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January 28, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Secretary Azar:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722 (November 18, 2019).

The proposed rule includes multiple changes to federal oversight of Medicaid fee-for-service (FFS) payment and financing policies. In addition to codifying existing policy, the proposed rule adds new requirements to increase transparency of supplemental payments and phases out use of payment and financing arrangements that CMS views as inconsistent with federal Medicaid payment principles.

The Commission strongly supports efforts to improve the transparency of supplemental payments and promote Medicaid fiscal integrity, which have been the focus of prior Commission discussions and recommendations. Since 2014, the Commission has recommended that CMS collect and report provider-level data on supplemental payments. These recommendations were based on the Commission's assessment that current data—which are needed to inform analyses of whether payments are consistent with statutory principles of efficiency, economy, access, and equality—are unreliable and incomplete. In addition, in March 2019, the Commission recommended that CMS establish better process controls to improve the data used to monitor compliance with upper payment limit (UPL) requirements (MACPAC 2019a, 2016, 2014).

However, the Commission urges CMS not to implement new limits for supplemental payments and financing arrangements at this time because CMS has not fully assessed the effects of these changes. In particular, the



Commission is concerned that the proposed changes could reduce payments to providers in ways that could jeopardize access to care for Medicaid enrollees. Before proposing to substantially change payment and financing policies, CMS should collect and rigorously examine data on the potential effects of such changes on beneficiary access. A careful review of the access implications of new federal policies is especially important given CMS's previous proposal to rescind the requirement that states evaluate access before reducing or restructuring provider payments (CMS 2019).

The Commission discussed the notice of proposed rulemaking at our December 12, 2019 public meeting and noted several areas for comment (MACPAC 2019b). Below, we offer comments in four areas:

- concern about the potential effects of the rule on access to care for Medicaid enrollees;
- support for provisions that address MACPAC's prior recommendations;
- general comments about the level of administrative burden for states and the federal government; and,
- technical comments in response to issues that CMS raised on topics that MACPAC has previously examined.

Concern about the potential effects of the rule on access to care

The rule proposes several new limits on Medicaid payment and financing policy that go beyond CMS's current rules. To the extent that these limits reduce Medicaid payments to providers, they may affect providers' willingness to accept new or continue treating existing Medicaid patients. However, without provider-level data on supplemental payments, it is difficult to assess which providers and enrollees would be most affected.

The Commission urges CMS to not implement these new limits at this time because the agency has not fully assessed the effects of these changes. Although the Commission recognizes the importance of properly enforcing payment and financing policies in order to promote Medicaid fiscal accountability, CMS should first collect and analyze data on the potential effects of any new limits before they are proposed. It is particularly important for CMS to evaluate the potential access implications of these policies given CMS's previous proposal to rescind state access monitoring requirements (CMS 2019).

New limit on supplemental payments to physicians and other practitioners. CMS estimates that the new limits on supplemental payments to physicians and other practitioners could reduce payments to these providers by up to \$222 million a year, affecting 22 percent of all FFS payments to providers receiving supplemental payments. Although it is possible for states to minimize the effects of this limit by increasing base payments to providers, it is unlikely that all states will do so.¹ The proposed limit only applies to FFS payments, but it will likely affect many states with managed care delivery systems that currently make large FFS supplemental payments to physicians and other practitioners.

Provider-level data are not available to assess how this new limit would affect particular providers. Based on MACPAC's review of FFS physician payment policies, 27 states made supplemental payments to physicians, most of which are targeted to academic medical centers affiliated with state universities



(MACPAC 2017a). In FY 2018, total spending on supplemental payments to physicians and other practitioners totaled \$1.3 billion (12.6 percent of total FFS spending on these services), but spending varied widely by state, from less than 5 percent of FFS spending in five states (Colorado, Kansas, Massachusetts, Nevada, and West Virginia) to more than 40 percent of FFS spending in three states (Florida, Iowa, and Michigan) (MACPAC 2019c). However, we do not know which states make supplemental payments in excess of the new limits proposed, and we do not know how the proposed reduction in supplemental payments compares to the total amount of other Medicaid payments that these providers receive.

Although current regulations require states to monitor access to specialists as part of their access monitoring plans and consider the effects of payment reductions on access to care before these take effect (42 CFR § 447.203(b)), the proposed rule provides no analysis on how the anticipated payment reductions may affect access to specialty care. In particular, it is important to consider the needs of Medicaid enrollees with complex medical conditions who often rely on academic medical centers for specialty care that may not be available from other providers. Specialty care physicians are less likely to accept new Medicaid patients than those of other payers, and research by MACPAC and others has shown that payment rates affect providers' willingness to accept new Medicaid patients (Holgash and Heberlein 2019, MACPAC 2015 and 2013).

Other limits on supplemental payments and financing mechanisms. The rule also proposes a number of other limits on supplemental payments and permissible Medicaid financing mechanisms but does not quantify the effect of these provisions. Some of these provisions are described as enforcing existing CMS policy, but they could be interpreted in ways that eliminate states' ability to continue payment and financing arrangements that CMS has previously approved.

In order to assess these new limits, CMS should first clarify how new limits will be enforced and how they compare to existing rules. For example, CMS proposes to evaluate supplemental payments based on the extent that payments advance the statutory goals of efficiency, economy, quality, and access, but does not specify the criteria it will use to make this assessment. While the Commission strongly supports efforts to tie Medicaid payments to value, more clarity about CMS's review criteria would provide more certainty about how to comply for states and for providers that currently rely on supplemental payments as an important source of revenue.

In addition, CMS should estimate the extent to which limits on a state's ability to finance Medicaid payments may result in reductions in Medicaid payments to providers. In the preamble of the proposed rule, CMS discusses several examples of payment arrangements that do not comply with the new proposed rules, but CMS does not assume that any of the proposed changes will result in a quantifiable reduction in Medicaid provider payments. Although it is difficult to estimate how financing changes may affect state spending, analyses by MACPAC and others have found that it is unlikely that states would be able to replace non-state sources of funding with state general revenue in order to continue making the same level of provider payments (MACPAC 2017b). For example, the Congressional Budget Office



estimates if the safe harbor for health care-related taxes were reduced, only about 50 percent of payments financed by these taxes would be replaced with other sources (CBO 2018).

Most importantly, CMS should consider how the potential reductions in Medicaid payments from these proposed limits may affect access to care for Medicaid enrollees and make its analyses available to stakeholders for comment during the rulemaking process. Although the Commission supports efforts to ensure that Medicaid payments are consistent with the statutory goals of efficiency and economy, CMS has an equal responsibility to ensure that payments are consistent with the statutory goals of access and quality.

Support for provisions that address prior MACPAC recommendations

The Commission supports provisions of the proposed rule that take steps to address MACPAC's prior recommendations regarding provider-level data on supplemental payments and improved oversight of UPL requirements. Below, we describe additional changes that CMS could make to fully implement these recommendations.

Provider-level reporting of supplemental payment data. The proposed requirements for states to report provider-level data on supplemental payments and how they are financed takes steps to address MACPAC's prior recommendations about improving the transparency of these payments (MACPAC 2016 and 2014). In fiscal year (FY) 2018, states made over \$56 billion in supplemental payments (10 percent of total Medicaid benefit spending), but provider-level data on these payments are not available (MACPAC 2019c). Moreover, because supplemental payments are often financed by providers that receive them, data on the source of non-federal share are important to understand net payments that providers receive. Complete data on net Medicaid payments for all providers are important for accurate analyses of whether supplemental payments are consistent with federal payment principles.

One limitation of the proposed rule is that it would only collect FFS payment data for providers that receive supplemental payments. In the Commission's view, it would be more useful to collect data on all types of Medicaid payments to all providers that receive them. For example, rather than only collecting data on payments to providers who receive supplemental payments, collecting data on FFS payments to all providers would help CMS monitor compliance with UPL requirements overall. Collecting data on managed care payments as well as FFS payments would be helpful to understand the full amount of Medicaid payments that providers receive. The Commission has previously commented about the importance of collecting provider-level data on managed care directed payments, which allow states to make additional payments to providers using similar mechanisms as FFS supplemental payments (MACPAC 2019d).

Similarly, the rule proposes to collect data on how supplemental payments are financed but does not propose to collect data on how base payments are financed. This omission would affect our ability to use these data to understand net payments to providers.



Finally, the rule only proposes to collect information about supplemental payments for providers subject to UPL requirements, and it does not propose to collect provider-level data about payments to physicians or other practitioners.² As discussed above, this information would be helpful in assessing the effects of the proposed limits on physician supplemental payments.

UPL oversight. The proposed rule codifies CMS processes for monitoring compliance with UPL requirements by requiring states to submit information annually about how total FFS spending for a class of providers compares to the UPL. Compared to current regulations that only describe CMS’s ability to review the UPL when states make changes to their payment methods, codifying an annual review process would allow CMS to more regularly monitor compliance with the UPL based on more current data.

It is important that the data used to monitor compliance with the UPL are accurate and complete. However, the rule continues CMS policy allowing states to demonstrate compliance with the UPL based on projected Medicaid spending, which may differ from actual spending. In MACPAC’s review of state fiscal year (SFY) 2016 hospital UPL demonstrations, actual FFS spending reported on CMS-64 expenditure reports was \$10.6 billion higher than spending projected on state UPL demonstrations for the same time period. In 17 states, the actual amount of UPL payments made appeared to exceed the limit calculated on state UPL demonstrations by \$2.2 billion in the aggregate (MACPAC 2019a). These discrepancies are so large and widespread that they suggest an underlying problem with the existing process.

To strengthen enforcement, MACPAC has recommended that CMS establish process controls to ensure that the limits calculated based on UPL demonstrations are used in the review of claimed expenditures. Although such process controls could be implemented through subregulatory guidance, it is important that the regulations provide CMS with the information it needs to enforce UPL rules. For example, the data that CMS proposes to collect on actual UPL payments to providers could be used to ensure that actual spending does not exceed the UPL, but to do so, CMS would need to ensure that the new supplemental payment reporting is comparable with the information provided in state UPL demonstrations.

Public availability of data. MACPAC has recommended that both provider-level payment and UPL demonstration data be made publicly available in a format that enables analysis, a feature absent in the proposed rule. Public availability of Medicaid payment data would help promote transparency and inform analyses of Medicaid payment policy. Although CMS has made some UPL demonstration data available to MACPAC, making these data public would allow other stakeholders to analyze these data as well.

Administrative burden for states and the federal government

While the Commission recognizes the added value of the proposed reporting requirements, the estimates of administrative burden in the proposed rule may be understated. For example, CMS estimates that states will need an additional 30 minutes per state plan amendment to provide information about how UPL payments relate to the statutory goals of efficiency, economy, quality, and access. The rule provides no estimates of the additional time and resources needed to meet the new monitoring and evaluation requirements. Administrative burden has been an area of focus by CMS in the past and it seems



appropriate that the same level of concern regarding administrative burden should be afforded to this proposed rule as well.

Technical comments

In the proposed rule, CMS requested comments on various technical issues that the Commission has previously examined. The Commission's technical comments on these issues are described below.

Definition of base and supplemental payments. The proposed definition of base and supplemental payments largely aligns with the definitions that MACPAC has used in its prior work, but it is not clear how graduate medical education (GME) and supplemental payments made under Section 1115 research and demonstration waivers would be defined.

On current CMS-64 expenditure reports, GME payments are reported on a separate line from other types of supplemental payments to providers. Some GME payments are made under FFS and are subject to UPL requirements, but others are made for services provided in managed care, similar to directed payments. Clarification of how these payments should be reported on the CMS-64 and the new supplemental payment report described in this proposed rule would help ensure consistency between these different sources of data.

Supplemental payments authorized under Section 1115 of the Social Security Act are not reported consistently on CMS-64 expenditure reports. In FY 2018, states made \$14.3 billion in Section 1115 supplemental payments to hospitals in FY 2018, including uncompensated care pools and delivery system reform incentive payment programs (MACPAC 2019c). However, many of these payments are not categorized as hospital payments on CMS-64 expenditure reports even though they are primarily made to hospitals.³ Because Section 1115 supplemental payments are such a large component of hospital spending in some states, it is important that data on these payments be captured and categorized correctly in the proposed supplemental payment reporting system.

Alignment of proposed reporting requirements with existing reporting systems. There are several opportunities for CMS to align the proposed supplemental payment and financing requirements with CMS-64 expenditure reports, the Transformed Medicaid Statistical Information System (T-MSIS), and other federal data sources. Doing so would help improve the reliability of data in these sources and the ability to use these data to inform broader analyses of Medicaid payment policy.

In addition to aligning definitions with the CMS-64 expenditure report as discussed above, CMS could align the proposed reporting requirements for the source of non-federal share with the existing Form CMS 64.11A, which collects information about taxes, fees, assessments, and donations used to finance Medicaid expenditures. In our review, we have found Form 64.11A data to be largely incomplete and not useful for payment analyses because data are not reported separately by type for each type of service.⁴ If the accuracy and completeness of Form CMS-64.11A were improved and these data were more clearly



linked to particular payments, then CMS could use these data to help validate the provider-level financing data submitted under the proposed reporting requirements.

The Commission agrees with CMS's assessment that T-MSIS does not currently provide reliable data on Medicaid supplemental payments, but we encourage CMS to continue its efforts to improve the quality of T-MSIS data. It could be helpful to provide states with more guidance about how supplemental payments should be reported in each data source and to compare T-MSIS data with the new supplemental payment data collected under the proposed reporting requirements.

As part of the proposed provider-level reporting requirements, it would also be helpful to have states identify providers using CMS certification numbers (CCNs), which are used to identify providers on Medicare cost reports. CMS currently requires states to submit CCNs for disproportionate share hospitals (DSH) on annual DSH audits; this information has enabled MACPAC to link DSH audit data with Medicare cost reports in order to better understand how DSH hospitals compare to other types of hospitals.

UPL calculation methods. Because the UPL is intended to ensure that Medicaid payments do not exceed a reasonable estimate of what would have been paid according to Medicare payment principles, CMS should consider how the UPL compares to the amount that Medicare would have paid for the same service. In several cases, CMS appears to allow UPL calculation methods that differ from current Medicare payment principles.

In particular, the proposed cost-based method of calculating the UPL would likely result in a limit on hospital payments that is higher than what Medicare would have paid. Medicare stopped using a cost-based payment method for most hospitals in 1983; in 2016, Medicare payments to hospitals were 90.4 percent of costs in the aggregate (MedPAC 2018). Moreover, if states use the cost-based method of calculating the UPL, CMS proposes to allow states to add hospital costs of health care-related taxes thereby increasing the total amount of Medicaid payments that hospitals can receive.

Acuity-adjusted price-based demonstrations of the hospital UPL using diagnosis-related groups (DRGs) most closely resemble how Medicare currently pay hospitals, but this method is not explicitly described in the proposed rule. Based on MACPAC's review of SFY 2016 UPL demonstrations, 20 states used DRG-based methods for calculating the UPL, so it is important to continue to allow states to use this method (MACPAC 2019a).

It is also important for CMS to consider the potential effects of Medicare payment changes on UPL calculations. For example, Medicare recently adopted a new payment method for skilled nursing facility services and no longer uses the resource utilization group (RUG) case-mix methodology. However, according to MACPAC's review of SFY 2016 nursing facility UPL demonstrations, 33 states used a RUG-based method for calculating the UPL (MACPAC 2019e). It is unclear whether these states will need to change their method for calculating the nursing facility UPL and when they will need to do so.



Recouping DSH overpayments. The Commission supports CMS's proposed process to expedite the recoupment of DSH overpayments since it will help ensure that DSH payments do not exceed the hospital-specific limit. According to MACPAC's review of SFY 2014 DSH audits, 419 DSH hospitals received \$2.6 billion in DSH overpayments (14 percent of DSH hospitals and of total DSH payments).

To better understand final DSH payments to providers, it would be helpful if CMS required states to update DSH audit reports after any recoupments are made, to reflect final DSH payment amounts to each provider. Based on MACPAC's review of state DSH targeting policies, it appears that many states have provisions to redistribute DSH funds from hospitals that received DSH payments above their hospital-specific limit to hospitals that received DSH payments below their hospital-specific limit. However, these redistribution payments are not reported on DSH audits and the audits are not updated to account for these changes, limiting our ability to understand the full amount of payments that providers receive.

Posting allotments online. CMS's proposal to remove the requirement for CMS to publish DSH and CHIP allotments in the *Federal Register* also removed the requirement that these data be published by April 1 of each year. However, it is important to maintain a target date for posting allotment data online in order to ensure timely availability of these data for states and stakeholders. Since most state fiscal years begin July 1, providing data by April 1 provides time for states to incorporate allotment amounts into their state budgets.

Value-based supplemental payments. The proposed limit on physician supplemental payments includes an exception for value-based payments that are attributed to a particular service and are available to all providers in the state. However, it is unclear whether many existing value-based payments to physicians meet these criteria, making it even more difficult to assess the potential effects of this limit on providers. According to MACPAC's review of FFS physician payment policies, 33 states made some type of quality-based incentive payment to physicians (MACPAC 2017a). However, some of these payments are targeted to particular geographic areas or exclude certain types of providers so they cannot be described as being made available to all providers in the state. More clarity about the proposed exception for value-based supplemental payments is needed to assess the potential effects of this policy.

Sincerely,



Melanie Bella, MBA
Chair

cc: The Honorable Chuck Grassley, Chairman, Committee on Finance, U.S. Senate
The Honorable Ron Wyden, Ranking Member, Committee on Finance, U.S. Senate

The Honorable Frank Pallone Jr., Chairman, Committee on Energy and Commerce, U.S. House of Representatives

The Honorable Greg Walden, Ranking Member, Committee on Energy and Commerce, U.S. House of Representatives

The Honorable Anna Eshoo, Chairwoman, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives

The Honorable Michael Burgess, Ranking Member, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives

Notes

¹ In interviews with state officials on the factors affecting development of Medicaid payment policies, MACPAC found that switching payments from supplemental payments to base payments takes time and may affect states' ability to target payments to particular types of providers (Marks et al. 2018).

² Specifically, Section 447.284(b) of the proposed rule appears to limit the reporting requirements to supplemental payments for which a UPL applies (42 CFR § 447.272 and § 447.321). Physician and other practitioner payments are not subject to the UPL and the new limit proposed for physician and other practitioner supplemental payments is described in a separate section that is not cross-referenced in the new reporting requirements (42 CFR § 447.406).

³ Because Section 1115 supplemental payments to hospitals are not always categorized as hospital payments, they also are not always reported on audits of disproportionate share hospital (DSH) payments.

⁴ For example, five states that reported health care-related taxes in SFY 2018 on the Kaiser Family Foundation annual survey did not report any health care-related taxes on Form 64.11A (Gifford et al. 2019). For states that did report data, the amount of health care-related taxes appears to be underreported. In SFY 2012, states reported receiving \$18.7 billion in health care-related taxes on a survey conducted by the U.S. Government Accountability Office, but only reported \$14.2 billion in taxes on Form CMS 64.11A (GAO 2014). Current regulations require states to present a complete and accurate disclosure of donation and tax programs and authorize CMS to withhold federal funding for non-compliance, but we are not aware of circumstances in which CMS has enforced this requirement (42 CFR § 433.74).

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