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Via electronic submission to: http://www.regulations.gov/

PUBLIC COMMENT LETTER

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

Re: Proposed Medicaid Fiscal Accountability Regulation (CMS-2393-P)

Dear Administrator Verma:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association urges the Centers for Medicaid and Medicare Services to withdraw its proposed 2019 Medicaid Fiscal Accountability Regulation that, if finalized, would force state and local governments to increase taxes, further erode the state's control of the Medicaid program and devastate the state's health care infrastructure.

About 4 million Texans, the majority of whom are children, rely on Medicaid to receive health care. Another 5 million Texans do not have health insurance, which results in billions of dollars in uncompensated care each year. Hospitals have a unique legal obligation to treat every patient suffering from an emergency condition or in active labor, regardless of how much — if anything — the hospital will receive for providing care. If enacted, the federal rule would jeopardize $11 billion in annual payments Texas hospitals rely on to offset chronic Medicaid underpayment and uncompensated care. The proposed rule would collapse Texas' already fragile rural health care infrastructure. Texas leads the country in rural hospital closures, with 26 closures in 22 Texas communities since 2010, twice the rate of any other state.

Medicaid is a partnership between each state and the federal government. In Texas, total Medicaid reimbursement for hospital care is funded by state general revenue (~15%), local governments (~25%) and federal matching funds (~60%). Over the years, Texas has worked hand-in-hand with CMS to implement methods of finance tailored to the unique needs of our growing, geographically diverse state. Texas, like other states, has developed a financing system that accounts for public hospitals, private hospitals, children's hospitals, large hospitals, small hospitals, rural hospitals, investor-owned hospitals, non-profit hospitals, general hospitals, specialized hospitals, teaching hospitals and research hospitals — all of which collaborate to provide care to Medicaid enrollees and the uninsured. This collaboration furthers the Administration's goals of coordinated care across environments.

CMS has outwardly made commitments to "granting states more freedom to design innovative local solutions"[1] and ushering in a new era of state flexibility."[2] However, CMS' rules would undermine state flexibility and the concept of federalism and could unravel the state's Medicaid program.

1. CMS intends to adopt a vague and arbitrary "net effect" test in lieu of the meaningful guidance necessary for states to raise their non-federal Medicaid shares.

CMS intends to apply an opaque "net effect" test where CMS could determine that a state's financing arrangement is impermissible without a written document, a legally enforceable agreement or even the state's participation. CMS could strike down a method of finance based on as little as a "reasonable expectation." CMS' new, variable evaluation standard would apply in three crucial evaluations: (1) whether a provider-related donation has occurred; (2) whether a guarantee to return all or a portion of a provider's donation exists; and (3) whether a tax is "generally redistributive." Not only is it operationally difficult to structure an arrangement based on subjective guidance, CMS also lacks the authority to implement its "net effect" test.

CMS' interpretation directly contradicts its statutory authority, which means the statute, and not the proposed rule, controls.[3] As part of its "net effect" test, CMS proposes a new standard where it will determine that an impermissible guarantee to return all or a portion of a provider's donation exists if the provider has a "reasonable expectation" of receiving a return of all or a portion of the donation. CMS' proposal violates the Social Security Act because the Act restricts CMS' authority to regulate health care related taxes. In addition, CMS attempts to impermissibly regulate the conduct of taxpayers, rather than the practices of state or local governments.[4]

Federal law explicitly states that HHS "may not restrict States' use of funds where such funds are derived from State or local taxes . . . " unless the state violates specific Medicaid finance restrictions in the Social Security Act.[5] Rather than adhere to the Social Security Act, CMS proposes by rule to re-write the provisions of the Act related to hold harmless arrangements. Under the Social Security Act, an impermissible hold harmless arrangement exists where the state or other unit of government provides for a positive correlation between the amount received by the state and the amount of tax paid by the provider; if there is a variation in receipt of money based solely on the amount of taxes paid by the provider; or where a guaranteed hold harmless is imposed by the state or other unit of government.[6] CMS would venture well outside the bounds of its enabling statute if it were to promulgate a rule finding that a hold harmless arrangement exists solely because a provider has a reasonable expectation of receiving some funding from Medicaid following a tax payment. At least some providers will expect to see a return in a portion of Medicaid dollars pursuant to a health care related tax, solely by virtue of

[1] Seema Verma, *Good Ideas Must Be Evaluated*, Centers for Medicare and Medicaid Services, Mar. 14, 2019, https://www.cms.gov/blog/good-ideas-must-be-evaluated.
[2] Seem Verma, *A New Era of Accountability and Transparency in Medicaid*, Centers for Medicare and Medicaid Services, Jun. 5, 2018, https://www.cms.gov/blog/new-era-accountability-and-transparency-medicaid.
[3] "When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984).
[4] *See* 42 U.S.C.A. § 1396b(w)(4) (West 2020) (requiring the state's or other unit of government's role in all three scenarios for an impermissible hold harmless arrangement); 42 USC § 1396b(w)(6)(A) (limiting CMS' authority to restrict funds derived from state or local taxes).
[5] 42 U.S.C.A. § 1396b(w)(6)(A).
[6] *Id.* § 1396b(w)(4).

participation in Medicaid supplemental payment programs, which, as a practical matter, could invalidate every Medicaid provider's tax payment.

Further, each scenario in the Social Security Act that contemplates a prohibited hold harmless arrangement envisions the active involvement of a unit of state or local government.[7] By rule, CMS is attempting to extend its regulatory authority to the taxpayers themselves. CMS has the authority to regulate the states' financing arrangements, not the "reasonable expectation" of state and local taxpayers. CMS proposes to exceed its statutory authority.

CMS' interpretation of the Social Security Act is arbitrary and capricious.[8] CMS' proposed "net effect test" abruptly abandons years of precedent, which entire states have relied on to develop their Medicaid financing arrangements. Moreover, CMS' "net effect" test is comparable to a "totality of the circumstances test," which is a vague, ad hoc method of scrutiny. "[A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process of law."[9] "Although the vagueness standard applies most frequently to penal statutes, a civil statute may also be so vague that it violates due process."[10] CMS' interpretation of the Social Security Act would render the plain language of the statute so vague that it is without meaning.[11]

2. CMS' proposal to require state or local funds, instead of public funds, to comprise the non-federal share is arbitrary and capricious and contrary to the Social Security Act, Congressional direction and prior CMS guidance.

CMS proposes to change the definition of "public funds" which have previously been permissible as part of the non-federal share, to a new definition of "state or local funds." Under the proposal, the non-federal share of Medicaid funding would need to come from state or local taxes or funds appropriated to state university teaching hospitals. Contrary to CMS' claims of codifying existing policy, this is an abrupt and substantive change from the way states are permitted to use intergovernmental transfers. States commonly use patient revenue to fund all or a portion of the non-federal share, even in instances where tax revenue would cover the provider's entire IGT obligation. When Congress amended the Social Security Act in 1991 to enact Section 1903(w)(6)(A), Congress explained that its amendments implemented a "moratorium" that was "permanent" on changes in CMS policy regarding a state's use of IGTs and that it intended the amendments to allow state entities to use more than solely tax revenue or state appropriations for IGTs. [12] Congress specifically intended the 1991 amendments to protect IGTs from "any public funds . . . from public entities," including hospital district revenues from "services

[7] 42 U.S.C.A. § 1396b(w)(4).
[8] *See Chevron*, 467 U.S. at 844 (articulating the standard).
[9] *Connally v. Gen. Const. Co.*, 269 U.S. 385, 391 (1926).
[10] *Bradley v. State ex rel. White*, 990 S.W.2d 245, 252 (Tex. 1999) (Abbott, J., concurring); *see A.B. Small Co. v. Am. Sugar Ref. Co.*, 267 U.S. 233, 239–40 (1925) (disagreeing with the argument that only a criminal statute could be void for vagueness).
[11] The rule itself is also vague, which has precedent in the U.S. Supreme Court. *See A.B. Small Co.*, 267 U.S. at 239 (finding"[i]t was not the criminal penalty that was held invalid, but the exaction of obedience to a rule or standard which was so vague and indefinite as really to be no rule or standard at all") (examining a series of cases cited by the Defendant).
[12] H.R. CONF. REP. 102–310, 1991 U.S.C.C.A.N. 1413, 1414 (Nov. 26, 1991) ("With respect to intergovernmental transfers, this moratorium would be permanent.") and 1426 ("A hospital district may transfer or certify to the State Medicaid agency a portion of its revenues, which may be collected by the district's facilities as payment for services rendered, or through its special taxing authority.").

rendered."[13] And, as recently as 2007, CMS indicated that a variety of sources of non-tax revenue "including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds" are permissible as the non-federal share.[14] Because of this additional red tape, most state and local jurisdictions would need to unnecessarily increase taxes to meet obligations that they are otherwise able to satisfy under the current method of finance.

3. CMS' proposal to use a "totality of the circumstances" test to evaluate whether an entity is a unit of government is vague and promotes uncertainty in financing the non-federal share.

CMS proposes to use a "totality of the circumstances" test to evaluate whether an entity may be classified as state or local unit of government permitted to contribute a portion of the non-federal Medicaid share to the state, which includes an evaluation of the entity's ownership and control, financial obligations and administrative control over state or local tax funds. This standard would place entities that the state considers as units of government in the uneasy position of questioning whether the state's approval is enough to survive federal scrutiny. As a matter of policy and deference to their state partners, CMS should accept a state's determination of whether or not an entity is a unit of its own government.

4. Based on legal issues and devastating effects on the Medicaid program, CMS should withdraw this proposed rule.

Despite the potential for significant negative consequences, CMS has provided little to no analysis to justify its policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. Many of the changes would violate the Medicaid law or are arbitrary and capricious in violation of the Administrative Procedure Act. CMS' Regulatory Impact Analysis is insufficient — noting only that the rule is "economically significant" but the fiscal impact "is unknown"[15] — and leaves states, providers and other stakeholders unable to prepare for the effects of the proposed rule. In Texas alone, the proposed rule threatens to jeopardize $11 billion in Medicaid payments that comply with the current rules. This economic impact will occur immediately — not after a transition period as suggested in the proposed rules — because CMS incorrectly characterizes many of the rule's changes to longstanding CMS policy as "clarifications," which will have immediate effect. This result will be devastating for the Texas safety net. 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' ability to ensure adequate oversight of the program.

Texas has long shared CMS' goal of transparency and the state has recently taken proactive steps to increase transparency of financing of the non-federal share of Medicaid payments. However, the scope of this rule extends miles beyond transparency. In fact, the rule would significantly decrease transparency in the Medicaid program by vesting CMS with unilateral authority to enforce subjective standards to scrutinize whether states' Medicaid funding should be allowed.

[13] *Id.*
[14] Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29767 (May 29, 2007) (later retracted by CMS).
[15] *Id.*

Texas has developed regional solutions that are well-suited to fund its obligations under the Medicaid program. Without these financing mechanisms, the state or local governments would need to increase taxes or divert funds from other state priorities to replace the billions of dollars in locally generated revenue. Otherwise, Texas will face irreparable damage to the state's health care system — especially in rural communities where Texas leads the nation in hospital closures. Hospitals are anchors in their communities, providing jobs to about 375,000 Texans and caring for millions more. However, if finalized, the proposed rule would create a national crisis that is not isolated to hospitals or even health care. THA urges CMS to withdraw this proposed rule.

Thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact me at cduncan@tha.org or 512/465-1000.

Respectfully submitted,

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Texas Hospital Association