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January 31, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850.

Re: CMS Docket No. CMS-2019-0169, RIN 0938-AT50, Comments in Response to Proposed Rulemaking: Medicaid Fiscal Accountability Regulation

Submitted via www.regulations.gov.

Dear Administrator Verma:

On behalf of the California State Association of Counties (CSAC) and the County Welfare Directors Association (CWDA), we oppose the proposed Medicaid Fiscal Accountability Regulation published on November 18, 2019. The proposed rule would undermine the financing foundations of our state's Medicaid program – known as Medi-Cal in California – ultimately affecting access and coverage for millions of low-income Californians. We urge CMS to withdraw the rule.

CSAC represents the elected county supervisors in our 58 counties. CWDA's membership consists of the individuals administering the services delivered at the 58 county human services agencies. Both of our associations help serve local communities statewide through a broad range of vital programs and services, to help ensure the health and well-being of our residents. Adequate funding and delivery of Medicaid services, including mental health and substance use disorder services, is critical in achieving that goal. In our state, Medicaid programs are funded in part at the county level and many of the safety-net services available under the program are delivered by our agencies and community partners, including public hospitals, behavioral health providers, public health, and primary care clinics.

We appreciate your consideration of our comments below.

Overview

As proposed, the Medicaid Fiscal Accountability Regulation (MFAR) would provide significant new authority to the Centers for Medicare and Medicaid Services (CMS) to restrict, approve and monitor the structure of a number of state and local financing mechanisms, including intergovernmental transfers (IGT's), certified public expenditures (CPE's) and provider taxes. CMS would also require substantial new reporting of data at a more frequent and granular level. And, overarching the proposal are a number of undefined terms which would give the Agency wide discretion in examining and authorizing Medicaid financing, including 'totality of the circumstances', 'net benefit', 'undue burden', and 'reasonable expectations.'

Impact of the Proposed Rule

The totality of these proposed regulations could significantly hinder county government's ability to financially support, administer and sustain our local health care systems. Underpinning these systems today is the predictable and consistent source of Medicaid funds derived from the federal state and county partnership established over fifty years ago. Section 1902(a)(2) of Medicaid allows states to fund up to 60 percent of the nonfederal share with local public funds, with no express limitations on the types of public revenues that would qualify. Our state has worked in partnership with CMS over decades to build this comprehensive program, including designing the sources and methods of collection of permissible nonfederal revenues with approval by your agency.

Congressional legislative history is clear on the intergovernmental financing of Medicaid. In 2007, CMS proposed to restrict local sources of the nonfederal share in regulation. Congress (P.L 110-28) and a federal court (*Alameda County Med. Ctr. V. Leavitt* (May 23, 2008) intervened, finding that CMS overstepped its statutory authority. It was not the first time that Congress had acted. In 1991, Congress enacted a provision to permanently prohibit the Secretary of the U.S. Department of Health and Human Services from issuing any regulation changing the treatment of public funds as a source of the State share (P.L. 102-234; (House Rept. 102-310)).

Those federal policies and interpretations have been foundational to California's negotiations with CMS in creating multiple approved Section 1115 demonstration projects since 2005. The Special Terms and Conditions (STCs) of each of those three ambitious and highly successful waivers expressly permit the uses of the very same financing mechanisms now at serious risk in the proposed rule.

Sources of Nonfederal Revenues: Despite the statutory intent and the administrative history described above, the proposed rule requires the nonfederal share to finance Medicaid be derived solely from state or local taxes or through funds appropriated to state university teaching hospitals. Under the proposal, payments derived from IGTs, CPEs, provider taxes, and other sources, including patient revenue and philanthropic efforts, could be at risk.

According to the Government Accountability Office (GAO), in FY 2012 (the most recent data available) 31 states used IGT funding and 28 states and the District of Columbia used CPEs. On average, 26 percent of the non-federal share of Medicaid costs were financed by provider taxes (10.4 percent), and IGTs and CPEs (15.5 percent). These percentages are probably higher now, with more states likely

relying on provider taxes. If states are unable to replace funding from providers and IGTs/CPEs with other sources (e.g. general revenues generated from higher taxes or from cuts to other parts of their budgets), they will have no choice but to reduce their spending on their Medicaid programs. Fewer state and local dollars spent on Medicaid will mean fewer federal Medicaid matching funds and more significant cuts to Medicaid and the individuals it serves.

The proposed rule's narrow definition tying Medicaid financing to state and local taxes and funds appropriated to state university teaching hospitals unduly infringes on the power of state and local governments to determine and create the structure of a governmental entity. Those local determinations and processes are deliberative and tied to the core responsibility of counties as safety-net providers. Depending on the state and/or locality, creating an entity such as a health care authority is a time-consuming, complicated process, often requiring state enabling legislation, local ordinances and/or local-level voter approval. Once authorities are created, they have the same legal rights and responsibilities as other government entities. CMS rulemaking subsequent to P.L. 102-234 affirmed that "States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived *from any governmental source*" (emphasis added). CMS has no statutory authority to change this provision. As an agency, it cannot dictate to states or counties how to structure or conduct their financing of any program or service.

At its core, the proposed rule creates huge uncertainties underpinning the basic financing mechanisms counties and states use for Medicaid. If finalized without substantial changes, the proposed rule could make it increasingly difficult for counties to continue to budget and innovate strategically to serve individuals eligible for Medicaid services.

Medicaid Provider Payments

Under the proposed rule, CMS focuses on how health care providers are reimbursed, including how those payments are allocated and valued. States and counties make supplemental payments to target support to entities serving large numbers of Medicaid-eligible individuals and/or to compensate for low reimbursement levels. The aggregate payments are constrained by "upper payment limits" (UPLs) by type of provider, ownership and health service rendered. The payment amount is also limited by law to the amount that Medicare would have paid. Operating under those financial rules, states have flexibility in distributing payments.

The proposed rule's preamble describes a concern that IGTs are used to establish payments that "favor certain providers solely on the basis of whether a unit of state or local government can provide the non-federal share" for such payments and that doing so "may serve to undermine the state and federal financing partnership." Although the payment is CMS's primary concern, the proposed rules do not impose any substantive limits on most types of supplemental payments.

The Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that supplemental payments - such as UPL or disproportionate share hospital (DSH) payments - represented about 20 percent of total Medicaid payments to hospitals in FY 2017 (MACPAC Issue Brief, December 2018). In California, nearly all providers receive supplemental payments. CMS's focus on the methods used to raise the revenues for these critical payments in isolation from the totality of Medicaid financing

ignores the complexity and adequacy of base payments and adjustments made to them. The proposed rule further conflates the issue by proposing to consider a "Non-State government provider" as such only if it has "access to and exercises administrative control" over either appropriated State funds or local tax revenue. CMS provides no justification for tying a *payment* designation, (i.e., classification for UPL or DSH purposes), to what type of funds the public provider is expending or whether it is contributing to Medicaid's nonfederal share.

CMS Review and Approval of Financing Mechanisms and Payments

The proposal contains numerous vague terms and concepts which would provide CMS with enormous discretion to determine whether to approve a particular financing arrangement and payments. States and counties will likely experience a high-level of uncertainty and attendant financial instability in attempting to determine with confidence whether their Medicaid plans will meet federal requirements.

When evaluating particular arrangements, CMS would consider "the totality of circumstances"—a subjective standard that is difficult, if not impossible, for a state to interpret when employing or proposing a financial mechanism or payment arrangement. A provider tax, for instance, could not place an "undue burden" on the Medicaid program. This CMS concept is not contemplated in federal statute and may have a devastating impact on our State's Hospital Quality Assurance Fee (HQAF) program. The program has been in place since 2009 and was approved subsequently by California's voters as a Constitutional Amendment in November 2016. HQAF helps ensure access to quality hospital services and overall support for the health care safety net.

Compounding the uncertainty, CMS proposes to review every supplemental payment program every three years, and would apply these vague concepts during that process. The reporting requirements alone will be extremely burdensome on all levels of government, up to and including CMS. Complying with the requirements would likely require the State to also review and re-negotiate all of its waivers and contracts in its health systems every three years. The proposed review and approval of financing mechanisms and payments every three years will destabilize California's health system and create a massive regulatory burden.

Impact on County Government and Individuals

Despite the broad-reaching impact of the proposed rule, CMS declares that the "fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." Yet, it also claims that costs imposed by the rule would not meet the threshold for regulatory analysis required under a number of federal laws and Executive Orders.

The California Association of Public Hospitals and Health Systems (CAPH) estimates that over a million patients could lose access to care in public health care systems alone, and projects that multiple public healthcare systems could cease operations as a result of the rule. We strongly believe that CMS must not finalize this rule without a full understanding and appreciation of the scale and scope of the adverse impacts it would have on all patients who need to access health care, including mental health and substance use disorder services.

Conclusion

Should this rule take effect in its current form, states across the country will face a serious threat to the sustainability of their Medicaid programs. Over the years, states have designed Medicaid financing structures to provide care in ways that most effectively leverage a historical county-state-federal financing partnership within federal rules and with repeated CMS approvals. The changes proposed in regulation would undermine the core framework of these structures.

Counties support maximum flexibility for states and counties to finance the non-federal share of Medicaid to meet the shared goal of providing Medicaid services to all who qualify. Counties oppose any new restrictions on that flexibility which could shift costs to state and local taxpayers and reduce access to essential health care services for low-income, uninsured and underinsured residents. Consequently, CSAC and CWDA urge CMS to rescind the proposal so that counties may continue to effectively operate health and behavioral health systems to serve our communities.

Thank you for the opportunity to submit comments.

Sincerely,

Graham Knaus
CSAC Executive Director

Frank Mecca
CWDA Executive Director