January 31, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: 42 CFR Parts 430, 433, 447, 455, and 457 [CMS-2393-P], RIN 0938-AT50, Medicaid Program: Medicaid Fiscal Accountability Regulation

Attention: File Code CMS-2393-P

To Whom it May Concern:

On November 19, the Centers for Medicare & Medicaid Services (CMS) published a proposed Medicaid fiscal accountability regulation in the *Federal Register* (Vol. 84, No. 222, page 63722). The Safety-Net Association of Pennsylvania, a group of private safety-net hospitals that care for especially large numbers of Medicaid patients, has a number of fundamental concerns with this proposed regulation and would like to bring those concerns to CMS's attention.

Pennsylvania has no public acute-care hospitals, so it falls to the private health care safety net to provide vital services to Medicaid patients. Unlike public hospitals in other states, Pennsylvania's private safety-net hospitals have no statutory entitlement to local or state funds to underwrite their costs and rely heavily instead on the state's ability and willingness to compensate safety-net hospitals for inadequate Medicaid payments through both DSH and non-DSH supplemental payments. Over time, a complex system of supplemental payments has evolved in Pennsylvania to ensure continued access to vital services for the state's most vulnerable residents.

SNAP is concerned that this proposed regulation would inappropriately restrict the state's ability to finance the non-federal share of the Medicaid program, would impose significant additional regulatory burdens – the cost of which would far outstrip their benefit – would inappropriately introduce subjectivity into the application of previously clear and objective regulatory standards, and is beyond the scope of the statutory authority granted to CMS.

Issue #1:
The Proposed Regulation Would Inappropriately Infringe on the Financing of the State Share of Medicaid

The Social Security law gives states considerable flexibility for how they choose to raise the state share of Medicaid funds. The funding mechanisms outlined in the law – intergovernmental transfers, certified public expenditures, and health care-related taxes – have been reviewed by federal regulators and approved for use by state government and approved for eligibility for federal Medicaid matching funds through various state plan amendments and waivers. Now, however, CMS proposes curtailing, in some

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cases drastically, the right of states to use these funding tools by establishing new limits on their use and new tests for whether their use would be legitimate. One aspect of those new limits that troubles SNAP is CMS's proposal to restrict its definition of public funds to exclude non-tax revenues. SNAP opposes this: Pennsylvania uses part of the proceeds of the national Tobacco Master Settlement Agreement to help safety-net hospitals with the costs they incur caring for uninsured and underinsured patients. In state fiscal year 2018, so-called tobacco payments to hospitals totaled nearly $60 million. CMS has long accepted this as a legitimate funding source and authorized the provision of federal Medicaid matching funds. Under the proposed Medicaid fiscal accountability regulation, however, this would no longer be possible, forcing Pennsylvania either to cut funding for private safety-net hospitals or find a new way – possibly such as by raising taxes – to generate replacement funding. This must not have been CMS's intention when defining public funds in this way. For this reason, SNAP strongly opposes this aspect of the proposed regulation.

Issue #2:
The Proposed Regulation Calls for Significant New Administrative Burdens for Hospitals and Regulators Alike

Hospitals

The proposed Medicaid fiscal accountability regulation would create new, significant administrative burdens for hospitals, state Medicaid programs, and federal regulators. Such a development runs directly contrary to this administration's directive to "cut the red tape" and ease the regulatory burden on the private sector (such as hospitals).

Pennsylvania's safety-net hospitals serve especially large numbers of Medicaid patients, and the proposed regulation would make their job even more challenging than it already is. Under this rule, these and other Pennsylvania hospitals could be subject to additional data reporting requirements related to supplemental payments, including an undefined and potentially limitless amount of new reporting to inform CMS of "the totality of circumstances" surrounding proposed payments to providers. Additionally, the administrative burden for hospitals to assist the state in complying with these new requirements was not accounted for in CMS's estimate of the state's burden. This is not SNAP's idea of reducing the regulatory burden for providers.

State Regulators

The proposed regulation would pose a similar challenge for Pennsylvania's Office of Medical Assistance Programs, which is already highly regulated by the federal government and subject to countless federal requirements, such as the current quarterly reporting requirements for supplemental payments with Form CMS-64. As described by CMS in the proposed rule, current guidelines for states, such as the DSH reporting requirements in Section 447.299, have already given CMS the tools it needs to "quickly identify areas where DSH payments have been made inappropriately or when the state has made a payment outside of the state plan methodology." Additional reporting and unnecessary administrative work would only weigh down Pennsylvania's Medicaid agency in red tape when it should be focused on improving Medicaid services for the 2.8 million individuals the program serves.

As described in the introduction, Pennsylvania's private hospital-based health care system relies heavily on supplemental payments to support institutions that provide significant amounts of care to low-income individuals. Because of this, our state would likely be disproportionately affected by the increased burden associated with the requirement to revisit approved state plan policies every three years regardless of

whether they have changed in any way. The proposed regulation estimates an administrative burden for state Medicaid programs averaging 67 hours per state at a cost of $2847 per state; SNAP believes it would actually be a significant multiple of these unrealistic estimates. Reviews of proposed Pennsylvania state plan amendments have been known to take up to six months or more, with significant back and forth between the state and the CMS regional office. This, too, is not SNAP's idea of reducing the regulatory burden for states.

Federal Regulators

Finally, it is worth noting that the proposed regulation would create an enormous new regulatory burden for CMS – one of the agencies the administration has publicly targeted, and that has publicly targeted itself, for a reduction of regulatory burden. Already struggling to meet legal deadlines for the review of proposed state plan amendments and waiver requests and often enough not meeting those deadlines, it would find itself on the receiving end of far more proposed state plan amendments and waiver requests than ever because of the proposed regulation's requirement that all such amendments and requirements be renewed every three years. Pennsylvania's Medicaid agency reports that approval of a state plan amendment can often take up to six months and include significant back and forth communication with the CMS regional office. The additional staffing necessary to accommodate a three-year renewal period would not just be a burden to the state but to CMS as well. CMS also would be receiving new, enormous amounts of data from state Medicaid programs – data it would need to organize, process, and actually analyze. It was challenges such as this that led CMS in 2019 to seek to reduce some of its oversight responsibilities, not increase them, through its July 15, 2019 proposed "Methods for Assuring Access for Covered Medicaid Services – Rescission," yet now, just a few months later, it is proposing to undo that anticipated reduction of oversight responsibilities, along with others the administration has implemented in recent years, by giving itself massive new responsibilities of unprecedented size and scope. SNAP opposes this granting of new oversight responsibilities and discretion to federal regulators.

Issue #3:
The Introduction of Unclear Standards State Medicaid Programs Would Have to Meet

Because of the important role they play in bringing to life the laws Congress passes, regulations need to be detailed and, more than anything else, clear. They need to establish parameters and be consistent and reliable, easily understood, and consistent in their application.

In the past, Medicaid regulations governing health care taxes and whether they pose an undue burden to state Medicaid programs and whether proposed taxes would lead to a hold-harmless situation between state governments and providers that violates the law were clear; states understood them. In the proposed Medicaid fiscal accountability regulation, however, CMS calls for health care taxes to meet new standards. It does so, it states, because it believes the current standards are insufficient to determine whether proposed taxes pose the undue burden and hold-harmless standards they were intended to evaluate. To address this concern, CMS proposes granting itself new authority to review the services and payments provided by state Medicaid programs and the sources of funding for those payments and to decide for itself whether they meet the undue burden/hold-harmless standards. Those new standards, however, are nowhere to be found in the proposed Medicaid fiscal accountability regulation.

SNAP, for example, is concerned about how CMS envisions determining whether proposed provider taxes are generally redistributive or sufficiently broad-based. Today it does so through two statistical tests: the B1/B2 and the P1/P2. Because these tests are objective and data-based, states can apply them for themselves; they do not need to wait for federal regulators to do so. If a state finds that its proposed tax fails to meet these standards, it understands that a state plan amendment with that tax will be rejected,

and vice versa. Now, however, CMS plans to add a new "undue burden" test – but a test that would have no comparable, objective, data-driven component. Its criteria, moreover, would not be tied to the Social Security Act's passages addressing uniformity. Instead, it would amount to CMS granting itself overly broad new authority, an unprecedented degree of discretion, to render subjective judgments in an area where it previously applied only objective standards.

The subjective standards that CMS proposes applying in this manner would rely heavily on the concepts of "totality of circumstances" and "net effect." These are extremely vague, subjective standards as envisioned by CMS, and SNAP believes it would be difficult for state Medicaid policy-makers to interpret them and then craft policies around them. Worse, SNAP fears that it would not be possible for CMS to apply these standards uniformly because of their lack of objective criteria. What might be acceptable to one regulator might be unacceptable to another, what might be viewed as appropriate in one part of the country, as determined by one CMS regional office, might not be considered appropriate in another part of the country, where another CMS regional office makes the decision. It is even conceivable that individual CMS regulators could apply these new standards differently over time, leading to the possibility of a provider tax approved by a regulator in, say, 2022, and then rejected by that same regulator in 2025 when that tax is subject to review and renewal. The Pennsylvania Medicaid agency has already encountered these types of differences among CMS staff members when applying for approval of state plan amendments. Some CMS reviewers might ask for much more additional information than others, leading to unpredictable approval time frames depending on which member of the staff is reviewing the submission. This ambiguity could potentially lead to chaos, and it is another reason SNAP opposes the proposed Medicaid fiscal accountability regulation.

Issue #4:
The Proposed Regulation Violates the Administrative Procedures Act

When published, the proposed Medicaid fiscal accountability regulation did not include a detailed analysis of its expected impact on the states and the Medicaid beneficiaries the states serve. This shortcoming violates the federal Administrative Procedures Act, which requires such an analysis. CMS acknowledges this failure, noting that it lacked the data it needed to perform it, but this very lack of data speaks to the inappropriateness of pursuing such a regulatory change at this time. It is certainly CMS's prerogative to attempt to promulgate new Medicaid regulations, but if it cannot even predict with a reasonable degree of certainty the effect those new regulations might have, attempting to advance them is, at the very least, premature.

As a result of this failure to meet the requirements of the Administrative Procedures Act, states are not in a position to understand completely how the proposed Medicaid fiscal accountability regulation might affect them; Pennsylvania's safety-net hospitals, and others, are not in a position to understand completely how the proposed Medicaid fiscal accountability regulation might affect them; and the 2.8 million Pennsylvanians who depend on Medicaid for their health care are not in a position to understand completely how the proposed Medicaid fiscal accountability regulation might affect them. This, SNAP believes, is reason enough to withdraw the proposed regulation at this time.

SNAP's Request

For the reasons outlined above, the Safety-Net Association of Pennsylvania respectfully requests that CMS withdraw its proposed Medicaid fiscal accountability regulation.

About the Safety-Net Association of Pennsylvania

The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the low-income and medically vulnerable residents of the commonwealth. These safety-net hospitals provide disproportionate amounts of care to the state's Medicaid beneficiaries recipients and uninsured residents. As a result of the patients they serve, safety-net hospitals face a significant, continuing, disproportionate challenge to their financial health. While all of these safety-net hospitals share the common characteristic of their unusual level of service to low-income and medically vulnerable residents, they are diverse in other ways: they include community hospitals, teaching hospitals, children's hospitals, and academic medical centers; they are large, small, and medium-sized hospitals; and they are located in urban, suburban, and rural areas as well as in the western, eastern, and central parts of the state.

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The Safety-Net Association of Pennsylvania appreciate the opportunity to submit these comments.

Sincerely,

Michael Chirieleison
President