Wyoming Hospital Association

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Via Electronic and Overnight Mail

Re: File Code CMS 2393-P; RIN 0938-AT50: Medicaid Program; Medicaid Fiscal Accountability Regulation; Proposed Rule Published November 18, 2019 at 84 Fed. Reg. 63722

Ladies and Gentlemen:

The Wyoming Hospital Association (WHA) respectfully submits comments on the proposed amendments to the Code of Federal Regulations issued by the Centers for Medicare and Medicaid Services (CMS) entitled Medicaid Program; Medicaid Fiscal Accountability Regulation (MFAR).

The WHA is comprised of thirty (30) member hospitals, twenty-seven (27) of which are located in rural areas. Many of these hospitals are also in Health Professional Shortage Areas, Medically Underserved Areas or serve a Medically Underserved Population. Many of our member hospitals are also critical access hospitals. With few exceptions, each hospital is the only hospital in its town. Even in towns with more than one hospital, the hospitals serve distinct populations. For example, in Casper, there is an acute care hospital, a surgical hospital, a psychiatric hospital and a rehabilitation hospital. In each of Cheyenne and Sheridan, there is an acute care hospital and a Veterans Affairs hospital. Due to the remote nature of the hospitals in Wyoming, virtually every member hospital must accept as a patient any person who comes in its doors, regardless of their ability to pay. There is no other hospital "down the street" that focuses its care on the Medicaid and uninsured population.

1. Summary of Comments

As of October 2019, 64,699,741 individuals were enrolled in the Medicaid program, constituting approximately 20% of the United States population.[1] Covering low-income pregnant women, children, aged, blind or disabled individuals, Medicaid provides important health benefits to some of the most vulnerable patients. Medicaid base rates, however, often do not cover a provider's

[1] Medicaid.gov, "October 2019 Medicaid & CHIP Enrollment Data Highlights," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

cost of treating its Medicaid patients. Consequently, states use supplemental Medicaid payment programs to offset their unreimbursed cost of treating Medicaid patients.

Medicaid supplemental payments are crucial to the viability of Wyoming hospitals. The aggregate Medicaid disproportionate share hospital payments statewide only totaled $508,784 in 2017. Consequently, Medicaid supplemental payments are the only mechanism available to Wyoming hospitals to partially cover the unreimbursed cost of treating Medicaid and uninsured patients. Without Medicaid supplemental payments, hospitals in Wyoming struggle to meet their financial obligations, which impacts the quality and, potentially, the availability of care to Wyoming residents.

MFAR violates various statutory requirements and creates hurdles for state and local financing of Medicaid programs. In particular, the terms of MFAR:

(a) Ignore the requirement that CMS conduct an analysis to determine the impact of the rule on the "efficiency, economy, and quality of care" standard that federal law requires CMS to ensure its Medicaid payments meet;

(b) Fail to consider the impact on small businesses in contravention of the Regulatory Flexibility Act;

(c) Create: (1) hold harmless language related to health care-related taxes that apparently attempts to regulate transactions to which the taxing authority is not a party in violation of federal law; (2) an ambiguous "net effect" standard related to assessing whether a hold harmless exists for purposes of provider-related donations and health care-related taxes, which if read in conjunction with the preamble text to the proposed regulations, exceeds CMS's statutory authority; and (3) an impermissibly vague and apparently repetitive "totality of the circumstances" analysis;

(d) Unnecessarily and unfairly limit the sources of the non-federal share of Medicaid payments;

(e) (1) Create definitions of "non-state governmental provider," "state governmental provider, and "private provider" that limit the use of legitimate management agreements; and (2) use an ambiguous "totality of the circumstances" standard to determine a provider's ownership; and

(f) Unnecessarily limit practitioner supplemental payments.

Many states rely on health care-related taxes, intergovernmental transfers (IGTs) and certified public expenditures (CPEs) to fund the non-federal share of Medicaid payments. Taken as a whole, MFAR could reduce the amount of non-federal share of Medicaid payments available to states. And if states cannot replace that funding with other appropriations from their stretched budgets, they will have to either cut the already low rates they pay to providers, reduce services available to beneficiaries or raise taxes to generate additional state general revenue to serve as the non-federal share of Medicaid payments.

WHA requests that CMS withdraw MFAR and replace it with a rule that that complies with its statutory authority and more clearly addresses specific violations of Medicaid financing laws that CMS has encountered without drastically cutting Medicaid funding.

2. Impact of MFAR on the Medicaid Program is "Unknown"

In its Regulatory Impact Analysis, under Anticipated Effects, CMS acknowledges that "[t]he fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is ***unknown.***"[2] WHA asserts that this simply is not good enough. CMS is proposing sweeping changes to the Medicaid program that, if adopted, would dramatically impact provider reimbursement and, potentially, patient access.

CMS has a responsibility to ensure that Medicaid "payments are consistent with efficiency, economy, and quality of care."[3] If Medicaid reimbursement decreases significantly, quality of care will decline. Providers would close or discontinue more costly services, reducing services and, therefore, access to care. CMS, however, has admittedly failed to consider the impact of MFAR on payments to providers and the impact payment reductions could have on access to care for Medicaid beneficiaries.

Additionally, Executive Order 12866 (the Executive Order) requires CMS to perform a Regulatory Impact Analysis that includes "**the best reasonably obtainable scientific, technical, and economic information** and is presented in an **accurate, clear, complete and unbiased manner**."[4] CMS did not fully use the information at its disposal to assess the impact on Medicaid payments of the proposed rule. Ultimately, the only monetary impact CMS included is the change in the amount of practitioner supplemental payments, although CMS is aware of the amount of supplemental payments it makes every year.[5]

Even if CMS cannot accurately calculate the benefits and the costs, it is required to perform an "uncertainty analysis."[6] The Office of Management and Budget (OMB) states that an agency's "analysis should be should be credible, objective, realistic, and scientifically balanced."[7] CMS performed no uncertainty analysis. OMB significantly states "[w]hen uncertainty has significant effects on the final conclusion about net benefits, your agency should consider additional research prior to rulemaking. The costs of being wrong may outweigh the benefits of a faster decision."[8] CMS should take OMB's advice and perform additional research before promulgating this rule.

[2] Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722, 63,773 (Nov. 18, 2019).
[3] 42 U.S.C. § 1396a(a)(30)(A).
[4] *See* Agency Checklist: Regulatory Impact Analysis, OIRA, https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/inforeg/inforeg/regpol/RIA_Checklist.pdf.
[5] 84 Fed. Reg. 63,773.
[6] See Circular A-4, OMB, at 18, 38-40 (Sept. 17, 2003), https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf.
[7] *Id.* at 39.
[8] *Id.*

When CMS sought to make significant changes to the physician self-referral law (Stark law), it issued a Request for Information to the public in June 2018.[9] CMS did not propose changes to the Stark law until October 2019, and even then, CMS provided different options and flexibility in its approach.[10]

Likewise, before adopting MFAR, CMS should conduct a more exhaustive analysis of the potential impact of these measures on provider payment and patient access. Additionally, CMS should allow stakeholders and states to provide information and comment on the results of its analysis.

3. Regulatory Flexibility Act (RFA) Implications

The RFA requires that, whenever an agency is required to publish general notice of proposed rulemaking for any proposed rule, the agency must prepare and make available for public comment an initial regulatory flexibility analysis.[11] This analysis must describe the impact of the proposed rule on "small entities."[12] "Small entities" include small businesses, small organizations, and small governmental jurisdictions, as those terms are defined in 5 U.S.C. § 601(3)-(5).[13] The Small Business Administration classifies hospitals as small businesses if their annual average receipts are less than $41.5 million.[14]

In this case, CMS certified that the rule would not have a significant economic impact on a substantial number of small entities, apparently because it says that the rule establishes requirements that are the responsibility of the states.[15] In the past, however, CMS has recognized in RFA analysis the impact on providers of changes to Medicaid regulations.[16] In 2007, in the comments to the rule entitled: "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership; Final Rule" (the 2007 Final Rule), CMS acknowledged that the provisions of the 2007 Final Rule would impact rural hospitals, stating "We expect this regulation to have a significant economic impact on a substantial number of small entities, specifically health care providers that are operated by units of government, including governmentally-operated small rural hospitals…"[17] CMS's position in MFAR is inconsistent with its statements in the 2007 Final Rule.

As mentioned above, small businesses and small governmental jurisdictions are providers of health care services and provide services to providers of health care services. This rule has a significant

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[9] *See* CMS Press Release, "CMS seeks public input on reducing the regulatory burdens of the Stark Law," June 20, 2018, https://www.cms.gov/newsroom/press-releases/cms-seeks-public-input-reducing-regulatory-burdens-stark-law.
[10] Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 84 Fed. Reg. 55,694 (Oct. 17, 2019).
[11] 5 U.S.C. § 603(a).
[12] *Id.*
[13] *Id.*
[14] *See* U.S. Small Business Administration, Table of Small Business Size Standards Matched to North American Industry Classification System Codes, at 39, https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf
[15] 84 Fed. Reg. 63722, 63,773 (Nov. 18, 2019).
[16] Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership; Final Rule, 72 Fed. Reg. 29,748 (May 29, 2007).
[17] *Id.* at 29,831.

financial impact on the providers because it could reduce the amount of Medicaid funding which they can receive. In Wyoming, the majority of our 30 members constitute small entities. And indirectly, MFAR will affect many small businesses that service these providers, as providers reduce costs, close their doors, or bring more services in-house.

Consequently, we recommend that CMS perform a full RFA analysis in connection with this rulemaking before adopting a final rule.

4. Comments on Health Care-Related Tax Hold Harmless Analysis

(a) *New "Hold Harmless" Language Related to Health Care-Related Taxes is Overbroad*

CMS appears to propose to expand the definition of when a hold harmless arrangement exists with respect to health care-related taxes. Specifically, current Section 433.68(f)(3) states:

> (f)(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.[18]

CMS proposes to add the following sentences to Section 433.68(f)(3):

> A direct guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount. The net effect of such an arrangement may result in the return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.[19]

The language in MFAR's preamble indicates that CMS believes that an arrangement (written or otherwise) among taxpayers under which taxpayers make redistribution payments to each other constitutes a hold harmless because the taxpayers effectively received some of their tax back in the form of redistribution payments and/or Medicaid payment.[20] CMS states "[t]he fact that a private entity makes the redistribution payment does not change the essential nature of the payment, which constitutes an indirect payment from the state or unit of government to the entity being taxed that hold it harmless for the cost of the tax."[21]

To be clear, according to the current (and proposed) rule, the State (or other unit of government) must "provide for" the "direct or indirect payment, offset, or waiver" that constitutes the hold harmless.[22] Consequently, the State (or other unit of government) must be a party to any such

[18] 42 C.F.R. § 433.68(f)(3).
[19] 84 Fed. Reg. 63722, 63,778 (Nov. 18, 2019).
[20] *Id.* at 63,734.
[21] *Id.* at 63,735.
[22] 42 C.F.R. § 433.68 (f)(3); 84 Fed. Reg. 63778 (Nov. 18, 2019).

"arrangement." If the State (or other unit of government) is not a party to an arrangement (written or unwritten), it cannot "provide for" the hold harmless, regardless of whether taxpayers have arrangements among themselves. Because CMS drafted this language, we assume that CMS agrees with it.

If CMS does not agree with either our assumption or its own language, and CMS thereby is attempting to regulate private transactions without participation from the governmental taxing entity, CMS is exceeding its statutory authority. *See,* section 1903(w)(4)(C) of the Social Security Act (the Act), which states in pertinent part:

> For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:
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> ***
>
> (C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.[23]

The statute specifically states that the State or other unit of government imposing the tax must "***provide for***" the payment, offset, or waiver that holds the taxpayer harmless from its tax. If the State or other unit of government does not actively require or cause the arrangement among taxpayers, an arrangement does not violate the statute, and CMS does not have the authority to prohibit such transaction, even if taxpayers make payments among each other.

Section 1903(w)(4)(C)(i) of the Act is very clear on this point. And the Act does not give discretion to the Secretary to broaden the definition of a hold harmless in the context of health care-related taxes. Regulations "must be consistent with the statute under which they are promulgated."[24] Consequently, we recommend that, if it does not choose to withdraw these proposed rules, CMS clarify in its responses to the comments it receives that it does not intend to regulate arrangements among private parties to which the entity levying the health care-related tax is not included.

(b) *"Net Effect" Definition in § 433.52 is Impermissibly Vague*

We appreciate CMS's attempt to add definitions to increase clarity in these regulations. That said, CMS proposes to define "net effect" as:

> [T]he overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in cash or in kind, among participating entities. The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities,

[23] 42 U.S.C. § 1396b(w)(4)(C).
[24] *Decker v. Northwest Envtl. Defense Ctr.*, 568 U.S. 597, 608 (2013).

> and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity.[25]

We believe that this definition contains ambiguous terms. There is no real standard involved in this analysis. The terms "reasonable expectations" and "reciprocal actions" are so vague as to be unenforceable. In comments to the regulations implementing provider taxes in 1993, CMS's predecessor, the Health Care Financing Administration stated "subjective analysis does not allow for a reasonable test of the hold harmless provisions. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured."[26] Here, CMS ignores its own guidance and implements an ambiguous and subjective standard.

For example, "arrangement" is not defined, nor is it defined what it means to be an entity "participating" in the arrangement. Is a state or other governmental entity imposing a health care-related tax always a party to any arrangement among taxpayers that are subject to the tax? Or is the taxing entity only participating in an arrangement if it requires or causes (that is, "provides for") some taxpayers to transfer value to other taxpayers in a manner that creates the "reasonable expectation" that they will be held harmless for their payment of some or all of the tax? As mentioned above, we believe that this is the only proper interpretation of Section 1903(w)(4)(C)(1) of the Act, thus requiring CMS to clarify this point to be consistent with the statute. Additionally, is a taxpayer that neither pays funds to other providers, nor receives funds from other providers (or the State or other unit of government), "participating" in an arrangement? Consequently, we recommend that CMS clarify what it means to "participate" in an "arrangement." Ultimately, however, we believe that "participation" is only relevant if the taxing governmental entity provides for some arrangement that returns tax funds to the taxpayers.

(c) *"Totality of the Circumstances" Language Is Vague*

The proposed revisions to Sections 433.54 and 433.68, and the proposed definition of "net effect" use the term "totality of the circumstances." Under both proposed provisions, a hold harmless guarantee will be analyzed using a "totality of the circumstances" test, and CMS will assess the net effect of an arrangement considering the "totality of the circumstances."[27] A "totality of the circumstances" standard is so non-specific that application of these rules would be unpredictable and subjective. The totality of the circumstances test is impermissibly vague and subject to differences in interpretation across the country. Health care providers will have no way to be sure that they are operating within the confines of the regulations.

Additionally, it is unclear whether CMS's use of this term is intended to refer to two different analyses that employ a totality of the circumstances test – one that is used to determine the "net effect" and one to determine whether there is a hold harmless – or if the totality of the circumstances analysis is designed to apply overall to a hold harmless analysis that includes consideration of an arrangement that implicates a "net effect" standard.

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[25] 84 Fed. Reg. 63722, 63,777 (Nov. 18, 2019).
[26] Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156, 43,167 (Aug. 13, 1993).
[27] *Id.* at 63,777, 63,778.

(d) *Summary of Comments*

In short, to make the aforementioned provisions of the proposed rule consistent with section 1903(w)(4)(C)(i) [42 U.S.C. §1396b(w)(4)], WHA asserts that CMS should withdraw the proposed rule, or at a minimum, withdraw the sections relating to health care-related taxes, "net effect," "totality of the circumstances," and hold harmless.

If CMS does not withdraw or better clarify this proposed rule to be consistent with the statute, states may not be able to use health care-related taxes to fund their Medicaid programs. States without the means to replace those dollars with state general revenue funds may be forced to reduce Medicaid services and rates. Providers' losses from treating Medicaid and other low-income patients will increase. More providers will refuse to accept Medicaid, and more providers with high Medicaid volumes, especially rural hospitals, will close. In short, CMS should not extend the limitations on the use of health care-related taxes beyond the plan language of the statute.

5. Comments on Changes to Definition of Public Funds

CMS proposes to amend Section 433.51 to limit the state and local funds that can constitute the non-federal share of Medicaid payments.[28] Specifically, the proposed revisions provide that states can only derive the non-federal share from: (1) state general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency, (2) intergovernmental transfer of funds from units of government in the state derived from state and local taxes or funds appropriated to state university teaching hospitals, and (3) certified public expenditures.[29] The preamble to the proposed regulations states that Section 1903(w)(6)(a) prohibits states from using any other funds as the non-federal share of Medicaid payments.[30] The statute does not say that, however.

Rather, Section 1903(w)(6)(A) states: "[n]otwithstanding the provisions of this subsection, the ***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…"[31] This section does not prohibit the use of other funds. It simply prohibits CMS from restricting the use of these funds for the non-federal share.

As recently as in the 2007 Final Rule, CMS acknowledged that non-tax funds were appropriate for use as the source of the non-federal share. Specifically, in responses to comments to the 2007 Final Rule, CMS explicitly recognized that non-tax revenues of governmental units that were not health care providers, including "fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds," were "acceptable sources of financing the non-Federal share of Medicaid payments."[32]

[28] *Id.* at 63,737.
[29] *Id.* at 63,737, 63,738.
[30] *Id.* at 63,737.
[31] 42 U.S.C. § 1396b(w)(6)(A).
[32] 72 Fed. Reg. 29,747, 29,766 (May 29, 2007).

Similarly, CMS agreed that a governmentally-operated health care provider could use patient care and other non-tax revenues as sources of the non-federal share of Medicaid payments.[33]

CMS asserts in the preamble that this new provision merely clarifies the existing rule by mirroring the statutory language. The statutory language, however, establishes a "safe harbor" for what funds may comprise an IGT. Nothing in the statute prevents states from using a broader set of public dollars, like commercial revenue received by a public entity, as an IGT. And the proposed change clearly contradicts prior CMS statements on this issue.

Limiting the sources of the non-federal share of Medicaid payments beyond what the current regulation allows will result in a significant disruption to Medicaid reimbursement. States should be able to implement new and maintain current Medicaid programs that appropriately (*i.e.*, without using non-bona fide provider-related donations or inappropriate healthcare-related tax mechanisms) use other public funds in addition to state general revenue, tax revenue, appropriations to state university teaching hospitals and certified public expenditures to serve as the non-federal share.

This approach by CMS also creates potential differences on a state-by-state basis because states fund their medical schools and public hospitals using different appropriation methodologies. In short, this one-size-fits-all approach simply does not work for funding Medicaid payments.

We request that CMS withdraw its changes to Section 433.51.

6. The Definitions of Non-State Government Provider, State Government Provider and Private Provider Are Too Restrictive

(a) *Definitions of "Non-State Government Provider" and "State Government Provider" Lack Clarity*

CMS's proposed definitions of "non-state government provider," "state government provider," and "private provider" may have the consequence of impermissibly converting public providers into private providers, thereby prohibiting them from using their public funds as the non-federal share of Medicaid payments. CMS proposes to define a "non-state governmental provider" as a health care provider "that is a unit of local government in a State, including a city, county, special purpose district, or other governmental unit in the State that is not the State, which has access to and exercises administrative control over State funds appropriated to it by the legislature or local tax revenue, including the ability to dispense such funds."[34] In addition, however, CMS proposes to add another "totality of the circumstances" analysis of vague factors to assess whether an entity is a non-state governmental provider. There is similar "totality of the circumstances" language for purposes of determining whether a provider is a state government provider.[35]

i. *"Totality of the Circumstances"*

[33] *Id.*
[34] 84 Fed. Reg. 63722, 63,780.
[35] *Id.* at 63,781.

The totality of the circumstances test would examine the extent to which a public entity shares responsibilities of ownership or operation of the provider, and CMS would consider factors such as whether the entity:

> (i) has the immediate authority for making decisions regarding the operations of the provider;
> (ii) bears the legal responsibility for risk from losses from operations of the provider;
> (iii) has immediate authority for the disposition of revenue from operations of the provider;
> (iv) has immediate authority with regard to hiring, retention, payment, and dismissal of personnel performing functions related to the operation of the provider;
> (v) bear legal responsibility for the payment of taxes on provider revenues and real property, if any are assessed; or
> (vi) bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or operations, activities, or assets of the provider.[36]

There is no statutory or current regulatory "totality of the circumstances" test to instruct how CMS would weigh these factors. In other words, enforcement would be subject to CMS interpretation and inconsistent application of these provisions. There would be no way for a provider to be certain whether it is a government provider or a private provider if it has any kind of operational agreement with a private entity until after it enters into the arrangement and makes IGTs. As with the bona fide provider-related donation and health care-related tax totality of the circumstances provisions, this test is impermissibly vague.

ii. "Unit of Non-State Government"

Confusingly, CMS also provides a definition of a statutorily and, heretofore, regulatorily undefined term, "unit of non-state government," but it does not clearly tie to the definition of "non-state government provider."[37] We assume CMS intends "unit of non-state government" to mean the same thing as "unit of local government" for purposes of the definition "non-state government provider." If not, CMS should clarify the applicability of this term.

Assuming CMS intends "unit of non-state government" to mean the same thing as "unit of local government," CMS proposes to expand on the statutory definition of "unit of local government" without statutory authority. Specifically, under the applicable statute, "'unit of local government'" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State."[38] There is no ambiguity or test of various factors.

In MFAR, however, CMS proposes to examine the "character" of the entity and determine whether it is a "unit of non-state government" by assessing if it: (1) is described in communication as a unit of non-state government; (2) is characterized by the State as a unit of non-state government for

[36] *Id.* at 63,780.
[37] *Id.* at 63,781
[38] 42 U.S.C. § 1396b(w)(7)G).

Medicaid purposes only; and (3) has access to and exercises administrative control over State funds appropriated to it and/or local tax revenue.[39] CMS's analysis would include but, apparently, not be limited to these factors.

CMS should not attempt to expand on the statutory definition of "unit of local government" (assuming that is what CMS intends). And CMS should certainly identity every factor it will use to determine whether an entity is a "unit of non-state government." Ultimately, however, either an entity is a city, county, special purpose district, or other governmental unit in the State, or it is not.

(b) *Factors Do Not Allow for Legitimate Management Arrangements*

Additionally, government providers often contract with management companies that provide the operational services for their businesses. While CMS acknowledges in the preamble to MFAR that many such arrangements are legitimate, the factors that CMS proposes to use to assess whether a provider is a "non-state government provider" or "state government provider" could result in a provider changing status by virtue of a legitimate management arrangement.

For example, one of the factors CMS proposes to use to determine whether a provider is a non-state or state government provider is whether the entity "has immediate authority to make decisions regarding the operation of the provider."[40] Many state and local governments contract out the operations of their facilities and the day-to-day decision-making that goes along with them. They do this specifically because, as governmental entities, they are not experts in providing health care, so they engage a private company with the required expertise to handle operations. Another proposed factor would assess whether an entity bears the legal responsibility for risk from losses from the operations of the provider.[41] Generally, the owner of the facility bears risk for operational losses, but often, owners require managers to indemnify them for losses. In that case, a private manager would have legal responsibility for risk from operating losses. Yet another factor examines whether the entity has "immediate authority with regard to hiring, retention, payment, and dismissal of personnel performing functions related to the operation of the provider."[42] Private management companies often provide personnel, including management personnel, to operate the providers. Again, delegating its management to a company with greater health care expertise does not change the actual ownership of a facility, so it should not determine its classification as a "non-state government provider" or "state government provider."

In short, this is an area where clarity is paramount. A governmental provider should know with certainty whether it is a government or private provider before the governmental entity makes IGTs to serve as the non-federal share of Medicaid payments. The "totality of the circumstances" test and this confusing term, "unit of non-state government," leave this question open to inconsistent interpretation across the country. And a provider which inadvertently converts from a government to a private provider based on the factors discussed above could unwittingly expose

[39] 84 Fed. Reg. 63722, 63,781 (Nov. 18, 2019).
[40] *Id.* at 63,752.
[41] *Id.*
[42] *Id.*

itself to enforcement under these regulations. The factors also limit the use of legitimate business relationships.

Consequently, WHA believes that CMS should withdraw this provision of the proposed rule.

7. Medicaid Practitioner Supplemental Payments

CMS proposes to implement a new regulation that would limit supplemental payments to certain practitioners. Historically, states have made payments to practitioners using an estimate of the average rate paid by commercial third-party carriers (ACR) for the same services provided by those practitioners to Medicaid beneficiaries. CMS has stated that it will limit practitioner supplemental payments to 50% of the fee-for-service base payments to the eligible provider for practitioner services or 75% of such payments for services provided in health professional shortage areas or rural areas.[43]

CMS states that when it approved the ACR methodology, ACR amounts were usually between 150% and 165% of Medicare rates, but now, ACRs have climbed to 300% to 400% of Medicare. One concern with this change is that it unfairly punishes providers in states that have lower base rates. In those states, practitioners already receive less base reimbursement, and often, the only way to cover their cost of treating Medicaid and uninsured patients is through practitioner supplemental payments. If CMS bases its limit on Medicaid base rates, it is likely to continue to disadvantage providers in states that have lower base rates.

Additionally, physicians already refuse to accept Medicaid patients at an alarming rate. Only 70.8% of physicians accept new Medicaid patients.[44] Without a strong primary care base, Medicaid patients will seek care in the emergency room, increasing costs to the Medicaid program. Supplemental practitioner payments, however, help incentivize these practitioners to accept Medicaid patients and treat them as part of their practice, keeping them out of the emergency room. If practitioners can receive commercial rates for treating these patients, the patients will have greater access to care and costs will be reduced because they will not incur large emergency department bills.

Additionally, CMS has already provided for Medicaid managed care organizations to pay providers at commercial rates. Specifically, section 438.6(c)(1)(iii)(E) of the November 14, 2018 proposed Medicaid managed care rule allows the state to direct Medicaid managed care organizations (MCOs) to pay any of the MCO's network providers a "Medicare equivalent rate, ***a commercial rate,*** or other market based rate."[45] In the preamble to the Medicaid managed care rule, CMS explains:

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[43] *Id.* at 63,762.

[44] *Physician Acceptance of New Medicaid Patients*, Medicaid and CHIP Payment and Access Commission, presentation Kayla Holgash and Marth Heberlein, January 24, 2019. https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

[45] Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care, 83 Fed. Reg. 57,264, 57,294 (Nov. 14, 2018) (emphasis added).

> To encourage states to continue developing payment models that produce optimal results for their local markets and to clarify how the regulatory standards apply in such cases, we are also proposing to add a new paragraph § 438.6(c)(1)(iii)(E) that would allow states to require managed care plans to adopt a cost-based rate, a Medicare equivalent rate, ***a commercial rate,*** or other market-based rate for network providers that provide a particular service under the contract.[46]

CMS is proposing a new approach that contradicts statements of policy it made only fourteen months ago. Given such a monumental shift in reimbursement and the potential harm to Medicaid practitioners and, therefore, beneficiary care, we suggest that CMS withdraw this proposed change to ensure the continued access of Medicaid patients to quality physician care.

8. Three-Year Limitation on Supplemental Payments

In the proposed changes to § 447.252 and 447.302, CMS proposes to limit Medicaid state plan amendment (SPA) approvals for Medicaid supplemental payments to not more than three years. Because of the amount of time involved in preparing, filing and receiving approval of Medicaid SPAs, states could be constantly working on their supplemental Medicaid SPAs. Alternatively, providers could experience significant gaps in their Medicaid supplemental payments. Some states require legislative and/or regulatory authority for SPAs and/or appropriation of supplemental payments. And many legislatures, including Wyoming's, meet for only a short time every year (or every other year in some states). As such, limiting the effective time of SPAs for supplemental payments could create situations where providers lose supplemental payments and, therefore, fail to recover their uncompensated cost of treating Medicaid and uninsured patients.

9. Conclusions

Through MFAR, among other things, CMS attempts to impose restrictions on health care-related taxes that exceed its statutory authority. It also proposes to redefine "public funds" in direct conflict with its statements in 2007. Similarly, MFAR purports to establish definitions of "non-state government provider," "state government provider," and "private provider" that are not actually related to the ownership of the provider. CMS also proposes to reduce supplemental payments to practitioners. And CMS proposes to make these changes without a proper Regulatory Impact Analysis. These are only a few of the many changes that MFAR implicates, but these are the ones that most concern WHA.

Collectively, these provisions result in reductions in Medicaid funding. States do not typically have surplus funds to spend on Medicaid. Consequently, if MFAR is adopted as is, states will have only three options: ***(1) cut services; (2) cut rates; and/or (3) raise taxes***. None of these is a good outcome.

And as such, the resulting reductions in Medicaid reimbursement and services, will create reductions in revenue for providers and access for patients. Providers, especially rural providers, will struggle to meet their financial obligations. Employees will be laid off. Hospitals will close. Physicians will continue to opt out of Medicaid. Patient access to primary and hospital care will

[46] *Id*. at 57,270 (emphasis added).

continue to decrease. Patients will become sicker and, ultimately, increase Medicaid costs when they appear in the emergency department for primary care or in distress for a chronic condition that has gone untreated.

On behalf of the members of the Wyoming Hospital Association and for these reasons, WHA requests that CMS withdraw the proposed rule and provide true clarity on the arrangements that CMS believes violate federal law consistent with applicable statutes. Thank you for allowing us to submit these comments. If you have any questions or need further information, please contact Eric Boley at 307-632-9344 or by email at eric@wyohospitals.com.

Very truly yours,

Eric Boley

Eric Boley
President