January 30, 2020

Ms. 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 (CMS-2393-P)

Dear Ms. Verma:

I am writing on behalf of LeadingAge New York to provide our comments on the above-captioned Proposed Rule. LeadingAge NY represents over 400 not-for-profit and public providers of long term care and senior services throughout New York State, including nursing homes. Our national affiliate, LeadingAge, is an association of 6,000 not-for-profit organizations providing long term care services and supports throughout the United States. LeadingAge NY endorses the separately submitted comments of LeadingAge.

Overview

The stated intent of the proposed Medicaid Fiscal Accountability Regulation (MFAR) is to enhance the transparency of supplemental payments to Medicaid providers under Medicaid state plan and demonstrations by requiring states to increase their reporting on such arrangements to the Centers for Medicare & Medicaid Services (CMS), including any applicable upper payment (UPL) limit considerations. The proposal also seeks to ensure that supplemental payments are consistent with the proper and efficient operation of the state plan and with efficiency, economy, and quality of care.

At a high level, LeadingAge NY is concerned that this proposed rule:

- Could disproportionately affect nursing homes, which tend to serve large numbers of Medicaid beneficiaries and are significantly under-compensated by baseline Medicaid payments;
- Includes vague and arbitrary proposed standards for provider taxes;
- Seeks to make changes to the requirements for Upper Payment Limit (UPL) compliance demonstrations and to supplemental payment requirements without adequate data;
- Fails to adequately estimate the impact of the rule on Medicaid-funded services;
- Incorrectly concludes that small entities/providers would not be impacted; and
- Provides for an unrealistically short three-year implementation/renewal timeline, which could create uncertainty for states and providers.

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We recommend that CMS withdraw the proposed rule and conduct further data analysis to justify any proposed changes prior to its republication.

MFAR Would Disproportionately Affect Nursing Home Care

The MFAR, as proposed, would disproportionately impact nursing homes compared to other types of providers. Medicaid is the predominant payer of nursing home care in New York, accounting for over 70 percent of resident care days on an annual basis. Medicare does not pay for nursing home care beyond short-term post-acute care, and private payment (including out-of-pocket and insurance payments) is shrinking and accounts for less than 15 percent of resident care days.

Other types of providers subject to this rule rely less on Medicaid for financing services. For example, just 11 percent of physician services is Medicaid-funded and almost 2 in 3 (66%) dollars for physician services come from private insurance or Medicare.[1] Less than one in four inpatient hospital discharges are covered by Medicaid, with over 70 percent covered by either Medicare or private insurance.[2] As a result, the MFAR proposal will have a more direct and significant impact on nursing homes than other types of providers, and the significant changes proposed could be disruptive to nursing home provider stability and beneficiary access.

New York's base Medicaid payments to nursing homes are price-based using facility costs incurred in 2007, and providers have received no inflation adjustment since 2007. According to a November 2018 report from a national accounting firm, New York's Medicaid program paid the average nursing home in New York 20 percent less than its actual costs of providing care, a $64 per patient per day shortfall.[3] This level of under-payment underscores the importance of supplemental payments and Medicaid reimbursement of provider taxes, and the disproportionate impact that MFAR could have on nursing home services.

Given the critical role that Medicaid plays as the predominant payer of nursing home care, CMS should exempt nursing home services from the proposed rule or delay making substantive changes to Medicaid supplemental payment rules relative to nursing home care until it can properly assess the impact of such changes on quality of care and access to services.

Proposed Provider Tax Changes are Vague and Arbitrary

Current Medicaid regulations require that state provider taxes be broad-based and uniform. If a state wants to provide an exemption to certain providers or exclude certain revenue sources, it may do so if incorporating those policies permits compliance with statistical tests set forth by CMS. Specifically, state provider tax waivers must pass either the B1/B2 test for waivers of uniformity, or the P1/P2 test for waivers of the broad-based requirement.[4]

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[1] CMS 2018 National Health Expenditure Data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.

[2] HCUP Fast Stats - Trends in Inpatient Stays, 2016, https://www.hcup-us.ahrq.gov/faststats/landing.jsp.

[3] *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*, Hansen Hunter & Company, PC, Nov. 2018: https://www.ahcancal.org/facility_operations/medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf.

[4] See current 42 CFR § 433.68 (e)(1) and (2)

We seek to clarify that the provisions at 42 CFR §433.68(d) and (e) would continue to permit a state to exclude from taxation Medicare revenue or payments without such exclusion being considered *prima facie* evidence of imposing an undue burden on health care items or services reimbursed by Medicaid, as well as providers of such items or services.

The proposed rule imposes additional requirements beyond the statistical tests, however the proposed new criteria for provider taxes are overly vague and provide excessive discretion to CMS. As a result, states and providers will be unable to reasonably determine what types of provider taxes would or would not comply with the proposed rule. In particular, proposed 42 CFR § 433.68 (f)(3)(i) and (iii) are unworkable as detailed below and CMS should not proceed with finalizing these provisions without significant revision.

- *Proposed CFR § 433.68 (f)(3)(i): Taxing providers that provide less Medicaid services at lower rates than those that provide relatively more Medicaid services.* This proposed criterion is overly vague in that CMS does not define what would constitute "relatively more" Medicaid services. Without additional guidance on "relatively more", this criterion would be exceedingly difficult for states to comply with, particularly as payer mixes change over time. ***CMS should not move forward with this proposed criterion or should at least provide quantitative criteria for what constitutes "relatively" more or less Medicaid services.***

- *Proposed CFR § 433.68 (f)(3)(iii): Not taxing, or taxing at a lower rate, groups of providers with no Medicaid services compared to other groups (e.g., those that take Medicaid).* This proposed criterion would force states to impose new taxes. Providers that do not furnish Medicaid services are not imposing a burden on the Medicaid program, and exempting such providers from a provider tax does not burden Medicaid. Taxes levied on non-Medicaid providers to fund Medicaid would be harmful to non-Medicaid providers and the people they serve. CMS should not impose a regulation that forces states to levy new taxes on non-Medicaid providers. ***This proposed criterion should be withdrawn*.**

In addition, CMS considered, but did not propose, requiring that provider taxes pass BOTH the B1/B2 test (uniformity) and the P1/P2 test (broad-based requirement) to be considered permissible. ***We agree with CMS's determination to not require states to utilize both tests unless they would already be required to do so under current regulations.***

Under current policy, states cannot have provider taxes in which a taxpayer is held harmless for the cost of the tax. As previously noted, there are two current statistical tests that determine this. The proposed rule would add language allowing CMS to consider the "net effect" of provider tax policies in considering whether they hold payers harmless. Rather than continue to use calculable statistical tests to determine hold harmless compliance, CMS is proposing to give itself discretion to pick and choose compliance. While CMS includes a definition for "net effect," this definition is overly broad and provides insufficient guidance to states or providers to determine whether their current arrangements would comply. Further, the implementation timeline for this section is too immediate. ***States and providers will need time to transition to any final rule, and this section if finalized should be on the same implementation timeline (i.e., 3 or 5 years) as other sections in this proposal.***

Proposed Changes to UPL and Supplemental Payments Not Data-Driven

New York State has had a supplemental payment program in place for several years which provides added financial support to non-state operated public nursing homes (i.e., those operated by counties and New York City) through an Intergovernmental Transfer (IGT) mechanism. Funding for the non-federal share is provided by the sponsoring local government, and the public nursing homes retain the full amount of the payments.

This program provides vitally needed support to these safety net providers. New York's public nursing homes serve a higher proportion of Medicaid beneficiaries than other facilities and consequently, are far more likely to incur operating losses than other nursing homes:

Financial Indicator (2018 data)	NY Public Nursing Homes	All Other NY Nursing Homes
Median Medicaid Utilization	80.4%	71.8%
Percentage with Negative Operating Margins	93.3%	36.6%
Median Operating Margin	-17.6%	1.8%

Source: LeadingAge NY analysis of 2018 NYS Medicaid cost report data.

Despite the financial challenges, public nursing homes in New York staff higher, exhibit better survey performance and comparable quality indicator outcomes versus non-public nursing homes:

CMS 5-Star Rating	NY Public Nursing Homes: Mean Value	All Other NY Nursing Homes: Mean Value	Percentage Difference
Overall	3.5	3.2	+9.3%
Survey	2.9	2.8	+3.6%
Staffing	3.3	2.5	+32.0%
Quality Measures	4.0	4.1	-2.4%

Source: LeadingAge NY analysis of the most current CMS 5-Star ratings as of Jan. 28, 2020.

The proposed rule would make substantial changes to how states calculate UPLs and the amount of non-Disproportionate Share Hospital (DSH) supplemental payments, but there are no data justifications supporting such changes. The rule proposes to limit the types of cost data used (e.g., no more than 2 years old) and the methodologies states can employ to calculate the UPL for purposes of determining whether supplemental payments may be made to one or more groups of providers. It also requires states to submit extensive data to CMS on quarterly and annual bases, which would be used to inform future decision making on supplemental payments and UPL calculations, including facility-specific data on base and supplemental payments received.

LeadingAge NY believes CMS is taking the incorrect approach to this section of the proposal. Instead of making changes to the supplemental payments and UPL rules and then using data, CMS should take a data-informed approach before making such major changes to these rules. ***Thus, CMS should not move forward with the proposed changes to UPL calculations or to supplemental payments without first gathering current, aggregate data that are needed to do so. The proposed sections should be***

delayed or withdrawn until CMS has data to justify them, rather than creating new policy and collecting data after the fact.

We question the rationale for the proposed Supplemental payment reporting requirements contained in 42 CFR § 447.288(c), which would require states to report voluminous data identifying each provider and the amount of base and supplemental payments paid to each provider and the authority for each such payment annually within 60 days of the end of the state's fiscal year. This requirement will create a significant reporting burden on states. Furthermore, we are concerned about whether and how CMS will utilize these provider-specific data. The proposed rule notes that CMS had considered but decided not to propose that the UPL calculation be administered at a provider-specific level for certain services rather than through the longstanding policy of grouping providers according to their ownership. ***Since CMS apparently does not intend to revise the application of the UPL to reflect a provider-specific determination, the proposed data reporting requirements at 42 CFR § 447.288(c) should be withdrawn from the MFAR.***

We are also concerned about the proposed requirement at 42 CFR § 447.288(b) that states' UPL analyses include only data with dates of service that are no more than 2 years prior to the dates of service covered by the UPL demonstration. As a practical reality, state Medicaid cost reports must be submitted 6-8 months following the conclusion of a cost reporting period. The state Medicaid agency must then review and configure the data for analysis, which can take several weeks. By the time the data are usable for UPL purposes, they are nearly 2 years old (i.e., the 2018 cost reporting period begins 1/1/18 and the associated data are not ready for analysis until late 2019). ***If CMS intends to proceed with this requirement, the 2-year timeframe should be lengthened to at least 3 years to give states sufficient time to complete their UPL analyses.***

CMS Fails to Estimate the Impact of MFAR on States and Medicaid Programs

In Section V (Regulatory Impact Analysis), Part C (Anticipated Effects), Item 3 (Effects on the Medicaid Program), CMS says "The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." Given the broad scope of the proposal, and its potential implications for beneficiaries, providers and state budgets, this is an insufficient response.

CMS should not finalize the MFAR – which could have major implications for the Medicaid program – without conducting the necessary data analysis to do so. Whether with its current data assets or through data the agency could reasonably obtain, CMS is equipped to conduct such analysis and could do so before moving forward with this wide-reaching rule.

In the absence of such analysis, CMS should give considerable attention to public comment about the proposal's potential impact on Medicaid. In New York, the state share of Medicaid spending is financed by a combination of the General Fund, indigent care support, provider assessment revenue, tobacco settlement proceeds and other resources. Broadly as a category, provider assessments account for nearly $1 billion in revenues each year, a major source of revenue supporting the Medicaid program. New York's federal Medical Assistance Percentage (FMAP) is 50 percent, the lowest rate possible, placing a proportionally greater burden on the State and its local governments to finance Medicaid expenditures and adding to the concern about the potential impact of MFAR. Any impact of the MFAR on New York's IGT program, which provided nearly $200 million in supplemental payments to public nursing homes in the most recent year, would add to the local tax burden of counties and

municipalities that operate safety net nursing homes. As it is, many of New York's counties that operated nursing homes have sold them to private operators due to ongoing operating losses. Any reductions in this IGT funding due to the proposed rule would further destabilize public nursing home finances and directly impact quality of care and access to services for Medicaid beneficiaries.

Accordingly, CMS should delay finalizing this rule until it has the requisite data analysis to support any changes to supplemental payments, provider taxes and UPL demonstrations. If CMS is unable to conduct this analysis, it should withdraw the rule entirely and/or the sections for which there is no estimated Medicaid impact (e.g., proposed provider tax changes, proposed non-DSH supplemental payment changes).

Impact on Small Businesses/Providers

In Section V (Regulatory Impact Analysis), Part C (Anticipated Effects), Item 2 (Effects on Small Businesses and Other Providers), CMS writes that *"This rule establishes requirements that are solely the responsibility of state Medicaid agencies, which are not small entities. Therefore, the Secretary certifies this proposed rule would not, if promulgated, have a significant economic impact on a substantial number of small entities."*

This is simply inaccurate. While state Medicaid agencies would be in large part responsible for carrying out the requirements of the proposed rule and could experience budgetary impacts from it, they are not the only entities that would be affected by policy changes resulting from promulgation of this rule.

According the U.S. Small Business Administration's 2019 Table of Small Business Size Standards , the small business size standard for nursing homes is $30 million in average annual receipts. [5] LeadingAge New York estimates that the average annual receipts for nursing homes in New York total less than $15 million, well under the SBA size standard. Without provider tax protections or appropriate safeguards on supplemental payments, small entities like nursing homes would likely experience tax increases and reduced Medicaid payments as a result of this proposal.

CMS cannot reasonably assert that this proposal would not have "a significant economic impact" on small businesses, as its finalization would likely result in state policy changes that would adversely affect small businesses and their customers, including nursing homes and the frail elderly and disabled residents who live in them. CMS may not be directly making that change, but the agency's rulemaking would be the proximate cause.

For these reasons, CMS should revise the small entities impact statement and propose a revised statement that considers small entities like nursing homes. CMS should also revise the proposed rule as necessary to protect small entities and reflect the revised proposed small business impact statement. Both the revised statement and the revised proposed rule should then be made available for further public comment.

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[5] Per SBA, "This is the "total income" (or "gross income") plus the "cost of goods sold." See https://www.sba.gov/federal-contracting/contracting-guide/size-standards

Unrealistic Timelines for Implementation

CMS has proposed a far-reaching set of changes to Medicaid financing which could impact billions of dollars in essential funding, including but not limited to the proposed changes to provider taxes and supplemental payments. The agency currently proposes that these changes go into effect 2 or 3 years after the date any final rule is published.

Three years is simply not enough time for states to revise their policies to comply with this major rule, nor is it enough time for providers to recalibrate their financial strategy to prepare for implementation. In addition, the data required from states in the proposal are complex and most states likely would need significant time and resources to create/augment data systems and to collect the required data. Similarly, 3 years is likely not enough time to do so.

In addition to the overall 3-year timeframe for the rule to become effective, states would be required to reapply for existing and new supplemental payment methodologies and provider tax waivers every 3 years and demonstrate compliance with UPL requirements annually. These added timeframes will create major additional burdens on states, while introducing much greater uncertainties into state budgeting processes and provider funding. ***If CMS intends to proceed with MFAR, it should delay implementation of the regulations in their entirety for 5 years and utilize a 5-year timeframe for the effectiveness of supplemental payment arrangements and provider tax waivers. The proposed requirement for annual demonstrations of UPL compliance should also be reconsidered.***

Conclusion

New York and other states rely on one or more of these payment or financing mechanisms, and the changes proposed in MFAR could have major implications for providers and state budgets. It is not clear how CMS would apply the new requirements given the significant discretion the agency would have available to it. This could leave providers, state Medicaid programs and other important stakeholders like Medicaid beneficiaries and local governments with considerable uncertainty about the impact of the changes. Given the magnitude of the potential changes and lack of data to determine the fiscal impact, LeadingAge NY calls for CMS to collect additional data and analyze existing datasets prior to proceeding with this rule.

Thank you for the opportunity to provide input on the proposed rule. If you have any questions on our comments, please contact me at (518) 867-8383 or dheim@leadingageny.org.

Sincerely,

Daniel J. Heim
Executive Vice President