Illinois Health and Hospital Association

January 31, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

RE: CMS-2393-P, Medicaid Program; Medicaid Fiscal Accountability Regulation; Proposed Rule (*Federal Register,* Vol. 84, No. 222, November 16, 2019)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to formally comment on the proposed Medicaid Fiscal Accountability Regulation. The proposed rule on Medicaid financing will threaten access to quality healthcare for Illinois' 2.9 million Medicaid beneficiaries and 875,000 uninsured individuals, as well as the 75 million individuals nationwide who rely on the Medicaid program as their primary source of health coverage. We request that the agency withdraw the proposed regulation in its entirety.

Illinois' Medicaid program is our healthcare safety net, providing coverage to:

- Nearly 1 in 4 Illinoisans;
- 43 percent of all children; and
- 461,584 of seniors or persons with disabilities.

Medicaid supports essential healthcare services[1,2] for Illinoisans, including care for:

- More than 50% of all births;
- 53% of all children's hospital visits;
- 17% of rural hospital patient care days; and
- 44% of behavioral-health emergency department visits.

[1] Data reflect services provided between October 1, 2018 and September 30, 2019, the most recent year of data available. Source: COMPdata, Illinois Health and Hospital Association.

[2] Illinois Department of Healthcare and Family Services, 2018 Perinatal Report, https://www.illinois.gov/hfs/SiteCollectionDocuments/HFSPerinatalReportfinalcompleted282018.pdf

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Despite the potential for such significant negative consequences, the Centers for Medicare & Medicaid Services (CMS) has provided little to no analysis to justify these policy changes and has declined to assess the impact on beneficiaries and the providers that serve them. Many of the proposed changes would violate Medicaid law or are arbitrary and capricious in violation of the Administrative Procedure Act. Moreover, at the same time the agency is proposing these changes, it is planning to rescind rules that require states to demonstrate Medicaid beneficiaries have sufficient access to care, thus weakening CMS' ability to ensure adequate oversight of the program.[3] For these reasons, we strongly urge CMS to withdraw this rule.

OVERREACH OF ADMINISTRATIVE AUTHORITY

If finalized, the rule would significantly change the functionality of supplemental payments and cripple state Medicaid program financing. CMS asserts it is clarifying current policies regarding providers' role in funding the non-federal share of Medicaid. However, the proposed rule goes far beyond clarification and introduces vague standards for determining compliance. These newly proposed standards are inconsistent with the long-held scope of CMS' statutory authority. The rule also contains significant changes to healthcare-related taxes (provider taxes), "bona fide" provider donations, intergovernmental transfers (IGTs) and certified public expenditures (CPE)[4], including definitional changes to supplemental hospital categories and public funds. Furthermore, the agency proposes to significantly change the review process for supplemental payment programs and provider tax waivers. The agency proposes to grant itself unfettered discretion in evaluating statutorily defined and permitted state financing arrangements through the application of new and vague review concepts such as "totality of circumstances," "net effect," and "undue burden." Such vague, subjective standards are open to capricious application and the opportunity for abuse of power, and as such, contradict the partnership arrangement between the states and federal government that defines the Medicaid program.

The proposed changes could have devastating consequences. **Nationally, the Medicaid program could face total funding reductions between $37 billion and $49 billion annually or 5.8 percent to 7.6 percent of total program spending.[5] Hospitals and health systems could see reductions in Medicaid payments of $23 billion to $31 billion annually, representing 12.8 percent to 16.9 percent of total hospital program payments. In nearly all states, the reductions from this rule would unquestionably result in cuts in enrollment and covered services. In some states, the impact could be catastrophic.**

[3] www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission

[4] IGTs are funds that government providers transfer to the state for the state to use for federal matching purposes. CPEs are expenditures government providers certify as qualifying expenditures to the state for the state to use for federal matching purposes.

[5] Analysis provided by Manatt Health, 2020

IGTs AND CPEs

The agency proposes to redefine "non-state government providers" as government providers which are a unit of local or state government or a state university teaching hospital with administrative control over funds appropriated by the state legislature or local tax revenue. CMS further proposes that beyond the new definition, the agency would have discretion to **arbitrarily** determine whether, "in the totality of the circumstances," the entity qualifies as a governmental provider.

CMS proposes to restrict what types of funds may constitute an IGT, and would limit IGTs to funds derived from the provider's state or local tax revenue (or funds appropriated to a state university teaching hospital). These changes would effectively cap the IGT and CPE amounts governmental providers may use to fund the state's non-federal share. Moreover, the ill-defined discretion CMS has reserved for itself in determining what entities are non-state government providers would create confusion and uncertainty for states in determining which public providers are permitted to transfer local funds for purposes of Medicaid financing.

These proposals raise a series of legal issues in that they are arbitrary and capricious, fail to provide adequate guidance, and restrict states' use of funds beyond what is authorized in statute.[6] The agency also has failed to account for the substantial reliance by states on prior policy and the harm that would be caused by such an abrupt change in policy.

PROVIDER DONATIONS AND HEALTHCARE-RELATED TAXES

States and local governments have long collaborated with providers to ensure access to healthcare services for Medicaid beneficiaries and to improve the health of the overall community. Healthcare providers are permitted, under federal law and regulation, to make "bona fide" donations to governmental entities with certain restrictions as long as the donation does not have a "direct or indirect relationship" to Medicaid payments. (In other words, the state cannot promise that any donation is returned to the provider making the payment, providers furnishing the same class of services, or any related entity.[7]) States also are able to tax providers to collect revenue to be used in the Medicaid program.

CMS has proposed a number of policy changes that would sharply reduce states' ability to employ such financing arrangements—despite clear statutory authority permitting them.[8] In general, CMS proposes to grant itself unfettered, subjective discretion in determining the permissibility of a financing arrangement. In order to do this, the agency again uses the "net effect" standard based on "the totality of circumstances." These new, vague terms would impermissibly create confusion and uncertainty for states. Additionally, the proposed rules would violate the statute by requiring only a "reasonable expectation" that the taxpayer may

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[6] 42 USC 1396b(w)(6)(A).
[7] § 433.54 Bona fide donations
[8] Social Security Act § 1903(w)(3).

be held harmless, rather than a "guarantee," as required by the statute.[9] The proposed rule also would introduce inconsistencies with existing regulatory language and violate the Administrative Procedure Act by changing policy and guidance upon which states and providers have long relied.

While the agency states its intention to quantify the standards governing payments, it has instead proposed new rules curtailing a state's ability to identify supporting revenues. These proposals would overly restrict or limit a state's ability to finance the program, even when all payments achieve the historically cited goals of economy and efficiency of the program. The proposed rules target the wrong issues. Finally, the proposal is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers.

MEDICAID SUPPLEMENTAL PAYMENTS

Several states, including Illinois, make federally compliant supplemental payments in addition to base rates for various purposes, such as compensating for low levels of reimbursement or providing targeted support to specific hospitals. In Illinois, the payments are financed at the state level through taxes on providers and IGTs—transfers from one unit of government to another (such as a state general fund).

All payments made to institutional providers are subject to "upper payment limits" (UPLs) that apply separately to different types of services (e.g., inpatient hospital, outpatient hospital, and nursing homes) by category of ownership (e.g., non-state-owned public, state-owned public, or private). In the past states have had the flexibility to make these supplemental payments, as long as they did not exceed the UPLs in the aggregate within each ownership category up to the amount Medicare would pay or cost, determined per Medicare cost principles. By making supplemental payments comply with the aggregate UPL, Illinois has utilized its flexibility to allocate payments to hospitals that are in addition to base rates under an effective rate approach, thus helping to ensure access to care for nearly 3 million Illinois residents.

The proposed rule requires states to explain, as a condition of approval, how their supplemental are consistent with "economy, efficiency, quality of care and access" without defining CMS' evaluation criteria. This creates new uncertainties regarding the amount that can be paid to hospitals through supplemental payments. Reductions to the flexibility of the use of supplemental payments could severely reduce access to care, especially at safety net and rural hospitals serving vulnerable communities

EFFECTIVE DATES, TRANSITION PERIODS

The proposed rule has virtually no transition timeline for states to make changes to their financing and supplemental payment programs. The only transition period CMS contemplates

[9] Social Security Act § 1903(w)(4)(C)(i).

is for renewal of the provider tax waivers and non-Disproportionate Share Hospital supplemental payments. However, even under those circumstances, there is insufficient time for states to manage a renewal process in the allotted time. In addition, CMS proposes to limit approval for supplemental payment programs to a three-year period. This will leave states with insufficient time to secure necessary approval from state agencies and legislatures.

Given the proposed rule would undermine the Medicaid program in Illinois, adversely impact those who rely on the program, and require considerable time for mitigation (if even possible), we request that it be withdrawn in its entirety.

We appreciate your consideration of these comments.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association