January 31, 2020

Hon. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid Fiscal Accountability Regulation (CMS–2393–P)

Dear Administrator Verma:

On behalf of over 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates this opportunity to submit comments in response to the proposed Medicaid Fiscal Accountability Regulation (MFAR).

The State of Florida administers the fourth largest Medicaid program in the nation. Over 4 million Floridians rely on Medicaid for their health care coverage. Pregnant women, elderly and disabled people make up the majority of those served by the program. However, low-income children are the largest group of people served, comprising 60 percent of the program’s enrollees. In addition, nearly 2.7 million Floridians are uninsured. Consequently, Florida ranks third in the nation for the highest number of uninsured residents – a growing challenge for our state’s health care system that provided $3.2 billion in charity care to low-income patients in 2018.

I. Transition Period.

The Medicaid financing arrangements that have developed in the states and territories over many years are often highly complex. Additionally, as the Center for Medicare and Medicaid Services (CMS) notes in the preamble to the MFAR, many states have increased over time their reliance on locally-derived revenues to provide the state share of Medicaid funds. These observations are applicable to the State of Florida, where the financing arrangements that have evolved over a long period of time rely to a significant degree on several provider taxes and substantial use of intergovernmental transfers (IGTs). Furthermore, much of the State’s program has been governed for many years by the complex terms and conditions of Florida’s Section 1115 Waiver, as renewed and revised periodically.

The changes proposed in the MFAR would appear to significantly impact the financing and operation of Florida’s Medicaid program as it exists today. As noted below, the FHA has questions and concerns regarding a number of these proposals.
However, we are not reflexively opposed to any changes in the mix of financing arrangements employed by the State. In fact, we have advocated for greater reliance on general revenues for many years. That said, it is important for CMS to recognize that once a final regulation is issued, a substantial transition period will be needed to implement whatever changes are ultimately required.

This could involve the need for new state legislation, extensive regulatory and administrative changes, and modifications to the existing State plan and waivers.

With some exceptions (e.g., the requirement that states comply with supplemental information reporting requirements by October 1st of the year following finalization), the MFAR is not clear as to when its various proposals would become binding on state Medicaid programs. FHA would ask that CMS provide a significant time period for states to implement the terms of whatever final rule is ultimately issued. Certainly, no less than one entire calendar year prior to the July 1 start date of Florida’s Medicaid program year will be needed.

II. Intergovernmental Transfers.

Under current regulations, funds transferred from public agencies to the State Medicaid agency are a permissible source of IGTs to fund the state share of Medicaid dollars. Under the MFAR, a significant change is proposed. The IGT funds would need to “derive” from state or local taxes (or funds appropriated to a state university teaching hospital). The FHA is not aware of any compelling justification for constraining the use of IGTs in this manner.

We have many public members who are supported by state or local revenues and can directly provide IGT support without specifically identifying the revenue to a state or local tax. Similarly, we have members who are not governmental entities but are supported by IGTs generated on their behalf by local government units that are not required to specifically identify the source of the transferred funds. We do not see how the imposition of this new federally mandated administrative burden would advance any substantial policy purpose under Title XIX or how it would otherwise be relevant or meaningful. It is certainly not necessary to effectuate any of the proposed changes in the MFAR that address “hold harmless” arrangements. Additionally, the proposal is ambiguous regarding what evidence would need to be produced and what requirements satisfied to demonstrate to the satisfaction of the federal government that a revenue “derives” from a state or local tax.

More fundamentally, some members and units of government may lack the capacity to directly levy revenues on their own behalf but nonetheless possess many commonly-recognized indicia of governmental status, for example, publicly elected and/or appointed leadership, open records requirements, sovereign status or eminent domain powers. We disagree that the presence or absence of the power to generate revenue should be the sole determinant of whether an entity should be determined to be governmental to be allowed to provide an IGT. Such a restriction
appears inconsistent with other legal understandings of what it means to be a governmental entity and, as mentioned above, unnecessary to effectuate other proposed changes in the MFAR respecting “hold harmless” arrangements.

Finally, the proposed restriction on the sourcing of governmental funds used for IGTs does not seem well aligned with the proposal to implement a new definition of “non-state government provider” for purposes of applying the Upper Payment Limit (discussed below). At a minimum, this ambiguity should be clarified.

III. Defining Non-State Government Providers.

CMS is proposing for purposes of the Upper Payment Limit (UPL) to revise the definitions governing public and non-public hospitals such that the three categories of hospitals for UPL purposes would be “state government providers,” “non-state government providers” and “private providers.” To be considered a non-state government provider, the entity would need to be a unit of local government that has access to, and exercises administrative control over, appropriated state funds and/or local tax revenue, including the ability to expend such funds. For an entity meeting this threshold requirement, non-state government provider status would then be determined based on a “totality of the circumstances” evaluation that would consider (but not be limited to):

- Whether any entity other than the provider shares the responsibility for ownership or operation of the provider (giving consideration to decision-making authority, legal responsibility for risk from losses, authority over operational revenue, control of personnel (e.g., hiring/dismissal), tax liability and responsibility for payment of malpractice premiums) and

- The “character” of the entity (giving consideration to whether it is described in communications as a unit of government, whether the state considers it governmental solely for Medicaid purposes, and whether it “has access to and exercises control over” appropriated funds and/or local tax revenue).

To begin with, we do not understand, and would request clarification of, what it would mean for a provider entity to access and exercise administrative control over state appropriations. Many provider entities may receive state appropriated funds for many purposes. Those funds could be for narrowly defined or largely unencumbered purposes. The MFAR is not clear as to what type of state appropriations would be considered and how “administrative control” is determined. To use one relevant example, CMS itself recognizes that a Medicaid Disproportionate Share Hospital (DSH) payment to a hospital is not expressly tied to reimbursement for a particular medical service. Would such a payment meet the proposed requirement for a state appropriation over which administrative control is exercised?
Secondly, assuming the definition of state appropriation is to be narrowly construed, and without restating the discussion above concerning IGTs, we think CMS is incorrect in proposing that taxation authority be treated as the *sine qua non* of non-state governmental status. Entities that lack the power of taxation should not be categorically excluded. Other factors should be used to make this determination, including public governance, sovereign immunity, eminent domain and the other features that commonly define a unit of local government.

More fundamentally, the FHA has concerns and questions related to the proposed totality of the circumstances test. The CMS proposal is entirely too vague as to how the criteria (and additional un-enumerated criteria) would be weighted and applied. It is unclear as to which, or how many, of the criteria an entity would need to meet to satisfy the federal government that they are a “non-state government.” CMS, at a minimum, should articulate a much clearer demarcation and provide extensive examples of how these criteria would be applied.

We are also concerned that the articulated “ownership and operation” considerations will be used to deny governmental status to many entities whose principle functions are directly related to fulfilling the traditional local governmental responsibility to provide health care services to individuals who are indigent, uninsured, covered by state programs, or served by Title XIX or Title XXI. In modern times, many health care providers that were once directly operated by local governments to fulfill these goals (i.e., a traditional “county hospital”) have had their management transitioned to entities with the appropriate experience and expertise to manage the delivery of complex health care services. The local government retains ultimate responsibility for the performance and fiscal soundness of the entity, but any number of the elements listed in the totality analysis may be transitioned to the purview of the hospital and its corporate administration.

In a related scenario, a local government may step in to heavily subsidize and support a local hospital with non-profit status and a mission of service to the uninsured and under-insured (i.e., a traditional “charitable hospital”).

These arrangements can, and do, evolve into scenarios with extensive governmental participation in the management, financing and other affairs of the hospital entity. The FHA is concerned that these ownership and operations criteria not only can, but will, be employed to treat as “private” many institutions and operating relationships better characterized as non-state governmental.

**IV. New UPL for Practitioners.**

CMS is also proposing to create a new upper payment limit for practitioner services and to limit supplemental payments to those practitioners to 50 percent of fee-for-service “base payments” (as defined in the MFAR) to the eligible provider, or 75 percent in the case of services provided within a Health Resources and Services Administration-determined Health Professions Shortage Area (HPSA). We have concerns with this proposal.
We believe CMS should recognize that recruiting and retaining highly skilled health care professionals is critical to our ability to provide care for all patients, including indigent, uninsured, under-insured and Title XIX patients. Medicaid reimburses well below the cost of care, so it is often necessary for hospitals to subsidize unmet costs to ensure adequate access to medical staff and services. These are real costs incurred to ensure a necessary level of services and access thereto as required under Title XIX, and they are not allowable costs for cost reporting and calculation of a Medicaid hospital-specific DSH limit. Many hospitals must have some means of working with their state Medicaid program to devise a method of financing these costs.

Second, we do not understand how the 50 and 75 percent limitations were derived. There does not appear to be an identifiable rationale for these benchmarks and, more fundamentally, they do not appear to be tied to any reasonable estimation related to practitioner costs, as we would think they should. Furthermore, the use of a limitation tied to a percentage of base payments could be highly problematic in states such as Florida that have largely transitioned to Medicaid managed care arrangements.

In sum, we think it important that CMS give this subject greater consideration and, if a UPL for practitioners is to be promulgated, that it be based on more reasoned consideration.

V. Health Care Related Taxes – Undue Burden.

CMS is proposing a number of tax-related changes. To determine that a tax that is not uniform, or broad based, qualifies for a waiver on the basis that it is “generally redistributive,” CMS would add a new test (on top of the two existing waiver tests) that asks whether the tax imposes an “undue burden” on the Medicaid program. This would essentially be defined as a tax that imposes a higher burden on groups with higher levels of Medicaid activity than it does on other taxed groups. Several methodologies would be used in applying this test. To address the relationship between health care-related taxes and hold harmless arrangements, CMS would consider a direct or indirect hold harmless guarantee to exist where, considering the totality of the circumstances, the net effect of any arrangement between the state or other unit of local government and the tax payer results in a reasonable expectation that the taxpayer would receive a return of some or all of the tax amount. This would apply regardless of whether the arrangement was written or legally enforceable. Moreover, the proposed rule would remove the existing hold harmless safe harbor for arrangements where tax revenues do not exceed six percent of revenues received by the taxpayer and the so-called “75-75” hold harmless test for larger revenue amounts.

In Florida, hospitals pay into the Public Medical Assistance Trust Fund (PMATF) an assessment of one percent on hospital outpatient net operating revenue and a one-and-one-half percent assessment on hospital inpatient net operating revenue. These funds are combined with general revenue funds and used to reimburse hospitals through fee-for-service payments and managed
care capitation rates. Consistent with current federal rules, not all hospitals get back all that they were assessed, and hospitals with very low Medicaid volume may not receive as much in increased rates as they paid out through the assessment.

FHA believes that the PMATF assessment meets the undue burden test as set forth. However, the lack of clarity, scope and breadth of CMS’s proposed change in the hold harmless rules could invalidate virtually any provider-related tax. This is not a reasonable way to evaluate whether a provider tax should be allowed. It is also inconsistent with the statutory language that has governed the evaluation of such arrangements since 1991 with respect to whether a “correlation” between taxes and payments or a “guarantee” of return of a tax exists.

While Florida’s PMATF meets the undue burden test, is broad based and contains no hold harmless provisions, CMS should reconsider the implications of what it is proposing given its potential impact on other assessments in Florida and the significant impact on Florida’s Medicaid program.

CMS should develop a clear hold harmless approach more akin to the essence of the “undue burden” test it is applying to the taxes themselves – where the tax is generally redistributive and neutrally applied to provider payments it should not be considered to guarantee a return as that term is used in statute and thereby create a hold harmless.

FHA appreciates the opportunity to provide these comments, and we look forward to working with your agency on meaningful transparency measures that ensure accountability in Medicaid state financing and payment policies without disrupting access to care for Medicaid beneficiaries.

Sincerely,

Crystal Stickle
Interim President
Florida Hospital Association