WSHA Comments on Proposed Medicaid Fiscal Accountability Rule

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January 31, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Re: CMS–2393–P, Medicaid Fiscal Accountability Proposed Rules
Submitted electronically via http://www.regulations.gov

Dear Administrator Verma,

The Washington State Hospital Association (WSHA), commenting on behalf of the 101 hospitals in Washington State, has deep concerns with the proposed rules on Medicaid fiscal accountability and urge its withdrawal. The proposed rules could have a substantial negative impact on people who rely on Medicaid hospital services in our state and the caregivers who serve them. Many of the proposed changes are legally not permissible, as we discuss in more detail below. We urge CMS to withdraw these rules in order to prevent significant harm to Medicaid services in our state.

Medicaid is the key vehicle through which 1.8 million Washingtonians get access to health care – including vital hospital services. Our state relies on several key alternate funding sources, in addition to state general tax revenue, to fund these services. These funds support additional supplemental payments but also for the base Medicaid program.

For the past decade, Washington has levied a hospital provider tax to generate funds to supplement base Medicaid payments and ensure people across our state can get the health services they need. This tax provides more than $150 million per year to enhance hospital payments and more than $150 million to the state for uses such as support of its base Medicaid program. The seniors, children, veterans, and people with disabilities who rely on Medicaid are direct beneficiaries of the tax.

Importantly, the supplemental funds are directed to safety net providers with a high proportion of Medicaid and uninsured. The provider tax is used to support the state's trauma center hospital and the state's major teaching hospital, both of which serve patients from a broad region including Washington, Wyoming, Montana, Idaho and Alaska. The tax also provides supports and DSH funding to rural hospitals. Washington State, unfortunately, has multiple small rural hospitals currently in financial distress for which this funding is a lifeline. It also provides supplemental fee-for-service payments and funds for Medicaid managed care plans to supplement Medicaid hospital payment rates for non-governmental hospitals. These supplemental payments provide needed revenues which enable these hospitals to continue to operate and serve people on Medicaid. Washington State has experienced closures of two

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hospitals that serve a high proportion of Medicaid enrollees in the last year. We are concerned reductions to Medicaid funding will jeopardize the viability of additional hospitals.

In addition to the provider tax program, Washington uses intergovernmental transfers and a certified public expenditure program. These programs provide further support to the state's governmental hospitals and to the state's Medicaid transformation program governed by a CMS waiver.

The proposed rules replace the current, clear approval criteria for provider taxes with ambiguous new criteria. The current Washington tax is not broad-based since the state excludes taxes on some of the governmental hospitals. The tax structure, however, is designed to meet all the additional tests required under current rules and does so on an annual basis. Under the proposed rule, Washington would need to have its tax reapproved by CMS three years after the effective rule date. This could be extremely challenging since it is not clear our current tax would meet the ambiguous new requirements. This becomes even more challenging when we consider the logistics of needing to get a tax approved by the Washington legislature prior to submitting to CMS.

WSHA and hospitals request withdrawal of the entire proposed rule, but we have specific concerns about several of the key provisions, noted below and detailed in the enclosure:

- Elimination of any language, such as in the preamble, that indicates most health care taxes are based on loopholes in the current law. The current Washington State program meets current requirements and bolsters the provision of Medicaid services in our state.
- No revision of the definition of the standard to determine a "direct guarantee." The current Washington State tax returns money to hospitals to enhance services for Medicaid patients, which we believe is a reasonable use of such funds.
- No change to current flexibility in allowance of funds from public hospitals that can be used for IGT purposes.

We also request no inclusion of new time limits imposed on states for renewals of their tax waivers and supplemental payment programs. The proposed rules require Washington State to renew its supplemental payment within two years and, as noted above, its tax waiver within three years. Given that our state budget requires a four-year balance, the need for reapprovals within that limited time frame creates clear uncertainties.

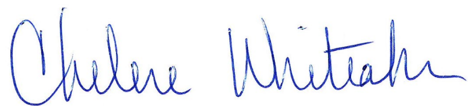
Finally, we request no additional change to state reporting requirements. CMS will receive detailed data on the amounts of payments provided through the fee-for-service system, but most of our provider tax supports the payments made by managed care organizations. How will the additional information be useful?

We understand the need for additional transparency on hospital payments. We and our hospitals, however, are very concerned these rules overturn long-standing programs that currently support patient access to hospital care across our state. Ultimately, many patients, not just Medicaid patients, will be hurt if the cuts to Medicaid resulting from this rule lead to limitations in services, reductions in investments in innovative or transformative programs, or in the worst-case closure of some of our smallest rural hospitals.

Despite the potential for such significant negative consequences, CMS has provided little to no analysis to justify these policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. Many of the changes would violate the Medicaid law or are arbitrary and capricious in violation of the Administrative Procedure Act. Moreover, at the same time the agency is proposing these changes, it is planning to rescind rules that require states to demonstrate that Medicaid beneficiaries have sufficient access to care, thus weakening CMS's ability to ensure adequate oversight of the program.

For these reasons, WSHA, along with the American Hospital Association, hospitals and many others, strongly urge CMS to withdraw this rule. We have provided more detailed comments on specific provisions of the rule in the following pages. Thank you for asking for feedback on the proposed rule, and please do not hesitate to contact us with questions.

Sincerely,



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WSHA Disputes CMS Statements Characterizing Health Care Taxes

WSHA opposes CMS's characterization in the preamble that States have taken advantage of loopholes in federal law when designing their health care-related taxes. CMS has previously worked with states such as Washington to identify permissible financing sources other than State general revenue. Washington State relied on these flexibilities and continues to rely on this as a financing source for our Medicaid program. Our state's hospital tax supports grants to large and small public hospitals, additional DSH funding for rural hospitals, and additional funding to support private hospitals that treat a substantial number of Medicaid patients.

CMS has made conscious decisions to allow States a degree of flexibility within the parameters of the Social Security Act and helped States design their health care-related taxes to ensure the sustainability of the Medicaid program. States have relied on these past decisions.

Our state worked to make sure its provider tax and financing mechanisms met all existing CMS guidelines and that the parameters were consistent with federal requirements. The changes in the proposed rule now threaten Washington State's ability to maintain the current tax structure into the future. Without health care-related taxes as a source of financing, it will be difficult for Washington to sustain its Medicaid program in its current form. This will likely result in escalating the financial crisis in several of our state's safety net providers in both rural and urban areas. The proposed rules will result in decreasing the sufficiency of states' Medicaid provider networks, in direct contradiction to the mandate of the Social Security Act.

WSHA Opposes Reasonable Expectation Standard (42 C.F.R. § 433.68 (f)(3))

WSHA believes CMS's proposed use of the "reasonable expectation" standard for identifying a direct guarantee in 42 C.F.R. § 433.68(f)(3) violates the Social Security Act. This new "reasonable expectation" standard effectively bans States from using health care-related taxes for Medicaid financing. Specifically, CMS explains a "direct guarantee" will exist any time a taxpayer has a "reasonable expectation" that it will receive a return of "any portion" of its tax. By definition, providers expect that if they are taxed to support the Medicaid program, some of those Medicaid funds will flow to the taxpaying providers as they provide needed services to Medicaid patients.

This position ignores Congress's mandate that States may use health care-related taxes for Medicaid payments. When addressing health care-related taxes, Congress specified that States could use them for Medicaid financing and clarified that nothing in the Social Security Act would "preclude States from relying on [Medicaid] reimbursement to justify or explain the [purpose of the] tax."[1] Consequently, CMS cannot argue the proposed rule complies with Congressional intent while also saying that providers may not have any expectation that a tax to support the Medicaid program will result in any benefit to the providers being taxed.

In 1991, when Congress passed these health care-related tax provisions, Congress laid out three clear hold harmless tests, which the Secretary enforces. Congress did not delegate any legislative authority to the Secretary to expand these tests. We believe CMS's proposed "reasonable expectation" standard is inconsistent with the statute and the explicit legislative history surrounding the Act's health care-related tax provisions.

The proposed changes to 42 C.F.R. § 433.68(f)(3) would effectively invalidate any tax used to fund Medicaid payments to the taxpayers. One motivation Congress had for passing these provisions in 1991 was to clarify to the Secretary that CMS could not prohibit the use of health care-related taxes as a source of Medicaid financing. Through this proposed rule, CMS is again attempting to do what Congress explicitly rejected in 1991. We strongly request CMS remove this proposed provision.

WSHA Opposes Subjective Tests to Identify Direct Guarantees (42 C.F.R.§ 433.68(f)(3))

WSHA opposes CMS's imposition of new subjective tests, such as "totality of the circumstances" and "net effects," for identifying a direct guarantee in 42 C.F.R. § 433.68(f)(3) because these tests are impermissibly vague. Nothing in these tests articulates a specific standard; without a specific standard, the regulated entities will be unable to identify permissible or impermissible activity. Instead, the proposed rule allows CMS to make ad hoc decisions on a case-by-case basis.

[1] 42 U.S.C. § 1396b(w)(4).

Since there is no clear test for identifying a direct guarantee, the proposed rule would allow CMS to subjectively approve or deny similar programs in different States. Federal courts have acknowledged that this "unfettered discretion is patently offensive to the notion of due process,"[2] and the Supreme Court has warned against rules that create a "trap for the wary as well as unwary."[3]

When enacting the initial provider tax regulations, HCFA (CMS's predecessor) emphasized the importance of applying "clear and specific rules" for identifying a hold harmless arrangement, and HCFA acknowledged that "subjective [tests] would be administratively burdensome and virtually impossible to apply fairly throughout the nation."[4] CMS did not have authority to utilize broad, subjective tests at that time and we believe CMS lacks the authority now. We request that these ambiguous wordings be eliminated from the proposed rule.

WSHA Opposes Adoption of Subjective Tests to Determine if Tax Is Generally Redistributive (42 C.F.R. § 433.68(e)(3)(iv))

WSHA opposes CMS's imposition of subjective tests as cited in the proposed changes to 42 C.F.R. § 433.68(e)(3)(iv), such as the "totality of the circumstances," for determining whether a health care-related tax is generally redistributive.

Such a subjective test is impermissibly vague and does not provide sufficient guidance to States on which classes would or would not be permissible groupings. Instead, the proposed rule allows CMS to make ad hoc decisions on a case-by-case basis. To operate effectively, laws must "provide explicit standards for those who apply them" in order to prevent arbitrary and discriminatory enforcement.[5]

Any rule that permits such a high degree of subjectivity would authorize CMS to approve or deny similar programs in different States and still be within the scope of the regulation because the regulation does not articulate a clear test. Without a clear standard, it will be difficult for states such as Washington to craft and enact legislation on a health care tax since it will be unclear if the design will garner CMS approval. The intersection of state legislative activity and federal oversight requires clear rules for State legislatures to follow.

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[2] *Bullfrog Films, Inc. v. Wick*, 847 F.2d 502, 513-15 (9th Cir. 1988).

[3] *Gentile v. State Bar of Nevada*, 501 U.S. 1030, 1051 (1991).

[4] 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) ("We believe that 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.").

[5] *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).

The current Washington State hospital tax meets all the current directives to establish that our tax is redistributive. To the extent CMS now believes the tests require additional refinement, CMS should develop and explain a new calculation. Establishing a broad and subjective catch-all standard without clear rules will lend itself to inconsistent and potentially discriminatory enforcement, particularly between different administrations. It will also impossibly complicate the process to renew our tax if Washington State has to enact a new tax at the state level and then seek approval based on unclear and potentially arbitrary criteria.

WSHA Opposes CMS's Proposed Restrictions on IGTs (42 C.F.R. Section 433.51)

WSHA opposes CMS's attempts to drastically reduce the use of intergovernmental transfers ("IGTs") of "public funds" from cities, counties, hospital districts, and other units of government for the nonfederal share of Medicaid payments, as proposed by the changes to 42 C.F.R. Section 433.51. CMS proposes to remove the definition of public funds eligible for IGTs and limit permissible IGTs from units of government solely to "tax revenue."[6] We do not believe that CMS has the authority to make these changes.

CMS states in the preamble to the proposed rules that it believes "IGTs from sources other than state or local tax revenue…[are] not permitted under" Section 1903(w)(6)(A) of the Social Security Act. This proposal ignores the key Social Security Act modifier of the term "derived from."[7].

At the time Congress enacted the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, CMS permitted IGTs of "public funds," broadly defined as funds transferred from another public agency to the state Medicaid agency that are not federal funds and are eligible for federal financial participation.[8] In enacting the 1991 Amendments, Congress made clear that it was imposing a moratorium on the Secretary and prohibiting CMS "from implementing any regulation that would change current policy with respect to the use by the States of revenues from … [IGTs] to finance their state share of the Medicaid program" and that "this moratorium would be permanent."[9]

Since the adoption of the 1991 Amendments, there has been no change in this moratorium prohibiting CMS from promulgating rules that would limit IGTs from units of government. Any effort to limit IGTs solely to the amount of tax revenue collected by a unit of government would render the phrase "derived from" tax revenue in Section 1903(w)(6) of the Act meaningless.

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[6] Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722, 63737-8 (Nov. 18, 2019).
[7] *Id.*
[8] 42 C.F.R. § 433.54 (1992).
[9] House Conference Report 102-409, 1991 USCCAN 1413 at 1414, 1419 (Nov. 26, 1991) (emphasis added).

Congress explicitly intended IGTs would include more than solely the government entity's tax revenue, and we believe CMS lacks the authority to restrict IGTs from units of government of public funds.

CMS has a longstanding policy that permits states and units of government to make IGTs of "public funds." In its 2007 rule, CMS clarified that non-tax revenue of a unit of government *is a permissible source of the nonfederal share of Medicaid payments*, and specifically cited as permissible sources the use of "fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, and tobacco settlement funds." CMS went on to say that "patient care revenues from other third party payers and others" are also permissible sources of funds for IGTs from units of government.[10] These are significant sources of money with a longstanding precedent of being allowed; denying them going forward would be a monumental shift.

This new departure from a longstanding rule could jeopardize the services financed through IGTs in Washington State. In particular, it could pull out critical sources of financing for our public hospitals, both urban and rural. These hospitals include our state's only Level I trauma center as well as some of the most frontier hospitals. Losing their IGT money could jeopardize the essential services they provide to vulnerable patients across our state.

[10] *Id.*