



Institute for  
**Policy Integrity**  
NEW YORK UNIVERSITY SCHOOL OF LAW

February 1, 2020

**VIA ELECTRONIC SUBMISSION**

Department of Health and Human Services

**Attn:** Centers for Medicare & Medicaid Services

**Re:** Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722 (proposed Nov. 18, 2019)

**Docket ID:** CMS-2393-P

The Institute for Policy Integrity at New York University School of Law<sup>1</sup> respectfully submits the following comments to the Centers for Medicare and Medicaid Services (“CMS” or the “agency”) at the Department of Health and Human Services (“HHS”) regarding the proposed Medicaid Fiscal Accountability Regulation (“Proposed Rule”).<sup>2</sup> Policy Integrity is a non-partisan think tank dedicated to improving the quality of government decision-making through scholarship in the fields of administrative law, economics, and public policy.

These comments focus on serious flaws in the regulatory impact analysis accompanying the Proposed Rule. Specifically, we note that CMS fails to:

- quantify reductions in Medicaid funding that will result from the Proposed Rule;
- assess the health impacts of those Medicaid funding cuts; and
- identify any significant benefits of the Proposed Rule’s limits on supplemental payments, intergovernmental transfers, provider taxes, and certified public expenditures.

**I. CMS does not adequately account for the Proposed Rule’s costs and benefits**

The regulatory impact analysis for the Proposed Rule satisfies the requirements of neither Executive Order 12,866 nor the Administrative Procedure Act (“APA”).

Executive Order 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action, including, but not limited to, the action’s expected effects on “the

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<sup>1</sup> This document does not purport to present New York University School of Law’s views, if any.

<sup>2</sup> 84 Fed. Reg. 63,722 (proposed Nov. 18, 2019).

efficient functioning of the economy and private markets,” “health,” and “safety.”<sup>3</sup> An agency should “propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs,” and after considering “all costs and benefits of available regulatory alternatives, including the alternative of not regulating.”<sup>4</sup>

The executive order further instructs agencies to base their analyses “on the best reasonably obtainable scientific, technical, economic, and other information,” and to quantify regulatory effects “to the extent feasible.”<sup>5</sup> Longstanding guidance on regulatory impact analysis from the Office of Management and Budget (“OMB”) similarly advises that “[s]ound quantitative estimates of benefits and costs, where feasible, are preferable to qualitative descriptions.”<sup>6</sup> Because some effects are “too difficult to quantify or monetize given current data and methods,” however, agencies must also “carry out a careful evaluation of non-quantified benefits and costs.”<sup>7</sup>

Separate from the requirements of Executive Order 12,866, courts have held under the APA that “when an agency decides to rely on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the rule unreasonable.”<sup>8</sup>

Because CMS fails to (1) quantify the extent to which the Proposed Rule will reduce Medicaid funding, (2) consider the health costs that will result from those funding reductions, and (3) identify any significant benefits that could justify those health costs, the agency’s regulatory impact analysis is fatally incomplete under both Executive Order 12,866 and the APA. Finalizing the Proposed Rule in reliance on this fundamentally flawed analysis would be arbitrary and capricious.

## **II. CMS fails to quantify the Proposed Rule’s effects on Medicaid funding**

CMS concedes that the Proposed Rule’s overall “fiscal impact on the Medicaid program” is “unknown.”<sup>9</sup> The agency estimates the potential funding reduction associated with only one of its proposed provisions—that limiting supplemental payments to practitioners.<sup>10</sup> With respect to

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<sup>3</sup> Exec. Order No. 12,866 § 6(a)(3)(C), 58 Fed. Reg. 51,735 (Oct. 4, 1993). The Department has concluded that the Proposed Rule is an economically significant regulatory action for the purposes of Executive Order 12,866. 84 Fed. Reg. at 63,772.

<sup>4</sup> Exec. Order No. 12,866 §§ 1(a), (b)(6).

<sup>5</sup> *Id.* §§ 1(b)(7), 6(a)(3)(C).

<sup>6</sup> Office of Mgmt. & Budget, Circular A-4, Regulatory Analysis 26 (2003) [hereinafter Circular A-4].

<sup>7</sup> *Id.* at 26–27.

<sup>8</sup> *Nat’l Ass’n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012); *see also Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (APA requires agency to “examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made” (internal quotation marks omitted)).

<sup>9</sup> 84 Fed. Reg. at 63,773.

<sup>10</sup> *Id.*

the remainder of the Proposed Rule, CMS claims to lack “sufficient data to predict or quantify the impact.”<sup>11</sup> But the agency cannot so easily shirk its analytic obligations.

“[R]egulators by nature work under conditions of serious uncertainty,” and “[t]he mere fact that the magnitude of [a regulatory effect] is uncertain is no justification for disregarding the effect entirely.”<sup>12</sup> While there may be “a range of [plausible] values” for the funding reductions caused by the Proposed Rule’s provisions other than the supplemental payment limit, those values are “certainly not zero.”<sup>13</sup> On the contrary, industry groups and health researchers alike predict that the Proposed Rule’s new limits on intergovernmental transfers, provider taxes, and certified public expenditures will have substantial fiscal impacts in a large number of states.<sup>14</sup>

In the absence of any estimate of the Proposed Rule’s total effect on state Medicaid funding, CMS cannot defensibly conclude that the policy’s benefits justify its costs, as Executive Order 12,866 requires.<sup>15</sup> Nor can the agency fulfill its duty under the APA to consider “important aspect[s] of the problem” it seeks to address through rulemaking.<sup>16</sup> An undeniably important aspect of an attempt to reform Medicaid funding *mechanisms* is the reform’s impact on Medicaid funding *levels*.

Accordingly, rather than finalize the Proposed Rule, CMS should conduct “additional research prior to rulemaking,” as OMB’s guidelines recommend for regulatory proceedings where “uncertainty has significant effects on the final conclusion about net benefits.”<sup>17</sup> Given the

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<sup>11</sup> *Id.*

<sup>12</sup> *Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219, 1221 (D.C. Cir. 2004) (emphasis omitted).

<sup>13</sup> *Ctr. for Biological Diversity v. Nat’l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1200 (9th Cir. 2008) (internal quotation marks omitted).

<sup>14</sup> *See, e.g.*, American Hospital Association, Fact Sheet: Medicaid Fiscal Accountability Rule (Jan. 2020), <https://www.aha.org/system/files/media/file/2020/01/fact-sheet-medicaid-fiscal-accountability-rule-mfar.pdf> (“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.”); Edwin Park, Center for Children and Families, Georgetown University Health Policy Institute, Comment Letter on Proposed Medicaid Fiscal Accountability Regulation 5 (Jan. 23, 2020), <https://ccf.georgetown.edu/wp-content/uploads/2020/01/Georgetown-CCF-Comments-to-CMS-MFAR-CMS%E2%80%93932393%E2%80%9393P.pdf> (deeming it “highly likely that the proposed rule could have a significant, widespread and harmful effect on most state Medicaid programs” and noting that “in 2012, 26 percent of the non-federal share of Medicaid costs, on average, were financed from provider taxes (10.4%) and IGTs and CPEs (15.5%), with those percentages likely higher today”).

<sup>15</sup> Exec. Order No. 12,866 § 1(b)(6).

<sup>16</sup> *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

<sup>17</sup> Circular A-4 at 39.

importance of the Medicaid program to several vulnerable patient populations,<sup>18</sup> this is a case in which the “costs of being wrong . . . outweigh the benefits of a faster decision.”<sup>19</sup>

### III. CMS fails to assess the health impacts of Medicaid funding cuts

In addition to failing to estimate the extent to which the Proposed Rule will reduce funding for state Medicaid programs, CMS fails to assess the effects of those cuts on the health of Medicaid beneficiaries and others in their communities.

A variety of stakeholders warn that states are likely to respond to the Proposed Rule’s funding constraints by scaling back their Medicaid programs—specifically, by reducing payments to providers, covering fewer services, or serving fewer beneficiaries. This retrenchment will, in turn, reduce access to healthcare. The American Hospital Association, for example, concludes that the Proposed Rule will “unquestionably result in cuts in program enrollment and covered services” and that “[t]he impact in some states could be catastrophic.”<sup>20</sup> The Center for Budget and Policy Priorities cautions that the Proposed Rule could “jeopardize access to care for millions of Medicaid beneficiaries.”<sup>21</sup> And Cindy Mann, former Deputy Administrator of CMS, predicts “dramatic ramifications for access to care, particularly in rural and other underserved areas.”<sup>22</sup>

The adverse health effects of reduced access to care undoubtedly qualify as costs that must be addressed in CMS’s cost-benefit analysis.<sup>23</sup> Indeed, HHS’s own guidelines for regulatory impact analysis explicitly cite “change[s] in health” resulting from “reductions in government payments to hospitals” as an example of a cost that “should be addressed in [an HHS agency’s] benefit-cost

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<sup>18</sup> Robin Rudowitz et al., Kaiser Family Foundation, 10 Things to Know about Medicaid: Setting the Facts Straight (Mar. 6, 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/> (“Medicaid plays an especially critical role for certain populations covering: nearly half of all births in the typical state; 83% of poor children; 48% of children with special health care needs and 45% of nonelderly adults with disabilities . . . and more than six in ten nursing home residents.”).

<sup>19</sup> Circular A-4 at 39.

<sup>20</sup> American Hospital Association, Fact Sheet: Medicaid Fiscal Accountability Rule (Jan. 2020), <https://www.aha.org/system/files/media/file/2020/01/fact-sheet-medicaid-fiscal-accountability-rule-mfar.pdf>.

<sup>21</sup> Judith Solomon & Jessica Schubel, Ctr. for Budget & Policy Priorities, Comment Letter on Proposed Medicaid Fiscal Accountability Regulation 1 (Jan. 24, 2020), <https://www.cbpp.org/sites/default/files/atoms/files/1-30-20-health-comments.pdf>.

<sup>22</sup> Cindy Mann & Anne O’Hagen Karl, “Proposed Rules on Medicaid Financing Miss Mark and Threaten Access,” *Health Affairs* (Jan. 8, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200108.392104/full/>.

<sup>23</sup> Exec. Order No. 12,866 § 6(a)(3)(C)(ii) (agency’s assessment of “costs anticipated from the regulatory action” should include “any adverse effects on . . . health”); *Michigan v. EPA*, 135 S. Ct. 2699, 2707–08 (2015) (explaining that “[a]gencies have long treated costs as a centrally relevant factor when deciding whether to regulate” and that costs “include[] more than the expense of complying with regulations”; instead, “any disadvantage could be termed a cost.”).

analysis, if significant.”<sup>24</sup> Yet CMS’s analysis does not even acknowledge the Proposed Rule’s potential to reduce healthcare access, much less attempt to assess how such a reduction will affect health outcomes. This omission renders the agency’s analysis—and any rule finalized in reliance on that analysis—unreasonable.

#### **IV. CMS fails to identify any significant benefits of the Proposed Rule’s limits on supplemental payments, intergovernmental transfers, provider taxes, and certified public expenditures**

Finally, CMS identifies no significant benefits of the Proposed Rule’s limits on supplemental payments, intergovernmental transfers, provider taxes, and certified public expenditures. The agency characterizes the Proposed Rule as seeking “to add additional accountability and transparency for Medicaid payments, and to provide CMS with certain information on supplemental payments.”<sup>25</sup> But these goals would justify the imposition of new data collection and reporting requirements, not new limits on the means by which states may fund their Medicaid programs.

CMS further claims that the Proposed Rule will “ensure the proper and *efficient* operation of the Medicaid state plan.”<sup>26</sup> But the Proposed Rule would increase the efficiency of the Medicaid program only if it either (1) achieved the same health outcomes at a lower cost, or (2) achieved cost savings that outweighed the value of any accompanying decline in health outcomes. The agency has not shown either to be the case here.

#### **Conclusion**

Because CMS cannot reasonably conclude based on available evidence that the Proposed Rule will do more good than harm, the agency should not finalize the action. Instead, CMS should conduct additional research that will enable it to better assess the fiscal and health consequences of any potential changes to existing Medicaid funding regulations.

Respectfully,

Jack Lienke, Regulatory Policy Director  
Iliana Paul, Policy Analyst

Institute for Policy Integrity  
jack.lienke@nyu.edu

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<sup>24</sup> Dep’t of Health & Human Servs., Guidelines for Regulatory Impact Analysis 23 (2016), [https://aspe.hhs.gov/system/files/pdf/242926/HHS\\_RIAGuidance.pdf](https://aspe.hhs.gov/system/files/pdf/242926/HHS_RIAGuidance.pdf).

<sup>25</sup> 84 Fed. Reg. at 63,772.

<sup>26</sup> *Id.* (emphasis added).