



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

January 31, 2020

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, D.C. 20201

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

Dear Administrator Verma:

On behalf of more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates this administration's commitment to ensuring the long-term financial sustainability of the Medicaid program by working with states on transformational changes that have led to more value-based care. California's Medicaid program (Medi-Cal) is an example of such transformation and innovation.

In reviewing the Medicaid fiscal accountability proposed rule, we are struck by the complexity and significance of the changes — as well as the negative impacts the changes, if implemented as proposed, would have on the Medicaid program. While the comment deadline extension was not the full 60-day extension requested for a complete analysis, the additional 14 days is appreciated and, we believe, will result in a robust set of comments submitted for CMS review and consideration.

**However, the proposed rule is of grave concern and, if implemented, will have devastating impacts on Medicaid recipients throughout the nation, disproportionately targeting care for the most vulnerable in California. While CHA supports goals of strengthening fiscal integrity in the Medicaid program, we believe CMS has overstepped with this proposed rule. CHA urges CMS to withdraw the rule. This is not a must-do rule — there is no requirement or deadline to be met. We believe that the current proposals will have a devastating effect on care for low-income people, and for everyone else as a result. CHA stands ready to assist CMS in developing a thoughtful and strategic approach that meets the agency goals while not undermining access to patient care.**

Collectively, Medicaid and the Children's Health Insurance Program (CHIP) serve more than 70 million low-income families and children, pregnant women, elderly, and disabled persons — more than one in five Americans. In California, the Medicaid program (Medi-Cal) provides important health coverage to one in three Californians, more than 40% of children, more than 50% of disabled people, and more than 1 million seniors. Together, Medi-Cal provides services to more than 13 million of California's most vulnerable populations. It serves as the largest part of California's safety-net program and is vital to

California's overall health delivery system, providing coverage and financing for 50% of the state's births, and for 50% of the residents in many rural areas of the state.

California's Medicaid program has among the lowest per capita spending in the country. According to the Kaiser Family Foundation, in fiscal year (FY) 2014, the Medi-Cal program's per capita spend for a full or partial scope beneficiary was \$4,193<sup>1</sup>. This ranks 49<sup>th</sup> of 52 Medicaid programs, with only Alabama, South Carolina, and Nevada spending less on a per capita basis. Considering California is a state with a high cost of living, this reflects a state that is already running a very efficient, low-cost Medicaid program.

Notably, efficiencies have been achieved while quality has continued to improve. According to publicly available data, California hospitals have seen marked improvement in several key patient safety measures, including:

- A significant decrease in health care-associated infection incidence from 2015 to 2018, including a 22% drop in MRSA, a 19% decrease central line-associated bloodstream infections, and a 41% decline in Clostridium difficile (C. diff)
- An 11% drop in early-term births between 2009 and 2016
- A decline of more than 31% in severe sepsis mortality between 2010 and 2016

As evident from these statistics, California hospitals have prioritized quality and the efficient use of our health care dollars. The Medi-Cal program was an early adopter of value-based care through the managed care delivery system, which has led to hospitals and health systems delivering high-quality care at a lower cost. **Despite the efficiencies, Medi-Cal today does not cover the costs of caring for Medi-Cal patients. The proposed rule would require states to either make significant cuts to Medicaid services or populations, or significantly increase local or state taxes to fill the gap — neither a viable nor sustainable solution.**

**Therefore, CHA asks CMS to withdraw the proposed rule for the reasons outlined and summarized below:**

- The impact of the proposed rule is unknown. CMS has failed to complete a rigorous regulatory impact analysis for the proposed rule, including an analysis of its impact on the statutorily mandated factors of access to care and quality, which would be placed at risk by the proposed rule.
- CMS is operating beyond its existing statutory authority and proposing broad discretion with no clear criteria for approvals, creating a black box and uncertainty for states.
- The proposal creates pressure on state/local communities to increase taxes to maintain support for the Medi-Cal program.
- The proposed rule runs contrary to President Trump's Executive Order and CMS' stated intent of reducing regulatory burden.

---

<sup>1</sup> Kaiser Family Foundation Medicaid Spending per Enrollee (Full or Partial Benefit) FY 2014; [Website Link](#)

***The impact of the proposed rule is unknown. CMS has failed to conduct a rigorous regulatory impact analysis for the proposed rule; access to care for Medi-Cal beneficiaries is at risk.***

As CMS recognizes in the preamble, it is required by federal law and Executive Orders to conduct a thorough analysis of the impact of the proposed rule, including an assessment of its costs and benefits<sup>2</sup>. Further, CMS is obligated under the Social Security Act (“SSA”), specifically section 1902(a)(30)(A) (“Section 30(A)”), to assess the impact of the proposed rule on the quality of and access of Medicaid recipients to health care services. **CMS has not complied with these obligations or first gathered the data and conducted the analysis to assess the proposed rule’s impact.**

States around the country will look to their partner, CMS, for guidance on the estimated impact of the proposed rule. States rely upon CMS’ thorough assessment of the administrative requirements, effects on small businesses and other providers, and overall estimated impact to the Medicaid program. Most will ask how these changes might impact their beneficiaries’ access to needed health care services. Unfortunately, Medicaid programs are being asked to make significant changes under the proposed rule but are provided with an incomplete, unsubstantiated impact analysis. CMS acknowledges it didn’t have the data to conduct a thorough regulatory analysis even though it has existing authority to request and collect such data<sup>3</sup>:

*“As discussed in this section and other sections of this preamble, the proposed revisions to 447.252, 447.288(b), and 447.302, include considerable data reporting requirements which would implement section 1902(a)(6) of the Act, requiring the state agency to make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. **The 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 and applicable UPL requirements.**”*

**Most concerning to CHA, CMS has failed to conduct an analysis of the impact on Medicaid beneficiaries. Our analysis of the proposed rule indicates that, if implemented, these policies would dramatically cut Medicaid funding and reduce access to care for our most vulnerable population.** In a state as large as California, there are wide disparities in access to care within the state. Today, Medi-Cal beneficiaries reside in 58 counties and make up one in three Californians. For 18 counties within the state — including most rural counties — Medi-Cal enrollment tops 40% of the county’s population. Specifically, in Tulare County, Medi-Cal enrollment tops 50% of the county’s population. Beneficiaries in this part of the state rely disproportionately on public infrastructure to receive their care — community services, county mental health or behavioral health services, and public hospitals. As is the case in every Medicaid program throughout the country, these counties rely greatly on the reimbursement of services from Medi-Cal, and frequently step up to the plate to provide local resources to serve as the non-federal share of payment. The proposed rule will disproportionately impact these counties because of their large Medicaid populations. While other more urban or less Medicaid-dependent counties might see

---

<sup>2</sup> 84 Fed. Reg. 63772

<sup>3</sup> 84 Fed. Reg. 63747

less of an impact, the unfortunate reality for beneficiaries in these rural, underserved communities is a reduction in their access to critical services.

CMS identifies the following as the anticipated impacts:

- Reporting requirements on state Medicaid programs would be collectively less than 3,700 hours, totaling less than \$150,000 as the total nationwide burden
- No significant effect on a substantial number of small businesses<sup>4</sup>
- Unknown impact on Medicaid program

When evaluating the impact of the proposed rule on small businesses, CMS states only that:

This rule establishes requirements that are solely the responsibility of state Medicaid agencies, which are not small entities. Therefore, the Secretary certifies this proposed rule would not, if promulgated, have a significant economic impact on a substantial number of small entities.

This statement is further evidence that CMS has not assessed the impact of the proposed rule on payments to providers, which include many small businesses. The Secretary may not validly certify there will be no impact on small businesses without thoroughly evaluating this factor.

*CMS has grossly underestimated the impact on state Medicaid programs*

CMS' estimate that the reporting requirements of the proposed rule would impose a nationwide burden of 3,637 hours and a cost of \$145,221 (67 hours per state, cost of \$2,847 per state) is wholly unreasonable. The California Department of Health Care Services (DHCS) has estimated the resources it would need to comply with the reporting requirements would far exceed what CMS has included in its analysis. DHCS has identified the need for the following alone to comply:

- 1) Significant improvements to existing reporting systems
- 2) Hiring new federal reporting staff
- 3) Personnel and data resources to comply with the new requirements to resubmit state plan amendments (SPAs) every three years
- 4) Similar resources needed to conduct new required evaluations for every supplemental payment program upon renewal

**In California, just one evaluation required by CMS under the Special Terms and Conditions (STCs) of the Medi-Cal 2020 (Waiver Number 11-W-00193/9) cost \$500,000 to complete. California alone has a significant number of supplemental payment programs that would need to be renewed. Assuming CMS expects evaluations and the going rate for an evaluation remains constant, the cost to California just with respect to these renewals imposed by the proposed rule would be over \$25 million.**

---

<sup>4</sup> 84 Fed. Reg. 63773

*CMS has not adequately analyzed the impact of the proposed rule on providers and access to quality care.*

CMS is charged by Congress with the important responsibility of ensuring that Medicaid payments for services are consistent with quality of care, and are sufficient to ensure that Medicaid beneficiaries have access to services that is equal to the access available to the general population.<sup>5</sup> Today in California, approximately 40% of the Medi-Cal program's non-federal share is comprised of allowable sources that are not appropriated by the Legislature through the state's General Fund. These non-federal sources include county public funds, special funds, provider taxes, and other permissible sources of non-federal funding. Implementation of this proposed rule will undoubtedly result in substantial reductions of the uses of non-federal sources, impacting provider payments under Medicaid and inevitably leading to reductions in access to quality care. Yet, in the regulatory impact analysis, CMS discusses only the possible impact on supplemental payments to physicians. As discussed below, that analysis is inadequate, as it fails to address supplemental payments to other providers, such as hospitals. As a result, CMS has failed to adequately address this critical factor or explain how the proposed rule is consistent with its obligation to ensure Medicaid beneficiaries have equal access to quality care.

As CMS recognizes in the preamble, many states use health care-related taxes, provider-related donations, certified public expenditures (CPEs), and intergovernmental transfers (IGTs) as the non-federal share of substantial Medicaid payments, including both regular payments and supplemental payments.<sup>6</sup> These payments support public, rural, and other safety-net hospitals to ensure they have adequate funds to sustain their operations, and in most states comprise a substantial portion of the payments to such hospitals. **These providers simply could not endure the payment reductions that would assuredly result from the implementation of the proposed rule — many such hospitals will be forced to close.** Others will be required to curtail operations. This will necessarily result in a widespread deterioration of the safety net and the loss of access to high-quality services for large numbers of Medicaid beneficiaries across the country.

Numerous studies have recognized a high correlation between the adequacy of Medicaid payments and access to quality care. For instance, the Medicaid and CHIP Payment and Access Commission (MACPAC)<sup>7</sup> recently found that higher Medicaid payments continue to be associated with higher rates of accepting Medicaid patients. This is consistent with prior research<sup>8</sup>, which has similarly found that low Medicaid payments — relative to other payers — are consistently shown an important factor in a provider's decision to participate in Medicaid.

---

<sup>5</sup> SSA § 1902(a)(30)(A)

<sup>6</sup> 84 Fed. Reg. 63728-29

<sup>7</sup> See MACPAC, *Physician Acceptance of New Medicaid Patients* (Jan. 24, 2019), available at: <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf>

<sup>8</sup> See, e.g., Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, Medical Care Research and Review, Vol. 62, No. 6 (December 2005) (finding that low physician participation in Medicaid has been shown to negatively affect enrollee access to medical care.)

Similarly, “[s]everal courts<sup>9</sup> have recognized the direct connection between Medicaid recipients' access to medical care and services and low reimbursement rates.” Moreover, both HHS and state Medicaid<sup>10</sup> programs have affirmed the importance of the link between the adequacy of rates and access. Yet, there is no indication that CMS has considered the impact of the proposed rule on payments to providers, apart from the limited and inadequate discussion of supplemental payments to physicians. **CMS may not properly go forward with the proposed rule without studying the effect it would have on Medicaid payments to hospitals and other providers, and then evaluating the impact that such payment reductions would have on access and quality of care received by Medicaid enrollees. The impact on Medicaid payments to providers, quality, and access are clearly relevant factors that CMS is obligated to consider and then demonstrate a reasonable connection between the proposed rule and the furtherance of Congress’ intent that Medicaid rates be adequate to ensure beneficiaries have access to high-quality services.**<sup>11</sup>

The type of study that CMS should have conducted prior to promulgating the proposed rule, and clearly prior to adopting it, would include, at a minimum, the following:

- 1) Which states use health-care related taxes, provider-related donations, CPEs, and IGTs?
- 2) For each state, how these funding sources effect provider payments:
  - a. By provider type
  - b. To specific providers
- 3) Do these funding sources support safety-net providers, including public providers, rural providers, private disproportionate share hospitals, trauma centers, and other providers critical to ensuring access to care?
- 4) Which Medicaid payments for which providers in which states would be placed at risk if the proposed rule were implemented? That is, which funding sources currently in place would not be matched by federal funds under the proposed rule?
- 5) What is the likelihood that each state will sustain the payments generated by these funding sources, either by modifying the manner in which these funding sources are designed and used to comply with the proposed rule, through the diversion of state general funds from other uses, or by raising taxes?

---

<sup>9</sup> *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 701 n.5 (5th Cir. 2007). *See, e.g., Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 (E.D. Cal. 2003), *rev'd on other grounds*, 140 F. App'x 677 (9th Cir. 2005) (“[P]laintiffs have presented sufficient evidence showing that at least some Medi-Cal providers will cease participating in the Medi-Cal program altogether or will refuse to take on new Medi-Cal patients if rates are reduced by 5%.”); *Clark v. Kizer*, 758 F. Supp. 572, 577 (E.D. Cal. 1990), *aff'd in relevant part*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992) (a “major factor that may be used in assessing compliance with the equal access provision is the level of reimbursement”); *Thomas v. Johnston*, 557 F. Supp. 879, 903-04 (W.D. Tex. 1983) (“The link between the adequacy of reimbursement rates paid to providers and the adequacy of care provided to Medicaid recipients is quite obvious.”)

<sup>10</sup> *See Equal Access for El Paso, supra*, at 701 n. 5 (taking judicial notice that the Texas state Medicaid program “expressly recognized . . . [that r]ate increases for physicians would promote access to care for Medicaid clients that would likely erode without the increase”); *Clark, supra*, at 576 (E.D. Cal. 1990) (discussing the amicus brief filed by HHS which explained that the two major factors it used to measure equal access were level of participation and level of reimbursement)

<sup>11</sup> *See, e.g., Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 418 (1971); *Motor Vehicle Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29, 44 (1983)

- 6) Will safety-net providers, rural hospitals, and others that serve a disproportionate share of Medicaid beneficiaries close or be forced to reduce services if the proposed rule were implemented?
- 7) After evaluating in detail the likely impact of the proposed rule on Medicaid payments to providers and their ability to continue to operate, what will the impact be on access for Medicaid beneficiaries as compared to access for other patients, and how will the payment reductions affect quality?

CMS must be able to offer a reasonable explanation for why the administrative record rationally supports its ultimate determinations. In order to do so, it must consider relevant factors — demonstrating its actions are consistent with its obligations to assure quality of care and equal access — such as the studies proposed above. These relevant factors will inform CMS as to whether the proposed rule would, as we suspect, significantly limit states’ ability to fund their Medicaid programs, whether states would be able to redesign their Medicaid funding to comply with the proposed rule, and whether states would be able to make up for the funding shortages that would likely result from implementing the proposed rule through the use of state general funds, either by diverting funds from other uses or by raising taxes to generate additional revenue. CMS must demonstrate that it has considered this type of critical analysis prior to concluding that the proposed rule is consistent with quality of care and equal access. **If CMS cannot come to this conclusion — through the gathering of data and conducting the sorts of analysis provided above — it cannot lawfully adopt the proposed rule.**

Completing this type of study is especially important on the heels of CMS’ recent efforts to rescind the process states must use to document whether payments in fee-for-service (FFS) Medicaid are sufficient to ensure access in a manner that is consistent with the equal access provision in the Social Security Act, Section 30(A). In 2015, the Supreme Court’s ruling in *Armstrong v. Exceptional Child Center, Inc.* eliminated the private right of action to contest payment rate changes under Section 30(A).<sup>12</sup> Several months later, CMS issued a long-awaited final access monitoring review regulation stemming from this obligation<sup>13</sup>. The FFS access monitoring final rule was implemented by CMS to strengthen its review and enforcement of Section 30(A) by requiring evidence-based state reporting.

CMS has subsequently eliminated its policies aimed at ensuring continual access monitoring, as well as its review mechanism for effectively stopping the clock on a state’s proposed rate reductions while a federal evidence-based review takes place. In September 2017, CMS issued a transmittal letter<sup>14</sup> titled “Medicaid Access to Care Implementation Guidance,” which carved out additional scenarios not contemplated by the FFS access monitoring final rule, where no access review would be required by states. Then, on July 15, 2019, CMS proposed to rescind the FFS access monitoring final rule altogether.<sup>15</sup> Rescission of the final rule leaves a substantial void with respect to CMS’ obligation to enforce the equal access provision of Section 30(A). This void was highlighted in MACPAC’s comments to the proposed rule: “[t]he proposed rule . . . does not indicate how the federal government will fulfill this responsibility. Furthermore, state activities to collect and report data are necessary for the federal

---

<sup>12</sup> *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 329 (2015).

<sup>13</sup> 80 Fed. Reg. 67576 (Nov. 2, 2015).

<sup>14</sup> State Medicaid Director (SMD) # 17-004

<sup>15</sup> 84 Fed. Reg. 33722.

government to carry out this obligation. The proposed rule does not provide a clear alternative approach to the existing requirements.”<sup>16</sup>

The proposed rule would have significant impacts to access in California as a significant proportion of the state’s non-federal share, annually, could potentially be at risk. While the exact magnitude of these reductions is unknown, **a reduction in Medi-Cal payments will assuredly result in reduced access to services if the proposed rule is implemented. The payment reduction that will likely occur if the proposed rule is adopted, combined with CMS’ rescission of the FFS access monitoring review requirements, is wholly inconsistent with Section 30(A)’s quality of care and equal access requirements.**

*The impact analysis on physician supplemental payments is inadequate and demonstrates the proposed rule should not be adopted.*

CMS addresses the fiscal impact on the Medicaid program in its regulatory impact analysis. CMS acknowledges that the fiscal impact is “unknown.”<sup>17</sup> CMS cannot validly adopt a regulation of this magnitude without doing better than to say the fiscal impact is unknown, particularly where the fiscal impact is clearly a relevant factor that will directly affect access to quality care for people.

The only component of the proposed rule addressed in the fiscal impact analysis is the limitation on supplemental payments to practitioners. There is no analysis of the impact of the proposed rule with respect to other providers. There is no analysis of the impact of the proposed rule’s provisions addressing IGTs, CPEs, health care-related taxes, and provider-related donations. Again, without such an analysis, CMS should not, and may not legally, adopt the proposed rule.

Further, CMS’ discussion of the limitation on practitioner supplemental payments demonstrates both the insufficiency of its analysis and the risks inherent in the proposed rule. CMS analyzes a subset of the physician supplemental payments in 2017, but for only 21 states. According to CMS, the 21 states made approximately \$478 million in supplemental payments, which — added to the base reimbursement — totaled \$990 million in reimbursement to eligible physicians. In this example for the 21 states, CMS estimated, if the proposed rule were finalized in 2017, total reimbursement would have been reduced to \$768 million, a reduction of \$222 million in payments or roughly 23%. Even in this example where CMS had confidence to include an estimated impact, CMS speculates it is unlikely that states wouldn’t intervene and raise base reimbursement or use other resources to mitigate the 23% payment reduction. However, CMS fails to actually analyze whether the 21 states have the ability to actually do so. Every state (including the 21 that CMS identifies) struggles with balancing their budgets to provide adequate funding for education, public health, public safety, and other important state priorities. It is unreasonable to assume that states will be able to close the Medicaid funding gaps created by this proposed rule without having to reduce services and cut reimbursement to providers, thereby jeopardizing access to care for beneficiaries.

---

<sup>16</sup> MACPAC, *RE: CMS-2406-P2 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Rescission* (Sept. 6, 2019), available at: <https://www.macpac.gov/wp-content/uploads/2019/09/MACPAC-Comments-on-Methods-for-Assuring-Access-to-Covered-Medicaid-Services%E2%80%94Rescission.pdf>.

<sup>17</sup> 84 Fed. Reg. 63773.



A 23% reduction in Medicaid payments to practitioners in these 21 states will undoubtedly have an adverse impact on access to care and result in access for Medicaid recipients that is not equal to the access enjoyed by other patients. Further, if this rate of supplemental payments as a component of total payments is reflective of payments to other providers, it is clear that a loss of supplemental payments due to the proposed rule will cause providers to close and deprive Medicaid recipients of access to high-quality services.

At the very least, this rate of supplemental payments provides CMS with a clear warning that it must carefully examine the portion of total Medicaid payments to specific provider groups and specific providers that supplemental payments, as well as other payments funded by IGTs, CPEs, health care-related taxed, and provider related-donations, comprise. We suspect in other states there are many provider groups, including safety-net providers, for which more than 23% of Medicaid payments are supported by these funding sources, and a loss of the related Medicaid payments will be catastrophic for these providers and the patients they serve.

***CMS is operating beyond its existing statutory authority and proposing broad discretion with no clear criteria for approvals, creating a black box and uncertainty for states.***

**CHA acknowledges CMS' responsibility to oversee the Medicaid program, but CMS cannot adopt a rule that restricts the use of local governmental funds, health-care related taxes, or provider-related donations in a manner that is outside the scope of the agency's statutory authority set forth by Congress. In the following provisions, CMS exceeds its statutory authority within this proposed rule — a reason this rule should be rescinded. At a minimum, these specific provisions must be removed.**

*The Social Security Act largely affords states with flexibility to determine how to fund their share of Medicaid expenditures*

The SSA requires only that state funds make up at least 40% of the non-federal share, with no limitation on the types of public funding sources that would qualify to fund the remaining non-federal share. Specifically, SSA Section 1902(a)(2) provides that a state plan must:

*“provide for financial participation by the State equal to not less than **40 per centum of the non-Federal share** of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;”*

It is well established that as much as “sixty percent of the non-federal share of a State's Medicaid expenditures may be funded by sources other than the State.”<sup>18</sup> As such, counties, municipalities, and other units of local government, including providers operated by local governments, contribute to the non-federal share of Medicaid spending in many states. These units of local government do so by either transferring local government funds in the amount of the non-federal share of Medicaid payments to

---

<sup>18</sup> *Ashley Cnty. Med. Ctr. V. Thompson*, 205 F. Supp. 2d 1026, 1030-31 (E.D. Ark. 2002).

the state Medicaid agency (IGTs) or by certifying the total expenditure incurred to provide Medicaid services (CPEs).

Section 1903(w)(1)(A) of the Act specifies limited and express restrictions on impermissible health care-related taxes and non-bona fide provider-related donations serving as the non-federal share. However, importantly, the Social Security Act does not otherwise dictate how states are to fund their share of Medicaid expenditures. To the contrary, Congress expressly limited CMS' ability to restrict states' flexibility with respect to funding the non-federal share:

*“Notwithstanding the provisions of this subsection, **the Secretary may not restrict States’ use of funds** where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in section 1396a(a)(2) of this title, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.”<sup>19</sup>*

**This provision of the Social Security Act places limitations on CMS’ ability to restrict states’ uses of funds for the non-federal share where such funds are “derived from State or local taxes” and transferred via IGTs or CPEs. It does not restrict states’ funding of the non-federal share to situations where such funds are “derived from State or local taxes.”**

Congress enacted section 1903(w)(6)(A) of the Act as part of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (the “1991 Amendments”).<sup>20</sup> When these amendments were enacted, the federal government permitted IGTs of “public funds,” which were broadly defined as funds transferred from another public agency to the state Medicaid agency that are not federal funds and are eligible for federal financial participation.<sup>21</sup> The 1991 Amendments were enacted partially to place a moratorium on CMS’ ability to restrict the States’ use of funds in certain circumstances.<sup>22</sup> This moratorium is expressly set forth in Section 1903(w)(6)(A), which says that CMS “**may not restrict States’ use of funds** where such funds are **derived from State or local taxes** . . . transferred from or certified by units of government within the State” (emphasis added).

This section plainly restricts CMS; it does not restrict states’ use of funds to situations where such funds are “derived from State or local taxes.” CMS and its predecessor agency, HCFA, have acknowledged this moratorium since the 1991 amendments were enacted.<sup>23</sup> Section 1903(w)(6)(A) certainly does not

---

<sup>19</sup> SSA § 1903(w)(6)(A).

<sup>20</sup> Public Law 102-234.

<sup>21</sup> See 42 C.F.R. § 433.54 (1992).

<sup>22</sup> See generally H.R. Rep. No. 102-310 (1991).

<sup>23</sup> See Medicaid Program: Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55118, 55119 (Nov. 24, 1991); 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).

authorize CMS to restrict a state's use of other local funds as the non-federal share of Medicaid funding, which would be inconsistent with the statutory scheme, as noted above.

**CMS cannot adopt a rule that restricts the use of local governmental funds, health-care related taxes, or provider-related donations in a manner that is more stringent than set forth by Congress in these provisions. Yet, that is precisely what the proposed rule would do.**

*The proposed rule would impermissibly restrict states' ability to fund the non-federal share*

As currently constructed, § 433.51 is consistent with the broad statutory authority afforded to state Medicaid programs to determine how to fund the non-federal share of Medicaid expenditures. Current § 433.51 provides that "public funds" may be considered as the non-federal share in claiming federal financial participation if they meet the following requirements:

*(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control or certified by the contributing public agency as representing expenditures eligible for FFP under this section.*

*(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.*

However, the proposed rule would dramatically revise § 433.51. "State or local funds may be considered as the State's share in claiming Federal financial participation" only if they meet paragraphs (b) and (c), below:

*(b) State or local funds that may be considered as the State's share are any of the following:*  
*(1) State General Fund dollars appropriated by the State legislature directly to the State or local Medicaid agency.*

*(2) **Intergovernmental transfer** of funds from units of government within a State (including Indian tribes), **derived from State or local taxes** (or funds appropriated to State university teaching hospitals), to the State Medicaid Agency and under its administrative control, except as provided in paragraph (d) of this section.*

*(3) **Certified Public Expenditures**, which are certified by a unit of government within a State as representing expenditures eligible for FFP under this section, and **which meet the requirements of § 447.206** of this chapter.*

*(c) The State or local funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.*

*(d) State funds that are provided as an **intergovernmental transfer from a unit of government within a State 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 that is non-bona fide under §§ 433.52 and 433.54.***

These proposed changes are inconsistent with the Medicaid Act in various respects. First, proposed section 433.51(b)(1) appears to limit permissible state funds to state general fund dollars appropriated to the state Medicaid agency. The apparent limitation to “general fund” dollars is not authorized by the Medicaid Act. Rather, federal law permits any state funds to be used as the non-federal share with express exceptions, such as the exclusion of certain health-related taxes and provider donations, regardless of whether such funds are part of a state’s general fund.

States, including California, use special funds for various purposes. These special funds are generally authorized legislatively or even voter-approved funding sources owned by the state and typically dedicated for specific purposes. 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 simply no authority for CMS to exclude such funds for the permissible source of the non-federal share of Medicaid expenditures. Such a proposal will have devastating and long-term consequences, making this provision as proposed unworkable.

An example is the voter-approved California tobacco tax. The California voters approved an initiative increasing the tax on tobacco products in 2016 through the approval of Proposition 56. The tax proceeds are deposited in a special fund, apart from the state’s General Fund. A significant portion of these proceeds are used to fund Medi-Cal payments to providers. These monies are clearly state funds that may be used as the non-federal share of California’s Medicaid expenditures under federal law. There is simply no basis for excluding these funds simply because they are deposited in a special fund.

Second, while proposed § 433.51(b)(2) continues to allow IGTs to serve as the non-federal share of Medicaid payments, it would impose new restrictions on the funds that can be used as IGTs to those “derived from State or local taxes” and “funds appropriated to state university teaching hospitals.”<sup>24</sup> As discussed above, these restrictions would be a misapplication of the **restriction placed upon CMS** under Social Security Act § 1903(w)(6)(A), and would be inconsistent with the intent of Congress to impose a permanent moratorium on further restrictions on the source of funding for IGTs. As noted, under this statute, Congress placed a restriction on CMS’ ability to limit states’ use of funds where such funds are “derived from State or local taxes,” but it did not restrict states’ ability to rely upon funding via IGTs only where they are “derived from state or local taxes (or funds appropriated to state university teaching hospitals).” Further, the statute does not otherwise restrict or authorize CMS to restrict a state’s use of other local funds as the non-federal share of Medicaid funding. Such a restriction would be inconsistent with Section 1902(a)(2), where Congress provides that up to 60% of a state’s non-federal share of Medicaid funding may come from local funding. Again, Congress does not limit such funding to funds derived from state and local taxes. By imposing this limitation, CMS would act beyond its authority. **Rather, CMS must comply with the broad mandate in Section 1902(a)(2) and allow all local funding sources except those specifically prohibited by Congress so long as they do not exceed 60% of the state’s non-federal share.**

Third, proposed § 433.51(b)(3) similarly continues to allow CPEs to serve as the non-federal share of Medicaid payments, but it would impose a new restriction that such funds must meet the requirements of proposed § 447.206. Proposed § 447.206(b)(4) requires “[t]he certifying entity of the certified public expenditure must receive and retain the full amount of Federal financial participation associated with

---

<sup>24</sup> 84 Fed. Reg. 63738.

the payment, consistent with the cost identification protocols in the Medicaid State plan and in accordance with § 447.207.” Proposed § 447.207(a) provides:

*Payments. Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable). The Secretary will determine compliance with this paragraph (a) by examining any associated transactions that are related to the provider’s total computable Medicaid payment to ensure that the State’s claimed expenditure, which serves as the basis for Federal financial participation, is consistent with the State’s net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied. Associated transactions may include, but are not necessarily limited to, the payment of an administrative fee to the State for processing provider payments or, in the case of a non-State government provider, for processing intergovernmental transfers. In no event may such administrative fees be calculated based on the amount a provider receives through Medicaid payments or amounts a unit of government contributes through an intergovernmental transfer as funds for the State share of Medicaid service payments.*

CMS states that proposed § 447.206 is a codification of “longstanding policies” implementing Section 1902(a)(4) for proper and efficient operation of the state plan; Section 1902(a)(30)(A) requiring that payments be economic and efficient; and Section 1903(w)(6)(A) permitting states to use CPEs.<sup>25</sup> However, **the incorporation of the retention requirements from proposed § 447.207 is completely outside the scope of any of these statutory authorities. No such restrictions are placed upon CPEs under the Social Security Act.**

Finally, proposed § 433.51(d) would add a provision that IGTs 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 that is non-bona fide” and, therefore, would not be federally matched. CMS states that proposed subsection (d) prohibits “any IGTs that are derived from, or are related to, non-bona fide provider-related donations. In the preamble to the proposed rule, CMS explains that this requirement is intended to implement SSA Section 1903(w)(6)(A). However, the contingency in proposed § 433.51(d) goes beyond this statutory authority because Section 1903(w)(6)(A) only permits CMS to restrict IGTs “**derived by** the unit of government from donations or taxes that would not otherwise be recognized as non-federal share.” CMS is barred from restricting the use of these funds where they are “**related to**” but not “derived” from such donations or taxes.<sup>26</sup> Further, the proposed rule invents novel requirements that funds may not be federally matched where they are “contingent upon” or “actually replaced in the accounts of” the transferring unit of government from an unallowable source. These new requirements are neither found in the Medicaid statute nor are they defined in the proposed rule, and they appear to be intended to give CMS broad discretion to govern transactions or practices that are beyond the scope of authority delegated to the agency by Congress.

---

<sup>25</sup> 84 Fed. Reg. 63744.

<sup>26</sup> SSA § 1903(w)(6)(A)-(B).

*The Social Security Act requires CMS to waive either the broad-based and/or uniformity requirements where a tax is generally redistributive*

Section 1903(w) of the Social Security Act provides that an amount to be paid to a state shall be reduced by the sum of revenues “from health care related taxes (as defined in paragraph (3)(A)), **other than broad-based health care related taxes.**” (SSA § 1903(w)(1)(A)(ii)-(iii).) In other words, “broad-based health care related taxes” are eligible for federal matching funds. Generally, “broad-based health care related taxes” are those levied against all non-governmental providers in a particular class<sup>27</sup> (not only those that accept Medicaid payments), and those imposing a tax rate that is uniform across all providers in the class (Section 1903(w)(3)(B)).<sup>28</sup>

Importantly, there is an exception to either the broad-based and/or uniform requirements: in Section 1903(w)(3)(E) of the Act, CMS is required to waive either the broad-based and/or uniformity requirements as long as the state can demonstrate that the net impact of the tax program is “**generally redistributive in nature**” and not directly correlated to Medicaid payment amounts.

*The proposed “undue burden” test is superfluous*

Under current § 433.68(e), if a state meets certain statistical tests, either the broad-based and/or uniformity requirements are waived, and a tax is deemed to be generally redistributive in nature.<sup>29</sup> The current P1/P2 and B1/B2 statistical tests in § 433.68(e) provide a clear connection to analyzing whether the net impact of the tax program is “generally redistributive in nature” with respect to a “class of health care items or services.” These tests provide a data-driven process to determine the general nature of proposed taxes. Further, these statistical tests are directly tied to the statutory broad-based and uniform requirements.

Proposed § 433.68(e)(3) would add an additional “undue burden” test that states need to meet, regardless of whether the state can meet the long-standing P1/P2 or B1/B2 tests. Under the proposed rule, a tax will be deemed to impose an undue burden where:

*“(i) The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity.*

*“(ii) Within each taxpayer group, the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (except as a result of excluding from taxation Medicare or Medicaid revenue or payments as described in paragraph (d) of this section).*

*“(iii) The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group, unless all entities in the taxpayer group with no Medicaid activity meet at least one of the following:*

---

<sup>27</sup> SSA § 1903(w)(7)(A) (setting forth each separate class of health care items and services).

<sup>28</sup> SSA § 1903(w)(3)(B).

<sup>29</sup> See 42 C.F.R. 433.68(e)(1) (the P1/P2 statistical test to waive the broad-based requirement), and (2) (the B1/B2 statistical test to waive the uniform tax requirement).

- (A) *Furnish no services within the class in the State.*
- (B) *Do not charge any payer for services within the class.*
- (C) *Are Federal provider of services within the meaning of § 411.6 of this chapter.*
- (D) *Are a unit of government.*

*(iv) The tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the **totality of the circumstances**, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group.*

The current P1/P2 and B1/B2 tests are directly tied to the Social Security Act's broad-based and uniformity provisions. They are also are rationally related to CMS' delegated authority to determine that a tax is generally redistributive through effective, statically driven, analysis. In juxtaposition, Congress does not direct CMS to require that a health-care related tax not place an undue burden on Medicaid, in addition, in order for the tax to be considered the non-federal share of Medicaid funding. **Proposed § 433.68(e)(3) also gives CMS unconstrained authority to decide that a health-care related tax imposes an undue burden on Medicaid based on the "totality of circumstances." This is an overly broad and amorphous standard, which fails to constrain the agency's potentially arbitrary decision making.**

The "totality of the circumstances" standard, as well as the "net effect" standard discussed below, are impermissibly vague. Laws must "provide explicit standards for those who apply them" in order to prevent arbitrary and discriminatory enforcement.<sup>30</sup> The proposed rule's totality of the circumstances and net effect standards fail to articulate standards that are sufficiently specific so that the regulated entities can identify permissible activity. Rather, the proposed rule would provide CMS unrestrained authority to make impromptu decisions on a case-by-case basis, which could lead to uneven application across state Medicaid programs. This is a violation of the requirement for laws to provide explicit standards for those who apply them. Moreover, this sort of "unfettered discretion is patently offensive to the notion of due process."<sup>31</sup>

The "undue burden" test is neither provided for under the Social Security Act nor grounded in a reasonable relationship to the determination as to whether the net effect of a tax is generally redistributive. Moreover, if states had to meet this test, it would have a disruptive impact on payers with a lower volume of Medicaid beneficiaries.

*Proposed net effect standard is amorphous and would grant CMS with unconstrained authority*

The proposed rule would add the following definition for "net effect" to § 433.52:

*Net effect means the overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in cash or in kind, among participating entities. The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities, and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity.*

<sup>30</sup> *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).

<sup>31</sup> *Bullfrog Films, Inc. v. Wick*, 847 F.2d 502, 513-15 (9th Cir. 1988).

This definition is incorporated to determine both that there is a hold harmless arrangement (proposed § 433.68(f)) and that there is a bona fide provider-related donation (proposed § 433.54). For example, under proposed § 433.54, there would exist a bona fide provider-related donation where:

*The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver **directly or indirectly guarantees** to return any portion of the donation to the provider (or other party or parties responsible for the donation.) **Such a guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement** between the State (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation. The net effect of such an arrangement may result in the return of all or a portion of the donation, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement*  
*Provider related donations.*

**Similar to the “undue burden” test discussed above, this is an overly broad standard that fails to constrain the agency’s decision making to ensure it is not arbitrary. Further, both “hold harmless” and “bona fide provider-related donations” are clearly defined terms in Sections 1903(w)(3)(B) (hold harmless) and (2)(B) (bona fide provider-related donation) of the Social Security Act, respectively. Application of the “net effect” standard to both the hold harmless and bona fide donation provisions also falls outside of CMS’ regulatory authority, and there is no basis for expanding these, particularly in a way that renders them unclear.**

***Reporting requirements, while critically important for oversight and transparency, contradict the agency’s goals of reducing administrative burden.***

CMS stated publicly that it is the administration’s top priority to put patients first. This is further supported by the President’s Executive Order that directs federal agencies to reduce burdensome regulations, which was committed to by CMS through the “Patients over Paperwork” initiative. When CMS launched the initiative in 2017, CMS laid out its intended goals to:

- 1) Reduce unnecessary burdens
- 2) Increase efficiencies
- 3) Improve the beneficiary experience

Unfortunately, this proposed rule includes administrative requirements that will adversely impact CMS and Medicaid agencies. More specifically, CMS proposes additional reporting requirements for upper payment limit (UPL) demonstrations and supplemental payments (§447.288), changes with state plan requirements (§447.252), limitations to waiver provisions applicable to health care-related taxes (§433.72), and state plan requirements including an evaluation prior to renewal (§447.302).

**While CHA fully supports CMS’ efforts to collect information that would inform a robust impact analysis, including access to care for beneficiaries, the provisions outlined in the proposed rule are excessive, and we do not believe CMS fully understands the magnitude or volume of data it is requesting.**



Most notably, CMS has not fully considered an appropriate timeline with which states would need to comply. There is no discussion of the need to develop additional information technology or personnel and the time it would take for CMS to manage the volume of data being sent. CMS and Medicaid agencies around the country learned through the launch of Transformed Medicaid Statistical Information System (T-MSIS) that there is no easy mechanism for transmitting significant volumes of data and a staged approach, including prioritization of information, is needed. Because CMS has not articulated how such data collection would be managed and utilized, or assessed the ability of states to comply with the proposed timeline, we believe that neither CMS or the state agencies are prepared to meet the requirements laid out in the proposed rule.

**It is unreasonable to assume that Medicaid agencies will be capable of supplying this level of information in a real-time manner immediately, while maintaining the strict program integrity requirements and patient-level confidentiality that is required for transmitting protected health information.**

For example, in California, simply imposing three-year limitations as proposed in § 447.252 on SPAs will require the Medicaid agency to open up hundreds of pages of the state plan that will be required to be reapproved. Not only does CHA believe this three-year limitation is arbitrary, but we believe this will add an unnecessary burden on state Medicaid agencies around the country, and the expected timeline as proposed does not stagger the SPAs for CMS. This will immediately result in a tremendous backlog. Even with CMS' recent changes with the SPA process that have created some agency efficiencies, this positive change has been in the context of the existing CMS and Medicaid agency workloads.

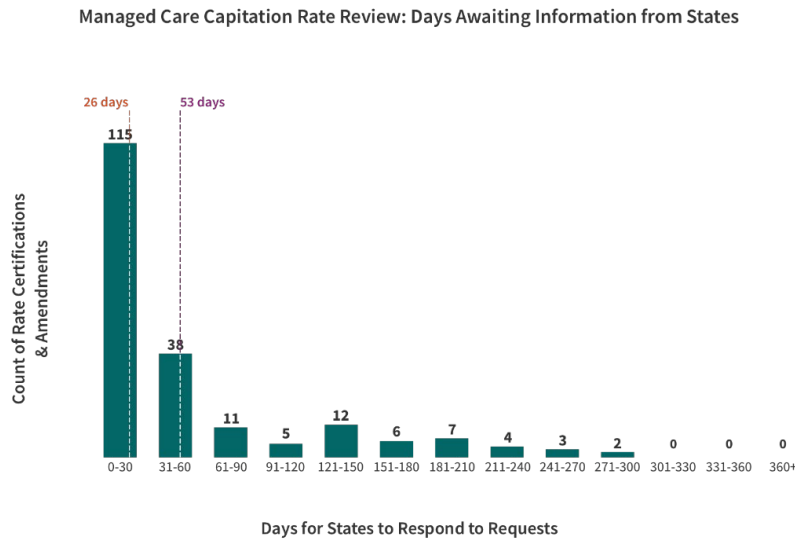
Working with stakeholders, CMS could further streamline processes to allow for further refinement and more timely approvals. The importance of the state plan or contract between a state and the federal government cannot be understated. The administration of all Medicaid programs is a joint state and federal partnership. Forcing a partner (i.e., state) to wait over two years before approval can be granted, is not only an inefficient way to manage the program but also disadvantages states, as they quickly lose their ability to obtain federal matching funds due to the two-year federal claiming limits. This inability to obtain federal funding then directly impacts the beneficiaries of Medicaid program services and the providers that are part of the delivery system.

CHA is concerned this proposed regulatory change (§ 447.252) will only add to states' regulatory burden, and we will see the federal approval process for more SPAs in California approach and possibly exceed two years. These unnecessary changes will create further delays in SPA approvals that we believe will resemble what is currently occurring with CMS approvals of managed care rates and contracts.

California is currently observing, on average, an 18-month CMS review and approval process with managed care rates and contracts. These delays negatively impact Medicaid agencies and providers around the country. CHA urges CMS to carefully review its recent data that illustrate the current complexity in the review/approval process is yielding significant delays for managed care capitation rate reviews.

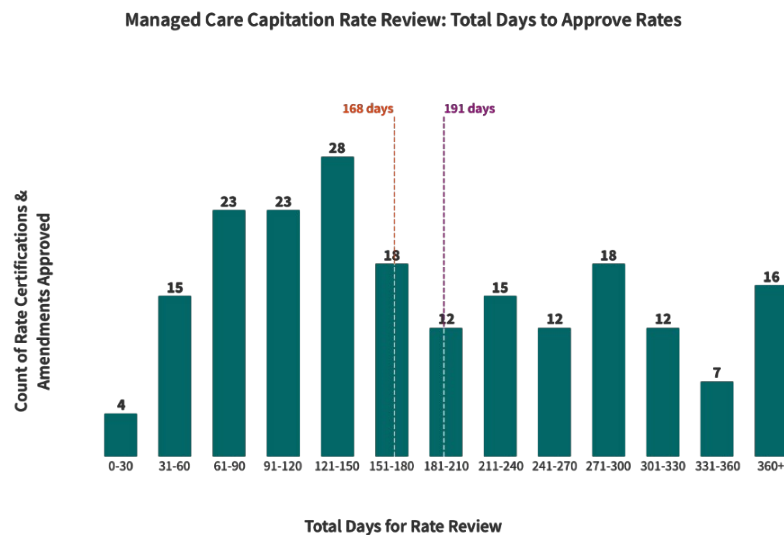
As Figure 1<sup>32</sup> shows, states are complying and responding quickly to the technical requests by the CMS Office of the Actuary (OACT). The vast majority of states are responding within 30 or 60 days to the hundreds of OACT technical questions.

Figure 1



While states are responding quickly to the CMS OACT questions, for nearly half of the rate packages CMS is taking more than six months to approve (Figure 2). More than 10% of states will wait a year or longer. As result, this has created a ripple effect impacting the entire health care delivery system.

Figure 2



<sup>32</sup> <https://www.medicaid.gov/state-overviews/scorecard/index.html>

***The proposed rule creates pressure on state/local communities to increase taxes to maintain support for the Medi-Cal program.***

As stated above, CMS' proposed changes to limit intergovernmental transfers to **state or local taxes** will create additional pressure on counties and states that utilize these arrangements. In California, this proposed rule effectively places every county in a position where they will be required to increase local taxes in order to maintain the funding of their share of the Medi-Cal program. In counties where a disproportionate share of the population is covered by the Medi-Cal program, this limiting provision of the proposed rule will have the greatest community impact.

CHA disagrees with CMS' premise that, in order to improve fiscal accountability in the Medicaid program, states should force their disproportionately impacted providers and communities to raise additional or create new health care-related taxes to support the existing programs. It is unrealistic and counter to the agency's congressional mandate to assume that an already efficient Medicaid program like California—with one of the lowest per capita spend—could withstand a 23% reduction and maintain equal access and quality. Nationally, Medicaid beneficiaries will suffer the consequences of decreases in access. In California, Medi-Cal beneficiaries will lose access to critical services and providers; local counties and their constituents will be required to raise taxes to protect and offset the expected reductions; and the indirect tax or hidden tax will shift greatly to other areas of the health insurance market (e.g., employer-sponsored beneficiaries, Covered California health plans, etc.).

Again, while CHA strongly supports the goal of strengthening fiscal integrity in the Medicaid program, we believe CMS has overreached with this proposed rule. **For all the reasons stated above, CHA urges CMS to withdraw the rule.**

We appreciate the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to me at [akeefe@calhospital.org](mailto:akeefe@calhospital.org) or (202) 488-4688, or my colleague Ryan Witz, vice president, health care finance initiatives, at [rwitz@calhospital.org](mailto:rwitz@calhospital.org) or (916) 552-7642.

Sincerely,

/s/

Alyssa Keefe

Vice President, Federal Regulatory Affairs