February 1, 2020

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicaid Fiscal Accountability Regulation [CMS–2393–P]

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the recently published proposed rule which establishes new reporting requirements for states to provide the Centers for Medicare and Medicaid Services ("CMS") with certain information on supplemental payments to Medicaid providers, including supplemental payments approved under either Medicaid state plan or demonstration authority, and applicable upper payment limits ("Proposed Rule" or "proposal").[1] Additionally, the Proposed Rule would establish requirements to ensure that state plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan and with efficiency, economy and quality of care. This Proposed Rule addresses the financing of supplemental and base Medicaid payments through the non-federal share, including states' use of health care-related taxes and bona fide provider-related donations, as well as the requirements on the non-federal share of any Medicaid payments.

The Chamber has long supported efforts to strengthen overall fiscal integrity of public programs such as Medicaid. CMS' efforts to improve transparency, clarify definitions, and address program integrity concerns are laudable in theory but need to be advanced carefully. Although we support the goals detailed in the preamble, the Proposed Rule could: have detrimental economic ramifications on communities across the country; put patient access to critical services in jeopardy, exacerbate cost-shifting onto privately insured communities; and violate state sovereignty and ability to manage state programs and populations by providing CMS unprecedented discretion over its evaluation of state financing and payment approaches. Additionally, we have operational and procedural concerns given that the time-table contemplated by the Proposed Rule is untenable, and the lack of meaningful regulatory impact analysis. We urge CMS to withdraw this Proposed Rule.

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[1] 84 Fed. Reg. 63,722 (November 18, 2019), *available at* https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf

DETRIMENTAL ECONOMIC RAMIFICATIONS NATIONWIDE

The proposal would improperly reduce non-federal share dollars that support Medicaid and could force state budgets to either find additional non-federal share dollars (tax increases or provider assessments) or reduce access to services and/or provider reimbursements. This could have an adverse impact on overall economic growth, not only in the health care sector, but if taxes are broad-based, on individuals and other businesses.

As the largest employers in many communities across the country, hospitals will suffer tremendous financial losses under this Proposed Rule. Nationally, the Medicaid program could face total funding reductions between $37—$49 billion annually or 5.8%— 7.6% of total program spending.[2] Hospitals and health systems specifically could see reductions in Medicaid payments of $23—$31 billion annually, representing 12.8%—16.9% of total hospital program payments. Moreover, the impact at the individual state level would vary significantly. With 41% of rural hospitals already operating at a negative profit margin and 120 rural hospitals closing in the last nine years, additional closures are likely if this proposal is implemented.[3, 4] These closures will affect not just employment in rural communities but cause a ripple effect on other businesses in those communities.

DETRIMENTAL IMPACT ON PATIENT ACCESS

Changes to Medicaid's financing structure and reimbursement may have an impact on Medicaid beneficiaries access to care as providers may choose not to participate in the program or reduce their patient panel size, which would force individuals to go without care or inappropriately utilize other high-cost settings due to limited access (e.g., inappropriate use of ER).

Additionally, Medicaid budget restrictions that are not mitigated could force states to make Medicaid eligibility and benefit changes to manage costs. Medicaid pays for approximately half of the births in the country, as well as care for almost half of all children and adults with special health care needs, such as physical and developmental disabilities, dementia and serious mental illness. The magnitude of financial loss to the program as a result of this rule would force states 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; reduction in benefits, which would decrease the quality of care; and lower provider reimbursement, which would lead to reduced access to care for many of our country's most vulnerable patients.

HARM TO EMPLOYERS: INCREASED COST SHIFTING

With a higher rate of uninsured individuals, providers will face increased uncompensated care rates that will exacerbate the cost shift onto private pay and commercial payers. This would have

[2] Analysis provided by Manatt Health, 2020

[3] Topchick, Michael. Rural Relevance 2017: Assessing the State of Rural Healthcare in America. The Chartis Group, 2017. https://www.chartis.com/forum/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf

[4] Hospital Closures, NC Rural Health Research Program. UNC Cecil G. Sheps Center for Health Services Research. https://www.shepscenter.unc.edu/programsprojects/rural-health/rural-hospital-closures/

an impact on overall competitiveness and wage growth in the health care and other economic sectors. Similarly, changes in benefit levels may impact proper utilization of services, specifically inappropriate use of emergency services for basic care.

IMPROPERLY CEDES POWER TO THE FEDERAL GOVERNMENT

Medicaid is a federal and state program that is jointly funded by the state and federal governments and managed by the states. In fact, the federal government's Medicaid website specifically states that "[a]lthough the Federal government establishes certain parameters for all states to follow, each state administers their Medicaid program differently."[5]

Section 1902(a)(2) of the Social Security Act allows states to use local sources of funding, and there is no statutory basis to limit legitimate sources of state funding as proposed by CMS. Instead, CMS should use its existing authority to address what CMS characterizes as "shady recycling schemes" until it collects the information it needs to prohibit unlawful arrangements without the broad changes proposed that affect legitimate sources of non-federal share funding. As proposed, these changes grant CMS substantial discretion to approve state financing arrangements, adding uncertainty to state funding, while acknowledging that "the fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."[6]

CMS previously issued a rule[7] addressing intergovernmental transfers that would have placed similar restrictions on non-federal share dollars, which was subsequently vacated by a federal court.[8] Congress further expressed disapproval of that proposal in the American Recovery and Reinvestment Act of 2009.[9] No statutory changes to the Social Security Act have occurred since that time to warrant a new interpretation of state Medicaid financing mechanisms by CMS.

The Chamber has long defended and supported state sovereignty and advocated for flexibility to permit states to make policy and fiscal decisions that best serve their communities and population. As such, we have significant concerns about the proposal's disruption of how states manage their Medicaid programs, particularly as states have financing and payment arrangements in place that CMS has previously approved. Many of the Proposed Rule provisions give CMS unprecedented discretion to choose which arrangements the agency would approve, while providing little clear direction to states on how to construct such arrangements. We believe this constitutes excessive federal overreach.

PROCEDURAL CONCERNS: UNTENABLE TIME-FRAME AND FLAWED REGULATORY IMPACT ANALYSIS

Because of the complexity of the rule, and the unknown interaction of proposed polices, we are suggesting that a more complete analysis be conducted on the impact of these financing and

[5] https://www.medicaid.gov/about-us/program-history/index.html

[6] 84 Fed. Reg. 63,773 (November 18, 2019)

[7] 72 Fed. Reg. 29,748 (May 29, 2007)

[8] Alameda County Med. Ctr. v. Leavitt, 559 F. Supp. 2d 1 (2008)

[9] Pub. L. No. 111-5, Section 5003(d)(1)

payment methodologies to influence future policy discussions aimed at improving Medicaid service delivery and budget accountability.

The proposals are numerous and varied, giving states vastly inadequate time to make policy and budgetary adjustments to offset the loss of federal funds, assuming they could be mitigated at all.

CMS' goal to assess the non-federal share of Medicaid financing should start with obtaining the information necessary to determine whether provider supplemental payments, taxes, intergovernmental transfers, and other financing arrangements meet statutory requirements and advance the objectives of the Medicaid program. A thorough analysis of that data will inform CMS whether changes to the rules governing these financing mechanisms are needed and the impact of each proposed change. Regulatory changes to long-standing and legitimate state financing arrangements should not be made without a clear and full understanding of the impact to both state budgets and patient access to care.

INSUFFICIENT REGULATORY ECONOMIC IMPACT ANALYSIS

CMS has failed to conduct a thorough and appropriate analysis of the likely economic impact of the Proposed Rule. Executive Order 12866 requires agencies to consider fully the potential impacts of proposed regulations and to carefully weigh the costs and benefits in order to ensure that regulations are only adopted that yield net benefits clearly in excess of the likely costs. Executive Order 12866 and nearly a century of economic practice make clear that an economic cost-benefit analysis of a proposed regulation must examine all of the likely impacts, both those that are immediate and direct and those that are indirect and longer-term. In this case CMS has focused almost exclusively on the immediate and direct impacts as reflected in its analysis of the information collection burden imposed on states. CMS has neglected to consider the more significant impacts that the Proposed Rule will likely have on citizens' access to health care and, ultimately, on the outcomes that will result.

CMS admits that the proposed 150% of fee-for-service base payments cap on supplemental payments will reduce Medicaid payments to physicians and other health service providers by $256 million per year, a 25% reduction from the current payment total.[10] CMS blithely dismisses this reduction as merely a "transfer" from Medicaid providers to the government.[11] CMS makes a fatal mistake by stopping there in its analysis. The impact characterized by CMS as a "transfer" has serious consequences that must not be ignored in a credible regulatory impact analysis. For a reduction in payments of that magnitude, it is essential for the regulatory impact analysis to consider what the effect will be on providers' behavior, the supply of health services, and individual's access to health services. CMS' assertion that "this potential decrease in Medicaid reimbursements could be mitigated if states take action" to increase the base payment amounts or to increase taxes is meaningless because CMS has no basis for assuming that any such mitigation will or can actually occur.[12] The likely default position is that payments to providers will be reduced to some significant extent by the Proposed Rule's fiat, and any reduction in payments to providers is likely to have an adverse impact on beneficiaries' access to health care. The end

[10] 84 Fed. Reg. at 63,773

[11] 84 Fed. Reg. at 63,775 ("from whom to whom" in Table 1)

[12] 84 Fed. Reg. at 63,773

result of reduction in access to health care is an increased risk of premature death facing each of the 75 million Americans who depend on the Medicaid system for health care each year.

It is routine for federal agencies to recognize that regulatory decisions have health consequences. The Environmental Protection Agency ("EPA") and the Occupational Safety and Health Administration have routinely recognized that their regulations impact citizen's morbidity and mortality. These agencies both have long histories of conducting regulatory cost benefit analyses that quantify the benefits of reduced exposure to health risks in the workplace or in the general environment. The economic concept of value of statistical life ("VSL") has been developed as a widely recognized and used metric over the past 40 years, largely as the result of the need to quantitatively measure the economic costs and benefits of federal regulation decisions. In its most recent regulatory decisions, the EPA has adopted $9.2 million as the benchmark measure of the cost or benefit associated with a one unit change in the annual probability of mortality across the U.S. population.

It is important to note that VSL is *not* intended as a measure of the value of a life. Rather, VSL is a measure of the value that consumers collectively express through their choices between more (or less) risky alternatives. Our willingness to pay some extra to avoid certain risks is an indicator that even small changes in the risk of exposure to mortality or morbidity have value. Those individual values associated with small individual changes in exposure to risk may themselves be quite small, but when summed across millions of potentially exposed individuals in the U.S. population, the resulting sums can be very large. That is the context in which to understand the $9.2 million per year value used by EPA.

By the same token that mortality risk reduction associated with an environmental or occupational safety regulation is counted as a benefit of the regulatory decision, it is also the case that the potential impact of a regulation that increases individuals' risk of mortality should be considered as a cost of such regulation.

The short comment period for this regulation makes it impossible to collect data and develop statistical models to estimate with precision the increased risk of death that Americans will face if the Proposed Rule is adopted. However, it should be clear that CMS cannot credibly assume that the impact will be zero.

Applying the $9.2 million per life unit risk value used by EPA to the 75 million Medicaid beneficiaries, we can extrapolate the following costs based on the estimated rate of increased death on the population:

- If the increased risk of death is only one in a million exposed individuals, the Proposed Rule would impose an annual cost impact of $690 million per year on the affected individuals and families;
- If the increased risk of death is only one in 100 thousand exposed individuals, the Proposed Rule would impose an annual cost impact of $6.9 billion dollars on the affected individuals and families; and
- If the increased risk of death is only one in 10 thousand exposed individuals, the Proposed Rule would impose an annual impact of $69 billion dollars on the affected individuals and families.

It is possible to construct a statistical model of relating reimbursement levels to access to health services and to population mortality rates in order to determine with some precision where in the range above the likely mortality cost of the Proposed Rule falls. This is the analytical work that

Executive Order 12866 required CMS to do *before* publishing its Proposed Rule. CMS's neglect of this fundamental task of regulatory analysis is astounding by itself, but equally astounding is the failure of CMS to present any estimate of any quantitative benefit of the Proposed Rule. Even if the cost of the risk of death imposed by this Proposed Rule is small, the rule is unjustified if the benefit of it is zero.

The administration has taken pride in the number of unnecessary, costly regulations that it has rolled back over the past three years. The claims of regulatory cost savings amount to hundreds of millions of dollars returned to the American people through reduced regulatory burdens. This one Proposed Rule alone has the potential to wipe-out the entire record of deregulatory achievement amassed by this administration.

CONCLUSION

We appreciate the goal of strengthening the overall fiscal integrity of public programs. However, because of our significant concerns regarding the detrimental effect the proposal will have on communities, employers, and state economies, we urge CMS to withdraw the Proposed Rule. An alternative to the Proposed Rule may be for CMS to collect data on the state financing mechanisms and then allow for sufficient time to assess and analyze this data to inform potential changes in future proposals or sub-regulatory guidance.

Sincerely,

Katie Mahoney
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U.S. Chamber of Commerce