America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

Matthew Eyles
President & Chief Executive Officer

January 31, 2020

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: Medicaid Program; Medicaid Fiscal Accountability Regulation [CMS-2393-P]

Dear Administrator Verma:

On behalf of America's Health Insurance Plans (AHIP), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed Medicaid Fiscal Accountability Regulation (MFAR) published in the *Federal Register* on November 18, 2019. We also appreciate the 15-day extension of the comment period CMS announced on December 26, 2019.

AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans, including many millions of people enrolled in the Medicaid program. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

While AHIP appreciates the need for CMS to safeguard the fiscal integrity of the Medicaid program through greater transparency and other rules designed to ensure states receiving federal matching funds are complying with federal law, we have very serious concerns with the proposed rule. We understand that the proposed restrictions could significantly hinder the ability of many states to fund their Medicaid programs, regardless of whether they use a fee-for-service (FFS), managed care, or mixed delivery system. This could have harmful impacts on Medicaid beneficiaries in affected states, including the potential for reduced benefits and/or termination of coverage for some eligible groups of low-income individuals. We are also concerned that several proposed restrictions would increase uncertainty and lead to seemingly subjective distinctions between permissible and impermissible budgeting mechanisms.

Rather than move forward with the rule as proposed, we urge CMS to consider a more limited initial step, focusing on the collection of data necessary to fully assess the current landscape of state Medicaid funding and payment mechanisms. The resulting information would enable CMS to develop a comprehensive impact analysis of the MFAR's proposals. This will ensure CMS, states, and other affected parties have the time and information they need to assess the scope of existing concerns and the state-by-state impacts of potential restrictions, and to consider alternatives.

Our detailed comments on the MFAR's proposals are set forth in the remainder of this letter.

Importance of Oversight/Level Playing Field
AHIP recognizes there have been longstanding concerns in the agency and Congress about certain types of state arrangements. Our members share CMS' commitment to protecting taxpayer dollars to ensure that Medicaid services are available for all Americans who need them.

We also believe that consistency in the treatment of supplemental payments in Medicaid FFS programs are desirable in promoting parity between FFS and managed care systems. States should be allowed to choose the Medicaid delivery system that best meets the needs of their citizens without arbitrary distinctions created by federal law or regulations.

AHIP has raised concerns in the past about policies that impose greater restrictions on the use of supplemental payments by states using managed care models. Under those rules, pass-through payments made by Medicaid managed care organizations (MCOs) must be linked to providers' provision of services or performance on quality measures, whereas FFS supplemental payments have no such constraint. While we appreciate the MFAR's focus on ensuring programs involving supplemental payments meet statutory requirements, we encourage CMS to consider additional requirements that resolve remaining disparities and ensure Medicaid payments are designed to address cost and quality considerations.

Impacts on Medicaid Funding
AHIP supports the integrity and transparency goals of the MFAR, but we are deeply concerned with the implications of the proposal. If implemented as proposed, the MFAR's new restrictions on funding mechanisms—such as health-related taxes, provider donations, and inter-governmental transfers (IGTs)—could significantly reduce the total amount of resources available to meet the healthcare needs of beneficiaries covered under state Medicaid programs by substantially reducing federal funding. Alternatively, states may need to expend additional general revenue funds to receive the same level of federal dollars and achieve the same level of total Medicaid program funding.

We believe it is critical that CMS consider the potential impacts of the MFAR on stakeholders, particularly in states most significantly affected:

- Some states may terminate Medicaid coverage for low-income people in optional coverage categories.
- States could have to reduce funding or impose significant restrictions on important optional benefits that significantly enhance beneficiary health and quality of life, and address barriers to care—for example, rehabilitation therapies.
- States may need to reallocate money from their general funds to address Medicaid shortfalls, thereby cutting back on funding for other necessary services, and/or impose additional taxes that could adversely affect economic growth and harm affected citizens or industries.
- Medicaid providers likely would experience reductions in Medicaid payments. This could threaten the continued financial viability of some providers, including critical access and safety-net providers. Other providers may restrict the number of Medicaid patients they see, or withdraw from Medicaid altogether, creating potential access issues for children, seniors, people with disabilities, pregnant women, and other Medicaid beneficiaries.

- Providers that have relied on supplemental payment revenues may seek to increase payments from other sources, such as employer-sponsored commercial coverage or individual market coverage, to compensate for reduced revenues from Medicaid sources. This type of cost-shifting hurts hard-working employees who could face higher premiums and increased cost sharing as well as those individuals who buy coverage on their own in the individual market.

Despite these potential impacts, the regulatory impact analysis (RIA) in the proposed rule states that "[t]he fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."[1] We strongly believe that CMS must provide states, health providers, and other stakeholders with accurate estimates of the magnitude of potential funding impacts on the Medicaid program to inform their comments on the proposed rule. While we appreciate the additional time CMS provided for comments, we urge CMS to issue supplemental information that includes meaningful estimates of impacts by state, so stakeholders have a frame of reference to assess the effects of proposed policy changes. In addition, CMS should ensure stakeholders have adequate time to consider those estimates so they can provide meaningful comments to the agency.

Moreover, after states assess the impacts of the MFAR on their programs, they will need adequate time to evaluate their current funding mechanisms, and design and implement changes to comply with the rule. In this regard, we are concerned that the MFAR does not provide adequate time for analysis, redesign, and transition. The MFAR would sunset current state funding mechanisms after two to three years. Thereafter, such arrangements would require review and approval to ensure compliance with requirements of the proposed rule.

Given the potential magnitude of impacts on states, Medicaid enrollees, and other stakeholders, and the absence of clear information to assess those impacts, we believe CMS should consider a more limited approach in implementing the MFAR that would involve a first step of obtaining information for potential future action. This approach is described below. Alternatively, if CMS moves forward with the rule as proposed, the agency should, among other things, consider significantly longer implementation timeframes to ensure states have sufficient time to develop permissible financing alternatives. Section (d) of the RIA solicits comments on a five-year period for renewable authorizations instead of the three-year proposal. We believe that five years clearly would be more appropriate, but we are concerned that even five years may not be enough time for states with complex financing arrangements or whose legislatures convene only every other year.

Substance of the Regulation

"Net effect" standard. CMS proposes in §433.68(f)(3) to apply a "net effect" standard in evaluating health-related taxes and determining whether they create "hold harmless" arrangements with respect to certain taxpayers. The proposed standard is based on vague criteria such as "considering the totality of circumstances," determining the "net effect," and "results in a reasonable expectation." We are concerned that such criteria are too uncertain and subjective for states and policymakers to rely on in setting state tax policy and passing related legislation. We recommend that CMS consider ways to implement a standard based on explicit and objective criteria, supported by examples that

[1] *Federal Register* / Vol. 84, No. 222 / Monday, November 18, 2019 / Proposed Rules, page 63773

state policymakers can follow with confidence to ensure that health care-related taxes and reimbursement arrangements are permissible and comply with applicable laws and regulations.

Subjective Distinctions. CMS proposes several new standards in the rule that draw seemingly subjective distinctions between permissible and impermissible state funding mechanisms. For example, the new "state and local funds" definition under §433.51 requires IGTs to be derived from state or local taxes or appropriations to state university teaching hospitals. Some states take all state university hospital revenue into their general fund, and then make appropriations back to the hospital for their operating costs. But most states let their university hospital keep its patient revenues and make additional appropriations if necessary to cover the hospital's budget. Under the MFAR, the hospitals in these two examples could only make IGTs equivalent to the appropriations they receive from the state. Even if the hospitals in each example had the exact same budget, the first hospital could make IGTs in far greater amounts than the second hospital due simply to different state budgeting mechanisms.

Another example is the limitation proposed in §447.406 restricting Medicaid practitioner supplemental payments to 50 percent of the base payment for services provided in most urban areas and 75 percent of the base payment for services in health profession shortage area designated by the Health Resources & Services Administration or a rural area. Currently, states are permitted to make supplemental payments up to either Medicare payments amounts or the average commercial rate , recognizing that Medicaid payments often fall below commercial and Medicare payments. While (as noted above) we are concerned about the lack of parity between requirements affecting supplemental payments in FFS programs as compared to managed care arrangements, we are also concerned that CMS does not lay out any basis for the new proposed limitations. Such a substantial decrease in supplemental payments could negatively impact provider participation in Medicaid and access for Medicaid beneficiaries.

Issues for Clarification

Application of the MFAR to MCO pass-through and performance payments. As proposed, the MFAR's supplemental payment provisions appear to apply only to Medicaid FFS arrangements and not to pass-through or directed payments made by Medicaid MCOs.[2] We recommend that the final rule clearly state that the supplemental payment provisions apply only to payments in Medicaid FFS programs. In addition, we request that CMS confirm that value-based purchasing or performance payments made by MCOs to providers are similarly outside the scope of this rule, as well as payments made by MCOs through Section 1115 demonstrations.

Permissible Tax Classes of Health Care Services and Providers. The MFAR proposes to add "services of health insurers" other than MCOs as specified in §433.56(a)(8) as permissible classes of health care items or services for purposes of taxation. In the preamble's discussion of tax classes, CMS proposes in part that "[t]he class may include cost sharing measures, including premiums, from Medicare, such as private FFS plans under Medicare Advantage offered as part of Medicare Part C or prescription drug insurance plans as part of Medicare Part D…"

[2] 42 CFR § 438.6 (c) and (d) Directed and pass-through payments under MCO, PIHP, and PAHP contracts.

We are concerned that states may rely on this preamble statement and incorrectly attempt to levy state taxes on Medicare Advantage (MA) and Medicare Part D plans as part of a restructuring of health-related taxes. Existing federal regulations preempt state taxation of MA and Part D plans. Specifically, 42 CFR 422.404(a) prohibits states from imposing premium taxes, fees, or other similar assessments on "any payment CMS makes on behalf of MA enrollees [to MA organizations], or with respect to any payment made to MA plans by beneficiaries, or payment to MA plans by a third party on a beneficiary's behalf."

With respect to Part D plans, a companion regulation at 42 CFR 423.440(b) prohibits states from imposing premium taxes, fees, or other similar assessments on "any payment CMS makes on behalf of Part D plans or enrollees under this part (including the direct subsidy, reinsurance payments, and risk corridor payments); or for any payment made to Part D plans by a beneficiary or by a third party on behalf of a beneficiary." We recommend that CMS emphasize this federal preemption of state taxation authority in its final rule.

Phased Approach

Given the sweeping potential implications of the proposal on states, Medicaid beneficiaries, and other stakeholders, we strongly encourage CMS to consider proceeding at this time only with the data collection activities described earlier. This would allow the agency to gain better insights into the funding methods used by states and how supplemental payments are distributed to providers. Once CMS assesses the state data and has a more complete understanding of funding and disbursement patterns, it would have an informed basis for promulgating new requirements that address potential patterns of non-compliance.

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On behalf of our members and the millions of Medicaid enrollees they serve, we thank you for providing this comment opportunity. If you have any questions, please contact Mark Hamelburg, Senior Vice President, Federal Programs, via email to mhamelburg@ahip.org or by telephone at (202) 778-3256.

Sincerely,

Matthew Eyles
President & Chief Executive Officer