January 31, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244
Submitted electronically to http://www.regulations.gov

Re: Medicaid Program; Medicaid Fiscal Accountability Regulation; Federal Register, Vol. 84, No. 222, November 18, 2019 [CMS–2393-P]

Dear Administrator Verma,

On behalf of over 220 children’s hospitals across the country, the Children’s Hospital Association (CHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services’ (CMS) Medicaid Fiscal Accountability Regulation (MFAR). We are concerned about the broad policy changes included in the proposed rule and the lack of analysis of these changes’ potential impact on state Medicaid programs, children covered by these programs, and the providers who care for them. Therefore, children’s hospitals urge CMS to withdraw the rule and instead conduct an evidence-based analysis to discern whether broad policy changes are needed and what the impact would be on the over 37 million children who rely on the program.

Children’s hospitals support CMS’ goal of “strengthening the overall fiscal integrity of the Medicaid program.” We understand the need to examine how federal Medicaid funding is being spent to ensure that policies in place at the state level are compliant with federal rules and support the goals of the Medicaid program. We also understand CMS’ role in oversight of the program and the need to address instances where current policy is not being followed. Instead of implementing broad and sweeping policy changes that could have significant funding consequences for state Medicaid programs, however, we recommend CMS focus on the limited situations where there has been a misapplication of policy. We agree that better data and analysis on the impact of these policies is warranted and ask that you engage stakeholders to explore the best ways to access meaningful, actionable information that supports Medicaid’s critical role for children and other beneficiaries. We believe a stakeholder process such as this would ensure that any resulting policy changes would support sufficient access to care under the program. This approach would be more consistent with the agency’s ongoing efforts to streamline regulations, reduce regulatory burden and improve beneficiary and provider experience.

We urge you to withdraw the rule for the following reasons:

- The proposed policy changes are likely to have a significant impact on federal Medicaid funding available to states and in turn, services and supports provided by Medicaid.

- As the largest beneficiary group, any funding reductions will have the greatest and disproportionately negative implications for children and their access to needed care.

Champions for Children’s Health
As major Medicaid providers, children’s hospitals are concerned about the rule’s impact on supplemental payments, which are critical to addressing traditionally low Medicaid reimbursement.

Children’s hospitals do not support implementing these potentially sweeping policy changes without an assessment of impact on state Medicaid programs overall and on children’s access to needed care.

**Overall Impact on State Medicaid Programs**

Medicaid is a partnership between the federal government and states to provide care for some of the most vulnerable citizens. Nearly half of children in the U.S. receive health care coverage through Medicaid, including many who have significant and complex health care needs. States have been granted substantial flexibility to finance their Medicaid programs in a way that addresses their unique characteristics, such as population, geography, and patient and provider mix. We recognize the need to examine how federal Medicaid funding is being spent to ensure policies in place at the state level are compliant with federal rules and support the goals of the Medicaid program. However, the proposed rule threatens to undermine the ability of state Medicaid programs to fulfill their missions by granting the federal government vague and broad discretionary authority over financing and payment arrangements, which have traditionally been allowed under the Medicaid program. The rule also includes enforcement mechanisms which would withhold or disallow funds, further reducing monies for states to provide needed services to children.

According to a Manatt study commissioned by the American Hospital Association, the Medicaid program would face total national funding reductions of $37 billion to $49 billion annually, or 5.8% to 7.6% of total program spending. Hospitals and health systems could face reductions in Medicaid payments of $23 billion to $31 billion annually, accounting for 12.8% to 16.9% of total hospital program payments. The impact state to state could be highly variable, but due to the magnitude of these estimated reductions, they could result in cuts to reimbursement, enrollment or coverage.

We are concerned about this estimated impact on funding of state Medicaid programs that have limited or no options to fill large budget gaps. Overall, states’ options to replace federal funding are narrow and losses in funding could impact access to care. A 2018 Congressional Budget Office (CBO) analysis of the impact of limiting states’ taxes on providers found that, “most states would not replace all of the revenues lost as a result” of the change and, “on average, states would replace half of lost revenues, but that estimate is highly uncertain.” In another report, CBO noted that reducing the taxes states are allowed to levy on a Medicaid provider shifts costs and could impact access, stating, “lower federal payments could shift more of the burden of Medicaid programs’ growing costs to the states...Unless states were willing to pay more of the costs themselves or were able to find ways to provide more cost effective care, access to health care services to low income people might be diminished.” If states need to fill such a large gap in Medicaid funding, they may look to reduce Medicaid provider reimbursement, with a direct negative impact on access to care and services for children. For states without income taxes, their ability to replace reduced funding would be even more limited.

**State financing mechanisms.** CMS proposes to enhance oversight and scrutiny of methods used to finance the non-federal share of Medicaid, such as provider tax programs, provider donations, intergovernmental transfers (IGTs), and certified public expenditures (CPEs). Changes in how states levy and utilize these mechanisms to finance their share could undercut federal funding for Medicaid programs and payments to pediatric providers.

We are particularly concerned about policy changes that would impact states’ ability to levy and use provider taxes. Provider contributions play a major role in states’ ability to finance supplemental payments to high Medicaid providers, such as children’s hospitals. Revenues from health care-related taxes on hospitals fund Medicaid hospitals services and support the

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Medicaid program more broadly. An Office of the Inspector General review of seven states’ hospital tax programs showed the revenues from these programs were used to increase Medicaid reimbursement as well as fund children’s health care coverage, direct grants to public hospitals, support psychiatric services, and increase managed care organization incentives and reimbursement, among other uses.³ Forty-nine states and the District of Columbia have at least one provider tax in place, and two-thirds of states report having three or more provider taxes.⁴ In FY 2017, provider taxes and donations accounted for 32% of non-federal funds for DSH supplemental payments.⁵

Although children’s hospitals do not generally participate in IGTs or CPEs, we are concerned the policies proposed in the rule are too restrictive and create additional fiscal uncertainty for providers and states. The rule would implement new policy on what type of funds qualify as allowable sources of the non-federal share—requiring that IGTs be “derived from state or local taxes”—and which entities can participate in IGTs. In FY 2017, 65% of the share of non-federal funds for non-DSH supplemental payments were funded through state funds, including state general funds, IGTs and funds from local governments.⁶ Any changes that impact states’ ability to finance their programs through these mechanisms could have far-reaching effects on Medicaid programs, beneficiaries and state budgets.

Children’s hospitals are very concerned about the proposed policies in the rule that have the potential to limit the use of provider taxes. We are particularly concerned about the lack of clarity on the new standards and how they will be applied.

- **Net Effect and Totality of Circumstances:** Current federal law on provider taxes prohibits provider tax arrangements that hold the contributing provider harmless directly or indirectly for the tax paid. In the rule, CMS proposes to change current regulations implementing the hold harmless provision by implementing a new standard—the “net effect.” In our view, the “net effect” standard would allow CMS significant discretion to look at the “totality of the circumstances” that the “net effect” a tax arrangement would have. This evaluation would include informal agreements, agreements not in writing, or agreements with no legally enforceable obligation. We are concerned these broad and subjective standards have the potential to unravel several states’ provider tax arrangements.

- **Undue Burden on Medicaid Providers:** For provider tax waivers, the addition of the “undue burden on Medicaid providers” standard is also not clear in terms of what this will mean for existing waivers that have demonstrated they are broad based, uniform and generally redistributive under current regulations. It is unclear how many of these existing waivers would meet this new standard and what this would mean for how states finance their programs.

CMS does not provide guidance on how these financing agreements will be evaluated and the subjective nature of the proposed standards creates great uncertainty given the variation and complexity of state Medicaid funding methodologies. An arrangement deemed permissible during one cycle could be deemed impermissible the next. These standards—depending on how they are applied—could disallow foundational financing streams that have been allowed for years. It has been hard for children’s hospitals to identify the specific impact of these provider tax policies because of the lack of clarity of these new standards and what would be permissible or not permissible moving forward. Due to their uncertainty, the proposed standards are putting entire provider tax programs on uncertain ground—which is very troubling for states, Medicaid providers and the patients they serve.

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⁶ Ibid.
Stability in Medicaid reimbursement is critical to ensuring a consistent level of access to care for beneficiaries. We are concerned the vague standards set forth in this rule will have the opposite effect. If there are instances of misinterpretation of policy that CMS is aware of, we recommend a focus on these limited situations rather than the implementation of broad, sweeping policies that could have significant and widespread unintended consequences for state Medicaid programs.

Impact on Children who Rely on Medicaid
The policies proposed in the rule are likely to have a significant impact on federal Medicaid funding available to states and, in turn, services and supports provided by Medicaid programs. As the largest beneficiary group in Medicaid, this will have the greatest and disproportionately negative implications for children. Children represent 43% of all Medicaid enrollees and 37 million children in the U.S. rely on Medicaid at some point during a year—including 7 million children with special health care needs. Some access to care challenges exist today for children enrolled in Medicaid, which would be exacerbated if states experience significant funding gaps due to this rule. The lack of an impact assessment is particularly troubling considering the recently proposed rule that would rescind the requirements that states monitor beneficiaries’ access to covered services in fee-for-service (FFS) Medicaid. If the rescission is finalized, this would leave the Medicaid program without vital regulatory oversight of access to care. We believe the combination of the rescission and the MFAR could reduce provider payments to a level that does not comport with the Medicaid statute’s equal access provision.

Ensuring access to care is critical for children, especially for children with special health care needs or serious, chronic or complex medical conditions. Children’s need for timely access to pediatric primary and specialty providers is particularly acute given their continuous growth and development. It is imperative children receive preventive care, well-child visits, and developmentally appropriate screenings to identify challenges early, and that they continue to access needed treatment services to achieve and maintain their highest level of functioning. Longer lag times between symptom onset and treatment due to challenges accessing needed services may not only result in poorer outcomes but also greater costs to patients and the health care system. It is imperative the federal government actively provides oversight and enforcement of the equal access provision of the Medicaid statute to ensure children have access to a full range of pediatric providers and services.

Coverage alone does not guarantee access to care, and appropriate Medicaid payment rates play a role in access to care for children. We know children currently face some challenges accessing needed services due to low payment rates. Access challenges for children may also be more severe since there are a smaller number of pediatric providers to begin with. For example, pediatric therapy providers in Texas are increasingly choosing not to participate in Medicaid due to historically low therapy reimbursement rates coupled with cuts implemented by the state. This not only creates provider shortages that will limit children’s access to needed therapy services, but also jeopardizes the state’s ability to ensure that any remaining or new therapy providers participating in the program are able to meet the unique needs of children.

Another example would be access to behavioral health services. This is also an area with significant unmet need, per CMS’ website, “According to the U.S. Surgeon General, while 11% of youth have been diagnosed with a mental illness, two-thirds of youth who have a condition are not identified and do not receive mental health services.” Although all of the unmet need cannot be attributed to access issues, certainly there are access gaps that exist for children when they need behavioral health services. While mental health disorders can and do occur at any age, children and adolescents are uniquely vulnerable. Mental health disorders diagnosed during adolescence often arose years earlier during childhood. Stigma, lack of awareness and inadequate access to resources can delay care by weeks, months or even years. Access to timely care and support keeps kids healthier, reduces symptoms of concurrent issues, allows them to do better in school and potentially avoid risky behaviors. Growing up healthier, children can go on to more successful careers, higher lifetime wages and fulfilling lives.

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Children also often face additional challenges when accessing care outside their state. For children in need of specialized care, traveling out of state is often not a choice, but a requirement. Children’s health care is organized quite differently than adult care and the small number of very specialized services children need often require travel. In many cases, this means traveling across the country to the one specialist familiar with a particular condition or needed procedure. As you think about the provisions in this rule related to state financing mechanisms, supplemental payments and reporting requirements, we ask you to keep these unique circumstances in mind. We articulate more specific possible impacts below.

Research has demonstrated that Medicaid payment rates are a factor that influences provider participation.\textsuperscript{10} The 2013 and 2014 federal Medicaid primary care payment rate increase to bring Medicaid payment rates on par with Medicare was associated with an increase in pediatrician participation in Medicaid\textsuperscript{11}. Given the connection between payments and access, it is critical that we work to ensure Medicaid coverage means children continue to access providers delivering the care they need for healthy growth and development.

As you continue work on this rule and the access rule, we ask you to determine the impact on access to care for children and integrate a review of this important Medicaid tenet into the overall program. It should be explicitly stated that an assessment of the impact on access to care for children be completed before policy changes are made at the state level or policies approved at the federal level.

**Impact on Children’s Hospitals and other Pediatric Providers**

Children’s hospitals are critical providers for all children, treating children across the country who are uninsured, underinsured, enrolled in Medicaid or covered by commercial insurance. Although they account for less than 5% of hospitals in the United States, children’s hospitals care for almost half of children admitted to hospitals and serve most children with serious illnesses and complex chronic conditions. They also serve most children in need of major surgical services.

Supplemental payments—including disproportionate share (DSH) payments, non-DSH payments, and, in some cases, directed payments under managed care—are vital to supporting children’s hospitals and ensuring children have access to the broad range of needed care. On average, more than half of the care provided at children’s hospitals is funded by the Medicaid program. Medicaid reimburses 80% of the cost of care and average payment rates in Medicaid are below Medicare rates in nearly all states. According to data collected by CHA from children’s hospitals, upper payment limit (UPLs) are by far the largest category of supplemental payments children’s hospitals receive. UPLs accounted for 65% of all supplemental payments for children’s hospitals based on data from 33 hospitals. Children’s hospitals serve a high volume of Medicaid patients and, depending on state Medicaid financing arrangements, will be hit hardest by any Medicaid payment reductions.

DSH and non-DSH supplemental payments enable children’s hospitals to fulfill their missions focused on prioritizing children’s health, training tomorrow’s pediatricians and pediatric specialists, and collaborating to improve children’s health in their communities, states and nationally. Medicaid supplemental payments often help them to invest in services and supports to ensure access to care for children on Medicaid is available in the community.

Other pediatric providers, especially smaller practices in underserved or rural areas, could be harder hit if, as a result of this rule, payment reductions are made. Many of these smaller providers may have to close or limit the number of patients they see who are covered by Medicaid. Since there are a smaller number of providers for children, this could have a disproportionate impact on them and their ability to access needed care closest to home.

\textsuperscript{10} Steve Berman et al., “Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients.” \textit{Pediatrics} 110, no. 2 (2002): 239-248, \url{https://doi.org/10.1542/peds.110.2.239}.

\textsuperscript{11} Suk-fong S. Tang et al., “Increased Medicaid Payment and Participation by Office-Based Primary Care Pediatricians,” \textit{Pediatrics} 141, no. 1 (2017), \url{https://doi.org/10.1542/peds.2017-2570}.
**Supplemental payments.** We have questions/concerns about the following provisions of the rule:

- **Base and supplemental payment definitions:** We are aware that some states have integrated supplemental payments into their base rates. Each state has done this differently. We have heard questions on how CMS would view these payments. We would ask CMS to be clear that if the payments are integrated into base rates then they would not be considered supplemental payments. We also have questions about whether GME payments are considered base or supplemental payments.

- **UPL calculations:** The rule codifies the current practice of defining the data sources for upper payment limit calculations, which is the Medicare equivalent payments and charge data as the primary data sources for UPL. The calculations of the UPL can be challenging for children’s hospitals since they are often providing services to children in their state or from other states that do not have a clear Medicare equivalent. At the most basic level, we should ensure that any UPL calculations include the revenue and costs of providing out of state care to Medicaid eligible children. It is our understanding that some of these calculations today do not include these costs, which would produce a skewed view of overall payment. Alternatively, exempting authorized out of state care from the UPL calculation would allow these typically complex patients to receive appropriate care. Finally, we would not want anything in this rule or other rules to constrain access to highly specialized care for children from other states. This highly specialized care is often high cost and does not have an equivalent in the Medicare program. Lastly, children’s hospitals often subsidize physicians or other services in short supply for kids, like home health and outpatient lab services, to ensure access for children covered by Medicaid. These costs should also be reflected in any UPL calculations.

- **Physician UPL cap:** CMS proposes to cap the amount of supplemental payments a Medicaid practitioner may receive to 50% of the total FFS base payment or 75% of FFS payments to the total base payment for those working in a health professional shortage or rural area. We do not support this change to the physician UPL because it could limit the ability to improve physician and practitioner access to care for children in vulnerable and underserved communities, particularly for specialized services. This is the only area for which CMS included impact information, and it found that instituting this change would reduce payments in 21 states by a total of $222 million. Payment levels are associated with provider participation in Medicaid and low reimbursement rates are often cited as a reason providers choose not to accept Medicaid patients. Furthermore, CMS does not distinguish between access to general physician services and subspecialty physician services. Without the ability to adequately compensate professional services, this could create disparate access issues across specialties.

- **Time limited approval for supplemental payments:** CMS proposes to limit the time period for any supplemental payments approved in a State Plan Amendment to three years and to sunset authorized supplemental payment methodologies within three years. These state financing mechanism changes have already been approved by CMS with no restrictions on the length of the approval of supplemental payments after the initial approval. Requiring approval of supplemental payment plans every three years would create great uncertainty in the state and any delay in approvals would financially impact high-volume Medicaid providers like children’s hospitals. Not only would this proposal add substantial administrative burdens on providers and states, it would decrease the confidence states and providers need in these payment streams as a long-term revenue source. If this confidence is eroded, it will greatly impact the ability of states to effectively budget or support long-term investments. Without supplemental payments, programs that provide patient care and family support are at risk of being curtailed or eliminated. If CMS moves forward with this proposal, we ask you to extend the time period for the renewal.

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Reporting requirements. The rule would substantially increase the volume of supplemental payment reporting by requiring aggregate and provider-level data including supplemental and base payments through state plans, state plan amendments, UPL demonstrations and in a state’s quarterly reporting of expenditures. States will also be required to report the non-federal source of Medicaid funding that supports UPL payments. Hospitals that receive DSH payments are required to report on certain provider characteristics and supplemental payment data and there are several areas of overlap with what is being required under the proposed rule and what is already being reported. States also report similar information on upper payment limit demonstrations. Generally, these requirements greatly increase administrative burdens on states and providers without any clear indication on how CMS will use the data.

Moreover, CMS assumes that this information is available and congruent with the definitions proposed in the rule. It is unclear if there are necessary resources and capacity at the state and federal level to provide information, review information, and approve state plan amendments in a timely manner. States should be given alternative methodologies, and appropriate transition periods, to ensure that Medicaid enrollees continue to have access to care.

We support CMS’ stated primary goal to increase transparency. We believe the rule goes beyond that goal and instead makes potentially significant policy changes without sufficient data. Alternatively, we recommend that CMS work with states and providers to identify what data is most needed while aligning any additional reporting requirements with existing reporting to determine a reasonable set of requirements that would allow a better assessment of what is happening in the states and if any further policy changes are needed. These reporting requirements should take into consideration the capacity and staffing at the state and federal levels to review, analyze and act on any data submissions.

Implementation Timeframes
CMS proposes several substantial policy changes that would take effect immediately upon finalization of the rule. State Medicaid spending is typically a state government’s second largest general fund expense after primary and secondary education costs. By the time the rule is finalized, states will have set their budgets based on certain revenue projections. Budget cycles are not consistent across states and some states may be able to address funding shortfalls more readily than others. States with biennial budgets are typically set using a 30-month revenue forecast and longer funding commitments than states with annual budgets. In the event sudden funding gaps arise, all states will be left with little time to adapt or identify other funding streams, with some states able to adapt more quickly than others. If the rule is finalized, we would ask for longer transition periods to allow more time to revise policies and programs at the state level and minimize impact on Medicaid programs and the critical services they provide to children.

Conclusion
As noted in the rule by CMS, “the fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown.” We believe that effective oversight is dependent on sound analysis of relevant data. To this end, we strongly recommend that CMS withdraw the rule and first gather, analyze and evaluate data on the potential impact on state Medicaid programs and beneficiaries. At that point, CMS should assess if and which policy changes are needed. We specifically request that CMS collect and analyze beneficiary access data to better understand what current access issues exist for children in Medicaid and how policy changes would impact kids’ access to care. We strongly support collecting this data before any policy changes are implemented that could have an unforeseen and potentially significant impacts.

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We hope our comments are helpful as you consider this proposed rule and its potential impact on the critical role Medicaid plays for children’s health. If you have any questions or comments, please contact Aimee Ossman, Vice President for Policy Analysis, at aimee.ossman@childrenshospitals.org or 202-753-5333.

Sincerely,

M. James Kaufman, PhD
Vice President, Public Policy