself. The authority for current supplemental payment SPAs—of which there are many—would expire on the same day, two calendar years following the effective date of the final rule, resulting in an influx of SPA renewal requests at the same time every three years in perpetuity. With an already significant backlog of SPA requests, it is inconceivable CMS would have adequate resources to timely approve SPA renewal requests, many of which will come up for review simultaneously. **CMS must withdraw the proposal because it is overly burdensome and unworkable.**

Reporting Requirements

9. The MFAR’s prescriptive requirements for annual UPL demonstrations unnecessarily restrict traditional state flexibility in demonstrating compliance.

⁵⁷ 42 U.S.C. § 1396a(b).

⁵⁸ 84 Fed. Reg. 33,722 (July 15, 2019).

Since 2013, CMS has required states to submit annual demonstrations confirming provider payments are consistent with regulatory UPLs. The regulations define the UPL as a “reasonable estimate” of the amount that would be paid to a group of facilities under Medicare payment principles. In practice, while CMS has increasingly provided guidance to states on how to determine the UPL, it has generally respected the concept that the UPL is a “reasonable estimate” and that there may be several different approaches to calculating it. The current guidance allows states to deviate from the methodologies CMS has suggested as long as the approach is reasonable and accepted by CMS.

The proposed rule codifies the requirement that states submit annual UPL demonstrations and provides detailed instructions for how to calculate the limits. In doing so, CMS is eliminating this traditional flexibility for determining the reasonable estimate, and in fact narrows the number of acceptable approaches. In particular, many states historically have determined the UPL based on a per-discharge methodology, which would not be permitted under the MFAR’s new restrictive approach.

CMS does not explain why it needs to limit states’ approaches to estimating the UPL. It does not indicate methodologies currently in use have been inaccurate in any way. The detailed and overbearing instructions in the proposed rule for calculating the UPL are simply going to require more work on states’ part, especially those states required to overhaul their UPL methodologies. **CMS must not infringe on traditional state flexibility in complying with UPL demonstration requirements.**

10. CMS’ proposed reporting requirements will increase administrative burden without improving Medicaid program integrity or yielding meaningful data.

America’s Essential Hospitals supports efforts to increase transparency to preserve the integrity of the Medicaid program. However, the MFAR’s proposals related to reporting seek to achieve that goal at the unacceptably high cost to states of decreased flexibility and increased administrative burden.

CMS has consistently attempted to reduce regulatory and administrative burden through initiatives such as Patients over Paperwork, with its aim of increasing efficiency in the delivery system by allowing providers to focus their time and resources on patient care.⁵⁹ However, the proposed provisions regarding state- and provider-level reporting in the MFAR would result in the opposite: a decrease in efficiency and additional burden on states and providers, without improving care or lowering program costs.

As proposed, the agency would collect a significant amount of aggregate and provider-level data on supplemental payments quarterly and annually, within 60 days of the end of the state plan year. The frequency of the proposed reporting would impose a significant burden on state Medicaid agencies and providers. Quarterly and annual reports might not fully capture the payments made to providers in a state fiscal year, as states have the flexibility to determine when Medicaid payments are claimed and dispersed. Current regulations permit states to file claims

⁵⁹ *Patients Over Paperwork*. CMS. <https://www.cms.gov/About-CMS/Story-Page/patients-over-paperwork>. Accessed December 27, 2019.

for FFP up to two years after making Medicaid expenditures.⁶⁰ As a result, requirements for reporting at the end of a year cannot yield complete and useable data. An incomplete picture does not lead to meaningful analysis or policymaking.

Nor has CMS demonstrated it is capable of adequately reviewing, verifying, or using the massive amounts of data it proposes to collect. While CMS has required states to submit annual UPL demonstrations since 2013, it is not apparent in the proposal that the agency has effectively used the collected data. Now it proposes to exponentially increase the reporting requirements but has not explained how it will have the capacity to confirm the accuracy of the data collected, let alone interpret or put into context the payment and financing data provided. Without such capacity, the reporting is simply a bureaucratic exercise in increasing red tape without any marked improvement in understanding the role and nature of supplemental payments and the critical need for this funding.

Last, the agency includes estimates of the administrative time and costs to comply with the provisions in the proposed rule, if finalized. We believe the agency's estimates are unreasonably low, especially given the scope of the proposed reporting requirements. CMS cannot impose burdensome reporting requirements without a clear and accurate estimate of the time and costs of compliance. Otherwise, states will be unable to plan accordingly so that fulfilling reporting requirements does not take state resources away from patient care.

In adopting new reporting requirements, CMS must balance administrative burden with program transparency. The proposed rule would impose significant administrative burden on states and providers without a guarantee that reporting will yield meaningful transparency. As such, CMS must withdraw the MFAR regulation.

⁶⁰ 45 C.F.R. § 95.7 (2010).