



STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

GRETCHEN WHITMER
GOVERNOR

GARLIN GILCHRIST II
LT. GOVERNOR

January 31, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Proposed Rule: Medicaid Fiscal Accountability Regulation; CMS-2019-0169-0001

Dear Administrator Verma:

On behalf of the state of Michigan, we thank you for the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation (MFAR). Consistent with federal law, we have long utilized flexibility granted to states to finance our Medicaid program in a way that allows us to best meet the unique needs of the nearly 2.5 million individuals who rely on Medicaid in Michigan. To eliminate or severely restrict this longstanding flexibility, as MFAR is proposing, would jeopardize provider participation and ultimately lead to many of Michigan's most vulnerable citizens losing access to critical care and services. We support the Administration's goals to improve transparency, efficiency and quality of care in the Medicaid program, so it should come as no surprise that we must request that this proposed rule be withdrawn in order to protect the health of our Medicaid population.

As stated, Michigan has utilized permissible Medicaid financing mechanisms to ensure that Medicaid program beneficiaries have sufficient access to care. Essential Medicaid services provided by hospitals, nursing facilities, physicians, and other provider groups utilize payment programs that are often funded using health care provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). As a Medicaid program that has at times been limited in the amount of general funding allocated by the state budget, these sources have been integral to maintaining adequate provider compensation and ensuring our most vulnerable citizens can access quality care. The proposed changes are likely to severely limit funding for Michigan's Medicaid program, reduce the number of participating providers in the state, and threaten access for beneficiaries in dire need of primary, specialty, or long-term care. The end result will be a decimated Medicaid program struggling to serve individuals deprived of options for quality care.

We are also concerned that the proposed changes would interfere with state tax laws, employ reporting that will be difficult to implement, and require that Michigan exercise oversight of health plans and hospitals beyond its current authority. Further, the new standards related to "undue burden" and "totality of circumstances" allow an unacceptable degree of subjectivity to any review or approval.

These policy concerns are only exacerbated by the operational impact on Michigan's Medicaid program. With respect to the legislative and organizational changes required by the imposition of this policy, the Centers for Medicare and Medicaid Services (CMS) has failed to provide adequate time for transition and implementation. Additionally, the required tracking and reporting of payments, provider taxes, IGTs,

CPEs, and any provider-related donations foists an unsustainable administrative burden on the state with little incentive or justification that these reports will improve CMS operations.

Finally, and most importantly, the loss of funding will inevitably cause significant reductions in provider reimbursements and limit beneficiary access to care. Our program currently boasts consistently high levels of utilization, access, and consumer approval among Medicaid beneficiaries for primary care, specialty services, pre- and post-natal obstetric services, and home health services. “Supplemental” financing mechanisms have helped to maintain this exceptional access over the last fifteen years, offsetting Medicaid base rates that are less than half of commercial payments.

Michigan relies heavily on practitioners eligible for these permissible and vital payments, with participating physicians accounting for two-thirds of all professional services provided to Medicaid beneficiaries in the state. The loss of these payments would leave many unwilling or financially unable to see Medicaid beneficiaries, causing an indeterminate reduction in the number of Medicaid-participating providers. In a state already struggling with potential physician shortages and difficulties incentivizing Medicaid participation, the resulting loss of access to providers and quality care for beneficiaries would be devastating.


For these reasons and those outlined in greater detail in the accompanying document, we would again request that CMS withdraw this proposed rule and allow us the continued flexibility to meet the health needs of Michigan’s most vulnerable citizens.

Thank you again for the opportunity to submit comments on this proposed rule—we hope that you will thoughtfully consider our concerns.

Sincerely,



Gretchen Whitmer
Governor



Robert Gordon
Director, Michigan Department of Health and Human Services



Kate Massey
Medicaid Director
Michigan Department of Health and Human Services

Subject (Section)	Comments
IGTs (433.51)	<p>Michigan is concerned with any attempt to restrict the use of non-State public funds to meet its non-federal share and believes the proposed rule is contrary to the plain language of the Social Security Act (SSA). The proposed revisions would specify that an intergovernmental transfer (IGT) would need to be “derived from State or local taxes (or funds appropriated to State university teaching hospitals).” While the SSA specifically states that CMS “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),” it does not limit the non-federal share of Medicaid payments to only these sources. Public entities may have multiple other sources of funding that would be considered permissible for use towards the non-federal share by the state under current statutes and regulations. CMS should not remove these legitimate revenue streams from being used to provide the non-federal share of Medicaid payments. It is the position of Michigan that the current regulation allows “public funds” to be used as non-federal share if they are appropriated directly or transferred from other public agencies (including Indian tribes) to the state Medicaid agency. Further, funds are available to use as the non-federal share if certified by the contributing public agency as representing expenditures eligible for federal financial participation (FFP). Determining whether the transferred amounts were directly related to State or local taxes would also be difficult and would potentially require states to perform an amount of oversight into the business of counties and other public entities that could be considered an overreach. Given how unique the budget process is in each state, the SSA and current regulations afford appropriate flexibility that permits states to appropriate funding in the most efficient, economic manner.</p> <p>All state plans are required by 42 USC 1396a(30)(a) to assure that provider payments “are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Michigan has used the permissible methods available to it under the SSA to utilize State, county, and municipal funds to preserve a robust network of providers and ensure access to quality care for all beneficiaries. It is unclear how the restrictions proposed in 42 CFR 433.51, which would limit a state’s use of allowable public funds for its non-Federal share, would result in meeting or promoting the Act’s objective. CMS emphasizes the clause of 1396a(30)(a) that says “payments are consistent with efficiency, economy, and quality of care” without appearing to acknowledge that phrase’s linkage with sufficiency of provider network.</p>
General Definitions (433.52)	<p>The proposed rule adds definitions for Medicaid activity, non-Medicaid activity, net effect, parameters of a tax, and taxpayer group. It also makes changes to the provider-related donation definition. These definitions are then referenced in other sections.</p> <p>Two terms that give Michigan pause are “net effect” and “totality of circumstances.” The first appears to require that the State examine “all parties” and any agreements that may be in existence, regardless if they are written or enforceable. It is</p>

	<p>later defined in part using the second term, which appears almost 30 times in the preamble of the proposal and remains solely under the subjective discretion of CMS. The totality of circumstances is occasionally paired with “included but not limited to” language, but CMS does not fully define how this will be applied to funding mechanisms or other currently permissible practices. Among others, these definitions provide little context, specific direction, or adequate description of the criteria and standards necessary for States to comply with CMS policies. This failure to be clear and concise limits our ability to provide full and thorough feedback on the proposed rules, as well as the actual or potential effect. Further, it highlights possible unintended consequences not contemplated by CMS when proposing these revisions by leaving such key aspects so ill-defined.</p>
<p>Bona fide donations (433.54)</p>	<p>According to the current hold harmless definition outlined in 42 CFR 433.54 (c), a hold harmless practice will exist if any one of three criteria are met. The third of these criteria articulates that the State holds harmless the taxpayer if any payment, waiver or offset “directly or indirectly guarantees to return any portion of the donation to the provider.” The proposed revision to 433.54(c)(3) adds that an indirect or direct guarantee will be found if “...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. The net effect of such an arrangement may result in the return of all or a portion of the donation, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.”</p> <p>This language uses undefined and unassigned terms, failing to specify the actual criteria that will measure the “totality of the circumstances” when determining if a donation is non-bona fide. Further, the language appears to create State liability for “arrangements” that may be unwritten, legally unenforceable, or do not involve the State as a party.</p> <p>In contrast, 42 USC 1396b(w)(2)(A), (B) and (C) provide clear definition of what is a provider related donation, as well as when a provider donation will be considered bona fide. The statute also clearly indicates the Secretary may, by regulation, specify the types of provider relations that will be bona fide provider-related donations. Rather than specify types of donations, this proposed rule uses undefined and unclear terms that are not instructive, illustrative, or helpful to States. It threatens the ability of states to comply with CMS regulations or guidance and avoid non-bona fide provider related donations.</p>
<p>Taxes (433.55)</p>	<p>According to the fact sheet provided on the CMS website, the proposed rule “would clarify the statutory prohibition on states circumventing health care–related tax requirements by masking health care-related taxes in a tax program that also taxes non-health care items and services, codifying existing policy.” Currently, a tax is determined to be a health care-related tax and subject to health care tax regulations if at least 85 percent of the tax burden fall on health care providers.</p>

	<p>The proposal would now allow for taxes to be considered health care-related, regardless of the 85 percent threshold, “if differential treatment exists for entities providing or paying for health care items or services relative to other entities.”</p> <p>Michigan does not have concerns with this additional language when it comes to the permissibility of its State tax programs. However, there are concerns that this would result in CMS conducting reviews on State tax programs that are not health care-related and have no connections to the State’s Medicaid program. For example, while a state-wide sales tax does not impose a differential treatment on healthcare items, CMS could still review the program streams of general fund dollars. This would be an unnecessary administrative burden and useless exercise. Michigan would appreciate additional clarification on the specific types of tax programs that inspired this rule, or at least an outline of taxes CMS would consider appropriate for review.</p>
Taxes (433.56)	<p>The proposed rule would add “Services of health insurers (other than services of managed care organizations as specified in paragraph (a)(8) of this section)” to the list of classes of health care services and providers that can be subject to a health-care related tax. However, CMS does not clarify whether this is only limited to insurers that sell or provide health coverage plans. Without further explanation, the change is left open to include insurers licensed that sell or provide non-health coverage policies with provisions related to medical, surgical, or hospital benefits, or other non-comprehensive insurance policies for illness, disability, death, or unemployment. It would be the position of Michigan that the regulation being broadly applied to any “services of health insurers” without further limitation that the taxpayer is also “health insurer.” This could cause CMS interference with the Michigan legislature’s general authority to levy taxes, assessments, or fees, and utilize the proceeds of its Michigan Constitutional authority to raise revenue as necessary and appropriate. Michigan requests more clarification regarding the impact of this change before it is finalized.</p>
Taxes (433.68)	<p>For health care related taxes that are broad-based and uniform, States are not required to obtain CMS approval. For taxes that do not meet the definition of being broad-based and/or uniform, States are required to apply to CMS for a waiver of the applicable requirements in order to implement. These waivers are automatically approved if the State can demonstrate that the tax passes certain CMS-defined statistical tests, designed specifically to indicate whether the tax would generally be considered redistributive. These include the “P1/P2 test” (required for taxes that are uniform, but not broad based) and the “B1/B2 test” (required whenever a tax is not considered uniform, regardless if it is considered broad-based).</p> <p>In addition to the current statistical tests, MFAR proposes to add section (e)(3) to 433.68. The new language adds a “requirement to avoid imposing undue burden on health care items or services reimbursed by Medicaid, as well providers of such items or services.” It then goes on to define four conditions, any of which would result in the tax being considered to impose an undue burden and would deem the tax unallowable by CMS.</p>

	<p>This undue burden provision is a significant change from current CMS practice and is an area of concern. Namely, this provision would add an unacceptable amount of subjectivity to CMS’s review and approval process. CMS justifies the new provision by stating that the current P1/P2 and B1/B2 tests “do not ensure, in all cases, that proposed taxes that pass the applicable test are generally redistributive.” While the tests may have flaws in their current format, they do give States clearly defined parameters and provide certainties necessary for the development of tax policy. With the additional undue burden provision, States would be left without any specific or objective standards when reviewed by CMS. Any alterations or revisions of the process for obtaining tax waiver approval should consist of clearly defined, objective parameters and any subjective components should be removed.</p>
<p>CPEs (447.206)</p>	<p>§447.206 is an entirely new section proposed by MFAR that would add rules and criteria that would apply exclusively to payments funded by certified public expenditure (CPE) for State government providers or non-State government providers.</p> <p>One issue Michigan identified in this section is that CMS specifies in (c)(1) that “A State must implement processes by which all claims for medical assistance are processed through Medicaid management information systems in a manner that identifies the specific Medicaid services provided to specific enrollees.” However, as CMS’ proposed definition in 447.286 of supplemental payment highlights, they are not attributed to a particular claim for a specific service. In Michigan, there are instances where CPEs are currently utilized are for supplemental payments or disproportionate share hospital (DSH) payments. In order to comply with DSH statute and regulations, aggregate hospital data is utilized for program calculations. Because this provision could be applicable to either supplemental or DSH payments, Michigan requests that CMS clarify whether it would apply.</p>
<p>State Plan approvals for supplemental payments (447.252, 447.302)</p>	<p>The proposed rule would create additional state plan requirements for supplemental payments by amending 447.252 (inpatient hospital and long-term care facility services) and 447.302 (other institutional and non-institutional services). These requirements include detailed descriptions of provider eligibility criteria, payment distribution methodology, and monitoring and evaluation plans.</p> <p>The change also limits the State Plan authority for any supplemental for a duration of three years, which would need to be explicitly stated in the State Plan. Upon the sunset of the approval period, States could submit an amendment to renew the supplemental payment authorization. In order to receive renewal, an analysis of the program would need to be submitted that evaluates “the impacts on the Medicaid program during the current or most recent prior approval period.”</p> <p>Annual upper payment limit demonstrations are currently required for the majority of supplemental payment programs approved in the State Plan. With the exception of physician services, which would be removed from the requirements due to other required MFAR changes (see Practitioner Supplemental Payments (447.406) below), these annual demonstrations</p>

	<p>would continue under the proposed rule. In fact, 447.288 would also be amended under this rule to include additional quarterly and annual requirements.</p> <p>The combined current annual reviews of supplemental payment programs, three-year approval limit, and additional reporting required under this section would place an excessive administrative burden on States. Further, the imposed limit on program duration severely limits States attempting to create dependable and consistent systems. If CMS moves forward with the three-year approval limit, administrative burden on states should be reduced through elimination of the annual upper payment limit demonstration requirement, as the majority of relevant information in those annual demonstrations would now be required with the reoccurring State Plan approval submissions.</p>
<p>Payment Reporting (447.284, 447.288)</p>	<p>The proposed rule would significantly increase the amount of reports submitted by States for payments authorized under the state plan and demonstration authority. Along with the annual upper payment limit demonstrations that are already required, CMS also proposes requiring quarterly reports which detail, at the provider level, base and supplemental payments, provider taxes, IGTs, CPEs, and any provider-related donations. The proposed rule is very prescriptive in detailing the information that would be required, much of which is not currently required in the annual upper payment limit demonstrations.</p> <p>Michigan believes that these requirements, particularly increasing the frequency of reporting to a quarterly basis, would create undue administrative burden, both for states and federal reviewers. It is also unclear how CMS would benefit from this additional reporting. Michigan would be supportive of having the states work with CMS to update general reporting requirements to support CMS goals, but does not believe that the requirements proposed are necessary.</p>
<p>Practitioner supplemental payments (447.406)</p>	<p>Along with being impacted by a number of other sections in the proposed rule, CMS specifically addresses additional changes to practitioner supplemental payments with the addition of a new section 447.406. Most notably, this proposed section would put new limits on the practitioner supplemental payment amounts. CMS currently allows State Medicaid programs to pay up to an average commercial rate (ACR) for practitioner services. The proposed rule instead limits practitioner supplemental payment rates to 50% of fee-for-service base rates, or 75% if within HRSA-designated geographic health professional shortage areas (HPSAs) or Medicare-defined rural areas.</p> <p>Michigan has significant concerns with this proposed section and the impact it would have on its providers and beneficiaries. For over ten years, Michigan has operated a program that pays up to ACRs for specific services provided by practitioners that are employed or contracted with a public entity identified explicitly in the approved State Plan. As a result, Michigan is currently very satisfied with the ability of Medicaid beneficiaries to receive access to care. Research for a 2016 "Access Monitoring Review Plan" indicated that "Michigan Medicaid beneficiaries do not encounter access to care</p>

	<p>issues and that access is consistent with that of Michigan’s general population.” The proposed rule puts this status at risk. The proposed limits would result in substantial payment reductions to physicians and other practitioners that are eligible for the supplemental payment programs. The sharp payment reduction would likely cause numerous providers to discontinue participation in the Medicaid program, ultimately resulting in beneficiaries losing access to care and services. These downstream effects would be detrimental to the health of the Medicaid population and would limit Michigan’s ability to efficiently and effectively manage the Medicaid program.</p> <p>Data analysis of Michigan’s practitioner supplemental payment program supports this concern. While the practitioners eligible for the program account for less than one third of all practitioners enrolled as a Medicaid provider, they account for roughly two thirds of all professional services provided to Medicaid beneficiaries. It is easy to infer that if there was a reduction in supplemental payments to providers, many would either limit the amount of services provided to Medicaid beneficiaries or stop participating in the program altogether. This would create serious access to care issues, leading to negative health outcomes and a rise in emergent situations with higher costs of care.</p> <p>Michigan also opposes using the 50 and 75 percent base rate concept due to the potential for payment limits to vary greatly depending on what a State can utilize for its base rates. This could cause states to have wildly different payment structures as there would not be a standard cap for which all states would be measured. While CMS notes that a state could “increase Medicaid base payment rates, which could enable the state to pay a further 50 percent (or 75 percent) of the increase in FFS base payments to eligible providers,” it fails to account for the unique political and budgetary circumstances in every state.</p> <p>While Michigan appreciates the opportunity to have higher base rates for HPSAs in rural areas, there are a number of questions on how this would be administered. First, CMS does not specify whether county, zip code, or another measure would be used to define or designate areas. Second, there is no indication whether the rate would be based on provider location or beneficiary address. Third, the type of service provided is not designated. This ambiguity raises concerns that a county could be HPSA designated for primary care but not dental, or vice-versa.</p> <p>Due to the detrimental impacts these proposed regulations could have on the Medicaid population, along with the non-standard measurement of payment limits and numerous administrative questions, Michigan strongly requests that this section be removed, should this proposal move forward.</p>
DSH (447.297, 447.299, 455.301)	CMS is proposing to add a new data element to annual DSH reporting to 447.299(c). This element “would require auditors to quantify the financial impact of any finding, including those resulting from incomplete or missing data, which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.”

While conceptually supportive of this new requirement, Michigan does have some concerns regarding how these impacts are determined. If data is missing or incomplete, estimated impacts could easily be exaggerated. Further, CMS does not specify whether additional time will be granted to hospitals that dispute findings. Rather than requiring an explicit quantitative impact in the audit that could be highly inaccurate, Michigan would recommend that CMS provide more targeted assistance to states when these situations occur.

The proposed rule would also uniformly codify how States report DSH recoupments and redistributions. This includes separately reporting a decreasing adjustment for any overpayments on the CMS-64, as well as requiring that any redistribution be made within two years from the date of discovery of the DSH overpayment. Given that this coincides with instructions Michigan received in prior years from CMS, there are no concerns with this process being promulgated.

Finally, CMS proposes to remove the required publishing of annual allotments through the federal register. Instead, allotment information would be posted on "Medicaid.gov and in MBES, or its successor website or system." Additionally, CMS proposes to "remove the date in which final national target and allotments are published from April 1st to as soon as practicable." Michigan does not oppose CMS modernizing the publication of allotments to save time and reduce administrative burden but would request that CMS maintain an explicit deadline for publication as the "as soon as practicable" language is ambiguous.