AdvocateAuroraHealth

Advocate Aurora Health
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515

T (630) 572-9393
F (630) 990-4752
advocateaurorahealth.org

January 31, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Rule: CMS-2393-P, Medicaid Program: Medicaid Fiscal Accountability Regulation (vol. 84, No. 222), November 18, 2019 and CMS-2393-N (vol. 84, No. 249) December 30, 2019

Dear Administrator Verma:

Advocate Aurora Health, one of the largest not-for-profit health systems in the United States and the largest health system in Illinois and Wisconsin, appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for Medicaid Fiscal Accountability Regulation (proposed rule).

Each year, we serve nearly three million patients across more than 500 sites of care, and we are engaged in hundreds of clinical trials and research studies. Our clinicians are nationally recognized for their expertise in cardiology, neurosciences, oncology, and pediatrics. Moreover, we are proud to be one of the nation's leaders in clinical innovation, health outcomes, consumer experience, and value-based care. We have historically been a strong and transformative partner with the federal government, state governments, and commercial payors in the journey from volume to value.

Individuals and families with insurance coverage through Medicaid constitute 18% of total insured in Illinois and 16% of total insured in Wisconsin. Medicaid provides much needed access to primary, acute, and long-term care for low-income children, pregnant women, adults, seniors, and individuals with disabilities, throughout Illinois and Wisconsin, who otherwise cannot afford – or do not have access to – health insurance. In 2018, Advocate Aurora was proud to have served more than 485,530 unique Medicaid patients with more than 1.5 million patient visits.

Advocate Aurora sincerely appreciates the leadership of policymakers at CMS for working to improve the fiscal integrity of the Medicaid Program, but we oppose the implementation of this rule due to the potential for drastic and severe reductions to the Medicaid program, including up to $49 billion in estimated annual reduction in total Medicaid spending and up to $31 billion in reductions to hospital program payments nationwide.[1] Payment reductions from this rule would unquestionably result

[1] *Financial Impact Analysis: Proposed Medicaid Fiscal Accountability Rule (MFAR) Could Result in Deep Medicaid Cuts,*

AdvocateAuroraHealth

Advocate Aurora Health
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515

T (630) 572-9393
F (630) 990-4752
advocateaurorahealth.org

in cuts in program enrollment and covered services, the impact of which could be catastrophic.

Unfortunately, the proposed rule restricts the access to important funding streams and the authority to make supplemental payments to offset base payments set below the cost of providing care. It also introduces uncertainty with respect to how CMS will evaluate state financing approaches, and it gives states little time to make policy and budgetary adjustments, many of which must be approved by state legislatures, to mitigate the loss of federal funds. We urge CMS to withdraw the proposed rule.

As discussed below, these proposed changes would be extremely detrimental to the efficacy of the Medicaid program.

1. Proposed Changes to the State Share of Financial Participation Affecting Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs) ***42 CFR §433.51 (amended), 42 CFR §447.286 (amended), 42 CFR §447.206 (proposed)***

Provider taxes and transfers of public funds from public entities are critical, statutorily permitted sources of state financing for the Medicaid program at large, including supplemental payments. The proposed rule would redefine "non-state government providers" as government providers that are a unit of local or state government, or a state university teaching hospital with administrative control over funds appropriated by the state legislature or local tax revenue. The proposed rule further proposes that, beyond the new definition, the agency would have discretion to judge whether, "in the totality of the circumstances," the entity qualifies as a governmental provider. In addition, CMS proposes to restrict what types of funds can constitute an IGT, and would limit IGTs to funds derived from the provider's state or local tax revenue (or funds appropriated to a state university teaching hospital).

Simply put, the proposed rule would implement new policy on what type of funds qualify as allowable sources of the non-federal share, require that IGTs be derived from state or local taxes, and influence which entities can participate in IGTs. These changes would effectively restrict the sources from which IGTs are derived and cap the IGT and CPE amounts governmental providers can use to fund the state's non-federal share. Moreover, the broad discretion CMS has reserved for determining what entities are non-state government providers would create uncertainty for states in determining which public providers are permitted to transfer local funds for purposes of Medicaid financing. These proposals fail to provide adequate guidance and restrict states' use of funds beyond what is authorized in statute.[2]

American Hospital Association and Manatt Health, January, 2020.

[2] 42 USC 1396b(w)(6)(A).

AdvocateAuroraHealth

Advocate Aurora Health
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515

T (630) 572-9393
F (630) 990-4752
advocateaurorahealth.org

2. Proposed Changes Affecting Provider Donations and Health Care Related Taxes *42 CFR §433.52 (amended), 42 CFR §433.54 (amended), 42 CFR §447.201 (proposed)*

States and local governments have long collaborated with providers to ensure access to health care services for their Medicaid population, as well as to improve the health of the overall community. Health care providers are permitted, under federal law and regulation, to make "bona fide" donations to government entities with certain restrictions as long as the donation does not have a "direct or indirect relationship" to Medicaid payments.[3] States cannot promise that any donation is returned to the provider making the payment, providers furnishing the same class of services, or an related entity. States are also able to tax providers to collect revenue to be put toward the Medicaid program.

In the proposed rule, CMS has proposed a number of policy changes that would sharply curtail states' ability to use these financing arrangements, despite clear statutory authority.[4] This includes a proposal to change current regulations implementing the hold harmless provision by implementing a "net effect" standard based on "the totality of circumstances." Net effect would give CMS significant discretion to look at the agreements, including those not in writing or with no legally enforceable obligation, possibly jeopardizing state provider tax arrangements. These vague terms without defined criteria would create uncertainty for states. Further, the proposed rule would violate the statute by requiring only a "reasonable expectation" that the taxpayer may be held harmless, rather than a "guarantee," as required by the statute.[5]

This rule would also introduce inconsistencies with existing regulatory language and violates the Administrative Procedure Act because, with little rationale, it changes policy and guidance upon which States and providers have long relied. Finally, the proposal is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers.

3. Medicaid Supplemental Non-Disproportionate Share Hospital (DSH) Payments *42 CFR §447.272 (amended), 42 CFR §447.321 (amended), 42 CFR §447.288 (proposed)*

States use both base payments and supplemental payments to reimburse providers. Base payments for providers are tied to claims for specific services and are typically set significantly below the cost of care. Historically, supplemental payments have served to improve provider payment rates, however, even the use of supplemental

[3] §433.54 Bona fide donations
[4] Social Security Act §1903(w)(3).
[5] Social Security Act §1903(w)(4)(C)(i).

AdvocateAuroraHealth

Advocate Aurora Health
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515

T (630) 572-9393
F (630) 990-4752
advocateaurorahealth.org

payments does not make providers whole. After accounting for supplemental payments, hospitals receive on average only 89 cents on every dollar spent for caring for Medicaid patients.[6]

CMS proposes significant changes to the policies for non-DSH supplemental payments, citing concerns about the growth in these payments. Specifically, the proposed rule proposes to change how upper payment limits payments (UPL) are calculated, limit such payments to physicians and other practitioners, and increase reporting requirements.

These changes could severely curtail access to care, especially at rural hospitals serving vulnerable communities whose providers would disproportionately be subject to the new practitioner caps. Meanwhile, the new provider-level reporting requirements would be considerable and would generate largely unusable data given inadequate guidance from CMS on some of the proposed reporting requirements. Further, this data would not be audited. Because CMS has not ensured that the federal statutory equal-access standard can be met with these policy changes in the proposed rule, they are also arbitrary and capricious.

4. Transition Process

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

These financing and payment programs are complex, and we would need considerable time to work with our state legislatures and impacted stakeholders to implement any possible mitigation strategies.

Conclusion

Advocate Aurora Health is strongly opposed to this proposed rule on Medicaid Fiscal Accountability Regulation which would severely underfund the Medicaid programs in Illinois and Wisconsin and subsequently negatively impact those who rely on the program, including nearly a half million Advocate Aurora patients. Advocate Aurora Health is committed to advancing value-based care and encourages CMS to work with stakeholders in crafting a proposal to increase savings in the Medicaid program.

[6] AHA January 2020 https://aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

AdvocateAuroraHealth

Advocate Aurora Health
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515

T (630) 572-9393
F (630) 990-4752
advocateaurorahealth.org

Thank you for the opportunity to provide our feedback. Please do not hesitate to contact me (Joyce.Rogers@AdvocateHealth.com or Tom McDaniels at Thomas.McDaniels@AdvocateHealth.com) should you have any questions of if we can be of any assistance.

Sincerely,

Joyce Rogers
Advocate Aurora Health
Chief Government Affairs Officer