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January 27, 2020

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

Re: Comments on Medicaid Program; Medicaid Fiscal Accountability Regulation [CMS–2393–P]

Dear Administrator Verma,

On behalf of the Massachusetts Medicaid and CHIP program, known as MassHealth, I am writing to provide comments on the Proposed Rule on Medicaid Fiscal Accountability (the rule).[1] MassHealth provides comprehensive, affordable health care coverage for over 1.8 million low-income Massachusetts residents, including 40% of all Massachusetts children and 60% of all residents with disabilities. MassHealth's mission is to improve health outcomes among our diverse members and families across the Commonwealth by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life.

Massachusetts supports CMS' stated goals of transparency, accountability and good governance; specifically, we support the fact that CMS has made program integrity and provider accountability among its priorities for the Medicaid program as part of its focus on both fiscal sustainability and delivery system reform through accountable care models. Massachusetts has worked closely and collaboratively with CMS to restructure many of its historical supplemental payments, a key subject of the proposed rule.

However, in an attempt to address a wide range of issues in the rule, CMS proposes far-reaching and consequential changes to Medicaid financing and introduces significant new state obligations. If implemented, the rule would represent an unprecedented federal overreach. It would create unnecessary barriers and limitations for states to manage their programs, and undermine states' efforts to reach delivery system and policy goals. In addition, the rule would create significant administrative and

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

operational burdens. Cutting across all of these issues is the fact that the rule is ambiguous and inconsistent.

The restrictions, requirements, risks and uncertainty that this rule creates for state Medicaid programs will ultimately have a negative impact on Medicaid beneficiaries, including children, seniors and individuals with disabilities, who depend on Medicaid for their health care.

Given the expansive scope and negative impacts of the rule on state Medicaid programs, Massachusetts strongly urges CMS to withdraw the rule as proposed and work collaboratively with the states to further its goals of program integrity and provider accountability.

The rule represents an unprecedented federal overreach

The rule aims to comprehensively update CMS's oversight of virtually all state arrangements to finance Medicaid state share, including health care related taxes and provider donations, intergovernmental transfers (IGTs), certified public expenditures (CPEs), and supplemental payments. This proposed rule exceeds CMS' statutory authority.

The rule proposes the use of a number of overly broad and indefinite standards of review to be used by CMS in analyzing aspects of payment and financing arrangements, including "totality of circumstances" and "net effect" tests. These tests can be used, among other things, to determine whether any exchange in value is a provider-related donation, whether any fee or assessment is a health care-related tax, and whether any newly identified or existing financial arrangement meeting either definition is permissible.

The poorly defined scope of these standards of review grants CMS nearly unlimited discretion to scrutinize the financial transactions of the Medicaid agency, providers, certifying entities, and other parties. This gives CMS significant leeway to make subjective decisions on what is a permissible state financing mechanism, creating significant uncertainty for states, both in terms of what current programs will remain allowable and what future programs might be approved by CMS. These provisions are highly susceptible to arbitrary and capricious application, particularly across administrations, and Massachusetts requests that they be removed if the rule is finalized.

The rule also imposes arbitrary limits on common financing arrangements. For example, the rule limits permissible certified public expenditures (CPEs) only to "payments" made to State government or non-State government "providers", such as a municipality. The rule also sets forth a prescriptive payment methodology for CPEs, requires that all claims related to CPEs be processed through a state's Medicaid management information system (MMIS), and requires that the certifying entity "receive and retain" the full amount of federal financial participation (FFP) associated with the CPE. Even for the types of CPEs for which this methodology could be appropriate, CMS has not provided justification for why that is the *only* permissible process and methodology. States currently use, and CMS has historically approved, other processes and methodologies that accomplish the same goals of tying expenditures to specific services and enrollees, and ensuring that certified expenditures do not exceed costs. Massachusetts requests that CMS continue to allow states the flexibility to utilize alternative methodologies where appropriate to meet policymaking and delivery system reform goals.

In addition, the rule's new requirements for intergovernmental transfers (IGTs) are problematic and more restrictive than the statute allows. These new requirements are also a significant departure from longstanding policy and practice. Specifically, the rule's requirement that IGTs must be derived from state or local taxes (or funds appropriated to state university teaching hospitals) is unjustified and is not supported by the underlying statute. By restricting the source of the non-federal share as proposed, CMS

is overlooking and prohibiting the use of other legitimate sources of state or local funds, such as bond issues, lottery funds, public college tuition, revenues from health care services provided by public providers, and other non-tax revenues. This proposed requirement is especially concerning in its interference of state autonomy to fund their share of Medicaid.

Imposes unnecessary limitations on policymaking and delivery system reform

The rule poses significant challenges for states and interferes with the legitimate and appropriate role of the state in the Medicaid program's federal-state partnership. The ambiguous and inconsistent nature of the rule creates significant uncertainty for states and would impose severe limitations on states' flexibility to channel funding toward new policy and delivery system reforms.

The rule would redefine "public funds" as "state and local funds" for purposes of specifying the permissible state share of Medicaid payments, and would impose an additional requirement that appropriations of these funds can only be considered state share if they are appropriated directly to the Medicaid agency from the state's general fund and do not include federal funds. It is simply not practical for earned federal revenue deposited in a state's general fund (and mixed with other revenue generated by the state through tax revenue, non-tax revenue, or some other source) to be segregated out for purposes of an appropriation, and CMS should not assert or maintain control over such revenue once it has been paid to a state and deposited in its general fund.

These proposed new restrictions on standard general fund appropriations would also hinder the role of state sister agencies in helping to accomplish the goals of the Medicaid program. Many state Medicaid agencies partner with sister agencies, such as agencies serving the elderly, individuals with intellectual and developmental disabilities, or individuals with substance use disorders, to provide covered Medicaid services directly or through contracted providers to some of their most vulnerable populations. These new restrictions on the use of standard general fund appropriations would substantially impact state operations that rely on sister agencies to best serve the Medicaid population.

In addition, the rule's handling of managed care organization (MCO) provider payments marks a departure from current practice. It appears that the rule will now require states to include payments to providers from MCOs for services rendered to Medicaid beneficiaries enrolled with those plans when calculating the state's upper payment limit (UPL). CMS recently implemented a wide-ranging managed care rule that created comprehensive processes and governance for directed and pass-through payments made through managed care vehicles. The managed care rule explicitly prohibits states from directing the expenditures of its MCOs, expect in certain limited circumstances that require special CMS authorization. Requiring a state to include MCO provider payments in its UPL demonstration could lead to unreasonable limitations on the state for actions outside of the state's control: namely, the rate-setting and benefit coverage decisions of its managed care contractors. Additionally, MCOs are permitted to cover services beyond those included under the state plan, and in an amount, duration, and scope that exceeds those covered under the state plan. Requiring these payments to be included in the UPL could unfairly impact the state based on the decisions of its managed care contractors to cover additional services. Massachusetts therefore requests that CMS clarify that states are not required to include MCO provider payments in their UPL calculations and continue to allow the current managed care rule to govern these payments.

Finally, the rule does not provide adequate guidance as to how its provisions will apply to supplemental payments for which states have existing approvals from CMS through section 1115 demonstrations, creating instability for states and providers. For instance, some approved section 1115 demonstrations already include detailed limits and requirements governing the supplemental payments authorized through those vehicles. Similarly, the rule includes a three-year approval cycle for supplemental

payments, while most supplemental payments approved through section 1115 demonstrations align with the five-year authorization period for such waivers. The rule does not describe how it would interact with those requirements or limits and creates confusion for states that are planning efforts to advance value-based care and delivery system reforms through those demonstrations. At minimum, Massachusetts requests that CMS clarify that any requirements or limits on a supplemental payment set forth in an existing section 1115 demonstration will govern the payment for at least the term of the demonstration.

The rule creates significant administrative burden and is operationally impractical

The rule introduces substantial new requirements for detailed quarterly and annual reporting on supplemental payments, including reporting on the business dealings of private entities that are not available to the state. Increasing mandatory reporting represents an enormous burden for states and providers. Massachusetts is also concerned that the reporting requirements attached to the periodic renewal of state plan authority of supplemental payments will result in a high volume of renewal requests that could result in substantial delays in processing state plan amendments.

The rule also creates the potential for substantial new ad hoc demands for information by CMS, as each potential program, arrangement, fee, assessment, or donation is considered under the vague and broad standards of review discussed above. This could exacerbate the administrative burden on states and providers, and result in potential delays by CMS as it attempts to digest and process this information. Such proposed requirements introduce potential new costs to state reporting systems as well as stress on state budgets and staff. Delays in approvals of necessary payments can also negatively impact providers and members' access to services. At minimum, Massachusetts requests that CMS delay implementation of these reporting requirements and associated potential FFP withholds, eliminate the quarterly reporting requirements entirely, and scale back the information required in the annual reports.

Conclusion

For the reasons described above, Massachusetts strongly urges CMS to withdraw the proposed rule. If re-proposed, we urge it be submitted if and when substantial revisions are made that address the unprecedented federal overreach it represents, the unnecessary limitations for policymaking and delivery system reforms it imposes, and the burden it will place on states. Massachusetts welcomes the opportunity to engage with CMS about these specific concerns with the proposed rule and how we might partner to more reasonably and effectively achieve the aims of transparency, accountability, and integrity.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth and Medicaid Director