WEST VIRGINIA HOSPITAL ASSOCIATION

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January 30, 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 (MFAR) (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 West Virginia Hospital Association (WVHA) and our sixty-three member hospitals and health systems, WVHA appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation related to Medicaid program financing and supplemental payments (MFAR). Medicaid provides coverage for more than 500,000 beneficiaries, or 28% of our state's citizens.

WVHA is concerned the MFAR would reduce access and availability of healthcare services to West Virginia Medicaid beneficiaries because MFAR provisions do not appear to be legally permissible. If finalized, the rule would significantly change hospital supplemental payments and possibly stymie state Medicaid program financing. CMS represents 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 may be unenforceable and inconsistent with CMS's statutory authority.

The rule also contains significant changes to healthcare-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. The agency also proposes to change the review process for supplemental payment programs and provider tax waivers. In addition, the

[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.

agency would grant itself significant discretion in evaluating permitted state financing arrangements through vague concepts such as "totality of circumstances," "net effect," and "undue burden." These proposed changes would likely have negative consequences for the West Virginia Medicaid program and its program recipients.

PROPOSED CHANGES AFFECTING PROVIDER DONATIONS AND HEALTH CARE RELATED TAXES

States and local governments have long collaborated with providers to ensure access to healthcare services for their Medicaid population, as well as to improve the health of the overall community. Healthcare providers are currently permitted, under federal law and regulation, 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; to providers furnishing the same class of services; or any related entity[2]. States can also tax providers to collect revenue to be utilized toward the operations of their Medicaid program.

CMS has proposed several policy changes that would curtail sharply a state's ability to use these financing arrangements – despite clear statutory authority permitting them.[3] In general, CMS would be granted unfettered discretion to assess whether a financing arrangement is permissible. In order to do this, the agency again uses the "net effect" standard based on "the totality of circumstances." These new, vague terms without defined criteria would create much confusion and uncertainty for states.

The proposed rule would also violate current statute by requiring only a "reasonable expectation that the taxpayer may be held harmless, rather than a "guarantee," as required by the statute.[4] This rule also would introduce inconsistencies with existing regulatory language and violate the Administrative Procedure Act because it is changing policy and guidance upon which states and providers have long relied on with too little rationale. We also believe the proposal is arbitrary and capricious because it includes vague language that would create uncertainty and unnecessary burdens for states and providers.

Provider Tax Waiver

WVHA requests CMS to consider proposing further statistical testing when considering a provider tax waiver, as outlined at §433.68. MFAR states the agency will consider the "totality" of a proposed tax waiver; however, the rule does not define the analysis or methodology to determine "totality". It is our recommendation that the term "totality" is vague and inadequate for the purpose of tax waiver decisions and should be replaced with definitive methodology.

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[2] § 433.54 Bona fide donations
[3] Social Security Act § 1903(w)(3).
[4] Social Security Act § 1903(w)(4)(C)(i).

MEDICAID SUPPLEMENTAL NON-DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

States use both base payments and supplemental payments to reimburse providers. Base payments to providers are tied to claims for specific services and are typically set significantly below the cost of providing such care. Historically, supplemental payments have served to improve provider payment rates that in the case of West Virginia Medicaid, are still below the cost of providing care. After accounting for supplemental payments, West Virginia hospitals receiving base and supplemental Medicaid payments receive, on average only 89 cents on every dollar spent for caring for Medicaid patients.[5]

CMS proposes significant changes to the policies for non-DSH supplemental payments, citing concerns about the growth in these payments. Specifically, the agency proposes 1) to change how upper payment limits payments (UPL) are calculated; 2) to increase reporting requirements; and 3) to limit such payments to physicians and other practitioners. These changes could severely curtail access to care, especially at public academic teaching hospitals and rural hospitals serving vulnerable communities whose providers would disproportionately be subject to the new practitioner caps. Meanwhile, the new provider-level reporting requirements would be considerable. Additionally, they 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, we believe that his portion of the proposal is arbitrary and capricious.

Base Payment Definition

WVHA requests CMS to further expand the definition of base payment for it to include any payment associated with a beneficiary service. A broader definition would permit provider quality bonus incentives including outcome related objectives, utilization baseline testing and directed payments as seen in both Fee for Service and Managed Care Medicaid environments.

Despite the potential for such significant negative consequences, CMS has provided little to no financial 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 appear to violate current Medicaid law, or are arbitrary and capricious in violation of the Administrative Procedure Act. Moreover, at the same time the agency is proposing these changes, it is 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.[6]

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[5] AHA January 2020 https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

[6] www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission

EFFECTIVE DATES, 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 for renewal of the provider tax 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 secure approval from state agencies and legislatures. These financing and payment programs are complex and states, such as West Virginia, would need considerable time to work with state legislatures and affected stakeholders to implement any possible mitigation strategies.

CONCLUSION

In our opinion, the proposed rule significantly undermines the Medicaid programs in our state and adversely impacts those who rely on the program. Additionally, it includes numerous legal infirmities and would require considerable time for mitigation (if even possible) by those affected by these changes.

For all the reasons identified herein, WVHA strongly urges CMS to withdraw this rule in its entirety.

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

Sincerely,

Joseph M. Letnaunchyn
President & CEO

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