January 31, 2020

Submitted via www.regulations.gov

The Honorable Seema Verma
Administrator
Center for Medicare and Medicaid Services
Attention: CMS–2393–P
7500 Security Blvd
Baltimore, Maryland 21214

RE: Medicaid Program; Medicaid Fiscal Accountability Regulation; RIN 0938–AT50/CMS–2393–P

Dear Administrator Verma:

The Consortium for Citizens with Disabilities (CCD) Health Task Force would like to thank you for the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation. The undersigned co-chairs of the CCD Health Task Force are seriously concerned that the proposed rule would have a negative impact on states' ability to finance their Medicaid programs and we strongly recommend that the Centers for Medicare and Medicaid Services (CMS) withdraw the parts of the proposed rule that would substantively change Medicaid financing mechanisms.

The CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The Health Task Force promotes policies that increase access to health care and promote health, independence and improved functioning.

I. Overview

Appropriate access to services under Medicaid is especially critical for people with disabilities and chronic conditions who rely on Medicaid to access basic health care services as well as services that ensure their functioning, independent living, and well-being, including:

- nursing and personal care services;
- specialized rehabilitation and other therapies;
- intensive mental and behavioral health services;
- special education services; and
- other needed services that are unavailable through other insurance.

Access to these services is often a matter of life, death, and independence for the millions of people with disabilities on Medicaid. The Medicaid protections provided by the equal access statute are of particular importance to our community.

Because Medicaid is a joint federal-state partnership, the federal government pays a fixed share of a state's Medicaid costs, while states contribute the remainder. Under current law, states may cover their share of costs using not just general revenues, but also taxes on health care providers such as hospitals and nursing homes, contributions from local governments (known as intergovernmental transfers or "IGTs") and spending incurred by public providers for Medicaid beneficiaries (known as certified public expenditures or "CPEs"). Further, states may choose to levy provider taxes under federally approved waivers of the requirements that usually apply to state Medicaid programs, allowing them, for example, to offer exemptions to some providers that do not primarily offer Medicaid services or that serve only a nominal number of Medicaid beneficiaries. The statutory and regulatory provisions governing these funding sources and mechanisms have been in place for 30 years, and states have designed their Medicaid revenue models around them.

II. The proposed rule would make a number of highly technical policy changes that would have the effect of foreclosing or otherwise restricting avenues for states to finance their share of Medicaid expenditures that cover the cost of providing health care and disability services to beneficiaries, as well as supplemental payments to the providers who serve the Medicaid population.

The proposed rule would have a significant detrimental impact on how states finance their Medicaid programs and pay providers like hospitals, other settings of care, and physicians. If the proposed rule is finalized as currently written, it could lead states to cut benefits and eligibility as well as provider payments, jeopardizing access to care for over 70 million Medicaid beneficiaries. The proposed rule states CMS' intention is to "better understand the relationship between and among the following: Supplemental provider payments, costs incurred by providers, current [Upper Payment Limit] UPL requirements, state financing of the non-federal share of supplemental payments, and the impact of supplemental payments on the Medicaid program (such as improvements in the quality of, or access to, care.)" Yet the rule's likely impact will be to severely restrict states' ability to use these mechanisms to finance their share of Medicaid expenditures and reimburse providers.

Specifically, we are concerned that the proposed rule would impose many substantive changes to requirements governing Medicaid financing and payment arrangements that have been legally permissible for decades. For example, current law allows public providers to make IGTs derived from any public funds. In contrast, the proposed rule would limit transfers to funding derived from state and local taxes or appropriations to teaching hospitals. This proposed change would effectively bar IGTs largely comprised of private insurance revenues and charitable donations. As a result, the proposed rule would reduce the flexibility states currently have to finance their Medicaid programs and would likely reduce the availability of IGTs in a material way.

If states are unable to replace IGT funding with other sources such as general revenues, as is likely in many states, this could lead to significant funding cuts for Medicaid programs. Because fewer state

funds for Medicaid results in fewer federal Medicaid matching funds, the impact of the cuts would be much larger than the state shortfall itself. The proposed rule also seeks to limit the use of provider taxes and other existing, legal funding mechanisms that states typically utilize to pay their share of Medicaid costs, and would restrict the use of supplemental payments to providers as well.

In addition, we are concerned that the proposed rule would establish discretionary standards of review for states' Medicaid funding arrangements and supplemental payments, creating uncertainty around permissible financing structures**.** The proposed rule significantly expands the scope of the agency's review authority and discretion to approve payment arrangements, while offering only vague and ill-defined criteria by which applications to CMS would be assessed. For example, states may currently levy provider taxes under federally-approved waivers if their taxes meet certain specific mathematical tests.

The proposed rule, however, would impose a new "undue burden" standard under which CMS would determine whether the tax applies disproportionately to Medicaid. The rule would also require that all provider tax waivers and supplemental payment arrangements be limited to a three-year duration, regardless of how long they have already been in place, after which they would have to be reviewed and re-approved by the agency. This could have a chilling effect leading states to eliminate or significantly scale back existing financing and payment arrangements in their Medicaid programs, due to confusion around the new (highly technical) policies and fear of running afoul of CMS regulation.

III. The proposed rule does not satisfy the administrative reporting requirements of Executive Order 12,866.

In addition to the concerns discussed above, we believe the Department of Health and Human Services (HHS) has failed to comply with Executive Order (EO) 12,866 in proposing this rule. EO 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action. As outlined in the EO, 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 HHS acknowledges that "[t]he fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is unknown." 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 EO 12,866, under the Administrative Procedure Act, 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 HHS' cost-benefit analysis for the Proposed Rule fails to adequately quantify the fiscal impact or to explain why HHS could not quantify those costs, HHS has not demonstrated an adequate assessment of the economic effects of the proposed rule. Finalizing the proposed rule is, therefore, unreasonable and the agency should withdraw the proposal for this reason alone.

IV. **Public reporting and data requirements should be designed to provide usable information that is transparent to the public**.

We fully understand and support the need for transparency in public programs, including at all levels of the Medicaid program. Transparency is absolutely vital to ensure that providers, state Medicaid agencies, managed care organizations, and CMS itself are held accountable for the outcomes of the program. While we agree that clear data collection procedures and reporting requirements are important to ensuring transparency, we are concerned that many of the proposed requirements in this rule make substantive changes to long-standing Medicaid policy that would jeopardize access to care for Medicaid beneficiaries with disabilities and chronic conditions. We urge CMS to take a far more tailored approach to gaining a better understanding of these Medicaid funding mechanisms, an approach that will not undercut well-established Medicaid funding streams that are vital to the health, function, and independence of people with disabilities.

Thank you for your consideration of our comments. If you have any questions, please contact Peter Thomas (Peter.Thomas@PowersLaw.com).

Respectfully Submitted,

The Health Task Force Co-Chairs:

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