



January 30, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2393-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS Docket No. CMS-2019-0169, RIN 0938-AT50, Comments in Response to Proposed Rulemaking: Medicaid Fiscal Accountability Regulation

Submitted via [www.regulations.gov](http://www.regulations.gov).

Dear Administrator Verma:

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH) and the millions of patients they serve, we appreciate the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation (MFAR). We write to you to express our deep concerns with the proposed rule and the severe disruption it would cause to the financial foundation of our state's Medicaid program, jeopardizing access and coverage for millions of low-income Californians, and we urge you to rescind the rule.

CAPH represents California's 21 county-operated or -affiliated public health care systems and the University of California medical centers who deliver care to all who need it, regardless of ability to pay or circumstance. As core safety-net providers to California's low-income population, public health care systems annually serve 2.85 million Californians and provide over 10 million outpatient care visits. Though just six percent of all California hospitals statewide, public health care systems provide 40 percent of all hospital care to the remaining uninsured and nearly 35 percent of all hospital care to Medicaid enrollees in the communities they serve. Public health care systems operate half of all top-level trauma and burn centers in California, and train half of all new doctors in hospitals across the state.

California's public health care systems' unique and essential role makes them a vital partner to the state's Medicaid program. Public health care systems are also heavily financed through Medicaid to meet ongoing community needs, which require them to fulfill the multiple roles of provider, payer, and government entity.

As currently proposed, the MFAR would upend the essential relationship between public health care systems and the Medicaid program, forcing our member systems to eliminate essential programs and services that our communities rely on and limiting access to critical care.

If the rule is finalized, we estimate over one million patients could lose access to care in our public health care systems alone, and several public health care systems could close their doors, leaving counties without a vital safety net system.

**We therefore urge the Centers for Medicare & Medicaid Services (CMS) to rescind this proposed rule for the following reasons, summarized below and in further detail in our comments, so that we can continue to provide our patients with access to high quality care and maintain our mission to serve our community:**

- The proposed rule is rooted in misinterpretations of the Medicaid statute that would depart from Congressional intent by inappropriately restricting state flexibility and local control.
- CMS has not met its basic obligation to regulate from a rational basis because it has performed only the most cursory impact assessment, and in particular has not evaluated how the proposed rule would impact patient access to care.
- The proposed rule does not adequately or appropriately take into account the longstanding partnerships between states and local governments, and the fundamental ways in which governmental providers fulfill multiple roles as governmental entities, providers, and payers.
- The proposed rule would impermissibly vest CMS with unbounded discretion, failing to establish clear standards that give states and providers notice of how they would be regulated.
- Contrary to express policy goals of this administration, the proposed rule would greatly increase administrative burdens on already overstressed federal and state agencies.

#### **I. CAPH Strongly Opposes the Finalization of the MFAR**

Throughout this sweeping rule, CMS proposes new restrictions on states along with boundless federal discretion that undermines the vision of state-federal partnership inherent in the Medicaid statute—a partnership in which states are entrusted to design their programs within concrete federal parameters, and the federal government guarantees matching funds whenever these rules are followed. Central to this proposed rule are new, exceedingly narrow limitations on how states finance the non-federal share of Medicaid program expenditures. The proposed changes reverse decades of federal interpretations and approvals, proposing new interpretations and restrictions that modify longstanding policy on which states and providers have long relied to design their programs. If the MFAR is finalized, states would face the grim choice of reducing services or raising taxes. As stated above, CAPH estimates that over one million patients across all public health care systems could lose access to care due to service reductions, and that several hospitals would be at risk of closing.

Since the beginning of the Medicaid program, Congress has recognized and consistently protected the ability of public agencies within a state to contribute public funds as the non-

federal share of Medicaid expenditures, allowing states or local agencies to impose health care-related taxes to fund enhanced Medicaid payments to providers. Further, CMS has authorized arrangements that rely on such local financing for decades. The significant restrictions proposed by the MFAR on these activities represent a dramatic departure from current and past CMS practices — a departure that was not contemplated or authorized by Congress and that undermines the careful balances struck in the Medicaid statute between federal oversight and state autonomy. Congress, not CMS, has the authority and responsibility for managing these fundamental areas of the Medicaid program and it is imperative that Congress authorize any proposed changes in this area.

The MFAR would also significantly re-work the state-federal partnership that characterizes the Medicaid program, transferring decision making from states to the federal government. In multiple areas, the MFAR proposes to grant CMS expansive new authority over essential program elements, including financing and payment methodologies, under broad and vague standards that fail to articulate clear rules states can understand and follow. While the Medicaid state-federal partnership requires CMS to take a central role, the partnership functions best when CMS issues clear rules and expresses a strong commitment to ensuring that federal funding will be available if those rules are met. Congress designed the Medicaid program to give states the opportunity to innovate within federal parameters and design and finance programs suited to local circumstances. The MFAR's unprecedented expansion of federal discretion over state arrangements would undermine this framework, shifting authority and control over how public services are funded and organized within a state away from states and localities to the federal government.

While these changes are far reaching with dramatic implications for coverage and access to services, CMS' impact analysis of the changes can only be described as deeply inadequate. According to CMS, the "fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." As noted above, CAPH's own estimates suggest that even with a narrow focus on California's public health systems, over one million patients would be impacted and multiple hospitals would be in jeopardy of closure. In light of this stark reality, the impact analysis offered in the MFAR is wholly inadequate to inform the public and governments at the federal, state and local levels of the significant impact of the changes proposed. The MFAR must not be finalized without a more comprehensive and realistic assessment of its potential impact.

With broad new oversight discretion comes the need for administrative capacity to carry out oversight responsibilities. Currently, both state and federal agencies struggle with significant backlogs for approval and implementation of key agreements and programs. The MFAR promises to increase this workload exponentially with new requirements for regular reviews of existing arrangements and mammoth new data reporting that would require updates to existing data systems. And yet, the MFAR's regulatory burden estimates implausibly downplay these considerations. For example, the rule estimates it will take no more than 30 minutes of a research assistant's time for a state to compile and submit the six categories of information that would be newly required for approval of a supplemental payment. These six categories include detailed and complicated information, including a comprehensive description of the methodology for calculating and distributing the payment, a monitoring plan to ensure the payment meets statutory requirements, and an evaluation of a payment's previous impact on the Medicaid

program. In reality, states would rely on teams of several people who would work for many hours, even weeks, to prepare and submit the information to CMS and evaluate CMS' responses. These regulatory burdens would increase dramatically were CMS to force states to make changes to existing supplemental payment programs. Administrative capacity is already a significant barrier in the existing Medicaid program; an appropriate accounting of the potential increase in these burdens is necessary to fairly evaluate the MFAR.

Finally, CAPH and its members have significant concerns about the potential finalization of the MFAR in light of other recent actions by CMS, including the proposed rescission of the Medicaid access rule, which requires states to document whether Medicaid payments are sufficient to enlist enough providers to ensure beneficiary access to covered services. While CAPH understands the Secretary's concerns about states' growing reliance on Medicaid supplemental payments, oversight over supplemental payments must be accompanied by a comprehensive evaluation of Medicaid payments overall, to ensure that those payments are adequate to guarantee Medicaid beneficiaries' access to care that is comparable to what is available to the general population.

Because of these serious deficiencies, CAPH urges the Secretary to withdraw the MFAR in favor of working with Congress and states to improve future financing and reporting rules for the Medicaid program.

## **II. Overarching Comments**

CAPH offers the following comments and considerations, which inform the subsequent comments in Section III on the specific regulatory changes proposed in the MFAR.

### **A. The MFAR misconstrues the Medicaid Act and impermissibly restricts local financing of Medicaid payments.**

In enacting the Medicaid statute, Congress carefully considered and addressed the ways in which states may finance their Medicaid program. The proposed changes that enumerate sources of the non-federal share in the MFAR do not acknowledge the key role local agencies play in their communities and in the Medicaid program, or Congress' intent to protect that role.

Since the inception of the Medicaid program, states have been permitted to use local sources of funding to finance the non-federal share of the program. This structure is grounded in the fact that local governments have long played a significant role in both financing and providing care to local indigent populations. Congress recognized this role when it expressly provided that up to 60 percent of the non-federal share of Medicaid expenditures may be derived from local sources, so long as the state assures that "the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan." (Social Security Act § 1902(a)(2), 42 U.S.C. § 1396a(a)(2).) This provision was designed to reassure states that they could continue to rely on community resources to serve the indigent if they implemented the Medicaid program, which was a critical concern when Congress developed the program and sought to encourage states to participate. This authority is further reflected in the fundamental structure and longstanding execution of the Medicaid program, which commits federal financial participation for all medical assistance

expenditures made consistent with an approved state plan, and does not require those expenditures to be made solely by the state. (See Social Security Act § 1903(a)(1), 42 U.S.C. § 1396b(a).) For decades, states and local governmental entities have relied on this authority to utilize local public funds to make medical assistance expenditures through both intergovernmental transfers (IGTs) and certified public expenditures (CPEs). State Medicaid programs were built upon these local public resources, and continue to rely on them today.

The ability to use IGTs and CPEs also significantly reduces the administrative complexity of arrangements between state and local governments. When local governmental agencies contribute to Medicaid expenditures, they retain control over how public funds are expended consistent with their public mission and charter, rather than ceding their budgeting authority to a state agency. The Medicaid partnership with local funding entities has yielded significant successes here in California. Through programs such as California’s Whole Person Care pilots, local government agencies both finance the nonfederal share through IGTs and assume a central role designing the interventions that are most effective in addressing the needs of their local communities.

The proposed rule fails to acknowledge the key role local agencies play in their communities and in the Medicaid program, and Congress’ intent to protect that role. To the contrary, the rule mistakenly derives the source of authority for the use of local financing of Medicaid expenditures from section 1903(w)(6)(A) of the Social Security Act, in which Congress, in 1991, enacted new provisions addressing non-bona fide provider-related donation and impermissible health care-related taxes. CMS misconstrues this provision as Congress’ *permission* for states to use IGTs and CPEs in certain circumstances, and a *prohibition* from using them in any other circumstance. (See 84 Fed. Reg. at 63738). But, in fact, the authority for states to use local financing, provided for since the inception of the Medicaid program, is in a different section: 1902(a)(2). Furthermore, the plain text of section 1903(w)(6)(A) upon which CMS is relying in this proposed rule reads:

*[T]he 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 within 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.*

This language reveals an exact opposite meaning from what CMS is currently advancing: rather than indicating that the ability to use local financing via IGTs and CPEs is restricted, the language actually prohibits *the Secretary* from restricting IGTs and CPEs derived from tax revenues (or appropriations to a State university teaching hospital) except when “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.” (Social Security Act § 1903(w)(6)(A), 42 U.S.C. 1396b(w)(6)(A).) In other words, section 1903(w)(6)(A) is a *safe harbor* that insulates certain IGTs and CPEs from the tax and donation restrictions in other provisions of Section 1903(w), unless the Secretary has specific evidence that the funds transferred or certified are

themselves derived from an impermissible source (*i.e.*, a non-bona fide provider-related donation or impermissible health care-related tax).

The existence of this safe harbor does not undermine the long-standing presumption that local financing of Medicaid payments is permissible and authorized by other provisions of the Medicaid Act. Local public agencies have had access to public funds from a variety of sources beyond those specifically mentioned in section 1903(w)(6)(A) since before the Medicaid program was enacted, and such funds cannot uniformly be construed as being derived from non-bona fide provider-related donations or impermissible health-care related taxes. Contrary to the interpretations in the MFAR, nothing in the 1991 law that enacted section 1903(w), the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234) (the “1991 Law”), indicates Congressional intent to restrict the use of these funds as the non-federal share. To the contrary, the language of the safe harbor in section 1903(w)(6)(A) indicates a specific intent to limit the Secretary’s scrutiny of such financing to instances where the local funds are the result of a provider-related donation or impermissible health care-related tax.

Other provisions of the 1991 Law corroborate Congress’ intent to preserve existing local financing. The 1991 Law included a section – “Section 5” – that prohibits the Secretary from issuing any “interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations [recognizing IGTs and CPEs]) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation” for public funds derived from impermissible provider-related donations or health care-related taxes. (*See* Public Law No. 102-234, Section 5 (Dec. 12, 1991).) This section further demonstrates that Congress did not intend the provider-related donation or health care-related tax provisions of the 1991 Law to disrupt local government financing of the non-federal share. The import of Section 5 was acknowledged at the time by CMS (then the Health Care Finance Administration) when it published regulations indicating that it was not changing the treatment of either CPEs or IGTs as the source of the non-federal share, affirmatively stating that “States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).” (57 Fed. Reg. 55118 (Nov. 24, 1992) (as corrected 58 Fed. Reg. 6096, Jan. 26, 1993).)

Congress’ concerns and exercise of authority in this area did not end in 1991. In 2007, CMS issued regulations that, among other things, proposed to modify sources of the non-federal share of Medicaid payments. (72 Fed. Reg. 29748 (May 29, 2007).) These regulations were halted by Congress, and voided by a court. (U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. Law. No. 110-28, § 7002(a), 121 Stat 112, 187 (2007); *Alameda County Med. Ctr. v. Leavitt*, 559 F.Supp.2d 1 (May 23, 2008).) Congress subsequently expressed its view that the invalidated regulations should not be promulgated. (Section 5003, American Recovery and Reinvestment Act of 2009 (Pub. Law No. 111-5).)

In consideration of this history, and the significant errors in the proposed reading of CMS’ legal authority, we encourage the Secretary to withdraw the proposed changes to Medicaid financing included in the MFAR in favor of working with Congress. The issues addressed in the

MFAR go to the heart of Medicaid’s federal-state partnership. Disrupting the status quo not only negatively impacts state and local budgeting significantly, it also unpredictably upsets the balance between matters of local, state, and federal concern. Congress has clearly, and repeatedly, expressed its intent to oversee this area of the Medicaid program because it recognizes these realities; accordingly, the Secretary should not act in this area without express congressional authorization and direction.

### **B. Medicaid supplemental payments are part of overall Medicaid compensation.**

The MFAR includes a number of provisions that seek to enhance CMS’ oversight of Medicaid supplemental payments, even though the Secretary currently has authority to evaluate aggregate level payments for many categories of services, including through the use of upper payment limits. CAPH acknowledges the Secretary’s concerns about states’ increasing reliance on supplemental payments, however, CMS cannot adequately evaluate Medicaid payment methodologies for compliance by focusing on supplemental payments alone. To determine whether payments are adequate, a more comprehensive view that considers both base and supplemental payments is needed. For this reason, we oppose the proposal to draw a distinction between base and supplemental payments, and to impose heightened scrutiny on those payments determined to be supplemental.

The need for a comprehensive evaluation is apparent from the cited MACPAC analysis finding that supplemental payments represented more than a quarter of total Medicaid payments to hospitals in FY 2016. (See “Medicaid Inpatient Hospital Services Fee-for-Service Payment Policy,” MACPAC Issue Brief, December 2018). The scale of supplemental payments cautions against considering them in isolation—these payments are significant enough that disrupting them is likely to have serious consequences on quality and access unless there are corresponding adjustments to base payments. Providers receiving several different kinds of Medicaid payments do not view one component as more or less essential as the other, rather, they evaluate whether to participate in the Medicaid program based on the total payments they receive.

Rather than a narrow focus on supplemental payments, CMS should evaluate whether overall provider rates are sufficient to protect access to care. Indeed, section 1902(a)(30)(A) of the Social Security Act requires the Secretary to ensure that payment is “consistent with efficiency, economy, and quality of care” and “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Under the MFAR, CMS is seeking to evaluate only one aspect of provider payments. Yet, in other rules has attempted to *reduce* its broader oversight of access, most recently in the proposed rescission of a rule requiring states to document whether Medicaid payments are sufficient to enlist enough providers to assure beneficiary access to covered services. *See* 84 Fed. Reg. 33723 (July 15, 2019). If CMS continues on its proposed course of *reducing* oversight over the impact of Medicaid rates on access, while increasing barriers to payments determined to be supplemental, the result will be a severely weakened Medicaid program, with corresponding adverse health consequences for patients. The Secretary currently has authority to evaluate aggregate level payments for many categories of services, including through the use of upper payment limits, and to evaluate compliance with the Medicaid statute’s focus on access.

### III. Comments on Specific Provisions of the MFAR

#### A. State share of financial participation (42 C.F.R. § 433.51)

CMS proposes significant changes to the fundamental ways in which states partner with the federal government to provide services under the Medicaid program, particularly related to sources of non-federal share. CAPH strongly opposes these changes, which are inconsistent with long-standing policy. CMS' explanation of its legal authority for the proposed changes materially omits and misconstrues provisions of the law, resulting in an inappropriately narrow view of public funding sources. These changes contradict Congressional intent and exceed the Secretary's authority to act in this area.

Under current and longstanding regulation, CMS has described sources of state non-federal share using the term "public funds." Under the proposed rule, CMS attempts to narrow the definition to:

- State general fund dollars appropriated by the State legislature directly to the State or local Medicaid agency (433.51(b)(1))
- Intergovernmental transfer of funds from units of government within a State (including Indian tribes), derived from State or local taxes (or funds appropriated to State university teaching hospitals), to the State Medicaid Agency and under its administrative control... (433.51(b)(2))
- Certified Public Expenditures, which are certified by a unit of government within a State as representing expenditures eligible for FFP under this section...(433.51(b)(3)).

CMS' rationale for replacing the term "public funds" with these more specific definitions is that the regulatory language is inconsistent with the 1991 Law that placed restrictions on taxes and donations, and that it causes "confusion" about sources of non-federal share. To the contrary, Congress itself used the term "public funds" in section 5 of the 1991 Law and referred to "public funds" throughout both the associated House Energy and Commerce Committee Report and House Conference Report (H.R. Rep. No. 102-310 (1991); (H.R. Rep. No. 102-409 (1991)). Congress understood that under then current law, "any public funds" received by the State Medicaid agency from other public agencies or local units of government could be used as the non-federal share, without limitation as to the source of such public funds except to the extent derived from restricted provider taxes or donations (*see e.g.*, H.R. Rep. No. 102-310 at p. 15 (1991); H.R. Rep. No. 102-409 at 17-18 (1991)). Notably, Congress did not change the definition or scope of "public funds" in the 1991 Law, or at any time subsequent.

The proposed new language in section 433.51(d) providing that in some cases non-federal share provided via IGT will be "considered" a provider-related donation is similarly misguided. To the extent CMS believes local financing is derived from a non bona-fide provider related donation, it must follow the mechanisms prescribed by Congress for evaluating donations. In particular, states are obligated to report on the source and use of all provider-related donations to allow for a determination to be made as to whether they are bona fide. If

donations are determined to be non bona fide, the consequence is that the state's medical assistance expenditures for a fiscal year are reduced by the amount of the donation. The Secretary has no authority to conclude a source of funding is the result of a non-bona fide provider-related donation without following these steps, nor to impose alternative consequences. The insertion of concepts related to donations into the question of whether a funding source is allowable in the first instance conflates two separate issues in a way that distorts Congressional intent.

Other proposed changes to section 433.51 would also introduce new ambiguity and uncertainty. For example, the reference to "state general funds" in proposed section 433.51(b)(1), introduces a new, undefined term, which could prohibit the use of state special funds that have long been eligible for the use as the non-federal share. Similarly, when the new proposed language is considered alongside the long-standing language in section 433.51(c), which asserts that to be considered a source of non-federal share, "the State or local funds [must not be] Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds," the proposed changes raise the question whether and how federal funds could also be state general funds or state or local taxes, introducing new uncertainty and confusion to the regulation.

#### **B. Definition of Non-State Government Provider (42 C.F.R. § 447.286)**

CMS proposes a new definition of "Non-State government provider" as

*a unit of local government in a State, including a city, county, special purpose district, or other governmental unit in the State that is not the State, which has access to and exercises administrative control over State funds appropriated to it by the legislature or local tax revenue, including the ability to dispense such funds. In determining whether an entity is a non-State government provider, CMS will consider the totality of the circumstances, including, but not limited to, the following...*

To determine whether a provider meets the above definition, CMS describes two broad inquiries it would undertake, focused on the identity and character of other entities that share responsibilities with the provider.

We object to the proposed definition on several fronts: it inappropriately inserts the federal government into matters of traditional state concern; interferes with local governments and constituents from achieving fiscal independence for their public providers; misleadingly blurs the distinction between upper payment limit categories of provider and sources of the nonfederal share; and, even if all of the above were not true, establishes an unworkable standard that would give CMS carte blanche to classify providers any way it desires.

The proposed section represents a fundamental intrusion into matters of state and local concerns because it displays no sensitivity to the many ways that states and local governments structure their public providers pursuant to state and local law. It would root the distinction between government and private providers on whether the provider has "access to *and exercises administrative control*" over either appropriated State funds or local tax revenue. There are many circumstances when these are not the right questions to ask. By honing in on access and control

over certain sources of funds, the proposed definition fails to focus on the inherent characteristics that distinguish government providers from private providers. These characteristics include the legal authorities under which the local government entity establishes, operates, or functions as a provider, its legal obligations to the residents in its jurisdiction and other constraints typically imposed in conjunction with those obligations, and whether the entity is subject to federal and state taxation on income. The result is that, as proposed, some long-standing governmental facilities would be incorrectly reclassified as private for payment purposes.

Significantly, other state and locally determined entities established as units of government under state law have always been considered governmental, regardless of whether they meet the proposed definition's criteria related to tax revenue. These other structures include local hospital or health care authorities, which are treated, and have the same rights and responsibilities, as other government entities. The rationales for their creation vary by locale; a predominant reason is to provide political separation that enables greater finance and operational flexibility for the hospital, such as in hiring, contracting and procurement, so it is competitive and viable, while retaining as top priority its public mission as a provider of last resort for all residents. The process for creating a health care authority involves state legislation, local ordinance, and in some cases local election. There is simply no place for a federal agency to insert itself into such matters of traditional state concern.

The federal intrusion is also evident in the ways the proposed section would undermine local governance over the operation and funding of public services. For example, a city or a county that operates a public hospital may establish a separate enterprise fund into which local funds are deposited, including the hospital's operating revenues and bond proceeds from revenue anticipation notes. Such an arrangement enables the public hospital to be managed economically and sustainably in a competitive environment. The proposed definition, however, presumes that the public hospital must exercise "control" over local tax revenues, as opposed to the city or county board. This presumption is inappropriate because often the city's or county's governing board is the entity that must administer and control the public funding that goes into the hospital enterprise fund, in amounts as needed to support hospital operations. As a practical matter, the public hospital does not "control" which dollars are being used for hospital operations, because when the public hospital incurs costs, what is expended from the enterprise fund is cash.

Further, the proposed definition is likely to have negative unintended consequences that could result in significant increases in state and local taxes. Local governments have an obligation to run their operations in a fiscally prudent manner. In the case of public hospitals and other public providers, this generally translates into focused efforts to generate and collect patient services revenue, and then relying on this revenue to support operating expenses. For example, a local government board may have directed by ordinance or resolution, or the constituents within a hospital district may have voted in an election, that the public hospital operate on hospital revenue or bonds. When a public hospital achieves self sufficiency by not relying on local taxes, it benefits the entire community – but the proposed definition would make this impossible. Under the definition, to retain the public hospital's public status, the local government would need to unnecessarily encumber tax revenue and essentially overfund the hospital enterprise fund, thereby hampering the local government from making public funds available for other public purposes. To maintain the same level of local services of all types, not just health care, being offered today, local governments would have to resort to increasing taxes.

CAPH is also concerned that the purpose of creating this definition, which is purportedly for upper payment limit (UPL) demonstration purposes, perhaps does not reflect CMS’s true concerns. Rather, it appears that CMS is more concerned about the types of public funds the public provider is expending and, implicitly, whether it is providing non-federal share. This focus is entirely misplaced. Even if access to and control over tax revenue were essential to the determination of whether certain sources of non-federal share are permissible (it is not, for the reasons discussed elsewhere), it would not be relevant to the classification of providers for upper payment limit demonstrations. CMS should not finalize a definition that is so poorly tailored to its purported purpose.

Finally, the proposed definition lacks structure, and creates significant risks that the standards for determining public provider status would be applied in an arbitrary and opaque manner. As noted before, the rule proposes that the Secretary would have unbridled discretion and limitless factors to assess “the totality of the circumstances” in reaching a determination that has potentially significant financial consequences. The proposed definition provides no parameters as to the number of factors or what combinations thereof should be met by non-state government providers. There would be no way for a public provider to know with any certainty whether or not it is at risk of being stripped of its long-standing payment status if the Secretary is making individualized determinations across the country, with no process for public review or scrutiny of the decisions or standards by which they are made. And, if the Secretary makes a provider-specific determination that would impact a provider’s Medicaid reimbursement, the provider should have a direct legal right to appeal the adverse determination before it takes effect.

Particularly confusing are the two inquiries CMS proposed to determine if a provider qualifies as a non-state government provider. These inquiries, described in more detail below, at best set forth examples of potential ways that CMS could examine the “totality of the circumstances,” to make its determination. Indeed, in saying the questions CMS would try to answer are “not limited to” the list in the proposed rule, CMS could, at its discretion, identify a much larger or very different list, presumably not subject to a new public comment period, to use in these determinations.

- The first inquiry into the “identity and character” of other entities that share responsibilities of ownership and operation of the provider assumes there is one or more entities different from the “provider.” The term “provider” itself is confusingly defined by reference to two other pre-existing definitions that, when cobbled together, include an “individual,” “entity,” or “institution” that receives payment for services or furnishes services. The lack of specifics as to how such “other” entities are identified and drawn into this analysis is disconcerting and potentially disruptive, as it would give the Secretary overarching latitude, for example, to separate a licensee from the provider, a hospital-based component from the main hospital, freestanding clinics and hospitals within an integrated public health care system, or employed physicians from the public entity employer. Local governments that operate struggling hospitals may also be delayed in making critical investment decisions about expanding services, if they must first consult with a federal agency that is under no time obligation on whether and how the standards would apply and financially affect them.

- The second inquiry in the definition is about the character of a “relevant” entity, yet this term is not defined or referenced in any other section of the proposed regulation, so it is unclear which entity is subject to this inquiry in the first place.

For all of the above reasons, the proposed definition of a Non-State Government Provider falls far short in providing sufficient and fair notice to public providers of the requirements necessary to retain their government provider payment status.

### **C. CPEs (42 C.F.R. § 447.206)**

The MFAR proposes a new regulatory section that, for the first time, would specifically address required processes for states utilizing certified public expenditure (“CPE”) methodologies. The language tracks certain requirements currently in place, and is not strictly necessary as a regulatory matter. In addition, the language holds the potential to introduce new ambiguities or impracticalities, which should be avoided.

For example, the regulatory text toggles between two different phrases, the “provider” and “the certifying entity.” We are unclear as to the intended distinction, but it is important to consider cases where CPEs are used to draw down federal financial participation based on services that may be provided through contracts with other entities. In these cases, it should be clarified that payments are based on the allowable costs of the certifying public entity that expended the funds, not the costs of the provider that renders services.

In addition, 42 C.F.R. § 447.206(c)(3) would require “final settlement” to be made no more than 24 months from the cost report year end, except in certain circumstances. This would be extremely challenging to achieve in the short-term. Our reading of the proposed changes is also that new requirements would not and should not modify the application of the two year claiming limit and exceptions thereunder for provider appeal rights.

While we do not feel this section is strictly necessary, we do appreciate CMS’ affirmation that CPEs may be reported and certified using state-developed Medicaid cost reports, rather than the Medicare cost report.

### **D. Physician and Non-Physician Practitioner Supplemental Payments (42 C.F.R. § 447.406)**

The MFAR seeks to create a new payment limitation for Medicaid physician and non-physician practitioners. This limit is not based on the aggregate payments the state makes to such practitioners, but instead is based on the ratio of payments classified as “supplemental” to the ratio of payments that are classified as “base” payments. As described in Section III.E., the murky distinction between base and supplemental payments, and the lack of predictability that CMS’ proposed approval process creates for state and provider planning, reveals that this proposal lacks any basis in policy, statute, or practicality. As such, CAPH opposes the new payment limitations and urges CMS to maintain existing policy.

While CAPH understands the Secretary’s concerns about the calculation of rates based on proprietary commercial rates, we encourage the Secretary to allow states to develop methodologies to approximate such rates or to reference commercial benchmarks as a tool for

evaluating payment levels. Commercial rates represent the best available estimates of the fair market value of furnished services and are sometimes necessary to ensure appropriate access, especially in cases of provider shortages. Commercial rates are also closely connected with the requirement in the Medicaid statute that rates be sufficient to enlist enough providers to ensure that care and services are available “at least to the extent that such care and services are available to the general population in the geographic area.” (Social Security Act § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A).) Payment of average commercial rates in a geographic area, or a reasonable approximation thereof, straightforwardly meets this standard. The Secretary should affirm the essential role practitioners and non-physician practitioners have in the effective management and delivery of services to Medicaid beneficiaries and develop more comprehensive methodologies for evaluating whether payments to such practitioners meet Medicaid requirements.

**E. Health Care Related Taxes, Provider Related Donations, and Retention (433.52, 433.54, 433.55, 447.207, 447.206(b)(4))**

CAPH’s members are also members of the California Hospital Association (CHA), and CAPH wishes to express its support for the thoughtful comments submitted by CHA.

In addition to those comments, CAPH wishes to emphasize our opposition to the multiple provisions of the MFAR that would significantly expand CMS’ authority to review and evaluate the arrangements of health care providers. The MFAR proposes allowing CMS to review “arrangements” to determine if they have an impact on health care-related taxes, provider-related donations, or to determine a violation of a proposed new requirement for providers to “retain” revenue. In each instance, the scope of CMS’ inquiry is vague and unbounded, and the rule provides no clarity to allow states and providers to determine what arrangements would be permitted, or even what aspects of the inquiry would be relevant. CAPH opposes these proposed changes, which exceed the Secretary’s authority and would vest CMS with impermissibly broad discretion. (See, e.g., *Oglala Sioux Tribe of Indians v. Andrus*, 603 F.2d 707, 718 (8th Cir. 1979); *Phelps Dodge Corp. v. Federal Mine Safety & Health Review Commission*, 681 F.2d 1189, 1192 (9th Cir. 1982)).

If finalized, the kinds of reviews contemplated by these sections, including evaluations of the “net effect” of an arrangement, the “totality of the circumstances,” and all “associated arrangements” would thrust CMS into the role of policing the full array of ordinary business interactions and relationships among health care providers, potentially and inexplicably far beyond any clear connection to the Medicaid program. The Medicaid statute does not contemplate these kinds of expansive and unconstrained reviews; Congress never intended CMS to insert itself into everyday aspects of the health care industry. *See Merck & Co. v. United States HHS*, 385 F. Supp. 3d 81, 92 (July 8, 2019) (which ruled that the Secretary’s delegated authority to administer Medicare and Medicaid does not authorize HHS “to regulate the health care market itself or market actors that are not direct participants in the insurance programs”).

CAPH is particularly concerned because the scope of the reviews are not tethered to any clear standards. In each case, new phrases are introduced that are not connected to the Medicaid Act or defined with clarity. The result would be sweeping new authority to evaluate arrangements, some of which have existed since the inception of the Medicaid program and have

longstanding CMS approval, under ad hoc and inconsistent interpretations that would have enormous financial consequences for states and providers. This boundless federal discretion undermines the vision of state-federal partnership inherent in the Medicaid statute—a partnership in which states are entrusted to design their programs within concrete federal parameters, and the federal government guarantees matching funds when the rules are followed.

**F. State plan requirements for supplemental payments (42 C.F.R. §§ 447.252(d), 447.286, 447.302)**

As discussed above in section I.B above, CAPH is deeply concerned about the MFAR’s attempt to draw sharp distinctions between supplemental payments and base payments and to subject payments classified as supplemental to a re-approval requirement every three years, without a broader assessment of overall rate adequacy or administrative feasibility, and the serious risks that poses to access for Medicaid enrollees.

- i. The proposed definitions of base and supplemental payments are unclear and unhelpful.*

The proposed rule offers new definitions for base and supplemental payments (42 C.F.R. §447.286):

- *Base payment means a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the State plan or that is paid to the provider through its participation with a Medicaid managed care organization. Base payments are documented at the beneficiary level in MSIS or T-MSIS and include all payment made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries, including any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to a particular service provided to the beneficiary, such as payment adjustments made to account for a higher level of care or complexity of services provided to the beneficiary.*
- *Supplemental payment means a Medicaid payment to a provider that is in addition to the base payments to the provider, other than disproportionate share hospital (DSH) payments under subpart E of this part, made under State plan authority or demonstration authority. Supplemental payments cannot be attributed to a particular provider claim for specific services provided to an individual beneficiary and are often made to the provider in a lump sum.*

These proposed definitions of base payments and supplemental payments are overly simplistic, and create more confusion than clarity. The proposed standard for distinguishing base from supplemental payments—whether the payment can be attributed to a Medicaid beneficiary and service—lacks any clear boundaries, as all payments can be attributed to an individual and service if they are to qualify as medical assistance. Further, the claims that are most difficult to attribute to individual services do not appear to have been considered by CMS in developing these definitions. The clearest example of what could be incorrectly classified as supplemental payments under the proposed definition are value-based payments. These payments, such as a

case rate or bundled rate to treat a specific health care condition, do not vary with the amount of services provided. This conclusion appears unintended, as it would be illogical to define these value-based payments, some the most prevalent type of Medicaid payment, as “supplemental.”

More generally, the focus on this arbitrary distinction ignores the important question of patient access. There is no legal or policy significance for whether a payment is explicitly linked to a particular service or bundled together in a compensation package to a provider for aggregated services. What matters is whether the payment is consistent with the approved Medicaid methodology for reimbursing the service, and otherwise meets the statutory requirements of section 1902(a)(30)(A)—that the payment be “consistent with efficiency, economy, and quality of care” and “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Creating artificial distinctions between per-service payments and lump-sum payments distracts from whether compensation as a whole is appropriate and adequate to meet the needs of the Medicaid program. Additionally, it could have the unintended consequence of moving providers away from value-based payments, which goes against the value trend CMS has been supporting for years.

The artificial nature of this distinction is particularly evident in the new proposed limitations for practitioner supplemental payments, which measure only the relative ratio of payments classified as supplemental against those classified as base. This ratio, by itself, is not tied in any way to the standards in section 1902(a)(30)(A).

- ii. *It would take significant expansion of administrative capacity to implement the proposed requirements for review of supplemental payments, and the required renewals will hamper long-term planning.*

CAPH supports transparency and accountability in the Medicaid program; however, the proposed rule to dramatically increase the frequency of CMS’ review and oversight of supplemental payments is impractical and will harm the Medicaid program. The MFAR requires states to seek renewal of supplemental payments at least every three years by submitting an application to CMS that includes qualitative and quantitative information about the payment. While it is not entirely clear what standards CMS will apply to evaluate whether supplemental payments may be approved, any substantive review would require significant time and attention from an experienced reviewer with Medicaid payment expertise. Current experiences, reflected in CMS’ own Medicaid Scorecard data, suggest that CMS lacks the administrative capacity to complete these kinds of detailed reviews in a timely manner. (See, for instance, Managed Care Capitation Rate Review: Total Days to Approve Rates at <https://www.medicaid.gov/state-overviews/scorecard/index.html>). Even without these new reporting and approval requirements, states and CMS each suffer under approval backlogs. CMS improbably estimates that “per state, the average annual burden of these new requirements to be 1 hours [sic]...at a cost of \$50” to comply with SPA requirements, to say nothing of additional work on CMS’ part to review and approve requests. We are deeply concerned about CMS’ failure to anticipate the true amount of work these new requirements would entail, and believe it is unwise to introduce a new approval requirement that the government does not have the ability to implement effectively.

Moreover, because the supplemental payments would be limited to three years, states would need to request renewals on a regular basis with no guarantee that a payment approved in the past would be approved again in the future. The result of these re-approvals would be an entirely avoidable disruption of payments while review and approval is pending, imposing unnecessary cash flow limitations and burdens on Medicaid providers. The risks posed by the re-approvals is exacerbated by the possibility that federal administrations may change from one renewal period to the next. States would be forced to justify the same payment to multiple versions of CMS, which are likely to have different perspectives, priorities, and agendas. The combination of expansive agency discretion, frequent renewals, and lack of standards would make it all but impossible for states and providers to plan effectively. A lack of assurances that payment methodologies would be allowed to run their natural course would hamper long-term planning and undercut efforts to leverage payment policy to incentivize delivery system reform and innovation.

### **G. Reporting Requirements for Upper Payment Limitations and Supplemental Payments (42 C.F.R. § 447.288)**

#### *i. Upper Payment Limit Demonstrations*

CAPH is concerned about a disconnect between the proposed UPL demonstration requirements at 42 C.F.R. § 447.288, identifying data elements, methodology parameters, acceptable UPL demonstration methodologies, and the long-standing regulations requiring compliance with UPLs (42 C.F.R. §§ 447.272, 447.321).

The proposed UPL demonstration requirements specify that calculations must be done for the following *provider categories*:

- (1) Inpatient hospital
- (2) Outpatient hospital
- (3) Nursing facility
- (4) Intermediate care facility for individuals with intellectual disabilities, and
- (5) Institution for mental diseases.

However, the proposed language does not clarify whether the demonstrations for each of the categories (1)-(5) above are to be applied separately to each *type of operating provider* identified in the existing regulations—private facilities, state facilities, and non-state governmental facilities—or in the aggregate across all operating provider groups. The Secretary should clarify, in accordance with current policy that a separate demonstration is provided for each operating provider group (e.g. three UPL demonstrations for each of the five provider categories listed above), and that a state may elect to use different methodologies for different types of operating providers (e.g. private facilities versus state facilities).

## *ii. Supplemental Payment Reporting*

As discussed previously in our comments with regard to the three-year reapproval requirement for supplemental payments, CAPH has significant concerns that new limitations and restrictions on supplemental payments would weaken the Medicaid program. These same concerns also apply to the annual and quarterly reporting requirements for payments classified as “supplemental.”

CMS justifies the detailed, provider-specific nature of the reporting by referencing the lack of adequate Medicaid provider payment data currently available, but nonetheless presumes that the information could be obtained with minimal additional burden. This confidence is unsupported and overlooks the significant new administrative costs likely to result. Currently, many states do not collect data in the form that would be necessary to complete the reports, which would require extensive review, oversight, and preparation to ensure they provide an accurate picture of provider payments and units of service. In addition, for quarterly and annual payments, the data proposed to be collected and reported to providers would need to include both interim and final payments, many of which are subject to additional reconciliation, adjustment, or finalization over longer time periods. As a result, significant investments of time and effort by states would be needed to evaluate and prepare the data for submission, and by CMS once they receive the data to ensure it can be meaningfully interpreted.

The MFAR glosses over these difficulties. In fact, CMS’ estimates of the regulatory burden consists of little more than repeating a simple data query, which CMS estimates would take “20 seconds at \$32.44/hr for a data entry keyer to query state MMIS system and/or copy and paste each data element into the required format for reporting.” Altogether, CMS estimates each state would expend an average of \$922 for all quarterly reporting. This estimate dramatically understates the time, cost, and difficulty of implementing new data reporting requirements for programs as complicated as Medicaid. The MFAR should not be finalized without a serious and good faith effort to estimate this burden.

### **H. DSH (42 C.F.R. §§ 447.297, 447.299, 455.301)**

The proposed rule would amend 42 C.F.R. § 447.299 to provide that DSH payments found in the independent certified audit process to exceed hospital-specific cost limits “are provider overpayments which must be returned to the Federal Government.” CMS acknowledges, however, that calculating a financial impact may be complex, and in some circumstances, even impossible. Given these inherent complexities, providers need the opportunity to challenge an auditor’s methodology or calculations in circumstances when the auditor’s approach may not be valid. CAPH requests clarification that the requirement imposed on states to return identified DSH payments that exceed hospital-specific cost limits would not foreclose any applicable appeal rights that would otherwise allow providers to challenge and reverse the financial impact determination made by an independent certified auditor.

### **I. State Plan Requirements - FMAP variation (42 C.F.R. § 447.201(c))**

Proposed new language in 42 C.F.R. § 447.201(c) would require states to ensure that there is no variation in fee-for-service payment based on a beneficiary’s Medicaid enrollment

category, Federal Medical Assistance Percentage (FMAP), or enrollment in a waiver or demonstration. CAPH believes this language as drafted may be overly broad to achieve its goals, as there may be circumstances in which payments can be expected to vary with the aforementioned categories for legitimate reasons. For example, a state may have a waiver or demonstration that specifically provides enhanced case management services to certain populations, and provides enhanced payments for those services. Alternately, a state may offer risk-adjusted rates for bundled services based on eligibility group. To accommodate these potential legitimate variations, it would be clearer to specify that a state plan may not vary fee-for-service payment for a Medicaid service *solely* on the basis of eligibility category, waiver or demonstration enrollment, or FMAP. This would allow CMS to consider reasonable circumstances that account for variations in rates that are correlated with the categories of concern.

#### IV. Conclusion

We appreciate the opportunity to submit comments and for your consideration of our detailed and significant concerns with the Medicaid Fiscal Accountability Regulation. As critical safety-net and governmental providers, **we urge CMS to rescind this harmful proposal so that we can continue to effectively operate, provide care to our patients, and maintain our mission to serve our community.** If you have questions, please contact Jackie Bender, Vice President of Policy, at [jbender@caph.org](mailto:jbender@caph.org) or 510-874-3408.

Sincerely,



Erica B. Murray  
President and CEO  
California Association of Public Hospitals and Health Systems