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January 28, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **Medicaid Program; Medicaid Fiscal Accountability Regulation (CMS-2393-P; RIN 0938-AT50)**

Submitted electronically via: www.regulations.gov

The California Department of Health Care Services (DHCS) submits the enclosed comments in response to the Proposed Rule entitled "Medicaid Program; Medicaid Fiscal Accountability Regulation" published November 18, 2019.

The Proposed Rule, nearly in its entirety, is significantly flawed and would have devastating impacts to State programs and budgets. While we agree with the importance of ensuring fiscal accountability and transparency in Medicaid administration, DHCS believes the proposal goes far beyond these purported goals by uprooting past and current policies on which Medicaid programs are built and financed. The Proposed Rule includes many instances of overreach or inconsistency with authorizing Medicaid statute and constitutes a significant departure from longstanding CMS interpretations (many in place for decades). As a result, we strongly object to the characterization that the proposal is largely a codification of existing CMS policies. In addition, the Proposed Rule would significantly diminish the objectivity of current regulations by affording CMS far too much discretion in approvals and in disallowing Medicaid expenditures. Finally, the rule imposes a multitude of new reporting requirements that are overly burdensome and duplicative and will require wholesale changes at the State and local levels.

Of particular concern, the proposed changes governing acceptable sources of nonfederal share funds, namely intergovernmental transfers (IGTs), Certified Public Expenditures (CPEs), and provider taxes, seemingly threaten a sizeable portion of the funds that support services and administrative activities performed by safety net providers that are the foundation of California's Medicaid Program (known as Medi-Cal). These proposed changes mark a sharp departure from longstanding CMS

interpretations. The proposed changes also exceed the authority granted in the Medicaid Act by codifying a type of open-ended discretion and ill-defined regulatory framework that is ripe for arbitrary and capricious treatment of States. If finalized, this will not only result in inconsistent results among programs, but will also leave States straddled with significant uncertainty over approvals or the availability of federal financial participation for such arrangements. This will make it nearly impossible to sufficiently plan for operational and budget needs.

Moreover, such impacts would almost assuredly diminish the ability of our beneficiaries to access timely care, would leave States hamstrung in pursuing value-based and other innovative payment and delivery initiatives, and would cause instability in health care markets even beyond Medicaid. Without substantial modification (or, preferably, outright rescission), the Proposed Rule would force States and their local public partners to make painful budgetary decisions, as it is simply not possible to replace all nonfederal share funds affected by the Proposed Rule with only State or local tax revenue. Such a result would stall the successful advancements made by States in implementing the Affordable Care Act and set Medicaid back many years at a time when its importance has never been greater as a safety net to millions of residents.

Further, we note the constitutional principle embodied in Spending Clause legislation, like Medicaid, that the relationship between the federal government and a participating State is contractual in nature. (See, e.g., *National Federation of Independent Business v. Sebelius* (2016) 567 U.S. 519, 576-580.) DHCS believes the Proposed Rule encroaches upon State flexibility in financing to such an extent that it fundamentally changes the nature of the underlying bargain. The availability of critical federal matching funds encourages States to participate in Medicaid according to the baseline terms set by Congress. However, the Medicaid statute also recognizes the importance of State sovereignty, including the right to manage and control local resources. We fear that various elements of the Proposed Rule would upset that careful balance and may very well exceed the constitutional limits placed on conditional spending. Congress unmistakably granted broad latitude for States to choose how to fund the nonfederal share of Medicaid expenditures and to set their own payment methodologies, in prioritization of State/local control and experimentation. Unfortunately, the Proposed Rule threatens to foreclose many instances where States have appropriately exercised that discretion over years of Medicaid administration. We feel that constitutes the type of surprise and coercive retroactive changes to the underlying terms of participation that is impermissible.

At a minimum, CMS must provide States with several years to perform the multitude of activities required to comply with these new requirements. If the Proposed Rule is finalized as is, States must undertake a wholesale reconstruction of many programmatic and financing components built over decades. This would include an overwhelming amount of analysis, negotiation, and change to State statute, regulations, and policy guidance; contracts (for both provider/plans and administrative contractors); State Plan and waiver/demonstration amendments; and systems and administrative processes across every Medicaid delivery system. Completing these tasks will require a minimum of three to five years. States will not be alone in confronting this immense workload, as

all of these changes require considerable time, guidance, and resources from CMS for each and every State program.

If the rule is finalized, it is imperative that CMS, at a minimum, make the following changes, which are discussed in more detail below:

1. **State/local taxes**: Revert to the existing "public funds" language at § 433.51 or add substantial clarification recognizing the legitimacy of patient care revenue and other sources of State/local funds.
2. **Provider tax waivers**: Rescind the "undue burden" test proposed at § 433.68(e), or provide for a safe harbor in waiver approvals with a reasonable 3:1 allowable magnitude of differential tax treatment between Medicaid and non-Medicaid activities.
3. **Supplemental Payments**: Allow for at least three State fiscal years following the finalized rule to begin a staggered phase-in of the time-limited approval periods for supplemental payments under § 447.252(d).
4. **Fee-for-Service Payment and Provider Contribution Reporting**: Provide States at least five State fiscal years following the finalization rule before § 447.288(c)(1)-(3) is effective. Limit new reporting to a single annual report on a cash accounting basis and that is due one year from the close of the fiscal year.
5. **Other Comments**

Our comments with respect to the specific proposals are as follows:

1. Acceptable Sources of Nonfederal Share Funds and State-Local Financing Arrangements

The potential contraction of nonfederal spending in the Proposed Rule threatens the fiscal bedrock upon which programs are built, especially in light of the scope and complexity of Medicaid. More than ever, State programs are necessarily reliant on a variety of fund sources, particularly at the local level. This need is properly accounted for in the flexibility of financing options afforded in Medicaid statute and past CMS policies and approvals. In accordance with this regulatory foundation, DHCS employs IGTs and CPEs in a wide variety of delivery systems and programs, most of which have been implemented with express CMS approval for quite some time. In fact, CMS has worked in partnership with CA, as it has likely done with many States, to develop the policies and procedures around these sources of non-federal share. This prevalence reflects the fiscal realities faced by State programs and the absolute necessity of funding flexibility in today's Medicaid programs.

The Proposed Rule reflects a marked departure from the financing flexibility guaranteed to States in the Medicaid Act and upends longtime CMS interpretations that States and their local partners have relied on for decades. Section 1902(a)(2) allows States to fund up to 60% of the nonfederal share of Medicaid expenditures using local public fund sources, with no express limitations on the types of public revenue sources that would qualify. The same is true in Section 1903(w), which does not exhaustively list the general categories of permissible or impermissible sources, but instead provides for

circumstances whereby federal financial participation would not be available for otherwise permissible sources such as health care related taxes or provider donations. Congress clearly intended to grant States wide discretion in determining the types of public revenue used for the nonfederal share of Medicaid expenditures, so long as the prohibitions in Section 1903(w) against non-bona fide donations, recycled federal funds, and hold-harmless arrangements are fulfilled. We take no issue with CMS promulgating sensible standards to improve enforcement of those financing restrictions that set the foundation for the federal-State Medicaid partnership in statute or to track and monitor the use of various types of public funds used. However, such standards must honor the cornerstone terms set by Congress governing States' decisions to participate in Medicaid and tailor their programs and financing according to unique local needs. Regrettably, we feel the changes included in the Proposed Rule, and seemingly the intent behind those changes, do not.

There is no statutory authority to limit nonfederal share funding to only revenue sources carrying the express label of tax as CMS has proposed in § 433.51. In fact, the relevant statutory provisions were intended and have long been interpreted to prevent what the Proposed Rule now attempts in narrowing allowable sources of nonfederal share Medicaid funding. The Proposed Rule purports to more closely align allowable sources under the regulation with the provisions of Section 1903(w), and cites subsection (w)(6)(A) for the premise that *States* may not "derive IGTs from sources other than state or local tax revenue (or funds appropriated to state university teaching hospitals)." (84 Fed. Reg. at 63737.) However, this provision is a clear limitation on *CMS*, not on States. The principal statute in question (i.e., Section 1903(w)(6)(A)) reads:

> **[T]he *Secretary* may not restrict *States'* use of funds** where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider . . . unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section. (Emphasis added.)

The intent to protect State flexibility in nonfederal share funding is unmistakably clear in Section 1903(w)(6)(A), which expressly and permanently prohibits CMS from precluding sources beyond what Congress has enumerated. The Proposed Rule plainly misinterprets this provision by concluding it is a restriction applicable to States, instead of a clear limitation on CMS. The purpose of this language is to prevent CMS from placing limits on funding beyond those expressly set forth in statute, and is certainly not a requirement on CMS to limit IGT and CPEs to only state and local tax revenue. Reading this section as a preclusion of all other sources of revenue is facially inaccurate, especially considering the accompanying congressional record, past years of CMS implementation, and the breadth of the accompanying definition for tax, as discussed below.

This reading is further clarified in the legislative history of subsection (w). Enacted into law on December 12, 1991 by PL 102–234, subsection (w) was added in response to regulatory efforts to restrict the ability of states to use certain forms of public funds for nonfederal share. (See generally House Report 102-310, discussing and summarizing efforts of Bush Administration to limit states use of public funds, particularly by proposed regulation.) The legislation establishing subsection (w) was intended to *permanently prohibit* the Secretary from inappropriately limiting sources of public funds used as the source of nonfederal share:

> The Committee bill would prohibit the Secretary from issuing any regulation that changes the treatment (specified in 42 C.F.R. § 433.45(a)) of public funds as a source of State share of financial participation under title XIX of the Social Security Act. This prohibition is permanent. It would apply to all public funds used as a source of the State share, regardless of whether the public agency contributing the funds is a health care provider delivering services under the State's Medicaid program. (House Rept. 102-310, at 15.)

Wielding this provision, which was drafted for the opposite purpose, to constrain State and local sources of funds for IGTs is clearly inappropriate. This is even more evident when considering the breadth of the controlling definition for "tax," which is seemingly ignored in the proposed replacement of the "public funds" standard in § 433.51. Section 1903(w)(7)(F) defines "tax" for purposes of the Section 1903(w)(6)(A) limitation on CMS to include "**any licensing fee, assessment, or other mandatory payment**" that is not "payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment)." (Emphasis added.) Reading these provisions together, Congress clearly intended to prohibit CMS from restricting States' use of a relatively wide variety of public funds, the scope of which is clearly not limited to only revenue generated from a traditional tax. And for good reasons, as States and their political subdivisions require sufficient options to account for diverse local circumstances in financing and delivery of health care. In interpreting the Section 1903(w)(6)(A) restriction on CMS, the word "tax" includes any "mandatory payments," which could reasonably include, for instance, payments that government-operated health care providers receive in the form of patient care revenue. We note that payments under Medicaid and Medicare from the State and federal governments, for purposes of (w)(6)(A), could reasonably be considered mandatory for public providers that comply with all requisite participatory standards in the respective programs. Along those same lines, the use of mandatory payments can also reasonably include proceeds from bond issuances, public transactions, non-federal grants, and legal settlements and judgments.

Even if Section 1903(w) could be construed to limit IGTs to only state or local taxes (which we believe it clearly cannot), CMS is obligated to incorporate this broad statutory definition of tax into its implementing regulations. The lack of clarity in the proposed text and in the accompanying preamble, however, fail to do so and thus the Proposed Rule does not fulfill the statutory assurance of funding flexibility to States.

Consistent with the intent behind these provisions, there is a long and well-documented history of permissible IGTs or CPEs being derived from sources much broader than

State or local taxes. In addition to the enacting legislation for Section 1903(w) discussed above, CMS policy in past rulemakings and approvals recognizes the broad intent that other sources of non-tax public funds are equally valid.

In CMS' first rulemaking after PL 102-234 enacted Section 1903(w), it noted "States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived **from any governmental source**." (57 Fed. Reg. at 55119 (emphasis added).) CMS implementation of Section 1903(w) in the year after it was codified makes clear that the thrust of the law was ***not*** to limit the sources of funds. In a subsequent rulemaking, CMS again confirmed that IGTs could be funded "from a variety of sources (including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds)." (72 Fed. Reg. at 29677.) That rulemaking goes on to clarify that a "governmentally-operated health care provider's account may include patient care revenues from other third party payers and other revenues similar to those listed above," and that "[s]uch revenues would also be acceptable sources of financing the non-Federal share of Medicaid payments." (*Id*.)

Over many years of practice, CMS has repeatedly recognized the allowability of varied sources of local funds in approving various financing arrangements. In the case of California, the last three Section 1115 demonstrations include language clearly authorizing the use of a variety of sources of funds. These approvals clearly state that patient care revenue received as payment for Medicaid and other public programs is an allowable source, *See e.g.*, CMS Special Terms and Conditions, 11-W-00193/9, California Medi-Cal 2020 Demonstration:

> The State must have permissible sources for the non-federal share of . . . expenditures, which may include permissible Intergovernmental Transfers (IGTs) from government operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid . . . For this purpose, federal funds do not include . . . patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid.

This same allowance was expressly granted for public providers in the Special Terms and Conditions (STC) for California's approved Section 1115 demonstration projects since their inception in 2005 (see, Medi-Cal Hospital/Uninsured Care Demonstration (11-W-00193/9) and the California Bridge to Reform Demonstration (11-W-00193/9). Outside of the Section 1115 setting, this same broad recognition has been repeatedly approved in Medi-Cal State Plan and manage care contract-based methodologies that employ either IGTs or CPEs.

Department of Appeals Board decisions have also recognized that "funds paid to states for allowable costs incurred or services rendered lose their character as federal funds once they are deposited in a state's treasury." (*North Carolina Dep't of Human Res.*,

DAB No. 1133 (1990) (quoting 423 Comp. Gen. 697, 699 (1964)). This principle applies equally to funds paid to government-operated providers for services rendered that are then deposited in their operating fiscal accounts. As these decisions and past CMS policy recognize, funds that were once federal in nature cannot maintain their federal character forever.

It is simply impossible for government-operated providers to refrain from utilizing patient care revenue and other permissible sources that trace in part back to federal financial participation. Moreover, once in local administrative control, it is by law their revenue to allocate as they choose. Quite often, as one would expect, it is the most practical and common source of revenue on hand in increasingly tight and complex local budgets.

Relatedly, in addition to the narrowing of sources in § 433.51, the Proposed Rule includes other revisions that unnecessarily impinge on the ability of States and local governments to administer their fiscal affairs as they see fit within the contours of the Medicaid Act. With respect to CPEs and IGTs, we are particularly concerned with the proposed § 447.207 on retention of payments which would prohibit any administrative fee that is linked to the associated payment or underlying contribution. The practice of applying a reasonable percentage for the processing and administration of CPEs and IGTs has been approved by CMS for many years. In addition, we are also concerned this same new section would allow only the certifying provider to receive the total computable payment thereby prohibiting what have been acceptable forms of fund redistributions at the local level, for which the State Medicaid Agency may not even be involved. These intra-State or local financing decisions and arrangements, some engrained into State law for decades, are outside the scope of CMS regulatory authority to restrict, so long as the prohibitions against non-bona fide donations, recycled federal funds and hold harmless arrangements are fulfilled. There is no evidence of abuse related to the types of percentage fees applied in Medi-Cal. As a result, States and local public providers should remain free to negotiate and implement reasonable methods to share in administrative costs free of arbitrary limitations.

For the reasons discussed above, CMS should retract its proposed changes to § 433.51 and retain the established “public funds” and “administrative control” characterizations which properly encapsulate the statutory intent and the realities faced in State and local fiscal administration. Along those same lines, CMS should rescind the proposed § 447.207 insofar as it encroaches on reasonable administrative financing mechanisms used by States and their local public partners.

In addition to local funds, the proposed language at § 433.51 inappropriately constricts sources of State revenue. The proposed subsection (a) only recognizes funds appropriated from a State’s General Fund, which conflicts with longtime accepted fiscal practices. In California, and presumably many other States, the nonfederal share of Medicaid expenditures is regularly financed with otherwise permissible State dollars appropriated directly from dedicated Special Funds, which are typically enacted to segregate a discrete source of revenue such as Medicaid provider taxes for specific spending purposes or to allow for continuous appropriation over multiple years. As far

as we are aware, State funds have not previously been limited to only those appropriated from the singular General Fund, nor has CMS explained why such a limitation is warranted. CMS has no authority to dictate how a State administers its fiscal affairs at an operational level, without any substantive reason or basis for doing so in the Medicaid Act.

We also note that the language at §433.51(b)(1) seemingly precludes what have been acceptable arrangements between the State Medicaid Agency and other State Agencies or Departments, whereby the State funds are appropriated to the non-Medicaid Agency or Department. The State Medicaid Agency then claims federal funds on behalf of the other Agency's medical assistance expenditures through an Interagency Agreement or similar instrument. This has been a long-accepted practice in California (for example, the administration of our In-Home Supportive Services program in partnership with the California Department of Social Services), and CMS fails to cite a reason for curtailing that framework.

For the above reasons, and because these funding sources clearly fit into the broad definition of "tax" in Section 1903(w)(7)(F), DHCS requests CMS revert to the previous "public funds" language in the existing § 433.51. Alternatively, if CMS retains the revised language in any final rule, we propose the following additions to the proposed text in recognition that the above-discussed sources remain permissible:

> Proposed § 433.51(b)(1)
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> (b) State or local funds that may be considered as the State's share are any of the following:
>
> (1) State General **or Special** Fund dollars appropriated by the State legislature directly to the State or local Medicaid Agency**, or to an otherwise authorized State Agency under an Interagency Agreement or similar instrument with the State Medicaid Agency**.

2. Changes to Approval of Provider Tax Waivers

For California and many other states, provider tax revenue is a critical and necessary source of nonfederal share funds within increasingly complex state fiscal environments and the post-ACA Medicaid framework. DHCS has approval, or approval is currently pending, for quality assurance fees imposed on hospitals, institutional long-term care facilities, managed care organizations, and ground emergency medical transportation providers. Such revenue is imperative to funding reimbursement for care through an array of base and supplemental payments in both fee-for-service and managed care delivery systems. By way of example, we highlight the Hospital Quality Assurance Fee (HQAF) program, which has been in place since 2009 and is integral to assuring access to quality hospital services in Medi-Cal and to maintaining the State's safety net more generally. DHCS, in conjunction with our hospital partners, has worked extensively with CMS over this period to maintain approval for the complicated model. Approval has been routinely granted based on adherence to the clear and objective standards set

forth in existing CMS regulations. Recognizing the value and success of this program, California voters made the existing HQAF model permanent in the State Constitution by enacting Proposition 52 in November 2016 (see Cal. Const., art. XVI, § 3.5, added by Initiative, Gen. Elec. (Nov. 8, 2016)). However, the changes in the Proposed Rule threaten to upend approval for longstanding and until-now permissible programs like HQAF by imposing entirely subjective standards that are not supported in Medicaid statute.

DHCS has significant concerns with the level of discretion CMS affords itself in approving provider tax waivers in the Proposed Rule, particularly given that the existing statistical tests (B1/B2 and P1/P2) in § 433.68(e) are retained. We believe CMS does not hold the authority to impose these new restrictions on provider taxes without congressional action to substantially change the existing Section 1903(w).

In addition to exceeding statutory authority, we believe the proposed provider tax changes create substantial uncertainty for a vital component of Medicaid budgeting and would almost certainly result in arbitrary treatment of States. Because there is no rational connection to the statutory antecedents, and given the lack of clear and objective standards, the proposed changes would violate the federal Administrative Procedure Act in that it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" and "in excess of statutory jurisdiction [and] authority…" pursuant to 5 U.S.C. §§ 706(2)(A) and (C).

Of utmost concern is the amorphous "undue burden" test proposed at § 433.68(e)(3), which is neither a necessary nor consistent interpretation of the statute's "generally redistributive in nature" requirement at Section 1903(w)(3)(E)(ii)(I). The proposed undue burden test is not authorized, and in fact runs contrary to CMS statutory mandate to approve waivers of the requirements in Section 1903(w)(3)(B) or (C). In that framework, Congress expressly allowed for waivers of the uniform and broad-based requirement without any language to suggest those waivers are limited to only certain types of varied tax application or treatment. The Proposed Rule would essentially eliminate the availability of tax waivers for practical purposes, in direct conflict with the clear statutory commands.

Section 1903(w)(3)(E)(ii) provides that the Secretary "shall approve" a waiver when a State establishes the "net impact" of the tax and associated Medicaid expenditures is "generally redistributive in nature" and the amount of the tax "is not directly correlated" to Medicaid payments. DHCS believes Congress necessarily allowed for some degree of differential tax treatment, including certain circumstances resulting in a higher tax impact on certain Medicaid activities in application, in using the non-precise "***generally*** redistributive ***in nature***" and in analyzing a tax model's "***net impact***." Under existing law and practice, a State is entitled to automatic approval upon demonstration that a tax is generally redistributive based on known, objective and sound criteria in CMS implementation (see Section 1903(w)(3)(E)(ii) and existing § 433.68(e)). The statute constrains CMS discretion in tax waiver approvals, and existing regulation gives States a clear path forward so they can confidently rely on provider taxes in setting their

budgets. The proposed undue burden test would do the opposite by granting CMS authority to require complete redistribution, and invalidate historically permissible models like HQAF.

The statutory language certainly does not require absolute redistribution in every single application to each individual Medicaid provider. If that were the intent, there would be no need to authorize or contemplate waivers. The test would deem *any level* of tax differential between Medicaid and non-Medicaid services or providers unacceptable, rather than requiring CMS to establish regulations specifying the requirements for the grant of waivers. Further, this ignores the concept of the word "generally," for which Merriam Webster offers the synonym "usually." Instead of usually, the rule would require absolute equivalence in every single instance.

This approach effectively renders the existing statistical tests meaningless for States, as CMS would still be able to deny waiver approval even if a State demonstrates that a tax is statistically generally redistributive. Those tests, in place since the 1993 Final Rule, offer clearly defined standards by which a provider tax may be measured. Unlike the existing guideposts, however, the undue burden test bears no relationship to the 1903(w)(3)(E)(ii)(I) and (II) requirements of general redistribution and non-correlation to Medicaid payments. The proposed rulemaking enunciates no connection between undue burdens and either of these concepts beyond conclusory statements that an undue burden is "inherently not generally redistributive." (84 Fed. Reg. 63742.) In addition, even if a State could demonstrate that a tax structure has zero facial differentiation between Medicaid and non-Medicaid activities, it still may be denied approval under the proposed § 433.68(e)(3)(iv). That provision vests in CMS virtually unlimited discretion to examine the "totality of the circumstances" to determine that some aspect of the tax structure includes a proxy for Medicaid activity.

This level of unfettered agency subjectivity could not possibly be what Congress intended. For a foundational revenue source like provider taxes, States and their many stakeholders must have a reasonable level of certainty to successfully legislate and implement tax models that are exceedingly intricate. DHCS believes that the Proposed Rule falls well short of that premise. The availability of federal financial participation in this context is a significant budget contingency that cannot be diminished, and we fear the Proposed Rule would make the prospect of approval far too speculative forcing States to look elsewhere to generate needed revenue that may not be there. The stakes and consequences are far too high for States and stakeholders to leave budgets at the mercy of CMS whim. The level of discretion reserved to CMS, combined with the lack of objective principles to guide that exercise of discretion, also invites arbitrary and unfair decisions in the waiver approval process. We think the proposed approach will inevitably lead to inconsistent outcomes among States and a potentially sharp uptick in disputes and litigation.

If CMS insists that an additional undue burden analysis is required for approval of Provider Tax waivers, California urges an objective and easily applied test, similar to what is currently in place for demonstrating general redistribution. If the key

consideration for CMS is to eliminate the more extreme levels of differentiation that are not accounted for in the retained statistical tests for general redistribution (as stated in the preamble), we would propose a quantified safe harbor that sets a reasonable level of allowable differentiation and that affords States the statutorily-contemplated certainty when developing tax models and programs. We suggest that if the relative impact of a tax on Medicaid activities is not greater than three times that of non-Medicaid activities, the tax should be approved by CMS (assuming, of course, compliance with the B1/B2 or P1/P2 test as applicable). We believe our proposed 3:1 safe harbor is a far more reasonable interpretation of the statutory wording and properly recognizes the nearly thirty years of practice in which CMS has consistently approved taxes that carry reasonable levels of differentiation. This type of safe harbor standard would allow States to properly plan their fiscal and operational affairs impacted by provider taxes going forward and would avoid some of the more negative consequences discussed above. In addition, our proposed 3:1 ratio would better meet the purported main goal outlined in the preamble to prevent those outlier scenarios that constitute the current "loophole" to the statistical tests.

In addition, while we appreciate the time-limited grandfathering period proposed, the three-year period is not sufficient when considering just how much this new framework differs from the existing rules. If finalized, many States will be forced back to the proverbial drawing board as the approvability of provider taxes has budget-wide consequences well beyond Medicaid. Worse yet, when considering the other changes in the Proposed Rule, States and local governments may face the real possibility of budget holes that cannot be filled, at least not in a short amount of time. Accordingly, and even if the rule is finalized in a scaled back form, we urge CMS to provide a longer phase-out period of the current regulatory framework. We would point to the phase-out of pass-through payments under 42 C.F.R. § 438.6(d) as a relevant corollary to the level of change proposed here.

3. New and Extensive Requirements for Supplemental Payments and UPL Demonstrations

DHCS does not object to the rulemaking's premise to codify general standards governing CMS evaluation and oversight of fee-for-service provider payments in furtherance of the "efficiency and economy" and "equal access" requirements of Section 1902(a)(30)(A). In Medi-Cal, supplemental payments are an essential mechanism to properly account for these principles across a broad spectrum of varied provider types and health care settings. Supplemental payments are also key in promoting value-based purchasing and incentivizing a program's underlying clinical and delivery goals, which may differ greatly from those of other States.

We also appreciate CMS statements in the preamble recognizing the hallmark principle in the Medicaid Act that States are primarily responsible for setting rates and payment policies according to their unique circumstances and markets. This is why the relevant statutes focus on more procedural elements to ensure transparency in establishing and implementing methodologies and are free of specific constraints on the level and manner of reimbursement, so long as such decisions are generally prudent from a

purchasing standpoint. Unfortunately, the Proposed Rule ventures too far into this province of State flexibility with onerous and recurring approval and reporting requirements for supplemental payments. Not unlike other elements discussed above, we believe the proposed response is disproportionate to alleged goals of the rule (fiscal accountability and transparency) and it vests too much discretion and subjectivity in CMS approvals without clear principles to guide approvals. Without substantial revisions, we think this will inevitably lead to delays in CMS action further driving uncertainty in State budgets and program operations and will lead to a sharp increase in CMS-State disputes and unequal results among programs.

Specifically, DHCS is concerned with the extensive level of data and justification that would be required under proposed § 447.252(d) for each and every supplemental payment program, particularly when considering this must be done every 3 years. We understand the need for CMS to have a reasonable understanding of the rationale behind an approved supplemental payment, the aggregate expenditure amounts, and what the State is attempting to accomplish, but the requisite information is excessive in light of CMS practice throughout the past. The reality is that supplemental payments may vary quite widely in terms of purpose and the extent to which it can be specifically evaluated in a relatively short period of approval time. We are especially concerned with the full-scale monitoring plan requirement for each supplemental payment at proposed (d)(5), and how that could be used to unfairly deny approval for renewal of a supplement payment under proposed (d)(6). The imposition of a specific monitoring plan for each supplemental payment seems to directly contradict the current CMS policy direction with respect to monitoring compliance with Section 1902(a)(30)(A) and the proposed rescission of the 2016 access rule in 84 F.R. 33722. The proposed rescission properly recognized the need to alleviate significant administrative burdens on States in access monitoring, while this Proposed Rule reverses course by requiring a recurring monitoring plan and evaluation for each supplemental payment. Given the above discussed flexibility for States to set their own payment policies so long as the relevant UPLs are not exceeded, we believe the proposed rule places too much subjectivity with CMS to substitute its own policy judgment for that of States; in denying approval or renewal for goals CMS does not favor or where CMS disagrees with a State in terms of the progress made towards those goals in a short time span of monitoring. We recommend a more simplified regulatory approach where, as a condition of approval, a State provides a more aggregate level of supplemental payment expenditures and a more general statement of how the payment fits into its larger framework for ensuring access according to Section 1902(a)(30) in lieu of the payment-specific monitoring plan and evaluation. Our proposed changes are as follows:

> Proposed § 447.302(c)
>
> (c) CMS may approve a supplemental payment, as defined in § 447.286, provided for under the State plan or a State plan amendment for a period not to exceed 3 years. A State whose supplemental payment approval period has expired or is expiring may request a State plan amendment to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent the requirements of this section. For any State plan or

State plan amendment that provides or would provide for a supplemental payment, the plan or plan amendment must specify all of the following:

(1) An explanation of how the State plan or State plan amendment will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers and beneficiaries.

(2) The criteria to determine which providers are eligible to receive the supplemental payment.

(3) A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including all of the following:

(i) The **projected aggregate** amount of ~~**the**~~ supplemental payment**s** **to be** made to ~~**each**~~ eligible provider**s for each subject fiscal year.**~~**, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment.**~~

(ii) If applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed State plan payment year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment.

(iii) The **projected** timing of the supplemental payment to ~~**each**~~ eligible provider**s**.

(iv) An assurance that the total Medicaid payment to other inpatient and outpatient facilities, including the supplemental payment, will not exceed the upper limits specified in § 447.325.

(4) The duration of the supplemental payment authority (not to exceed 3 years).

~~**(5) A monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries.**~~

~~**(6) For a SPA proposing to amend or renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the**~~

~~**supplemental payment on compliance with section 1902(a)(30)(A) of the Act.**~~

In recognition of the wholesale changes a State like ours will need to perform, we urge CMS to allow for at least three full State fiscal years following finalization of the rule before the new approval requirements for supplemental payments are effective. As noted above, for each supplemental payment program, a State may need to negotiate and make changes to its own law and policy, State plan and waivers, and contracts and systems. Doing all of this at once in such a short timeframe is likely impossible and we suspect the same is true for CMS purposes as well. In order to successfully implement this new framework in the least disruptive fashion, DHCS urges CMS to provide for at least three full State fiscal years following finalization before the new approval requirements are effective. We also ask that CMS work with individual States with a large volume of existing supplemental payment methodologies by staggering reauthorizations proportionately over multiple years following the requested delay in effective date. That way, the State and CMS are not flooded with supplemental payment SPAs (or waiver amendments) requiring reauthorization in the same fiscal quarter (alongside, of course, any other SPAs that may be pending at that time).

We also request that the proposed limits on practitioner supplemental payments at proposed § 447.406 not go into effect until at least three State fiscal years following finalization. In addition, DHCS is concerned with the seemingly arbitrary 50% limit (75% for providers in certain shortage areas) imposed on practitioner supplemental payments in that it unnecessarily interferes with State decision-making in how it structures base and supplemental reimbursement for these providers. Given the above discussed flexibility for States in setting payment methods, CMS has no authority to dictate how a State distributes reimbursements between base and supplemental categories. We would recommend instead that CMS employ aggregate ceiling limits using comparative commercial payment data as has been the historic practice.

Given the scope of the new supplemental payment requirements and reporting, we think it especially important for CMS to promulgate clear boundaries for the types of payments subject to the UPL demonstrations and the reporting requirements in § 447.288(c)(1)-(3). Specifically, CMS should make absolutely clear this does not include payments received by Medicaid providers from Medicaid managed care plans, including directed payments pursuant to § 438.6(c) and pass-through payments under § 438.6(d). We do not believe CMS has the authority to regulate managed care payments under Part 447 and it would also be duplicative to the oversight already present for such payments. These individual managed care payments are not subject to the fee-for-service payment requirements derived from Section 1902(a)(30) nor the UPL demonstrations under Part 447. Instead, managed care payments are subject to the actuarial soundness requirements at Section 1903(m)(2)(A)(iii) and § 438.4 and plan-provider payments are governed by § 438.6(c) under the general rule that plans are free to negotiate downstream payments on their own without interference from the State (except when required by federal law or approved as a directed payment). When such direction of expenditures has been approved, a State is already subject to intensive and recurring CMS scrutiny and evaluation. In our experience with programs under § 438.6(c) thus far, DHCS in each instance has submitted considerable documentation

through multiple rounds of CMS questions to justify the reasonableness of directed payment amounts for various classes of hospitals and other providers.

The proposed language appears to maintain the separation of fee-for-service and managed care payments except for the proposed definition of "base payment" at § 447.286 (which includes "*or that is paid to the provider through its participation with a Medicaid managed care organization*"). Mixing in managed care here creates a significant issue, because this definition is used for purposes of the UPL demonstrations and the new reporting regime in Subpart D (discussed below). We note this directly conflicts with the basis and purpose in § 447.284 which (appropriately) limits the Subpart's application to supplemental payments "made under the State plan and implements sections 1902(a)(6) and (a)(30) of the Act" and "to which an upper payment limit applies…." For these reasons, we request the following changes to the definition of "base payment" at proposed § 447.286:

> *Base payment* means a payment, other than a supplemental payment, made to a provider in accordance with the **fee-for-service** payment methodology authorized in the State plan or **demonstration authority** ~~that is paid to the provider through its participation with a Medicaid managed care organization~~. Base payments are documented at the beneficiary level in MSIS or T-MSIS and include all **fee-for-service** payments made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries…

Under this same rationale, we ask that CMS expressly clarify that references to "demonstration authority" in the same Subpart do not refer to waiver authorizations of managed care and provider payments made by plans under Part 438.

4. New, Extensive and Duplicative Requirements for Fee-for-Service Payment Reporting

The Proposed Rule would institute a bevy of new and administratively burdensome reporting requirements that would require considerable modifications to State operations and systems. Such changes would not be limited to the State level as Medi-Cal providers and local governments would have to make conforming changes to their systems and administrative processes as well. Notably, the Proposed Rule includes: (1) a new quarterly report due with the CMS-64 with extensive provider-level detail on supplemental payments; (2) a new annual report detailing base and supplemental payments received by *each* provider and submitted within 60 days from the close of the State fiscal year; and (3) a new annual report detailing payments and contributions to the nonfederal share by *each* provider and submitted within 60 days of the close of the State fiscal year.

We feel these new obligations are a disproportionate response to the problems the Proposed Rule attempts to solve and in many respects are duplicative and unrealistic.

The efforts required to implement these changes alone would be significant enough, but coupled with the substantive proposals discussed above, the Proposed Rule would necessitate a complete restructuring of Medi-Cal financing policies and fiscal administration. This is further exacerbated by the sheer size of Medi-Cal and its multitude of delivery systems and accompanying payment systems. We also note these efforts would require extensive CMS involvement and guidance, which would be multiplied across all State programs. If that were not enough, providers and local governments will also need to devote considerable time and resources to adapt their systems and practices to this new regime. Even once the new reporting is up and running, we have significant concerns with the ability of CMS to even process this volume of information coming from each Medicaid agency. This is made even more problematic when considering that States are given only 60 days to turn around voluminous reports, or else face sizable and destabilizing deferrals. Finally, DHCS believes the proposed enforcement remedy for CMS to "estimate" the amount of federal funds it thinks is attributable to alleged deficient reporting is disproportionate and unfair.

For these reasons, DHCS recommends that CMS provide a 5-year transition period before the new reporting is effective. At that point, we think it is far more sensible and operationally efficient (for both States and CMS) to require a single, annual report that encompasses the desired provider-level payment and contribution data. Since, at the time of reporting (particularly with a deadline of only 60 days from the close of a fiscal year), many payments or contributions may not yet be complete, we think the reporting in any final rule must be performed on a cash-basis and States must be given at least one year from the close of the State fiscal year to complete its annual reporting. Lastly, we think CMS should be required to institute corrective action on States that fail to timely, completely, and accurately report prior to the potentially draconian and overly speculative deferral remedy in proposed § 447.290(b).

5. Comments to Other Changes in the Proposed Rule

- **Electronic Submission (proposed § 430.42(b)-(d))**: While DHCS welcomes the change to electronic submission of reconsideration requests, we request CMS revise the pertinent language to recognize a State's submission is made on the date *sent* instead of the date *received* by CMS. This would align with the standard applied with respect to CMS notifications under the very same section, which seems to be the fair result especially when moving to the instantaneous electronic communication. This would also preclude the added complication on States potentially having to prove actual receipt.

- **New "totality of circumstances" standard to determining if net effect is a hold harmless arrangement (proposed § 433.68(f)(3))**: The new test for hold-harmless arrangements would evaluate the "totality of the circumstances" to ascertain the "net effect of an arrangement," including downstream transactions between private entities that may be unknown to or out of the control of the State. We think this is another example of overreach in the Proposed Rule and affords far too much discretion and subjectivity into the approval process. The test

focuses on "reasonable expectations" of the taxpayer related to an arrangement (regardless of whether it is reduced to writing or legally enforceable), and grants CMS authority to punish States for perceived wrongdoing in private transactions that the State is likely not privy to. We do not think CMS should be able to penalize State programs without evidence of impermissible State action.

- **No Variation in Payment based on Federal Medical Assistance Percentage (FMAP) Rate (proposed § 447.201(c)):** DHCS agrees with the core premise of the change in (c) that fee-for-service rates should not vary based on the level of FMAP available alone. However, we think the proposed language goes too far in prohibiting variation based on eligibility category or enrollment under a waiver or demonstration project. There are many cost and acuity factors that can cause variation in payment rates across different populations, and States should be able to demonstrate that those differences are not related to the level of FMAP available. As such, we request that CMS narrow § 447.201(c) to align with the standard used for actuarial soundness in managed care rates at § 438.4(b)(1). Suggested revision as follows:

  Proposed § 447.201(c):

  (c) The plan must provide for no variation in fee-for-service payment for a Medicaid service **that is solely attributable to the** ~~on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration project, or~~ FMAP rate available for services provided to an individual in the beneficiary's eligibility category.

- **Limiting CPE Payments to Service Costs (proposed § 447.206(b))**: Subsection (b)(1) limits CPE payments to actual, incurred costs of providing covered services to Medicaid beneficiaries. We are concerned this would prohibit existing and permissible CPE-based programs designed to reimburse local infrastructure costs (such as Medi-Cal's Construction and Renovation Reimbursement Program) or other delivery-system reform initiatives. We suggest the following clarification:

  Proposed § 447.206(b):

  (1) Payments are limited to reimbursement not in excess of the provider's actual, incurred cost of providing services to Medicaid beneficiaries**, or other allowable costs related to the provider's participation in Medicaid,** using reasonable cost allocation methods….

- **CPE reconciliation timing (proposed § 447.206(c)(3))**: This proposed subsection would require final settlement and reconciliation of any interim CPE-based payments within two years of the end of the cost report year. DHCS is concerned that this marks a significant and unrealistic change from current policy

and will be problematic for all currently approved CPE-based methodologies in Medi-Cal. From a practical standpoint, we note that two years is not nearly enough time to conduct all necessary audit and review activities, particularly as cost reports are not available to the State until well after the year is over. In our experience, we do not believe Medicare cost reports would be available under a two-year timeline. Instead, if a deadline is necessary, we urge CMS to adopt a four year timeframe based on the realities faced in administering these types of methodologies.

- **Definition of Non-State Governmental Provider (proposed § 447.286):** We are concerned that the proposed definition for "non-State governmental provider" could be used to preclude certain local government structures from qualifying as permissible CPE entities, contrary to historical practice. Specifically, the requirement that a provider must have access to and exercise administrative control over directly appropriated State funds and/or local tax revenue may exclude Indian tribes or certain local hospital authorities that have been created as unique and express units of government within California. Similar to the above, this is another area of the Proposed Rule where CMS overextends itself into matters of purely State/local law and politics, and seemingly without a program integrity justification for doing so. There are numerous, legitimate reasons why a political subdivision would choose to structurally separate public hospital administration from other components of a city or county government, including control over local tax revenue. We do not think this is an appropriate subject to be addressed in federal Medicaid regulations. As such, we request that CMS rescind the proposed definition.

- **The ability of tribal providers to CPE (proposed § 433.51(b)(3):** In addition to proposed § 447.286, the text of the proposed 433.51(b)(3), when contrasted with 433.51(b)(2), seems to preclude CPEs by tribal providers. We do not believe that was CMS' intent, but nonetheless recommend adding the parenthetical clarification "including Indian tribes" in the proposed § 433.51(b)(3) after "certified by a unit of government within a State." We note that clarification is already included in the proposed § 433.51(b)(2) on IGTs.

- **Single Data Source for All Providers in UPL Demonstration (proposed § 447.288(b)(1)(i)(C))**: We think it is unnecessarily restrictive to require States to use the same data source selection for all providers within a service category that is subject a UPL. That restriction is certainly not in place today, and we do not believe there is any evidence that such flexibility has proved problematic. In recognition of the legitimate reasons why a State would want to employ a different data source within a category, we recommend CMS rescind that provision in finalizing § 447.288.

- **Reporting Requirements (proposed 447.252, 447.288(b), 447.302):** DHCS recognizes CMS aims to fill data gaps with respect to the CMS-64 and T-MSIS. However, DHCS urges CMS to consider a timeline that could integrate this

reporting into T-MSIS to align with CMS goals of reducing redundancy and improving efficiency of reporting. Additionally, DHCS urges CMS to consider consistency in definitions between CMS-64, T-MSIS, and the reporting in the Proposed Rule.

- **DSH Audit Reporting Requirements (proposed § 447.290(b))**: This subsection would require DSH auditors to quantify or estimate the financial impact of any finding which may affect whether a hospital received DSH payments in excess of its hospital-specific DSH limit. We feel the "may affect" standard here is overly burdensome and speculative in the context of DSH audits. Instead we recommend a standard along the lines of "more likely than not in the exercise of the auditor's professional judgment." In addition, in light of existing DSH reconciliation processes and their complexity, DHCS proposes to extend the time period for redistribution of any DSH overpayments from two years to three.

Conclusion

DHCS agrees that fiscal accountability in Medicaid administration is paramount, but the Proposed Rule goes far beyond its stated purpose to constrict traditional State and local funding sources that have long been acceptable under the Medicaid Act and CMS policies. The rule also injects an unprecedented level of subjectivity in CMS approvals that exceeds the authority conferred under statute and will lead to unequal and inconsistent outcomes among States. If finalized in its proposed form, the Proposed Rule would put into jeopardy access to needed services for Medicaid beneficiaries as it would severely limit the State's ability to continue to pay for services in the way that is done, appropriately, today. In addition it would force States into restructuring their Medicaid fiscal administration and policies on an exceedingly large scale. For these reasons, DHCS believes the Proposed Rule should be rescinded or revised substantially to better fulfill its stated purpose.

Sincerely,

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