Shriver Center on Poverty Law

For economic and racial justice

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February 1, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

Re: CMS-2393-P: Medicaid Program; Medicaid Fiscal Accountability Regulation

Dear Sir or Madam:

We appreciate the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation and thank you for extending the comment deadline so that key stakeholders could fully assess the impact of the rule and effectively comment. Today, we write to express our strong opposition to the proposed rule for reasons set forth below.

The Shriver Center fights for economic and racial justice. Over our 50-year history, we have secured hundreds of victories with and for people living in poverty in Illinois and across the country. Today, we litigate, shape policy, and train and convene multi-state networks of lawyers, community leaders, and activists nationwide. Together, we are building a future where all people have equal dignity, respect, and power under the law. Our communities and clients rely on Medicaid to provide affordable quality healthcare coverage for their families. Medicaid funding provides the backbone of our critical access hospital and provider network including, for example, access to specialty care for children with special health care needs. Medicaid funding significantly contributes to the infrastructure for our primary care health networks, prevention services including immunizations and disease control in our public health systems, pregnancy and postpartum care for pregnant women, long-term care for our most vulnerable older adults, and behavioral healthcare for people suffering from mental illness.

Medicaid is a critical public health insurance program that currently provides coverage to almost 3 million Illinoisans including children, older adults, individuals with disabilities, pregnant women, parents and low-income adults. Medicaid covers comprehensive benefits such as physician, hospital, health clinic and pediatric services, and is also the primary source of long-term care for Americans.[1] Not only is it a critical lifeline for many individuals and families, but it

[1] Robin Rudowitz, Rachel Garfield, Elizabeth Hinton, *10 Things to Know About Medicaid: Setting the Fact Straight*, Kaiser Family Foundation, March 6, 2019, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

is also a critical financial support for health care providers such as hospitals and community health centers.

Unfortunately, this proposed rule would substantially undermine this vital program by excessively and unnecessarily restricting the ways in which Illinois can raise revenues to cover the costs of our Medicaid program. As a result, Illinois may be forced to make cuts to eligibility, benefits or provider rates, which will in turn hinder the ability of Medicaid enrollees to access the care they need. ***For these reasons, we strongly oppose the proposed rule in its entirety and urge CMS not to move forward with finalizing it.***

The proposals violate statutory intent

CMS relies on Section 1902(a)(30(A) as the basis for its proposed rule, which requires states to "assure that [provider] payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan." However, it's worth noting that the agency recently rescinded a rule designed to ensure that enrollees have access to care consistent with this statutory requirement. CMS rescinded this rule based on a claim that it was burdensome for states to collect information on whether provider payments were sufficient to ensure equal access.[2] However, as explained below, CMS is imposing various new burdensome administrative requirements with this proposed rule, which will only make it harder for Medicaid agencies to provide health coverage and care.

The rule also proposes to limit the use of intergovernmental transfers (IGTs) as a means of financing the state share of Medicaid expenditures by narrowing the definition of entities that can make IGTs and limiting the types of funds those entities can transfer. Specifically, it proposes to restrict the definition of "public funds," which entities can use to make IGTs, to only funds derived from state or local taxes or appropriations to state university teaching hospitals. CMS asserts that changing the definition of "public funds" in this way better aligns the regulatory language with the statutory language, but this is incorrect. The statutory language merely establishes a floor for what may constitute an IGT.[3] Nothing in the statute prevents the Secretary from allowing states to use a broader set of public dollars, like commercial revenue received by a public entity, as an IGT. Therefore, the proposed rule falls outside the scope of what Congress intended and is arbitrary and capricious.

The proposed rule violates Executive Order 12,866 and the Administrative Procedure Act

CMS has also failed to comply with Executive Order (E.O.) 12,866 in proposing this rule. E.O. 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action. An agency should propose a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs, and after considering all costs and benefits of available regulatory alternatives, including the alternative of not proposing a rule. Yet CMS acknowledges that "[t]he fiscal impact of the Medicaid program from the implementation

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[2] CMS-2406-P2, *Proposed Rule: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission*, July 15, 2019, https://www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission

[3] 42 U.S.C. 1396b(w)(6)(A)

of the policies in the proposed rule is *unknown* [italics added]."[4] The only estimate of the fiscal effects on state Medicaid programs that HHS provides is for the single provision establishing the new, lower limit on Medicaid supplemental payments to physicians and other practitioners.

Separate from the requirements of E.O. 12,866, under the Administrative Procedure Act (APA), courts have held that when an agency relies on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the rule unreasonable. Because CMS' cost-benefit analysis for the proposed rule fails to adequately quantify or to explain why CMS could not quantify those costs, CMS does not adequately assess the economic effects of the proposed rule. Therefore, the proposed rule in its current form is an abuse of discretion that violates the APA.

The rule severely and unnecessarily restricts the ability of states to finance their Medicaid programs

Although the purported goal of the rule is to regulate supplemental payments that states make to providers, in actuality the rule restricts how states raise the revenue used to make supplemental payments, even though the ways states raise this revenue have been longstanding, legally authorized financing mechanisms.[5] Additionally, the proposed rule imposes new and vague standards of review for both current and new state financing and supplemental payments arrangements which give CMS a large amount of discretion for approval and may discourage states from continuing or entering into new arrangements. As a result, states could end up eliminating or significantly scaling back existing financing and payment arrangements out of fear and confusion, which could then lead to overall cuts to their Medicaid program.

Illinois has a large and comprehensive Medicaid program covering close to 3 million people including children, adults, people with disabilities and older adults. In addition, Illinois administers several Home and Community Based Waiver programs and 1115 Waivers to transform the delivery system in order to efficiently deliver medically necessary medical and behavioral healthcare to the low income populations in a coordinated care setting. Illinois has long relied on various legal methods to finance our Medicaid program including supplemental payments, intergovernmental transfers and provider taxes. These mechanisms have been authorized by CMS and are in line with how states around the nation ensure that there are adequate provider payments and equal access to care for Medicaid patients. This rule, if finalized, will jeopardize our ability to finance and administer our Medicaid program in a manner that provides for adequate funding to meet the needs of our populations. We are very concerned that Illinois may not, as a result of this rule if finalized, have the funding to provide coverage to our most in need communities and to be able to pay providers adequately in order to maintain equal access to the insured population as the Medicaid Act requires.

By hindering the ability of states to finance their Medicaid programs, the rule may adversely impact how providers are paid

As explained above, the ways that the proposed rule seeks to limit both what types of entities can make IGTs as well as what funds can be used to make IGTs will unduly restrict the ability of

[4] 84 FR 63773 https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf

[5] Cindy Mann, Anne O'Hagen Karl, *Proposed Rules on Medicaid Financing Miss the Mark and Threaten Access*, Health Affairs Blog, January 8, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200108.392104/full/

states to raise revenues to support the costs of their Medicaid programs, including how much they pay Medicaid-participating providers. Though one of CMS's proposed changes is to prohibit states from retaining any part of a provider payment when the payment is based on a certified public expenditure, we are nevertheless concerned that this provision will adversely impact one specific type of Medicaid provider – local education agencies – as these agencies have arrangements with states that make it possible for school-based health providers to participate in the Medicaid program and rely on the state for processing their claims.

Illinois has a large educational system relying on over 800 local school districts and municipalities to provide education, special education, physical accommodations, and health services to students. In some schools, school-based health centers (SBCHs) are the primary medical center serving children in the area due to healthcare provider shortages in the community. SBHCs provide primary care, dental and behavioral health care to large student populations. We are concerned that the financing of school health services and administrative efficiencies in the school Medicaid billing system will be harmed by this rule if finalized.

By hindering how providers are paid, the proposed rule will harm access to and quality of care
Our primary concern with this rule is the ultimate effect it will have on Medicaid enrollees. Constraining how states raise revenues for their Medicaid program overall will inevitably effect their ability to maintain provider rates. If provider rates are cut, many providers may decide to no longer participate in the Medicaid program, which will then harm the ability of patients to see their preferred providers and access the care they need.

As mentioned above, provider rates are a key indicator of access for Medicaid recipients. We are very concerned that this rule if finalized will detrimentally impact access because it will force Illinois to make dangerous provider rate cuts. Illinois already has historically low Medicaid rates and access has suffered as a result. We are counsel for the Plaintiffs in *Memisovski v. Maram 92 C 1982 (N.D. IL)* in which we represent over one million children on Medicaid in Cook County under a Consent Decree that mandates equal access to Medicaid providers. A significant finding in the case was that access was impaired for children on Medicaid as the result of low Medicaid rates. The Consent Decree sought to remedy the problems with access primarily through significant increases in Medicaid pediatric reimbursement rates. This rule, if finalized, could jeopardize the state's ability to comply with the Consent Decree and could impair access to care for hundreds of thousands of children. Many studies have proven the close association between Medicaid rates and access to care. In particular, when rates decrease studies show that appointment availability for Medicaid patients goes down. [6]

The rule excessively impedes on the authority of states to administer their Medicaid programs
Since January 2017, CMS has proposed many new rules under the guise of wanting to increase state autonomy and flexibility when it comes to how states administer their Medicaid programs, as well as remove "burdensome" administrative requirements as a way to better realize and take advantage of their autonomy.[7] In this rule, however, CMS proposes to institute a large amount of

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5833510/

[7] For example, in its Medicaid and Children's Health Insurance Program Managed Care rule, CMS states that its goal was to "streamline the managed care regulations by reducing unnecessary and duplicative administrative burdens and further reducing federal regulatory barriers." 83 FR 57265. In its proposed rescission of the Methods for

new and onerous reporting requirements for states, including requirements to report new types and amounts of data, as well as to use specific reporting formats. Additionally, CMS proposes to withhold federal financial participation funding from states if they do not meet these new requirements. Many states are concerned about their ability to meet these new reporting requirements and the potential to lose some of their federal funding if they do not meet them. For example, the state of Arizona released a report warning that the proposed rule would impose "unprecedented system programming changes" and concluding that "the analysis of costs in the NPRM significantly underestimates the cost to the States to modify systems, educate providers on new coding requirements, and for ongoing reporting efforts."[8] Overall, imposing large amounts of burdensome new reporting requirements will generate no real benefit and only make it harder for state Medicaid agencies to focus their energy, time and resources on administering their programs efficiently and effectively.

The rule will create uncertainty among states about whether and how they can raise revenue for the Medicaid program, and cause a harmful chilling effect as a result

CMS seeks to impose many new vague standards that states must meet before the agency will approve their financing and supplemental payment arrangements, including "undue burden" and "totality of circumstances" standards. However, the language of the rule does not sufficiently spell out what would constitute an "undue burden", nor what an examination of the "totality of circumstances" would entail. Not only that, but CMS also proposes to have the authority to review and approve not only new financing arrangements, but current, previously-approved ones as well. The uncertainty and discretion afforded to CMS to disapprove longstanding arrangements could have a chilling effect on states, making it more likely that they make cuts to their Medicaid programs rather than risk disapproval of their financing arrangements.

CMS should collect more information about the potential impact of this rule to determine whether regulatory action is warranted

Although the proposed rule significantly increases state reporting requirements, as explained above, the information CMS is requesting is not sufficient enough to allow it to properly assess the impact of the rule on state Medicaid budgets, Medicaid providers and Medicaid patients. CMS admits this is the case by acknowledging in the preamble that more information is needed. Moreover, the agency has provided a completely inadequate regulatory impact analysis that only reviews one of the many changes the rule would make, despite finding that the rule is economically significant.

Overall, major policy changes shouldn't be made without a full understanding of their impact, particularly when the potential impacts could limit access to health care for low-income and vulnerable people. Moreover, CMS seems to be conflating how states raise revenue to finance their Medicaid program with how states make supplemental payments to providers. Therefore, CMS should first get the information it needs to fully understand the issues it's trying to regulate

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Assuring Access to Covered Medicaid Services, CMS states that its goal is to provide states with more "flexibility" and "address some of the states concerns regarding undue administrative burden." 84 FR 33723.

[8] Arizona Health Care Cost Containment System, *Summary of AHCCCS Response to the Proposed Medicaid Fiscal Accountability Regulation*, https://www.azahcccs.gov/shared/Downloads/News/2019/AHCCCSMFARSummary_200117.pdf

before embarking on any rulemaking. For example, CMS should collect data to determine whether supplemental payments, provider assessments, and other financing arrangements are consistent with statutory requirements, whether they advance the objectives of Medicaid, whether changes in the rules governing these arrangements are necessary, and what the impact of any such changes would be. CMS should then use this data and analysis to work with states, providers and other stakeholders to develop more evidence-based policies that curb inappropriate arrangements that violate current statutory and regulatory requirements but also avoid significant structural changes that could seriously undermine state budgets and substantially threaten the financial viability of hospitals, nursing homes and other health care providers.[9]

Since CMS does not have the information it needs to assess the impact of the rule, we strongly urge the agency to withdraw the rule and instead establish a transparent process to (1) determine what information is essential to better understand state financing arrangements; (2) develop and implement a plan for obtaining that information; and (3) disseminate the information CMS gathers during this process in a public and accessible format to stakeholders. For example, the agency could issue a request for information or Advanced Notice of Proposed Rulemaking.

Overall, we are concerned that if the rule is finalized as proposed, hundreds of thousands of Illinois individuals and families that Medicaid was created to serve will not be able to access the health care they need to maintain their health and well-being. Therefore, we urge you not to move forward with the rule and to withdraw it in its entirely.

Thank you for your consideration.

Respectfully submitted,

Stephanie F. Altman

Stephanie F. Altman
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Shriver Center on Poverty Law

[9] Edwin Park, *Administration Fails to Assess Impact of Major Changes For State Medicaid Financing and Supplemental Provider Payments*, Health Affairs Blog, January 16, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200116.391921/full/