AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

January 31, 2020

VIA ONLINE SUBMISSION
regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2393-P Medicaid Fiscal Accountability Regulation

Dear Administrator Verma:

On behalf of Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) notice of proposed rulemaking on the Medicaid Fiscal Accountability Regulation (MFAR). Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 89 hospitals and more than 300 other health facilities in 15 states.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. Due to the difference among our hospitals and their geographic locations, our comments provide an objective and sound policy voice that work for health care as a whole.

Our patients reflect the communities we serve: diverse in age, race, ethnicity, income and payor. AHPA seeks to provide an informed policy voice that reflects our experience delivering whole person care to these communities. On a daily basis, our systems observe the unique benefit that a safety-net program like Medicaid—administered jointly between states and the federal government—offers to patients and health care systems. The complex and myriad health and economic issues faced by different communities demand preservation of states' discretion to meet the health care needs of their citizens.

As our partner health systems are responsible for the care of millions of patients across 15 states, AHPA takes seriously the stewardship of state and federal resources and our mission to deliver whole person care to everyone who needs it. Overall, with the lessened administrative flexibility, reduced services and higher taxes encouraged by this rule, those whom Medicaid is designed to help most will experience greater access issues than ever before. This burden will be displaced across communities, rather than

addressed by the safety-net systems that are designed to move Americans out of poverty and illness into wellness and productivity. Harmful impacts will be felt across the care continuum, from hospitals to skilled nursing facilities.

When Medicaid was enacted in 1965, Congress sought to introduce a pathway to health care coverage for low-income individuals and families. As this program has been successful in extending health care to our nation's most vulnerable, Congress has expanded the classes of people who can receive Medicaid benefits. Medicaid has continued to evolve, and Congress has devised new means, such as waivers, of allowing states to tailor the program to the specific needs of their economies, populations and health care systems. This is congruous with the intent of Medicaid to be jointly and flexibly administered between the federal government and state governments.

We appreciate CMS's commitment to ensuring that Medicaid is administered with integrity and transparency, and we applaud the Agency's efforts to ensure taxpayer dollars are accounted for. As a preliminary matter, we believe that CMS lacks the statutory authority for policies relating to provider taxes. We also join the American Hospital Association, America's Essential Hospitals and numerous state hospital associations in expressing our deep concern about the impact these changes would have on access to care for Medicaid beneficiaries.

AHPA believes that the proposed policies would impede state flexibility, reduce the provision of health care services and force states to raise taxes—any one of which would negatively impact access to care on its own. Accordingly, our comments on this notice of proposed rulemaking urge CMS to consider the impact that restrictions on financing arrangements could have on the flexibility that makes Medicaid one of the central pillars of our current health system. Specifically, we urge the Agency to consider how this could burden hospitals with expenditures that far exceed Medicaid reimbursement. These shortfalls could prevent them from maintaining or expanding their capacity to care for Medicaid patients and the uninsured, and compounding access barriers to the nation's most vulnerable children, families and individuals.

Lack of Statutory Authority for Regulating Private Arrangements

CMS proposes a change to existing regulations that would allow CMS to apply a net effects test to determine whether private-party indemnification agreements give a health care taxpayer (e.g., hospitals, physician practices, etc.) the reasonable expectation that they would be held harmless for all or a portion of the tax amount. This could effectively allow CMS to regulate agreements between private parties, which is beyond the limited scope of the authority granted by Congress.

AHPA does not believe that CMS has the statutory authority to enact proposals in this rule that construe arrangements between private parties as indirectly creating a reasonable expectation of repayment. In contemplating the scope of hold harmless provisions for private indemnification, Congress specifically focused on payments provided for by a "state or other unit of government," not private arrangements.[1] The underlying statute focuses on regulating state action, not private action, and a policy shift of this size merits consideration from Congress before the rule expands. We urge the Agency to withdraw policies aimed at regulating agreements between private healthcare providers.

Restricting State Administration Will Limit Access to Care

CMS proposes to reduce the number of ways that states can legally fund their share of costs for the Medicaid program. The Agency seeks to limit the use of intergovernmental transfers (IGTs) as a funding stream to those generated from state or local taxes. Overall, the proposed changes would restrict state Medicaid dollars to appropriated funds for state Medicaid agencies, tax-derived IGTs and Certified Public Expenditures (CPEs).

Specifically, the Agency proposes to redefine "non-state government providers" as government providers that are a unit of local or state government or a state university teaching hospital with administrative control over funds appropriated by the state legislature or local tax revenue. In addition, the Agency would have discretion to judge whether, "in the totality of the circumstances," the entity qualifies as a governmental provider.

CMS also proposes to restrict what types of funds can constitute an IGT, limiting the definition to funds derived from the provider's state or local tax revenue (or funds appropriated to a state university teaching hospital). These changes would restrict the IGT and CPE amounts governmental providers can use to fund the state's non-federal share.

AHPA opposes the proposed modifications to the definitions of IGTs and non-state government providers, as well as limitations on the other traditional sources of funding, such as provider taxes. While accountability ensures the longevity of the Medicaid program, we do not support the extent of the proposed changes in the financing arrangements, as they would hinder states' ability to affordably and sustainably fund indigent care.

One of Medicaid's enduring and defining characteristics is its adaptability. If the Agency reserves the authority to decide, without clear boundaries, what qualifies as a governmental provider under a "totality

[1] 42 U.S.C. 1396b(w)(4)

of circumstances" standard, states become unable to rely on established and successful funding mechanisms and are instead faced with confusion and risk. We ask that the Agency explicitly delineate the boundaries of its discretion and provide states with specific definitions for "governmental providers" and permissible "financing arrangements."

Furthermore, the proposed definitions will force states to take measures to either reduce Medicaid services or raise revenues to meet their state Medicaid share obligations. Limiting IGTs, CPEs, governmental providers and provider taxes will result in either **a reduction in services, thus hindering access**, and/or **an increase in taxes**, resulting in negative statewide impacts on income and economic viability, **especially in vulnerable areas** (such as rural counties).

Reduction in Services Will Further Limit Access to Care

CMS proposes to limit how states can legally fund their share of costs for the Medicaid program. The Agency seeks to restrict the use of IGTs as a means of generating state Medicaid shares to those generated from state or local taxes. Additionally, CMS would cap supplemental provider payments at 50 percent of the base rate, instead of the average commercial rate that averages closer to 89 percent. Overall, the proposed changes would have the effect of making it more difficult for states to adequately reimburse providers for indigent care.

AHPA opposes the proposed definitional modifications and restrictions. Nearly every state in the U.S. funds its Medicaid share through IGTs, provider taxes or some combination of the two. By limiting the ways that states can generate this funding, the federal government positions states to be unable to meet the full obligation of their share. The most concerning effect of this policy change would be a reduction in the care available to Medicaid patients.

The reduction in upper payment limits and the aggregate effect of the other payment source limitations would ultimately result in lower reimbursement to providers for services furnished to Medicaid beneficiaries—which is already about 40 percent below cost. As a result, health care systems may be forced to reduce services, resulting in additional barriers to access for the patients who need it most.

Resulting Tax Increases Will Further Limit Access to Care

CMS proposes reallocating discretion to the federal government to determine the appropriateness of financing arrangements, including health care taxes and provider donations. Currently, 49 states have some form of health care donation or provider tax that helps to generate state revenue used for the Medicaid program. These taxes, along with provider donations, are essential to helping states meet the

need of Medicaid beneficiaries. Without them, states may have to turn to tax increases that takes money out of the pockets of families and individuals, creating additional financial-related barriers to care.

AHPA opposes the Agency's proposed polices restricting provider donations and health care taxes because these changes, coupled with the proposal to require IGTs to originate from state and local taxes, will require states to generate critical Medicaid revenue through additional taxes. We anticipate that these policies would harm families and communities by reducing disposable incomes and taking money away from municipalities that could be used toward local needs. Indeed, the arrogation of discretion the Agency proposed contravenes the policies of federalism and localized government that makes Medicaid a bedrock of American health care. By increasing household expenses by forcing states to raise taxes in order to sustain Medicaid programs, state populations—particularly those who are already financially and medically struggling—will be further burdened.

Conclusion

AHPA supports measures to monitor responsible use of Medicaid dollars, and we urge the collaboration of the federal and state governments to find solutions for appropriate accountability measures. Those proposed by CMS in this rule, however, are inappropriate and are likely to burden states and health care systems in a way that makes population health worse for the most vulnerable.

We welcome the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AdventHealth.com.

Sincerely,

Carlyle Walton, FACHE
President
Adventist Health Policy Association