January 29, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Docket No. CMS-2019-0169, RIN 0938-AT50, Comments in Response to Proposed Rulemaking: Medicaid Fiscal Accountability Regulation

Dear Administrator Verma:

On behalf of the Urban Counties of California (UCC), I write to express deep concerns with the proposed Medicaid Fiscal Accountability Regulation (MFAR), released by the Centers for Medicare and Medicaid Services (CMS) on November 18, 2019.

UCC represents 14 of the most populous counties in California –Alameda, Contra Costa, Fresno, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura – and more than 80 percent of the state's population. UCC's mission is to improve the lives of urban county residents by providing a strong, unified voice to advance policy and funding decisions for a broad array of vital public health, human services, behavioral health, public safety, community corrections, public works and other local services and programs.

In California, counties are political subdivisions of the state and administer many state and federal programs as delegated by state law. In the context of Medicaid, California counties act as county mental health plans delivering mental health services to individuals with serious mental illness, provide substance use disorder services, and administer In-Home Supportive Services. Additionally, nearly all urban counties operate county hospitals that (1) provide approximately 30% of Medicaid hospital care in their communities and serve approximately 2 million patients annually, (2) operate top-level burn and trauma centers, and (3) train new doctors. By assuring delivery of these vital services, counties act as critical safety net providers in their communities. California counties also partner with the state in financing Medicaid services.

As currently proposed, the MFAR rule would severely impact California's Medicaid program (known as Medi-Cal), jeopardizing access and coverage for millions of low-income Californians by unsettling the program's financial underpinnings. Our member counties, particularly those that operate county hospitals, would need to re-evaluate essential programs and services, likely limiting access to needed

care. **UCC urges CMS to rescind this proposed rule because of the negative and potentially life-threatening impacts to the low-income residents who rely on Medicaid.**

Medi-Cal provides services to more than 13 million of California's most vulnerable populations. It serves as the largest part of California's safety-net program and is vital to California's overall health delivery system, providing coverage and financing for 50% of the state's births. Medi-Cal provides important health coverage to:

- One of three Californians;
- Over 40% of children;
- Over 50% of disabled people; and
- Over 1 million seniors.

California's Medicaid program has among the lowest per capita spending in the country. According to the Kaiser Family Foundation, in fiscal year 2014, the Medi-Cal program's per capita spend for a full or partial scope beneficiary was $4,193[1]. California ranks 49th of 52 in spending among Medicaid programs, with only Alabama, South Carolina, and Nevada spending less on a per capita basis. Considering California is a state with a relatively high cost of living, the ranking indicates that the state is already running a very efficient, low-cost Medicaid program.

UCC presents the following concerns to support our request for the rule's rescission:

1) **The rule would inappropriately restrict California's ability to finance the non-federal share of funding, and reverses longstanding policy.**

   The proposed regulation requires that the non-federal share be derived from state or local taxes or funds appropriated to state university teaching hospitals. This limitation goes against the spirit of state flexibility and longstanding local financing of Medicaid and, furthermore, is inconsistent with congressional authorization permitting use of local sources of funds.[2] When CMS proposed to restrict local sources of the non-federal share in regulation in 2007, both Congress and a federal court halted the rule based on concerns that CMS had overstepped its authority in statute.[3]

   Local financing has not only been permitted within Medicaid, it has brought significant benefits to the program through state and local flexibility that, in turn, enables providers to continue caring for local indigent populations. Upending this longstanding system threatens both the fundamental functioning of the Medi-Cal program and the success of innovative system transformation. Diminishing counties' ability to participate in the federal-state Medicaid partnership through financing the non-federal share will inevitably mean reduced funding for our system, resulting in reduced access and diminished care for patients in our community.

[1] Kaiser Family Foundation Medicaid Spending per Enrollee (Full or Partial Benefit) FY 2014; Website Link

[2] See SSA § 1903(a)(1), 42 U.S.C. § 1396b(a), SSA § 1902(a)(2), 42 U.S.C. § 1396a(a)(2), and SSA § 1903(w)(6)(A), 42 U.S.C. § 1396b(w)(6)(A).

[3] See U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub.L. No. 110-28, § 7002(a), 121 Stat 112, 187 (2007); and *Alameda County Med. Ctr. v. Leavitt*, 559 F.Supp.2d 1 (May 23, 2008).

Despite this potentially broad reaching impact, CMS inexplicably declares that the "fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." CMS cites its rulemaking obligations under the Regulatory Flexibility Act, Social Security Act, Unfunded Mandates Reform Act, Executive Order 13132, and Executive Order 13771, but in each case claims that costs imposed by the rule would not meet the threshold for analysis in these respective authorities. As we have noted, we believe the impacts would be very substantial to governmental providers as well as state and local governments, and again note that CMS acknowledges the impact is unknown. The program partners in California estimate that over a million patients could lose access to care in public health care systems alone, and project that multiple public health care systems could be forced to close as a result of this rule. We strongly believe that CMS cannot finalize MFAR without a full understanding and appreciation of the scale and scope of the adverse impacts it would have to patients. CMS should rescind the rule given the lack of a thorough impact analysis from the many provisions of MFAR.

2) **Medicaid supplemental payments are an integral component to overall Medicaid compensation, and CMS should evaluate them as such. Supplemental payments help preserve access to critical safety-net services. States' ability to implement and maintain them should not be compromised, as proposed in this rule.**

While we understand CMS's desire for oversight of supplemental payments, any evaluation of Medicaid payment methodologies must take a broader view of payments, looking at base and supplemental components together. According to a nationwide analysis by the Medicaid and CHIP Payment and Access Commission (MACPAC), supplemental payments represented more than 25% of total Medicaid payments to hospitals in FY 2016.[4] In California, and in many states, virtually all providers receive supplemental payments, which are necessary components of Medicaid reimbursement for services. Looking at only one part of a total payment that represents a meaningful portion of a provider's total reimbursement fails to consider the full picture and potential consequences for significant reductions. Restrictions on supplemental payments must be weighed against the adequacy of base payments and any corresponding adjustments to base payments.

We are deeply concerned that new barriers to supplemental payments are being proposed at the same time that CMS proposes to rescind a rule requiring states to document whether Medicaid payments are sufficient to enlist enough providers to assure beneficiary access to covered services.[5] Proposing to reduce oversight of the impact of overall Medicaid rates on access while restricting supplemental payments will threaten provider participation in the program and harm beneficiary access and quality of care.

3) **The proposed new definition of "Non-State government provider" is a matter of state, not federal concern.**

[4] https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Feefor-Service-Payment-Policy.pdf.
[5] See 84 Fed. Reg. 33723 (July 15, 2019).

Our state and local governments have established local health care districts as well as local hospitals or health care authorities under state law as units of government within the state. For all intents and purposes, such authorities are treated and have the same rights and responsibilities as other government entities.

The process for creating a health care authority involves state legislation, local ordinance, and, in some cases, local election. These local political processes highlight that what form a local governmental entity can take is a matter of state, not federal concern. CMS's proposed conditions for determining whether a provider is local is overly simplistic and narrow. It not only incorrectly classifies providers that are clearly government entities, it adds no inherent policy value for the purposes of setting upper payment limits.

The rule also proposes that a "Non-State government provider" will only be considered as such if it has "access to and exercise[s] administrative control" over either appropriated State funds or local tax revenue. There is no justification given for tying a *payment* designation (i.e., classification for upper payment limit purposes) to what type of funds the public provider is expending – assuming that information is even realistic to label or track – or whether it is providing nonfederal share.

4) **The rule imposes a new 24 month "final settlement" deadline for Certified Public Expenditures (CPEs) that could result in county providers not receiving federal funds for services provided.**

Under the MFAR proposal, providers would have to meet a new deadline for "final settlement" of no more than 24 months from the cost report year end, except in certain circumstances. This proposed deadline would be extremely challenging to achieve in the short-term. Our reading of the proposed changes is also that new requirements would not and should not modify the application of the two year claiming limit and exceptions thereunder for provider appeal rights.

Should this rule take effect in its current form, states across the country will face a serious threat to the sustainability of their Medicaid programs. Over the years, states have designed Medicaid financing structures to provide care in ways that most effectively leverage a historical state-federal financing partnership within federal rules and with CMS approvals. Changes proposed in this policy would undermine the core framework of these structures.

Urban counties urge CMS to rescind this harmful proposal so that we can continue to effectively operate, provide care to our patients, and maintain our responsibility for health of our residents.

Thank you for the opportunity to submit comments and for your consideration of our concerns.

Sincerely,

Kelly Brooks-Lindsey
UCC Legislative Advocate