ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

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Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

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

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the proposed rule, Medicaid Program; Medicaid Fiscal Accountability Regulation (CMS-2393-P).

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care. ACHP's member health plans provide coverage and care for more than 21 million Americans across 34 states and the District of Columbia. ACHP members focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and quality of care, including primary care redesign, payment reform, accountable health care delivery and use of information technology.

As Medicaid Care Organizations and Community Care Organizations, ACHP members are in many cases direct or delegated contractors serving Medicaid members. We acknowledge concerns raised regarding Medicaid directed payments, including those that are designed solely to maximize federal financial participation rather than drive coverage gains or quality. However, this proposed regulation and related regulatory impact analysis fails to account for the significant impact this rule would have on state budgets, hospital financing, health plans and community and safety net providers.

Given that CMS has not fully evaluated the data to assess the impact of this rule on these critical stakeholders – and on state budgets – we respectfully request that CMS withdraw and re-propose the regulation with the necessary information for meaningful review and comment. Should CMS move forward with the proposed regulation, we offer the following comments.

State Share of Financial Participation

The proposed regulation attempts to make significant changes to the permissible sources of non-federal share of Medicaid payments. CMS proposes to inhibit the development of community-based partnerships that can improve the care delivery for Medicaid beneficiaries by limiting the available sources of funds for the state share of the Medicaid program. Specifically, the proposed limitation on intergovernmental transfers penalizes a wide array of public-private partnerships

that provide care and coverage. Secondly, language restricting payments from only the state Medicaid program as eligible for matching dollars is too narrow. Often, multiple state agencies administer Medicaid benefits outside of the designated state Medicaid agency. Medicaid covered benefits or shared services that are administered under delegation by the Medicaid agency could be at risk under the current construction of the proposed regulation. Such a change would be detrimental to funding legitimate services currently furnished by non-Medicaid state agencies.

Defining these existing practices as non-bona fide would limit state options to fund the Medicaid program and move health plans and providers into the unenviable position of having to assume significant funding reductions in an already financially strapped program. The new burden of financing critical health care services for indigent populations would negatively impact premiums if health plans are unable to absorb higher prices from provider groups as a result of uncompensated care and put additional stress on limited state resources. Additionally, disproportionate share hospital payments would inevitably make up for some of the uncompensated care and thereby increase federal expenditures.

Permissible Health Care-related Taxes

The proposed rule clarifies hold harmless provisions to consider the totality of circumstances to determine if the taxpayer expects some or all taxes will be returned. Limits around hold-harmless arrangements and other mechanisms could increase the costs that states must incur to obtain federal Medicaid matching funds. The resulting budget impacts could have a range of unforeseen implications for Medicaid programs, including the decisions states make to use managed care, program design and rate-setting practices, populations or benefits. ACHP recommends that the final rule remove limitations around hold-harmless arrangements to protect Medicaid beneficiaries.

Additionally, CMS has not provided an adequate estimate of new expenses states would incur under the proposed rule. CMS should furnish a fiscal impact report to each state about what the new burdens of this regulatory change would be.

Waiver Provisions Applicable to Health Care-related Taxes

The proposed rule would limit broad-based and uniformity tax waivers to three-year terms. ACHP opposes this proposed change as it would add administrative burden by requiring states to continually provide proper documentation, including the preparation of said documents every three years. Additionally, the proposed rule grants CMS significant authority to itself in reviewing these proposals, which could result in delays in approval or longer implementation timelines for states seeking changes. The result would be further instability to Medicaid financing and significant burden on health plans implementing the Medicaid program. States would face the uncertainty of being required to qualify for funding every three years, and health plans, especially those closely aligned with providers, would also face significant difficulty in establishing value-based arrangements that require a longer time commitment.

State Plan Requirements for Population Health

ACHP agrees that directing payments toward populations solely to maximize federal financial participation is not the most appropriate use of Medicaid dollars. However, CMS must be cautious not to penalize health plans and providers who invest in vulnerable communities' care. As proposed, CMS does not provide meaningful distinctions between what will be judged as detrimentally maximizing federal financial participation as opposed to simply providing care. CMS should define exactly how they would measure payments deemed to be excessive, with their sole purpose of maximizing federal financial participation. Otherwise, CMS expects that plans should be able to judge for themselves based on non-existent criteria when payments become excessive with the sole purpose of maximizing federal financial participation.

In the proposed rule, CMS specifies that a state plan may not provide for variation in fee-for-service payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan. ACHP recommends that states be provided latitude to adjust payments based on a population's health risk or needs. CMS is attempting to solve one problem by creating another. While states are incentivized to spend resources where they receive the highest match from the federal government, that funding is also directed towards the most vulnerable and needy communities.

Payments Funded by Certified Public Expenditures Made to Providers that Are Units of Government

The proposed regulation would codify standards for states to document Medicaid expenditures and introduce further administrative burden via new reporting requirements. ACHP appreciates that states which have developed their own cost reports will be able to continue using them. ACHP requests additional flexibility in instances when Medicare cost reports are insufficient, that states still be given the leniency to experiment and develop their own cost reports.

CMS also proposes to establish and implement documentation and audit protocols for certified public expenditures. These include an annual cost report to be submitted by the state government provider or non-state government provider to the state agency that documents the provider's costs incurred in furnishing services to Medicaid beneficiaries during the provider's fiscal year. Providers will be forced to devote greater time and resources to this new administrative burden, further diminishing the amount of money spent on care. ACHP recommends CMS collect initial data before committing to an audit schedule. When considering an audit schedule, CMS should attempt to limit regulatory burden.

CMS also proposes to require that certified public expenditures must receive and retain the full federal financial participation associated with the Medicaid payment, consistent with the cost identification protocols in the Medicaid state plan. Although ACHP may support the intent in principle, in practice, the proposed regulation would be severely detrimental to the Medicaid program. Limiting the flexibility of federal financial participation payments would have the effect of limiting Medicaid expenditures that states currently rely on to make other payments. The net effect of this proposal is to create a larger problem than may be solved.

This is further reinforced by CMS' proposal to limit reimbursement to only the costs incurred, as measured by Medicare cost reports. CMS is aware that Medicare cost reports, and the Medicare fee schedule generally, does not reflect the true cost of delivering care. By limiting reimbursement to the arbitrary threshold of Medicare costs, health plans will again be forced to pay more for care, and perhaps even raise premiums to account for these new costs.

These attempts to cut costs by eliminating "waste" in the Medicaid system will simply force new costs onto insurers who will have to continue subsidizing the Medicaid program. By attempting to eliminate "waste" in the program that was used to pay for Medicaid services, CMS will limit the real amount of dollars available, thereby limiting coverage, services offered, or the scope of other Medicaid benefits. In the proposed rule, CMS makes no mention of replacing federal dollars it proposes to eliminate, even though states rely on these same dollars to deliver services.

Reporting Requirements (Disproportionate Share Hospital Audits)

CMS proposes to specify that states must return disproportionate share hospital payments in excess of hospital-specific cost limits to the federal government identified through an annual audit. ACHP urges CMS to redistribute funds, rather than decreasing adjustment. Disproportionate hospital payments currently are insufficient to cover the total cost of uncompensated. At a minimum, CMS should redistribute disproportionate share hospital funds to qualifying hospitals within the same state regardless of whether this is provided for in the state plan. In the case it is not provided for in the state plan, CMS should develop its own system to redistribute funds consistent with the requirements for Medicaid generally.

Hospitals suffering financially from uncompensated care often respond by raising prices during the next renegotiating period. CMS has the authority, and the tools to act against this through Medicaid. Private insurers would be forced to pay for greater hospital prices under CMS' proposed rule. By internally redistributing state disproportionate share hospital funds, CMS could blunt many price spikes as the result of reducing disproportionate share hospital payments overall.

Medicaid Practitioner Supplemental Payments

CMS proposes to limit supplemental payments to practitioners because of alleged concerns they are not economic and efficient. Specifically, CMS proposes limiting Medicaid practitioner supplemental payments to 50 percent of Medicaid fee-for-service base payments to the eligible provider for practitioner services, or 75 percent of payments for services provided withing HRSA-designated health professional shortage areas or Medicare-defined rural areas.

Limiting supplemental payments to specialty physicians and other practitioners simultaneously limits the options available to states to address health conditions among unique populations. After collecting data and developing an understanding of the landscape, ACHP recommends CMS issue sub-regulatory guidance that provides an opportunity for states to experiment with different provider payments for different interventions. Diverse state populations necessarily produce differentiation in health status among beneficiaries – health conditions can vary by region of the country, and even further by state, county and municipality. Proposing that states must abide by strict guidelines set at the federal level does not allow for the diversity of health conditions

present in the United States, especially the clustering of health conditions of Medicaid beneficiaries.

ACHP appreciates that CMS has made exceptions in the proposed rule for rural and underserved geographic areas. However, for areas of the country still experiencing challenges without meeting precise eligibility standards for health professional shortage areas or Medicare-defined rural areas, states must retain the flexibility to innovate to serve those populations without the ability to pay variable amounts to physicians and other medical practitioners curtailed.

Conclusion

Thank you for consideration of ACHP's comments and recommendations. Specifically, ACHP reiterates that we respectfully request that CMS withdraw and re-propose the regulation with the necessary information for meaningful review and comment. If you have questions or require additional information, please contact Michael Bagel, ACHP's Director of Public Policy, at mbagel@ahcp.org.

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