MISSOURI HOSPITAL ASSOCIATION

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Medicaid Program; Medicaid Fiscal Accountability Regulation (CMS-2393-P)

On behalf of its 140 member hospitals, the Missouri Hospital Association offers the following comments regarding the Centers for Medicare & Medicaid Services' proposed Medicaid Fiscal Accountability Regulation. The Medicaid program provides essential financial assistance to Missouri's hospitals, ensuring Missouri's most vulnerable populations — the poor, the children, the disabled and the elderly — have access to quality health care. If CMS moves forward with the proposed rule as drafted, we are alarmed by its opaque standards, insufficient statutory authority and financial and patient care implications. At least one of the provisions has the potential to undermine Missouri's use of provider taxes to fund its Medicaid program. As such, it would have enormous consequences for Missouri's state budget, hospitals and Medicaid enrollees.

HEALTH CARE-RELATED TAXES

CMS proposes to decide whether a tax structure is valid by considering the "totality of circumstances" about its "net effect."

CMS contends in the proposed rule that the addition of the "net effect" standard to § 433.68(f)(93) represents a clarification of existing policy and would not impose any new obligations or place any new restrictions on states that do not currently exist. We respectfully disagree.

The proposed "net effect" standard is not a clarification of existing policy. Instead, the proposed rule would require only a "reasonable expectation" that the taxpayer may be held harmless, rather than a "guarantee," as required by the current 42 CFR § 433.68(f). CMS' latitude to interpret "reasonable expectations" of the participating entities would create substantial uncertainty for states and providers. Further, the proposed definition of "net effect" is extremely broad and does not provide states or providers with guidance on how the agency would enforce this provision. As a result, we believe this proposal is impermissibly vague and overbroad, in violation of the Administrative Procedures Act. With insufficient detail or rationale, it is changing policy and guidance upon which states and providers have long relied.

In the preamble to the proposed rule, CMS unambiguously states that **any** arrangement among taxpayers, including voluntary arrangements funded from **any** source will be considered impermissible if the "net effect" results in the taxpayers having a reasonable expectation to be held harmless for all or a portion of their tax. This text diverges substantially from that of the proposed rule, which purports to examine the "net effect of an arrangement **between the State (or other unit of government) and the taxpayer**." CMS' stated interpretation of the revised text is contrary to the plain text of the Medicaid statute and exceeds the agency's statutory authority. Section 42 U.S.C. 1396b(w)(4) defines an impermissible hold harmless provision to exist only when the State or other unit of government imposing the tax engages in redistribution or the Medicaid payments made to a provider account for the amount of tax paid. However, under the proposed "net effect" standard, an indirect guarantee would exist if a redistribution arrangement between private entity taxpayers exists, even if the state or local government imposing the tax is not involved in or aware of the private arrangement. Moreover, the blunt effect of CMS' proposed application of the rule would be to invalidate mitigation arrangements that actually furthered the redistributive aims of health care-related taxes, frustrating Congressional intent.

In fact, CMS has on more than one occasion extensively reviewed Missouri's hospital provider tax and pooling arrangements, which are implemented by private contracts between hospitals and the MHA Management Services Corporation, and explicitly deemed them permissible. Under the overbroad interpretation of this revision set forth in the preamble, CMS is ostensibly attempting to regulate private transactions funded solely by provider-owned revenues. Reaching that far into the private marketplace violates providers' due process rights in their duly earned reimbursements and constitutes a taking. These proposed changes are a clear departure from established policy and not a clarification of it.

Lastly, we believe the proposed federal rule is crafted to give CMS unbridled authority to decide whether to allow or prohibit a provider tax mitigation arrangement based on its interpretation of a "totality of circumstances." We do not believe CMS has the authority to dictate how private entities can use revenue from Medicaid payments they have received for allowable services provided to Medicaid patients. It certainly does not have the authority to do so using an opaque standard that provides no guidance for those seeking to comply with the regulations. In sum, the provisions of the rule relating to health care-related taxes violate the Administrative Procedures Act and should be withdrawn on the grounds that they exceed the agency's authority, and are overly broad, arbitrary and capricious.

SUPPLEMENTAL PAYMENTS AND UPL DEMONSTRATIONS

The proposed rule requires that CMS evaluate and reauthorize a state's authority to make Medicaid supplemental payments every three years.

We believe that the proposal to evaluate and reauthorize a state's authority to make Medicaid supplemental payments every three years will create significant administrative burden for states and CMS, and could result in long delays in processing state plan amendments. It likely will not

allow sufficient time for states to secure approval from state agencies and legislatures. In addition, the rule would give CMS complete discretion not found in the Medicaid statute to determine whether supplemental payments meet statutory standards of economy and efficiency regardless of whether the payments are under the upper payment limit. This would result in a substantial level of uncertainty and instability for those who must develop and implement strategic plans for hospital investments and operations.

CMS is proposing to codify and narrow UPL methodologies.

The proposed rule eliminates methodologies that previously were acceptable under CMS' subregulatory guidance. For example, the proposed payment-based methodologies do not include references to payment per discharge or diagnosis-related group-based calculations that currently are allowed and were included in the Inpatient Hospital UPL Guidance that was published on Medicaid.gov in conjunction with the March 2013 State Medicaid Director letter (SMD #13-003). CMS also no longer would accept alternative methodologies that were previously accepted, which further limits states' flexibility. These changes are an arbitrary and capricious departure from established payment methodologies on which states and providers have relied to provide access to quality care for a vulnerable population.

Additionally, CMS no longer would allow states to utilize different methodologies for different types of hospitals within the same UPL classification. This is troubling because often specialty hospitals (i.e., children's hospitals) do not align with the Medicare principles designed for nonspecialty hospitals.

The new standards related to allowable data sources are expected to significantly increase administrative burdens for states, with unsubstantiated justification for the changes. Missouri hospitals are concerned the burden will disrupt agency operations and management of payments and ultimately disrupt care for beneficiaries.

CMS is proposing to limit Medicaid practitioner supplemental payments.

The proposed rule would establish a new limit on Medicaid practitioner supplemental payments. Currently, supplemental payments to contracting groups of practitioners are limited to the average commercial rate. Under the proposed rule, Medicaid practitioner supplemental payments could not exceed 50% of fee-for-service base payments for services provided in most urban areas or 75% of base payments for services in a Health Professional Shortage Area or Medicare-defined rural area. It is unclear if these limits would continue to be applied to contracting groups or applied on an individual practitioner basis.

CMS recently approved Missouri's state plan amendment authorizing the use of the average commercial rates for this type of supplemental payment. Moving from a cap based on ACRs to a cap based on a percentage of the Medicaid fee schedule arbitrarily impacts academic medical centers and safety net hospitals that serve vulnerable communities in Missouri. Because

Medicaid base payments to physicians and other practitioners often are well below Medicare rates, the proposed limit would further cut reimbursement rates and ultimately impede patient access.

INTERGOVERNMENTAL TRANSFERS

CMS, in its proposed rule, redefines "non-state government providers" and would restrict the type of entities that can participate in funding the non-federal share through intergovernmental transfers. 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. This provision is overly broad and ambiguous in granting CMS unfettered discretion, while creating uncertainty for states in determining which public providers are permitted to transfer local funds for purposes of Medicaid financing.

In addition, CMS proposes to limit IGTs to "state or local taxes (or funds appropriated to state university teaching hospitals)" rather than "public funds." This would eliminate the longstanding ability of public providers (often safety net providers) to use patient revenues and other sources of income for transfers, which restriction is not found in statute. This would be a substantial change from guidance previously provided and likely would cause significant financial strain on the public hospitals that utilize IGTs. CMS has failed to account for the substantial reliance by states on the current policy and the harm that this change would cause.

REPORTING REQUIREMENTS

CMS would require three new reporting requirements for supplemental payments.

The proposed rule first would require states to report numerous data elements for each supplemental payment included on the CMS-64 quarterly report. Second, states would be required to submit aggregate and provider-level information for **all** payments no later than 60 days after the end of the state fiscal year. Lastly, states would be required to report aggregate and provider-level information on each provider contributing funds to the state or local government that are used as a source of nonfederal share for Medicaid supplemental payments.

The new reporting requirements not only would add significant administrative burden for states, they also would substantially increase the amount of information collected by CMS. It is unclear how CMS intends to process or use the voluminous amounts of newly reported data and whether the information will be made public.

The proposed rule also establishes that if a state fails to timely, completely and accurately report the required information, federal financial participation will be withheld until the state complies. While we understand CMS' interest in greater transparency, we are concerned that states may not meet the required deadlines, which could have damaging consequences. It may take a significant amount of time for states to accumulate the required data, establish workflows, and

develop the necessary reports. If FFP is withheld, it would unquestionably result in reduced payments and subsequently reduced access to care for many of our most vulnerable citizens.

Numerous provisions of this rule could have catastrophic consequences for states, providers and patients. The budgetary consequences alone could destabilize Medicaid programs and health care systems, to the detriment of the beneficiaries served. As noted, several changes are legally impermissible under the authority granted to CMS by the Medicaid statute and the Administrative Procedures Act. Due to these shortcomings, MHA urges CMS to withdraw the rule in its entirety.

Thank you for the opportunity to comment. If you have any questions, please contact us at 573-893-3700, ext. 1349 or dlandon@mhanet.com, or jdrummond@mhanet.com or ext. 1328.

Sincerely,

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