



Lutheran
Services
in America

January 27, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

As President and CEO of Lutheran Services in America, I write to offer comments on file code CMS-2393-P, a proposed rule entitled the “Medicaid Fiscal Accountability Regulation.” The proposed rule would make changes to how states are able to finance their share of the cost of Medicaid and how they pay health care providers. We welcome the opportunity to share input on this proposed rule.

For context, Lutheran Services in America leads one of the largest health and human services networks in the U.S., made up of over 300 Lutheran social ministry organizations that operate with over \$22 billion in annual revenue. Efforts of the dedicated people who make up our national network help improve the lives of 1 in 50 Americans each year. Guided by God’s call to love and serve our neighbors, we empower our faith-based member organizations in their mission to lift up the nation’s most vulnerable people. In providing services to seniors, children and people with disabilities, along with veterans, refugees and the homeless, our members work in 1,400 communities throughout the country—in rural and urban areas—as shown on this map:

http://bit.ly/LSA_member_map .

We have long focused on supporting the healthy, independent aging of America’s seniors – particularly people struggling with limited resources, isolated settings, or challenges like lack of transportation or food insecurity. Over 200 of our member organizations work with seniors, providing home- and community-based services from home health care, senior centers, and care coordination to



transportation, behavioral health and respite care. Our members also work with seniors via residential care, whether through affordable housing or independent living efforts, or assisted living, nursing homes or memory centers.

Another vital part of our organization is the Lutheran Services in America-Disability Network (LSA-DN), a nationwide network of Lutheran social ministry organizations, faith-based organizations and Lutheran professionals supporting people with intellectual and developmental disabilities and related conditions. LSA-DN includes 19 member organizations that provide support to individuals with intellectual and developmental disabilities across the country. Many of the people served by Lutheran Services in America's member organizations rely on Medicaid for health coverage.

As a large non-profit provider of services to these Medicaid constituents, the Lutheran Services in America network recognizes the importance of Medicaid in providing high-quality health coverage to millions of Americans. Medicaid provides access to critically important preventive care, early identification and intervention services for children, and long-term services and supports for vulnerable seniors and people with disabilities: over 60% of seniors in nursing homes and over 10 million people with disabilities rely on Medicaid for health care coverage.

Because Medicaid is a joint federal-state program, the federal government pays a fixed share of states' Medicaid costs, with states responsible for contributing the remainder. Under current law, states may cover their share of costs using not just general revenues, but also taxes on health care providers such as hospitals and nursing homes, contributions from local governments (known as intergovernmental transfers or IGTs) and spending incurred by public providers for Medicaid beneficiaries (known as certified public expenditures or CPEs). Further, states may choose to levy provider taxes under federally approved waivers of the requirements that usually apply, allowing them, among other things, to offer exemptions to some providers that do not primarily provide Medicaid services or that serve only a nominal number of Medicaid

beneficiaries. The statutory and regulatory provisions governing these sources of funding have been in place for 30 years, and states have designed their Medicaid revenue models around them. The Government Accountability Office (GAO) found that in 2012, 26 percent of the non-federal share of Medicaid costs were funded through these avenues,¹ while The Kaiser Family Foundation reports that in state fiscal year 2019, 49 states plus the District of Columbia used one or more provider taxes to finance their share of the cost of Medicaid programs.²

States are also currently permitted to make supplemental payments to hospitals, nursing homes, physicians and other health care providers, in addition to base reimbursement rates, for a variety of purposes including closing the gap between providers' costs and Medicaid reimbursements. Almost every state makes such payments.

In the name of “increasing transparency” of these supplemental payments, the proposed rule would make a number of highly technical policy changes that could prohibit or limit existing financing and supplemental payment arrangements, impacting states' Medicaid budgets far beyond the supplemental payments themselves. First, the rule would substantially expand the scope of review and agency discretion for federal approval of these arrangements, including those already in place, while offering only vague and ill-defined criteria and standards for how approvals would be considered. For example, currently states may levy provider taxes under federally approved waivers if their taxes meet certain specific mathematical tests. The proposed rule, however, would impose a new “undue burden” standard under which CMS would determine whether the tax applies disproportionately to Medicaid

¹ Government Accountability Office, *Nonfederal Share Separated into State Funds, Funds from Health Care Providers, Funds From Local Governments, and Other Sources of Funds for Four Types of Medicaid Payments Combined in State Fiscal year 2012* (2012), <https://www.gao.gov/special.pubs/gao-15-227sp/sectionb212.html>.

² Kaiser Family Foundation, *States With at Least One Provider Tax in Place* (2019), <https://www.kff.org/medicaid/state-indicator/states-with-at-least-one-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

providers using, among others, a “totality of circumstances” and reasonable determination test—neither of which is adequately explained. The rule would also require that all provider tax waivers and supplemental payment arrangements be limited to a three-year duration, regardless of how long they have already been in place, after which they would have to be renewed.

Second, the rule would impose many substantive changes to longstanding requirements governing financing and payment arrangements once approved. For example, current law allows public providers to make IGTs derived from any public funds. In contrast, the proposed rule would limit transfers to funding derived from state and local taxes or appropriations to teaching hospitals. That would effectively bar IGTs largely comprised of private insurance revenues and charitable donations. States use IGTs and provider taxes to fund many aspects of their Medicaid programs, not just the supplemental payments that are most concerning to CMS. Accordingly, the sweeping changes in the proposed rules would affect far more than just supplemental payments. Despite the broad scope of this proposal, CMS itself acknowledges that the fiscal effects on state Medicaid programs are largely “unknown.”

Because the proposed standards of review are so nonspecific and give CMS so much discretion and because reviews would occur at least every three years, the proposed rule could have a major chilling effect. States could decide to scale back or eliminate existing financing and supplemental payment arrangements in their Medicaid programs out of caution and confusion. Then, the proposed changes to governance requirements would likely further reduce available funds for states to contribute to their Medicaid programs.

If states are unable to replace these lost funds with other sources such as general revenues and thereby maintain the current level of state spending on Medicaid, they would face budget shortfalls. Less state spending on Medicaid also means fewer federal Medicaid matching dollars coming to states. States would then have no choice but to make drastic cuts to their overall Medicaid programs in the areas of eligibility, benefits and provider payments. Similarly, if states are



unable to raise base provider payment rates to replace supplemental payments, providers would face significant financial hardship and may have to scale back the services they now provide to low-income Medicaid beneficiaries. As a result, beneficiaries could face reduced access to needed care or lose their Medicaid coverage entirely.

In sum, the proposed changes would inject unacceptable uncertainty into this crucial safety net program for states, for beneficiaries, for providers who benefit from supplemental payments, for providers who currently pay provider taxes, and for providers who do not now pay provider taxes, and would result in less funding for Medicaid overall.

Therefore, we urge the Administration to reconsider this rule change and ensure that the Medicaid program remains stable, strong, and available for the country's most vulnerable people.

Respectfully,

A handwritten signature in black ink that reads "Charlotte Haberaecker".

Charlotte Haberaecker
President and CEO