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


Dear Administrator Verma:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, thank you for the opportunity to offer comments on the Centers for Medicare & Medicaid Services (CMS) Proposed Medicaid Fiscal Accountability Rule (MFAR). AzHHA is the leading trade association in Arizona representing general acute care, rural, specialty, post-acute care, federal, tribal, and public hospitals, as well as affiliated healthcare partners. Our members are united with the common goals of improving healthcare delivery, access and quality of care throughout the state. We submit these comments in furtherance of these goals, and because we are uniquely situated to provide information on the state-specific impacts of the MFAR.

It is our belief that the MFAR, if finalized, could cripple Medicaid program financing in Arizona and severely curtail the availability of healthcare services to millions of citizens nationwide. Moreover, as delineated below, many of the MFAR’s provisions are not legally permissible. For these reasons, we are requesting that the agency withdraw the proposed regulation in its entirety.

General Comments

While we understand and support CMS’s interest in enhancing its stewardship of the Medicaid program, the proposed regulations go far beyond increasing transparency in the financing and administration of Medicaid. The proposals regarding states’ authority to utilize healthcare-related assessments\(^1\), “bona fide” provider donations, intergovernmental transfers (IGTs) and certified public expenditures (CPE), and

\(^1\) In this letter, “provider assessment” is used instead of “provider tax” to reflect the terminology used by the State of Arizona.
the proposals to significantly modify supplemental payment programs, would have the effect of severely restricting states’ access to important funding streams, limit the use of supplemental payments, and introduce significant uncertainty with respect to how the agency will evaluate state approaches.

Although CMS asserts it is clarifying policies regarding the role of providers in funding the non-federal share of the Medicaid program, the rule unfortunately achieves the opposite effect. Through the MFAR, the agency would grant itself unfettered discretion in evaluating the permissibility of state financing arrangements through vague, subjective concepts such as “totality of circumstances,” “net effect,” and “undue burden.” These extremely broad standards for determining compliance are unenforceable and inconsistent with CMS’s statutory authority.

If finalized, the MFAR 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 Medicaid payments of $23 billion to $31 billion annually, representing 12.8% to 16.9% of total hospital program payments. In nearly all states, the rule’s funding restrictions unquestionably would result in cuts to program enrollment and covered services.

In Arizona, over 400,000 adult Medicaid beneficiaries rely on medical services provided by the Arizona Health Care Cost Containment System (AHCCCS) and funded through a hospital assessment. Services provided to these vulnerable adults face an uncertain future depending on how CMS would exercise its unfettered discretion granted by the proposed rule. Funding for other programs approved by the Arizona Legislature, such as graduate medical education (GME) and rural disproportionate share hospital (DSH) payments are also in jeopardy under the vague standards proposed by CMS.

Despite the potential for such significant and pervasive negative consequences, CMS has provided little to no analysis to justify these proposed policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. Moreover, at the same time the agency is proposing these changes, it is also planning to rescind 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.³

And, as further delineated below, many of the proposed changes would also violate the Medicaid statutes and/or are arbitrary and capricious in violation of the Administrative Procedure Act.

Finally, we have serious concerns about CMS’s plan for rolling out the rule provisions. The proposed rule has virtually no transition timeline for states to modify their financing arrangements and supplemental payment programs. The only transition period CMS contemplates is for renewal of the provider assessment waivers and non-DSH supplemental payments, but even here, 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, which will leave states with insufficient time to

² Analysis provided by Manatt Health, 2020.
secure approval from state agencies and legislatures. These financing and payment programs are complex. States, including Arizona, may need considerable time to work with state legislatures and affected stakeholders to implement required changes, as well as any mitigation strategies. **Should CMS proceed with the proposed rule, these provisions must be phased in over a reasonable timeline to allow states sufficient time for implementation.**

**Detailed Comments**

For three decades, states have relied on local jurisdictions and private providers to help finance their share of Medicaid program dollars just as Congress intended. Arizona, like other states, has looked to these partnerships in order to:

- Address reimbursement shortfalls for providers serving vulnerable communities and populations,
- Improve access to physician services,
- Fund value-based payment incentives,
- Expand pediatric services, and most significantly
- Finance acute medical services for the state’s adult population.  

We fully understand that CMS, Congress and other government agencies have raised concerns over certain state financing arrangements that they believe artificially inflate state Medicaid spending. However, we strongly disagree that this is the case in Arizona—where only 11% of the AHCCCS program is funded by local revenues (IGTs and county taxes) and 12% is funded by provider assessments. Moreover, even with these financing mechanisms in place, Arizona hospitals are only paid 70% of the cost of treating Medicaid patients. We are not opposed to CMS identifying and targeting problematic financing arrangements provided this is done under clear, consistent and transparent rules and processes. However, CMS’s proposed rule sweeps much more broadly, casting doubt on a wide range of legitimate financing arrangements that CMS and Congress have long endorsed.

Moreover, the proposed rule suggests that CMS has not seriously considered the consequences of limiting such arrangements or the challenges states would face in attempts to mitigate these consequences. The Congressional Budget Office’s own analysis on the impact of limiting Medicaid provider assessment programs notes that most states would not be able to replace all revenue lost and that access to healthcare services may be reduced along with reductions in provider payments.

As mentioned above, CMS asserts in the Preamble that it is clarifying policies regarding providers’ role in funding the non-federal share of Medicaid, such as IGTs, CPEs, provider assessments, and bona fide provider donations. However, the rule itself proposes new and significant changes to current policy – well beyond the goal of clarification. In addition, the agency has granted itself considerable discretion in

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4 Arizona’s hospital assessment program currently funds medical services for the Medicaid adult expansion population, as well as the state’s existing adult population that includes TANF parents and adults up to 100% of the federal poverty level.
evaluating permitted state financing arrangements through new concepts, such as “totality of circumstances,” “net effect” and “undue burden.” The following is a discussion of AzHHA’s policy concerns regarding key provisions of the proposed rule, including a discussion of legal issues identified.

1. Proposed Changes Affecting IGTs and CPEs

The agency proposes to redefine “non-state government providers” as government providers that 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 judge whether, “in the totality of the circumstances,” the entity qualifies as a governmental provider.

Additionally, CMS proposes to restrict what types of funds can constitute an IGT, and it proposes to limit IGTs to funds derived from the provider’s state or local tax revenue (or funds appropriated to a state university teaching hospital). This proposal would preclude states from using other legitimate governmental funding sources that are not derived from taxes, such as patient and operating revenues, collected State university tuition, issued bonds, lease payments, and awarded civil damages.

In Arizona, this could impact all programs in which the state match share is funded by public universities, tobacco settlement receipts, the state share of drug rebates, hospital and healthcare district non-tax revenue, and Arizona’s hospital and nursing facility assessments. These programs include, but are not limited to, DSH, GME, the Access to Physician Services Initiative, and the Pediatric Services Initiative—as well as medical services provided to Arizona’s adult Medicaid population.

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. In Arizona, for example, there are no “state university teaching hospitals” to which the Legislature can appropriate funds. Rather, the Legislature makes appropriations to state university medical schools, who use IGTs to support medical teaching programs throughout the state. CMS has approved this arrangement for a number of years. However, the uncertainty resulting from the proposed rule casts a cloud over this legitimate financing mechanism approved by the State Legislature, and it could cripple Arizona’s GME programs and our physician pipeline—further exacerbating our state’s Medicaid network adequacy challenges. A similar predicament holds for the State’s rural DSH program.

It is critical that these aforementioned programs have a certain level of predictability in state and federal financing. The wide and unfettered discretion granted to CMS in the proposed rule eliminates any semblance of predictability, and will place these programs at risk.

Moreover, 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. And,

7 42 USC 1396b(w)(6)(A).
as mentioned above, the agency also has failed to account for the substantial reliance by states on the prior policy and the harm that this change in policy would cause.

2. Proposals Modifying Supplemental Payment Rules

States use both base payments and supplemental payments to reimburse providers for Medicaid-reimbursable services. Base payments for providers 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 make providers whole. After accounting for supplemental payments, hospitals receive on average only 89 cents on every dollar spent for caring for Medicaid patients.\(^8\) In Arizona, the rate is just 70%.

In the MFAR, CMS proposes significant changes to the policies for non-DSH supplemental payments, citing concerns about the growth of these payments over time. Specifically, the agency proposes to limit approval for supplemental payments to a period of three years, change how upper payment limits payments (UPL) are calculated, increase reporting requirements, and limit such payments to physicians and other practitioners.

These changes could significantly reduce beneficiaries’ access to care, especially at public academic teaching hospitals and rural hospitals (including critical access hospitals) serving vulnerable communities whose providers would be subject to the new practitioner caps disproportionately.

Meanwhile, the proposed new provider-level reporting requirements would constitute a considerable administrative burden and would generate largely unusable data given inadequate guidance from the agency on some of the proposed reporting requirements, as well as the fact that the data would not be audited. Because the agency has not ensured that the federal statutory equal-access standard can be met with these policy changes, the proposal is arbitrary and capricious.

At a minimum, if the rule is finalized, CMS should provide for longer approval processes and a defined grace period for supplemental payments.

3. Proposed Changes Affecting Provider Donations and Healthcare-Related Assessments

States and local governments have long collaborated with providers to ensure access to healthcare services for the state’s Medicaid population, as well as to improve the health of the overall community. Healthcare providers are permitted, under federal laws and regulations, 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.\(^9\) States are also permitted to assess providers to collect revenue for Medicaid program expenditures.

Despite clear statutory authority permitting these financing arrangements, CMS has proposed a number of policy changes in the MFAR that would significantly restrict states’ ability to use them.\(^{10}\) In particular, CMS proposes to give itself full discretion to invalidate healthcare-related assessments on the basis that they constitute an “undue burden” on the Medicaid program or if the agency (again, in its sole discretion) deems that the net effect of the assessment, considering the totality of the circumstances, is that entities paying the assessment have a reasonable expectation that they will be held harmless for all or any portion of the assessment amount. There is no basis in federal law for these newly proposed restrictions on the use of provider assessments, which are permitted by federal law to help fund the Medicaid program.

4. The MFAR’s Proposed Standards are Overly Broad, Ambiguous and Vague

In the MFAR, CMS maintains that the statistical tests set forth in the Code of Federal Regulations at 433.68(e) are not always effective in ensuring that healthcare assessments are generally redistributive. CMS proposes to apply an additional requirement: an assessment must not impose an “undue burden” on healthcare items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid.

Under this provision of the proposed rule, CMS may determine that an assessment imposes an “undue burden” if providers subject to the assessment are divided into payor groups and certain groups are exempt from the assessment or they pay a lower assessment rate relative to other groups with a higher level of Medicaid activity. This conflicts with the prior CMS practice of accepting as sufficient state documentation of compliance with statistical requirements. Vesting CMS with this unfettered discretion could impact both the nursing facility and hospital assessments in Arizona, the latter of which is currently used to fund acute medical services to AHCCCS members (and not to enhance payments to providers) and the former of which is critical to ensuring network adequacy for elderly and frail Medicaid beneficiaries.

CMS also asserts in the MFAR that the hold harmless tests set forth in the Code of Federal Regulations at 433.68(f) are inadequate. CMS proposes a new standard to be applied in addition to the current tests: CMS in its own discretion may deem a hold harmless arrangement to exist if the net effect,” considering the totality of the circumstances,” is that providers paying the assessment have a reasonable expectation that they will be held harmless for all or any portion of the assessment amount.

It is widely accepted that laws must “provide explicit standards for those who apply them” in order to prevent arbitrary and discriminatory enforcement.\(^{11}\) In 1993, when enacting previous regulations, CMS’s predecessor agency emphasized the importance of applying “clear and specific rules” for identifying a

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\(^{9}\) 42 C.F.R § 433.54

\(^{10}\) Social Security Act § 1903(w)(3).

hold harmless arrangement and acknowledged that “subjective [tests] would be administratively burdensome and virtually impossible to apply fairly throughout the nation.”

None of the new standards CMS proposes articulate a specific rule, directive, or even a guideline that regulated entities can use to identify permissible or impermissible activity. Instead, the MFAR would give CMS unfettered discretion to make ad hoc decisions on a case-by-case basis. These proposed standards in the MAFR have a high degree of subjectivity that would authorize CMS to approve or deny similar programs in different states and/or over time and still be within the scope of the regulation, rendering the standard quite meaningless and causing great uncertainty within states and among stakeholders. Federal courts have acknowledged that this “unfettered discretion is patently offensive to the notion of due process,” and the Supreme Court has warned against rules that create a “trap for the wary as well as unwary.”

As overly broad and ambiguous standards that would create vast uncertainty as well as unnecessary burdens for states and providers, the proposed “reasonable expectation,” “undue burden,” “totality of circumstances,” and “net effect” tests could also be considered arbitrary and capricious on the part of CMS.

Applying these overly vague, subjective standards to Arizona could result in the assessment on inpatient hospital revenues, which is used to cover the cost of medical services to an expanded Medicaid population, constituting an impermissible hold harmless arrangement, since hospitals would reasonably expect reduced uncompensated inpatient costs as a result of the eligibility expansion.

5. Other Legal Considerations

It is a basic tenet with agency rulemaking that regulations “must be consistent with the statute under which they are promulgated.” Congress has made clear that States may use healthcare-related assessments for Medicaid payments. In fact, one motivation Congress had for passing these provisions in 1991 was to clarify to the Secretary that CMS could not prohibit the use of healthcare-related assessments as a source of Medicaid financing.

The MFAR could very likely have the effect of making provider assessments obsolete despite the fact that these arrangements are expressly permitted under federal law. Under the MFAR, arrangements are not permitted that allow providers to expect any benefit to flow to them as a result. Logically, private sector providers will be less interested in voluntarily agreeing to pay an assessment if the providers believe they have no reasonable chance of benefitting in any way. Consequently, the MFAR would effectively strip states of their statutory right to use healthcare assessments to help fund Medicaid expenditures.

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12 Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156, 43,167 (Aug. 13, 1993)
Under the proposed rule, CMS also prohibits hold harmless arrangements between private providers, which may be seen as an inappropriate attempt to regulate private transactions.\(^{17}\) Since Congress adopted the hold harmless tests in 1991, the tests have clearly required the “State or other unit of government imposing the tax” to be the entity that is holding a payor harmless in order for the Act to be violated.\(^{18}\) CMS does not have the authority to broaden the scope of the hold harmless tests to regulate transactions that occur exclusively between private entities with no governmental direction or participation.

Furthermore, the proposed rule violates the Administrative Procedure Act because it is changing policy and guidance upon which states and providers have long relied with too little rationale.

6. Practical Implications of the Proposals to Restrict Medicaid Funding

It is evident that the MFAR’s proposals to greatly restrict the use of IGTs, provider assessments and CPEs that help fund states’ share of Medicaid costs are extremely problematic from a legal perspective. They also constitute an ill-advised attempt to arbitrarily cut Medicaid spending without regard for the negative effects they would have on the Medicaid program and the very individuals that Medicaid was designed to protect.

These proposals seem to be rooted in a belief that arrangements with local entities and the private sector to help fund the Medicaid program give states less of a financial stake in the Medicaid program and that this undermines the fiscal integrity of the Medicaid program.

Medicaid has operated as a federal-state partnership since its inception, and states are well aware of the urgent need to bend the cost curve of healthcare spending. Specifically, we are aware that Medicaid spending has increased to approximately $616 billion in 2018, and this increase is not due solely to higher enrollment.\(^{19}\) The average per-enrollee cost also climbed year after year and was up a record to $8,106 in 2018.\(^{20}\)

Arizona has operated a managed care program since the inception of our Medicaid program in 1982, and we are one of the most successful states at containing Medicaid costs. For example, our annual cost per Medicaid member enrolled in a managed care plan is $5,900, compared with national average of $7,200 per managed care member per year.\(^{21}\)

Arbitrarily and drastically reducing Medicaid spending by billions of dollars annually by making it extremely difficult, if not impossible, for states to continue leveraging local government and private sector funding is not a responsible answer to the nation’s healthcare cost-containment challenges. If the MFAR is finalized, severe reductions in Medicaid funding will hit hardest those states that already operate tightly-managed, cost-contained Medicaid programs. States like Arizona that have been very

\(^{17}\) 42 C.F.R. § 433.68(f)(3).
\(^{18}\) 42 U.S.C. § 1396b(w)(4) (emphasis added).
conscientious about controlling costs will have fewer levers to pull and will be forced to make the hardest decisions about which important benefits to cut, which vulnerable Arizonans who are relying on Medicaid for healthcare to disenroll, or both.

Throughout the country, the MFAR inevitably will lead to increased rates of rural hospital closures, reduced access to care for the country’s most vulnerable, and increased costs of commercial insurance to subsidize hospitals’ and other providers’ losses on treating Medicaid and indigent patients.

**Conclusion**

Among other legal pitfalls, the overly vague standards CMS proposes in the MAFR would give the agency unfettered discretion to approve or deny financing arrangements that states heavily rely on to fund their Medicaid programs. Virtually every state has successfully leveraged provider assessments and/or IGTs to help finance the growing cost of providing Medicaid services to acutely ill, frail and vulnerable Americans. Finalizing the MFAR with its overly broad and subjective standards would cause a great deal of uncertainty and upheaval in healthcare systems and communities throughout the country.

We recognize the need for cost containment in healthcare, and our members continually strive to bend the cost curve. But the MFAR is far too blunt a tool and would have the effect of undermining Medicaid programs across the country and hurting the vulnerable individuals who rely on this program. Arizona has run an efficient, cost-contained, managed care Medicaid program since the inception of its program in 1982. Arizona’s reliance on CMS-approved provider assessments and IGTs to fund the state share of Medicaid expenditures has likewise been judicious.

If finalized, the MFAR would severely limit Medicaid program financing and curtail the availability of healthcare services to millions of Americans and hundreds of thousands of Arizonans. Moreover, CMS lacks the legal authority to promulgate many of the provisions contained in the proposed rule. For all of the reasons outlined in this letter, we respectfully request that CMS withdraw the proposed regulation in its entirely.

Sincerely,

Debbie S. Johnston
Senior Vice President, Policy Development
Arizona Hospital and Healthcare Association.