MEDICAID FISCAL ACCOUNTABILITY RULE
THREATENS ACCESS TO CARE, STATE BUDGETS

In November 2019, the Centers for Medicare & Medicaid Services (CMS) published the proposed Medicaid Fiscal Accountability Regulation (MFAR), which would severely limit how states pay for their share of Medicaid spending. The rule would:

- threaten the stability of state budgets;
- significantly narrow and weaken Medicaid; and
- inevitably deny access to care for millions of Americans.

Congress must step in immediately and demand that CMS withdraw this damaging rule in its entirety.

STATE DISCRETION AND PATIENT ACCESS AT RISK
Medicaid is fundamental to the health care safety net. Millions of working Americans and families rely on the program to meet their health care needs, and beneficiaries include people with disabilities, children, the elderly, and those struggling with addiction. The MFAR would sharply curtail flexibility states now have to finance and structure Medicaid to serve these vulnerable populations. States will face the untenable and unpopular choice of massive cuts to Medicaid and other critical state programs, or tax increases.

The MFAR would prove costly not only to state budgets but also to essential hospitals, which provide a disproportionate amount of care to patients who rely on Medicaid. So, the rule would harm patients who face financial hardships and further erode access to care in underserved communities.

The MFAR would intrude on the state role in Medicaid by granting the federal government broad and arbitrary discretion to restrict how states finance their program. It would restrict congressionally sanctioned and regulated local sources of the nonfederal share, including intergovernmental transfers (IGTs), certified public expenditures (CPEs), and provider taxes. Current Medicaid policy clearly states that 60 percent of the nonfederal share can come from local sources.

States rely on long-standing financing arrangements with local governments and providers to support Medicaid and fund supplemental payments to providers, such as Medicaid disproportionate share hospital (DSH) and graduate medical education (GME) payments. These arrangements allow states to achieve policy priorities and respond to public health threats, such as the ongoing opioid epidemic.

FLYING BLIND UNDER PROPOSED RULE
It is particularly confounding CMS proposes these expansive changes without a full analysis of their impact on states and providers—the agency even acknowledges this shortcoming. America’s Essential Hospitals believes these changes would be substantial and impose high costs on states, providers, and beneficiaries. The agency would be irresponsible to finalize a rule of this magnitude without a detailed impact analysis available for stakeholder review and comment.

At a time when budgets already are stretched thin, states cannot afford federal overreach that will curb their ability to fund Medicaid at adequate levels. Further, CMS would implement these sweeping changes without adequate transition time for states to prepare and plan ways to mitigate the damage. Ultimately, the rule would dismantle state budgets, unravel the nation’s health care safety net, and jeopardize access to care for millions of low-income people.

On back: Detailed summary of restrictions and impact on Medicaid funding
### MFAR: Restrictions and Impact on Medicaid Funding

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<td>IGTs AND CPEs</td>
<td>CMS proposes to redefine the allowable sources of IGTs or CPEs.</td>
<td>This would render existing IGTs and CPEs derived from nontax or appropriated sources impermissible, limiting public providers’ ability to make IGTs and CPEs and significantly reducing Medicaid payments to providers in many states.</td>
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<td>CMS would redefine provider designations to delineate which entities can and cannot provide the source of the nonfederal share.</td>
<td>Narrowing the definition of a governmental provider would restrict the types of entities that can fund the nonfederal share and allow CMS to second-guess state determinations of provider designations.</td>
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<td>PROVIDER DONATIONS</td>
<td>CMS would expand the definition of impermissible donations.</td>
<td>This would increase the risk that existing business arrangements between governmental entities providing IGTs and private providers would be deemed an impermissible donation. It would give CMS significant discretion, creating uncertainty for states and providers as they try to predict the permissibility of financing arrangements.</td>
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<td>HEALTH CARE-RELATED TAXES</td>
<td>CMS proposes to expand the circumstances in which it would deem a tax to include an impermissible hold-harmless arrangement, and to modify standards for obtaining a waiver from the broad-based or uniformity requirements to ensure tax arrangements do not impose an “undue burden” on Medicaid items, services, or providers.</td>
<td>Under new standards, CMS purports to have authority to find a hold-harmless arrangement even where there is no governmental involvement. This introduces new CMS discretion and uncertainty into formerly automatic statistical waiver tests. Ultimately, it limits the feasibility of maintaining, expanding, or adopting provider taxes and might upend tax programs on which states and providers have relied for years.</td>
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<td>SUPPLEMENTAL PAYMENTS FOR PHYSICIANS</td>
<td>CMS would limit supplemental payments to 50 percent of Medicaid fee-for-service base payments or 75 percent for physicians providing services within Health Resources and Services Administration–designated health professional shortage areas or Medicare-defined rural areas.</td>
<td>The proposed limitations on supplemental payments to physicians are arbitrary and would serve only to narrow access to Medicaid providers. CMS estimates this provision would cut payments by $222 million, but that grossly underestimates the true impact of these payment limits.</td>
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