January 31, 2020

Seema Verma
Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Rm. 314G
Washington, DC 20201

RE: CMS-2393-P: Medicaid Program; Medicaid Fiscal Accountability Regulation

Dear Administrator Verma:

Thank you for the opportunity to review and provide comment on the proposed Medicaid Fiscal Accountability Regulation (CMS-2393-P), as published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register of November 18, 2019.

As Arizona's Medicaid Agency, the Arizona Health Care Cost Containment System (AHCCCS) has long been a leader in innovation, serving 1.8 million members through the creation and effective use of managed care delivery systems. Since its inception in 1982, service delivery for the majority of Medicaid members has been provided through AHCCCS contracted Managed Care Organizations (MCOs). Consistent with one of its founding principles, AHCCCS is committed to providing comprehensive, quality health care to its members while bending the cost curve. As such, AHCCCS is pleased to present the following comments on specific aspects of CMS' proposed Medicaid fiscal accountability rule.

Arizona shares CMS' interest in ensuring fiscal accountability, efficiency, and transparency among Medicaid programs across the country, as evidenced by AHCCCS' strong commitment to cost containment. AHCCCS continues to lead the nation's Medicaid programs with the country's lowest administrative expense ratio. Furthermore, AHCCCS is in the top ten most efficient states in regard to programmatic cost, according to MACPAC. AHCCCS looks forward to collaborating with CMS to accomplish these goals, and continuing the effort to deliver the highest quality medically necessary services to Arizonans in need.

As discussed in more detail below, Arizona has concerns regarding CMS' approach to State financing of the Medicaid program as reflected in the proposed regulations. Among other comments, AHCCCS has specific concerns regarding the proposed treatment of certified public expenditures (CPEs), the "net effect" test as applied to the determination of hold harmless arrangements, the "undue burden" standard for health-care related taxes, and provisions that would limit the ability for Medicaid programs to finance the non-federal share utilizing healthcare-related taxes and provider-related donations. As currently proposed, the regulation will have significant implications for the ways in which States finance Medicaid programs and pay for Medicaid services.

Proposed Revisions Regarding Certified Public Expenditures

Most urgently, Arizona is particularly concerned about the requirement that an entity providing a CPE must retain 100% of the federal financial participation (FFP) claimed. The treatment of CPEs as proposed

in the regulation is inconsistent with Arizona's experience with CPE funding that has been accepted by CMS for years and exceeds CMS' authority under the Medicaid Act.

Proposed section 447.206(b)(4) would require that an entity providing a CPE statement in support of a State's claim for FFP must retain 100% of the FFP claimed for payments to governmental providers. At 84 FR 63745, the Secretary incorrectly concludes that a State's retention of any portion of the FFP is inconsistent with provisions of the Act and regulations that do not permit the use of federal funds to be used to match other federal funds. Application of those provisions to the State's retention of some or all of FFP claimed based on a CPE is unwarranted because the FFP received is the return of a portion of a cost that was initially funded wholly using the revenue of the State and/or its political subdivision. As such, the FFP received is a reimbursement of State or local revenue that CMS has no authority to restrict.

Simply put, CMS lacks authority under the Act to regulate the apportionment of State and local revenues among the State and its political subdivisions. This is particularly true where a State governmental provider (such as a State hospital) is also the certifying entity that uses an appropriation from the State to provide the services that are the basis for CPE. It is also true that it would be an infringement of States' rights for the Secretary to attempt to control the apportionment of state and local taxes among the state and its political subdivisions.

Arizona is also concerned about proposed section 447.206(c), which would require that "all claims for medical assistance (that are funded through a CPE) are processed through Medicaid management information systems (MMIS) in a manner that identifies the specific Medicaid services provided to specific enrollees." The proposed regulation, read literally, applies to base payments, disproportionate share hospital (DSH) payments, and supplemental payments. However, proposed section 447.286 defines "supplemental payments" as "payments [that] cannot be attributed to a particular provider claim for specific services provided to an individual beneficiary and are often made to the provider in a lump sum." It is not uncommon for DSH payments to be funded through a CPE. This could also be true of other supplemental payments, such as graduate medical education or critical access hospital payments. All of these payments share the same characteristics of supplemental payments in that they cannot be attributed to specific services provided to individual beneficiaries. As such, the State would not be able to comply with the proposed requirement that those payments be processed through the MMIS at the service and beneficiary level of detail. The final rule should reflect that the requirements of proposed section 447.206(c) do not apply to DSH or supplemental payments.

Furthermore, the State would request clarification on two related topics. The State would like to confirm its understanding that cost reconciliation payments made as part of a CPE as described in section 447.206 are adjustments to base payments and are not supplemental payments as defined in section 447.286. The State would also like to confirm its understanding that, where a claim for the services of a governmental provider is supported by a CPE, an administrative fee calculated on a per-claim or per claim line basis is not an "associated transaction" that would prohibit the State's retention of a portion of the FFP based on such an administrative fee.

Proposed Revisions to Hold Harmless Provisions & Health Care-Related Taxes

Arizona has particular concern regarding the proposed language surrounding the "net effect" test. First and foremost, CMS effectively proposes the deletion of the existing language of paragraph (f)(3) of section

433.68. This revision is explicitly prohibited by section 1903(w)(4)(C)(ii) of the Social Security Act and cannot be adopted as part of any final regulation.

The proposed definition in section 433.52 of "net effect" as applied to the "hold harmless" requirement for health care-related taxes in proposed 433.68(f)(3) conflicts with section 1903(w)(4) of the Act. That section of the Act states that a valid health care-related tax does not exist if 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" (emphasis added). However, the proposed definition in section 433.52 as applied in section 433.68(f)(3) equates a "reasonable expectation" of the return of any portion of the tax with the statutory requirement that the State or local unit of government "guarantee" the return of the tax. This is inconsistent with the commonly understood meaning of a guarantee.

Furthermore, based on the language of section 1903(w)(4)(C)(i) of the Act, labelling the "reasonable expectation" standard in proposed 433.68(f)(3) as a type of "direct guarantee" is inconsistent with the commonly understood meaning of both "direct" and "guarantee." To the extent the existence of a reasonable expectation of a return of the tax might be characterized as an indirect tax, section 1902b(w)(4)(C)(ii) of the Act explicitly prohibits the Secretary from deviating from or adding to the regulatory definition of an indirect guarantee as set forth in the current version of the regulatory provision. As such, "net effect" as defined in section 433.52 and as applied in section 433.68(f)(3) is inconsistent with the Medicaid Act and should not be adopted as part of a final regulation.

In addition, proposed 433.68(f)(3) would find a direct guarantee 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" (emphasis added). Stated this generally, any health care-related tax that in any way benefits the taxpayer would constitute a direct guarantee. For example, a tax on inpatient hospital revenues that is used to cover the cost of all covered services to an expanded Medicaid population would, under this language, be a direct guarantee because hospitals would reasonably expect reduced uncompensated inpatient costs as a result of the eligibility expansion. For this additional reason, section 433.68(f)(3) should not be adopted as part of a final regulation.

Arizona has more broad concerns regarding how the proposed language impacts health care-related taxes and the process for establishing compliance. For example, proposed section 433.72(d) regarding States' obligation to ensure ongoing compliance of health care-related taxes does not address the impact of a period of noncompliance and whether States will be afforded any type of grace period. Many factors that could impact continued compliance with the statistical tests are beyond the control of the State Medicaid agency. Given the nature of the legislative process, it could be a year or more before the State legislature could amend a health care-related tax to come back into compliance with the proposed regulations. Similarly, the rule should provide for longer approval processes and a defined grace period for supplemental payments. The sudden prohibition of a previously approved health care-related tax would likely have adverse impacts on access to care and compliance with section 1902(a)(30)(A) of the Act.

Proposed Addition of an "Undue Burden" Test

The application of an "undue burden" standard as articulated in section 433.68(e)(3) is inconsistent with health care-related taxes that have been submitted to and approved by CMS for many years. The proposed provision deviates from prior CMS practice of acceptance of documentation of compliance with

statistical requirements as sufficient to establish that a health care-related tax is generally redistributive or qualifies for a waiver from uniformity. Subsection (e)(3)(iv) establishes a "totality of the circumstances" test for undue burden that would permit CMS to exercise broad discretion to prohibit health care-related taxes even if the tax complies with current regulations or subparagraphs (i) through (iii) of the proposed subsection. Vesting CMS with that type of discretion substantially impairs the ability of State legislatures to plan and execute their authority to raise revenues. It is impractical to assume that legislatures can predict during a legislative session what types of taxes would pass muster with CMS under the undue burden standard.

Proposed Provision Regarding Sources of State Financial Participation

While not technically listed as a definition, Arizona also takes exception to proposed amendment to section 433.51(b) regarding the sources of the State financial participation. The proposed amendment would unnecessarily limit the sources of the non-federal share to state or local taxes, and, for purposes of this particular regulation, should not be amended. Section 1902(a)(2) sets the requirement for "financial participation" but does not limit the sources of those limitations to state and local taxes. The Secretary's reliance in the NPRM on section 1903(w) is misplaced (see 84 FR at 63722). That section of the Act places limitations on the use of provider donations and health care-related taxes as sources of the non-federal share, but does not purport to exclude the use of state and local sources other than taxes or certain donations. For example, the proposed rule would not allow other governmental payment sources, such as funds raised through a governmental provider delivering services not funded by Medicaid, the issuance of bonds, tuition collected by State universities, or income from leases of governmental property. Nothing in sections 1902(a)(2) or 1903(w) imposes a general restriction on the use of those revenues as sources of the non-federal share.

Proposed Provisions Regarding Reporting Requirements

The reporting requirements detailed in the proposed amendment to Part 447 Subpart D will require unprecedented system programming changes to include new data fields for the state plan number or waiver demonstration number to be assigned to individual payments, as well as new provider categories (state government, non-state government or private) to be reported on at the individual payment level. Arizona believes the analysis of costs in the NPRM significantly underestimates the cost to the States to modify systems, educate providers on new coding requirements, and comply with ongoing reporting efforts. In Arizona's experience, the completion of monitoring plans and evaluations associated with waiver programs has required significant administrative resources and effort, including staffing and consultant costs. Therefore, to the extent that monitoring plans and evaluations would be required for all supplemental payments, including DSH and GME, the State would anticipate a significant increase in the administrative burden to states to continue to operate those existing programs.

Proposed section 447.290(b) unfairly deprives States from being able to fully understand the consequences of a failure to timely report required information regarding supplemental payments. That subsection provides that CMS will, through the deferral process, reduce future grant awards "by the amount of Federal financial participation (FFP) CMS estimates is attributable to payments made to the provider or providers as to which the State has not reported properly." This provision should be stricken or revised such that there is a discernible standard for the deferral and such that it does not vest CMS with arbitrary authority to reduce FFP.

Proposed Provisions Regarding Managed Care and Limits to Supplemental Payments

Proposed section 447.406(a) provides that practitioner supplemental payments "are supplemental payments as defined in § 447.286 that are *authorized under the State plan* for practitioner services and targeted to specific practitioners *under the methodology specified in the State plan*" (emphasis added). Proposed section 447.252(d) states that CMS has approval authority over supplemental payments, as defined in proposed section 447.286. Arizona is seeking clarification from CMS that the proposed limit on practitioner supplemental payments section 447.406 are not applicable to managed care directed payments approved by CMS under section 438.6(c) since these payments to providers are made by managed care entities under the terms of the managed care contracts. Specifically, Arizona is requesting clarification that, since the managed care directed payments are not "supplemental payments" as that term is used in section 447.406, the section 438.6(c) arrangements are not subject to the approval or reporting requirements of proposed sections 447.252 and 447.288.

If it is CMS' position that managed care directed payments are supplemental payments as defined in the proposed rule, the proposed limit on practitioner supplemental payments to a percentage of the base rates appears to be inconsistent with the stated goals of CMS in the November 14, 2018 Federal Register (83 FR 47264) to "encourage states to continue developing payment models that produce optimal results for their local markets," including using "average commercial rate reimbursement," and to provide corresponding regulatory flexibility. This proposed overall limit to practitioner supplemental payments of either 50% or 75% of base rates is concerning in several respects.

First, CMS justifies the 50%/75% limit based on information that nationally, among providers receiving average commercial rate (ACR) supplemental payments, those payments averaged 75% of base payment rates in 2016 and 93% in 2017, stating that the new proposed limits "would not diverge excessively" from payments that have been previously approved. On its face, a limit of 50%/75% is a material divergence from the 2017 average of 93%, and some states and providers would be more significantly impacted than others if they are above the average. No additional supporting data or analysis is provided to support the 50%/75% limit, which therefore appears to be arbitrary.

Second, the proposed limit of 50%/75% is not consistent with either national or state-specific ACR data that Arizona has reviewed. A recent ACR analysis produced for one of AHCCCS' payment programs, the Access to Professional Services Initiative (APSI), demonstrated that participating providers in Arizona calculated a weighted average ACR of 188%, which is the basis for the state's implemented average. National data that was summarized as part of that analysis identified that among 34 provider ACRs, the range was 153% to 472%, with a mean of 293% and a median of 275%. Among states with programs similar to Arizona's, the average ACR ranged from 201% to 346%.

Third, implementing such an indiscriminate and arbitrary national standard is not a data driven approach that would effectively account for regional and local variations in both ACR rates and base Medicaid reimbursement rates in the manner needed to truly assess the efficiency and economy of overall Medicaid reimbursement in a localized context as required by section 1902(a)(30)(A) of the Act. As noted by CMS, Medicaid base payment rates for practitioners may vary widely from state to state, both as a result of local economic factors as well as due to reimbursement rate setting methodologies. Similarly, payment rates for different types of practitioners may vary widely even within a given state, such as rates for dental providers in comparison to anesthesiology providers. The proposed limit on all practitioner

payments does not attempt to account for these known complexities and the implementation of a single standard would likely result in unintended and inequitable outcomes for states and providers.

Arizona supports transparency and accountability in reimbursement rates and agrees with CMS that states should not be permitted to manipulate the ACR data or analysis used to support increased practitioner reimbursement, such as by comparing facility to non-facility rates in order to overstate the variance between Medicaid and ACR reimbursement rates. However, implementing a proposed flat percentage limit is not the most appropriate way to achieve this objective. Arizona and other states have already addressed these concerns by implementing specific ACR methodologies that require appropriate accounting for facility, non-facility, and modifier factors. Instead of implementing the proposed rule, CMS should instead define the specific technical parameters that states must meet in preparing ACR computations in order to ensure consistency and transparency in those calculations. This approach would ensure that ACR payments are based on sound technical computations and valid data, which address the complicated reality of provider reimbursement as it exists in different states.

Other Proposed Regulations

Arizona does not see issues with the proposed timelines related to recoupment and redistribution of DSH overpayments described in section 433.316. Regarding DSH audits with qualified findings resulting from incomplete or missing data, for those cases in which providers have not submitted the required information for the DSH audit, Arizona has recouped the DSH payments made to those providers. However, the addition of a requirement for the independent audit to quantify the financial impact of any finding, including those resulting from incomplete or missing data, would be a material addition to the scope of work of the auditors and is anticipated to result in a significant increase in administrative costs to the state. Given that CMS has identified that for 2010 DSH audits submitted by states, 228 of 2,953, or only 7.7%, had data reliability or documentation issues, it does not seem reasonable to add this additional administrative burden to all states.

Arizona supports streamlining certain administrative functions as proposed in section 430.42, primarily by relying on electronic communication in the disallowance process and using MBES/CBES and Medicaid.gov to publish annual DSH and CHIP allotments, but notes that it is extremely important that there is no ambiguity between CMS and the State regarding the officials who are authorized to send and receive the electronic communications. Arizona would suggest that, even if the electronic communication is deemed the official communication, that the communication should also be provided by regular mail.

Proposed section 447.201(c) purports to prohibit variation in fee-for-service rates based on, among other things, the federal medical assistance percentage (FMAP) available for the services. As drafted, that section would prohibit variation in FFS payment rates based on the "FMAP rate available for services provided to an individual in the beneficiary's eligibility category." Based on the language of the preamble (84 FR 63779) it appears that the Secretary's intention is to prohibit variation based on the FMAP associated with a particular eligibility category; however, the proposed language could be interpreted to preclude variations based on the FMAP for a particular service. For example, payments to an Indian Health Service (IHS) and 638 facilities are claimable at 100% FMAP, while payments to other facilities are claimed at a lesser FMAP. As drafted, the proposed regulatory provision could be understood to prohibit States from making payments to IHS and tribally owned or operated facilities at the all-inclusive rates for inpatient and outpatient services, if other facilities are paid on a different basis. That differentiation in payments is common among States, and it has been the long-standing position of the Department of Health & Human Services that payment to those facilities at the published all-inclusive rate is appropriate

for both the Medicare and Medicaid programs. See, for example, the summary statement associated with the notice provided at 84 FR 2241 (Feb. 6, 2019). The State believes, based on the language in the preamble, that it is not the Secretary's intention to prohibit variation in rates based on variations in the FMAP available for services, and would ask that the language be clarified.

Proposed section 447.207(a) would require that the provider retain 100% of total computable payment and that compliance with this requirement will be determined by the Secretary after taking into consideration "associated transactions" including "payment of an administrative fee to the State for processing provider payments or, in the case of a non-State government provider, for processing intergovernmental transfers." Under Arizona's Medicaid School Based Claiming (MSBC) Program, AHCCCS charges and maintains a 1.5% administrative fee on net new federal funds generated to each local educational agency (LEA). CMS is proposing to eliminate the State's flexibility to structure administrative fees based on the amount a provider receives through Medicaid payments. As an alternative, Arizona assumes that, under the proposed regulation, a flat amount charged to each LEA could be an acceptable methodology. However, this may disproportionately harm smaller providers or in this case LEAs, as the amount of administrative fee charged may exceed the net new federal funds to be received through the CPE or settlement process. As such, further analysis must be conducted to determine the best methodology for structuring administrative fees in the future.

Thank you for the opportunity to provide comment on the proposed regulation. Should you have any questions or need additional information, do not hesitate to contact me.

Sincerely,

Jami Snyder
Director