GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

January
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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 145 acute care member hospitals in the Greater New York Hospital Associations (GNYHA), I am writing to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule on fiscal accountability in the Medicaid program.

The proposed rule would significantly curtail state Medicaid financing mechanisms and restrict provider supplemental payments. It would reverse longstanding CMS policy and impose vague and arbitrary standards that are unlawful. As a result, the rule would impose significant cuts to state Medicaid programs, translating into loss of coverage for beneficiaries and provider reimbursement cuts.

Medicaid provides coverage for more than six million New Yorkers, or nearly one-third of state residents. New York hospitals are a critical component of the Medicaid delivery system, delivering more than three million emergency room visits, nearly six million outpatient clinic visits, and one million mental health and substance abuse services. In addition, Medicaid is the payer for more than 33% of hospital discharges. The Medicaid financing system in New York, like many other states is already strained. Medicaid payments only cover 72% of hospital costs, leading to significant financial distress for safety net hospitals that provide a disproportionate share of services to Medicaid patients.

While CMS did not estimate the financial impact of the rule, a survey by the American Hospital Association (AHA) conducted by Manatt Health Solutions estimates that total Medicaid funding reductions under the proposed rule could reach $37 to $50 billion nationally per year, or 5.8% to 7.6% of total Medicaid spending, creating funding gaps that would be impossible for states to backfill through other mechanisms. For hospitals, the consequences are even more significant, with the proposals reducing current Medicaid payments by an estimated 12.8% to 16.9%. If implemented, it would result in the loss of coverage for an unknown number of the nation's most vulnerable individuals and upend the Medicaid financing system for states, creating significant health care delivery and access challenges in communities.

GNYHA strongly urges CMS to rescind the proposed rule and instead work with stakeholders to develop reasonable alternatives to ensure accountability in the Medicaid program, while preserving access for Medicaid beneficiaries.

Technical Comments

Our technical comments on the proposed rule are separated into three parts. First, we discuss our general concerns on issues such as CMS's failure to conduct an impact analysis and the proposed supplemental reporting requirements. In the subsequent sections we raise our concerns about the proposed changes specific to state financing arrangements and Upper Payment Limits (UPLs). Although many of our specific comments will focus on the proposed changes in the context of New York's Medicaid program, we note that the proposed rule would have significant consequences for Medicaid providers and beneficiaries nationwide, including our member hospitals in New Jersey, Connecticut, and Rhode Island.

General Concerns

CMS Failed to Conduct an Impact Analysis

CMS is required under federal law to conduct an impact analysis of proposed rules, including its costs and benefits. In addition, the Medicaid Act (42 U.S.C. §1396(a)(30)(A)) requires the agency to assess the impact of Medicaid policies to ensure that Medicaid payments are sufficient to provide access to quality services for Medicaid beneficiaries. CMS's failure to provide an impact analysis, merely stating that there is an "unknown impact," is woefully insufficient given the magnitude of the changes in the proposed rule. This fact alone is grounds for CMS to withdraw its proposal.

Reporting Requirements and Approval Periods

Provider-Level Payment Detail

CMS proposes extensive new reporting requirements for supplemental payments, provider taxes, and intergovernmental transfers (IGTs). The proposed rule would require states to report provider-level detail on UPL payments, as well as payments made under Medicaid waivers, identify the non-federal source(s) of Medicaid funding for each payment, detail the applicable approved State Plan Amendment (SPA), and explain how the payments meet the statutory access standard. The reporting requirements would be due in the form of a quarterly supplemental report at the time the state submits the CMS-64. CMS also proposes similar annual reporting requirements, with some additional data elements included.

The new requirements would impose significant burdens on state Medicaid programs, with an unclear value to CMS or policymakers, especially since the reporting is limited to FFS payments. We also question the usefulness of the data given the frequently significant lag between the service date or corresponding year for UPL payments and when a state receives CMS SPA approval, which can lead to volatility in Medicaid payments. It would be nearly impossible to tease these reasons out in data reports and could lead to faulty conclusions. We also note that the requirement for states to detail how each payment is consistent with Medicaid access requirements appears inconsistent with the agency's recent decision to rescind the Medicaid access rule.

Three-Year Approval Periods

The proposed rule would require states to renew applicable SPAs for provider tax waivers and supplemental payment methodologies every three years. This would add significant burdens on states and CMS alike, leading to problematic delays in federal approvals and leaving billions of dollars of Medicaid financing in limbo for states. Specifically, states could experience significant delays in provider tax collections due to pending provider tax waivers, while providers would likely experience additional delays in UPL payments.

- Provider tax waivers: The proposed three-year limit on provider tax waivers is an arbitrary timeframe that would lead to significant uncertainty in the financing of state Medicaid programs.

In addition, it provides an insufficient timeframe for states to develop necessary calculations, pursue any necessary legislative changes through their state legislature, and seek CMS approval. Instead, CMS should work with states individually to evaluate the unique circumstances of their waivers and determine appropriate frequency of reviews.

- UPLs: New York has standing approval that gives the state the authority to make UPL payments, including the ability to use a formula for voluntary hospitals and to make separate payments up to approved limits to certain public hospitals. In addition, New York submits annual SPAs that detail the actual approved aggregate UPL payment amounts. We believe that this is a reasonable approach, balancing the burdens on the state Medicaid program and CMS, with accountability for ensuring that UPL payments are made within available limits. It is unclear how the proposed rule might impact this approach and request that CMS clarify that the approach would continue to be permissible in the future.

Proposed Changes to State Financing Arrangements

IGTs

IGTs from public entities play an important role in state financing of the non-federal share of Medicaid. For example, in New York, IGTs contributed by local government hospitals are used to fund a significant portion of the state's public hospital DSH funding. As recognized by the Medicaid and CHIP Payment and Access Commission (MACPAC), such financing arrangements are protected by statute:

> *"IGTs are commonly used by counties to contribute the non-federal share for certain governmental providers (e.g., community mental health centers, hospitals) located in those counties. IGTs may also be contributed directly by governmental providers themselves, such as hospitals operated by state or local government. The ability of states to use IGTs to finance their Medicaid programs is recognized in both federal statute and regulation."*[1]

The Social Security Act (§1903(w)(6)) also explicitly recognizes and protects the use of IGTs:

> *"…the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider…"*

Under the proposed rule, CMS would limit IGTs by changing the phrase "public funds" to "state and local funds" in § 433.51, the regulations governing the use of public funds for the state share of federal financial participation. By changing all references of "public funds" to "State or local funds," and adding paragraph (d), CMS would restrict permissible sources of IGTs to state or local tax revenues or to state funds appropriated to state teaching hospitals. Alarmingly, in a significant departure from current policy and practice, the proposed rule prohibits public hospitals that do not have taxing authority, such as most county and municipal hospitals, from making IGTs. CMS also implies that it might consider IGTs from such providers to be prohibited non-bona fide provider-related donations.

The statute and current CMS regulations clearly allow IGTs to be derived from all public funds, including patient care revenues from third-party payers,[2] yet CMS disregards this longstanding policy in the proposed

[1] MACPAC, summary of non-federal financing. https://www.macpac.gov/subtopic/non-federal-financing/.
[2] Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29,748 (May 29, 2007).

rule. If CMS were to finalize the proposal, it would have devastating impacts on public hospitals and the communities that they serve. In addition, the proposal could significantly impact the ability of states to finance 1115 waiver demonstrations as many states use IGTs to finance the non-Federal share of waiver demonstrations, derailing delivery system reform efforts to improve quality of care for Medicaid beneficiaries.

CMS has not only failed to recognize the impact of this significant change on State Medicaid programs and public hospitals, but the proposal also exceeds the Secretary of Health and Human Services (HHS's) authority under §1903 and is clearly contrary to Congressional intent.

Provider Taxes

Currently, in order for a state Medicaid program to secure a waiver of the "broad-based and uniform" provider tax rules, the state must demonstrate that the tax passes certain statistical tests and does not hold providers harmless for the cost. However, CMS asserts that in some cases, provider taxes may meet the current statistical tests even though the tax is not generally distributive.

CMS proposes to replace the current statistical tests with vague new standards such as examining the "net effect" and "totality of circumstances" when evaluating state tax programs to ensure that a tax does not pose an "undue burden" on the Medicaid program. This would create an impossible situation for states and providers to govern their Medicaid programs, creating great uncertainty as to what provider tax structures would be deemed permissible. In addition, it could lead to significant delays in securing approvals of new and/or revised provider tax programs both by CMS, as well as the potential need for states to secure state legislative changes.

The proposed standard should be abandoned—it violates current law and is arbitrary and capricious because it creates uncertain standards for states and providers. In addition, it would result in great instability for state Medicaid programs, the provider community, and the Medicaid beneficiaries that they service. We also note that these uncertainties are exacerbated by the proposed three-year limit on provider tax waivers.

Proposed Changes to Supplemental Payments

New Limits on UPL Payments

CMS proposes to require that SPAs for UPL supplemental payments explain how the payments are consistent with the "economy, efficiency, quality of care and access" standard. Concerningly, CMS does not discuss the evaluation criteria that would be used to determine whether a state meets this standard, nor does it specify the repercussions if the agency determines that a state has failed the standard.

In addition, the proposed rule appears to unlawfully limit the flexibility of states to direct UPL payments to a subgroup of providers within a class. This proposal is clearly contrary to Congressional intent. Congress expressly established maximum hospital-specific reimbursement levels (in the form of the charge cap[3])—CMS cannot circumvent these provisions to impose its own limits. In addition, Congress separately imposed maximum aggregate limits on a "class of provider" in the form of UPL limits and in doing so, expressly permitted states to establish reimbursement methodologies targeting payments to specific providers.

GNYHA urges CMS to abandon its proposal and maintain the existing state flexibility to direct supplemental payments within aggregate approved limits.

[3] 42 U.S.C. §1396b(i)(3)

Changes to the UPL Calculation

The proposed rule includes detailed standards for UPL calculations, several of which raise concerns.

Uniformity Requirements

First, CMS proposes to require states to apply a single UPL methodology to all providers within a UPL class and service type. Requiring uniformity of methodologies for all providers within a class and service type for UPL demonstrations would be problematic given the availability of data and the capacity of states to standardize data from various sources. For example, New York bases its UPLs on Medicare payments for acute care services but relies on a per-diem cost method for "exempt" psychiatric and rehabilitation services. The Medicare rate for exempt services is adjusted for patient-level factors such as cognitive function or comorbidities, a methodology that the state Medicaid program cannot replicate without certain patient-level data that is not collected. States should therefore continue to be able to use different methodologies for different institutional service types.

Issues for All-Inclusive Rate Hospitals

CMS should also, at a minimum, provide an exemption from the uniformity requirements for all-inclusive rate hospitals. Under current policy, CMS allows a different methodology for all-inclusive rate hospitals that do not differentiate service-level charges, such as New York City's (NYC) public hospital system, NYC Health + Hospitals. CMS has long recognized the unique charge structure of all-inclusive rate providers—which have been approved to bill a flat fee charge on either a per-day or per-stay basis for inpatient services furnished—by providing exceptions for these hospitals in various payment methodologies. For example, CMS has used proxy methodologies to distribute Medicare uncompensated care payments to all-inclusive rate hospitals, noting issues with the cost-to-charge ratios for these providers. CMS should preserve the ability for states to apply alternative UPL methodologies for all-inclusive rate hospitals consistent with current policy.

Data Requirements: Claims Lags and Trending

CMS also proposes to require that the Medicare payment and charge data used to calculate UPLs has dates of service that are no more than two years prior to the dates of service covered by the UPL demonstration. These are complex, time-consuming calculations for states, and a two-year lag is likely to be too short to ensure data quality. Although CMS claims it is merely codifying existing policy, this direction appears to be a departure from current practice. For example, we are aware of situations in which CMS has approved the use of three-year-old data because it is the most recent comprehensive data available (including claims runout and complete set of matching cost reports).

The proposed rule also discusses requirements for trending the base year data to reflect Medicaid payments during the period of the UPL demonstration using inflation- and volume-based adjustments. We recommend that CMS also continue to allow states to trend the base year data for up to an additional two years to reduce administrative burden. In fact, CMS's current guidance documents for calculating inpatient and outpatient UPLs acknowledges that states may trend the data to project future experience. Given the hundreds of hours of staff time that it takes for states to complete UPL calculations, including performing claims runout calculations, matching the claims data to the applicable cost reports, and completing state review and CMS approval processes, the ability to trend the data beyond the initial rate year is essential. We believe this strikes a balance between minimizing administrative burden on states and CMS, while also ensuring program integrity.

Inclusion of Provider Assessments in Cost-Based UPLs

We support CMS's proposal to allow states to include the cost of provider assessments such as health care-related taxes paid by each provider when calculating the aggregate UPL using a cost-based demonstration. These are important allowable costs incurred by Medicaid providers and should be applied to the UPL calculation to the extent that they are not reflected in the Medicare cost report data.

Caps on Supplemental Payments for Practitioners

Under current CMS policy, practitioners can receive supplemental payments—treated similarly to UPL payments—up to the average commercial rate (ACR) for comparable services. These payments are a critical to ensuring adequate access to physician services for Medicaid beneficiaries at safety net and state teaching hospitals, a core component of the Medicaid delivery system.

The proposed rule would arbitrarily limit the amount of supplemental payments for practitioners to a percentage of their base Medicaid FFS payments—50% for most providers and 75% for those practicing in Health Professional Shortage Areas. CMS argues that because commercial rates generally exceed Medicaid rates, they are inappropriate to use for this purpose. However, this proposal raises several legal concerns: 1) CMS fails to consider the impact of disallowing the ACR-based methodology on patient access; and 2) CMS does not adequately explain its reasoning behind its proposed percentage-based caps of 50% and 75% of the Medicaid rate—thus, they appear to be arbitrarily selected.

In fact, the limits are so arbitrary and casually considered that CMS did not evaluate the appropriateness or impact of the caps on other currently approved practitioner supplemental payment methodologies, such as use of the Medicare rate. One GNYHA member public hospital system that receives a Medicare-based supplemental payment estimated that their practitioner supplemental payments are approximately 150% of their base Medicaid rates. Therefore, the proposal would result in a $10 million loss for their system, severely compromising their ability to continue to provide services to their communities.

The proposed caps on supplemental payments to practitioners would result in significant cuts to safety net providers and harm beneficiary access to care, is arbitrary and capricious, and must be abandoned.

Implementation Timeframe

CMS provides insufficient time for states to evaluate the impact of the proposed provisions and develop remediation policies (where possible) to replace current financing mechanisms with alternatives. In many cases, states would be required to pursue legislative changes that may take several years to achieve. In addition, the rule fails to contemplate a transition period for states to comply with many of the new rules, including in some of the provider tax and IGT policies, abruptly upending the financing system for state Medicaid programs. This is contrary to prior approaches—for example, CMS provided a 10-year transition period when it finalized its 2016 managed care rule.

As we have detailed in this letter, we believe the only appropriate course of action is for CMS to withdraw the proposed rule—however, if the agency decides to proceed, it must provide an appropriate and reasonable implementation timeline.

Thank you for the opportunity to comment. Please contact me at (212) 259-0719/wynn@gnyha.org with any questions.

Sincerely,

Elisabeth R. Wynn
Executive Vice President, Health Economics & Finance