UAB HEALTH SYSTEM
EXECUTIVE OFFICES

Submitted electronically via www.regulations.gov

January 30, 2020

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Administrator Verma:

The University of Alabama at Birmingham (UAB) Health System welcomes this opportunity to comment on the proposed Medicaid Fiscal Accountability Rule (MFAR). The UAB Health System is one of two academic health centers in Alabama and is the backbone of critical safety net services, providing specialized services to residents of the entire State. Part of our mission is to use our resources efficiently to provide cutting-edge and routine life saving compassionate care to Alabama's patients, regardless of income or insurance status. As one of the premier medical facilities in the State and region, UAB Health System delivers a high level of complex care and provides a disproportionate share of the Medicaid services and uncompensated care.

UAB Health System has serious concerns with the impact of the proposed MFAR on state Medicaid programs and their beneficiaries. The proposed MFAR goes far beyond a transparency and accountability initiative. As discussed in detail below, the proposed rule will undermine state Medicaid programs by prohibiting states from using traditional funding sources, limiting supplemental payments, imposing vague standards for compliance, and restricting how hospitals can use their reimbursement. If finalized, the proposed rule will reduce funding for state Medicaid programs, which will reduce access to quality care for Medicaid beneficiaries. Consequently, UAB Health System asks CMS to withdraw MFAR in its entirety.

The proposed restrictions on funding sources for the nonfederal share will likely reduce Alabama's already low reimbursement, which will negatively impact Medicaid beneficiaries' access to quality health care, and negatively impact graduate medical education.

Under longstanding CMS regulations, states have been permitted to rely on the use of "public funds" from "public agencies" as the state's share in claiming federal financial participation for Medicaid expenditures.[1] Congress has permitted the use of such "local sources" of funds since the inception of the program, provided the state itself funds a portion of the state share.[2] The tradition of allowing the use of local public funds as the state share finds its roots in the origins of Medicaid itself, as Congress intended in 1965 for the new program to draw on then-existing indigent care funding sources through local

[1] 42 C.F.R. § 433.51 (2010).
[2] Social Security Act (SSA) § 1902(a)(2).

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governments and public hospitals and clinics.[3] The public funds regulation, as it has existed for decades, reflects these roots.

Consequently, states like Alabama have come to rely on the use of intergovernmental transfers (IGTs) to fund their Medicaid programs. Because of limited resources within our state, Alabama hospitals have stepped forward to bear the cost of funding the state share for the Medicaid hospital program. Of the state share dollars provided by the hospitals, the majority of these dollars are provided through IGTs.

The proposed rule would restrict the source of funds for both IGTs to those "derived from State or local taxes (or funds appropriated to State university teaching hospitals)." CMS does not further define funds "derived from State or local taxes," but presumably the rule intends to exclude public funds derived from other traditional sources, such as the earned nontax revenues of a public agency, including public hospital patient care revenues.

In addition, the proposed MFAR restricts the types of local governmental entities that can provide the non-federal share. First, the proposed rule would change the regulatory language that allows "public agencies" to provide IGTs so that only "units of government" would be able to do so. CMS does not further define a "unit of government" (although the statutory definition of a unit of local government appears to allow broad leeway for states to determine whether a particular governmental entity is a unit of local government).[4] More intrusively, however, CMS proposes new definitions of a "non–state government provider" and a "state government provider"—purportedly for purposes of determining UPLs on provider reimbursement.[5] However, in the preamble, CMS makes clear it intends to use these definitions to regulate IGTs as well. Only those providers that meet one of the new governmental provider definitions will be permitted to participate in funding the nonfederal share.

The loss of these funding options will reduce Medicaid beneficiaries access to quality health care services—especially in rural areas of the state where lack of access is already an issue. Because the overwhelming majority of the Alabama hospitals currently pledging IGTs would likely be unable to do so under the proposed rule and because Alabama could face challenges in raising sufficient state and local tax revenue to replace this funding, Alabama's Medicaid program would likely be forced to reduce its already low reimbursement.

These additional decreases in state Medicaid dollars will further limit Medicaid beneficiaries access to care. With regard to hospitals, almost 90 percent of Alabama's rural hospitals are operating at a loss, and since 2011, 13 Alabama hospitals have closed. Further reductions could result in more closures, and those hospitals that remain open could be forced to reduce their services.

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[3] MACPAC. Issue Brief: The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending. July 2017. https://www.macpac.gov/wp-content/uploads/2017/07/The-Impact-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf. Accessed January 3, 2020.

[4] SSA § 1903(w)(7) defines a unit of local government as "a city, county, special purpose district, or *other governmental unit in the State*" (emphasis added).

[5] The proposed definitions would be incorporated into 42 C.F.R. § 447.286, which by its terms contains definitions "For purposes of this subpart" (which is Subpart D-Payment for Services). The IGT regulations are contained in Part 433, Subpart B-General Administrative Requirements for State Financial Participation.

In addition, Medicaid reimbursement for primary care physicians and medical professionals is directly correlated with access to primary health care services.[6] Of Alabama's 67 counties, 63 counties are currently designated as a primary care health provider shortage area, and every county contains a medically underserved area or population.[7] To the extent Alabama is forced to fund other aspects of its Medicaid program by reducing physician reimbursement or is unable to support physician reimbursement through the use of IGTs, access to primary care services will be further reduced.

Lastly, graduate medical education programs could be negatively impacted. UAB Health System currently trains approximately 1,000 residents to help meet the Alabama's health care needs. However, 150 of these resident slots are above the 1996 cap and, therefore, unfunded. In total, UAB invests $69,000,000 annually in excess of reimbursement for direct and indirect costs for training residents. At a time of physician shortages, it is untenable to put at risk money that states have decided should be made available to teaching hospitals and physicians. To have these funding sources put in jeopardy will be a blow to the health of the communities the hospitals serve and to the physicians whose training is supported by this funding.

The proposed policy change is purportedly intended to align the regulatory text with the statutory language used in the Social Security Act under section 1903(w)(6)(A), a provision adopted as part of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.[8] But CMS misreads the language and intent of this provision. The provision restricts HHS' authority to narrow the scope of IGTs; it does not impose a limit on permissible IGTs as CMS now appears to assume in the proposed rule. The current public funds regulation has remained in place, unamended, both before and since the enactment of section 1903(w)(6)(A), and states have continued to use these traditional nontax sources of local public funding without objection throughout that period. This confirms Congress did not intend section 1903(w)(6)(A) to enable CMS to narrow the types of allowable public funding sources.

Rather, the MFAR represents an optional policy choice by the agency to restrict states' use of these historical funding sources. CMS does not explain how or why IGTs derived from patient care revenues earned by a public hospital represent more of a threat to the fiscal integrity of the program than those derived from a local taxpayer-funded subsidy provided to a public hospital. The reality is public hospitals, as well as state university teaching hospitals, are much less reliant on taxpayer support than they once were, having worked hard to adopt efficiencies and attract more insured patients to reduce reliance on taxpayer funding.

CMS' prohibition on the use of local public funding sources as the state share of Medicaid will hamstring states' ability to adequately fund their Medicaid programs. This will force states into the untenable position of having to choose between drastic cuts to the program (with associated impacts on access to

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[6] *See, e.g.*, Diane Alexander and Molly Schnell, *Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health* (Federal Reserve Bank of Chicago, Working Paper No. 2017-10).

[7] HRSA Map Tool, *available at* https://data.hrsa.gov/maps/map-tool/ (last accessed January 28, 2020).

[8] Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. P.L. 102-234. 102nd Cong. (1991). Section 1903(w)(6)(A) of the SSA provides that "Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government with a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(A)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section."

and quality of care); significant increases in state or local taxes or reshuffling of general fund dollars to replace the traditional public funding sources; or, more likely, a combination of these politically unpopular options. All of this will occur without an articulated or discernible improvement in accountability. **Restrictions of funding sources for the nonfederal share will only serve to decrease critical dollars in state Medicaid programs.**

The provider donation provisions are vague, violate principles of federalism, fail to advance reasonable policy objectives, and are inadequately supported.

The proposed rule substantially and inappropriately expands the scope of arrangements that CMS can treat as impermissible non–bona fide provider-related donations. It does so in several ways, while ignoring that many arrangements between public and private providers serve important and legitimate public purposes. First, CMS proposes to redefine the term "provider-related donation," such that a donation would be found whenever a private provider assumes a prior obligation of a governmental entity, unless the private provider receives fair market value compensation. Concerningly, in determining whether an obligation has been assumed, CMS proposes to apply vague "net effect" and "totality of the circumstances" standards. In addition, CMS proposes to modify the "hold harmless" test for donations to consider the "totality of the circumstances." In doing so, CMS would consider the "net effect" and "overall impact" of any arrangement between a unit of government and a private provider, and whether the parties have a "reasonable expectation" the provider will receive a return of some or all of the donation. These terms and provisions are so vague that providers will have difficulty knowing whether an arrangement is permissible.

The donation provisions in the proposed rule, as well as the preamble characterizing the provisions as current policy, must be withdrawn for numerous legal- and policy-based reasons. First, the "totality of the circumstances," "net effect," "reasonable expectations," and "overall impact" standards CMS proposes are too vague and arbitrary to withstand legal scrutiny. Under these regulatory criteria, providers and states would have no way to determine whether a particular business arrangement between a unit of government providing IGTs and a private provider complies with the law or conforms to CMS' expectations.[9] Essentially any transfer or practice could be treated as a donation or a hold-harmless arrangement if desired by CMS. In the past, courts have struck down similarly vague regulatory standards, declaring that where regulatory standards require "the exercise of extraordinary intuition" or "the aid of a psychic," as the proposed standards in the donation provisions of the MFAR do, they are unlawful.[10]

Second, the proposed changes—in particular, characterizing the assumption of an obligation formerly held by a governmental entity as a "donation"—again violate bedrock principles of federalism (as well as CMS' own pillar of state flexibility). The MFAR would interfere substantially in state operations, restricting state and local governments from partnering or contracting with health care providers to achieve better, more cost-effective services for local citizens, simply because the government once provided the services itself. The proposed rule also would discourage private providers from stepping up

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[9] The impossibility of determining what is permissible and what is prohibited is apparent from the face of the proposed regulatory text. Take, for example, a single sentence from proposed 42 C.F.R. § 433.54(c)(3): "[A] guarantee will be found 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 provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation."

[10] U.S. v. Chrysler Corp., 158 F.3d 1350 (D.C. Cir. 1998) (striking down vague seat belt testing standards); *see also supra* notes [11-12].

to provide needed charity care and other traditional governmental functions when governmental entities are no longer able to provide the services, for example, due to budget constraints. The modest carveout allowing for fair market value compensation is wholly inadequate. CMS appears to have given no thought to how the concept of "fair market value" can and should apply in this context. From a business and policy perspective, local governments should be encouraged to partner with private providers to achieve cost efficiencies, in which case the amounts paid for services should drop. And yet, any reduction in governmental expenditures when services shift to a private provider likely would be viewed with suspicion and presumed non–fair market value under the proposed rule. Moreover, many arrangements between local governments and providers are not susceptible to an objective fair market value assessment. For example, many longstanding arrangements between governmental entities and private providers have involved the provision of health care to the indigent, for which there is no standard for market value.

The proposed rule would leave states and providers with an undesirable set of choices: (1) unwind all partnerships between public and private entities to be certain Medicaid financing arrangements continue to be viable and compliant; (2) cease the practice—long allowed by CMS—of permitting governmental entities to fund the nonfederal share of Medicaid payments to other providers; or (3) bear the significant burden of a potential retroactive disallowance. None of these options advance reasonable policy objectives. Option 1 would eliminate many legitimate, beneficial partnerships that serve the public interest without jeopardizing the integrity of the Medicaid program. Option 2 would upend many states' Medicaid programs, shifting the burden of funding the nonfederal share to taxpayers or requiring substantial cuts, harming beneficiaries and destabilizing states' health care systems. Option 3 would require states and providers to divert funding from the treatment of Medicaid beneficiaries to build substantial reserves to account for regulatory uncertainty, or risk a potentially devastating disallowance in the future.

Despite these harsh and negative effects, CMS provides a paltry explanation for its proposed changes. CMS repeatedly asserts it is seeking to codify policies articulated in a letter to state Medicaid directors, SMD 14-004, that currently is the subject of a legal challenge.[11,12] Thus, it is premature to finalize the policies therein. Moreover, the proposed regulatory text goes well beyond SMD 14-004. As the HHS Departmental Appeals Board (DAB) recognized, "SMD 14-004 does not state that a donation occurs any time a private entity offers a service that a governmental entity has ever at any time provided."[13] Yet, that is the effect of the proposed expansion to the definition of "provider-related donation" at 42 C.F.R. § 433.52. Likewise, the MFAR is so overreaching it could be interpreted by CMS to prohibit arrangements identified by the DAB as acceptable, such as a private hospital offering health screenings or mammograms to the public after a governmental hospital ceases to offer such services. CMS expresses a desire to "eliminat[e] complex financing arrangements designed to obfuscate" non–bona fide provider-related donations, but this generic and circular rationale falls far short of the agency's legal obligation to provide a well-reasoned basis for its rules.[14] As such, the proposed provider donation provisions are too vague, violate principles of federalism, and fail to advance reasonable policy objectives.

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[11] SMD 14-004. Accountability No. 2: Financing and Donations. CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-004.pdf. Accessed December 27, 2019.
[12] Texas Health and Human Services Commission v. HHS, No. 3:19-cv-02857-S (N.D. Tex. Dec. 2, 2019).
[13] Texas Health and Human Services Commission, DAB No. 2886, at 20 (2018).
[14] *See, e.g.*, Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29, 43 (1983); City of Kansas City v. Department of Housing & Urban Development, 923 F.2d 188, 189 (D.C. Cir. 1991).

The proposed hold-harmless provisions undermine the clarity Congress intended and mischaracterize an impermissible change in policy as a codification of current rules.

Under federal statute, provider taxes cannot hold harmless a taxpayer for the amount of the tax. When Congress adopted the 1991 provider tax provisions, it created a detailed statutory structure so states could have confidence in designing taxes that satisfy federal requirements and would not be subject to later federal challenge. Congress outlined a series of standards by which to determine if the structure of a tax is permissible or includes a hold-harmless provision. When promulgating the initial regulations implementing the hold-harmless provision, then-HCFA was careful to create clear rules following the language of the statute, acknowledging "subjective analysis would be administratively burdensome and virtually impossible to apply fairly."[15] That is exactly the problem with the approach proposed in the MFAR.

The proposed regulatory language at 433.68(f)(3) incorporates overly broad and vague provider donation standards, as detailed above, providing a guarantee to hold harmless a taxpayer would be found where:

> "... *considering the totality of the circumstances*, the *net effect* of an arrangement between the State (or other unit of government) and that taxpayer results in a *reasonable expectation* that the taxpayer will receive a return of all or any portion of the tax amount."

States and local governments have a variety of financial arrangements with taxpaying providers unrelated to Medicaid (e.g., contracts for services outside of Medicaid, a variety of grant programs related to their various missions in their communities). Given the vagueness of the proposed standards, it would be difficult for a state or local government to know whether CMS might disagree with their determination that a particular arrangement is relevant to the provider tax. Likewise, it would be difficult for states or local governments to predict whether a taxpayer might view such an arrangement as a return of a provider tax amount. More precisely, it would be impossible to interpret whether CMS would conclude a taxpayer had such expectations.

In addition, taken at face value, the scope of this language could reach any arrangement for which the state or local government is adopting a reimbursement program that compensates taxpayers for the cost of the tax at a higher rate than the tax they paid. But this is not consistent with Congress' expectation that provider taxes would be used to increase Medicaid reimbursement to taxpayers. In 1991, Congress specifically amended the statute to protect this use:

> "The provisions of this paragraph ***shall not prevent*** use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process."[16]

Taking into account the preamble discussion, the MFAR is inconsistent not only with this statutory limit on restricting the use of provider taxes, but also with Congress' entire standard for determining a hold-harmless arrangement exists. The proposed rule would make the existence of a hold-harmless entity dependent on what is in the mind of the taxpayer, and not require involvement of the state or local government. CMS states a hold-harmless arrangement exists any time taxpayers have a "reasonable expectation" of receiving payments that will offset losses from the tax.[17] This is true "regardless of whether *the taxpayers participate voluntarily*, whether the taxpayers receive the Medicaid payments from a managed care organization, or whether taxpayers themselves make redistribution payments from funds

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[15] 58 Fed. Reg. 43,166, 43,167 (August 13, 1993).
[16] Social Security Act § 1903(w)(4).
[17] 84 Fed. Reg. 63,722, 63,735 (November 18, 2019).

other than Medicaid to other taxpayers."[18] Voluntary payments between private taxpayers that have the effect of offsetting some or all of a taxpayer's tax amount—entirely separate from and even unbeknownst to the state or local government—could constitute hold-harmless arrangements.

CMS' interpretation is contrary to the plain language of Congress' hold-harmless standard. Under Section 1903(w)(4) of the Social Security Act, a hold-harmless provision is in effect if:

> "(A) The ***State or other unit of government*** imposing the tax provides (directly or indirectly) for a payment (other than under this title [i.e., non-Medicaid]) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.
>
> (B) All or any portion of the ***payment made under this title*** [i.e., Medicaid payment] to the taxpayer varies based solely on the amount of the total tax paid.
>
> (C) 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."[19]

Critically, none of these provisions incorporate notions of taxpayer intent—unsurprising given the concerns for clarity that permeated Congress' development of the hold-harmless standard. The provisions require some involvement of the government—either that the hold-harmless payment come from the state or local government imposing the tax (in A and C), or that the hold-harmless payment is a Medicaid payment (that is, made under this title, in B). Further, the Office of Inspector General (OIG) previously concluded that agreements between taxed providers were consistent with Medicaid law "because the agreements were voluntary between the hospital providers."[20]

The involvement of the state or other unit of government is critical to the workability of the standard; a state attempting to implement a permissible tax could examine whether other state programs exist that might violate the hold-harmless policy, but the state would have no way of knowing about private arrangements that, by definition, do not include the government. CMS' proposal would give the agency discretion to consider any and all such arrangements, as well as its subjective determination of the expectations of parties outside of the state itself, to retroactively piece together circumstances warranting a disallowance.

Unless a state is willing to take on the risk of significant financial disruption in the event of a later disallowance, it would need to seek explicit CMS approval of any provider tax. But even the concept of preapproval is unreasonably burdensome and would not protect from a later disallowance. CMS would have to review all potentially relevant transactions, and if the state were not aware of or did not think to mention an unrelated arrangement, CMS later could determine the undisclosed transaction was, in fact, a hold-harmless agreement. As a result, the proposed rule would only serve to chill the use of legitimate state or local provider tax funds to finance Medicaid payments.

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[18] 84 Fed. Reg. 63,722, 63,734 (November 18, 2019).
[19] Social Security Act § 1903(w)(4) (emphasis added).
[20] HHS, OIG. Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri, A-07-02-02097. April 2003. Where the state hospital association pooled Medicaid payments financed by the assessment and distributed with explicit intent to withhold some amount from "winner" hospitals and redistribute amounts to "losers," OIG concluded the arrangement was consistent with Medicaid law "because the agreements were voluntary between the hospital providers and the [association], and because there are no regulations precluding the arrangement."

Even more problematic, CMS mischaracterizes this change in policy as "merely codif[ying] currently prohibited practices."[21] CMS implies (without directly stating) the interpretation derives from the preamble to its 2008 provider tax final rule describing as a hold-harmless provision a situation "when a *state payment* is made available to a taxpayer ... in the reasonable expectation that the payment would result in the taxpayer being held harmless ..."[22] It would require "extraordinary intuition" for a state to understand this preamble language served to extend the hold-harmless definition to private payments among providers. CMS also points to its statement in the preamble to the 2008 provider tax final rule that "an indirect payment" can be the basis for a hold-harmless arrangement.[23] But CMS fails to mention the additional 2008 provider tax final rule preamble description of how CMS would identify "problematic indirect payments" as payments "***controlled or directed by the state.***"[24] In explaining this language, CMS offers two additional examples:

- a nursing facility tax, in which the state Medicaid agency imposes the tax while a different state agency (the governor's office) implements a nursing facility resident grant program (offsetting the impact of the tax); and
- that "[s]tates will not be permitted to recycle monies through third parties, by making payments to such third parties ***and requiring that the*** money be used to reimburse taxpayers for any portion of their health care related tax."[25]

Neither of these examples involve purely private, voluntary transactions between private taxpayers that do not involve the state or local government. Even under the strictest reading of the 2008 provider tax final rule preamble, the state must require the third party to reimburse the other taxpayers. It is unreasonable to assert the 2008 provider tax final rule provided any notice of this newly asserted interpretation. The only guidance that has addressed purely private, voluntary transactions is the 2003 HHS OIG report, which concluded "there are no regulations precluding the arrangement" between private taxpayer hospitals to redistribute the Medicaid payments funded by the tax.[26] The hold-harmless policy discussed in the preamble, if enforced, would be a change to existing policy and thus subject to strong legal challenge. CMS should explicitly withdraw the preamble discussion purporting to clarify current law and regulations.

Finally, CMS fails to adequately articulate the newly-proposed standard it intends to apply through the new language of the MFAR. Despite CMS' stated goal of "clarifying" the hold-harmless standard and "solidifying a shared understanding regarding what constitutes a guarantee to hold taxpayers harmless," CMS explores this issue only in the preamble. The text of the proposed regulation does not state CMS would look beyond "an arrangement between the State (or other unit of government) and the taxpayer."[27]

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[21] 84 Fed. Reg. 63,722, 63,735 (November 18, 2019).
[22] Ibid (emphasis added).
[23] 84 Fed. Reg. 63,722, 63,735 (November 18, 2019), citing CMS Health Care-Related Taxes Final Rule, 73 Fed. Reg. 9,685, 9,896 (Feb. 22, 2008).
[24] 73 Fed. Reg. 9,685, 9,694 (February 22, 2008).
[25] Ibid.
[26] HHS, OIG. Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri, A-07-02-02097. April 2003; see supra note [41] for description of OIG conclusion.
[27] 84 Fed. Reg. 63,722, 63,739 (November 18, 2019).

The proposal to limit supplemental payments will reduce access to care and negatively impact the physician workforce.

Current Medicaid rules allow states substantial flexibility to determine Medicaid benefits and to fund their Medicaid programs in order to meet states' needs and the needs of Medicaid beneficiaries, and states have the flexibility to supplement providers' base rates with reimbursements that bring payments closer to Medicare and commercial rates. CMS' proposed limit on these payments is arbitrary—the agency provides no explanation for why it chose 50 and 75 percent as the limits. The existing policy limiting these payments to the average commercial rate is based on market forces and is an objective standard well-grounded in the underlying statutory economy-and-efficiency standard. CMS does not explain why paying essential professional providers the same rate as they have negotiated with private payers is inappropriate or excessive. Instead, CMS cites what it admits are "outlier" payment rates recently proposed by states that are larger than it had previously seen and decides to clamp down on all supplemental professional services payments rather than examining the methodology by which the outliers were calculated.

Supplemental payments to physicians help safeguard access to care by ensuring adequate reimbursement and retention of Medicaid providers. The proposed limitations on supplemental payments to physicians are arbitrary, narrow access to Medicaid providers, and undervalue critical physician services.

The proposed rule applies impermissibly broad and vague standards, making it impossible for states and providers to ensure compliance, while granting vast new oversight authority for CMS.

Throughout the proposed rule, CMS uses vague terminology to describe prohibited Medicaid financing practices it intends to terminate. In many cases, the preamble attempts to describe particular payment or financing practices, but CMS' proposed regulatory text gives the agency "catchall" authority to regulate (and prohibit) additional practices not described in the regulation, through terms such as "totality of the circumstances," "net effect," "undue burden," and "associated transactions." This sweeping new federal oversight authority leaves states and other Medicaid stakeholders without any means of ensuring a given supplemental payment or funding arrangement is permissible.

This vague language would cause a chilling effect for the states, in which states decline to use permissible funding sources for fear CMS will decide—either now or at some future time—that considering the "totality of the circumstances" (i.e., any factor deemed relevant by CMS), the arrangement is no longer permissible. The vague language also would allow CMS to adopt arbitrary enforcement practices as the agency has not laid out any objective standards against which permissible and impermissible practices are measured.

This vague language does not comport with federal law. Federal administrative law, rooted in the constitutional requirement for due process, does not allow federal agencies to adopt vague and arbitrary standards of this nature, particularly where, as here, the consequences to regulated parties are so severe.[28] The proposed rule does not satisfy the legal requirement of giving states and providers "ascertainable certainty" of the standards to which they are subject, nor does it serve CMS' own stated policy goal of

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[28] *See, e.g.*, Oglala Sioux Tribe of Indians v. Andrus, 603 F.2d 707, 718 (8th Cir. 1979) ("A court need not accept an agency's interpretation of its own regulations if that interpretation ... deprives affected parties of fair notice of the agency's intentions."); Phelps Dodge Corp. v. Federal Mine Safety & Health Review Commission, 681 F.2d 1189, 1192 (9th Cir. 1982) ("[T]he application of a regulation in a particular situation may be challenged on the ground that it does not give fair warning that the allegedly violative conduct was prohibited.").

improving transparency in the Medicaid program.[29] Therefore, CMS does not have the legal authority to implement the ambiguous standards in this policy.

The impact analysis for the proposed rule is inadequate.

For a rule of its magnitude, with the potential for great harm to state economies, providers and patients alike, CMS' impact analysis and stated bases for the MFAR are inadequate. CMS estimates the total cost to states of complying with the MFAR's new reporting requirements will be $145,221 per year in the aggregate. The only other dollar estimate CMS gives in the proposed rule—$222 million—is tied to a single provision in MFAR's 64 *Federal Register* pages, a new cap on fee-for-service physician supplemental payments.

Remarkably, in the very same rule in which CMS asserts that data regarding Medicaid financing and supplemental payments is inadequate and justifies substantial new reporting burdens on providers and states, CMS purports to have adequate information to impose fundamental changes to the Medicaid program's financing structure. CMS provides no dollar estimate for the myriad financing provisions, explicitly acknowledging that "[t]he fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."[30] Under federal administrative law, agencies must provide a reasoned explanation for their policies, especially when altering prior policies as the MFAR does.[31] Agencies also must demonstrate that they have considered the relevant factors and important aspects of their proposals.[32] The MFAR does not satisfy these requirements.

Should the rule be finalized, a long transition period is needed.

If CMS finalizes this or any portion of this rule, it must provide an adequate transition period. As was described above, it is likely that most states will be unable to meet the requirements of this rule without making significant changes in their Medicaid programs. CMS should acknowledge that changes of this magnitude will require years to implement and must provide a timeline that reflects this reality.

Conclusion

For the reasons stated above, UAB Health System asks that CMS withdraw the proposed MFAR. If implemented, the proposed rule will reduce funding for state Medicaid programs, which will reduce access to quality care for Medicaid beneficiaries.
If you have any questions regarding our comments, please contact Nate Horsley at nhorsley@uasystem.edu or 334-242-2263.

Sincerely,

Will Ferniany, PhD
Chief Executive Officer

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[29] General Electric Co. v. EPA, 53 F.3d 1324 (D.C. Cir. 1995).
[30] 84 Fed. Reg. 63,722, 63,773 (November 18, 2019).
[31] *See* 5 U.S.C. § 706(2)(A); Motor Vehicle Mfr. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 48 (1983) ("We have frequently reiterated that an agency must cogently explain why it has exercised its discretion in a given manner."); City of Kansas City v. Dep't of Hous. & Urban Dev., 923 F.2d 188, 189 (D.C. Cir. 1991).
[32] *See, e.g.*, Motor Vehicle Mfr. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).