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January 31, 2020

Alex Azar, Secretary
Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: Medicaid Program; Medicaid Fiscal Accountability Regulation (RIN 0938–AT50/CMS–2393–P)

Dear Secretary Azar and Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment in response to the proposed **Medicaid Fiscal Accountability Regulation**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

The Medicaid program, now over half a century old, is a success story. Through Medicaid, millions of low-income Americans have built well-being and gained greater economic security via access to health insurance. This coverage helps guarantee health care to 12 million older adults and people with disabilities who also rely on Medicare.¹

On our National Consumer Helpline, we frequently hear from people with Medicare who are struggling to afford their coverage. For those who qualify, Medicaid can be a lifeline, helping close affordability and access gaps.²

¹ Medicare-Medicaid Coordination Office, "People Dually Eligible for Medicare and Medicaid," Centers for Medicare & Medicaid Services (March 2019), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

² Medicare Interactive, "How Medicaid works with Medicare," Medicare Rights Center (last accessed January 31, 2020), <https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-and-medicaid/how-medicaid-works-with-medicare>.

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For example, Medicaid can help people with Medicare pay their premiums and cost sharing amounts, allowing them to maintain coverage.³ The access to care this facilitates is critical for dual eligibles, who tend to have high health needs. Nearly 75% of duals have three or more chronic conditions, such as diabetes or heart disease, which can require regular doctor appointments, multiple prescription medications, and frequent medical tests.⁴ The beneficiary's share of those costs can add up quickly, often making needed services difficult or impossible to afford for without support from Medicaid.

Medicaid also covers services that Medicare does not, including long-term services and supports in the community and long-term care in nursing facilities.⁵ This care is highly utilized among dual eligibles. Over 60% of people with Medicare and Medicaid need help with activities that are important for independent living—such as eating, bathing, and dressing—and nearly 60% have a cognitive or mental impairment, such as dementia, which can create the need for supports to live safely at home.⁶

The value of this care is significant. While Medicare beneficiaries account for an estimated 15% of all Medicaid enrollees, their intensive health needs result in 36% of Medicaid spending.⁷ Nearly three-quarters of states devote more than 30% of their Medicaid dollars to people with Medicare, and spending for Medicare beneficiaries comprises more than 45% of Medicaid budgets in six states.⁸

Based on this data and our experience, we know that Medicaid is critically important to the health and well-being of people with Medicare and their families. Because of this, we strongly oppose policy changes that would undermine Medicaid's ability to continue to provide these supports. This proposed rule would do just that. Accordingly, and for the reasons outlined below, we urge you to withdraw this rule in its entirety.

Impact of the Proposed Rule

The proposed rule would have a significant and detrimental impact on how states can finance their Medicaid programs and pay providers. It could lead to cuts in benefits, eligibility, and provider payments, jeopardizing access to care for over 70 million Americans.⁹

In the proposal, CMS says it wants to “better understand the relationship between and among the following: Supplemental provider payments, costs incurred by providers, current UPL requirements, state financing of the non-federal share of supplemental payments, and the impact of supplemental payments on the Medicaid program (such as improvements in the quality of, or access to, care.)”¹⁰ The text of the proposed rule, however, does not appear to advance this objective. Instead, it would severely restrict states' ability to use these mechanisms to finance their share of Medicaid expenditures and reimburse providers.

³ Centers for Medicare & Medicaid Services, “Medicare Savings Programs” (last accessed January 31, 2020), <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs>.

⁴ MaryBeth Musumeci, “Medicaid's Role for Medicare Beneficiaries,” Kaiser Family Foundation (February 16, 2017), <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-medicare-beneficiaries/>.

⁵ Medicare Interactive, “Medicaid eligibility for Medicare beneficiaries who need long-term care in the home or community,” Medicare Rights Center (last accessed January 31, 2020), <https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-and-medicare/medicaid-eligibility-for-medicare-beneficiaries-who-need-long-term-care-in-the-home-or-community>.

⁶ MaryBeth Musumeci, “Medicaid's Role for Medicare Beneficiaries,” Kaiser Family Foundation (February 16, 2017), <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-medicare-beneficiaries/>.

⁷ *Id.*

⁸ *Id.*

⁹ Centers for Medicare & Medicaid Services, “October 2019 Medicaid & CHIP Enrollment Data Highlights” (last accessed January 31, 2020), <https://www.medicare.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

¹⁰ Fed. Reg 84 63722, 63724.

The proposed rule would, for example, limit the use of provider taxes and effectively prohibit public providers from using private insurance revenues or charitable donations to fund portions of the Medicaid program. If states are unable to make up these losses, which is likely, they would be forced to cut their Medicaid programs. And because fewer state funds for Medicaid results in fewer federal matching funds, the cuts would be much larger than the shortfall in state funding.

The proposed rule is clear that these changes would come without a full understanding of the implications. The preamble explicitly states: “The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown.”¹¹ Significantly more work must be done to understand and explain such consequences before making changes of the magnitude proposed. We are also concerned that the proposed rule would establish discretionary standards of review for states’ Medicaid financing arrangements and supplemental payments. This would create uncertainty about what is allowable and potentially create wide discrepancies between states.

The subject matter of the proposed rule is extremely complex and the lack of specifics or a true analysis of the costs and impacts makes it difficult to respond to the rule’s effects on access to care. Based on the information provided, however, we are very concerned that the proposal would directly—and negatively—affect those we serve.

Despite acknowledging that more information is needed, CMS proposes making immediate, sweeping changes. If finalized as written, this proposed rule would force many states to make rapid, downward revisions to the way they finance their share of Medicaid expenditures and reimburse providers. In response to these lost funds, it is unlikely that most states would increase the amount of general revenue they devote to Medicaid, forcing them to make cuts in provider payments, benefits, and eligibility. Similarly, states are unlikely to increase base payments to providers or otherwise offset the reduction or elimination of supplemental payments. Further, the lack of data and vagueness throughout the rule make it impossible to fully understand its impact and provide appropriate comments.

These flaws make it imperative that CMS withdraw this rule and instead work to establish a transparent process for obtaining a full understanding of various Medicaid financing arrangements, including their impact on the program and the necessity of any such changes.

Thank you again for this opportunity to comment. We look forward to working together to advance Medicaid’s purpose in providing health coverage to people with lower incomes, including those who are also eligible for Medicare. For additional information, please me at LCopeland@medicarerights.org or Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org.

Sincerely,



Lindsey Copeland
Federal Policy Director
Medicare Rights Center

¹¹ Fed. Reg 84 63722, 63773.