January 31, 2020

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

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

Dear Ms. Verma:

On behalf of the Georgia Hospital Association (GHA) and its 161 hospital and health system members, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed Medicaid Fiscal Accountability Regulation (MFAR or the "Proposed Rule") on Medicaid financing and supplemental payments. Given the Proposed Rule would severely curtail the availability of health care services to millions of individuals, diminish states' flexibility in the operation of their Medicaid programs and because many of its provisions are not legally permissible, **we respectfully request that CMS withdraw the proposed regulation in its entirely.**

If finalized, the Proposed Rule would significantly change hospital supplemental payments and cripple state Medicaid program financing. CMS claims to be clarifying policies regarding providers' role in funding the non-federal share of Medicaid, but in fact, the rule goes far beyond clarification and introduces vague standards for determining compliance that are unenforceable and inconsistent with CMS's statutory authority. The Proposed Rule also contains significant changes to health care-related taxes (provider taxes), "bona fide" provider donations, intergovernmental transfers (IGTs) and certified public expenditures (CPE),[1] including definitional changes to supplemental hospital categories and public funds. CMS also proposes to change the review process for supplemental payment programs and provider tax waivers. In addition, CMS would grant itself unfettered discretion in evaluating permissible state financing arrangements through vague concepts such as "totality of circumstances," "net effect," and "undue burden."

The Proposed Rule could have devastating consequences. Nationally, the Medicaid program could face total funding reductions between $37 billion and $49 billion annually or 5.8% to 7.6% of total program spending.[2] Hospitals and health systems specifically could see reductions in

[1] 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.

[2] Analysis provided by Manatt Health, 2020.

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Medicaid payments of $23 billion to $31 billion annually, representing 12.8% to 16.9% of total hospital program payments.[3] Moreover, **the proposals could impact a significant amount of Georgia's Medicaid funding, which derives $730 million in state matching funds from IGTs and provider taxes.[4] These state matching funds generate $2.3 billion in total Medicaid payments annually or 21% of our state's total Medicaid spending.[5]**

While we understand CMS's interest in enhancing its stewardship of the Medicaid program through greater transparency of Medicaid financing and supplemental payments, the Proposed Rule goes far beyond increasing transparency. Specifically, it would restrict state access to important funding streams, limit the use of supplemental payments, and introduce significant uncertainty with respect to how CMS will evaluate state approaches. The proposed changes are numerous and varied and would give states virtually no time to make policy and budgetary adjustments to offset the loss of federal funds, assuming they could be mitigated at all. These potential cuts come at a critical point for Georgia's Medicaid program and health care infrastructure. The state has recently submitted applications for both a Section 1115 Medicaid demonstration waiver and a Section 1332 state innovation waiver, which if approved would overhaul the way health care is financed in Georgia. **The risk of such a substantial cut in Medicaid spending would jeopardize the state's ability to fund its waiver proposals.**

The 1.9 million Georgians, including children, who rely on the Medicaid program as their primary source of health coverage are the most at risk. The magnitude of financial loss to the program as a result of this Proposed Rule would force Georgia to make untenable choices regarding eligibility, benefits and provider reimbursement. Each of these choices is fraught with negative consequences such as: eligibility rollbacks that would thwart important public health interventions; reduced benefits, which would decrease the quality of care; and lower provider reimbursement, which would lead to reduced access to care for many of our state's most vulnerable patients. Even if the state has the ability and receives approval from CMS to mitigate these funding cuts with additional state funds, such mitigation will inevitably hinder the state's ability to finance its waiver proposals. This means the uninsured Georgians who are projected to benefit from Georgia's proposed waivers are also at risk of losing future access to affordable health insurance.

Despite the potential for such significant negative consequences, CMS has provided little to no analysis to justify these policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. Many of the changes would violate the Medicaid law or are arbitrary and capricious in violation of the Administrative Procedure Act. Moreover, at the same time CMS is proposing these changes, it is planning to rescind

[3] *Id.*

[4] Georgia Amended Fiscal Year 2019 Appropriations.

[5] *Id.*

rules that require states to demonstrate that Medicaid beneficiaries have sufficient access to care, thus weakening CMS's ability to ensure adequate oversight of the program.[6] For all these reasons, we strongly urge CMS to withdraw this rule.

Virtual Elimination of IGTs

CMS proposes to redefine "non-state government providers;" give itself the discretion to judge whether, "in the totality of the circumstances," an entity qualifies as a governmental provider; and restrict the types of funds non-state government providers can use to make an IGT. These changes would effectively cap the IGT amounts governmental providers can 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. The structure and authority of public hospitals varies greatly from state to state and has typically evolved over decades. For this reason, **states are in the best position to determine which providers in their state constitute non-state government (*i.e.*, public) providers.**

In Georgia, public hospitals are operated by, or on behalf of, local hospital authorities. These authorities are statutory entities created by county or municipal governments and are authorized to exercise public and essential governmental functions.[7] The Georgia General Assembly first authorized the creation of these public entities over 75 years ago. Hospital authorities have always been considered non-state governmental hospitals by both the state and CMS and are, therefore, currently eligible to make IGTs to fund the state share of Medicaid payments. However, hospital authorities do not have taxing authority. Local governments are authorized to levy an ad valorem tax and enter into contracts with a hospital authority to provide such tax revenue to the hospital to help cover the cost of care provided to indigent residents. Not all hospital authorities have such an arrangement with their local government, and the ones that do typically do not receive enough tax funds to cover the amount of the IGTs made to the state Medicaid agency. Of the 75 Georgia counties with hospital authorities that currently make IGTs, none of the state's large safety net hospitals and only 3 of our small, rural hospitals receive enough local tax funding to cover the full amount of the IGT.

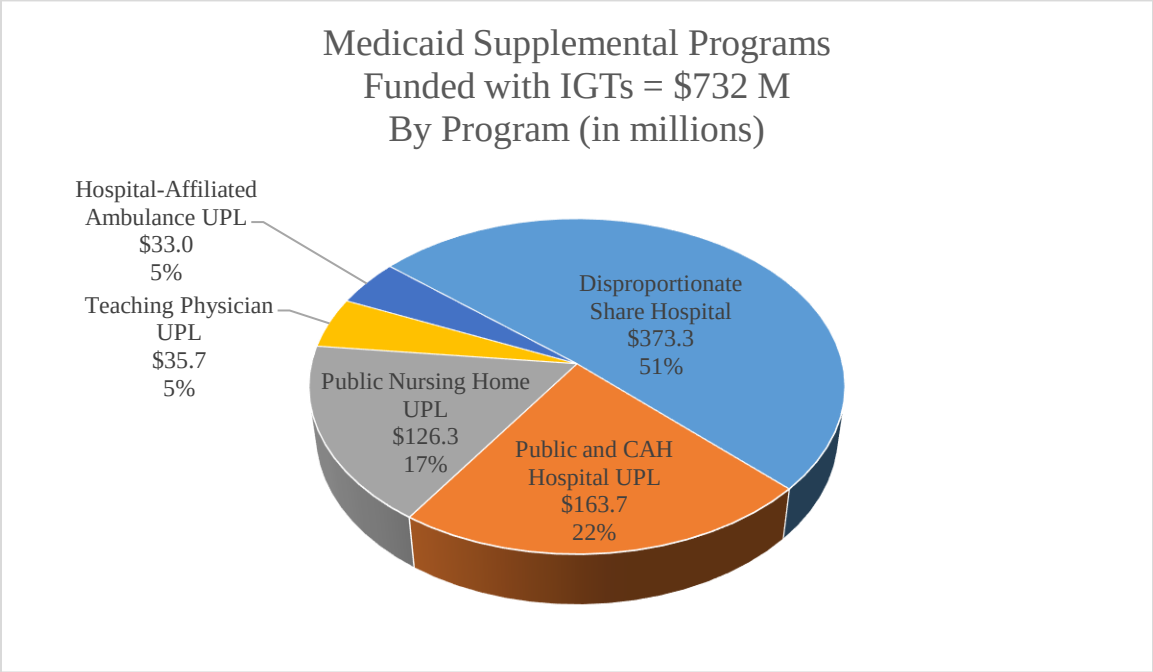
We commend CMS on its desire to eliminate certain egregious arrangements whereby public-private partnership are created for the sole purpose of generating an IGT and avoiding the restrictions on non-bona fide provider-related donations. However, the Proposed Rule goes too far and would also eliminate the IGT ability of legitimate public hospitals, like those in Georgia. Given the complex nature of each state's health care delivery systems, it is the states themselves that should have the authority to designate which hospitals and other providers qualify as non-

[6] 84 Fed. Reg. 33722 (July 15, 2019).

[7] *See* O.C.G.A. § 31-7-70 *et seq*.

state governmental within the confines of the Medicaid law. The Proposed Rule's strict new definition along with the vague "totality of the circumstances" test would make it virtually impossible for states to know which entities may be eligible to make IGTs from year to year. Georgia, like many states, uses IGTs as the state share for a variety of supplemental Medicaid payments totally $732 million annually. *Figure 1* provides a breakdown of these payments.

Figure 1



This means 7% of Georgia's total Medicaid expenditures and 12% of Medicaid hospital expenditures will be subject to CMS's arbitrary review of whether the state's longstanding public hospitals qualify as non-state government providers. The impact is even greater in rural areas where IGTs account for 14% of Medicaid hospital expenditures.

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.[8] CMS has also failed to account for the substantial reliance by states on the prior policy and the harm that this change in policy would cause.

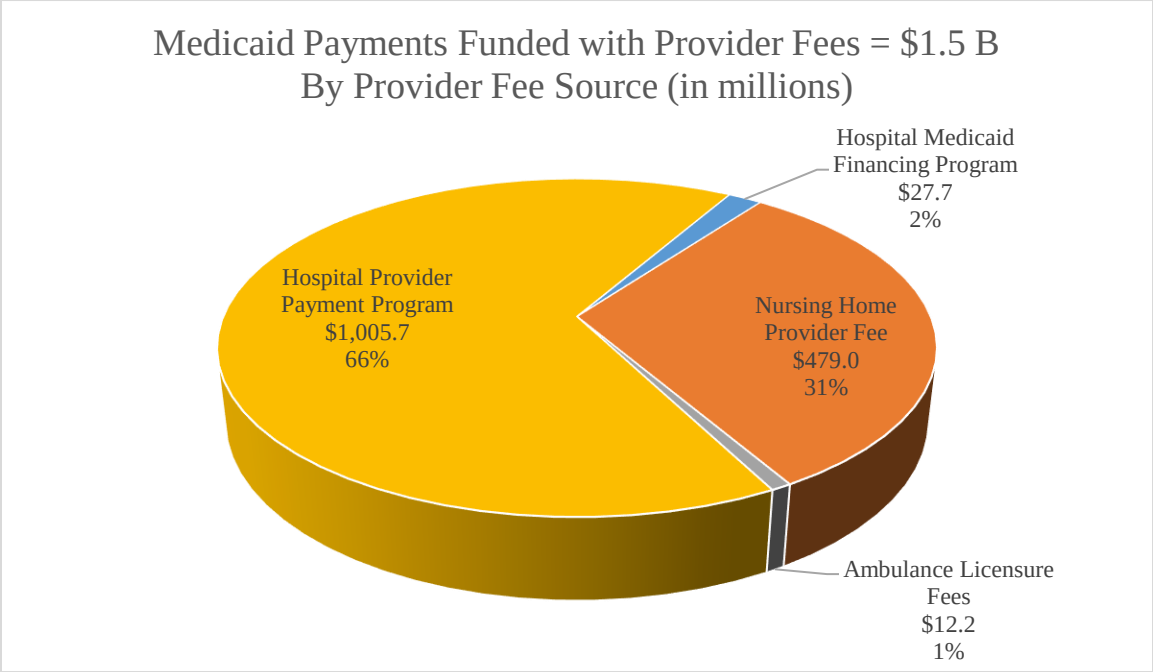
Uncertainty regarding Health Care Related Taxes

States have long been able to tax health care providers to collect revenue to be put toward the Medicaid program. In Georgia, $1.5 billion in Medicaid payments are financed by provider taxes

[8] Social Security Act § 1903(w)(6)(A).

each year, which accounts for 14% of total Medicaid expenditures. *Figure 2* provides a breakdown of these payments.

Figure 2



CMS has proposed a number of policy changes that would sharply curtail states' ability to use these taxes – despite clear statutory authority permitting them.[9] In general, CMS would grant itself unfettered discretion to assess whether a financing arrangement is permissible. In order to do this, CMS again uses the "net effect" standard based on "the totality of circumstances." These new, vague terms without defined criteria would impermissibly create confusion and uncertainty for states.

The Proposed Rule would violate the statute by requiring only a "reasonable expectation that the taxpayer may be held harmless, rather than a "guarantee," as required by the statute.[10] This rule also would introduce inconsistencies with existing regulatory language and violates the Administrative Procedure Act because it is changing policy and guidance upon which states and providers have long relied with too little rationale. Finally, the Proposed Rule is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers.

[9] Social Security Act § 1903(w)(3).

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

Cuts in Medicaid Supplemental Non-Disproportionate Share Hospital (DSH) Payments

States use both base payments and supplemental payments to reimburse Medicaid providers. Base payments are tied to claims for specific services and are typically set significantly below the cost of care. Historically, supplemental payments have served to improve provider payment rates. However, even the use of supplemental payments does not typically make providers whole. After accounting for supplemental payments, Georgia hospitals receive on average only 88 cents on every dollar spent for caring for Medicaid patients.[11]

CMS proposes significant changes to the policies for non-DSH supplemental payments, citing concerns about the growth in these payments. Specifically, CMS proposes to change how upper payment limits payments (UPL) are calculated, increase reporting requirements, and impose new limits on such payments to physicians and other practitioners. These changes could severely curtail access to care, especially at Georgia's academic teaching hospitals whose providers would disproportionately be subject to the new practitioner caps. Meanwhile, the new provider-level reporting requirements would be considerable and would generate largely unusable data given inadequate guidance from CMS on some of the proposed reporting requirements, as well as the fact that the data would not be audited. Because CMS has not ensured that the federal statutory equal-access standard can be met with these policy changes, the Proposed Rule is arbitrary and capricious.

Increased Administrative Burden on States

The Proposed Rule places a number of new reporting requirements on state Medicaid agencies and would significantly increase the administrative burden. In addition to the new provider-level reporting requirements for non-DSH supplemental Medicaid payments referenced above, the Proposed Rule requires states to seek new CMS approval every three years for supplemental payments. States would also be required to seek new CMS approval every three years for any waivers the state may receive to the broad-based and uniformity requirements for provider taxes. Georgia has three such waivers. These new burdens come at a time when Georgia and many other states already have an increased administrative load under the Affordable Care Act. At the same time the Proposed Rule would go into effect, Georgia will also likely have increased administrative responsibilities related to its pending Section 1115 Medicaid demonstration waiver. The increase in administrative work for states is inconsistent with CMS's Patients Over Payment initiative.

Effective Dates and 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 is

[11] FY 2019 Medicaid Disproportionate Share Hospital calculations from the Georgia Department of Community Health. The national average is 89 cents for every dollar spent. AHA January 2020.

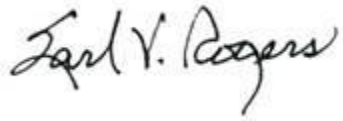
for renewal of the provider tax waivers and non-DSH supplemental payments, but even here, there is insufficient time for states (and likely CMS) to manage a renewal process in the allotted time. In addition, CMS proposes to limit approval for supplemental payment programs to a three-year period, which will leave states with insufficient time to secure approval from state agencies and legislatures. These financing and payment programs are complex and states, such as, Georgia, need considerable time to work with state legislatures and affected stakeholders to implement any possible mitigation strategies.

Conclusion

Given the Proposed Rule undermines the Medicaid program in our state and thus adversely impacts those who rely on the program, suffers from numerous legal infirmities and would require considerable time for mitigation (if even possible), **we respectfully request that it be withdrawn in its entirety.**

We appreciate your consideration of these comments. We look forward to working with CMS to explore reasonable transparency measures to ensure accountability in Medicaid state financing and payment policies.

Respectfully submitted,



Earl V. Rogers
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