



January 30, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Service
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-2393-P, Medicaid Program: Medicaid Fiscal Accountability Regulation

Dear Ms. Verma:

On behalf of the New Jersey Hospital Association (NJHA) and its over 400 members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on proposed regulation related to Medicaid program financing and supplemental payments. Given the proposal would severely curtail the availability of health care services to millions of individuals and because many of its provisions are not legally permissible, we request that the agency withdraw the proposed regulation in its entirety.

If finalized, the rule would change significantly hospital supplemental payments and cripple state Medicaid program financing. CMS claims to be clarifying policies regarding providers' role in funding the non-federal share of Medicaid, but in fact, the rule goes far beyond clarification and introduces vague standards for determining compliance that are unenforceable and inconsistent with CMS's statutory authority. The rule also contains significant changes to health care-related taxes (provider taxes), "bona fide" provider donations, intergovernmental transfers (IGTs) and certified public expenditures (CPE),¹ including definitional changes to supplemental hospital categories and public funds. The agency also proposes to change the review process for supplemental payment programs and provider tax waivers. In addition, the agency would grant itself unfettered discretion in evaluating permitted state financing arrangements through vague concepts such as "totality of circumstances," "net effect," and "undue burden."

The proposed changes could have devastating consequences. **Nationally, the Medicaid program could face total funding reductions between \$37 billion and \$49 billion annually or 5.8% to 7.6% of total program spending.² Hospitals and health systems specifically could see reductions in Medicaid payments of \$23 billion to \$31 billion annually, representing 12.8% to 16.9% of total hospital program payments. Moreover, the impact at the individual state level would vary significantly. In nearly all states, the reductions from this rule would**

¹ IGTs are funds that government providers transfer to the state for the state to use for federal matching purposes. CPEs are expenditures government providers certify as qualifying expenditures to the state for the state to use for federal matching purposes.

² Analysis provided by Manatt Health, 2020

unquestionably result in cuts in program enrollment and covered services. The impact in some states, however, could be catastrophic.

While we understand CMS's interest in enhancing its stewardship of the Medicaid program through greater transparency of Medicaid financing and supplemental payments, the proposed regulations go far beyond increasing transparency. Specifically, they would restrict state access to important funding streams, limit the use of supplemental payments, and introduce significant uncertainty with respect to how the agency will evaluate state approaches. The proposals are numerous and varied, and would give states virtually no time to make policy and budgetary adjustments to offset the loss of federal funds, assuming they could be mitigated at all.

The 75 million individuals who rely on the Medicaid program as their primary source of health coverage are the most at risk. The program pays for approximately half of the births in the country, as well as care for almost half of all children and adults with special health care needs, such as physical and developmental disabilities, dementia and serious mental illness. The magnitude of financial loss to the program as a result of this rule could force New Jersey to make difficult choices regarding eligibility, benefits and provider reimbursement. Each of these choices is fraught with negative potential consequences such as: eligibility rollbacks that would thwart important public health interventions; reduce benefits, which would decrease the quality of care; and lower provider reimbursement, which would lead to reduced access to care for many of our country's most vulnerable patients.

Despite the potential for such significant negative consequences, CMS has provided little to no analysis to justify these policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. Many of the changes would violate the Medicaid law or are arbitrary and capricious in violation of the Administrative Procedure Act. Moreover, at the same time the agency is proposing these changes, it is planning to rescind rules that require states to demonstrate that Medicaid beneficiaries have sufficient access to care, thus weakening CMS's ability to ensure adequate oversight of the program.³ For all these reasons, we strongly urge CMS to withdraw this rule.

Proposed Changes Affecting IGTs and CPEs

The agency proposes to redefine "non-state government providers" as government providers that are a unit of local or state government or a state university teaching hospital with administrative control over funds appropriated by the state legislature or local tax revenue. CMS further proposes that, beyond the new definition, the agency would have discretion to judge whether, "in the totality of the circumstances," the entity qualifies as a governmental provider.

In addition, CMS proposes to restrict what types of funds can constitute an IGT, and would limit IGTs to funds derived from the provider's state or local tax revenue (or funds appropriated to a state university teaching hospital). These changes would effectively cap the IGT and CPE amounts governmental providers can use to fund the state's non-federal share. Moreover, the ill-defined

³ www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission

discretion CMS has reserved for the agency in determining what entities are non-state government providers would create confusion and uncertainty for states in determining which public providers are permitted to transfer local funds for purposes of Medicaid financing.

These proposals raise a series of legal issues in that they are arbitrary and capricious, fail to provide adequate guidance, and restrict states' use of funds beyond what is authorized in statute.⁴ The agency also has failed to account for the substantial reliance by states on the prior policy and the harm that this change in policy would cause.

Proposed Changes Affecting Provider Donations and Health Care Related Taxes

States and local governments have long collaborated with providers to ensure access to health care services for their Medicaid population, as well as to improve the health of the overall community. Health care providers are permitted, under federal law and regulation, to make “bona fide” donations to governmental entities with certain restrictions as long as the donation does not have a “direct or indirect relationship” to Medicaid payments. (In other words, the state cannot promise that any donation is returned to the provider making the payment, providers furnishing the same class of services, or any related entity.⁵) States also are able to tax providers to collect revenue to be put toward the Medicaid program.

CMS has proposed a number of policy changes that would curtail sharply states' ability to use these financing arrangements – despite clear statutory authority permitting them.⁶ In general, CMS would grant the agency unfettered discretion to assess whether a financing arrangement is permissible. In order to do this, the agency again uses the “net effect” standard based on “the totality of circumstances.” These new, vague terms without defined criteria would impermissibly create confusion and uncertainty for states. The proposed rule would violate the statute by requiring only a “reasonable expectation that the taxpayer may be held harmless, rather than a “guarantee,” as required by the statute.⁷ This rule also would introduce inconsistencies with existing regulatory language and violates the Administrative Procedure Act because it is changing policy and guidance upon which states and providers have long relied with too little rationale. Finally, the proposal is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers.

Medicaid Supplemental Non-Disproportionate Share Hospital (DSH) Payments

States use both base payments and supplemental payments to reimburse providers. Base payments for providers are tied to claims for specific services and are typically set significantly below the cost of care. Historically, supplemental payments have served to improve provider payment rates. However, even the use of supplemental payments does not make providers whole. After accounting for supplemental payments, hospitals receive on average only 89 cents on every dollar spent for caring for Medicaid patients.⁸

⁴ 42 USC 1396b(w)(6)(A).

⁵ § 433.54 Bona fide donations

⁶ Social Security Act § 1903(w)(3).

⁷ Social Security Act § 1903(w)(4)(C)(i).

⁸ AHA January 2020 <https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid>

CMS proposes significant changes to the policies for non-DSH supplemental payments, citing concerns about the growth in these payments. Specifically, the agency proposes to change how upper payment limits payments (UPL) are calculated, increase reporting requirements, and limit such payments to physicians and other practitioners. These changes could severely curtail access to care, especially at public academic teaching hospitals and rural hospitals serving vulnerable communities whose providers would disproportionately be subject to the new practitioner caps. Meanwhile, the new provider-level reporting requirements would be considerable and would generate largely unusable data given inadequate guidance from the agency on some of the proposed reporting requirements, as well as the fact that the data would not be audited. Because the agency has not ensured that the federal statutory equal-access standard can be met with these policy changes, the proposal is arbitrary and capricious.

Effective Dates, Transition Periods

The proposed rule has virtually no transition timeline for states to make changes to their financing and supplemental payment programs. The only transition period CMS contemplates is for renewal of the provider tax waivers and non-DSH supplemental payments, but even here, there is insufficient time for states to manage a renewal process in the allotted time. In addition, CMS proposes to limit approval for supplemental payment programs to a three-year period, which will leave states with insufficient time to secure approval from state agencies and legislatures. These financing and payment programs are complex and states need considerable time to work with state legislatures and affected stakeholders to implement any possible mitigation strategies.

Conclusion

Given the proposed rule undermines the Medicaid programs in our state and thus adversely impacts those who rely on the program, suffers from numerous legal infirmities and would require considerable time for mitigation (if even possible), we request that it be withdrawn in its entirety.

We appreciate your consideration of these comments. We look forward to working with the agency to explore reasonable transparency measures to ensure accountability in Medicaid state financing and payment policies.

Sincerely,

Jonathan Chebra
Senior Director, Federal Affairs