



January 31, 2020

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-2393-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: Comments to CMS-2393-P  
Proposed Rule: Medicaid Program; Medicaid Fiscal Accountability Regulation

Dear Administrator Verma:

Thank you for the opportunity to comment on the proposed rule, "Medicaid Program; Medicaid Fiscal Accountability Regulation."

Our organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including many who rely on Medicaid as their primary source of healthcare coverage. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource to the Centers for Medicare and Medicaid Services (CMS) in its administration of the Medicaid program.

In March of 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the

treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefits package.

As the nation's largest publicly-funded health insurance program, covering over 70 million Americans, Medicaid is central to the achievement of these principles. Medicaid provides the primary and specialty care, prescription medications, long-term services and supports, and other services necessary to treat the chronic conditions of people we represent. Further, the lifetime risk that individual Medicaid beneficiaries may acquire one of the diseases or conditions that our organizations represent is high. Without the health insurance coverage provided by Medicaid, access to vital health care services and the quality of health outcomes diminishes, making it more difficult to manage the myriad of illnesses and chronic diseases that millions of Americans, including those we represent, fight every day. Reducing access to health care through Medicaid also risks reversing the benefits that Medicaid has had on reducing racial and ethnic health disparities.<sup>1</sup>

Because of the importance of Medicaid, we strongly support transparency in its operation. Without transparency, state Medicaid agencies, managed care plans, providers, and CMS itself cannot be held accountable for performance. The proposed rule contains some data collection and reporting provisions that have the potential to advance transparency in Medicaid finance and payments. However, we are concerned about the potential harm that the other provisions in the proposed rule pose to the ability of states to pay for their share of the Medicaid program and reimburse hospitals, nursing homes, physicians and other providers. Disrupting state financing and supplemental payments, as the proposed rule would do, will severely undermine the ability of Medicaid as a health insurer to effectively address the needs of patients with the diseases and chronic health conditions on which our organizations are focused.

As discussed below, we believe CMS should withdraw provisions in the proposed rule, including but not limited to, the changes to the standards for review and approval of state financing mechanisms (provider taxes, Intergovernmental Transfers (IGTs), and Certified Public Expenditures (CPEs)), as well as supplemental payments. Instead, any final rule should focus solely on transparency by setting forth reasonable requirements for public reporting of information related to current state financing and supplemental payment arrangements. Once policy-relevant information becomes available, CMS should work with states, the Medicaid and CHIP Payment and Access Commission (MACPAC), organizations like ours, and other stakeholders to develop a new proposed rule that articulates information-based, narrowly-targeted, and well-defined changes to state financing and supplemental payment regulations—changes that promote the integrity of the program but do not disrupt the ability of states to pay for their share of Medicaid or provide supplemental payments to providers.

### **Proposed Rule Would Make Major Changes to Current State Financing of Medicaid Without Mechanisms in Place to Protect Patients, States, and Providers**

Medicaid is a federal-state matching program; the federal government only matches state expenditures for covered services for eligible individuals and states rely on a variety of funding

sources, including provider taxes, IGTs, and CPEs, to pay for their share of the program. Reliance on these funding sources is widespread; in state fiscal year 2019, almost all states raised revenues from assessments on hospitals, intermediate care facilities, and/or nursing facilities,<sup>2</sup> and some states have assessments on managed care plans as well. In fact, some states established or increased provider taxes to help finance the state cost of the Medicaid expansion, which has helped patients in these states receive earlier stage cancer diagnoses, decreased maternal and infant deaths, reduced deaths from opioid overdoses, and eliminated racial disparities in timely treatment for cancer patients, among numerous other beneficial health outcomes.<sup>3</sup> Most states use IGTs and/or CPEs as well.<sup>4</sup>

The proposed rule would dramatically revise the current regulations relating to each of these state revenue sources. These regulations, and the statutory provisions on which they are based, have been in place for over 25 years. States, providers, managed care plans, and beneficiaries have relied on this policy stability to develop financing arrangements that enable states to fund their share of Medicaid. Congress has made no changes in the underlying statute that suggest, much less require, necessity of such major revisions. These mechanisms are used by states to help them meet their mandate to provide crucial services to Medicaid beneficiaries. Disallowing them without providing another source of funds will lead to gaps in access and worsening health outcomes.

Nationally-recognized Medicaid experts, including a former director of the Center for Medicaid and CHIP Services, have publicly raised concerns about the proposed rule.<sup>5</sup> These experts point out that the numerous substantive changes in the proposed rule and its broad, loosely-defined standards which provide undue discretion to CMS could prohibit or limit existing financing for Medicaid derived from provider taxes, IGTs, and/or CPEs. If these proposed changes were adopted and resulted in disapproval of current state Medicaid financing arrangements, states would have to make a difficult choice. They could replace the revenues from these newly disallowed sources with revenues from new sources such as higher taxes; they could transfer funds from other parts of their budgets to Medicaid; or they could reduce their spending on Medicaid by restricting eligibility, reducing benefits, and/or cutting payments to providers and managed care plans. For example, because of budget shortfalls, states may drop eligibility expansions,<sup>6</sup> impose more red tape that makes it harder for eligible individuals and families to enroll, eliminate optional benefits or reduce reimbursement to providers that discourage Medicaid participation among providers including physicians. This would severely compromise Medicaid's critical role in ensuring access to needed health care services for over 70 million Americans.

### **Proposed Rule Does Not Explain its Potential Impact on States, Providers, and Beneficiaries**

A proposal to make fundamental changes to the longstanding rules for how states pay for their Medicaid programs and provide supplemental payments to providers should explain what the likely effects of those changes will be on states, providers, managed care plans, and beneficiaries. Not only is such an explanation required by Executive Order 12866, it is fundamental to the responsible exercise of the power to issue regulations by federal agencies under the Administrative Procedure Act. Without such an explanation, stakeholders, including

our organizations, cannot understand the implications of the proposed changes or provide informed comments on them.

The Regulatory Impact Analysis accompanying the proposal rule states: “The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown.” The preamble goes on to state that “we do not have sufficient data to predict or quantify the impact of the proposed provisions on health-care related taxes, although we would expect that states may modify existing state tax policy or arrangements....”<sup>7</sup> In our view, it is simply unacceptable for CMS to propose major changes to the way in which states pay for Medicaid without knowing what the fiscal impact on states, providers, plans, and beneficiaries, including those with serious, acute and chronic conditions, will be. And if the agency does not have sufficient data to quantify the fiscal impact, it should first collect and analyze the data, then propose changes (if necessary) based on that data and analysis – and explain what it thinks the impact will be.

An analysis by the Arizona Medicaid agency underscores this point.<sup>8</sup> For example, according to the agency, the proposed change to 42 CFR 433.51(b) “could impact all programs in which the State match share is funded by public universities, tobacco settlement receipts, the State share of drug rebates, and the hospital and nursing facility assessments,” including Medicaid programs to support graduate medical education and supplemental payments to certain hospital-based physicians to ensure continued participation. We doubt that the intent of the proposed rule was to undercut graduate medical education or reduce physician participation in Arizona or any other state. But the fact that these consequences are unintended does not prevent them from happening, and it certainly does not excuse CMS from proposing major changes to long-standing regulations without sufficient data.

### **Final Rule Should Promote Transparency, Not Disrupt State Financing**

As we indicated at the outset of these comments, our organizations support transparency in Medicaid payment and financing. Beneficiaries, other stakeholders, and the public all have a legitimate interest in knowing whether and how federal and state Medicaid funds are being spent for their intended purpose of paying for health and long-term care services needed by low-income Americans. The proposed rule contains a section, 42 CFR 447.288(c), that would establish detailed reporting requirements relating to provider taxes, IGTs, CPEs, and supplemental payments. It also contains a section, 42 CFR 447, to enforce the reporting requirements.

Our organizations ask that CMS focus the final rule only on data collection and reporting requirements that will produce reliable and accurate information necessary to an understanding of Medicaid payment and financing arrangements in each state. The final rule should be designed to minimize administrative burden, allow for a reasonable timeframe for implementation, and make clear that the data required to be reported by providers to the states, and by the states to the federal government, will be available to the public in an accessible format. The final rule should also include enforcement provisions to ensure that providers and states submit the required information. Until these new reporting requirements

are implemented, and the required data have been collected and analyzed, we believe all of the remaining provisions in the proposed rule are premature and urge CMS to withdraw them. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association  
American Kidney Fund  
American Lung Association  
Arthritis Foundation  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Family Voices  
Hemophilia Federation of America  
Leukemia & Lymphoma Society  
March of Dimes  
Mended Little Hearts  
Muscular Dystrophy Association  
National Alliance on Mental Illness  
National Hemophilia Foundation  
National Organization for Rare Disorders  
National Patient Advocate Foundation  
United Way Worldwide

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<sup>1</sup> <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access>

<sup>2</sup> <http://files.kff.org/attachment/Tables-Report-A-View-from-the-States-Key-Medicaid-Policy-Changes>

<sup>3</sup> Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, “Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses”, *American Journal of Public Health* 108, no. 2 (February 1, 2018): pp. 216-218. Available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166>; Adam Searing and Donna Cohen Ross. “Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies,” (May 2019). Georgetown University Health Policy Institute, Center for Children and Families. Accessed at: <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>; Kravitz-Wirtz N, Davis CS, Ponicki WR, et al. Association of Medicaid Expansion With Opioid Overdose Mortality in the United States. *JAMA Netw Open*. 2020;3(1):e1919066. doi:10.1001/jamanetworkopen.2019.19066. Accessed at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476>; American Society of Clinical Oncology, “Racial Disparities in Access to Timely Cancer Treatment Nearly Eliminated in States with Medicaid Expansion.” American Society of Clinical Oncology Annual Meeting. June 2, 2019. Access at: <https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly>.

<sup>4</sup> <https://www.gao.gov/special.pubs/gao-15-227sp/sectionb212.html>

<sup>5</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20200116.391921/full/>;  
<https://www.healthaffairs.org/doi/10.1377/hblog20200108.392104/full/>

<sup>6</sup> [https://familiesusa.org/wp-content/uploads/2019/09/MCD\\_States-Share-10-Percent\\_Fact-Sheet.pdf](https://familiesusa.org/wp-content/uploads/2019/09/MCD_States-Share-10-Percent_Fact-Sheet.pdf)

<sup>7</sup> <https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf#page=52>

<sup>8</sup> [https://www.azahcccs.gov/shared/Downloads/News/2019/AHCCCSMFARSummary\\_200117.pdf](https://www.azahcccs.gov/shared/Downloads/News/2019/AHCCCSMFARSummary_200117.pdf)