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Via Electronic Filing on Regulations.gov

January 31, 2020

The Honorable Seema Verma, 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: Comments to Proposed Rule, Medicaid Fiscal Accountability Regulation, CMS–2393–P, Joined by Twelve (12) State Agencies

Dear Administrator Verma:

The following comments are joined by twelve (12) state agencies (the "Commenting States"), to express serious concerns about the Centers for Medicare & Medicaid Services' ("CMS") proposed Medicaid Fiscal Accountability Regulation ("MFAR"), 84 Fed. Reg. 63722 (Nov. 18, 2019).[1]

The Commenting States have numerous concerns about many aspects of the proposed changes set forth in the MFAR, many of which are being addressed in individual comments by States or in the comments submitted by the National Association of Medicaid Directors. Of most concern, the proposed rule eliminates or substantially limits the sources of non-federal funding that have long been available to state Medicaid programs. Given tight state budgets, and a lack of alternative funding available to support Medicaid, the MFAR (if finalized as proposed) would likely force states to cut Medicaid eligibility, benefits, and/or provider payments, which would have the effect of decreasing low-income individuals' access to

[1] The Commenting state agencies are: the Colorado Department of Health Care Policy & Financing; the Illinois Department of Healthcare and Family Services; the Louisiana Department of Health; the Michigan Department of Health & Human Services; the Missouri Department of Social Services; the Missouri Department of Mental Health; the Oregon Health Authority; the New York State Department of Health; the Pennsylvania Department of Human Services; the South Carolina Department of Health and Human Services; the Tennessee Division of TennCare; and the Washington State Health Care Authority.

important health care services. Accordingly, the Commenting States urge CMS not to finalize the MFAR in its current form.

The comments below are focused on those aspects of the rule that the Commenting States believe to be inconsistent with the governing provisions of the Social Security Act ("the SSA" or "the Act") and CMS's own longstanding interpretations of the Act.

1. **Proposed 42 C.F.R. § 433.68(f): CMS's "Net Effect" Test for Health Care-Related Taxes Is Not Consistent with the Statutory Definition of "Hold Harmless."**

SSA Section 1903(w)(4) lays out three definitions of a "hold harmless" provision with respect to health care-related taxes.

> (A) The State or other unit of government imposing the tax provides (directly or indirectly) for a [non-Medicaid] payment . . . to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.
>
> (B) All or any portion of the [Medicaid] payment made . . . to the taxpayer varies based only upon the amount of the total tax paid.
>
> (C) The State or other unit of government imposing the tax provides (directedly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the tax.

CMS's current regulations at 42 C.F.R. § 433.68(f) are consistent with these statutory definitions.

CMS now proposes to revise Section 433.68(f)(3) to include a new definition of a "direct guarantee" for purposes of the third "hold harmless" test set forth in the statute. Under the proposed rule, CMS would define a "direct guarantee" to exist where the "net effect" of an arrangement "between the State (or other unit of government) and the taxpayer" results in "a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party of the arrangement."

The Commenting States respectfully submit that the new "net effect" test is not a reasonable interpretation of a "direct guarantee," as it is neither "direct" nor a "guarantee."

First, an oral, legally unenforceable "expectation" that certain events will occur is hardly a guarantee. *See* Oxford Learners Dictionary (defining guarantee as "[a] formal assurance (typically in writing) that certain conditions will be fulfilled"); Black's Law Dictionary (defining guarantee as "an assurance that a contract or legal act will be duly carried out"). There is no

indication that Congress intended the statutory language that a hold harmless provision must involve a "guarantee" to have any definition other than its plain meaning.

In the MFAR's preamble, CMS relies on a Departmental Appeals Board decision applying the "reasonable expectation" test in interpreting the hold harmless rules related to provider-related donations, *Texas Health and Human Servs. Comm'n,* DAB No. 2886 (2018) (interpreting 42 C.F.R. § 433.54). 84 Fed. Reg. at 63736. Even assuming that the *Texas* case was correctly decided by the Board, that case does not provide authority for a similarly expansive interpretation of a hold harmless provision with respect to health care-related taxes. Section 1903(w)(4) specifically defines the criteria for a hold harmless with respect to taxes, as described above, whereas it gives the Secretary broad authority to define the circumstances in which a donation is determined to have a "direct or indirect relationship" with a provider payment. *Compare* § 1903(w)(4) (defining hold harmless for health care taxes), *with id.* § 1903(w)(2)(B) (providing that "the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) . . . as established by the State to the satisfaction of the Secretary," and "[t]he Secretary may by regulation specify types of provider-related donations . . . that will be considered to be bona fide provider-related donations"). Thus, even assuming the Secretary can define a "hold harmless" for purposes of determining whether a donation is bona fide, he does not have the same latitude with respect to defining a "hold harmless" for purposes of health care-related taxes.

Second, even if CMS did have some latitude to interpret what constitutes a tax-related "guarantee," defining it to include a "reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount" is so broad as to be contrary to clearly-expressed congressional intent. The broad language of the proposed definition could be read as prohibiting States from using money from a provider tax to fund Medicaid rate increases to the provider being taxed, because the provider being taxed ("the taxpayer") arguably has "a reasonable expectation that" it "will receive a return of . . . [a] portion of the tax amount" through an increased Medicaid payment funded by the tax. But Congress has expressly authorized States to use funds from health care-related taxes to fund Medicaid provider rate increases: Section 1903(w)(4) provides that the definition of a hold harmless provision "shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process." CMS cannot adopt an interpretation that would prohibit situations that Congress has expressly permitted.

Third, while the proposed definition of "net effect" refers to "an arrangement between the State (or other unit of government) and the taxpayer," the preamble suggests that CMS intends to apply the new proposed language defining "net effect" to include "any redistribution payment from another taxpayer or taxpayers . . . [r]egardless of whether the taxpayers participate voluntarily, whether the taxpayers receive the Medicaid payments from a MCO, or whether taxpayers themselves make redistribution payments from funds other than Medicaid to other taxpayers." 84 Fed. Reg. at 63734.

The Commenting States do not believe that the interpretation set forth in the preamble is consistent with the terms of the regulation, much less the terms of the statute. The statutory provision that CMS purports to be interpreting refers to arrangements in which "the State or other unit of government imposing the tax provides for any payment . . . that guarantees to hold taxpayers harmless." § 1903(w)(4) (emphasis added). There is no reasonable interpretation of

the statute under which a private arrangement between private parties, without state involvement, can be interpreted to be "the State" "provid[ing]" for a payment that "guarantees" to hold the taxpayer harmless.

Section 1903(w)(4) does not give CMS the authority to regulate (or to require States to regulate) transactions between private providers in which the State is not involved. If a State is not involved in pooling or redistribution arrangements, the statute – which addresses only the conduct of the state or local government imposing the tax – provides no basis for CMS to assert that it has the authority to find a hold harmless, and it creates potentially enormous state liability for private conduct.

Finally, the Commenting States disagree with CMS's statement that the proposal "does not reflect any change in policy or approach, but merely codifie[s] currently prohibited practices." 84 Fed. Reg. at 63735. The Commenting States are aware of numerous situations in which CMS has known about, and not moved to prevent, hospitals redistributing Medicaid payments among themselves (without involvement from the State) in the manner CMS now seeks to prohibit. In one State, CMS has for years annually reviewed the redistributed amounts pursuant to a written agreement acknowledging that the arrangement exists.

2. Proposed 42 C.F.R. § 433.51(b): Limiting the Source of Intergovernmental Transfers is Contrary to Longstanding CMS Policy and Not Required by Statute.

Current CMS rules provide that "public funds" may be used as the non-federal share of Medicaid expenditures if they are "appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing pubic agency as representing expenditures eligible for FFP." 42 C.F.R. § 433.51(b).

CMS proposes to amend this regulation to limit the use of intergovernmental transfers ("IGTs") to funds that come "from units of government within a State (including Indian tribes), derived from State or local taxes (or funds appropriated to State university teaching hospitals)." Proposed § 433.51(b) (emphasis added). CMS states that it is revising the regulatory language to limit the source of IGTs to state or local taxes or funds appropriated to state university teaching hospitals because other sources are "not permitted under the statute in section 1903(w)(6)(A) of the Act." 84 Fed. Reg. at 63737.

This is a clear misreading of Section 1903(w)(6)(A). Section 1903(w)(6)(A) defines the sources of funds that CMS cannot limit; it does not provide any limit on the sources of funds that a State may use (other than impermissible donations or taxes). Specifically, Section 1903(w)(6)(A) provides:

> [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 . . . 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.

This language does not restrict sources of funding that may be used for the non-federal share (beyond impermissible taxes or donations). It prohibits CMS from "restrict[ing] States use of funds . . . derived from State or local taxes (or funds appropriated to State university teaching hospitals)," but that does not mean that CMS must prohibit other sources of funds from being used as IGTs.

This straightforward reading of Section 1903(w)(6)(A) is apparent in the legislative history. In describing the legislation, Congressman Norman Lent, one of its two sponsors, stated that:

> Several States have raised concerns about the impact of the . . . regulation on intergovernmental transfers. This bill provides that States may continue to use funds transferred to the State from counties, cities, or other governmental entities as the State share of Medicaid expenditures. The use of such transfers would, however, be disallowed if the source of the funds was donations or taxes that would not otherwise be recognized as the non-Federal share under this legislation.

Debate Regarding Conference Report on H.R. 3595, Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, 137 Cong. Rec. H11865, H11871 (Nov. 26, 1991); *see also* Statement of Congressman Henry Waxman in Support of H.R. 3595, 137 Cong. Rec. E3463, E3463 (Oct. 21, 1991) (proposed legislation "would also protect the current policy regarding intergovernmental transfers").

In fact, the public law adopting Section 1903(w)(6), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. 102-234, expressly states that one of its purposes is to "maintain the treatment of intergovernmental transfers" as a source of state funding.

CMS itself has repeatedly confirmed that Section 1903(w) permits IGTs of funds that are not derived from taxes or appropriated to State university teaching hospitals, as long as they do not come from impermissible donations or taxes. In 1992, in implementing regulations after Section 1903(w) was enacted, CMS told States that they "may continue to use . . . transferred or certified funds derived from any governmental source" as long as they were not "impermissible taxes or donations." 57 Fed. Reg. 55118, 55119 (Nov. 24, 1992). Similarly, in 2007, CMS confirmed that IGTs can be funded "from a variety of services," including "fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds" and, in the case of governmentally-operated health care providers, "patient care revenues from other third party payers." *See* 72 Fed. Reg. 29748, 29766 (May 29, 2007).

CMS's conclusion that Section 1903(w)(6) limits sources of IGT funding to taxes and appropriations is also contradicted by Section 5 of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. That section specifies that "[t]he Secretary may not issue any interim final regulation that changes the treatment . . . of public funds" for use as the non-federal share except with respect to funds derived from provider-related donations or health care-related taxes. Pub. L. No. 102-234, § 5(b)-(c). That provision would be irrelevant if, as CMS contends, Congress intended Section 1903(w)(6) to limit IGTs to state taxes and appropriations.

Not only is CMS's proposal inconsistent with the statute and its own longstanding interpretation, it also is bad policy to narrowly limit IGTs to funds derived from taxes or appropriations to state university teaching hospitals. What is the policy value in prohibiting a state or county from using revenue from fees or settlement proceeds from opioid litigation, for example, to support health care services for low-income people?

In particular, the Commenting States believe that government providers should be able to use patient revenue for intergovernmental transfers. Doing so encourages providers to deliver cost effective services so as to have revenue to transfer for use as the non-federal share for Medicaid services.

Limiting IGTs in the manner proposed by CMS would substantially limit an important and longstanding funding source for state Medicaid programs. Without use of these governmental funds, many States would not have the non-federal funding sufficient to operate their Medicaid programs in their current form and would likely be forced to cut back on eligibility, benefits and/or provider payments.

3. Proposed 42 C.F.R. § 447.286: CMS's Definition of a "State Government Provider" and a "Non-State Government Provider" As Requiring Access to Tax Revenue Is Contrary to the Sense of Congress Expressed in 2008.

CMS proposes to adopt definitions of "state government provider" and "non-state government provider," both of which adopt a "totality of the circumstances" test to determine whether a provider is a "unit of State government" or "unit of non-State government." The question of what constitutes a state or local unit of government is uniquely a question of state law. For that reason, the Commenting States do not object to a "totality of the circumstances" test, as long as the list included in the regulations is not exhaustive and State Medicaid Agency or other appropriate state entity is responsible for making a reasonable decision as to whether the totality of circumstances test has been met in a particular case. It would not be appropriate for a federal agency to be making a determination as to what constitutes a unit of state or local government under state law.

In addition, there is one part of the proposed definitions that the Commenting States believe to be unduly narrow and contrary to congressional understanding. Both the definition of "state government provider" and "non-state government provider" state that the provider must have "access to and exercises administrative control of State-appropriated funds from the legislature or State tax revenue, including the ability to dispense such funds." Proposed 42 C.F.R. § 447.286.

This is an excessively narrow view of governmental entities. For example, many long-existing public hospitals do not have access to state appropriations or local tax revenue, even though they are controlled and operated by a public entity.

Further, this narrow definition of "unit of government" is inconsistent with the "sense of the Congress" expressed through the American Recovery and Reinvestment Act ("ARRA") of 2009, Pub. L. No. 111-5, § 5003. In 2007, CMS proposed defining a unit of government as one with access to tax revenue, 72 Fed. Reg. 2236 (January 18, 2007), as it is trying to do again in the MFAR. Although CMS finalized that rule, *see* 72 Fed. Reg. 29748, it was later struck down as having been promulgated in violation of a congressional moratorium, and remanded to the agency, *see Alameda Cnty. Med. Ctr. v. Leavitt*, 559 F. Supp. 2d 1 (D.D.C. 2008). In February

2009, as part of ARRA, Congress expressed the "sense of the Congress" that CMS "should not promulgate [that rule] as final." Pub. L. No. 111-5, § 5003. This "sense of the Congress" remains in effect, and it applies to the "unit of government" provisions in this rule, just as it did to the 2007 rule.

4. Proposed 42 C.F.R. § 447.206: Certain Limits on Certified Public Expenditures Are Unworkable and Contrary to Longstanding CMS Policy.

The Commenting States have several concerns about the proposed new requirements governing certified public expenditures ("CPEs").

First, the proposed changes could be read as providing that CPEs may only be made by public entities that are providers. While the new proposed Section 433.51(b)(3) recognizes that CPEs can be made by a "unit of government within a State," it then requires that such certifications "meet the requirements of § 447.206." Proposed Section 447.206 is limited to "providers that are units of government," and has provisions that would appear to apply only to providers, such as the requirement for an annual cost report establishing the cost of services. But, as CMS recognized in its 2007 rulemaking (later withdrawn), many CPEs are made by units of government that are not providers, such as school districts, county governments, state mental health agencies, and developmental services agencies. *See, e.g.*, 72 Fed. Reg. at 29756, 29761. In the 2007 rule, CMS explained that:

> The options available to a unit of government for purposes of compliance with the CPE provisions of the regulation depend on whether or not the unit of government is the provider of the service. A governmental entity that is not a health care provider and that pays for a covered Medicaid service furnished by a health care provider (whether governmentally-operated or not) can certify its actual expenditure in an amount equal to the Medicaid State plan rate (or the approved provisions of a waiver or demonstration, if applicable) for the service. In this case, the CPE would represent the expenditure by the governmental unit to the service provider on behalf of the State Medicaid agency (and would not necessarily be related to the actual cost to the health care provider for providing the service).
>
> If the unit of government is the health care provider, then it may generate a CPE from its own costs if the Medicaid State plan (or the approved provisions of a waiver or demonstration, if applicable) contains cost reimbursement methodology. If this is the case, the governmentally-operated health care provider may certify the costs that it actually incurred that would be reimbursed under the Medicaid State plan.

Id. at 29768. The current proposal, however, appears to have eliminated the first scenario described above, when the CPE is made by a non-provider unit of government.

The proposed changes to Section 433.51(b)(3) are particularly problematic when combined with proposed Section 433.51(b)(1), which would allow "State General Fund dollars"

to be used as the non-federal share only if they are "appropriated . . . directly to the State or local Medicaid agency." By prohibiting non-provider state agencies from certifying expenditures, and also prohibiting those agencies from spending state general fund dollars appropriated to them, CMS would be effectively cutting off financial support for the Medicaid program from state sister agencies, such as state mental health agencies and state agencies that serve individuals with intellectual disabilities. These sister state agencies help administer and fund critical parts of the Medicaid program in many States, including Section 1915(c) waiver programs.

There is no indication in the preamble that CMS meant to change the longstanding practice of allowing non-provider public entities to certify expenditures or state sister agencies from spending money to support the Medicaid program, although it appears to have done so unintentionally in the regulatory language.

Second, proposed Section 447.206 would require that the "[t]he certifying entity . . . must receive and retain the full amount of Federal financial participation associated with the payment . . . ." Proposed § 447.206(b)(4). While federal financial participation ("FFP") associated with a certified expenditure is often passed through to the certifying entity, CMS has never required the State to do so, and imposing such a requirement is inconsistent with the concept of a certified expenditure. As CMS explains in the preamble to the proposed rules, CPEs are "transactions which take the place of a regular FFS payment." 84 Fed. Reg. at 63744, That is, the CPE is not just certification of the state share, but rather it is a certification of actual total computable incurred costs. Accordingly, the federal share of the payment has already been expended by the certifying entity; the claimed FFP is a reimbursement for funds that have already been expended. As CMS explained in its 2007 rulemaking:

> Under the CPE process, a unit of government (including a governmentally-operated health care provider) has expended funds to provide services to Medicaid individuals, which means that the unit of government has satisfied both the Federal and State share of these Medicaid costs. Therefore, Federal matching funds are effectively repayment of the Federal share of the total computable expenditure initially satisfied at a State or local government level.

72 Fed Reg. at 29799.

In this 2007 rulemaking, and in subsequent guidance, CMS repeatedly recognized that the funds claimed through a CPE need not be passed through to the certifying entity. *See id.* ("To the extent a State agency chooses to distribute those Federal funds in a manner that is not proportional to the costs incurred by other governmental units within the State, CMS does not plan to interfere with such decisions between States, local governments and/or governmentally-operated health care providers."). In 2009, CMS issued guidance explaining that "[u]nder a CPE financing mechanism the applicable percentage of the non-Federal share for claiming purposes is no less than 100 percent (but could be more if the State does not share with the subdivision the Federal payment)." *See* American Recovery and Reinvestment Act of 2009 Frequently Asked Questions from States (July 7, 2009), Q34 (emphasis added). This echoed similar guidance issued in 2006. *See* State Medicaid Director Letter #06-014 (June 9, 2006) (addressing the situation where a State "assigns . . . the full right to the federal matching share" to a tribal organization that has certified an expenditure).

The reason given in the preamble for the new provision requiring the State to pass the federal share to the certifying entity is "to prevent inappropriate recycling of federal funds and any other potential redirection of federal funds that would be prohibited under the statute." 84 Fed. Reg. at 63745. CMS intends to stop the practice of States "drawing down FFP to match CPEs, retaining the federal share and using these federal funds as the non-federal share for other Medicaid payments." *Id.* This is a mischaracterization of what occurs when a State claims FFP in a CPE. When a State claims FFP in a CPE, the public entity has already incurred the total computable amount, and the State is receiving reimbursement for the public entity having fronted the federal share of the certified expenditure. Thus, the FFP the State receives for that CPE is a reimbursement, and the State has discretion to spend it as it wishes. As the Departmental Appeals Board has explained, "funds paid to states for allowable costs incurred or services rendered lose their character as federal funds once they are deposited in a state's treasury." *North Carolina Dep't of Human Res.*, DAB No. 1133 (1990) (quoting 43 Comp. Gen. 697, 699 (1964)). It is perfectly appropriate for a State to use those funds earned, which are now in the state treasury, as the non-federal share of future Medicaid funds. Prohibiting States from doing so places an unnecessary and unreasonable limit on their ability to use their own money to support the Medicaid program.

Third, proposed Section 447.206(c)(1) requires that "all claims for medical assistance [must be] processed through Medicaid management information systems" to "identif[y] the specific Medicaid services provided to specific enrollees." This new requirement is inconsistent with many approved CPE protocols that CMS has accepted over the years, including for disproportionate share hospital ("DSH") payments, where a certification is of unreimbursed costs of providing services to Medicaid and the uninsured (which is not measured on a claim-by-claim basis); supplemental payments, where the amount of the payment is not based on "specific Medicaid services provided to specific enrollees" but aggregate differences between Medicaid payments and the upper payment limit; and graduate medical education ("GME") payments.

Fourth, proposed Section 447.206(c)(3) establishes a 24-month timeframe for "reconciling any interim payments to the finalized cost report for the State plan rate year in which any interim payments were made." CMS states in the preamble that it chose "[t]he 24-month period . . . to comply with the generally applicable 2-year limit for claiming payment for expenditures in 45 C.F.R. § 95.7."

This proposal is problematic for two reasons. First, audits of cost reports (which the rule would require) frequently are not complete for more than two years. Second, the 24-month proposal is inconsistent with the two-year claiming rule in Section 95.7. That regulation includes as an exception to the general rule that federal funds must be claimed within 2 years of an expenditure for "any claim for an adjustment to prior year costs." "An adjustment to prior year costs" is defined as "an adjustment in the amount of a particular cost item that was previously claimed under an interim rate concept and for which it is later determined that the cost is greater or less than that originally claimed." 45 C.F.R. § 95.4. Thus, the "reconciliation" of a CPE interim payment (based on projected costs) and a final payment (based on actual costs) falls squarely within the "adjustment to prior year costs" exception to the 2-year claiming rule.

5. Proposed 42 C.F.R. § 447.201(c): Prohibiting Variation in Provider Payments Based on Eligibility Group or Waiver Enrollment Is Not Consistent with Section 1902(a)(30)'s Access Requirements.

CMS proposes to prohibit States from varying fee-for-service ("FFS") payments "on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration project, or FMAP rate available for services provided to an individual in the beneficiary's eligibility category." Proposed 42 C.F.R. § 447.201(c).

This proposal would limit a State's ability to ensure access to Medicaid services for all populations, and thus is in tension with Section 1902(a)(30)(A), which requires a State to pay rates that are consistent with efficiency and economy and are sufficient to secure access to services. While the Commenting States would not oppose a proposal to limit States from varying payments solely on the basis of the available federal medical assistance percentage ("FMAP") rate, there are important policy reasons to allow States to vary payments on the basis of a Medicaid eligibility category or enrollment in a waiver or demonstration. For example, if there is insufficient access to psychiatric services for children, but not for adults, a State may want to increase its payments rates for psychiatrists for children only. In addition, a State may be reimbursing providers serving individuals through a Section 1915(c) waiver differently than providers delivering similar services through the state plan.

In CMS's view, "where payment rates under the state plan do result in insufficient access for Medicaid beneficiaries, the state must increase rates to rectify the access problem for all Medicaid beneficiaries, not only those for whom the statute provides for an increased FMAP." 84 Fed. Reg. at 63744. But Section 1902(a)(30)(A) does not require (and arguably prohibits) a State from increasing rates for populations for which it does not identify an access issue.

CMS states that it has already implemented a similar rule in managed care. Section 438.4(b)(1), adopted in 2016, provides that any differences among capitation rates according to covered populations must be based on valid rate development standards and not be based on the FFP associated with the covered populations. For the reasons stated above, the FFS proposal in the MFAR sweeps more broadly and would prohibit variation based on valid concerns such as access.

6. Proposed 42 C.F.R. § 447.406: Capping Supplemental Payments for Medicaid Practitioners at 50% of the Base Payments Is Arbitrary and Not Supported by the Statute.

CMS proposes to add a new 42 C.F.R. § 447.406, which would cap supplemental payments to Medicaid practitioners, including physicians, at:

(1) 50 percent of the total fee-for-service base payments authorized under the State plan paid to an eligible provider for the practitioner services during the relevant period; or

(2) For services provided within HRSA-designated geographic health professional shortage areas (HPSA) or Medicare-defined rural areas as specified in 42 C.F.R. 412.64(b), 75 percent of the total fee-for-service base payments authorized

> under the State plan paid to the eligible provider for the practitioner services during the relevant period.

Congress intended States to have considerable discretion in establishing their Medicaid payment rates, as long as they are consistent with efficiency, economy, and access to care. The Commenting States do not believe that Section 1902(a)(30) gives CMS the authority to prevent a State from paying providers with both base and supplemental payments, as long as the combined total meets the statutory standard of efficiency and economy. Permitting Medicaid agencies to make payment at the same level as commercial payors for certain services is fully consistent with Section 1902(a)(30), whether that payment is paid as a single payment (base payment) or as two payments (base payment and supplemental payment). The Commenting States do not see any basis in the statutory language that would authorize CMS to limit States to a lesser amount simply because the State, acting within its discretion under Medicaid, has chosen to pay providers with both base and supplemental payments, rather than relying exclusively on base payments.

In the preamble, CMS expressed concern that States have sought to make average commercial rate ("ACR")-based payments "reflecting amounts of approximately 300 percent to 400 percent of the Medicare rate." 84 Fed. Reg. at 63763. To the extent this is true, this may reflect the fact that Medicare rates for certain practitioner services are too low, not that Medicaid payments are too high.

CMS also alleges that the practice of calculating the ACRs "present a clear oversight risk because they are based on proprietary commercial payment data and thus not verifiable or auditable." *Id.* at 63762. If this oversight risk is driving CMS's proposal, it should amend the rules to require that ACRs used to set rates be based on commercial payment data that CMS can verify and audit, not scrap ACR-based rates altogether.

Finally, CMS's proposed definitions of "base payment" and "supplemental payment" are internally inconsistent. CMS proposes to define these terms as follows:

- Base payment: payment "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: payment "in addition to" the base payments that "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."

Proposed 42 C.F.R. § 447.286.

But most state payments to practitioners that are referred to as "supplemental payments" are also calculated based on the provider claims for "specific services rendered to individual Medicaid beneficiaries," and therefore would not appear to meet CMS's definition of a supplemental payment. For example, such lump sum payments may be calculated based on the difference between the FFS rate paid to the practitioner and the amount the provider would

have been paid for delivering the same, specific services if the practitioner was paid the ACR (or some percentage of the ACR).

7. Proposed 42 C.F.R. § 447.290: The Penalty for Failure to Report Required Information is Not Consistent with the Social Security Act.

CMS has proposed imposing substantial new reporting requirements on the States, *see* proposed 42 C.F.R. § 447.288, and has proposed giving itself the authority to "reduce future grant awards through deferral in accordance with § 430.40 of this chapter, by the amount of Federal financial participation (FFP) CMS estimates is attributable to payments made to the provider or providers as to which the State has not reported properly, until such time as the State complies with the reporting requirements," proposed 42 C.F.R. § 447.290.

The Social Security Act has a statutory remedy for noncompliance with CMS regulations: Section 1904 provides that CMS may only withhold funds "after reasonable notice and hearing to the state agency." The deferral regulations that CMS refers to in the proposed regulation apply only when CMS questions the allowability of a claimed expenditure, which is different than noncompliance with a CMS regulation. Further, those deferral regulations generally only allow CMS to defer funds for 90 days, at which point CMS must either release the funds or take a disallowance (and provide appeal rights to the State). *See* 42 C.F.R. § 430.40(c)(5)-(6). Neither CMS regulations nor the SSA permit CMS to withhold funds based on failure to comply with a regulation outside of the Section 1904 process, without reasonable notice and an opportunity for a hearing. The sole remedy for noncompliance is set forth in Section 1904.

8. If CMS Does Finalize the MFAR, It Should Provide for a Multi-Year Transition Period, as It Has in Other Major Rules That Threaten to Disrupt State Budgets.

For all of the reasons set forth above, CMS should not finalize the MFAR proposal. If it does, however, finalize those aspects that limit sources of non-federal share that have long been available to States, CMS should provide for a multi-year transition plan. Any other approach may well throw state programs into chaos.

CMS has historically provided multi-year transition plans when it has proposed significant changes affecting state funding practices. For example, when CMS changed the upper payment limit ("UPL") rules in 2000 to segregate "non-State government facilities" from "private facilities," it proposed a transition period of up to five years so as not to "disrupt State budget arrangements." 65 Fed. Reg. 60151, 60154 (Oct. 10, 2000). When it finalized the rule in 2001, it extended the transition period to up to eight years, noting that a transition was necessary so as not to adversely impact beneficiary access to care. 66 Fed. Reg. 3148, 3160 (Jan. 12, 2001). Likewise, when CMS finalized the DSH audit rules in 2008, it required audits beginning in state plan rate year 2005, but provided for a six-year "transition period" until state plan rate year 2011 during which time payments in excess of DSH limits were not considered overpayments that had to be recouped. *See* 73 Fed. Reg. 77907, 77908 (Dec. 19, 2008). Most recently, in 2016, when CMS finalized its rules governing pass-through payments in managed care, it provided a 10-year transition period for pass-through payments to hospitals, and a five-year transition period for payments to nursing facilities and physicians, "[u]nderstanding that it will take significant time to design and implement alternative approaches consistent with the final rule and the amount of funding involved," and to avoid "the disruptive nature to hospitals

and beneficiary access if such pass-through arrangements were abruptly eliminated." 81 Fed. Reg. 27498, 27590 (May 6, 2016).

The changes proposed in the MFAR surpass all of the above regulatory changes in terms of the anticipated impacts on longstanding funding practices of which CMS has long been aware. The current proposal provides for only limited three-year transitions and only for certain provisions of the proposed rule. This is insufficient to protect against widespread disruption to funding for state Medicaid programs across the country. Consistent with CMS's past practice, the implementation should provide for at least an eight-year period for all proposed changes related to funding of the nonfederal share.

* * * *

Thank you for your consideration of the Commenting States' comments on the proposed rules.

Sincerely,

/s/ Caroline M. Brown

Caroline M. Brown
Philip J. Peisch

Joined by the Illinois Department of Healthcare and Family Services; the Louisiana Department of Health; the Michigan Department of Health & Human Services; the Missouri Department of Social Services; the Missouri Department of Mental Health; the New York State Department of Health; the Oregon Health Authority; the South Carolina Department of Health and Human Services; the Tennessee Division of TennCare; the Washington State Health Care Authority; the Colorado Department of Health Care Policy & Financing; and the Pennsylvania Department of Human Services.[2]

[2] While the Colorado Department of Health Care Policy & Financing and the Pennsylvania Department of Human Services join these comments in full, Brown & Peisch PLLC is not counsel for either state or state agency.