



January 31, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–2393–P/2393-N  
P.O. Box 8016  
Baltimore, MD 21244

*Submitted electronically via email to <http://www.regulations.gov>*

***Re: Medicaid Fiscal Accountability Proposed Regulation; Federal Register, Vol. 84, No. 222, November 18, 2019 [CMS–2393-P] and Federal Register, Vol. 84, No. 249, December 30, 2019 [CMS-2393-N].***

Dear Administrator Verma:

The Medicaid Health Plans of America (MHPA) is the national trade association representing 90 member health plans that contract with state Medicaid agencies in 36 states plus the District of Columbia to provide comprehensive, high-quality health care to more than 23 million Medicaid beneficiaries in a coordinated and cost effective way.

On November 18<sup>th</sup>, 2019, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule, “*Medicaid Program; Medicaid Fiscal Accountability Regulation.*” Through this proposed rule, CMS is seeking to increase oversight and improve fiscal integrity of the Medicaid program and further its goals of transforming Medicaid by “putting patients first, increasing state flexibility, and ensuring accountability and integrity of the program.” MHPA supports CMS in its efforts to advance the goals of transparency and strengthening the overall fiscal integrity of the Medicaid program; however, we have significant concerns with this proposed rule.

As you know, Medicaid is a large, complex, federal-state partnership that facilitates access to health care for a diverse, vulnerable population of more than 70 million people. Recognizing the critical importance of the program to our entire health care system, MHPA has worked for years to strengthen the funding and structure of the program in order to ensure appropriate access to comprehensive care for all intended populations. However, due to the broad scope of the proposed rule, we are concerned that without a thoughtful and thorough analysis prior to the implementation of the rule, there is the potential for significant unintended consequences – the

disruption to the current health care delivery system for all Medicaid beneficiaries regardless of whether they are served through fee-for-service or managed care.

While the proposed rule appears primarily directed at Medicaid fee-for-service, we believe its provisions would place significant pressures on the overall framework of state Medicaid financing structures and create significant budgetary challenges for state Medicaid funding in its entirety due to a potential restrictions on aggregate Medicaid financing. MHPA is concerned that these provisions lack a process to collect, analyze, and evaluate data in a deliberate and transparent manner and would force state partners to manage Medicaid budgets through either reductions or the elimination of benefits, services, and programs. The resulting impact on provider payments would very likely affect the willingness of providers to see Medicaid patients, putting access to care at risk for all Medicaid beneficiaries. Additionally, states may be forced to make challenging budget decisions about how to allocate money from their general funds, putting pressure on other state-funded programs and services, such as education.

We appreciate that the proposed rule is, in part, intended to improve CMS access to timely Medicaid financial data to allow for appropriate oversight related to state supplemental payment programs and the financing of the Medicaid program. However, we believe this proposal would significantly increase regulatory and reporting burden on states and providers.

We also believe that several of the provisions lack clarity and provide CMS broad discretion to determine whether a particular Medicaid financing arrangement complies with the proposed requirements. This would create uncertainty for states and providers about how to comply with the proposed standards, potentially resulting in subjective interpretation and/or enforcement, which would be disruptive and burdensome. The lack of uniform standards will likely cause inequity amongst states due to the broad discretion. The proposals would also have the effect of curtailing state flexibility in administering the Medicaid program that runs counter to the Administration's previously articulated goal of encouraging and supporting state innovation in the Medicaid program.

MHPA also has concerns with the scope of change being proposed prior to a thorough analysis that should, at a minimum, include an assessment of the impact on future eligibility and access to care for Medicaid beneficiaries. The proposed rule would implement sweeping changes to the overall financing and payment policies in the Medicaid program and does not include a meaningful assessment of the potential for beneficiary access and eligibility issues nor consider any actual data on the fiscal impact of these proposed policy changes. In addition, it is likely that due to the absence of well-informed, data-driven analysis, many states will not have a line of sight to these problems until the rule has been implemented and enforced.

***Given these concerns, we recommend that CMS withdraw the proposed rule at this time. We encourage CMS to instead consider proposing new data collection requirements that are not overly burdensome to states or providers that will help inform its decision-making on state financing policy changes required to ensure the integrity of the Medicaid program. Only after a comprehensive analysis of actual data on the impact of these proposals on the Medicaid program should CMS move forward with any clarifications or changes to current policy. Any assessment should include, at a minimum, consideration of issues related to access to care for***

***beneficiaries in the fee-for-service and managed care delivery systems and the financial sustainability of the Medicaid program. We further recommend that the process for conducting the analysis appropriately engages state Medicaid program partners, state legislatures, and affected stakeholders, including providers and Medicaid beneficiaries.***

Our specific concerns with the Medicaid Fiscal Accountability proposed rule relate to proposals establishing or revising the following regulatory sections: *State-Share of Financial Participation –Intergovernmental Transfers(IGTs) and Certified Public Expenditures (CPEs) (42 CFR 433.51; 42 CFR 447.206); Definition of “Net Effect” for Provider-Related Donation (42 CFR 433.52; § 433.54; § 433.68); Bona Fide Donation (42 CFR 433.54); Health Care-Related Taxes (42 CFR 433.55; § 433.68; § 433.72); State Plan Requirements (42 CFR 447.252; § 447.302); Reporting Requirements (42 CFR 447.288; § 447.290).*

**I. The proposed rule would curtail state flexibility and eliminate appropriate and legal state financing methods for the Medicaid program.**

***State-Share of Financial Participation –IGTs and CPEs (42 CFR 433.51; 42 CFR 447.206); Definition of “Net Effect” for Provider-Related Donation (42 CFR 433.52; § 433.54; § 433.68); Bona Fide Donation (42 CFR 433.54); Health Care-Related Taxes (42 CFR 433.55; § 433.68; § 433.72).***

Through this proposed rule, CMS explicitly acknowledged its intent to address concerns with Medicaid *payments* to providers that are characterized by CMS as being inappropriately used to draw down a higher federal match rather than being tied to the provision of Medicaid services, access, or quality of care. (*Medicaid Program Financing*, 84 FR 63728 through 63730). However, rather than regulate the payment with which CMS has expressed concerns, the proposed rule would eliminate or significantly constrain the *financing mechanism* used to fund the payments.

MHPA believes the proposed rule’s focus on Medicaid financing does not comport with the intent of the proposed rule. As a result, the proposed rule instead would quash the ability of states to rely on appropriate and legally authorized methods of financing that currently support many aspects of the Medicaid program. We believe this approach, coupled with the fact that these structures have already been approved by CMS, is a strong federal overreach.

Similarly, the proposed rule seeks to prohibit the practice in some states where providers pool their supplemental payments and redistribute the payments relative to the providers’ payment of fees or taxes. Instead of regulating or barring the payments that are then redistributed among providers, the proposed rule would override state laws and strike down the fee or taxes, even if only a portion of the fee or tax financed the so-called pool payments at issue. Many states have relied on new or increased provider taxes to finance the non-federal share of the Medicaid expansion authorized under the Affordable Care Act and this proposal could disrupt care for Medicaid beneficiaries who receive their care in states who finance the expansion through provider taxes.

**II. The proposed rule threatens the financial sustainability of the Medicaid program putting access to care at risk for all Medicaid beneficiaries.**

*State-Share of Financial Participation –IGTs and CPEs (42 CFR 433.51; 42 CFR 447.206); Definition of “Net Effect” for Provider-Related Donation (42 CFR 433.52; § 433.54; §433.68); Bona Fide Donation (42 CFR 433.54); Health Care-Related Taxes (42 CFR 433.55; § 433.68; § 433.72).*

The Medicaid program is structured as a unique federal-state partnership with financing as a statutorily shared responsibility. The Medicaid statute permits states to generate their share of Medicaid expenditures through multiple sources, including state general revenue, contributions from local governments (including providers operated by local governments), and specialized revenue sources such as health care-related taxes.

For the non-federal share of Medicaid financing of supplemental payments, states often rely on sources of funding other than state general funds. States may use intergovernmental transfers (IGTs) and provider taxes to fund many aspects of their Medicaid programs, in addition to supplemental payments. The Kaiser Family Foundation reports that in state fiscal year 2019, 49 states plus the District of Columbia used one or more provider taxes to finance their share of the cost of Medicaid programs. A 2015 GAO report (<https://www.gao.gov/special.pubs/gao-15-227sp/sectionb212.html>) noted in 2012 that 31 states used IGT funding and 28 states plus the District of Columbia used certified public expenditures (CPEs); it also found that 26 percent of the non-federal share of Medicaid costs, on average, were financed from provider taxes (10.4%) and IGTs and CPEs (15.5%).

CMS proposes broad changes to Medicaid program policies that would increase federal scrutiny of supplemental payments, IGTs, CPEs, and situations in which providers are being taxed or contributing resources (financial or otherwise) to their state to help draw down the federal match for Medicaid services. MHPA has significant concerns that the net impact of these proposed changes to the state share of the Medicaid program financing would reduce the total amount of Medicaid funds available to a state resulting in a direct and detrimental impact on Medicaid program providers and the beneficiaries they serve. To be clear, the proposals would impact the state budget in its entirety which would cause cascading impacts across Medicaid health care delivery systems whether the care is provided through fee-for-service or through managed care plans.

MHPA believes the proposed rule threatens to disrupt financing practices permitted by the enabling statute that states have long relied on to finance the state share of Medicaid financing while not providing a clear path for Governors, budget directors and Medicaid programs to mitigate current reimbursement methodologies that may be seen as inconsistent with CMS policies and objectives under MFAR. States rely on supplemental payments for various purposes, including compensating for low levels of reimbursement and providing targeted support to specific providers. This disruption potentially jeopardizes access to critical funding streams that have been put in place precisely because the Medicaid program is often budgetarily challenged. The proposed policy changes would most likely exacerbate these budgetary challenges and the Medicaid program could face significant erosions in funding. Simply, the

proposed changes would undermine the core framework of state Medicaid financing structures putting the Medicaid program at financial risk and forcing providers to reduce or eliminate services and critical programs for Medicaid beneficiaries. This would have the undesirable effect of dramatically reducing beneficiary access to care.

### **III. The proposed rule would impose considerable burden and uncertainty for state Medicaid programs.**

#### *A. Financial and Programmatic Uncertainty.*

***Definition of “Net Effect” for Provider-Related Donation (proposed addition and revisions to 42 CFR 433.52; § 433.54; § 433.68); Bona Fide Donation (42 CFR 433.54); Health Care-Related Taxes (42 CFR 433.55; § 433.68; § 433.72); State Plan Requirements (42 CFR 447.252; § 447.302).***

The proposed rule includes several new provisions that are vague or lack specificity, creating significant uncertainty and potential confusion for states and providers trying to comply with the requirements and could greatly impair the overall operation of the Medicaid program.

For example, CMS would have significant discretion in determining whether a provider qualifies as a public provider and in understanding whether financial transactions are compliant with rules by looking at the “net effect” that considers “the totality of circumstances” which is then broadly defined. The proposed rule would also require states to explain how their supplemental payments are consistent with “economy, efficiency, quality of care and access” without providing specific evaluation criteria. This creates new uncertainties regarding the amount that can be paid to individual providers through a supplemental payment.

The proposed rule also provides greater federal discretion to approve, deny, or reduce payments and establishes shorter approval periods for supplemental payment arrangements; these policy changes would introduce an increased level of risk and uncertainty for states and providers. We also believe such instances of ambiguity could lead to uneven or arbitrary enforcement and might deter states or providers from entering into legitimate, beneficial arrangements for fear of being found non-compliant. MHPA believes that without further clarification, CMS appears to be retaining significant discretion to make policy decisions in the future that could even further impair the ability of states to operate Medicaid programs in an appropriate and efficient manner.

#### *B. Administrative Burden.*

##### ***Reporting Requirements (42 CFR 447.288; § 447.290)***

The proposed rule would implement new quarterly and annual reporting requirements on states to include detailed provider-level data and aggregate reports for base and supplemental payments. While MHPA supports efforts to facilitate transparency through reporting, we believe these additional reporting requirements would increase regulatory and reporting burden significantly, take years to implement, and require changes and investment in data infrastructure as well as require reporting time by providers, as well as time and resource use by state and

federal resources. We recommend a single, standardized data collection tool or format developed in collaboration with state Medicaid agencies, CMS, and Medicaid health plans in order to avoid reporting that will fail in aggregation at all levels.

***State Plan Requirements (42 CFR 447.252; § 447.302)***

The proposed rule would also implement a new level of CMS scrutiny and oversight for state Medicaid programs. This would introduce additional levels of administrative complexity including requiring states to obtain approval for supplemental payment methods that would be reauthorized by the state and CMS within either two or three years of the effective date of the rule, depending on how recently they were approved. To request authorization for a supplemental payment, the state would need to include an explanation of the purpose and intended effects of the payment as well as a monitoring plan and a comprehensive description of the methodology for calculating and distributing the payment. The approval process would add considerable costs for states that would be managing the process more frequently and with additional administrative requirements.

**IV. The proposals have not been properly vetted for their impact on the Medicaid program overall, particularly for Medicaid beneficiaries.**

The proposed rule does not quantify any of the potential effects of its proposed financing provisions other than the potential reduction in physician supplemental payments. (See *Regulatory Impact Analysis*, 84 FR 63772 through 63776). Given the broad scope and complexity of these proposals, we believe that states will need time to fully assess the impact of the proposed changes and, specifically to assess how and the extent to which these changes would impact their Medicaid and overall state budgets directly and tangentially.

Under the proposed rule, states that would need to change their current state Medicaid financing mechanisms in order to be compliant would likely need to consider alternative arrangements that could include increasing overall tax revenue, increasing provider assessments and taxes, cutting spending, and/or removing benefits, services, or populations from the Medicaid program. Coupled with corresponding changes in payment methodologies prescribed by the rule, these changes could lead to a significant financial burden on providers who may find that the new arrangement is not financially sustainable and may choose to reduce their services or exit the Medicaid program, rather than incur the additional tax burden. MHPA believes that CMS has not sufficiently considered the proposed rule's impact on the Medicaid program as a whole, most notably, on providers and beneficiaries in both the fee-for-service and managed care delivery systems.

Similarly, we note that the proposed changes to the supplemental payments for physicians do not consider the impact of these changes on access, particularly related to specialty services for children or geographic impact in rural and frontier regions.

We believe that a proper assessment of available data and the collection and analysis of data that would better inform the impact of these policy changes, particularly the immediate impact on access and the long-term impact on sustainability, that is critical to ensuring that Medicaid

beneficiaries do not experience disruptions to care, regardless of whether their care is received in hospitals, nursing facilities, or via managed care plans.

**V. MHPA recommends CMS consider an alternative approach to achieve its goals of transparency and fiscal integrity that is informed by data and balances increased transparency with sustainability of state Medicaid programs.**

We appreciate and support CMS's intent to promote transparency and fiscal integrity in the Medicaid program. While additional data reporting is a critical component of the proposed rule as a means of achieving these goals, we question the approach of simultaneously seeking data and implementing such significant policy changes. We therefore recommend that CMS not move forward with this proposed rule in order to provide sufficient time to collect the data and then assess and analyze this data to inform its policy proposals. The requested data should be directly related to helping CMS achieve its stated goals and CMS should confirm that there are systems in place that have the ability and capacity to collect and analyze the data. We also recommend that the data be collected in a manner that is sensitive to the administrative burden associated with additional data collection and reporting requirements.

We also recommend that CMS consider the impact of current rules and regulations on managed care and other providers and develop this rule in alignment with established timelines and administrative requirements to mitigate against administrative duplication and the potential for provider and beneficiary confusion.

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Thank you for your attention to this important matter. MHPA believes that the uncertainty surrounding the proposed policies and their potential impact on state Medicaid financing and supplemental provider payments would disrupt the entire Medicaid program eco-system putting access to care for all Medicaid beneficiaries and their families at risk. Our member plans are committed to serving Medicaid beneficiaries and we respectfully request that CMS not move forward with the proposed rule at this time.

Should you need any additional information, please feel free to contact me at [sattanasio@mhpa.org](mailto:sattanasio@mhpa.org).

Sincerely,

*Shannon Attanasio*

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