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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
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 Ms. Verma:

On behalf of our member hospitals and health systems, the Massachusetts Health & Hospital Association (MHA) writes to express its significant concerns and objections to the Medicaid Fiscal Accountability Regulation that the Centers for Medicare and Medicaid Services (CMS) has proposed. The proposed changes are sweeping and greatly interfere with long-accepted and important financing mechanisms that support care provided to low-income patients, including healthcare-related taxes, supplemental payments, and intergovernmental transfers. **Because of the unquestionable devastating effect these changes will have on patients and providers in Massachusetts and across the United States, we respectfully request the proposed regulation be withdrawn.**

At its core, the Medicaid program is a state and federal partnership focused on ensuring access to healthcare for millions of people, including more than 1.8 million enrollees in Massachusetts in our MassHealth program. Since its creation, the Medicaid program has required states and the federal government to work collaboratively to develop health coverage offerings and financing arrangements that take into consideration the unique situations of a population's healthcare needs, the local providers that serve these patients, and the varying state resources to support the care. Flexibility has been a hallmark of the Medicaid program, which has led to significant reductions in the number of uninsured and meaningful transformation in how healthcare is financed and delivered. While CMS has an obligation to ensure that the program is implemented with integrity and in a manner that complies with federal statute, maintaining a productive and flexible relationship with local governments and healthcare providers is of equal importance if the Medicaid program is to continue to innovate and sustain its successes.

Massachusetts hospitals and health systems are very proud of the successes we have made in the Medicaid program in conjunction with state and federal government. Our state's Medicaid program has been a key component of our impressive high rate of health insurance coverage. MassHealth has also been a leader in incentivizing healthcare providers to transform how they care for patients in the

provider setting as well as in the community. The federal government, most notably through 1115 waiver flexibility CMS has afforded, has been an instrumental partner in these achievements.

Unfortunately, the proposed Medicaid Fiscal Accountability Regulation will seriously damage the critical partnership with states and will ultimately threaten these successes. Given the size and nature of the proposed changes – which introduce a significant level of uncertainty, administrative burden, and loss of federal funding – no state is spared, including Massachusetts. We anticipate state Medicaid programs will be forced to make drastic budget-cutting decisions that will negatively affect patients and providers, given the magnitude of the funding reductions. We believe CMS' mandated regulatory impact analysis of the rule falls far short of a substantive review of the likely effect on states and Medicaid providers. That is, we believe the fiscal impact that will result from this rule far exceeds the CMS estimate and will likely be closer to other estimates that range between $37 and $49 billion.[1] Funding reductions of this size will not only affect specific provider payment arrangements but also the bottom-line of state Medicaid programs and their ability to maintain support of the program generally.

With the underlying Medicaid financing in question, innovative approaches in Medicaid programs will be at risk, such as our state's MassHealth Accountable Care Organization (ACO) program. Seventeen new Massachusetts ACOs serving more than 900,000 people are now entering the third year of the program where they are responsible for controlling Medicaid cost growth through creative approaches to population health management. This bold experiment requires financial and enrollment stability within the Medicaid program, both of which would be threatened if the proposed rule were to be adopted. Critical safety-net providers will be especially vulnerable and their ability to serve patients and offer a broad array of services will be harmed if the proposed rule were to be adopted; for some their very existence could be put into question. Hospitals, physicians, and other providers would bear the brunt of reduced federal support of the Medicaid program as provider reimbursement rates are often first targeted when state revenue challenges arise. Given the potential size of these reductions, the state's ability to continue to offer comprehensive health benefits to an expanded Medicaid population will also be put into question.

Not only will this rule damage the Massachusetts Medicaid program's ability to innovate and serve low-income patients, the magnitude of the funding losses would extend to the overall economy. Healthcare services are a major part of the economy, contributing significantly to gross domestic product and employment. Hospitals are the largest component of that sector, employing all ranges of jobs from highly specialized medical and administrative professionals to personnel who enable hospitals to operate efficiently and in a high-quality manner. Massachusetts hospitals employ approximately 190,000 people and, through the ripple effect in the economy, contribute to more than 400,000 jobs in the commonwealth. Like much of the nation, the Massachusetts economy is thriving, with unemployment at record lows, driven in part by healthcare employment. The effect of the proposed changes will undoubtedly result in less Medicaid funding for healthcare providers, which will dampen the economic contributions of hospitals and other providers. Healthcare providers that rely heavily on Medicaid financing to support the care they deliver already have undergone cost-cutting measures to remain financially viable, and any further cutbacks would likely affect their ability to continue employment and services at current levels.

[1] Manatt & American Hospital Association, MFAR Financial Impact Analysis, January 2020

Other sectors of the economy will also experience the negative effects of this rule, not only because of a dampened economy but due to reduced state government investments. The Medicaid program is the largest expenditure within the Massachusetts state budget and any attempts to mitigate the negative effects of this rule will come at the expense of other programs. States, including Massachusetts, could also be faced with the prospect of raising taxes to offset these federal funding losses. Continued growth in our state's economy and improvements in other important aspects such as transportation, education, and housing are all highly dependent on a strong and financially stable Medicaid program.

Because of the overwhelming negative effects on access for low-income citizens, the ability of healthcare providers to serve their patients, innovation within the Medicaid program, and the overall economy, we believe it is imperative that the proposed rule be withdrawn. Regarding many of the specific proposals related to the complex financing arrangements with the Medicaid program, we offer the following comments to further illustrate our significant concerns.

Healthcare-Related Taxes & Bona Fide Donations

In 42 CFR 433.52, CMS proposes new definitions regarding healthcare-related taxes and provider donations. These include a new term called "net effect" that in and of itself introduces new concepts, such as the undefined "totality of circumstances." The "net effect" definition seeks to identify the overall impact of a Medicaid financing arrangement, including all relevant financial transactions among participating entities and potential reciprocal actions among these entities. However, this definition is exceedingly vague, effectively allowing CMS to cast an unjustified wide net in its evaluation of permissible Medicaid financing vehicles. Because of the lack of clarity, the application of this definition will not be able to be accomplished in a consistent manner across states and varying provider arrangements, resulting in arbitrary and capricious decisions that will not be consistent with the Medicaid statute. The vague definition will also inappropriately allow for wide-ranging interpretations depending on the CMS administration of the day.

The proposed "net effect" definition creates a tremendous amount of uncertainty for state Medicaid programs in structuring healthcare-related taxes as well as financial exposure for states and providers thereafter. Existing CMS rules aimed at determining whether healthcare-related taxes meet the statutory requirements of being generally redistributive are clear and mathematically based. Such methods allow states to design and receive assurances that a healthcare-related tax can be relied upon to fund the state share of an approved Medicaid payment. On the other hand, the new "net effect" definition inserts a high level of ambiguity that unfairly leaves states and healthcare providers in the position of seeking approval of a permissible healthcare-related tax through an arbitrary process. Further, any supplemental funding made to providers would always carry a high level of risk that the payment could retroactively be found impermissible based on changing interpretations of the rule, putting providers in an extremely vulnerable financial position.

Healthcare-related taxes are a critical component of Medicaid financing, which Congress has adopted in statute in recognition of limited state resources. Rules are certainly needed to ensure statutory compliance and program integrity. However, these proposed rules introduce an unacceptable level of arbitrary decision making in favor of a federal agency, eroding the state and federal partnership that is supposed to be defined by clear rules and goals. For these many reasons, we respectfully request this proposal be withdrawn.

State Share of Financial Participation and Intergovernmental Transfers
In 42 CFR 433.51, CMS proposes new criteria for what constitutes an allowable state share in claiming federal financial participation. Specifically, CMS proposes that intergovernmental transfers of funding within a state must be derived from state or local taxes (or funds appropriated to a state university teaching hospital). MHA is strongly opposed to this proposed change. If this proposed rule were to proceed, states would be faced with choices that they or the federal government would not welcome, including drastic reductions in payments that support care provided to Medicaid patients by safety net providers, increases in state and local taxes to offset these funding restrictions, or other funding diversions from state priorities.

In the preamble, CMS states the basis for this change stems from federal statute and its current reading that the statute does not permit revenue sources other than state or local tax revenue to be permitted for intergovernmental transfers.[2] However, the statute merely prohibits Health and Human Services from restricting intergovernmental transfers that are derived from state or local taxes.[3] The absence of other tax revenues mentioned in statute does not and should not mean Congress intended these revenues are not to be permitted. Any deduction to this effect would be faulty reasoning as the statute clearly states which revenues cannot be restricted, not which revenues are acceptable. We strongly dispute that a clarification is needed based on this unusual interpretation of the statute.

The proposed limitation also contradicts long-standing practice by CMS to approve such financing arrangements. Many units of government, including non-state-owned government healthcare providers, do not have access to tax revenue. However, these units do have other revenues available to them, which should continue to be available to finance the non-federal share of a Medicaid payment. In the case of non-state-owned government hospitals, this funding includes revenues received from commercial health insurance companies. Other sources of revenues available to state and local governments include revenue generated by lotteries, bond issues, and public tuition. For decades, CMS has approved these legitimate sources of revenues under the aforementioned statute. Given the extensive history of CMS approval of the broad types of funding available to government entities and our strong disagreement with the statutory rationale for this recent proposal, we respectfully request this proposal be withdrawn.

Supplemental Payments
In 42 CFR 447.288, CMS proposes numerous new reporting requirements for states related to supplemental Medicaid provider payments. States would be required to submit new quarterly and annual reports that include provider-specific details related to the payments as well as related intergovernmental transfers and healthcare provider taxes. In 42 CFR 447.302, CMS proposes to require new supporting information to be submitted when states seek to incorporate supplemental payments in their Medicaid state plans, including analyses to justify the continuation of payments. It further seeks to limit approved supplemental payments for a period not to exceed three years.

MHA understands the federal government's need for greater information on these payments given the federal resources that support them. We are not opposed to appropriate transparency in the Medicaid program or other areas of healthcare. However, in any initiative that seeks to increase transparency, important questions related to the administrative work that produces new information must be taken into account. As drafted, we believe the amount of new reporting and requirements related to

[2] 84 Fed. Reg. 63738, (November 18, 2019)
[3] Social Security Act 1906 (w) 6(A)

supplemental payments will create a significant burden on states and healthcare providers. We believe the level of detail required and frequency of reporting will create substantial obstacles that could discourage states from using these appropriate mechanisms. The level of detail required by the state to provide, and for CMS to review, will also affect the timing of the payments. Providers already struggle with the timing and reliability of these important payments. We believe the proposed reporting processes as drafted will negatively affect the receipt of these payments, and worse, may put into question whether the supplemental funding is pursued.

In an ideal world, supplemental payments would not be needed if state Medicaid reimbursement rates covered the cost of providing care to patients. This is unfortunately not the reality, including in Massachusetts where hospital fee-for-services rates reimburse well below the cost of care. With limited resources, supplemental payments are an essential financing approach to ensuring that healthcare providers, including safety net, disproportionate share, and pediatric hospitals, receive added support for the care they provide to Medicaid patients. Supplemental payments help to ensure that access to comprehensive healthcare for low-income people is maintained in communities where large numbers of Medicaid patients live and seek care. While increased transparency is an understandable goal, it must be undertaken in a manner that does not create significant barriers that dissuade states from using these appropriate and needed financing arrangements.

Further, the proposed three-year approval period raises concerns about the need to provide this added level of detail and supporting analysis on a very frequent basis for various supplemental payments. It also raises the question of how this time period would align with 1115 Waivers that can extend as much as five years. As is the case in Massachusetts, supplemental payment arrangements are closely connected with innovations incorporated into the 1115 Waiver, such as our state's ACO program. Safety net providers participating in these innovations are taking on financial risk and making major investments in their organizations over the course of this five-year demonstration. These efforts require predictability and stability in all forms of their financing, including supplemental payments. The proposed three-year term will present conflicting time periods for approved funding sources, creating an unacceptable level of uncertainty and risk for healthcare providers. We strongly encourage CMS to take into consideration this timing concern in any future policy making on this issue.

Certified Public Expenditures

In 42 CFR 447.206, CMS proposes a number of new requirements related to Certified Public Expenditures (CPEs). State Medicaid agencies use CPEs to certify certain expenditures made by other state and public entities for Medicaid-covered services, thereby receiving a federal match. In Massachusetts, this is done for many services administered by our departments of public health, mental health, and developmental services.

One of the proposed changes would require claims that fall under the authority of these agencies to be processed under the state's Medicaid Management Information System (MMIS). As these services are managed and paid for under systems and methodologies separate from the Medicaid program, this would create a new burden and complexity for states. If states were unable to continue to use this permissible financing method in an efficient manner, federal funding for Medicaid-covered services would be put into question and potentially forfeited. Ultimately, a loss in Medicaid funding would negatively affect the program generally, as well as healthcare providers and enrollees. We respectfully request CMS to work collaboratively with states to ensure this appropriate mechanism continues to be available without added restrictions.

In summary, the proposed Medicaid Fiscal Accountability Regulation will result in catastrophic changes in Medicaid programs across the country, if adopted. The ultimate effect of the rule's vague definitions, arbitrary processes, and administrative burdens will be a significant loss of federal support for care provided to Medicaid enrollees. States will have little choice but to make drastic decisions that will negatively affect enrollee access to care and financial support of healthcare providers. Important innovations such as our state's ACO program and commitment to health coverage will suffer.

MHA strives to be constructive in all aspects of policymaking, here in Massachusetts and at the federal level. While we understand the intent of CMS is to improve transparency and ensure program integrity, this proposed rule is too drastic in nature and unworkable. For the many reasons articulated in this letter, we respectfully request this proposed rule be withdrawn. We appreciate your consideration of our comments and would welcome the opportunity to further engage with CMS on this issue.

Sincerely,

Steven M. Walsh
President & CEO
Massachusetts Health & Hospital Association