January 31, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on Medicaid Fiscal Accountability Regulation (CMS-2393-P)

Dear Administrator Verma,

The Association for Community Affiliated Plans (ACAP) thanks you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule “Medicaid Fiscal Accountability.” ACAP is a national trade association representing 67 not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than 20 million people through Medicaid, Medicare, the Marketplaces, and other publicly-supported coverage programs. Our mission is to support our member plans’ efforts to improve the health and well-being of people with low incomes and with significant health care needs.

Medicaid is a joint federal-state program that provides coverage to over 72 million people. Medicaid provides coverage for health and other related services for the nation’s most economically disadvantaged populations, including low-income children and their families, low-income seniors, and low-income people with disabilities. As a major payer in the health care system, it accounted for about 17 percent of national health care spending in 2016.¹

With Medicaid’s large role in the health care system, it is important that CMS works to improve transparency and program integrity efforts. However, ACAP is concerned that the proposed rule undermines state flexibility, reduces Medicaid funding, and reduces access to necessary services. This will leave the program and its beneficiaries in jeopardy. ACAP is also particularly concerned that CMS has stated in the proposed rule that the “fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown.” This is incredibly alarming as CMS is proposing to implement significant changes to Medicaid financing but is unaware of how it will affect the program overall, states, providers, plans, and, most importantly, beneficiaries.

Our main concerns, outlined in more detail below, fall into the following categories:

- **Decreased State Flexibility, Medicaid Funding, and Access to Care**
  - ACAP is concerned that these changes will limit state flexibility to generate state share, which will have downstream effects on state Medicaid funding and ultimately reduce access to critical services for Medicaid beneficiaries.

- **Increased Program Oversight Opacity**
  - ACAP is concerned that these changes provide CMS increased authority without specific review criteria and will create increased confusion and Opacity for states and stakeholders when trying to abide by Medicaid program rules.

- **Increased Burden on States**
  - As a result of repurposing agency resources to comply with these administrative requirements, ACAP is concerned that the states’ ability to actually provide and finance services through the Medicaid program will be reduced.

- **Lack of Data to Determine Overall Effects**
  - ACAP is concerned that CMS is proposing to make these significant changes to Medicaid financing without quantifying the fiscal impacts of the changes.

**ACAP urges CMS to withdraw this rule and instead consult with the appropriate stakeholders on how to improve the financing and operation of state Medicaid programs and assess the effects of the proposed changes on Medicaid programs and beneficiaries.**

We appreciate this opportunity to comment on the proposed rule and have outlined our concerns regarding the rule in more detail below.

**I. Decreased State Flexibility, Medicaid Funding, and Access to Care**

Through the proposed rule, CMS outlines a number of changes that reduce states’ ability to generate state share to finance their Medicaid program. CMS is proposing changes to the structure and definitions relating to intergovernmental transfers (IGTs), certified public expenditures (CPEs), provider donations, and health care related taxes. **ACAP is concerned that these changes will limit state flexibility to generate state share, which will have downstream effects on state Medicaid funding and ultimately reduce access to critical services for Medicaid beneficiaries.**

CMS has continually advocated for increased state flexibility when administering the Medicaid program. However, this proposed regulation runs in contrast to that philosophy.
Instead, through changes to IGTs, CPE, provider donations, and health care related-taxes, CMS has reduced state’s ability to generate state share, while also failing to provide additional or other avenues for states to generate state share funding. These changes reduce states’ control in administering a Medicaid program that meets the unique needs of the state.

Additionally, these changes will reduce state budgets, including state Medicaid budgets. Reducing states’ ability to generate funding through IGTs, CPEs, provider donations, and health care related-taxes reduces state Medicaid funding. This will likely force states to reduce Medicaid services or provider reimbursement. That will ultimately increase financial burden on the health care safety net, which will continue to provide services to vulnerable populations regardless of reimbursement for the provision of services.

Additionally, under § 447.406 of the proposed rule, CMS is outlining changes to Medicaid practitioner supplemental payments. Specifically, CMS is proposing limiting supplemental payments to Medicaid practitioners to 50 percent of base payments for services provided in most urban areas and 75 percent of base payments for services in a HRSA-designated health profession shortage area or a rural area. Currently, states calculate supplemental payments based on average commercial rate (ACR). This change is effectively removing ACR calculations and capping supplemental payments to 50 or 75 percent of base payments for services.

ACAP is concerned that this will drastically reduce reimbursement to providers. Medicaid base payments are historically lower than Medicare and private payer rates. The ACR calculation allows states to provide Medicaid practitioners supplemental payments to account for low Medicaid reimbursement. Capping supplemental payment rates will reduce provider reimbursement and place increased strain on the health care safety net. ACAP is also concerned that this change will result in less providers accepting Medicaid patients, which will reduce access to care for beneficiaries.

ACAP urges CMS to remove provisions that decrease state flexibility in generating state share or reduce states’ ability to provide supplemental payments to providers.

II. Increase in Program Opacity

The proposed rule also makes several changes that increase CMS authority and discretion. However, the rule does not outline specific criteria CMS will use in reviewing and approving supplemental payment arrangements or data files. ACAP is concerned that these changes
provide CMS increased authority without specific review criteria and will create increased confusion and opacity for states and stakeholders when trying to abide by Medicaid program rules.

For example, § 433.55 changes the definition of health care-related taxes. In the proposed rule, CMS is considering a tax to be health care-related “if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to individuals or entities that are providers or payers of any health care items or services that are not subject to the tax, or other individuals or entities that are subject to the tax.” This change gives CMS broad discretion in determining when a tax is a health care-related tax. Specifically, the agency will be responsible for concluding when providers/payers are included selectively or taxed differently, and when the tax targets providers/payers with high Medicaid activity.

However, CMS provides little to no guidance on the criteria it will use to determine whether a tax is health care-related or not. Without specified criteria, states, providers, and plans are unable to determine how CMS will review current health care related-tax structures and if they meet program rules, nor will they be able to effectively make changes to current structures to meet regulatory requirements. This lack of clarity regarding CMS’ new requirements creates ineffective and inappropriate administration of the Medicaid program at the federal and state level.

In addition, under § 447.290 of the proposed rule, CMS is proposing to reduce federal financial participation (FFP) if the state fails to report “timely, accurate, and complete” information. CMS has given itself broad authority in determining what data are “timely, accurate, and complete,” but has not provided states information regarding the definitions of these terms to support their data collection efforts. States will be unable to determine whether their data collection are effective or efficient, and if they will face potential reduction in FFP due to data issues. This creates uncertainty in program funding for states and reduces states’ ability to improve data collection efforts.

Moreover, the proposed rule includes vague terms throughout the rule that will be used by CMS to make assessments of current supplemental payment arrangements. For example, the proposed rule refers to the term “totality of the circumstances” and notes that it will be used when assessing when assessing a provider’s ownership group. However, a clear definition of “totality of the circumstances” has not been outlined in the proposed rule, so
stakeholders are unsure how CMS will use the term to assess relationships between the state and provider. This term is also referred to in the regulation in sections outlining whether or not differential treatment occurs for health-care related taxes. Again, there is not a clear definition of this term or how CMS intends to utilize it when reviewing health care-related taxes.

**ACAP urges CMS to reconsider any changes that increase CMS authority without providing adequate criteria and requirements to meet regulation requirements.**

**III. Increase Burden on States**

Along with reducing state flexibility to generate state share, the proposed rule would also implement a number of provisions that place an increased administrative and fiscal burden on states. For example, under § 447.288 of the proposed rule, CMS has detailed new and substantial reporting requirements for states regarding upper payment limit (UPL) demonstrations and supplemental payments. Although increasing transparency regarding these payments can help improve program integrity, the reporting requirements under the proposed rule will place significant administrative and financial burden on states. States will have to implement new data collection and reporting systems to meet this new requirement. This effort will take significant resources from the state Medicaid agency, through staff time and funding, to implement these changes. The rule also does not provide mechanisms to help support state data collection efforts. As a result, ACAP is concerned that these requirements will reduce states’ ability to actually provide and finance services through the Medicaid program.

Coinciding with the reporting requirements, the proposed rule (as noted above) penalizes states for failure to report “timely, accurate, and complete” data. This penalty fails to account for the increased administrative burden placed on states, the feasibility of collecting these data, and states’ ability to make quick changes to their current reporting systems.

Through the proposed rule, CMS is also limiting state plan approvals for fee-for-service (FFS) supplemental payments, as well as broad-based and uniformity tax waivers, to three years. For health care tax waivers, states currently receive approval once and resubmit only when the state changes the relevant tax structure. For state plans, currently, there are no restrictions on the length of approval of supplemental payments once approved under a state plan amendment. These changes, through § 447.252 and § 433.72, will increase state
administrative burden by having to continually resubmit and receive approval for state plans and waivers.

**With this rule already jeopardizing Medicaid funding and creating increased uncertainty for states, CMS needs to reconsider changes that increase the administrative and financial burden on states.**

**IV. Lack of Data to Determine Overall Effects**

However, what is most alarming is that CMS is proposing to make these significant changes to Medicaid financing without quantifying the fiscal impacts of those changes. As noted above, the proposed rule states “the fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown.” Due to the complicated and various financial structures between states, providers, and plans, it is impossible to determine the overall effects of the changes that are included in the proposed rule. Each state, provider, and plan will have a varying effect dependent on the current financing structure. Implementing massive changes that affect program financing without understanding the effects is dangerous policymaking that affects providers and plans, but also vulnerable beneficiaries who rely on the Medicaid program for critical services.

Additionally, as noted above, some of the changes in the proposed rule are subjective to CMS opinion. CMS has not outlined criteria for reviewing allowable supplemental payment structures through many of its proposed changes. At this time, it is impossible to determine how CMS will review current supplemental payment structures and how CMS discretion in determining allowable funding mechanisms will affect Medicaid financing.

**Before implementing any of the changes, CMS must determine the fiscal effects on the Medicaid program. This can be done through consultation with states, providers, plans, and other stakeholders. Moving forward without this information is dangerous to the efficiency and operation of any Medicaid program, and jeopardizes beneficiary services.**

**V. Immediate Implementation**

Finally, ACAP is concerned regarding the immediate effective dates for many of the policy changes in the rule, along with the lack of transition time for states and providers. It is expected that this regulation will be extremely disruptive for administering state Medicaid programs and for Medicaid providers and beneficiary. As a result, states, providers, plans,
and other stakeholders need an adequate implementation timeline to implement any necessary changes.

If the rule is not withdrawn, we strongly encourage CMS to delay immediate implementation of the proposed changes. This will allow time to CMS to consult with stakeholders in understanding the feasibility and time needed to implement the requirements of the rule.

We thank you for this opportunity to comment on this proposed rule. Please contact me (mmurray@communityplans.net, 202-204-7509) or Enrique Martinez-Vidal, our Vice President for Quality and Operations (emartinez-vidal@communityplans.net, 202-204-7527), if you would like to discuss these issues in greater depth.

Sincerely,

/s/
Margaret A. Murray
Chief Executive Officer