



January 29, 2020

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

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

Dear Administrator Verma,

Trinity Health appreciates the opportunity to comment on the proposed rule entitled *Medicaid Program; Medicaid Fiscal Accountability Regulation*. We understand that this proposed rule aims to increase Medicaid program sustainability and transparency, goals that we share in light of our commitment to affordable, high-quality and people-centered care for all. However, we are concerned that the implications of the Centers for Medicare & Medicaid Services' (CMS) proposals extend well beyond its stated goal of increased transparency and that the proposed policies will impede states' abilities to maintain current payment levels and financing structures, negatively impact access to care for low-income Medicaid beneficiaries and place significant new burdens on states. We are strongly opposed to this rule, as it would harm those at the heart of our mission and the most vulnerable people we serve.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Our People-Centered Health System puts the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns \$1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models (APMs).

We are concerned that some provisions of the proposed rule, while intended to improve oversight of the Medicaid program, stand to have unintended and significant consequences for states and providers that, in turn, create risks for Medicaid beneficiaries. We believe that CMS's proposals overstep the Agency's intended aim and will ultimately threaten the stability of the Medicaid program. Changes to Medicaid program financing and payments threaten not only access to care for beneficiaries, but also access to coverage, especially for those who have been covered under

Medicaid expansion. Additionally, because Medicaid plays a large role in driving the movement to value-based payment, we are concerned that limitations on state options for financing Medicaid could significantly impede states' abilities to invest in payment and delivery transformation initiatives.

The specific provisions raising concerns include those related to supplemental payments, how states fund the nonfederal share of Medicaid expenditures, and new reporting and oversight requirements pertaining to implementation of these provisions. We believe the proposed provisions on supplemental payments will impact some states' abilities to maintain current payment levels, which, if reduced, could have an adverse effect on beneficiary access to care. Furthermore, new proposals related to state Medicaid financing will place added burden and potential financial strain on those states that would need to modify how they fund their share of Medicaid expenditures. The proposed reporting requirements will also increase states' administrative burdens, subjecting to additional strain those Medicaid programs and staff that are already facing resource constraints. Finally, many of the proposals related to CMS oversight and evaluation of state supplemental payment and financing approaches give CMS substantial discretion while creating financial uncertainty for states because the new policies do not provide sufficient detail for states to assess whether or not they would meet the new requirements.

If finalized, the impact of these policies will vary significantly across states, placing the greatest burden on states that need to take steps to come into compliance. CMS's acknowledgement in the rule that "[t]he fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is unknown" is concerning given the potential, significant impact.¹ A 2020 analysis of national data performed by Manatt estimates that, Medicaid spending could decrease by \$37 billion to \$49 billion annually—approximately 5.8 percent to 7.6 percent of total national Medicaid program spending.² The same analysis estimated that hospitals and health systems could see reductions in Medicaid payments totaling \$23 billion to \$31 billion annually—representing between 12.8 percent to 16.9 percent of total hospital program payments. These projections demonstrate the potential, significant impact that the proposed policies could have on Medicaid program spending and payments, and reinforce the need for CMS to perform a comprehensive assessment of the state-by-state impact before any of the proposed policies are implemented. Further, during the Medicaid and CHIP Payment and Access Commission's (MACPAC) discussion of the proposed rule in its December 2019 public meeting, there appeared to be consensus on the part of many commissioners that CMS should collect all necessary data on the impact of the proposed policies before the provisions are finalized and implemented.³

Trinity Health is also concerned with CMS's short timeline for implementing the proposed policies. Without a transition period, states will not have sufficient time to work with their relevant agencies, legislatures, providers, local governments and other stakeholders to develop and implement new strategies to mitigate potential negative impacts on the Medicaid program and beneficiary access to care.

Given these concerns—presented in more detail below—**Trinity Health recommends that CMS maintain current policies, rather than proceed to implement new provisions that could**

¹ CMS, *Medicaid Program; Medicaid Fiscal Accountability Regulation*, Federal Register, Vol. 84, No. 222, November 18, 2019.

² Manatt Health, "Financial Impact Analysis: Proposed Medicaid Fiscal Accountability Rule (MFAR) Could Result in Deep Medicaid Cuts," 2020.

³ <https://www.macpac.gov/wp-content/uploads/2018/03/December-2019-Meeting-Transcript.pdf>; <https://www.macpac.gov/wp-content/uploads/2019/12/Review-of-Proposed-Rule-on-Supplemental-Payments-and-Financing.pdf>

significantly, negatively impact Medicaid beneficiaries' access to care and critical providers. We strongly oppose this rule for the aforementioned reasons and believe it is bad public policy for those whom we hold near and dear—the poor and underserved—who are at the heart of our mission. If CMS instead chooses to move forward with the proposed policies, we recommend that CMS:

- **collect additional data and perform further state-by-state analyses on the impact, prior to finalizing any of the proposed policies;**
- **work with the Office of the Actuary to develop a robust regulatory impact analysis (RIA) and release an interim final rule containing the RIA for additional public comment before implementation of any current proposals;**
- **narrow the scope of the proposed policies based on the analyses of state-level data and push back the effective date of the proposed policies to allow states at least 5 years to come into compliance; and,**
- **phase-in any changes to payment, financing and reporting while working closely with states to ensure these changes do not negatively impact access to care.**

Finally, it is also important to note that as CMS has proposed this rule, the Agency is simultaneously planning to rescind requirements for states to demonstrate that Medicaid beneficiaries have sufficient access to care. Together these two proposals appear to be in conflict with CMS's goals of increasing transparency and oversight and these proposals could significantly threaten access to care for millions of vulnerable, Medicaid beneficiaries.

We appreciate the opportunity to partner with CMS and other stakeholders to implement policies that ensure continued access to high-quality, people-centered care. Below we outline in greater detail our concerns and recommendations.

Proposed Supplemental Payment Policies Could Impede Access to Care

CMS's proposed rule creates new limits on supplemental payments to physicians or other practitioners and develops new definitions for classes of providers subject to upper payment limit (UPL) supplemental payments. States rely on supplemental payments as a mechanism to improve payment rates for Medicaid providers. This approach is particularly important because Medicaid base rates are already lower than Medicare or commercial rates—and often do not cover provider costs. For example, an AHA analysis found that, on average, hospitals only receive 89 cents for every dollar spent caring for Medicaid patients even after supplemental payments are factored in.⁴ Trinity Health is concerned that the proposed policies may further erode provider payments and negatively impact Medicaid beneficiary access to critical providers and care.

Practitioner Supplemental Payments. We are concerned with CMS's proposal to limit practitioner supplemental payments to a percentage of base payments—50 percent of Medicaid base payment rates for most providers and 75 percent of base payment rates for providers in Health Professional Shortage Areas—rather than maintaining the current limit based on average commercial rates. CMS estimates this could reduce provider payments by \$222 million annually with the state-by-state impact varying significantly.⁵ Given that Medicaid base provider rates are already lower than other

⁴ American Hospital Association, "[Fact Sheet: Underpayment by Medicare and Medicaid](#)," January 2020

⁵ CMS, *Medicaid Program; Medicaid Fiscal Accountability Regulation*, Federal Register, Vol. 84, No. 222, November 18, 2019.

payer rates, CMS's proposal could result in significant reductions in payments to safety-net providers such as rural hospitals and those providers serving vulnerable, underserved populations, impacting provider participation and further exacerbating barriers to beneficiary access. This proposed policy could be particularly detrimental, and disproportionately negatively impact Medicaid beneficiaries in states with already low base rates.

- **Reflecting these concerns, we oppose the rule and strongly recommend that CMS maintain the current policy related to limits for supplemental payments. At a minimum, we urge CMS to conduct additional review of the policies, including state-by-state analyses, to assess the impact on states, Medicaid beneficiaries and providers before finalizing these proposals.**

Changes to Definition of Provider Groups. CMS also proposes to define three groups of providers as it relates to supplemental payment policies to include providers who are “state government owned or operated,” “non-state government owned or operated,” and “private.” These new definitions will likely result in changes in supplemental payments to some providers, given that some providers currently classified under one group may move to another under the new definitions. This shift would impact the aggregate UPL supplemental payments to each class of providers—as they are calculated for each group separately—and could erode certain critical providers’ payments.

- **We strongly recommend that CMS assess the impact these new definitions could have on supplemental payments across providers before finalizing to ensure it will not result in significant reductions in payment to essential safety net providers.**

Changes in UPL Demonstration and Payment Reporting. CMS proposes to codify existing guidance requiring states to submit upper payment limit (UPL) demonstrations annually, which includes data sources for each UPL calculation component, a description of allowable UPL methodology data standards (e.g., utilization and cost trend factors), and a description of allowable UPL demonstration methodologies (e.g., cost-based or payment based).

While CMS's proposed provisions would build on existing guidance, CMS would require UPL demonstration methodologies be consistent for all hospitals in a class, which is not current practice in all states, and could result in negative changes to supplemental payments. **As such, we recommend CMS maintain current policies.**

Proposed Changes to Nonfederal Financing Could Put Medicaid Programs at Risk and Increase State Burden

In the proposed rule, CMS includes a number of provisions impacting how states fund the nonfederal share of Medicaid payments. More specifically, CMS proposes changes to provider taxes, intergovernmental transfers (IGTs), certified public expenditures (CPEs), and provider donations that would make some current state practices impermissible. For example, CMS proposes to expand the definition of “health care-related tax” and make changes to “bona fide” donations” which could result in more taxes and donations being deemed impermissible for Medicaid financing. CMS also proposes policies that would limit the number of entities able to make IGTs and restrict the types of funds that could constitute an IGT. Together, the proposed changes to IGTs and CPE policies would limit states’ abilities to use existing, legally authorized mechanisms to fund the nonfederal share of Medicaid financing. If states are unable to identify other sources of funding for their Medicaid programs, states may be forced to make program cuts.

Significant variation exists across states in terms of how states fund the nonfederal share of Medicaid payments and, as a result, the impact of the proposed changes and associated compliance burden will vary significantly across states. The Kaiser Family Foundation reports that in 2019, 49 states and DC used at least one provider tax to finance their share of Medicaid expenditures—demonstrating that the proposals changing states’ abilities to use provider taxes to finance Medicaid could impact a majority of states.⁶ Further, a 2014 GAO report found that in 2012, states relied on provider taxes, IGTs and CPEs to fund 26 percent of the nonfederal share of Medicaid expenditures, further corroborating that a large portion of state’s nonfederal share financing could be impacted by CMS’s proposals.⁷ The potential scope of the impact of these proposals paired with CMS’s own acknowledgement that it does not “have sufficient data to predict or quantify the impact of the proposed provisions on health-care related taxes” reinforces the need for CMS to conduct additional analysis before finalizing the proposed rule.⁸ If all of the proposed provisions related to state Medicaid financing are finalized, together these policies could significantly impact the stability of state Medicaid program financing, which could result in significant program cuts and barriers in access to care.

Trinity Health is concerned about the impact CMS’s proposals may have on state Medicaid programs, as proposals would put existing, critical funding sources on which states rely to finance their Medicaid programs at risk, and could have spillover impacts on state and local budgets. We therefore recommend that CMS should take the following steps to ensure program stability and access to care if the proposed rule is finalized:

- **collect more state-by-state data on approaches to financing and the impact of the proposed policies before finalizing these proposals;**
- **narrow the scope of the proposed policies based on CMS’s state by-state analyses; and,**
- **delay or phase-in these changes to allow states time to develop new approaches to Medicaid program financing.**

Reporting Requirements and Oversight May Significantly Increase States’ Administrative Burden

While we understand CMS’s goals of increasing transparency and oversight, we believe that many of the new reporting requirements—for which CMS does not provide sufficient detail—will create high levels of uncertainty, confusion, and place undue burden on states, Medicaid agencies and some providers. Specifically, a number of proposed policies related to supplemental payments could meaningfully increase states’ administrative burden. For example, CMS proposes to require states to submit every three years a new state plan amendment (SPA)—including monitoring and evaluation plans—for CMS approval of supplemental payment methodologies. Currently there is no limit on the duration of these policies. Further, CMS’s supplemental payment evaluation criteria are unclear. The proposed policies require that supplemental payment rates are consistent with “economy, efficiency, quality of care and access” yet the proposed rule does not appear to provide sufficient clarity to states regarding how CMS will evaluate states proposals, creating uncertainty for

⁶ Kaiser Family Foundations, “[States With At Least One Provider Tax in Place, FY 2019](#)”

⁷ Government Accountability Office, [Medicaid Financing States’ Increased Reliance On Funds From Health Care Providers And Local Governments Warrants Improved CMS Data Collection](#), June 2014.

⁸ CMS, *Medicaid Program; Medicaid Fiscal Accountability Regulation*, Federal Register, Vol. 84, No. 222, November 18, 2019.

states around how CMS will evaluate their proposals. Additionally, the new and vague provider-level reporting requirements could increase provider burden and are unlikely to yield meaningful data necessary to help the Administration meet its transparency and oversight goals. We believe these proposed changes will place undue burden on states, especially in cases where CMS is likely to re-approve existing supplemental payment methodologies. We therefore recommend:

- **CMS re-evaluate this proposal and only require states to submit SPAs when making significant changes to supplemental payment methodologies.**
- **If CMS chooses instead to place a time limit on approval of these methodologies, we recommend it require states to submit new plans every 5 to 10 years—similar to section 1115 waivers—as this will allow more time for evaluation and decrease burden on states.**

More generally regarding the proposed policies related to reporting and oversight, Trinity Health recommends:

- **CMS should thoroughly assess on a state-by-state basis the administrative burden its proposals for reporting and oversight will place on states and other stakeholders before finalizing these policies.**
- **At a minimum, CMS delay or phase-in new reporting standards to ease burden on states coming into compliance.**

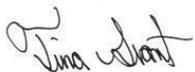
Conclusion

Trinity Health recognizes CMS's aim to better understand and increase transparency around Medicaid program payments and financing and supports CMS's goal of ensuring the stability of the Medicaid program. However, we are concerned that the agency's proposals related to supplemental payments, state Medicaid program financing, and new reporting and oversight requirements could have a significant, negative impact on states, Medicaid beneficiaries and providers.

We are concerned that the proposed policies will impede states' abilities to maintain current payment levels and financing structures, creating risks for beneficiaries' access to care.

Thank you for the opportunity to respond to this proposed rule. If you have questions on our comments, please feel free to contact me at granttw@trinity-health.org or 734-343-1375.

Sincerely,



Tina Weatherwax Grant, JD
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Trinity Health