TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

January 31, 2020

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

Submitted electronically via: http://www.regulations.gov/

Re: Medicaid Fiscal Accountability Regulation, CMS-2393-P

Dear Administrator Verma:

On behalf of the Texas Medical Association, Texas Academy of Family Physicians, Texas Pediatric Society, Texas Association of Obstetricians and Gynecologists, American College of Obstetricians and Gynecologists-District XI (Texas), and The Texas Chapter of the American College of Physicians Services, which together represent more than 53,000 Texas physicians and medical students, we are writing regarding the proposed Medicaid Fiscal Accountability Regulations, as published by the Centers for Medicare & Medicaid Services (CMS) on Nov. 18, 2019. Thank you for the opportunity to comment.

As written, the proposed rules will upend long-standing regulations regarding how states finance their Medicaid programs, including drastically limiting the use of supplemental funding. Additionally, the rules will require extensive and likely costly new reporting requirements. The stated intent of the proposed rules is to "strengthen fiscal integrity of the Medicaid program and to help ensure that state supplemental payments and financing arrangements are transparent and value driven." These are goals we share. However, if adopted, the highly technical and vague rules undoubtedly will have serious unintended consequences.

As a state-federal partnership, Medicaid requires both partners to contribute dollars to support it. Currently, Texas (and every other state) uses both general revenue (GR) – state tax dollars – and supplemental funds to pay its required "nonfederal" share. Provider taxes and intergovernmental transfers (IGTs) – tax dollars transferred to the state from local taxing entities (e.g., hospital districts) – are common forms of supplemental payment arrangements and permissible under federal regulations.

Over more than two decades, Texas, like other states, has increased its reliance on supplemental funding, with oversight from the Centers for Medicare & Medicaid Services. The growth of supplemental funding stems largely from lawmakers' reluctance to increase the amount of GR allocated to Medicaid. As a result, hospital finance experts report that supplemental dollars now account for as much as 60% of Texas hospital Medicaid payments. These dollars serve as the lifeblood of safety net hospitals and health systems, including teaching facilities, children's hospitals, and rural hospitals, which together serve the vast majority of Medicaid and low-income Texans while also providing critical community services, such

as neonatal, maternity, and trauma care. Without these dollars, many of these facilities would cease to exist or be forced to sharply limit their services.

Moreover, the state's Medicaid 1115 Transformation Waiver relies almost exclusively on supplemental funding to pay for the state's nonfederal portion. The waiver, which will provide an additional $25 billion in funding to the state's safety net from 2018 to 2022, has benefited thousands of low-income Texans by:

- Improving access to health and dental care services;
- Expanding availability of behavioral health care;
- Promoting innovative new models of care, such as patient-centered medical homes, to increase availability of prenatal care or to better serve children and adolescents with special health care needs; and
- Enhancing funding to ensure the continued viability of safety net hospitals, particularly rural ones.

Yet, under the proposed rules, it is unclear whether and how CMS would even authorize IGTs or other supplemental payment mechanisms for the waiver or other uses. While the rule purports to make supplemental funding more transparent, it instead relies upon vague standards and gobbledygook – phrases such as "undue burden, "net effect," and "totality of circumstances" – to describe how it will assess a state's use of supplemental funding.

Perhaps most significantly, the rules also would require that a state's non-federal share be raised via state or local taxes (or dollars appropriated by the legislature, such as to university-affiliated hospital), precluding hospitals from using patient revenue in the calculation of local dollars available. Most public hospitals rely on patient revenue as well as local taxes to fund IGT or other supplemental funding arrangements. If CMS were to adopt the new standard, the most likely outcome would be to force local communities to raise taxes. However, Texas caps the amount of annual property tax increase local governments can raise before seeking voter approval. As such, the new rule would most certainly create a large shortfall in supplemental dollars available to pay Texas' non-federal share.

To be clear, we believe that supplemental funding mechanisms must be more accountable and fairer. Our organizations have publicly called for Texas to redesign how the state distributes Medicaid waiver dollars as well as to ensure greater transparency in how supplemental dollars are used. Yet by no means do we support draconian restrictions on supplemental funding itself. Without it, Texas will be unable to compensate safety net hospitals adequately, support graduate medical education training programs, or maintain its current waiver. The Texas Legislature simply will not be able to replace IGT with general revenue.

Moreover, Texas' ability to meaningfully reduce the number of people without health insurance – the highest percentage in the country – will most certainly be foreclosed. That is because a future Medicaid 1115 waiver, financed fully or partially with supplemental dollars, is the most likely path forward for the state to implement new coverage. Without the ability to use supplemental funding, state lawmakers are unlikely to even consider such a proposal.

Lastly, restricting Texas' use of supplemental funds will ultimately jeopardize the health and well-being of Texans. If Texas must make up the lost revenue, lawmakers may very well instead choose to cut benefits, services, and physician and provider payments to make up for the lost dollars.
Today, Texas Medicaid provides coverage to nearly 4 million low-income people, paying long term dividends for:

- Children getting access to the preventive, primary, and specialty care they need to thrive and succeed in school;
- Pregnant women obtaining vital prenatal and postpartum care, essential to promoting better birth outcomes;
- People with disabilities getting a range of acute and long-term care services needed to live and thrive within their communities; and
- Seniors receiving supportive long-term care services.

As noted within the rule's regulatory impact statement, CMS itself cannot ascertain the impact of the rules on the Medicaid program, an alarming statement from an agency charged with ensuring that Medicaid patients receive high-quality, timely health care services. Without further analysis, it would be irresponsible to proceed.

We respectfully urge CMS to withdraw the rules and instead work with interested stakeholders to address legitimate concerns raised by the agency regarding the need for more transparency and accountability on state supplemental Medicaid payments.

Thank you for your thoughtful consideration.

Sincerely,

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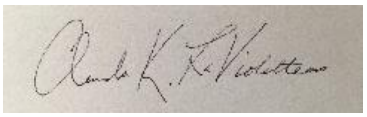

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