



JANUARY 31, 2020

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244
Submitted electronically to <http://www.regulations.gov>

Re: Medicaid Program; Medicaid Fiscal Accountability Regulation (CMS–2393-P)

Dear Administrator Verma:

On behalf of the National Association of Counties (NACo) and the 3,069 counties we serve, we respectfully submit comments to the Centers for Medicare & Medicaid Services (CMS) proposed rule *Medicaid Program: Medicaid Fiscal Accountability Regulation (MFAR)*. NACo recognizes the importance of CMS's efforts to improve transparency and maintain the integrity of the Medicaid program. However, we are concerned that the proposed rule undermines state and local government flexibility, reduces Medicaid funding, and will ultimately reduce access to necessary services. NACo urges CMS to reconsider this rule and consult directly with states and counties on how best to improve state Medicaid operations, without decreasing local flexibility to fund the program and limiting access to services.

Medicaid operates and is jointly financed as a partnership between federal, state and local governments. The program is the largest source of health coverage in the United States, covering more than 70 million individuals, and provides care for some of our nation's most vulnerable citizens, including children, elderly, people with disabilities and low-income adults. Counties across the nation deliver Medicaid-eligible services and, in many instances, help states finance and administer the program.

MFAR would significantly change the ways that states and counties would be permitted to finance the non-federal share of their Medicaid programs, including new restrictions on IGTs, CPEs, provider taxes and other mechanisms.

Counties make key financial contributions to the Medicaid program, contributing up to 60 percent of the share of costs that are not covered by the federal government in each state. Currently, counties contribute to Medicaid in 26 states. Of these, 18 mandate counties to contribute to the non-federal share of Medicaid costs and/or the administrative, program, physical health and behavioral health costs. Mandated county contributions are highest in New York counties, where they spend \$7 billion



per year, or approximately \$140 million per week in Medicaid costs. Restrictions on financing mechanisms such as IGTs could drastically impact these and other counties ability to pay the non-federal share of their state program costs.

NACo supports the current rules that reinforce the federal-state-local partnership for financing the Medicaid program, including disproportionate share hospital (DSH) payments and other supplemental payments. These rules permit using an array of public funds for intergovernmental transfers (IGTs), certified public expenditures (CPEs) and other financing mechanisms. We support maximum flexibility for states and counties to finance the non-federal share of Medicaid, and we are concerned about the impacts of the proposed rule on this flexibility and the limits it places on states and counties' ability to provide essential health care services for low-income, uninsured and underinsured residents.

If these new restrictions are implemented, counties and states would be forced to spend less on Medicaid due to limitations on funding sources. The diminished resources could result in less Medicaid funding available to support local health care systems, including county hospitals, clinics, behavioral health programs and long-term care facilities.

Counties deliver health services, including those covered by Medicaid, through 903 county-supported hospitals, 824 county-owned and supported long-term care facilities, 750 county behavioral health authorities and 1,943 local public health departments. Medicaid covers 24 percent of rural residents and has surpassed Medicare as the largest source of public health coverage in rural areas. The program provides a key source of patient revenue that enables communities to retain health care facilities and providers. Counties have made the most of Medicaid's flexibility by leveraging local funds to construct systems of care for populations that private insurance does not cover. New limits on counties' ability to receive supplemental payments or raise the non-federal match would compromise the stability of the local health care safety-net.

Medicaid reduces the frequency of uncompensated care provided by local hospitals and health centers to low-income residents, particularly through supplemental payments such as the Medicaid Disproportionate Share Hospital payments, which lessens the strain on county budgets.

Two-thirds of all county supported hospitals are in rural or small counties and serve as "providers of last resort" as they provide care to all patients regardless of their ability to pay. Medicaid covers in-patient and out-patient hospital services. While Medicaid reimbursement has historically been below costs, it remains a vital source of revenue for county-supported hospitals and must be sustained.

MFAR would significantly expand CMS discretion to review both new and existing state and local financing arrangements. Moreover, these new reviews would be required every three years, creating burdensome reporting requirements.

Section §447.288 of the proposed rule details new and substantial reporting requirements regarding upper payment limit (UPL) demonstrations and supplemental payments. The rule specifies that for



each supplemental payment, states must submit a report on provider-level data which include details on service types for which the reported payment was made. While increasing transparency of these payments can help improve program integrity, the reporting requirements under the proposed rule will place significant administrative burden directly on county facilities that receive supplemental payments and administer Medicaid services.

To meet this new requirement, local governments will have to implement new data collection and reporting systems, which will require additional personnel time and funding. NACo is concerned about the feasibility of meeting these new reporting requirements with no additional funding or technical assistance mechanism to help support the data collection efforts needed to fulfill the requirements. We are also concerned that the penalty for failing to report “timely, accurate, and complete” data does not take into account the lack of funding or technical assistance needed to meet the outlined requirements for reporting.

As proposed, MFAR introduces ambiguity to the basic financing mechanisms underpinning county government Medicaid funding, it could make it increasingly difficult for localities to continue to budget and innovate strategically.

Counties are the front door to our nation’s health system, investing \$83 billion annually in community health. Although the need for health care services and assistance remains pressing in communities across the country, many states place limits on counties’ already limited options for raising revenue. In fact, currently 43 states impose some form of county property tax limits, affecting the main revenue source for counties, while at the same time mandating the delivery of indigent care and human services- often forcing counties to choose between critical programs.

Given the fiscal limitations counties already face from states, the federal government’s commitment to programs helping those most in need and to supporting local stakeholders and service providers is increasingly crucial. Diminished flexibility in financing mechanisms resulting in less federal funds would force many counties to reduce service levels for critical Medicaid programs.

NACo appreciates the opportunity to provide comments, and we are committed to working with you as stakeholders to strengthen the Medicaid program given the important role it plays in meeting the needs of our county residents. If you have any questions, please feel free to contact Blaire Bryant, NACo Associate Legislative Director, at bbryant@naco.org or at 202.942.4246.

Sincerely,

Matthew D. Chase
Executive Director
National Association of Counties