

January 30, 2020

Submitted electronically via [www.regulations.gov](http://www.regulations.gov)

The Honorable Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Ave., SW  
Washington, DC 20201

**RE: Medicaid Fiscal Accountability Regulation (CMS-2393-P)**

Dear Administrator Verma:

On behalf of the National Council for Behavioral Health (National Council), thank you for the opportunity to comment on CMS's notice of proposed rulemaking on the recent Medicaid Fiscal Accountability Regulation. The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with our 3,326 member organizations serving more than 10 million adults, children and families living with mental illnesses and addictions, we are committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

Under current regulations, states are provided with flexibility within federal limits for how they finance Medicaid programs and distribute payments to providers. Intergovernmental Transfers (IGTs), certified public expenditures (CPEs), and provider taxes are congressionally sanctioned and regulated sources of the nonfederal share of funding for the program dating back to Medicaid's inception. In the rule, CMS proposes policies that could significantly limit the use of these long-established financing arrangements. The proposed policies apply subjective standards without providing adequate guidance on how the new criteria will be applied, giving CMS vast new oversight authority and making it very difficult for states and providers to ensure compliance.

The National Council appreciates the opportunity to comment on the proposed rule. Given the vast scope of state activities that would be affected by the proposed changes—and the lack of detail in key parts of the regulation outlining how CMS plans to address the impact on states' long-term financial planning and beneficiaries' access to services—**we strongly urge CMS to withdraw the proposed rule, engage in data collection and analysis to fully understand the impact of the proposed changes, and seek further input from stakeholders before promulgating any additional rulemaking.**

Among our concerns with the NPRM are three areas that would have a particularly devastating impact on states' ability to administer their Medicaid programs:

1. The proposed change to the definition of “public funds” which fails to account for the complexities of states’ delivery systems and introduces unnecessary subjectivity;
2. The lack of clarity around how CMS proposes to determine the “net effect” of taxes;
3. The significant administrative burden and inability for states to engage in long-term planning arising from the proposed sunseting of financing mechanisms after three years; and
4. Ultimately, the severe anticipated loss of resources for state Medicaid programs resulting in loss of access to services.

### **Proposed Definition of “State and Local Funds” Lacks Clarity, Fails to Account for Delivery System Complexities**

Under current regulations, the term used to define allowable sources of the non-federal share of Medicaid financial participation is “public funds.” Historically, CMS has recognized the diversity of state approaches to organizing and financing health care delivery by allowing states reasonable latitude to define what constitutes “public funds” as they relate to non-state governmental entities. In the draft rule, CMS proposes to replace the term “public funds” with “state or local funds.”

The proposed rule defines state or local funds as:

1. State general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency;
2. Intergovernmental transfers (IGTs) from units of government, derived from state or local taxes (or funds appropriated to state university teaching hospitals), and transferred to the state Medicaid Agency and under its administrative control (unless determined to be a non-bona fide provider-related donation); or
3. Certified Public Expenditures (CPEs) which are certified by the contributing unit of government as representing expenditures eligible for federal financial participation and appropriately reported to the state.

While the proposed change ostensibly makes non-substantive changes to align regulatory language with language in the Social Security Act, the actual impact is a substantive reversal of longstanding and necessary latitude. This move is contrary to CMS’ stated goal of bringing a “new era of flexibility” to states in the Medicaid program.<sup>1</sup> Additionally, the proposed definition introduces levels of uncertainty and subjectivity of interpretation that will have a detrimental effect on state Medicaid financing structures.

Medicaid programs are reflective of the unique characteristics of participants including population, patient and provider mix, and individual state approaches to addressing state-specific public health and

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<sup>1</sup> Price, T. & Verma, S. (2017, March 14). Letter to the Nation’s Governors. Letter to the Nation’s Governors. Retrieved from: <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>.

policy priorities. It is common for state general fund dollars appropriated for Medicaid to flow through multiple levels of state and county government, including units of government that do not have taxing authority, as well as managed care entities which may or may not also be governmental entities. State and local tax funds may flow from the legislature through state and/or county agencies before they reach providers.

Under each of these arrangements, the funds that ultimately become the non-federal share of the match (via IGT or CPE, for example) should be considered state general fund dollars or dollars derived from state or local taxes—and do in fact meet the definition of “public funds” as used today. Yet, the proposed definition would seem to permit CMS to deny that such funds are allowable as the state share if they first passed through one or more other administrative entities. The proposed regulations cause stakeholders to question whether longstanding, widely accepted financing arrangements necessary for the delivery of services will be prohibited under the new rule.

Additionally, CMS proposes a new definition, replacing “non-state government-owned or operated” facilities with “non-state government provider.” The new, proposed definition of “non-state government provider is unnecessarily subjective and lacks required clarity.

In determining whether a provider is a non-state government provider, a threshold question for purposes of determining a provider’s ability to fund the non-federal share, the proposed rule relies on a “totality of the circumstances” test built around an open-ended set of factors. CMS proposes to define a non-state government provider to include a governmental unit that has access to and exercises administrative control over state appropriated funds or local tax revenue, including the ability to dispense such funds. To determine whether an entity meets the definition of non-state government provider, CMS proposes to consider the totality of the circumstances, “including *but not limited to*” the identity and character of any other entities involved in operation of the provider and the nature of any relationships between the provider and other such entities. §447.286 (emphasis added).

More specifically, CMS also proposes an open-ended consideration of “the character of the entity, which would include, *but would not be limited to*” how the entity describes itself in communications, how the entity is characterized by the state for purposes of Medicaid financing, and whether the entity has access to and exercises administrative control over state appropriated funds and/or local tax revenue, “including the ability to expend such appropriations or tax revenue funds, based on its characterization as a governmental entity” §447.286(2) (emphasis added).

Under the proposed rule, the state and impacted providers cannot know with any degree of confidence whether CMS will consider a provider a non-state government provider, because the totality of the circumstances test allows for application of unidentified factors (“not limited to”).

Just as damaging as the subjectivity and lack of clarity in the new rule, is the potential elimination of participation of governmental entities without taxing authority. These units of state or local government

have access to and exercise administrative control over state and local funds, including: state funds appropriated from the legislature that may be appropriated to the state Medicaid agency and then allocated to a non-state government entity acting as a provider of state-funded services; funds transferred from a local taxing authority to such a provider; and other public funds.

Public policy will not be served by placing restrictions on these state and local government units who provide valuable Medicaid-funded services in their communities, supported by allowable IGT and CPE funding sources.

**Recommendation:** The National Council urges CMS to rescind the proposed definition of “state and local funds” and retain the term “public funds” in the definition of the allowable non-federal share. This would fully account for the diverse ways that states organize their delivery systems and would preserve states’ flexibility to implement financing arrangements that best suit their specific health care delivery environment and needs.

After careful review of stakeholder comments on the proposed rule, if CMS determines to go forward with rule implementation, the National Council requests CMS initiate a robust process for data collection and stakeholder feedback. This feedback should inform a new, proposed definition that is founded in a data-driven understanding of the financial implications of the proposal for states’ Medicaid programs and takes into account necessary flexibility, while accounting for CMS’ interest in aligning language and increasing transparency. It must also allow a sufficient transition period for states to bring their financing arrangements into compliance.

Additionally, CMS should make good on its stated intent in the rule’s preamble: “Nothing in this proposed rule would result in limiting state and local government units from contributing to the Medicaid program through allowable IGT and CPE funding sources.” A revised definition of non-state government provider should include non-state government entities (or providers) that are not taxing authorities, but do have access to and exercise administrative control over state and/or local funds, including: state funds appropriated from the legislature that may be appropriated to the state Medicaid agency and then allocated to a non-state government entity to administer and manage state-funded services; funds transferred from a local taxing authority to such an entity; and other public funds.

### **Proposed Standards for Health-care Related Taxes Are Vague and Open the Door for Inconsistent Enforcement**

Current federal law permits states to impose a health care-related tax on a permissible class of health care items or services without a reduction in Federal Financial Participation (FFP), so long as the tax complies with certain requirements that they be:

1. Broad-based

2. Uniformly imposed
3. Not violative of hold harmless provisions in federal rule

CMS has traditionally waived the broad-based and/or uniformity requirements when a state can establish that net impact of the tax and associated expenditures is “generally redistributive” in nature, and the amount of the tax is not directly correlated to Medicaid payments for items and services. CMS established clear statistical tests for evaluating requests for waivers of the broad-based and uniformity requirements.

In the proposed regulation, CMS states a position that the statistical tests do not ensure proposed taxes are generally redistributive in all cases. CMS suggests that certain taxes may pass the statistical test(s) despite an imposition of “undue burden” on the Medicaid program. Further, CMS indicates that additional standards are needed to identify whether a hold harmless arrangement exists. CMS does not support the need for regulatory changes with a data-driven analysis or a description of the scope of these perceived instances of improper taxation.

Under current rules, a provider is considered to be held harmless if any of a number of conditions apply, including that the State imposing the tax “provides for any direct or indirect payment, offset, or waiver such that the provision of payment, offset, or waiver directly or *indirectly guarantees to hold* [providers] harmless for all or any portion of the tax amount” (emphasis added). 433.68(f)(3).

The proposed regulations introduce the subjective standards of “totality of the circumstances” and “net effect” to 433.68(f)(3). The language added by the proposed rule specifies that a direct or indirect hold harmless guarantee exists where, considering the totality of the circumstances, the net effect of an arrangement between the state and the provider results in a reasonable expectation that the provider will receive a return of all or any portion of the tax amount.

In contrast to CMS’ stated goal of providing clarity to the analyses of taxes and provider donations, the totality of the circumstances and net effect standards introduce a damaging level of uncertainty for states and provider entities and open the door for inconsistent application over time, across states, and by different federal administrations. Nothing in these tests articulates a specific standard that would allow regulated entities to identify permissible or impermissible activity; instead, the proposed rule allows CMS to make decisions on a case-by-case basis, leaving room for arbitrary or discriminatory enforcement.

**Recommendation:** The National Council urges CMS to withdraw the proposed rule and develop a detailed, data-driven analysis justifying the need for any further regulatory changes and the impact such changes would have on state Medicaid programs. Before finalizing any further rulemaking, CMS should provide sufficient detail clarifying the scope and application of any tests or analysis that will be used in granting or denying waiver requests and must provide ample time for additional public comment.

## **Sunsetting Financing Mechanisms Imposes a Significant Administrative Burden and Inhibits States' Long-Term Planning**

Financing mechanisms subject to the draft rule account for substantial Medicaid financing in many states. Most of these arrangements have been in place for decades, constituting an ongoing structural part of states' overall budgets. Individual state Medicaid agencies do not have capacity to simultaneously reevaluate and renegotiate all approved funding mechanisms that would sunset under this proposal. The proposed regulation does not include a robust and comprehensive analysis of the anticipated burden on state Medicaid agencies of complying with this requirement.

We anticipate proposed sunset provisions will lead to a nationwide state Medicaid budget crisis as states grapple with how to restructure and replace the financing mechanisms they have relied upon for many years, including supplemental payments, IGTs, and CPEs.

Many states have multiple different and separate of these mechanisms in place; in most cases they took years to negotiate and put in place. Individual state Medicaid agencies do not have the internal staff to simultaneously reevaluate and renegotiate all of their current approved funding mechanisms that would sunset under this proposal. Not only does this create additional administrative burden on states, it is not clear how CMS would manage timely review of these arrangements given the agency's current SPA and waiver review backlog. Any review and approval delays would cause significant uncertainty for states and providers, disrupting state fiscal planning and increasing the risk associated with investing in longer-term priorities such as residency programs, delivery system restructuring, or population health initiatives that span multiple renewal periods.

Looking ahead, the proposal to sunset new financing mechanisms every three years would stymie states' ability to engage in long-term planning for Medicaid programs. Financing mechanisms such as supplemental payments, IGTs and CPEs often take years to implement. If mechanisms must be reapproved every three years, in many cases the renegotiations will need to begin immediately after the most recent approval in order to be ready for a prospective re-approval in three years—a significant administrative burden on states and providers.

Meanwhile, without assurance that a particular financing arrangement will continue beyond a three-year time period, states and providers will not be able to build and maintain capacity—much as any business would not make long-term investments in its growth and development if it did not know whether and how it would receive funding beyond the next three years. States work hard to engage in long-term planning and financing for Medicaid programs to build infrastructure and ensure they will be able to meet the projected needs of their populations into the future. With the proposed changes, states will no longer be able to guarantee continuation of the financing structures they have relied upon to invest in longer-term priorities such as residency programs, delivery system restructuring, or

population health initiatives that span multiple renewal periods; instead, they will find themselves trapped in three-year planning cycles with the financial tools to meet only short-term programmatic needs. Potential funding reductions stemming from the proposed rule are likely to further strain state budgets and undermine the ability of states to fulfill their Medicaid obligations.

**Recommendation:** The National Council recommends CMS rescind its proposal to automatically sunset all existing and future financing arrangements after three years. The proposal would impose a substantial administrative burden on states while decimating their ability to engage in long-term planning for Medicaid programs. These changes directly contravene CMS' recent work to remove administrative burdens on states and grant states greater authority to administer their own Medicaid programs.

Before continuing with any rulemaking, CMS should conduct a thorough impact analysis of the administrative burden on state Medicaid agencies, including modeling the staff and contractor time and costs necessary to revise and renegotiate all current financing arrangements every three years.

If CMS insists on moving forward with the proposed rule, at a minimum, all existing approved mechanisms should be grandfathered in with no sunset date. Additionally, CMS should put forward a plan outlining how it intends to work with states to reduce the administrative burden of this regulation while supporting their ability to engage in long-term planning. Further public comment should be solicited before finalizing the revised rule.

### **Proposed Changes Threaten Access to Care in Medicaid**

At their core, the National Council's objections to the proposed rule arise from our concern about loss of access to services for our nation's most vulnerable populations. By restricting widespread mechanisms that today are universally accepted as a core part of state Medicaid financing, the draft rule threatens an irreversible loss of resources to Medicaid programs across the country. We are concerned that the proposed rule does not include an impact assessment on beneficiaries' access to care.

As a result of these restrictions, states will experience Medicaid shortfalls that will force them to enact provider pay cuts and restrictions on benefits or eligibility to offset reduced funding. These actions directly harm beneficiary access to care. In some cases, classes of providers subject to IGTs and CPEs may be the only provider type offering a particular service, meaning that access to those services could be completely eliminated or sharply reduced. Even when certain classes of providers or services are not subject to IGTs and CPEs that may be deemed unallowable, they will suffer from an overall loss of resources in the Medicaid environment.

The draft regulation fails to account for how the loss of resources within Medicaid programs could affect beneficiaries' access to care. This looming crisis in access comes at a time when CMS has also proposed rescinding prior regulations requiring states to demonstrate how they are working to ensure access in their Medicaid programs. Importantly, among the provisions of the access rule that would no longer be in effect is the requirement that states engage in a transparent process including public comment before implementing cuts to provider pay that may impact access to services. Without these protections in place, it is not clear that CMS, states or the public would have a clear understanding of how cost-cutting measures forced by the changes outlined in the proposed fiscal accountability regulation affect beneficiary access.

To implement changes such as those in the proposed rule, CMS must first have data to understand the impact of what it is proposing, what coming into compliance means, and how this will impact providers, states, and beneficiaries. Once those data have been collected and the agency understands the scope and scale of what it is proposing, only then should the agency proceed with implementation.

CMS has often stated its commitment to flexibility, clarity and transparency—yet, at the confluence of the newly proposed fiscal accountability regulation and the proposed rescission of prior access regulations is a tangled knot of contradictions: state flexibilities that are granted on the one hand while repealed on the other; changes made in the name of clarity creating a ripple effect whose full impact on access is masked by a lack of transparency.

**Recommendation:** The National Council requests that CMS engage in exhaustive data collection and analysis to fully understand the impact of the proposed regulation on beneficiary access to care. The process should be followed by development and public release of a plan to work with states to ensure beneficiaries' access to services as CMS undergoes the process of re-evaluating and potentially restricting states' financing mechanisms. The proposed fiscal accountability regulation should be withdrawn until such time as CMS releases the plan, followed by a period of stakeholder input and comment, to include both beneficiaries and providers, among others.

The National Council appreciates the opportunity to provide comments on this important topic. We welcome any questions or further discussion about the recommendations described here. Please contact Rebecca Farley David at [RebeccaD@thenationalcouncil.org](mailto:RebeccaD@thenationalcouncil.org) or 202-684-7457 ext. 235.

Thank you for your time and consideration.

Sincerely,







Jeff Richardson, MBA, LCSW-C, Board Chair  
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