



January 31, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244
Submitted electronically to <http://www.regulations.gov>

Re: Medicaid Program; Medicaid Fiscal Accountability Regulation; *Federal Register*, Vol. 84, No. 222, November 18, 2019 [CMS–2393-P]

Dear Administrator Verma,

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition of health care providers, safety net health plans, counties and labor—the undersigned organizations appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) proposed rule *Medicaid Program: Medicaid Fiscal Accountability Regulation (MFAR)*. We understand CMS’ role as a steward of the Medicaid program in order to ensure effective fiscal oversight, as well as to ensure access to high-quality Medicaid services. However, we are concerned that the proposed rule could severely limit how states fund their Medicaid programs, which could negatively impact beneficiaries’ access to care and the providers they rely on. **We respectfully request that CMS withdraw the MFAR.**

Medicaid is a partnership between the federal government and states to provide care for some of our nation’s most vulnerable citizens, including children, elderly, people with disabilities and low-income adults. The program provides health insurance coverage for approximately 20% of the U.S. population, serving as a lifeline for tens of millions of Americans. Medicaid plays an important role in providing access to necessary health services that include maternity care, pediatric services, behavioral health services, primary and dental care, specialized inpatient and emergency hospital services, and long-term services and supports. Medicaid is recognized as an efficient program associated with improved health outcomes, long-term educational attainment for children, and improved productivity among beneficiaries.¹ Compared to those who are uninsured, Medicaid beneficiaries are more likely to have a regular source of care, more likely to

¹ Kaiser Family Foundation, “10 Things to Know about Medicaid: Setting the Facts Straight,” (March 6, 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

have seen a primary care physician or specialist in the past year, and less likely to postpone or forgo needed care due to cost.²

The proposed rule makes potentially sweeping policy changes that could substantially impact how states finance their Medicaid programs and, in turn, negatively affect access to care for beneficiaries. Medicaid is a large program with significant expenditures, and we recognize CMS' interest in ensuring state policies are compliant with federal regulations. However, CMS does not present data-driven justifications supporting the need for these policy changes, how the proposed changes address the agency's concerns about improper payment arrangements, or how these changes may affect access to care under the program. To implement changes such as those in the proposed rule, CMS must first produce data to demonstrate the impact of what it is proposing, what coming into compliance means, and how this will impact providers, states and beneficiaries. Once those data have been collected, analyzed and shared with the public—so CMS and the public understand the scope and scale of this proposal—only then should the agency proceed with implementation and compliance.

CMS Must Have Meaningful Review and Oversight Mechanisms in Place to Ensure Total Medicaid Reimbursement Supports Quality Care

Prior to moving forward with the proposed rule, we strongly recommend CMS put meaningful review and oversight mechanisms in place to ensure total Medicaid reimbursement supports quality care. Examining supplemental payments separately, as this rule proposes, will not achieve this aim and is likely to lead to misinformed policy decisions. **CMS' proposed changes to how states finance the state share of Medicaid are likely to create significant state budget problems and negatively impact state and local economies. Accordingly, any changes made must be thoughtful and deliberate.**

Under current regulations, states are provided with flexibility within federal limits for how they finance Medicaid programs and distribute payments to providers. Intergovernmental Transfers (IGTs), certified public expenditures (CPEs), and provider taxes are congressionally sanctioned and regulated sources of the nonfederal share of funding for the program dating back to Medicaid's inception. In the rule, CMS proposes policies that could significantly limit the use of these long-established financing arrangements. The proposed policies apply subjective standards without providing adequate guidance on how the new criteria will be applied, giving CMS vast new oversight authority and making it very difficult for states and providers to ensure compliance. States and other Medicaid stakeholders would be left without means of knowing if a given state financing or supplemental payment arrangement is permissible. This will create considerable uncertainty for states.

According to a Manatt study commissioned by the American Hospital Association study, nationally, the Medicaid program would face total funding reductions of \$37 billion to \$49 billion annually or 5.8% to 7.6% of total program spending under the proposed rule. Although

² Medicaid and CHIP Payment and Access Commission, "Key findings on access to care," (Jan. 2020), <https://www.macpac.gov/subtopic/measuring-and-monitoring-access/>

the impact could vary greatly state to state, the proposed rule could result in significant cuts to reimbursement, enrollment or coverage due to the magnitude of these estimated reductions.

The Proposed Rule Will Impact Beneficiary Access to Care

The statutory language of Section 1902(a)(30)(A) of the Social Security Act (Section 30(A)), also known as the equal access provision, clearly indicates the Congress intended that the Secretary of Health and Human Services consider the requirements of efficiency, economy, quality of care, and access in tandem and with equal importance given to each. Irrespective of how CMS interprets state Medicaid financing programs, the proposed rule will impact access—and potentially quality—due to the reduced availability of federal matching funds. Any efforts related to Section 30(A) in this proposed rule must be coordinated with CMS’ plans to develop a uniform methodology for analyzing Medicaid access data. This is especially important in light of the agency’s proposed rescission of requirements that states conduct and submit access monitoring review plans to assure beneficiaries can obtain covered Medicaid services.³ **To address this obligation, CMS should convene stakeholders—including providers—to identify the data truly necessary to achieve its fiscal oversight goals while also supporting access to quality care for beneficiaries.**

The proposed rule does not sufficiently capture the complexity of Medicaid programs. Medicaid programs are reflective of the unique characteristics of participants including population, patient and provider mix, and individual state approaches to addressing state-specific public health and policy priorities. Potential funding reductions stemming from the proposed rule are likely to further strain state budgets and undermine the ability of states to fulfill their Medicaid obligations.

Overall, states’ options to replace federal funding are limited and losses in funding could impact access to care. State Medicaid spending is typically a state government’s second largest general fund expense after primary and secondary education costs.⁴ A 2018 Congressional Budget Office (CBO) analysis of the impact of limiting states’ taxes on providers found that, “most states would not replace all of the revenues lost as a result” of the change and, “on average, states would replace half of lost revenues, but that estimate is highly uncertain.”⁵ In another report, CBO notes that reducing taxes that states are allowed to levy on a Medicaid provider shifts costs and could impact access: “lower federal payments could shift more of the burden of Medicaid programs’ growing costs to the states... Unless states were willing to pay more of the costs themselves or were able to find ways to provide more cost effective care, access to health care services to low income people might be diminished.”⁶ **If states need to fill such a large gap in**

³ 84 Fed. Reg at 33,722

⁴ The Pew Charitable Trusts, “Decade After Recession, Tax Revenue Higher in 45 States,” *Fiscal 50: State Trends and Analysis* (Jan. 9, 2020), <https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2014/fiscal-50#ind0>.

⁵ Congressional Budget Office, *Budget Options Volume 1: Health Care* (Dec. 2008), <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-healthoptions.pdf>.

⁶ Congressional Budget Office, “Limits States’ Taxes on Health Care Providers,” *Options for Reducing the Deficit: 2019 to 2028* (Dec. 13, 2018), <https://www.cbo.gov/budget-options/2018/54727>.

Medicaid funding, they may look to reduce Medicaid provider reimbursement, with a direct negative impact on access to care and services for beneficiaries.

Medicaid traditionally has provided low reimbursement and further payment reductions to providers could result from this rule. Research has shown that Medicaid payment rates are a factor that influence provider participation and can affect access to care. After a provision in the Affordable Care Act raised Medicaid payments for primary care to Medicare levels in 2013 and 2014, the availability of appointments for those with Medicaid coverage increased by nearly 8%⁷. We are concerned the proposed rule does not include an impact assessment on beneficiaries' access to care. The potential implications on beneficiary access are particularly troubling, as CMS simultaneously has proposed rescinding requirements that states monitor beneficiaries' access to covered services in fee-for-service Medicaid. Considering that some access challenges already exist for Medicaid beneficiaries, particularly for behavioral health⁸ and specialty care,⁹ it is vital that CMS take a thoughtful and informed approach to ensure Medicaid policies support strong provider participation and maintain—if not improve—access to the broad range of services needed by beneficiaries.

Concern for Administrative Burden on States, Plans and Providers

Additionally, the proposed rule would require states to submit supplemental state plan amendments (SPA) and health care-related tax waiver requests every three years. Not only does this create a substantial, additional administrative burden for states, but it is unclear how CMS would manage timely review of these arrangements given the agency's current SPA and waiver review backlog. **Any review and approval delays would cause significant uncertainty for states and providers, disrupting state fiscal planning and increasing the risk associated with investing in longer-term priorities such as residency programs, delivery system restructuring, or population health initiatives that span multiple renewal periods.**

We support the goal of transparency and accountability in the Medicaid program, but urge the agency not to impose a high cost of compliance on states and providers by increasing states' already overloaded administrative burden with substantial new reporting requirements. Rather, we recommend CMS work with states and providers to determine what is already being reported to streamline data collection efforts in line with the agency's ongoing efforts to reduce regulatory burden and improve beneficiary experience.

We are also concerned about the near-immediate effective dates for many of the proposed rule's policy changes and the failure to provide sufficient transition time for states and providers to bring their programs into compliance. CMS itself even acknowledged this problem in its notice of comment period extension that stakeholders require "appropriate implementation timelines"

⁷ Polsky D, Richards M, Basseyn S, Wissoker D, Kenney GM, Zuckerman S, Rhodes KV. Appointment availability after increases in Medicaid payments for primary care. *N Engl J Med*. 2015 Feb 5;372(6):537-45. doi: 10.1056/NEJMsa1413299. Epub 2015 Jan 21.

⁸ Centers for Medicare and Medicaid Services, "Children and Youth," (Jan. 2020), <https://www.medicaid.gov/medicaid/benefits/bhs/children-and-youth/index.html>

⁹ Kaiser Family Foundation, "10 Things to Know about Medicaid: Setting the Facts Straight," (March 6, 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

and that the agency would take the comment period extension into consideration when determining effective dates in any final rule. If the rule is not withdrawn, we strongly encourage CMS to delay immediate implementation of the proposed changes until the agency can engage in a stakeholder process to better understand states' ability to meet the rule requirements and until a comprehensive impact analysis on beneficiaries, providers, and Medicaid programs is completed.

Conclusion

CMS cannot implement regulations of this magnitude with an uncertain effect on states and, as such, must withdraw the MFAR in its entirety. While we support CMS' goal to "strengthen the overall fiscal integrity of the Medicaid Program," we believe that goal should be grounded in sound analysis of relevant data. To this end, we recommend that CMS convene a stakeholder process to identify the data that are truly necessary to achieve its fiscal oversight goals while also supporting access to quality care for beneficiaries.

The Partnership for Medicaid appreciates the opportunity to provide these comments and looks forward to working with CMS to strengthen the Medicaid program and support its critical role for beneficiaries. If you have any questions, please contact Shelby Higgins at the American Academy of Family Physicians at shiggins@aafp.org.

Sincerely,

American Dental Education Association
American Health Care Association
America's Essential Hospitals
Association for Community Affiliated Plans
Catholic Health Association of the United States
Children's Hospital Association
The Jewish Federations of North America
Medicaid Health Plans of America
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Council for Behavioral Health
National Health Care for the Homeless Council
National Hispanic Medical Association
National Rural Health Association