FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

February 1, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments Proposed Rule: Medicaid Program; Medicaid Fiscal Accountability Regulation

To Whom It May Concern:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAWG) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV and hepatitis C-related healthcare and support services. We appreciate the opportunity to provide comments on the Medicaid Fiscal Accountability Notice of Proposed Rulemaking (NPRM) published by the Centers for Medicare & Medicaid Services (CMS).

The Medicaid program is a critical source of health coverage for life-saving care for people living with HIV. A significant portion (42 percent) of people living with HIV in care count on the Medicaid program for the health care and treatment that keeps them healthy and productive.[1] Ensuring uninterrupted access to effective HIV care and treatment is important to the health of people living with HIV and to public health.[2] When HIV is effectively managed, the risk of transmitting the virus drops to zero.[3]

Given the importance of Medicaid to people living with HIV, HHCAWG supports increased transparency in the operation and financing of Medicaid. Absent transparency, CMS has little means by which to hold state Medicaid agencies, managed care organizations, and providers accountable for the quality of care delivered to Medicaid enrollees. While we applaud CMS for its efforts to promote transparency, HHCAWG is concerned about the far-reaching negative

[1] Medicaid and HIV, Kaiser Family Foundation. October 1, 2019.
[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL. pdf.
[3] Cohen, MS., et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839. September 1, 2016.

consequences the NPRM could have on access to and quality of care for people living with HIV, hepatitis c, and other chronic health conditions.

The current operation of the Medicaid program allows states significant flexibility to fund their non-federal share of Medicaid dollars. While attempting to address transparency concerns, the NPRM goes too far and would significantly restrict the flexibility Medicaid programs currently enjoy, causing, at best, significant disruption to state enrollees, providers, managed care plans, and program administrators. CMS states that is wants to "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.)" However, instead of proposing methods by which these mechanisms could be better understood, the NPRM sets out a number of highly technical policy changes that will limit how states pay for their share of the Medicaid program and reimburse hospitals, nursing homes, physicians and other providers.

For example, public providers can currently make "Intergovernmental Transfers" (IGTs) using any public dollars. The NPRM would severely curtail the source of IGTs, limiting them solely to funding from state and local taxes or those appropriated to teaching hospitals. This would result in a reduction in the amount of IGTs available to finance Medicaid if states are unable to replace this funding with other general revenues, leading to a cut in services to Medicaid enrollees. The proposed rule also seeks to limit the use of provider taxes and other existing, legal funding mechanisms states utilize to pay their share of Medicaid costs. It also would restrict the use of supplemental payments.

Disturbingly, the regulatory impact statement in the NPRM states that the "fiscal impact on the Medicaid program from the implication of the policies in the proposed rule is unknown." States' reliance on the financing mechanism curtailed or limited by the NPRM varies widely state-by-state. A report by the Government Accountability Office examining the percentage of the non-federal share of Medicaid funds financing by health care provider assessments and local government IGTs reveals this disparity, as percentages range from 0 to over 50 percent.[4]

The subject matter of the NPRM is extremely complex and the lack of specifics makes it difficult for us to respond to the rule's potential impact on access to care. Because the impact of the NPRM is unknown, the public has not been given a meaningful opportunity to provide input on the proposed rule. For example, HHCAWG has no way to measure the impact the NRPM would have on HIV care in the Medicaid program, nor can it assess the strain that decreased Medicaid funding would create on other critical HIV safety-net providers such as the AIDS Drug Assistance Program and Federally Qualified Health Centers.

[4] Government Accountability Office, *States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627, July 29, 2014.

Given the lack of specificity or coherent regulatory impact statement, the NPRM does not comply with the requirements of the Administrative Procedure Act (APA). In particular, the (APA) requires that, through notice-and-comment rulemaking, CMS provide the public with a meaningful opportunity to present their views, arguments, and data as feedback.[5] Importantly, this process is meant to invite reasoned decision-making, and is "not meant to be an empty charade," and should provide the public with enough detailed information that it does not foreclose thoughtful input.[6] As the Supreme Court has noted, to comply with the APA an agency must examine the relevant data and articulate a reasoned explanation for its proposals.[7] As noted above, CMS fails to quantify or explain why it cannot quantify the costs and assess the economic effects of the NPRM.

In addition to the concerns we discuss above, we believe CMS has failed to comply with Executive Order (E.O.) 12,866 in proposing this rule. E.O. 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action.[8] An agency should propose 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 proposing a rule. Yet CMS acknowledges that "[t]he fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is *unknown* [italics added]." The only estimate of the fiscal effects on state Medicaid programs that CMS provides is for the single provision establishing the new, lower limit on Medicaid supplemental payments to physicians and other practitioners.

Given the concerns outlined above related to the impact of the NPRM on the Medicaid program and access to care for people living with HIV, as well as the procedural deficiencies outlined above, HHCAWG urges CMS to rescind the proposed rule in its entirety. Please contact HHCAWG co-chairs HHCAWG Co-Chairs Phil Waters with the Center for Health Law and Policy Innovation at pwaters@law.harvard.edu, Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, or Rachel Klein with The AIDS Institute at rklein@taimail.org.

Respectfully submitted by the undersigned organizations:

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[5] 5 USC § 553.
[6] *Connecticut Light and Power Co. v. Nuclear Regulatory Commission*, 673 F.2d 525, 528 (D.C. Cir. 1982). *See also Florida Power & Light Co v. US*, 846 F.2d 765, 771 (DC. Cir. 1988); *Forester v. CPSC*, 559 F.3d 774, 787 (DC. Cir. 1977).
[7] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43, 103 S.Ct. 2856, 2866-67, 77 L.Ed.2d 443 (1983)
[8] Exec. Order No 12,866, 58 FR 51735 (Oct. 4, 1993).

ADAP Educational Initiative | AIDS Alabama | AIDS Action Baltimore | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin | Bailey House, Inc. | Black AIDS Institute | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association| HIV + Hepatitis Policy Institute | Housing Works | Legal Council for Health Justice | Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Latino AIDS Action Network | NMAC | Positive Health Solutions of the University of Illinois | Positive Women's Network - USA | Ryan White Medical Providers Coalition | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | The AIDS Institute | Treatment Access Expansion Project | Thrive Alabama | Vivent Health