



January 31, 2020

The Honorable Alex Azar, Secretary of Health and Human Services
The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-2393-P (Medicaid Fiscal Accountability Regulation)

Submitted via regulations.gov

Dear Secretary Azar and Administrator Verma:

Families USA is pleased to provide comments on CMS-2393-P, the *Medicaid Fiscal Accountability Regulation*. Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals.

The Medicaid program and its sister program, the Children's Health Insurance Program (CHIP), form the backbone of the nation's health care safety net, providing health care coverage to a diverse group of more than 70 million beneficiaries. Among those covered by Medicaid and CHIP are 35 million children (nearly half of all enrollees), and more than 15 million people with disabilities and low-income seniors. Medicaid covers more than half of all births in the country and covers more than sixty percent of all nursing home residents. It is on behalf of these low income and vulnerable enrollees that we provide these comments. Because Medicaid coverage is so vital to millions of families, Families USA strongly supports program integrity in Medicaid. Any dollar spent in Medicaid that is misused or does not further the program's intent is wasted and should be redirected to the benefit of enrollees.

Since its inception in 1965, Medicaid statute contemplates various ways in which states can pay for part of their share of Medicaid spending outside of use of general funds.¹ Over the years, previous congresses and administrations have taken steps to stop abuses and misuses of these financing mechanisms. The proposed Medicaid Fiscal Accountability Rule propagated by the Centers for Medicare and Medicaid Services (CMS) seeks to improve transparency regarding how states finance the non-federal share of Medicaid spending – in particular, the use of Intergovernmental Transfers

(IGTs), Certified Public Expenditures (CPEs), and provider taxes – and supplemental payments to certain Medicaid providers – in particular, Medicaid Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments. Further, the rule would substantially curtail certain financing arrangements and supplemental payments. **While we appreciate the administration’s interest in ensuring program integrity, the vagueness of the rule, its lack of required impact assessment, and the potentially disastrous consequences of the rule on beneficiary access to care dictate that we strongly urge CMS to withdraw the regulation in its entirety.**

This comment letter seeks to address the following issues:

- Lack of clarity regarding rule implementation
- Lack of required impact assessment of the rule
- Potential negative impact on beneficiaries
- Recommended next steps

Lack of Clarity Regarding Rule Implementation

Despite having potentially profound impacts on access to care for Medicaid beneficiaries, the proposed regulation is breathtakingly vague. The proposed rule would seek to implement vague new tests referred to throughout the rule, such as “net effect” or “totality of the circumstances” to determine whether ongoing financing arrangements comply with federal law. The “totality of the circumstances” standard is not further defined in the rule, while the “net effect” definition refers to the otherwise undefined “totality of circumstances” standard.² Thus, the subjective nature of these tests will make it hard for states to know whether their payment arrangements will pass muster, creating uncertainty and a potential chilling effect that could lead states to curtail their programs to protect against a worst case scenario.

Further, the vagueness of those requirements, and lack of clarity in how the rule will be implemented, give rise to deep concerns that the rule could be implemented by this or future administrations in a way that is partisan, arbitrary, or capricious. The vagueness of the rule also makes it impossible for beneficiary advocates to properly assess how this rule will impact access to care for enrollees, a problem that is exacerbated by the rule’s lack of required impact assessment, as discussed below.

Lack of Required Impact Assessment

We are concerned that in propagating this rule without a thorough impact analysis, CMS may have violated by the Administrative Procedures Act (APA) and Executive Order (E.O.) 12,866. The executive order requires agencies to conduct a cost-benefit analysis, including the economic impact of a proposed rule. In the proposed rule, and in clear violation of those requirements, CMS explicitly states that *“the fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is*

*unknown.*³ The legal importance of these impact analyses cannot be over stated. In fact, courts have held that when agencies rely on a cost-benefit analysis as part of their rulemaking, a serious flaw undermining that analysis can render the rule unreasonable and therefore invalid.⁴

With literally the lives of millions of low-income and vulnerable children, seniors, and people with disabilities at stake, it is deeply irresponsible and illegal for CMS to propose finalizing and implementing this rule.

Potential Negative Impact on Beneficiaries

The financing mechanisms contemplated in this rule – IGTs, CPEs, and provider taxes – have been a major source of non-federal share derived by states since the inception of the Medicaid program. In fact, these funding mechanisms are so ubiquitous an analysis recently released by the American Hospital Association, found that this proposed regulation would threaten \$37-49 billion in annual Medicaid spending, or between 5.8 – 7.6 percent of the total program.⁵

It is important to note that the impact of the rule would fall particularly hard on key safety net providers that rely on targeted supplemental payments, including public, and other safety net hospitals, and nursing homes. These institutions provide a disproportionate amount of care to low-income and vulnerable patients – both those enrolled in Medicaid and others – and often operate on relatively narrow financial margins. To the extent that this rule damages the financial health of these vital institutions, it is unquestionable that irreparable harm would occur to Medicaid beneficiaries.

Recommended Next Steps

In the preamble to the proposed rule, CMS says “... *the goal of this proposed rule is to strengthen overall fiscal integrity of the Medicaid program.*”⁶ We appreciate this goal and believe CMS has an important interest in ensuring program integrity. Medicaid financing arrangements are often opaque and difficult to track. Much of the rule focuses on substantially enhanced reporting from states, localities, and individual providers regarding their role in financing the non-federal share of Medicaid, and in receiving supplemental payments. Unfortunately, the rule goes far beyond requirements for additional reporting. It simultaneously seeks to ban long-standing financing and payment arrangements. Without reviewing the information provided through these new transparency requirements before banning the financing mechanisms, CMS truly would be “putting the cart before the horse” – with people’s lives on the line.

Given the profound potential negative consequences on beneficiaries, the vagueness in which new requirements are described, and the irresponsible lack of impact analysis conducted by CMS, we strongly urge CMS to:

- 1) Withdraw this rule in its entirety.**
- 2) Consider a new rule, which focuses exclusively on enhanced reporting and transparency requirements.**

Once CMS has gathered and publicly disseminated accurate information regarding the financing arrangements and payments in question, it may use this information to consider whether to propose a new rule that makes changes to how states finance the non-federal share of their Medicaid programs and how supplemental payments are made to providers. Such a rule should include a full impact analysis and be developed in careful consultation with state Medicaid agencies, Medicaid beneficiary advocates, Medicaid providers, and other stakeholders.

We appreciate the opportunity to submit these comments. If you have any questions, please contact Shawn Gremminger at sgremminger@familiesusa.org or 202-626-0612.

Respectfully Submitted,



Frederick Isasi, JD, MPH
Executive Director
Families USA

¹ 42 CFR 433.51; § 433.68-433.72; § 433.54; § 433.66-433.67

² § 433.52 G

³ 84 FR 63773

⁴ Nat'l Ass'n of Home Builders v. EPA, 682 F.3d 1032, 1040 (D.C. Cir. 2012); see also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983)

⁵ American Hospital Association. "Fact Sheet: Medicaid Fiscal Accountability Regulation," 2020. <https://www.aha.org/system/files/media/file/2020/01/fact-sheet-medicaid-fiscal-accountability-rule-mfar.pdf>

⁶ 84 FR 63722