National
MLTSS
Health Plan Association

February 01, 2020

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicaid Program; Medicaid Fiscal Accountability Regulation [CMS–2393–P]

Dear Administrator Verma,

Thank you for the opportunity to provide comment on the Centers for Medicare and Medicaid Services (CMS)'s proposed regulation *Medicaid Program; Medicaid Fiscal Accountability Regulation*.

The National MLTS Health Plan Association represents health plans that contract with states to provide long-term services and supports (LTSS) to beneficiaries through the Medicaid program. Our members currently cover the large majority of all enrollees in MLTSS plans and assist States in delivering high quality long-term care services at the same or lower cost as the fee for service system with a focus on ensuring beneficiaries' quality of life and ability to live in the community instead of an institution. Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem, Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, Inclusa, L.A. Care Health Plan, UPMC Health Plan, VNSNY CHOICE, and WellCare Health Plans Inc.

As CMS indicates, the purpose of the Medicaid Fiscal Accountability Regulation (MFAR), is to, "strengthen the oversight and fiscal integrity of the Medicaid program." The rule aims to achieve this through three broad types of proposed reforms: improving reporting on supplemental payments, clarifying Medicaid financing definitions, and reducing questionable financing mechanisms. The Association supports CMS's efforts to obtain further data and information to support its role as a responsible steward of federal funds; this is a goal that Association members share and deeply understand as health plans who are entrusted with state Medicaid funding. However, as CMS points out, it currently lacks the data necessary to evaluate the impact of the entirety of the rule, including the proposals affecting health-care related taxes. Therefore, we ask that CMS only proceed with collecting the proposed data elements so that it can properly model the financial implications of the other proposals. Allowing only the data collection process to move forward would give CMS and other stakeholders the necessary data and information to promulgate new requirements to address potentially non-compliant funding mechanisms and payments.

Relatedly, as CMS works to gather the proposed data elements from states, we ask that it recognize and make accommodations for states who make a good faith effort to process the proposed reporting requirements, given the penalties associated with noncompliance. And, if CMS chooses to include similar proposals in future rulemaking, we ask that it apply clear and consistent standards in evaluating potentially questionable funding mechanisms so as not to unintentionally remove crucial funding from the system; communicating and applying these standards will be critical to ensuring stable levels of funding for provider and continued beneficiary access through the Medicaid program, including the ability for health plans to meet requirements for network adequacy.

Below we offer specific comments on the issues raised above.

Partial Implementation of the Proposed Rule
We ask that CMS only move forward with the data collection requirements so it can conduct a more detailed regulatory impact analysis of its proposals to assist stakeholders in understanding the potential impact of the proposed rule. Particularly, we ask for a more thorough analysis of the impact of the proposed changes to health-care related taxes. CMS currently states that the "fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." We understand the data challenges associated with modeling the impact of this proposal and encourage CMS to work with state partners and other relevant stakeholders through the regulatory process to collect any relevant data that would assist with a better understanding of the fiscal implications of the proposals. In the absence of such an analysis, the stakeholder community cannot adequately prepare itself to adopt to this new regulatory landscape, which could cause abrupt changes to state funding and unintended consequences related to beneficiary access.

Reporting Requirements for UPL Demonstrations and Supplemental Payments
CMS proposes that, beginning October 1, of the first year following the year in which the final rule may take effect, and annually thereafter, by October 1 of each year, each state would be required to submit a demonstration of compliance with the applicable upper payment limit (UPL) for each of the following services for which the state makes payment: inpatient hospital, outpatient hospital, nursing facility, ICF/IID, and institution for mental diseases (IMD).

Additionally, CMS proposes that if a state fails to "timely, completely and accurately" report this information as required then CMS may reduce future grant awards through deferral by the amount of federal financial participation (FFP) it estimates is attributable to payments made to the provider or providers as to which the state has not reported properly, until the state complies with the reporting requirements. CMS may also defer FFP if a state submits the required report, but the report fails to comply with applicable requirements. Otherwise, allowable but deferred FFP would be released when CMS determines that the state has complied with all reporting requirements.

We support CMS in its efforts to gather this additional data and information but ask that it provide states with additional time and guidance if they make a good faith effort to comply with the new requirements, given the proposed penalties. As CMS has indicated, organizations such as the Government Accountability Office (GAO), the Office of the Inspector General (OIG), and the Medicaid and CHIP Payment and Access Commission (MACPAC) have made recommendations for CMS to better understand the nature of Medicaid supplemental payments. In light of these recommendations and as CMS's position as a steward for federal funds, we support and understand the need for CMS to require additional reporting requirements. However, we also believe that states should be afforded the necessary time and technical assistance to gather and report on this information. In cases where a state may not be fully compliant with these requirements, we ask that CMS apply a staggered approach to bringing the state into compliance. That is, before CMS chooses to withhold a certain portion of the FFP, we ask that CMS work with and support the state in correcting any submission before withholding any funds, so along as the state demonstrates a good faith effort. The possibility of withholding FFP raises issues such as the ability for states to make timely payments to providers which could then result in reduced beneficiary access; we believe both situations would be an unintended consequence.

Standards for Evaluating Funding Mechanisms

CMS proposes several methods for evaluating different funding mechanisms along with revising definitions of certain terms (e.g. provider-related donations, parameters of a tax, Medicaid activity, etc.) to clarify and limit permissible state or local funds that may be considered a state share for Medicaid funding. For example, with respect to its evaluation of permissible health care-related taxes, CMS proposes to add a "net effect" standard. This standard would specify that a direct or indirect hold harmless guarantee would be found to exist "where, considering the totality of the circumstances, the net effect of an arrangement between the state (or other unit of government) and the taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount as discussed above."

We agree with CMS's intent to further clarify certain definitions and standards for evaluation to provide stakeholders with a better understanding of permissible and non-permissible funding mechanisms. Furthermore, we commend CMS for putting forward these proposals, in part, to reduce disparities, However, if CMS chooses to move forward with these new standards, we urge CMS to provide additional and timely guidance and communication to all relevant stakeholders if it begins to review funding mechanisms under these new requirements. We believe that all stakeholders should be compliant and held accountable to a consistent set of regulatory standards as they relate to receiving federal funds. We also believe that in order to maintain the greatest possible level of compliance and to reduce the overall burden on states and other stakeholders, CMS should provide further guidance for compliance tests such as the "net effect" standard for permissible health care-related taxes.

One unintended consequence that may arise from confusion regarding these standards is an unnecessary and avoidable reduction in Medicaid funding to states and providers. We recognize that CMS has built in waivers (e.g. health care-related tax waivers) for states to apply for to avoid these unintended consequences, but we believe further guidance is necessary for states and stakeholders to understand when such waivers may be necessary. These reductions could impact the viability of Medicaid providers to maintain their overall business operations and/or their participation in the Medicaid program. This could then lead to reductions or delays in beneficiary access, with further downstream effects for Medicaid managed care organizations that must meet certain network adequacy standards. In the context of long-term services and supports (LTSS), this is particularly concerning given that there already exist workforce issues and the ability to meet the growing need for LTSS over time. Furthermore, the complexity and financial impact of these new requirements could impede states who wish to transition to MLTSS. Specifically, overall reductions in Medicaid funding may impede the ability of states to adequately develop and expand their Medicaid programs to support MLTSS. These unintended consequences should be avoided where possible and we ask that CMS carefully apply these new standards and definitions to reduce disruptions in provider operations and beneficiary care.

Limits on Medicaid Practitioner Supplemental Payments

CMS further proposes to place new quantitative limits on supplemental payments to practitioners. These limits would be no more than 50 percent of the FFS base payments to practitioners authorized under the state plan or, for services provided within HRSA-designated geographic health professional shortage areas (HPSAs) or Medicare-defined rural areas, up to 75 percent of the FFS base payments.

If CMS proceeds with these quantitative limits, we would ask that CMS broaden the scope of providers eligible to receive supplemental payments of up to 75 percent of base payments to also include LTSS providers. As we refer to above, there is a systemic shortage of LTSS providers able to meet the needs of an aging population. However, the current definition of HPSAs does not include LTSS providers. Therefore,

explicitly including LTSS providers within the higher cap on supplemental payments would help mitigate the impact of these new quantitative limits on the LTSS system.

Other
CMS additionally proposes to specify that states may not provide for variation in FFS payment for a Medicaid service based on a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan. This proposed requirement mirrors the finalized requirement as put forward under the 2016 Medicaid managed care final rule. CMS further considered, but did not propose, to require states to pay the same rate to a facility "for all beneficiaries, unless the state could demonstrate that different case mixes or health care needs, or other reasons consistent with economy, efficiency, quality of care, and access justified paying a different rate for a different group of beneficiaries."

As we have previously discussed in our comments on the Medicaid managed care final rule and the subsequent proposed rule revising the managed care regulations, we appreciate CMS's concerns with some of these practices, but we would like to highlight the potential unintended consequences of the prohibitions that CMS proposes for specific practices. Specifically, states should be allowed to account for the increased risk associated with creating or expanding an MLTSS program for a new population of complex care individuals. In addition, these proposed changes may have the unintended consequence of reducing access to LTSS, such as instances when states may wish to utilize the Community First Choice (CFC) state plan option, due to the increased FMAP, but would be restricted to providing historically low reimbursement rates which would discourage providers from participating in the CFC program. CMS's considered approach to require states to pay a facility the same rate for all beneficiaries would further exacerbate this issue.

Conclusion
We support CMS in its efforts to improve its functions to more effectively conduct oversight of the Medicaid program and to be an effective steward of federal funds. If CMS chooses to move forward with its proposed requirements, we ask that it provide clear and timely communication to all stakeholders to avoid the unintended consequence of removing funding from the Medicaid system due to either challenges among states in meeting these new reporting requirements or a lack of clarity in what is considered an appropriate funding mechanism. This decrease in funding could lead to reduced provider participation in the Medicaid program and reduced beneficiary access, both of which would also impact Medicaid managed care organizations.

Thank you for your consideration of our comments. If you have any questions, please contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Executive Director