January 30, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: 42 CFR Parts 430, 433, 447, 455, and 457 [CMS-2393-P], RIN 0938-AT50, Medicaid Program: Medicaid Fiscal Accountability Regulation

Attention: File Code CMS-2393-P

To Whom it May Concern:

The National Alliance of Safety-Net Hospitals (NASH), an association of private safety-net hospitals, wishes to submit formal comments on the proposed Medicaid fiscal accountability regulation that the Centers for Medicare & Medicaid Services (CMS) published in Volume 84, Number 222 of the *Federal Register* on November 18, 2019 beginning on page 63722.

While NASH supports greater transparency in Medicaid, that support is outweighed by too many troubling aspects of the proposed regulation. In this letter, NASH is especially interested in commenting on five aspects of the proposed regulation: how it would deprive states of important, established policy-making prerogatives; its creation of major new administrative burdens for state governments and for hospitals; its inappropriate regulation of financing of the state share of Medicaid spending; its proposed introduction of new, unspecified standards that state Medicaid programs would be held accountable for meeting; and its violation of the Administrative Procedures Act.

Based on these concerns, which we elaborate on below, NASH urges CMS to withdraw this proposed regulation.

Depriving States of Important, Established Policy-Making Prerogatives

It is almost universally accepted that the 50 states all have very different circumstances and that a one-size-fits-all approach to Medicaid should not be imposed on them. For this reason, NASH, like many others – including members of Congress – believes that whenever possible, state Medicaid policies should be made by the states. The proposed Medicaid fiscal accountability regulation, however, would take a good deal of this policy-making prerogative away from the states and give it instead to the federal government by giving broad responsibility for judging Medicaid program economy, efficiency, and quality to federal regulators. It would compound the challenge this poses, moreover, by also imposing new limits on states' ability to finance their own (non-federal) share of the money they spend on Medicaid payments to providers.

21351 Gentry Drive, Suite 210, Sterling, VA 20166
Phone: 703-444-0989
www.safetynetalliance.org

NASH disagrees with both aspects of this approach: the reassignment of important policy-making responsibilities to federal regulators and the imposition of new guidelines that would effectively narrow the financing options available to states seeking to pay for Medicaid services. We believe such changes are especially inappropriate in light of three years of this administration's insistence that it wishes to remove federal regulators from policy-making at the state level as much as possible and to reduce the regulatory burden the federal government imposes on the states and on the private sector.

Because NASH disagrees with the reassignment of important policy-making prerogatives from state officials to federal regulators and with the introduction of a new, increased regulatory burden on the states and health care providers, we oppose these aspects of the proposed Medicaid fiscal accountability regulation and urge CMS to withdraw this regulation.

The Creation of Major New Administrative Burdens for State Governments and Hospitals

As noted above, the introduction of the proposed Medicaid fiscal accountability regulation would result in a significant increase of the regulatory burden for all parties involved in regulating and administering Medicaid programs and serving Medicaid patients: federal regulators, state Medicaid programs, and hospitals, including private safety-net hospitals such as those that belong to NASH.

The proposed regulation would unquestionably increase the regulatory burden on CMS – doing so, curiously, at the very time that the administration has publicly articulated on numerous occasions its commitment to reducing the extent of federal regulation in the business of the states and the private sector. Even now, the regulatory burden posed by one aspect of the proposed regulation, the review of proposed state plan amendments, is a considerable challenge to CMS, with the agency taking months to review applications for changes in state Medicaid plans and often running up to and occasionally going past legal deadlines for such reviews. In fact, even as CMS proposes increasing its degree of involvement in the regulation of the financing of state Medicaid programs it is actively working to decrease its involvement in another aspect of its regulation of state Medicaid programs, proposing regulatory changes that would, if adopted, reduce its role in monitoring the adequacy of access to care for Medicaid patients (via its "Methods for Assuring Access for Covered Medicaid Services – Rescission," which was published in the *Federal Register* on July 15, 2019).

The proposed regulation also would increase the regulatory burden for state governments. State Medicaid programs are vast enterprises with literally thousands of moving parts – doctors and health care professionals, hospitals, insurers, suppliers, contractors, and of course, Medicaid enrollees (from the 57,000 such enrollees in North Dakota to more than 13 million in California) – and to this challenge this proposed regulation would add more regulatory requirements. State Medicaid programs, for example, would be required to delineate the specific federal authority underlying every payment it makes to hospitals and the source of their (state) funding for every single one of those payments. This would be a truly massive undertaking – one the federal government has not yet assessed for the time it would take or the costs states would incur to comply with these new requirements. NASH questions whether CMS truly appreciates how much data this would involve, how many additional staff members might be needed to produce it, how much state Medicaid programs might need to invest in additional or expanded management information systems capacity to make it all possible, and how much time this would all take.

As noted above, one of the most time-consuming aspects of operating a state Medicaid program is developing proposed state plan amendments and then working those proposed amendments through the federal regulatory process. Under this proposed regulation, this aspect of state Medicaid endeavor would expand enormously because of the proposed requirement that certain state plan amendments and waiver applications be renewed every three years – even after they have already been approved by federal

regulators and regardless of whether anything about the individual amendments, waivers, or programs has even changed.

These and other new responsibilities could create so much work and pose such a distraction from the business of operating a state Medicaid program that they could threaten the ability of those programs to do their basic job: enroll beneficiaries and providers, pay for services, and ensure that those services are accessible and of appropriate quality. They also could have a chilling effect on the ability of regulators to engage in the kind of Medicaid innovation that regulators, elected officials, and the public have been demanding in recent years. Regulation should help improve the delivery of care to the Medicaid population, not jeopardize it, and NASH fears that the proposed Medicaid fiscal accountability regulation could jeopardize the quality of Medicaid services and access to those services for those who meet the criteria to qualify for Medicaid. NASH thinks it is telling that in the proposed regulation, CMS makes no meaningful effort to estimate the time states will need and the costs they might incur to comply with these new requirements. The one estimate it does offer – that coming into compliance with the proposed regulation would take 3637 hours of labor at a cost of $145,221 nation-wide, or an average of 67 hours of work at a cost of $2847 per state – is unquestionably unrealistic and nowhere near what states will need. In fact, the individual states would almost certainly require more than the nation-wide projection of resources CMS suggests.

Finally, and most relevant from NASH's perspective, the proposed regulation would greatly increase the regulatory burden for hospitals that serve Medicaid patients – and safety-net hospitals all serve especially large proportions of Medicaid patients. These hospitals would be subject to significant new reporting requirements, such as requiring even more detailed auditing within the already extremely onerous hospital-specific DSH limit audits and providing a potentially unlimited amount of additional information that CMS might request so it could evaluate the "totality of circumstances" surrounding state proposals. This would be an enormous undertaking that would be very costly to individual hospitals, taking resources away from their more important job of caring for their Medicaid patients – and their many other Medicare and privately insured patients as well.

The requirements that would be imposed by the proposed Medicaid fiscal accountability regulation would be considerable: considerable for federal regulators, considerable for state Medicaid programs, and considerable for hospitals. At the very time that the federal government is pursuing an oft-stated policy of attempting to reduce federal regulatory burden, its actions would directly contradict its words through this increase, not decrease, in federal regulation of state Medicaid programs.

Inappropriate Regulation of Financing of the State Share of Medicaid Spending

While NASH recognizes CMS's authority to oversee how states finance their share of their Medicaid programs, it believes that in this proposed regulation CMS calls for exceeding its legal authority to do so. The Social Security Act establishes the baseline for state financing of their Medicaid programs, giving states flexibility for doing so and requiring only that state funds constitute at least 40 percent of the state share. This makes it possible for other sources, such as municipalities, counties, and other units of government, to participate in the financing of their state Medicaid programs. They can do so in a number of different ways, including transferring local government funds via intergovernmental transfers (IGTs) or certifying their expenditures incurred providing Medicaid services through certified public expenditures (CPEs). States also raise additional state share by levying health care-related taxes that are eligible for federal Medicaid matching funds.

All of these funding mechanisms are well-established, are explicitly permissible under federal statute, and all have been approved in the past by CMS as part of state plan amendments or waivers. On occasion CMS has rejected specific proposed taxes, for a variety of reasons, and states have returned to the

drawing board, addressed the concerns CMS raised in its initial rejections, resubmitted their state plan amendment applications, and gained CMS approval for their taxes. Between them, CPEs, IGTs, and provider taxes have long been accepted as appropriate, legal, federally approved tools for raising the non-state share of state Medicaid spending.

In the proposed Medicaid financing accountability regulation, however, CMS calls for curtailing states' ability to use these funding mechanisms by imposing new limits and tests on their use. The manner in which it proposes doing so, however, exceeds the scope of CMS's statutory authority as established by Congress. In fact, the Social Security Act specifically states that "…the 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…" In the 1991 Provider Specific Tax Amendments, Congress specifically prohibited CMS "…from implementing any regulation that would change current policy with respect to the use by the States of revenues from…[IGTs] to finance their state share of the Medicaid program…" This provision, moreover, specifically declared this policy to be permanent.

Thus, NASH believes that in the proposed regulation, CMS seeks to exceed its authority to regulate the manner in which states raise the state share of their Medicaid spending, doing so in a manner that Congress explicitly rejected. The proposed changes are inconsistent with the Medicaid Act and with congressional intent, and for this reason NASH believes they should not be adopted as proposed.

The Proposed Introduction of New, Unspecified Standards for State Medicaid Programs

Regulations, it is widely understood, are intended to fill in the blanks left by broad legislation and provide a roadmap for how laws will be implemented. They are the details that need to be added to an outline, the techniques that bring together the list of ingredients in a recipe into a final dish that is greater than the sum of its parts.

But a vital aspect of regulations is that they need to be clear and unambiguous and all involved parties need to be able to understand them. In this regard, NASH believes the proposed Medicaid fiscal accountability regulation falls short. In the past, CMS has offered states predictable, concrete guidelines for ascertaining whether health care taxes pose what it considers to be an undue burden and whether the implementation of such taxes would result in a "hold-harmless" situation between providers and their state governments.

The proposed regulation seeks to deviate from this approach. In it, CMS proposes that health care taxes must meet new standards because of its view that the current standards do not adequately show whether such taxes result in hold harmless situations or pose an undue burden to a state Medicaid program. To address this concern, CMS proposes delegating to itself new authority to evaluate the funding sources, payments, and services provided by state Medicaid programs and reach its own conclusions regarding undue burdens and inappropriate hold-harmless situations. In so doing, however, it has chosen not to reveal what those new standards would be, essentially leaving state Medicaid programs, and their stakeholders, in the dark on the question of whether proposed changes in state Medicaid programs have any reasonable prospect for passing federal review.

Specifically, NASH is troubled by the ambiguity surrounding how CMS proposes determining whether provider taxes are sufficiently broad-based or generally redistributive. Today, CMS applies the P1/P2 and B1/B2 statistical tests to determine whether proposed taxes impose an undue burden on the Medicaid program. This is an objective, data-driven approach that states can apply for themselves so that they know, even before they submit a proposed state plan amendment, whether the tax they propose will pass regulatory muster. In the proposed regulation, however, CMS calls for adding a subjective component to

the review of proposed provider taxes. This means that even if a tax meets the criteria of the P1/P2 or B1/B2 test (as applicable), a CMS regulator could – with no objective metric – simply assert that the tax posed an undue burden and was therefore impermissible. This is the textbook definition of arbitrary and would, in NASH's view, give CMS new, overly expansive authority that can be interpreted broadly and has little basis in the laws governing the Medicaid program.

NASH objects in the same way to the proposed use of the concept of "totality of the circumstances" and a new "net effect" standard. Both standards are extremely vague, would be difficult for state Medicaid officials to interpret and craft policies around, and would potentially be subject to personal interpretation by individual CMS regulators. Regulations should provide explicit standards, both for those seeking to comply with them and those who enforce them, but in the case of the "totality of circumstances" and "net effect" standards, NASH believes CMS does not meet this baseline requirement.

NASH believes this approach would be harmful. In the absence of clear, objective guidelines, state Medicaid programs would be left to operate blindly, jeopardizing their ability to continue serving Medicaid beneficiaries. Worse, there is little to ensure that new, unarticulated standards would be uniformly applied nation-wide. Subject to interpretation by individual CMS staff in the agency's 10 regional offices, they could be interpreted in different ways on a national or regional basis or even within individual CMS offices or by individual CMS staff members, and with certain aspects of state plan amendments subject to renewal every three years under this proposed regulation, states would have no assurances that what passed regulatory muster in the past would do so again – even if it proposed no changes. This would lead to great ambiguity at the least and to potential chaos at most, jeopardizing the ability of state Medicaid programs, providers, and stakeholders to do their jobs and the ability of Medicaid beneficiaries to receive the services to which they are entitled, and for this reason.

Finally, NASH is concerned that such unchecked authority could prove tempting for abuse, giving future regulators, whether for policy or political reasons, an inappropriate amount of power that they could use to compel arbitrary changes in state Medicaid programs – or starve such programs of the resources they need to serve beneficiaries.

As proposed, this regulatory change is simply not ready for implementation.

Violation of the Administrative Procedures Act

Federal law requires that when new regulations are proposed, they are accompanied by a careful analysis of their expected impact. As proposed, the Medicaid fiscal accountability regulation violates this requirement of the Administrative Procedures Act because it includes no such analysis. In the proposed rule, CMS acknowledges this responsibility, yet it concedes that it does not have the data to perform the required analysis and then proceeds to offer an incomplete, largely undocumented analysis. This, in NASH's view, is a major problem, leaving stakeholders without the information they need to draw informed conclusions about how the proposed regulation might affect them. Because of this shortcoming, stakeholders have been left in the dark about many factors, including how the proposed regulation might affect them and how much it might cost them. This affects both state Medicaid programs and providers, including hospitals, which means it also affects the more than 70 million Americans who rely on Medicaid today for their health care. NASH urges CMS to withdraw the proposed regulation because it fails to meet the requirements of the Administrative Procedures Act.

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they serve patients who are more dependent on Medicare and Medicaid for health care; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

*　　　*　　　*

NASH invites CMS questions about the views expressed in this letter and appreciates the agency's consideration of those views.

Sincerely,

Ellen Kugler, Esq.
Executive Director