January 31, 2020

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

Submitted electronically via regulations.gov

Re: CMS-2393-P: Medicaid Program; Medicaid Fiscal Accountability Regulations

To Mr. Richard Kimball and colleagues:

West Virginians for Affordable Health Care submits these comments in strong opposition to the proposed Medicaid Fiscal Accountability Regulation package in its entirety and urges CMS to not move forward with finalizing any aspect of these regulations. ***We ask that CMS withdraw these regulations in their entirety.***

West Virginians for Affordable Health Care is a state-based, state-wide non-profit that brings the voices of health care consumers to state and federal policy debates. We have a network of close to 6,000 West Virginians who actively support our efforts to protect the West Virginia Medicaid program – for themselves, their families, their friends, and their neighbors. We work closely with our Department of Health and Human Resources, and the Bureau of Medical Services (our Medicaid Agency) to improve the quality and efficiency of the Medicaid program.

There is no question that these proposed regulations will put West Virginia at risk of losing what has been long-accepted ways to raise state funds for our Medicaid program and reimbursing participating providers. If finalized, the proposed regulations will significantly change West Virginia hospital system supplemental payments and undermine overall state Medicaid program financing.

CMS purports to be clarifying policies regarding providers' role in funding the non-federal share of Medicaid, but in fact, the rule introduces vague standards for determining compliance that may be unenforceable and inconsistent with CMS's statutory authority. CMS would grant itself significant discretion in evaluating permitted state financing arrangements through vague concepts such as "totality of circumstances," "net effect," and "undue burden."

The proposed regulations will create vaque, unnecessary and misguided restrictions on how West Virginia can raise state raise revenues to cover the state share of the cost of our Medicaid

program. This uncertainly will lead to cuts in eligibility, benefits and/or provider rates, which will lead to more uninsured and underinsured West Virginians, and in turn, an increase in uncompensated care costs for our rural health providers and lead to health facility closures. Thus, these proposed regulations will harm the low-income population of West Virginia families who rely on Medicaid for health care, West Virginia rural health providers, and all West Virginians who utilize those providers.

Medicaid is critical to West Virginia families. More than 550,000 individuals rely on Medicaid in our state, including children, older adults, individuals with disabilities, pregnant women, parents and low-income adults. Not only does it provide an affordable source of health insurance and care for a third of the total West Virginia population, it is an essential financial support for our state's rural health care providers such as hospitals and community health centers. And the Medicaid program is an important economic development tool in our low-income state, bringing in new federal dollars that generate jobs and business activity in our state.

Our opposition to the proposed Medicaid Fiscal Accountability Rule is summarized in the following points:

1. The proposed regulations violates statutory intent.
2. The proposed regulations violates Executive Order 12,866 and the Administrative Procedure Act.
3. The proposed regulations will create uncertainty West Virginia's current provider assessments and whether and how they can raise revenue for the Medicaid program. In turn, the proposed regulations could severely restrict the ability of West Virginia to finance our Medicaid program
4. By restricting the ability of West Virginia to finance our Medicaid program, the proposed regulations will adversely impact how much our rural providers are paid.
5. By adversely impacting how much our rural providers are paid, the proposed rules will harm access to care for West Virginians who rely on Medicaid.
6. By restricting the ability of West Virginia to finance our Medicaid program, the proposed regulations will increase the number of individuals who are uninsured or underinsured, and in turn, increase the uncompensated care burden on our rural providers.
7. A higher uncompensated care burden on West Virginia rural providers will force some of them to close the doors, thus hurting both Medicaid enrollees *and all West Virginians*.

The proposed regulations violate statutory intent.

The proposed regulations propose to limit the use of intergovernmental transfers (IGTs) as a means of financing the state share of Medicaid expenditures by narrowing the definition of entities that can make IGTs and limiting the types of funds those entities can transfer. Specifically, CMS proposes to restrict the definition of "public funds," which entities can use to make IGTs, to only funds derived from state or local taxes or appropriations to state university teaching hospitals. CMS asserts that changing the definition of "public funds" in this way better

aligns the regulatory language with the statutory language, but this is incorrect. The statutory language merely establishes a floor for what may constitute an IGT.[1] Nothing in the statute prevents the Secretary from allowing states to use a broader set of public dollars, like commercial revenue received by a public entity, as an IGT. Therefore, the proposed regulations fall outside the scope of what Congress intended and is arbitrary and capricious.

The proposed regulations violate Executive Order 12,866 and the Administrative Procedure Act.

CMS has also failed to comply with Executive Order (E.O.) 12,866 in proposing these regulations. E.O. 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action. An agency should propose a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs, and after considering all costs and benefits of available regulatory alternatives, including the alternative of not proposing the new regulation. Yet CMS acknowledges that "[t]he fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is *unknown* [italics added]."[2] The only estimate of the fiscal effects on state Medicaid programs that HHS provides is for the single provision establishing the new, lower limit on Medicaid supplemental payments to physicians and other practitioners.

Separate from the requirements of E.O. 12,866, under the Administrative Procedure Act (APA), courts have held that when an agency relies on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the regulations unreasonable. Because CMS' cost-benefit analysis for the proposed rule fails to adequately quantify or to explain why CMS could not quantify those costs, CMS does not adequately assess the economic effects of the proposed regulations. Therefore, the proposed regulations in their current form is an abuse of discretion that violates the APA.

CMS relies on Section 1902(a)(30(A) as the basis for the proposed regulations, which requires states to "assure that [provider] payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan."

CMS recently rescinded a rule designed to ensure that enrollees have access to care consistent with this statutory requirement. CMS rescinded this rule based on a claim that it was burdensome for states to collect information on whether provider payments were sufficient to ensure equal access.[3] Ironically and inconsistent with previous action, these proposed regulations impose new burdensome administrative requirements which will make it harder for Medicaid agencies to provide health coverage and care.

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[1] 42 U.S.C. 1396b(w)(6)(A)
[2] 84 FR 63773 https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf
[3] CMS-2406-P2, *Proposed Rule: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission*, July 15, 2019, https://www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-rescission

These proposed regulations create onerous reporting requirements, including requirements to report new types and amounts of data, as well as to use specific reporting formats. Additionally, CMS proposes to withhold federal financial participation funding from states if they do not meet these new requirements. West Virginia's Bureau of Medical Services is concerned about their ability to meet these new reporting requirements and the potential to lose some of their federal funding if they do not meet them. Imposing large amounts of burdensome new reporting requirements will generate no real benefit and only make it harder for West Virginia to focus BMS staff energy, time and resources on administering the Medicaid program efficiently. Our state is already facing the challenges of administering a new SUD waiver as well as transitioning our foster system population into managed care.

The proposed regulations will create uncertainty West Virginia's current provider assessments and whether and how they can raise revenue for the Medicaid program. In turn, the proposed regulations could severely restrict the ability of West Virginia to finance our Medicaid program.

Although the purported goal of the proposed regulations are to regulate supplemental payments that states make to providers, in actuality the rule restricts how states raise the revenue used to make supplemental payments, even though the ways states raise this revenue have been longstanding, legally authorized financing mechanisms.[4] The proposed regulations impose new and vague standards of review for state financing and supplemental payments arrangements which give CMS a large amount of discretion for approval. CMS seeks to impose many new vague standards that states must meet before the agency will approve their financing and supplemental payment arrangements, including "undue burden" and "totality of circumstances" standards. However, the language of the rule does not sufficiently spell out what would constitute an "undue burden", nor what an examination of the "totality of circumstances" would entail.

Not only that, but CMS also proposes to have the authority to review and approve not only new financing arrangements, but current, previously-approved ones as well. The uncertainty and discretion afforded to CMS to disapprove longstanding arrangements could have a chilling effect on West Virginia, forcing cuts to our Medicaid program rather than risk disapproval of both old and new financing arrangements. As a result, West Virginia could end up eliminating or significantly scaling back existing financing and payment arrangements out of fear and confusion, which could then lead to overall cuts to their Medicaid program.

In the 2019 West Virginia Legislative Session, with bipartisan support, our legislators placed a tiered assessment on all Health Care Maintenance Organizations (HMOs) in order to "permit the maximization of federal matching dollars for use in the state Medicaid program." All HMOs operating in the state are subject to the assessment except PEIA (state-employee plans), FEHBP

[4] Cindy Mann, Anne O'Hagen Karl, *Proposed Rules on Medicaid Financing Miss the Mark and Threaten Access*, Health Affairs Blog, January 8, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200108.392104/full/

(federal employee plans), and Medicare Advantage plans. The assessment rate would be based on a per member per month basis and is higher for Medicaid members than for non-Medicaid members. It will raise an initial estimated $12 million annually in new state tax collection dollars. We also passed an additional tax of 0.13 percent on the gross receipts of acute care hospitals that goes into a special fund dedicated to Medicaid. The estimated state tax collections are $4.2 million annually for this increase. West Virginia was very careful to design these revenue measures to comply with all federal regulations regarding revenue generation. Under these proposed regulations, it is unclear if one or both of these new revenue sources could be challenged.

By restricting the ability of West Virginia to finance our Medicaid program, the proposed regulations will adversely impact how much our rural providers are paid.

As explained above, the ways that the proposed rule seeks to limit both what types of entities can make IGTs as well as what funds can be used to make IGTs will unduly restrict the ability of the West Virginia legislature to raise revenues to support the costs of our Medicaid programs, including how much we pay Medicaid-participating providers.

CMS is proposing to change fundamental "rules of the game" at a time when West Virginia is struggling to confront an opioid addiction epidemic and Substance Use Disorder crisis that is hitting families hard in every community in our state. Medicaid is the single most important and critical tool in West Virginia's battle to prevent addiction and provide treatment to salvage individuals and families so that they can return to health and productivity. For West Virginia, there could not be worse timing for CMS to pursue this capricious attempt to undermine state Medicaid funding mechanisms and Medicaid providers with new vague restrictions.

By adversely impacting how much our rural providers are paid, the proposed rules will harm access to care for *all* West Virginians

Our primary concern with this rule is the ultimate effect it will have on Medicaid enrollees. Constraining how states raise revenues for their Medicaid program overall will inevitably effect their ability to maintain provider rates. If provider rates are cut, many West Virginia providers could decide to no longer participate in the Medicaid program, which will then harm the ability of patients to see their preferred providers and access the care they need. This increase in the number of individuals who are uninsured or underinsured will increase the uncompensated care burden on our rural providers. A higher uncompensated care burden on West Virginia rural providers will force some of them to close the doors, thus hurting both Medicaid enrollees *and all West Virginians*.

We urge you not to move forward with the rule and to withdraw it in its entirely.

Respectfully submitted,
Kathleen D. Stoll
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