

The Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) in November 2019 issued the Medicaid Fiscal Accountability Regulation (MFAR) that would significantly change state Medicaid program financing and supplemental payments for providers. Comments on the rule are due by Feb. 1, 2020, and, as is typical when there is no statutory deadline, the agency has not set a target date for finalizing the rule.

What It Does

The agency asserts that the proposed rule is intended to increase program transparency; however, it goes far beyond this purported objective. It proposes significant policy changes to health care-related taxes (provider taxes), bona fide provider donations, intergovernmental transfers (IGTs) and certified public expenditures (CPEs).¹ The rule also would restrict states' use of certain provider supplemental payments, which are critical to ensuring access to care by making up for base rates that are well below the cost of providing care. The agency also proposes to change the review process for supplemental payment programs and provider tax waivers. Finally, the agency would grant itself unfettered discretion in evaluating permitted state financing arrangements through vague new concepts, such as "totality of circumstances," "net effect" and "undue burden." These vague standards for determining compliance are contrary to the legal requirements of administrative law because they will make it impossible for a state to know whether its program complies with the Medicaid statute.

Who Is Affected

The 75 million individuals who rely on the Medicaid program as their primary source of health coverage are the most at risk as a result of the proposed regulatory requirements. Medicaid pays for approximately half of the births in the country, as well as care for almost half of all children and adults with special health care needs, such as physical and developmental disabilities, dementia, and serious mental illness. The magnitude of financial loss to the program as a result of this rule would force states to make untenable choices regarding eligibility, benefits and provider reimbursement. Each of these choices is fraught with negative consequences, such as: eligibility rollbacks that would thwart important public health interventions, reduced benefits that would adversely affect the quality of care, and reduced provider reimbursement that would jeopardize access to care.

Financial Impact

MFAR goes far beyond increasing transparency. Instead, it restricts state access to important funding streams, restricts states' ability to make supplemental payments to offset base payments set below the cost of providing care, and introduces significant uncertainty with respect to how CMS will evaluate state financing approaches. The proposals are numerous and varied, and, if finalized, they would give states virtually no time to make policy and budgetary adjustments to mitigate the loss of federal funds, assuming they could be mitigated at all. These proposed changes would have devastating consequences for the Medicaid program.

Nationally, the Medicaid program could face total funding reductions between \$37 and \$49 billion annually, or 5.8% to 7.6% of total program spending.² Hospitals specifically could experience reductions in Medicaid payments of \$23 billion to \$31 billion annually, representing 12.8% to 16.9% of total hospital program

payments. Although the impact at the individual state level will vary significantly, in nearly all states this rule would unquestionably result in cuts in program enrollment and covered services. The impact in some states could be catastrophic.

Action Needed

CMS has provided little or no analysis to justify these policy changes, and it has declined to assess the impact on beneficiaries and the providers that serve them. **Many of the changes would violate the Medicaid statute or are arbitrary and capricious in violation of the Administrative Procedure Act. Moreover, at the same time the agency is proposing these changes, it is planning to rescind rules that require states to demonstrate that Medicaid beneficiaries have sufficient access to care, thus weakening CMS's ability to ensure adequate oversight of the program.³ There is no other viable course of action: the proposed rule should be withdrawn.**

Sources

1. IGTs are funds that government providers transfer to the state for the state to use for federal matching purposes. CPEs are expenditures government providers certify as qualifying expenditures to the state for the state to use for federal matching purposes.
2. Analysis provided by Manatt Health, 2020.
3. www.federalregister.gov/documents/2019/07/15/2019-14943/medicaid-program-methods-for-assuring-access-to-covered-medicare-services-rescission.