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January 31, 2020

Seema Verma
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: Proposed Rule: CMS-2393-P, Medicaid Program: Medicaid Fiscal Accountability Regulation (Vol. 84, No. 222), November 18, 2019 and CMS-2393-N (Vol. 84, No. 249) December 30, 2019

Dear Administrator Verma:

The Wisconsin Hospital Association appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed Medicaid Fiscal Accountability Regulation ("MFAR"). WHA is a statewide nonprofit association with a membership of more than 140 Wisconsin hospital and health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also large urban medical centers with significant numbers of Medicaid patients. Wisconsin hospitals ultimately provide the health care safety net for those in need.

For many years, Medicaid program financing has relied on a strong partnership among multiple levels of government, health care providers, academic medical centers, and other organizations to safeguard stable funding for a program that, even with those efforts, generally reimburses providers less than the cost of providing care. As the aim of the Medicaid program has evolved, CMS's foresight to allow states funding flexibility to address state specific circumstances has enabled states to meet the needs of their most vulnerable populations. We urge CMS not to view this flexibility negatively, but rather to recognize that this flexibility has strengthened the Medicaid partnerships and the commitment to this critical program, which provides access to health care services to nearly one million people in Wisconsin.

While WHA understands CMS's interest in enhancing its stewardship of the Medicaid program through greater transparency of Medicaid financing, the proposed regulations go far beyond increasing transparency. The proposal would introduce significant uncertainty with respect to how the agency would evaluate state financing arrangements. CMS is concerned about "shady recycling schemes", yet rather than targeting what it deems to be problematic financing arrangements, the proposed rule sweeps much more broadly, casting doubt on a wide range of legitimate financing arrangements that CMS and Congress have long endorsed.

Because the proposal as written would upset funding for the Medicaid program, harming access to crucial health care services for vulnerable patient populations, we join provider and patient organizations, state and local governments, and other stakeholders across the country in urging CMS to withdraw the proposed rule.

Beyond asking CMS to withdraw the proposed rule, we have specific comments on the following issues.

Health-care related taxes and supplemental payment programs. As part of the effective partnership discussed above, states have been able to assess providers, collecting revenue to help finance the state's Medicaid program. In many states, this stable funding source has enabled the state to offer health care services that otherwise would be unavailable to some populations or improve access to those services through adequate reimbursement rates. MFAR, however, would impose impermissible roadblocks to this financing method.

States have the statutory authority to assess providers as a source of state funding and have relied on statistical tests for adherence, demonstrating the state's method is generally redistributive and providers are not "held harmless" from the tax. MFAR, however, by introducing new standards based on vague terms, would grant CMS seemingly unfettered discretion to evaluate a state's method. For example, MFAR's "net effect" standard would require only a "reasonable expectation" that a taxpayer would receive all or a portion of the tax amount rather than the statutory standard of a "guarantee." Through these and other terms and standards, the proposed rule introduces a degree of subjectivity that would create a concomitant level of uncertainty for a state attempting to fund its Medicaid program and reimburse providers adequately, including through essential supplemental payments, to ensure Medicaid enrollees have access to care.

Beyond vague and impermissible standards, CMS proposes a maximum approval time period of three years for health-care related tax waivers and supplemental payment programs. The proposed approval time period for a previously acceptable arrangement is insufficient for complex programs that can require significant work by the agency and approval by the state legislature. Currently, health care related tax waivers and supplemental payment programs undergo significant scrutiny from CMS prior to approval, which can often take months to obtain. As a result, CMS has correctly determined that once approved, states do not need to go through the lengthy process of re-approval. The proposed resubmission and re-approval time period for previously acceptable arrangements creates unnecessary administrative burden on both the states and CMS. We agree, however, that re-submission may be necessary if a state changes an important part of the methodology upon which CMS based its approval. We ask CMS to withdraw this proposal and rely, instead, on resubmissions and re-approvals when there are material changes to the arrangement.

States and the key stakeholders involved in providing services to Medicaid beneficiaries benefit from a program that is stable and predictable. The proposed rule would create confusion and uncertainty. It is entirely possible given the vague standards that CMS could approve an arrangement one year, only to disapprove the exact same arrangement three years later. The proposed rule would introduce inconsistencies with existing regulatory language and violates the Administrative Procedure Act because it is changing policy and guidance upon which states and providers have long relied with too little rationale. The proposal is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers.

Intergovernmental Transfers and Certified Public Expenditures. MFAR would restrict the types of funds that would be available for an IGT, limiting the IGTs to funds derived from the provider's state or local tax revenue or funds appropriated to a state university teaching hospital. MFAR's changes would cap amounts or eliminate sources of funding currently used to finance some states' non-federal share of the Medicaid program. MFAR also would create new, arbitrary definitions for "non-state government provider" and "government provider" that creates an unworkable standard and, thus, uncertainty for states about which public providers are permitted to transfer local funds for purposes of Medicaid financing. We also are concerned the proposed changes to CPEs reduce state flexibility to advance the goals of the program.

We are disappointed CMS did not seem to consider states' longstanding reliance on these funds and the destabilizing impact of these changes. For instance, MFAR's rigid requirements could threaten continued funding for legitimate public/private partnerships where governmental entities work in partnership with

private organizations to serve a public good. We ask CMS to reject the narrowed definition of what would be considered appropriated funds and rely on the states to determine which entities are public. And we ask CMS to continue to provide states the flexibility needed to meet the goals of the program. Without these changes, MFAR would restrict states' use of a key funding source in a manner that arguably is inconsistent with CMS's statutory authority and established CMS policy on which states and provider have relied.

Base and Supplemental Payments. MFAR would define "base" and "supplemental" payments. In so doing, we are concerned that CMS is limiting the flexibility of states to make lump sum payments that are tied to service or utilization and that are based on quality, access, or other important programmatic goal. For example, states may wish to implement quality programs that involve a "withhold" of the FFS payment, to be paid back out in a lump sum based on achievement of certain quality performance metrics. These FFS payments are still 'base' payments, even though they may be paid out in a lump sum after the state assesses service quality. States must have the ability to explore value-based payment arrangements. The definitions of "base" and "supplemental" as proposed appear to be too limiting and inconsistent with state innovations in payment and reimbursement.

Variable fee for service payments. MFAR would prohibit a state plan from providing a variable FFS payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan. We acknowledge CMS's concern about establishing rates that are higher for a specific population group based solely on the federal matching rate. The proposed rule, however, goes further, in its prohibition of variable rates for demonstration populations. Waivers are an important tool for CMS and the states to test new and innovative models of care delivery. There may be circumstances, in which variable rates could be a key part of a waiver or demonstration that furthers the goals of the program. CMS reviews and assesses the details of each state's waiver application(s), and maintains control over approval of any waiver demonstration project. As CMS, the state, and other stakeholders weigh the benefits of expanded access for a vulnerable population with required budget neutrality standards, variable rates would not increase the federal share. Thus, we encourage CMS to maintain the flexibility allowed in the waiver process and remove from this provision the reference to waiver populations since service delivery and reimbursement to those populations should fall under the terms of the waiver agreement.

Summary. Again, we urge CMS to withdraw the proposed rule as written. We further encourage CMS not to view state flexibility negatively, but rather to recognize that this flexibility has strengthened the Medicaid partnerships and the commitment to this critical program. We appreciate CMS's interest in transparency and stewardship, but rather than transparency, the rule allows for significant subjectivity on the part of CMS that will result in greater uncertainty for states and providers working diligently to provide care to vulnerable populations in an efficient manner.

WHA appreciates the opportunity to provide comment on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO