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The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS-2393-P, Medicaid Program; Medicaid Fiscal Accountability Regulation.

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members – all of which treat Medicaid patients in their safety net role – include teaching and non-teaching full-service local hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our views in response to the proposed Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,772 (Nov. 18, 2019) (Proposed Rule).

General Comments

Medicaid's continued fiscal strength and overall stability is essential for beneficiaries, providers, and for states. As you know, state and federal governments together finance the cost of the Medicaid program. Since its inception, the states and the federal government have successfully combined forces with healthcare providers to ensure that over 70 million of the country's most vulnerable citizens are able to access necessary medical care. These include individuals who are elderly, blind, disabled, and children and adults living with income below or near the federal poverty level. Medicaid, as the country's payer of last resort is often the final lifeline for low-income Americans in need of medical care making its continued availability essential.

Although the FAH supports CMS's goals of promoting transparency and ensuring that state plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan the FAH strongly opposes and urges CMS to withdraw the Proposed Rule, for the reasons described below.

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CMS’s Proposal Significantly Limits State Flexibility

If the Medicaid Fiscal Accountability Rule (MFAR) were to be finalized as proposed, it would threaten access to health care services and undermine Medicaid programs across the country. The consequences include impeding access to Medicaid services, and threatening the fiscal health of states and of many health care providers.

Federal law authorizes states to fund the non-federal share of Medicaid payments from a variety of sources, including state general funds, provider taxes, and intergovernmental transfers (IGTs). Rather than protecting states’ ability to use those sources of funds to provide adequate Medicaid care, services, and payments, the proposed rules aim to limit or restrict states’ flexibility to finance their share of Medicaid. This would shift additional costs to states or result in program cuts. Rather than increasing Medicaid’s fiscal integrity, we fear that the proposals, if finalized could have the opposite impact on the fiscal health of Medicaid programs and the states. The rules would reduce states’ flexibility to identify and choose the sources of state funds for their state matching share thereby reducing states’ ability to fund their Medicaid programs. The implications for consumers’ access to care and for ensuring the availability of critical providers could be consequential.

The Proposed Rule’s “Clarifications” Represent a Major Expansion of Federal Regulatory Control, Contrary to the Medicaid Act

In the preamble to the Proposed Rule, CMS repeatedly states that the Proposed Rules are largely clarifications or codifications of existing policies. The FAH disagrees. Many of the provisions substantially expand CMS’s regulatory authority over states and eliminate states’ ability to finance their Medicaid program costs, despite CMS’s lack of any statutory direction to do so. Indeed, a number of provisions—rather than clarifying CMS’s approach for reviewing supplemental payments and state share financing—incorporate unspecified and highly subjective language to usurp a state’s authority to manage its budget, assess taxes, and set individual payment rates within federal statutory limits. These changes transfer vast amounts of regulatory responsibility from states to CMS and create such vague standards that it would be nearly impossible for states to know with any certainty that CMS would continue to approve their existing programs, despite prior approvals. The Medicaid Act is clear that Congress never intended to confer this level of regulatory control to CMS.

Specifically, the Proposed Rule rejects payments that take into account available financing, that exceed what CMS believes a state should pay an individual provider, or that CMS perceives, in its sole discretion, as not an “equitable distribution.”¹ CMS’s proposed changes significantly limits a state’s ability to analyze its own budget to determine the amount to pay specific types of providers. If states are unable to consider available financing or available access in allocating payments, it will threaten access to patient care for elderly, underserved, and vulnerable patient populations.

The Proposal Will Result in Underfunding of Critical Medicaid Providers

Payment rates are required by federal law to be “consistent with efficiency, economy, and quality of care and ... sufficient to enlist enough providers so that care and services are

¹ Medicaid Program; Medicaid Fiscal Accountability Regulation 84 Fed. Reg. 63,722, 63,724 (Nov. 18, 2019) [hereinafter “Proposed Rule”].

available” to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area.²

Despite those requirements, on average, base payments to hospitals for inpatient hospital services are and have historically been well below hospitals’ costs of providing services to Medicaid enrollees and below Medicare payment rates for comparable services. In 2011, for example, fee-for-service (FFS) base payment rates were 78 percent of Medicare rates for a set of 18 Medicare-severity diagnostic-related groups examined by MACPAC.³ Base payments also grow more slowly than general cost growth -- especially in economic downturns. The result has been significant underpayments.⁴ For example, the American Hospital Association estimates that in 2017, Medicaid underpaid hospitals by a total of \$22.9 billion (Medicaid shortfall).⁵ This is problematic because provider payment rates are an important determinant of provider participation and access to services for Medicaid beneficiaries.⁶

States, however, have relied on supplemental payments to offset the traditionally low levels of Medicaid base payments. According to the Commonwealth fund, after the recession of 2008, supplemental payments became an essential strategy for states to ensure that access to services could be maintained.⁷

To the extent that these rules, if finalized, impose barriers or increase disapprovals of states’ supplemental payment programs, providers may be forced to rely on only base payments for Medicaid services. Inadequate payments rates threaten the continued financial stability of healthcare providers and can impact participation.⁸

Weak federal oversight of base payment rates and the resulting impact on access to care only serves to compound the problem and efforts to strengthen state monitoring have been unsuccessful. For example, final regulations established in 2015 that required states to

² 42 U.S.C. 1396a(a)(30)(A).

³ MACPAC Issue Brief, *Medicaid Base and Supplemental Payments to Hospitals*, March 2019, <https://www.macpac.gov/wp-content/uploads/2018/06/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf>

⁴ Kaiser Family Foundation, *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, June 9, 2016, <https://www.kff.org/report-section/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes-issue-brief/>

⁵ American Hospital Association, *Underpayment by Medicare and Medicaid Fact Sheet*, January 2019, <https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf>

⁶ Bienstock, J. *Administrative oversight of State Medicaid Payment Policies: Giving Teeth to the Equal Access Provision*. https://www.acslaw.org/wp-content/uploads/old-uploads/originals/documents/Bienstock_Note%20-%20Administrative_Oversight_of_State_Medicaid_Payment_Policies.pdf; and Cunningham, P.J. and Nichols, L.M. *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, 62 MED. CARE & RESEARCH 676 (2005).

⁷ Mann, C. and Bachrach, D. *Integrating Medicaid Supplemental Payments into Value-Based Purchasing*, November 22, 2016, <https://www.commonwealthfund.org/publications/fund-reports/2016/nov/integrating-medicaid-supplemental-payments-value-based>.

⁸ Sack, K. As Medicaid Payments Shrink, Patients are Abandoned, *New York Times*, March 15, 2010.

assertively monitor access have been weakened, and recently proposed eliminated by the current Administration.⁹

We are further concerned that proposals that threaten supplemental Medicaid payments will undermine the financial viability of hospitals. The combination of reductions to supplemental payments under this MFAR with the coming reduction in Medicaid Disproportionate Share Payments required by federal law likely altogether will have a devastating impact on hospitals. These changes are occurring as the number of Medicaid beneficiaries are increasing and the proportion of those beneficiaries who are older and have multiple chronic conditions is rising. The continued ability to meet the needs and expectations of the Medicaid population while experiencing large and growing Medicaid shortfalls is a major cause for concern.

CMS's Lack of Impact Analysis Makes the Rule Impermissible

Although the FAH supports CMS's goals of promoting transparency, and ensuring that state plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan, the FAH strongly opposes the finalization of the Proposed Rule because CMS has not analyzed, and stakeholders have not had an opportunity to comment on, any assessment of the likely impact of the Proposed Rule on state plan rates, quality of care, and equal access to services for Medicaid beneficiaries. *Congress tasked CMS with the important responsibility of ensuring that Medicaid payment for services are consistent with the quality of care and equal access to care "at least to the extent that such care and services are available to the general population in the geographic area."*¹⁰ *CMS, however, has failed to conduct or consider any analysis related to the Proposed Rule's impact on rates, quality of care and equal access, contrary to explicit statutory requirements.* In fact, the Proposed Rule states, "The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."¹¹ *Therefore, the FAH urges CMS to withdraw the Proposed Rule and instead work with stakeholders—including providers, health plans, beneficiaries, and State Medicaid agencies—to identify the data needed to determine that Medicaid payments are made in a manner consistent with federal statute and regulations, including Section 30(A).*

The overarching federal substantive requirement with respect to Medicaid payment policies is found in Section 30(A).¹² Under this section, CMS has the important responsibility of ensuring that state plan payments for medical assistance "assure that payments are consistent with efficiency, economy, and *quality of care*" (emphasis added). CMS must also assure that payments comply with the "equal access" requirement, meaning that they "are *sufficient to enlist enough providers* so that care and services are available under the plan at least *to the extent that such care and services are available to the general population* in the geographic area" (emphasis added). Notably, in approving Medicaid state plan payments, CMS must make an administrative decision that payment rates are consistent with Section 30(A). As CMS acknowledges in the Proposed Rule, were state plan payments to result in

⁹ Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, Final Rule, 80 *Federal Register* 67576 (November 2, 2015) and Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission, Proposed Rule, 84 *Federal Register* 33722, (July 2019).

¹⁰ 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

¹¹ 84 Fed. Reg. at 63,773.

¹² 42 U.S.C. § 1396a(a)(30)(A).

insufficient access, CMS would require the state to increase rates to rectify the access problem.¹³

Given the clear correlation between the adequacy of Medicaid payments and access to quality care, the FAH remains concerned that the impact of the Proposed Rule on Medicaid payments would result in catastrophic rate cuts to providers, which would undermine quality of care and equal access. Yet, CMS has completely failed to consider the impact of the Proposed Rule on Medicaid payments and access to services for Medicaid beneficiaries. CMS acknowledges in the Proposed Rule that it has the authority to collect data to conduct such an analysis, and yet CMS has neither collected such data nor requested States to submit such data in order to provide stakeholders with an appropriate impact analysis for the Proposed Rule.¹⁴

CMS may not properly finalize the Proposed Rule without studying the effect it would have on Medicaid payments, evaluating the impact that such payment reductions would have on quality of care and equal access, and obtaining stakeholder comments on the Proposed Rule in light of this impact analysis. The impact on Medicaid payments to providers, and on quality and access are clearly *relevant factors*, which CMS is obligated to consider, and to then demonstrate a reasonable connection between the Proposed Rule and the furtherance of Congress' intent that Medicaid rates be consistent with quality of care and equal access as set forth in Section 30(A).

This data-based analysis is particularly critical because CMS has recently undertaken to eliminate the process for states to demonstrate that their state plans satisfy Section 30(A). In 2015, CMS issued a final rule (2015 Final Rule) designed to strengthen CMS's review and enforcement of the sufficiency of Medicaid payments by requiring states to submit specific access monitoring data related to rates and access.¹⁵ However, in September 2017, CMS issued a transmittal letter carving out numerous exceptions to states' access monitoring obligations that were not contemplated by the 2015 Final Rule.¹⁶ Then, in July 2019, CMS proposed to rescind the 2015 Final Rule altogether.¹⁷ The FAH is concerned that CMS's recent actions related to the elimination of access monitoring and data reporting requirements severely compromise the agency's ability to fulfill its obligation of assuring that Medicaid payments are consistent with Section 30(A). CMS's ability to fulfill this obligation, and oversee state plan payments, is particularly critical when judicial limitations on review of provider challenges under Section 30(A) are considered. ***In light of CMS's proposed elimination of the access monitoring requirements as well as CMS's obligations under Section 30(A), the FAH urges CMS to study the effect its proposals would have on Medicaid payments, along with any related impact on quality of care and equal access and***

¹³ 84 Fed. Reg. 63722, 63743-44 (Nov. 18, 2019).

¹⁴ 84 Fed. Reg. 63722, 63747 (discussing state reporting authorities under the Social Security Act and explaining "[t]he submission of more robust payment data would assist us in providing proper oversight of the Medicaid program in determining the state Medicaid payments are made in a manner consistent with federal statute and regulations, including section 1902(a)(30)(A) of the Act").

¹⁵ 80 Fed. Reg. 67576 (Nov. 2, 2015).

¹⁶ SMD # 17-004, "Medicaid Access to Care Implementation Guidance" (November 16, 2017).

¹⁷ 84 Fed. Reg. 33722 (July 15, 2019)

then provide an opportunity for stakeholders to comment on the impact analysis and any resulting proposals.

The Proposed Rule Impacts Rural Hospitals in a Disproportionately Negative Way

In many rural areas, healthcare-related tax programs are integral to financing Medicaid payments, and, in some cases, may represent the only option for this financing. Given the Proposed Rule could effectively ban states from using health care-related taxes for Medicaid financing, the rule represents a direct threat to health care in rural areas.

Elimination of any financing mechanisms will undoubtedly result in more hospital closures and further reductions in access to healthcare in some rural communities.

Comments on Specific Provisions of the Proposed Rule

I. Sources of Non-Federal Share

The FAH opposes the adoption of the proposed changes to § 433.51, which would drastically rewrite long-standing rules addressing how states may finance the non-federal share of Medicaid payments in a manner that imposes new restrictions that are inconsistent with the intent of Congress. The changes to proposed § 433.51(a) removes the longstanding reference acknowledging that states may use “public funds” as the non-federal share, and replaces it with “State or local funds.” Proposed § 433.51 then proceeds to place limitations on the use of monies derived from tax revenues or other sources, intergovernmental transfers (IGTs) and certified public expenditures (CPEs).

A. The Medicaid Act Does Not Give CMS Authority to Limit State Contributions to the Non-Federal Share to “State General Fund Dollars”

The FAH opposes the amendment to paragraph (b)(1) which would limit the source of permissible State contributions of the non-federal share to “State General Fund dollars appropriated by the State legislature directly to the State or local Medicaid agency.”¹⁸ The Medicaid statute makes no reference to “state general funds,” and states access many funding sources that might not qualify under this new, undefined regulatory term. Failure to remove this proposed restriction would jeopardize state Medicaid funding in numerous states which rely upon special funds—which are monies that are owned by the state that are typically dedicated for specific purposes—to finance the non-federal share. Like the State’s General Fund, these monies may be derived from tax revenue or from other sources, and they are clearly state funds to the same extent as monies in the General Fund. There is neither a reasonable justification nor authority in the Medicaid Act to restrict the use of these funds. As a result, the FAH urges CMS to remove the proposed language limiting State funds to State General Fund dollars appropriated directly to the Medicaid agency.

¹⁸84 Fed. Reg. 63722, 63737 (Nov. 18, 2019)

B. The proposed derived-from-taxes requirement for IGTs departs from long-standing policy and is not required by statute

In proposed section 433.51(b)(2), CMS proposes to limit IGT funds to those “derived from State or local taxes (or funds appropriated to State university teaching hospitals)”¹⁹ on the basis that the statute, 42 U.S.C. § 1396b(w)(6)(A), *requires* this limitation.²⁰ This contention disregards the statutory flexibility provided to states under the Medicaid Act.

CMS previously asserted this derived-from-taxes requirement in its 2007 proposed rule,²¹ and stakeholders have repeatedly explained that this is a misreading of the statute that would “radical[ly] curtail[] the types of public funds that have traditionally been used as the non-Federal share of Medicaid expenditures.”²² These same comments and concerns continue to apply to the current proposal.

Moreover, CMS’s assertion that the current regulation “*has led to* state requests to derive IGTs from sources other than state or local tax revenue (or funds appropriated to state university teaching hospitals)”²³ is belied by the fact that states have a history—predating even the enactment of the Medicaid program—of relying on local sources of funding other than state or local tax revenue to support healthcare for the indigent. In fact, CMS has previously confirmed that non-tax revenue of a unit of government is a permissible source of nonfederal share of Medicaid payments. For example, CMS (then the Health Care Finance Administration (HCFA)) affirmatively stated in 1991 that “States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds from *any governmental source* (other than impermissible taxes or donations derived at various parts of the State government or at the local level).” (57 Fed. Reg. 55118 (Nov. 24, 1992) (as corrected 58 Fed. Reg. 6096, Jan. 26, 1993), *emphasis added*). Moreover, in its 2007 final rule, CMS cited with approval the use of “fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds,” and “patient care revenues from other third party payers and others” as permissible sources of funds for IGTs from units of government.²⁴ Against this backdrop, CMS’s current proposal to adopt a “derived-from-taxes” requirement in § 433.51(b)(2) cannot be properly portrayed as an attempt to cure a misunderstanding flowing from the regulatory text or as fulfilling a statutory mandate. Rather, this proposal represents a significant

¹⁹ 84 Fed. Reg. at 63,776 (proposed 42 C.F.R. § 433.51(b)(2)).

²⁰ 84 Fed. Reg. 63,737 (stating that the derivation of IGTs from sources other than state or local tax revenue (or funds appropriated to state university teaching hospitals) “is **not permitted under the statute** in section [1396b](w)(6)(A)”) (*emphasis added*).

²¹ Proposed Rule, Cost Limit for Providers Operated by Units of Government, 72 Fed. Reg. 2,236, 2,246 (Jan. 18, 2007) (proposed 42 C.F.R. § 433.50(a)(1)).

²² Joint Comments of 17 States (Mar. 20, 2007) (comments from Alaska, Connecticut, Illinois, Louisiana, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Washington, and Wisconsin); *See, e.g.*, Comment Ltr. Of 58 U.S. Senators (Mar. 20, 2007) (“Current law does not limit the types of local sources that may be used to only those sources derived from tax revenue.”); Comment Ltr. Of Tex. Health & Human Svcs. Comm’t (Mar. 16, 2007); Comment Ltr. Miss. Div. of Medicaid (Mar. 19, 2007).

²³ 84 Fed. Reg. 63,737.

²⁴ *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership*, 72 Fed. Reg. 29,748, 29,766 (May 29, 2007) (CMS subsequently retracted the rules, but the accompanying guidance remains illustrative).

departure from longstanding policy that is not required by statute and not rationally explained in the Proposed Rule.

Departure from CMS’s longstanding policy will severely jeopardize an extraordinary amount of crucial Medicaid funding nationwide, as numerous state Medicaid programs rely upon non-tax revenue of a unit of government as a permissible source of IGTs used to fund the non-federal share. As noted, CMS has failed to collect and/or provide data assessing the magnitude of Medicaid funding which would be compromised by the proposed derived-from-taxes rule, despite its statutory obligations under Section 30(A). ***The FAH stresses that a derived-from-taxes rule will likely lead to a reduction in available Medicaid funding, jeopardizing the adequacy of Medicaid payments and access to care.*** The derived-from-taxes rule is also operationally infeasible insofar as it might require local governments (and universities) to trace the source of funds used for IGTs so that it could be demonstrated that the IGTs were derived from local tax revenue (or state appropriations, in the case of universities). However, money is fungible – and such tracing would place an undue burden on the use of local funds. Finally, the Proposed Rule is inconsistent both with Congressional intent and CMS’s longstanding policy. ***As such, the FAH strongly opposes the proposed restrictions placed upon IGTs in the Proposed Rule.***

C. Proposed subsection (d) impermissibly restricts funds that are “related” to but not “derived” from donations and taxes under 41 U.S.C. § 1396b(w)(6)(A)

CMS proposes to add a new subsection (d) to 42 C.F.R. § 433.51 to “clearly indicate that state funds provided as an IGT . . . but that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation.”²⁵ CMS continues, stating that proposed subsection (d) prohibits “any IGTs that are derived from, or are related to, non-bona fide provider-related donations.”²⁶ Although CMS asserts that this provision is “intended to implement the preclusion under” 42 U.S.C. § 1396b(w)(6)(A), the proposed language exceeds CMS’s statutory authority. Congress only permits CMS to restrict IGTs if the IGTs are “derived by the unit of government from donations or taxes that would not otherwise be recognized” as permissible.²⁷ If funds are “related to” but not “derived” from such donations and taxes, CMS is barred by statute from restricting the use of those funds and CMS “shall not consider [such IGT funds] to be a provider-related donation or a healthcare-related tax.”²⁸ Because proposed subsection (d) would treat some IGTs as non-bona fide provider-related donations even though the funds were not “derived . . . from” unallowable sources, the proposal exceeds CMS’s statutory authority.

Furthermore, the proposal goes far beyond implementing any statutory language—it invents entirely new concepts and terminology when it provides that funds may not be considered as the state share if they are “contingent upon” or “actually replaced in the accounts of” the transferring unit of government from an unallowable source. These novel phrases are not found in the Medicaid statute, and they are not defined in the proposed rule.

²⁵ 84 Fed. Reg. at 63,738.

²⁶ *Id.*

²⁷ 42 U.S.C. § 1395b(w)(6)(A).

²⁸ *Id.* at § 1396b(w)(6)(A) – (B).

As written, they appear designed to give CMS broad discretion to point to unrelated transactions or practices. This level of discretion is inconsistent with the Medicaid statute.

D. The Medicaid Act Does Not Give CMS Authority to Require the Retention of Funds Derived from CPEs, and Such a Requirement Would Be Administratively Burdensome

With respect to CPEs, CMS proposes an unworkable and burdensome payment retention rule in §§ 447.206(b)(4) and 447.207. Under this proposed rule, “[t]he certifying entity of the [CPEs] must receive and retain the full amount of Federal financial participation associated with the payment, consistent with the cost identification protocols in the Medicaid State plan and in accordance with § 447.207.”²⁹ Proposed § 447.207 would require providers “to receive and retain the full amount of the total computable payment for services furnished under the approved State plan.”³⁰ Moreover, the Proposed Rule would inappropriately confer broad discretion to “determine compliance” with this section.

CMS states that proposed § 447.206 is the codification of longstanding policies in Sections 1902(a)(4), (a)(30)(A) and 1903(w)(6)(A) of the Act. However, the retention requirements from proposed § 447.207 are outside the scope of any of these statutory authorities, as no such restrictions are placed upon CPEs under the Social Security Act. Moreover, the proposed restriction is infeasible because money is fungible, and it is unclear how states could monitor the retention of funds. In fact, in a 2001 letter to the Office of Inspector General (OIG) responding to a draft OIG report HCFA, disagreed with the OIG’s recommendation that state plans should assure that supplemental payments will be retained by the hospitals and used to provide services to Medicaid-eligible individuals, saying “HCFA does not have the authority to prescribe how facilities are to use the Medicaid payments they receive from state Medicaid agencies.”³¹ The proposed payment retention rule is thus impracticable, exceeds CMS’s authority, and is not reasonably related to the “proper and efficient operation of the state plan.”

For the forgoing reasons, the FAH believes that CMS should retain current § 433.51 in its entirety, as it works with stakeholders to identify more appropriate means of ensuring the proper and efficient use of Medicaid funding.

II. Bona-Fide Donations

The FAH opposes CMS’s proposed expansion of “provider-related donation,” and the “hold harmless” restrictions for bona-fide donations. Proposed §§ 433.52 and 433.54 would use broad and ambiguous standards of “totality of circumstances,” “net effect,” and “reasonable expectation” to define what constitutes a provider-related donation and when a hold harmless practice exists. The Proposed Rule also would authorize CMS to make such a finding “regardless of whether the arrangement is reduced to writing or is legally

²⁹ 84 Fed. Reg. at 63,779 (Proposed 42 C.F.R. § 447.206(b)(4)).

³⁰ *Id.* (Proposed 42 C.F.R. § 447.207).

³¹ OIG, Review of Medicaid Enhanced Payments to Hospitals and the Use of Intergovernmental Transfers in North Carolina, App. B (June 2001) (A-04-00-00140), at <https://oig.hhs.gov/oas/reports/region4/40000140.pdf>; see also, OIG, Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers, App. C. (Sep. 2001) (A-03-00-00216), at <https://oig.hhs.gov/oas/reports/region3/30000216.pdf> (“Once a Medicaid payment is made to a medical provider, the funding is then available to that provider to use as the provider sees fit.”).

enforceable.” The proposed definitions of “net effect” and “provider-related donation” and the proposed hold harmless provision of the bona fide donations rule would each incorporate a “totality of the circumstances test.” At present, the Medicaid regulations do not contain a single reference to a “totality of the circumstances” test,³² but the Proposed Rule proposes to incorporate this test into eight separate regulatory provisions,³³ a proposal that would jeopardize the predictable application of Medicaid financing rules and risk evolution in CMS’s emphasis on various circumstances over time without the benefit of notice-and-comment rulemaking.

It is axiomatic that laws should provide explicit standards for those who apply them in order to prevent arbitrary and discriminatory enforcement. The Proposed Rule fails to articulate a specific standard so that the regulated entities can identify permissible activity. Rather, the Proposed Rule’s “totality of the circumstances” standard would risk fostering *ad hoc* decision making, which could lead to uneven application of the provider-related donation rules across state Medicaid programs and *de facto* changes in policy without the benefit of notice-and-comment rulemaking. A “totality of the circumstances” test would jeopardize the predictable application of Medicaid financing rules. In fact, these descriptions are so vague that they do not offer an administrable standard; far from giving healthcare providers meaningful guidance, these definitions invite confusion and arbitrary, after-the-fact decision making.

The proposed language would allow CMS to inquire into all aspects of the business practices and relationships between public and private entities ***regardless of any implication for the Medicaid program***, to determine the “reasonable expectations” held by the parties about the arrangement. The breadth of this inquiry is further exacerbated by the discretion built into the other definitions CMS proposes to rely on. As discussed above, the proposed definition of “net effect” would grant CMS broad discretion to consider and evaluate the “totality of the circumstances” to determine what the “reasonable expectations” of an “arrangement” are. Taken together, the final rule appears to grant CMS discretion to investigate any conduct it desires and to reach any conclusion it desires.

This broad scope is inconsistent with the specific tests laid out by Congress. As the courts have explained, administrative agencies are “bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.” *Colo. River Indian Tribes v. Nat’l Gaming Comm’n*, 466 F.3d 134, 139 (D.C. Cir. 2006) (quoting *MCI Telecomms. Corp. v. AT&T*, 512 U.S. 218, 231 n.4 (1994)). Congress has not empowered HHS to insert itself deep into the day-to-day workings of providers and local governments so that it can evaluate unwritten, unenforceable “expectations” of the parties in non-Medicaid areas of concern.

Further, proposed §§ 433.52 and 433.54 are inconsistent with longstanding CMS policy. In 1993, when enacting previous regulations, HCFA emphasized the importance of applying “clear and specific rules” for identifying a hold harmless arrangement. HCFA acknowledged that “subjective [tests] would be administratively burdensome and virtually

³² See 42 C.F.R., ch. IV, subchapter C.

³³ See 84 Fed. Reg. 63,777 – 78, 63,7780 – 81 (Proposed §§ 433.52 [net effect definition and provider-related donation definition], 433.54 [hold harmless and bona fide donations], 433.55 [differential treatment and health-care related taxes], 433.68(e)(3)(iv) [undue burden], 433.68(f) [hold harmless and healthcare-related taxes], 433.286 [non-state government provider definition and state government provider definition]).

impossible to apply fairly throughout the nation.”³⁴ CMS recognized that it did not have authority to utilize broad, subjective tests, to apply the hold harmless provision, in 1993. It lacks that same authority, now.

Moreover, CMS lacks the authority to apply these new rules to events predating the effective date of any final rule. In the Proposed Rule, CMS asserts that the proposed amendments to §§ 433.52 and 433.54 constitute mere “clarifications” of current law, suggesting that the final rule may be given retroactive effect. However, any condition imposed on the grant of federal moneys to state must be imposed “unambiguously” and “‘retroactive’ conditions” are impermissible.³⁵ Here, the “net effect” and “reasonable expectation” standards proposed are inconsistent with CMS’s established regulations and practices and could only have prospective effect after notice-and-comment rulemaking. In previous rulemaking, CMS has only articulated the “reasonable expectation” standard in the context of permissible healthcare-related taxes and made no reference to this standard or a “net effect” standard in the context of bona fide donations and 42 C.F.R. § 433.54(c).³⁶ At this time, the Texas Health and Human Services Commission is challenging a Department Appeals Board decision applying the “reasonable expectations” and “net effect” standards to affirm a disallowance of over \$25 million for the provision of indigent care to patients in county hospital district facilities. In its complaint, the Texas Health and Human Services Commission argues, among other things, that the “net effect” and “reasonable expectation” standards are inconsistent with CMS’s established regulations and practices and therefore cannot be applied to disallow supplemental Medicaid payments.³⁷

For the forgoing reasons, the FAH opposes the proposed standards, as they are impermissibly vague and fail to appropriately constrain the agency’s decision making to ensure it is not arbitrary.

III. Healthcare-Related Tax

A. The Reasonable Expectation Standard CMS Proposes for Identifying a Direct Guarantee Violates the Medicaid Act

The FAH opposes CMS’s proposed “reasonable expectation” standard for identifying a direct guarantee in proposed § 433.68(f)(3) because it violates the Medicaid Act and effectively bans states from using health care-related taxes for Medicaid financing. Providers and others that pay health care-related taxes will naturally expect that revenue from such taxes will support key state health policy objectives, including appropriate reimbursement for Medicaid services. Recognizing this reality, Congress explicitly provided that the hold harmless limitation at Section 1396b(w)(4) “shall not prevent use of the tax to reimburse health care providers in a class under this subchapter nor preclude states from relying on such reimbursement to justify or explain the tax in the legislative process.”³⁸ Under proposed

³⁴ Medicaid Program; Limitations on Provider-Related Donations and Healthcare-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156, 43,167 (Aug. 13, 1993) (“We believe that subjective analysis does not allow for a reasonable test of the hold harmless provisions. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured.”).

³⁵ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 & 25 (1981).

³⁶ See 73 Fed. Reg. 9,685, 9,694 (Feb. 22, 2008).

³⁷ Plaintiff’s Original Complaint ¶ 41, *Tex. Health & Human Servs. Comm’n v. HHS*, No. 3:19-cv-02857 (N.D. Tex. Dec. 2, 2019), ECF No. 1.

³⁸ 42 U.S.C. § 1396b(w)(4).

§ 433.68(f)(3), however, CMS explains that a “direct guarantee” will exist any time a taxpayer has a “reasonable expectation” that it will receive a return of “*any portion*” of its tax.³⁹ This direct guarantee test impermissibly expands the hold harmless limitations so broadly as to effectively prohibit states from using all health care-related tax revenue as the non-federal share of Medicaid spending.

When Congress passed these health care-related tax provisions in 1999, Congress laid out three clear hold harmless tests, which the Secretary enforces, but Congress did not delegate any legislative authority to the Secretary to expand these tests in any way.⁴⁰ It is a “basic tenet” that the regulations “must be consistent with the statute under which they are promulgated.”⁴¹ CMS’s proposed “reasonable expectation” standard violates the Medicaid Act and the explicit legislative history surrounding the Medicaid Act’s health care-related tax provisions. Notably, the 1991 Amendments were enacted in part to clarify that *the agency could not prohibit the use of health care-related taxes as a source of Medicaid financing*.⁴² HCFA proposed a rule in 1991 that prohibited health care-related taxes if there was any “linkage” between payments to the provider and the tax.⁴³ In response to this proposal, a 1991 House report noted, “In short, it appears that the Secretary has attempted by regulation to convert the statutory provision enacted in OBRA 90 from a general authorization for states to use the revenues from provider-specific taxes into a broad prohibition against the use of provider-tax revenues.”⁴⁴ The report further called the agency’s attempts to subvert the Medicaid Act “an illogical and patently impractical result.”⁴⁵ Despite Congress’ explicit rejection of a broad prohibition on provider-tax revenues in 1991, the Proposed Rule once again seeks to broadly prohibit the use of revenue from provider taxes as a permissible source of Medicaid financing.

B. The Tests for Identifying Direct Guarantees are Impermissibly Vague

The FAH also opposes CMS’s imposition of impermissibly vague standards of “totality of circumstances,” “net effect,” and “reasonable expectations” for identifying direct guarantees that constitute impermissible hold harmless arrangements in proposed § 433.68(f)(3).⁴⁶ Nothing in these tests articulates a specific standard so that the regulated entities can identify permissible or impermissible activity; instead, the Proposed Rule allows CMS to make ad hoc decisions on a case-by-case basis. It is widely accepted that laws must “provide explicit standards for those who apply them” in order to prevent arbitrary and discriminatory enforcement.⁴⁷ Any rule that permits such a high degree of subjectivity would authorize CMS to approve or deny similar programs in different states and still be within the scope of the regulation because the regulation does not articulate a clear test for identifying a direct guarantee. Federal courts have acknowledged that this “unfettered discretion is patently offensive to the notion of due process,”⁴⁸ and the Supreme Court has warned against rules that

³⁹ 84 Fed. Reg. at 63,778.

⁴⁰ See 42 U.S.C. § 1396b(w)(6).

⁴¹ Decker v. Northwest Envtl. Defense Ctr., 568 U.S. 597, 608 (2013).

⁴² H.R. Rep. No. 102-310, at 25 (1991).

⁴³ Medicaid Program; State Share of Financial Participation, 56 Fed. Reg. 46,380 (Sept. 12, 1991).

⁴⁴ H.R. Rep. No. 102-310, at 25 (1991).

⁴⁵ *Id.*

⁴⁶ 84 Fed. Reg. at 63,778.

⁴⁷ Grayned v. City of Rockford, 408 U.S. 104, 108 (1972).

⁴⁸ Bullfrog Films, Inc. v. Wick, 847 F.2d 502, 513-15 (9th Cir. 1988).

create a “trap for the wary as well as unwary.”⁴⁹ The “totality of circumstances” and “net effect” tests proposed by CMS fail to provide explicit and cognizable standards to guide compliance and enforcement. The proposed tests would permit a high degree of subjectivity, which CMS acknowledged in 1993 “would be administratively burdensome and virtually impossible to apply fairly throughout the nation.”⁵⁰

Moreover, the proposed test for a direct guarantee reinterprets words to mean the opposite of what one would expect. A guarantee is a formal assurance that certain conditions will be fulfilled, typically made in writing. Yet, under the Proposed Rule, guarantees need not be written, and may be found “regardless of whether the arrangement . . . is legally enforceable by any party.”⁵¹ The apparent view adopted in the Proposed Rule that an unwritten and unenforceable “expectation” of receiving funds is equivalent to a “guarantee” is not reconcilable with the ordinary meaning of the term.

CMS seems to confer to itself unlimited authority to review any unrelated transaction, including private transactions. CMS clearly lacks authority to regulate this activity under the Medicaid Act. Since Congress adopted the hold harmless tests in 1991, the tests have clearly required the “*State or other unit of government imposing the tax*” to be the entity holding a taxpayer harmless in order to violate the Medicaid Act.⁵² CMS does not have the authority under the Medicaid Act to broaden the scope of Congress’ hold harmless tests to regulate transactions that occur exclusively between private entities with no governmental direction or participation.

Strikingly, the Proposed Rule establishes a looser test for identifying a “direct guarantee” than the existing test for identifying an “indirect guarantee.” Currently, an indirect guarantee will be found only when a tax fails two statistical tests—when it produces revenues greater than six percent of the revenues received by the taxpayer for the assessed class of health care items and services and 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other state payments.⁵³ The current statistical tests offer sufficient clarity for taxpayers and states to know whether health care related taxes are permissible or not. They also recognize that health care-related taxes are permissible in some circumstances even when certain taxpayers will receive enhanced Medicaid payments. In contrast, the proposed test for “direct guarantee” would potentially make *any* tax that results in someone receiving enhanced Medicaid payments impermissible—regardless of whether the tax passes the two statistical tests for indirect guarantees.

The Proposed Rule improperly characterizes the proposed direct guarantee test as “a clarification of existing policy [that] would not impose any new obligations or place any new restrictions on states that do not currently exist.”⁵⁴ This statement, however, is not grounded in fact. The proposed amendment to 42 C.F.R. § 433.68(f)(3) would, in fact, represent a

⁴⁹ *Gentile v. State Bar of Nevada*, 501 U.S. 1030, 1051 (1991).

⁵⁰ Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156, 43,167 (Aug. 13, 1993) (“We believe that subjective analysis does not allow for a reasonable test of the hold harmless provisions. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured.”).

⁵¹ 84 Fed. Reg. at 63,778.

⁵² 42 U.S.C. § 1396b(w)(4) (emphasis added).

⁵³ See 42 C.F.R. § 433.68.

⁵⁴ 84 Fed. Reg. at 63,742.

marked change from the current hold harmless test. CMS cannot impose the proposed direct guarantee test on events predating the effective date of any final rule because the rule does not represent current policy, and Congress has not expressly conveyed to CMS the authority to engage in retroactive rulemaking.⁵⁵

Finally, the preamble to the Proposed Rule omits seemingly important rationale in describing CMS's concern with the application of the hold harmless standard. As noted, the preamble states: "The net effect of the arrangement is clear evidence that taxpayers have a reasonable expectation that their forthcoming Medicaid payment (including any redistribution) [sic], which results in participating taxpayers being held harmless for all or a portion of the tax amount." The text that is missing after "(including any redistribution)," is important for the public to meaningfully comment on this aspect of the Proposed Rule. Further, courts have agreed that CMS should provide an accurate picture of the reasoning behind the proposal so that the public can meaningfully comment.⁵⁶

Therefore, the FAH urges CMS to remove the proposed amendments to 42 C.F.R. § 433.68(f)(3) and retain the regulation in its current state.

C. The Undue Burden Test CMS Proposes Violates the Medicaid Act and Is Impermissibly Vague

The FAH opposes the "undue burden" test in proposed § 433.68(e) as it is contrary to the Medicaid Act and impermissibly vague. Under 42 U.S.C. § 1396b(w)(2)(3)(E)(ii), CMS "shall approve" a state application to treat a tax that does not meet the requirements of subparagraphs (B) or (C) as a broad-based health care related tax if the state establishes to the satisfaction of the Secretary that the net impact of the tax is "generally redistributive" and "the amount of the tax is not *directly* correlated to *Medicaid payments*." Under current regulations implementing this provision, if a tax meets the P1/P2 and B1/B2 statistical tests, it is deemed to be "generally redistributive" in nature.⁵⁷ The regulation also implements the direct correlation requirement using language nearly identical to the Medicaid Act.⁵⁸

The Proposed Rule would not alter the two current "generally redistributive" tests, but would instead add an additional "undue burden" test.⁵⁹ Although the proposed "undue burden" test is characterized in the Proposed Rule as a component of the "not generally redistributive" requirement, it in fact focuses on the relationship between the amount of the tax and Medicaid payments, which the Medicaid Act already explicitly addresses with the direct correlation requirement. Under the statutory direct correlation requirement, a tax is permissible if "the amount of the tax is not *directly correlated to payments*"⁶⁰ under the Medicaid program. CMS's proposed undue burden test, however, grossly expands this requirement to address *indirect* correlations rather than only direct correlations specified in statute.⁶¹ Moreover, CMS's proposed undue burden test measures the correlation with the

⁵⁵ See *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) (noting that a grant of legislative rulemaking authority does not "encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms").

⁵⁶ *Shands Jacksonville Med. Ctr. v. Burwell*, 139 F. Supp. 3d 240, 261–62 (D.D.C. 2015) (quoting *Conn. Light & Power Co. v. Nuclear Reg. Comm'n*, 673 F.2d 525, 530 (D.C. Cir. 1982)).

⁵⁷ 42 C.F.R. §§ 433.68(e), 433.72(b)(1).

⁵⁸ *Id.* at § 433.72(b)(2).

⁵⁹ 84 Fed. Reg. at 63,778 (Proposed 42 C.F.R. § 433.68(e)(3)).

⁶⁰ 42 U.S.C. § 1396b(w)(3)(E)(ii)(II) (Emphasis added).

⁶¹ Compare 84 Fed. Reg. at 63,778 (Proposed 42 C.F.R. § 433.68(e)(3)) with 42 U.S.C. § 1396b(w)(3)(E)(ii)(II) and 42 C.F.R. § 433.72(b)(2).

level of “Medicaid activity” rather than only measuring “Medicaid payments.”⁶² Under the Proposed Rule, “Medicaid activity” would be expansively defined as “any measure of the degree or amount of health care items or services related to the Medicaid program or utilized by Medicaid beneficiaries” (e.g., Medicaid patient bed days).⁶³ The Medicaid Act explicitly requires that correlations must be “direct” and must measure “Medicaid payments.”⁶⁴ CMS does not have the authority to amend the clear statutory language to prohibit correlations that are “indirect” and measured based on “Medicaid activity.”⁶⁵

Moreover, the proposed “undue burden” test is impermissibly vague, giving CMS unconstrained authority to decide that a health-care related taxes imposes an undue burden on Medicaid based on the “totality of circumstances.”⁶⁶ This broad and amorphous standard fails to constrain the agency’s potentially arbitrary decision making. Overall, the nebulous “undue burden” test is neither provided for under the Medicaid Act nor grounded in a reasonable relationship to the determination as to whether the net effect of a tax is generally redistributive. If this test were finalized, it would have a disruptive impact and would create significant uncertainty for states with long-standing waivers that would expire under the proposed amendment to 42 C.F.R. § 433.72(c) and those seeking to design and adopt new taxes for which a waiver would be granted.⁶⁷

D. Three-year Waiver Validity Period (42 C.F.R. § 433.72(c))

CMS proposes to limit the term of an approved waiver under § 433.72 to three years from the effective date of the final rule (for currently approved waivers) or three years from the date the waiver is approved. As with the proposed three-year limitation on supplemental payment programs discussed below, the FAH is concerned that the three-year waiver validity period will introduce unnecessary instability and uncertainty into longstanding tax programs that currently fund Medicaid under CMS-approved waivers. Moreover, the three-year renewal imposes excessive operational burdens that will divert program funds from patient care and threaten delays in CMS’s review and approval of waiver applications. The destabilizing impact of the proposed three-year validity period for waivers is particularly acute in light of the ill-defined “undue burden” test that CMS will apply on each review and the threat that, over time, CMS will evolve or vacillate in how it interprets and applies this test, leaving states and stakeholders uncertain of the treatment they will receive during each renewal cycle.

⁶² *Id.*

⁶³ 84 Fed. Reg. at 63,777 (Proposed 42 C.F.R. § 433.52). Medicaid activity “could include, but would not necessarily be limited to, Medicaid patient bed days, the percentage of an entity’s net patient revenue attributable to Medicaid, Medicaid utilization, units of medical equipment sold to individuals utilizing Medicaid to pay for or supply such equipment or Medicaid member months covered by a health plan.” *Id.*

⁶⁴ 42 U.S.C. § 1396b(w)(3)(E)(ii)(II).

⁶⁵ *Id.*

⁶⁶ 84 Fed. Reg. at 63,778.

⁶⁷ The proposed amendment to 42 C.F.R. § 433.72(c) magnifies the uncertainty associated with the proposed undue burden test. Many states have previously “establishe[d] to the satisfaction of the Secretary” that they meet the requirements for a waiver under 42 U.S.C. § 1395b(w)(3)(E)(ii) and have therefore had their waivers approved. Under the Proposed Rule, these existing waivers would expire in three years, and CMS could then deny a waiver for the exact same program despite its prior conclusion that it was required to approve the waiver.

Since Congress first required CMS to approve waivers in 1991,⁶⁸ CMS has never imposed a temporal limit on waivers; rather, once a state establishes that the waiver conditions are satisfied, the waiver becomes effective on the first day in the quarter in which the waiver is received by CMS.⁶⁹ Although Congress has imposed express time limitations on other CMS waiver and demonstration-project approvals and clearly knows how to enact such limitations,⁷⁰ temporal limitations are conspicuously absent from 42 U.S.C. § 1396b(w)(3)(E). Instead, once the state establishes that the requirements for a waiver are met, Congress requires that the “Secretary shall approve” the state’s application for a waiver. This statutory construct neither mandates any temporal limits on waivers nor permits CMS to adopt any such limits. Thus, the FAH urges CMS to withdraw the proposed amendments to § 433.72(c) as in excess of CMS’s statutory authority.

In addition to imposing time limits on new waivers, the Proposed Rule would cause existing waivers—many of which have been in place for a number of years—to expire on three years after the effective date of the final rule.⁷¹ Even if CMS could permissibly impose prospective time limitations on new waivers under 42 U.S.C. § 1396b(w)(3)(E), CMS cannot impose any such limitation on already-approved waivers. Congress has not expressly conveyed to CMS the authority to engage in retroactive rulemaking,⁷² and therefore CMS cannot retroactively alter the terms of existing waivers through proposed 42 C.F.R. § 433.72(c)(4).

IV. State Plan Requirements and Three-Year Limitation on Supplemental Payment Programs

In proposed revisions to §§ 447.252 (inpatient hospital and long-term care facility services) and 447.302 (outpatient hospital services), CMS proposes to limit approval for any Medicaid supplemental payments to not more than three years and to require states to monitor a supplemental payment program during the term of its approval. While the FAH supports CMS’s stated justification for its proposed state plan requirements – to ensure that the supplemental payments are consistent with the efficiency, economy, and quality requirements under Section(30)(A) – the FAH has concerns about CMS’s proposed time frames for both approval and the transition time period.

The FAH is concerned that the three-year SPA renewal timeline, like the three-year waiver validity limit, will strain the operational resources of state Medicaid programs and CMS and will improperly divert state and federal funds from patient care to the preparation and review of SPA applications. If SPAs span only three years, state Medicaid agencies may need to begin preparations for the next SPA submission shortly after the first SPA is granted, placing the state on a never-ending cycle of SPA submissions, particularly given the need in some cases to obtain authorization from legislatures that meet only biennially. In addition, given the retroactive dates of many SPAs, providers would face unnecessary and avoidable

⁶⁸ Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 § 2(a), Pub. L. 102-234 (codified at 42 U.S.C. § 1936b(w)(3)(E)).

⁶⁹ 42 C.F.R. § 433.72(c)(2).

⁷⁰ *E.g.*, 42 U.S.C. §§ 1315(f)(6) (3-year and 5-year demonstration waiver projects), 1396n(c)(3) 3-year waiver), 1396n(d)(3) (3-year waiver with 5-year renewal), 1396n(h)(2) (2-year waiver limit).

⁷¹ 84 Fed. Reg. 63,778 (Proposed 42 C.F.R. § 433.72(c)(4)).

⁷² *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) (noting that a grant of legislative rulemaking authority does not “encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms”).

gaps in payments as SPAs are reviewed and approved. Moreover, the proposed limit of three years is simply insufficient to provide the necessary security and predictability for state Medicaid agencies, providers, beneficiaries, and other stakeholders, many of whom rely on these critically important supplemental payments.

The FAH is not aware of congressionally authorized temporal limitations on SPAs, and CMS does not cite to any statutory provision granting the agency the authority to so time limit SPAs in the Proposed Rule. As with the waiver-renewal timeline, the FAH urges CMS to withdraw the proposed time-limiting amendments to §§ 447.252(d) and 447.302(c) as in excess of CMS's statutory authority.

In addition to imposing time limits on new SPAs, the Proposed Rule would cause existing SPAs—some of which have been in place for a number of years—to expire on either two or three years after the effective date of the final rule.⁷³ Even if CMS could permissibly impose prospective time limitations on new SPAs, CMS cannot impose any such limitation on already-approved SPAs. As noted above, Congress has not expressly conveyed to CMS the authority to engage in retroactive rulemaking, and therefore CMS cannot retroactively alter the terms of existing SPAs through proposed 42 C.F.R. §§ 447.252(e) and 447.302(d).

V. The Definitions of Non-State Government Provider, State Government Provider and Private Provider Lack Clarity

CMS's proposed definitions of "non-state government provider," "state government provider," and "private provider" may impermissibly prevent public providers from using their public funds as the non-federal share of Medicaid payments. CMS proposes to define a "non-state governmental provider" as a health care provider "that is a unit of local government in a State, including a city, county, special purpose district, or other governmental unit in the State that is not the State, which has access to and exercises administrative control over State funds appropriated to it by the legislature or local tax revenue, including the ability to dispense such funds."⁷⁴ In addition, however, CMS proposes to add another "totality of the circumstances" analysis of vague factors to assess whether an entity is a non-state governmental provider. There is similar "totality of the circumstances" language for purposes of determining whether a provider is a state government provider.⁷⁵

As has been described above, there is no statutory or current regulatory "totality of the circumstances" test to instruct how CMS would apply this new regulatory term. Enforcement would be subject to CMS interpretation and likely result in inconsistent application of these provisions.

CMS's application of this new standard could jeopardize legitimate management arrangements. Government providers often contract with management companies that provide the operational services for their businesses. While CMS acknowledges in the preamble to MFAR that many such arrangements are legitimate, the factors that CMS proposes to use to assess whether a provider is a "non-state government provider" or "state government provider" could result in uneven and inappropriate application of the standard. As such, the FAH believes that CMS should withdraw this provision of the proposed rule.

⁷³ 84 Fed. Reg. at 63,780 and 63,785 (Proposed 42 C.F.R. §§ 447.252(e) and 447.302(d)).

⁷⁴ *Id.* at 63,780.

⁷⁵ *Id.* at 63,781.

VI. Reporting Requirements for Supplemental Payments and DSH Audits

CMS proposes in § 447.288(c)(1)-(c)(3) to add three sets of significant reporting requirements: (1) quarterly expenditure reports describing the supplemental payments included on the CMS-64; (2) not later than 60 days after the end of the state fiscal year, annual reports containing aggregate and provider-level information on both base and supplemental payments; and (3) not later than 60 days after the end of the state fiscal year, annual reports containing aggregate and provider-level information on each provider contributing to the state or any unit of local government any funds that are used as a source of the non-federal share for any Medicaid supplemental payment. The latter requirement in § 447.288(c)(3) would include the data elements in (c)(1) and (2), plus total fee-for-service base payments, total supplemental payments, total Medicaid payments, and total DSH payments made to the provider. The proposed regulation also would require information such as the total amount of each healthcare-related tax, provider-related donation, IGT contribution, and/or costs certified as CPE by the provider.

The FAH is concerned that each of the proposed reports is operationally infeasible and will strain the operational resources of state Medicaid programs and CMS. Specifically, the quarterly provider-level reports on supplemental payments do not make operational sense given that many states distribute supplemental payments on an annual basis. Coupled with the proposed annual reporting requirements, the quarterly requirement would provide data that is not only duplicative, but also potentially misleading, given the timing of supplemental payments.

The extensive annual reporting requirements also impose significant burdens on states with operationally infeasible 60-day submission requirements. Reconciliation of CPEs, DSH payments, healthcare-related taxes and other required elements can take years, and certainly longer than 60 days

Unfortunately, the Proposed Rule glosses over these difficulties, and suggests that data can be prepared for the new reports with minimal effort. CMS's estimates of the regulatory burden associated with required reports consists of little more than copying and pasting from a simple data query, which CMS estimates would take "20 seconds at \$32.44/hr for a data entry keyer to query state MMIS system and/or copy and paste each data element into the required format for reporting." Altogether, CMS estimates that each state would expend an average of \$922 for all quarterly reporting. This estimate grossly understates the time, cost, and difficulty of implementing new data reporting requirements for programs as complicated as Medicaid. The Proposed Rule should not be finalized without revision to include a better estimate of this burden.

The FAH has significant concerns about imposing these potentially infeasible and potentially misleading reports, in light of both CMS's intended oversight use of the data collected and the significant penalty for failing to timely and accurately report the required information—reduction or deferral of FFP. For these reasons, the FAH encourages CMS to withdraw its quarterly reporting proposal and provide at least one year for states to submit their annual reports. Moreover, CMS should consider and provide instruction to states on how to report data elements that take longer than one year to reconcile. The FAH recognizes CMS's interest in transparency, but the FAH has significant concerns that CMS's proposed reporting requirements are designed in a way that will force states to sacrifice accuracy for expediency.

CMS proposes to add new DSH audit reporting requirements at § 447.299(c)(21) to require that states include the financial impact associated with the DSH audit findings in their annual DSH reports. While the FAH supports transparency and accuracy in Medicaid DSH payments, CMS proposes to require *auditors* to quantify the financial impact of any finding in an effort to “limit the burden on both states and CMS of performing follow-up reviews or audits.” 84 Fed. Reg. at 63,727. CMS explains that a lack of financial findings by auditors, which in some circumstances are a result of missing data or lack of documentation, hampers CMS’s ability to make an immediate determination that an overpayment has occurred and causes the state and/or CMS to conduct a secondary review or audit.

By proposing that this new financial impact provision will limit the burden on states and CMS of performing follow-up reviews or audits, CMS appears to shift responsibility for determining an overpayment has occurred to independent financial auditors. The FAH urges CMS to reconsider its proposal to require independent auditors to effectively determine whether an overpayment has occurred. Such a determination should be made by state and federal governmental authorities. We urge CMS to provide states with adequate time and the responsibility to review DSH audit findings and, at a minimum, that state and/or federal governmental authorities be tasked with secondary review of any potential overpayment determinations.

VII. Hospital Outpatient Services State Plan

We object to the proposed new state plan requirements for hospital outpatient services proposed at § 447.302 for the same reasons described above with respect to the state plan requirements for inpatient services.

Thank you for the opportunity to comment. Should you have any questions, please contact Steve Speil, Executive Vice President, Policy at (202) 624-1500.

Sincerely,



