

January 30, 2020

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

Re: Medicaid Program; Medicaid Fiscal Accountability Regulation; *Federal Register*, Vol. 84, No. 222, November 18, 2019 [CMS-2393-P]

Dear Administrator Verma:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL or Association) represents more than 14,000 non-profit and proprietary skilled nursing facilities, assisted living communities, sub-acute centers, and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day. We appreciate the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule, "Medicaid Program; Medicaid Fiscal Accountability Regulation; *Federal Register*, Vol. 84, No. 222, November 18, 2019 [CMS-2393-P]."

AHCA/NCAL understands CMS' role as a steward of the Medicaid program in order to ensure effective fiscal oversight, as well as to ensure access to high quality Medicaid services. However, the Association has an array of serious concerns and questions about the proposed rule and, for this reason, asks that CMS withdraw the proposed rule. Our detailed comments are provided below. AHCA/NCAL's key points on steps we believe CMS should take as the agency considers next steps are summarized as follows:

- 1) **Full Implementation and Robust Oversight of Section 1902(A)(30)(A), Including Stakeholder Engagement Through Technical Expert Panels.** Section 1902(a)(30)(A) of the Social Security Act (Section 30(A)) instructs that a state plan must provide "such methods and procedures related to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The statutory language clearly indicates the Congress intended that the Secretary of

Health and Human Services (Secretary) consider all of these requirements—efficiency, economy, quality of care, and access—in tandem and with equal importance given to each, not as separate efforts, treating some (efficiency and economy) as more important than others (quality of care and access).

Irrespective of how CMS interprets state Medicaid financing programs, the proposed rule will impact access and potentially quality due to the reduced availability of federal matching funds. Because of this, AHCA/NCAL believes any efforts related to Section 30(A) in this proposed rule must be coordinated with CMS' plans to develop a uniform methodology for analyzing Medicaid access data. To address this obligation, CMS should: a) convene a technical expert panel (TEP) made up of stakeholders to identify the data that are truly necessary to meet its goals while meeting its obligations under Section 30(A) and b) ensure this TEP work is coordinated with CMS' upcoming work to uniformly assess access to care.

- 2) **Collect and Analyze Data Before Requiring Compliance.** To implement changes such as those in CMS' proposed rule, CMS must first have data to understand the impact of what it is proposing, what coming into compliance means, and how this will impact providers, states, and beneficiaries. Once those data have been collected and the agency understands the scope and scale of what it is proposing, only then should the agency proceed with implementation and compliance.
- 3) **The Proposed Changes Do Not Look at Total Provider Payments.** CMS must have meaningful review and oversight mechanisms in place to ensure that **total** Medicaid reimbursement supports quality care. Examining supplemental payments separately, as this rule proposes, will not achieve this aim and could lead to misinformed policy decisions. It is critically important for CMS to recognize and understand the chronic underfunding of Medicaid nursing facility base rates that exists in many states. CMS' proposed changes to how states are able to finance the non-federal share are likely to create significant state budget problems and negatively impact state and local economies. Any changes made must be thoughtful and deliberate, not broad strokes as proposed in this rule.
- 4) **The Proposed Implementation Timeframes Are Likely to Result in Serious Challenges at the State Level.** Many states maintain their Medicaid policy in statutory language. To comply with the proposed rule, statutory language would need to be agreed to, be vetted by CMS for compliance, be enacted by the State Legislatures, and have subsequent rulemaking conducted. In addition, states pursue these activities and negotiations in consultation with providers and other key stakeholders. Following our consultation with states, the proposed timelines are not sufficient to comply with CMS' proposed compliance dates. Additionally, while we recognize state budgets are state issues, we respectfully request that CMS consider, as part of any implementation plan, adequate time for states to make any necessary budgeting changes to avoid irreparable damage to the Medicaid program.

## Detailed Comment Discussion

### **CMS must provide strong and equal oversight of all provisions in Section 1902(a)(30)(A) of the Social Security Act.**

#### ***Key points:***

- Medicaid is the major payor of nursing facility services.
- Federal oversight of Medicaid payments has not been strong.
- CMS should not implement the rule without the data to know the impact these proposed changes are likely to have.
- To address these concerns, CMS must convene a technical expert panel to gather and assess the data needed first.

#### ***A lack of effective federal oversight of Section 1902(a)(30)(A) of the Social Security Act.***

The Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*<sup>1</sup> (*Exceptional Child*) that the federal Medicaid statute does not grant beneficiaries or providers the right to sue the state to ensure beneficiary access to covered services when rates are cut places incredible weight on CMS' oversight of Medicaid rates. In light of the court ruling, CMS implemented access monitoring review plans through the equal access rule. Since the rule has been finalized, CMS appears to have done little to implement the rule and provide effective oversight.<sup>2</sup> For example, we are aware of no instance in which CMS has required a state to increase its reimbursement rates because they fail to satisfy Section 30(A)'s quality-of-care and access requirements. With the proposed rescission of that rule,<sup>3</sup> AHCA/NCAL is extremely concerned this will result in less transparency and raises questions about CMS' implementation of Section 1902(a)(30)(A) of the Social Security Act (Section 30(A)).

Many states already pay low rates for nursing facility care, as MedPAC analyses have shown.<sup>4</sup> In fact, rates below cost leave no room to modernize and seriously jeopardize nursing facilities' ability to comply with considerable federal and state regulatory burdens while maintaining a high level of quality. In addition, with workforce being the greatest expense for businesses and the challenge that low unemployment rates present with workforce recruitment and retention, even slight rate reductions will pose significant barriers to maintaining an adequate

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<sup>1</sup> *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015).

<sup>2</sup> See, e.g., *Hoag Mem'l Hosp. Presbyterian, Corp. v. Price*, 866 F.3d 1072, 1081 (9th Cir. 2017) (finding CMS acted arbitrarily and capriciously in approving a state plan amendment submitted by California because CMS failed to consider whether the post-amendment payment rates would be sufficient to satisfy Section 30(A)'s access requirement).

<sup>3</sup> Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Rescission; *Federal Register*, Vol. 84, No. 135, July 15, 2019 [CMS-2406-P2]

<sup>4</sup> Medicare Payment Advisory Commission. 2019. Report to the Congress: Medicare payment policy. Chapter 8: Skilled Nursing Facility Services. Washington, DC: MedPAC.

workforce.<sup>5,6</sup> Beneficiaries will ultimately be the ones who are negatively impacted by these payment challenges.

With already thin margins under the program's existing financing structure, dramatic cuts that, depending on state policy decisions result in drastic reductions to nursing facility rates, would not be sustainable. Such problems could hit rural areas particularly hard, which is concerning as data show that not only are older adults a growing part of the population as a whole, but rural areas have a higher share of adults who are ages 65 and older.<sup>7</sup> An AHCA member in rural Ohio described the potential impact of the proposed rule as follows:

"A cut to federal funding like the one described in the proposed rule would certainly close our facility and many, many others if the state didn't find a way to maintain the rates without the lost federal match. We are a traditional "long term care" facility that cares primarily for people covered by Medicaid. Our margin is 1.3 percent and could not absorb the cuts described in the proposed rule. Our biggest struggle is attracting and keeping the numbers of qualified, caring, professional direct care staff (nurses and nursing assistants) that we believe are necessary to properly care for our average daily census of 93 residents, 72 of whom are covered by Medicaid. We must provide competitive wages and benefits to attract these employees, and we work hard to provide a working environment that encourages them to stay with us once they are hired. Cuts of the magnitude that could occur under this proposal would stifle our ability to provide competitive wages and benefits and would certainly require us to rethink our staffing patterns and eliminate some current direct care positions. Reducing direct care staff has a direct correlation on the quality of care for our residents, as it means longer response time to call lights, less time for the staff to engage with a resident while providing care, less time for creative thinking related to care planning interventions, and many other repercussions. Our facility has a very strong activities department which increases our residents' quality of life. Cuts of this magnitude would also mean eliminating some of the positions in this department that are especially critical to our long term residents who will probably spend their remaining time with us. Our facility has focused on improving the care we provide to our residents with dementia, and many of these programs require expenditures that would not be possible if we were to endure any significant cuts to our Medicaid rate. We provide CARES training to all of our staff, we utilize the music in memory program among many individualized programs to benefit our seniors with dementia. We have

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<sup>5</sup> CliftonLarsonAllen, 32<sup>nd</sup> Edition Skilled Nursing Facility Cost Comparison Report – More Data and More Insight.

<sup>6</sup> CliftonLarsonAllen, 33<sup>rd</sup> Edition Skilled Nursing Facility Cost Comparison Report- An Industry in Transition.

<sup>7</sup> <https://www.pewsocialtrends.org/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/>

been very successful in reducing our antipsychotic rate in our long term residents with dementia through identifying each individual's unique fears, frustrations and preferences; this takes a tremendous amount of staff time that would not be possible if we had to reduce our nursing, nurse aide and activity staffing.”

Because Medicaid is the largest payor of nursing facility services, it is critical that payment policies ensure needed beneficiary access and support high quality, efficient care, with CMS and states both acting as good, effective partners. Respectfully, there has not been effective oversight of statutory requirements of Section 30(A) as it applies to Medicaid base rates. As we explain in more detail in the *Supplemental Payments* section of this comment letter, looking at elements of provider payments independently does not provide adequate information to make policy decisions, oversee the program, and, importantly, meet CMS' responsibilities under Section 30(A).

***Recommendations to address data concerns.***

Below we provide recommendations on next steps we believe CMS should take given the current lack of data. We also propose steps we believe the agency should take to effectively comply with Section 30(A).

- During its December 12, 2019 meeting, a number of Medicaid and CHIP Payment and Access Commission (MACPAC) commissioners noted the importance of having data to know the impact of these proposed changes, and the lack of this information currently.<sup>8</sup> AHCA/NCAL shares this concern and in the absence of information about what the impact will be on a state-by-state basis, CMS should not finalize this existing proposed rule.
- Section 30(A) instructs that a state plan must “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” The statutory language clearly indicates the Congress intended that the Secretary consider these provisions in tandem, not as separate efforts. Given the broad discretion CMS appears to want to exercise when interpreting how states finance their Medicaid program, the proposed rule will impact access and quality through the reduced availability of federal matching funds. Because of this, AHCA/NCAL believes any efforts related to Section 30(A) must be coordinated. To appropriately address the Secretary's responsibilities under Section 30(A), CMS should:
  - a) Convene a technical expert panel (TEP) made up of stakeholders, including providers, to identify the data that are truly necessary to

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<sup>8</sup> MACPAC December 12, 2019 Meeting Transcript.

- achieve CMS' fiscal oversight goals while also supporting access to quality care for beneficiaries with respect to this proposed rule; and
- b) Develop a method of ensuring coordination with the efforts CMS committed to regarding the development of a uniform methodology for analyzing Medicaid access data<sup>9</sup> and this Medicaid fiscal accountability TEP effort.

## **Proposed Changes Impacting Medicaid Financing and Payments**

In this section, we highlight our concerns with changes proposed relative to provider tax waivers, supplemental payments, and intergovernmental transfers. We include recommendations and areas we believe require clarification, as well as highlight areas where we believe CMS has overstepped its authority.

### **Provider Taxes**

AHCA/NCAL has serious concerns regarding the proposed CMS changes with provider taxes. Below we provide an in-depth analysis as to why we believe a more targeted approach should be taken to address the concerns CMS has in this area. We also believe that CMS is giving itself inappropriately broad discretion with regards to how states might implement provider taxes, which would further hinder the use of this legal and allowable financing mechanism.

#### ***Key Points:***

- Nursing facility provider tax waivers were developed in a transparent manner working with CMS.
- AHCA/NCAL completed an analysis that shows nursing facility provider tax waivers do not put an undue burden on the Medicaid program. Based on this analysis, there are a number of recommended changes we suggest CMS make before it takes any steps to finalize the proposed rule.
- CMS should require states to meet the redistributive test only at the time a waiver is approved and upon renewal.
- CMS' proposed "net effect" standard that looks at the totality of the circumstances to determine whether an impermissible "hold harmless" arrangement exists (the Tax Net Effect Rule) and its proposal that already approved tax waivers will expire automatically within a set number of years after the effective date of the final rule (the Tax Waiver Sunset Rule) exceed CMS' statutory authority.

#### ***Concerns with changes to permissible health care-related taxes.***

The proposed § 433.68(e)(3)(i) and § 433.68(e)(3)(iv) specify that tax structures that divide taxpayers into groups or classes with varying tax rates for each group will create an undue burden on Medicaid if:

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<sup>9</sup> 84 Fed. Reg at 33,724

1. The groups that, on average, have lower Medicaid activity are exempt or pay lower rates; and/or
2. CMS determines, based upon the totality of circumstances, that a provider class paying a lower rate is, in effect, a proxy for no or low Medicaid volume providers.

These new provisions will invalidate almost all the current nursing facility provider tax waiver programs approved by CMS. Yet, given their structure and design, the approved nursing facility waiver models do not create an undue burden on Medicaid activity.

In 2003 and 2004, CMS worked collaboratively with 11 states and provider groups to establish waiver structure criteria that would meet the redistributive test under either § 433.68(e)(1) or § 433.68(e)(2), and not violate the hold harmless provisions of the regulations and statute.

In that process, CMS dictated that a waiver class could not be based solely on low or no Medicaid volume (though high Medicaid volume was an acceptable waiver class). CMS did agree that waiver classes could, however, be based upon criteria such as bed size, ownership status, services provided (continuing care retirement communities (CCRCs) providing a full continuum of housing, assisted living and nursing facility services on a contiguous campus), and location. These waiver class structures were acceptable to CMS even if these groups had lower Medicaid volume, on average, than other groups paying higher tax rates if each waiver group had a range of Medicaid volume. In addition, the waiver program, in concert with the Medicaid rate methodology detailing the use of the tax proceeds, could not guarantee taxpayers would be held harmless from the tax. That test involved ensuring that not all providers were held harmless by either being exempt from the tax or receiving rate increases in excess of their tax payments.

The CMS analysis and review process was very transparent, with every state submitting a workbook detailing their waiver program, the waiver categories, the range of Medicaid volume in each waiver group, the tax amount for each provider, and the anticipated Medicaid payment increase by provider as a result of the tax program. Also, typically submitted with the waiver request was the state statute authorizing the tax program and the state plan detailing the changes to the payment methodology.

CMS also allowed states to submit waivers for preliminary review and comment prior to final waiver submission. This expedited the CMS review process upon final submission, and many states took advantage of the opportunity.

That collaboration and transparency over the past 15 years resulted in approved nursing facility tax waiver programs in 26 states, each utilizing some or all the accepted waiver classes.

Almost all of these approved waiver programs will be invalid based upon the new undue-burden tests since some of these waiver groups typically have lower average Medicaid activity than other classes paying higher rates. However, an undue tax burden on Medicaid is not necessarily created simply by virtue of certain tax groups with lower Medicaid activity being exempt or paying lower rates. In fact, an in-depth review of the approved nursing facility provider tax waiver models reveals little added burden on Medicaid as a result of the waivers.

***Analysis of nursing facility provider tax waiver programs and recommended changes.***

AHCA/NCAL examined CMS-approved nursing facility provider tax waiver models in 22 states in which we were able to obtain the spreadsheets detailing the waiver groups, the tax by provider, and the redistributive test calculations. The waiver groups in each state were very consistent, delineated based upon some or all the following criteria:

1. CCRC status;
2. Bed size;
3. Location;
4. Type of ownership;
5. High patient days or high Medicaid days; and
6. All other facilities not meeting any of the above criteria.

Provider taxes in all 22 states were assessed per patient day, per non-Medicare day (as permitted under section 1903(w)(3)(D)(ii) of the Act) or per bed. The assessment rates varied by group with certain groups being exempt or paying lower tax rates. On average, groups exempt or paying lower rates **did** have lower Medicaid volume, but that was offset by a combination of:

1. Providers with high Medicaid volume paying lower tax rates; and
2. All providers in a waiver class being charged the same rate, regardless of Medicaid volume. Since each class paying lower rates had providers with a wide range of Medicaid volume, the Medicaid days of all the providers in these classes benefited from the lower tax rate.

AHCA/NCAL applied a quantitative and pragmatic approach to quantify the additional tax burden on Medicaid activity from these nursing facility provider tax waiver programs. The total amount of tax assessed on Medicaid days under the approved waiver model was compared to the total amount of tax assessed on Medicaid days, assuming the tax was imposed uniformly on all providers using the assessment statistic applied in that state (total patient days, non-Medicare patient days or beds). The total tax applied to Medicaid days for all providers under each approach was then converted to a per diem tax rate by dividing the total tax assessed on Medicaid days by total Medicaid days. The increase in the Medicaid day-weighted average tax rate under the approved waiver model over that based upon a uniform rate using the assessment statistic applied in that state represents the additional tax burden on Medicaid activity resulting from the waiver.

The results by state are presented in Attachment 1. The additional tax burden on Medicaid days in the 22 states examined averaged just 52 cents per Medicaid day. The Medicaid day-weighted average tax rate on Medicaid days across these 22 states was just 3.45 percent higher than if the tax were imposed uniformly on all providers based upon each state's Medicaid statistics.

In these 22 states, we also calculated the percentage of the total tax that was assessed on Medicaid days under each tax waiver program in comparison to the percentage assessed on Medicaid days if the tax were imposed uniformly on all providers based upon each state's assessment statistic. The results, presented in Attachment 2, reveal that on average, the percentage of the total tax assessed on Medicaid days across these 22 states under their tax waiver programs was only 2.5 percentage points higher than if the tax were imposed uniformly based upon each state's assessment statistic. In total in these 22 states, 75.8 percent of the total tax was applied to Medicaid days under the tax waivers compared to 73.2 percent if the taxes were imposed uniformly.

These nursing facility provider tax waiver programs were structured collaboratively with CMS, and approved by CMS, certainly do not impose an undue tax burden on Medicaid. The additional tax burden on Medicaid for these tax waiver programs averages only 52 cents per patient day – only 3.45 percent higher than if the tax were imposed uniformly based upon the assessment “statistic” in each state.

AHCA/NCAL has clearly demonstrated that provider tax waiver programs with varying tax rates by group do not, in and of themselves, create an undue burden on Medicaid activity simply because some of the groups with average Medicaid volume lower than other groups are exempt or pay lower tax rates. Therefore, proposed § 433.68(e)(3)(i) and § 433.68(e)(3)(iv) should be withdrawn.

Based upon these two new tests, as included in the proposed rule, it is impossible for a non-uniform or non-broad-based tax to meet the undue-burden test unless:

1. Lower Medicaid volume providers pay a tax rate equal to or higher than the rates imposed on higher Medicaid volume providers;
2. The only low volume Medicaid providers exempted or paying lower tax rates are 100 percent charity care facilities; or
3. Providers with low Medicaid volume are merged with high volume Medicaid providers to form one waiver group that, on average, has as high or higher Medicaid volume as the other providers in the state paying a higher tax rate. This approach to designing a waiver group is not permissible based upon current CMS guidelines, nor likely permissible under the proposed rule based upon the “totality of circumstances” test.

***Recommended changes based on our undue-burden analysis.***

Based on our analysis, we believe CMS should make the following changes to the proposed rule if it is finalized.

1. Eliminate the vague and amorphous Medicaid burden test (proposed § 433.68(e)(3)) and maintain the P1/P2 and B1/B2 tests, which are designed to prevent undue burden on Medicaid and give states clear guidance on what is and what is not allowed in waivers. The proposed Medicaid burden test gives no guidance to states on what is approvable and allows CMS to disapprove waivers at whim. If CMS believes that there are loopholes in the statistical tests that allow states to evade their intent, CMS should address the loopholes instead of imposing a new test that would eliminate existing and future waivers whether or not they are based on such a loophole.
2. If an undue-burden test is to be applied, it must be objective and quantify the allowable incremental tax burden on Medicaid created by the waiver program, like the approach detailed in these comments. Otherwise, there is no clarity as to what is considered “undue.” Some variation must be allowed between the average per diem tax rate imposed on Medicaid days under the waiver versus the per diem tax rate if imposed uniformly on all providers based upon each state’s assessment statistic.
3. A provider tax waiver, where certain groups with lower Medicaid volume pay lower rates, should still be permitted if there is not a significant difference in the percentage of the tax in total that is assessed on Medicaid days under the waiver versus the percentage if imposed uniformly on all providers based upon the state’s assessment statistic.
4. Waivers that have been approved by CMS should be grandfathered and not subject to the undue-burden test unless the tax program is modified pursuant to § 433.72(d)(2).
5. A new waiver subject to an undue-burden test should not be required for grandfathered programs if the tax rates of high-volume Medicaid providers or the Medicaid volume needed to qualify for this waiver group are changed simply to meet the redistributive test upon waiver renewal.

***Ongoing compliance with waiver conditions and recommended changes.***

Section 433.72(d) requires the approved tax waiver program to meet certain conditions throughout the term of the waiver. One of those conditions at § 433.72(b)(1) requires the net impact of the tax to be generally redistributive as described in § 433.68(e). This provision appears to mandate that throughout the waiver term, the tax program must comply with the redistributive test (P1/P2 or B1/B2).

Section 433.72(d)(2) indicates that states can modify the tax in a uniform manner during the three-year term of the waiver without seeking a new waiver or reapproval of their existing waiver. However, as a result of a uniform change in the tax rate, or even without a change in tax rates, a state may fall out of compliance with the redistributive test simply due to annual changes in payer mix and patient

day volume of each provider. All these factors are relevant in the redistributive test computation.

If states must comply with the redistributive test throughout the waiver, then many states will be forced to seek reapproval annually. Annual changes in patient days and payer mix will result in non-uniform tax rate changes to stay in compliance with the redistributive test. As such, most states will not even have a three-year window to modify their waiver, and this would unnecessarily increase administrative burden on both states and the federal government.

We recommend CMS rectify this discrepancy by requiring states to meet the redistributive test only at the time a waiver is approved and upon renewal rather than throughout the term of the waiver unless the tax program is modified pursuant to § 433.72(d)(2).

***Overstepping its authority on provider taxes.*** Our analysis indicates that CMS does not have the statutory authority to apply the Tax Net Effect Rule to events that transpired prior to the effective date of a final Medicaid Fiscal Accountability Regulation (MFAR) for the same reasons discussed later in this letter with respect to the Donation Net Effect Rule. CMS' assertion that the Tax Net Effect Rule is a mere "clarification of existing policy [that does] not impose any new obligations or place any new restrictions on states that do not currently exist"<sup>10</sup> appears to be factually unfounded.

The MFAR would also provide that tax-related waivers already approved by CMS will expire automatically within three years after publication of the final MFAR<sup>11</sup> and that future tax-related waivers will be limited to three years.<sup>12</sup> Social Security Act § 1903(w)'s language regarding the Secretary's discretion to grant such waivers does not expressly grant the Secretary authority to impose timing restrictions on already-approved waivers, nor does the statute expressly grant the Secretary authority to impose timing restrictions on new waivers.<sup>13</sup> Congress knows how to impose such timing restrictions (e.g. in the context of demonstration projects under Social Security Act § 1115 and waivers under Social Security Act § 1915). That Congress did not include such language in Social Security Act § 1903(w) indicates that the Tax Waiver Sunset Rule also exceeds CMS' statutory authority.

## **Supplemental Payments**

### ***Key Points:***

- CMS should work with stakeholders to identify what data are needed to achieve its fiscal oversight aims, which should be done through a TEP.

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<sup>10</sup> Proposed MFAR, 84 Fed. Reg. at 63,742.

<sup>11</sup> See *id.* (proposed 42 C.F.R. § 433.72(c)(4)).

<sup>12</sup> See *id.* (proposed 42 C.F.R. § 433.72(c)(3)).

<sup>13</sup> See Social Security Act § 1903(w)(3)(E), 42 U.S.C. § 1396b(w)(3)(E).

- To accurately and effectively implement Section 30(A), CMS should look at total payments to providers relative to allowed Medicaid costs.
- CMS has overstepped its statutory authority by proposing timing-related limitations on existing and new state plan amendments (SPAs) providing for supplemental payments.

***CMS should first create a technical expert panel to identify what data are needed to achieve its aims.***

We understand CMS' concerns with supplemental payments and the need to tie payments to direct care. As we note above, CMS has a clear statutory responsibility under Section 30(A) with respect to access, efficiency, economy, and quality. However, we have concerns with the approach CMS proposes in this rule. Instead, we would suggest a more measured approach that we believe would allow CMS to be successful in its objective of strengthening the overall fiscal integrity of the program. A Medicaid fiscal accountability TEP must be convened to identify what data are needed to help CMS achieve its oversight goals and how to efficiently collect this information. Based on the data recommendations from the TEP, states should then submit data for a period of three (3) years to ensure that the data are accurate before making policy decisions.

Having this data would also provide CMS with the full picture needed to ensure all four prongs of Section 30(A) (economy, efficiency, quality, and access) are treated equally and to ensure that payments to providers, in their totality, are sufficient to meet these aims.

***Supplemental payments are primarily used to ensure greater accuracy and compliance with state budgets as they relate to nursing facilities.***

CMS notes the increasing role of supplemental payments.<sup>14</sup> However, relative to nursing facilities, supplemental payments are not designed to simply draw down federal matching funds up to the upper payment limit (UPL), as CMS states in its proposed rule. In fact, relative to nursing facilities, few states are at or near their UPL even when factoring in their supplemental payments.

As they relate to nursing facility services, most supplemental payments are the result of provider tax programs where legislation at the state level mandated these funds be paid in the form of supplemental payments typically to:

- Reimburse the Medicaid share of the tax, as permitted under federal law;
- Supplement base rates to more adequately cover the cost of care due to inadequate base rates; and
- Fund quality-based programs.

Structured this way by state legislatures, such steps ensure a more accurate accounting for these expenditures and that changes in payer mix and/or utilization

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<sup>14</sup> Proposed MFAR, 84 Fed. Reg. at 63,724

of services will not impact the overall level of spending as it would if these funds were put into the base rates.

Because of the way these programs have been structured relative to nursing facilities and supplemental payment programs funded by provider taxes, we see no benefit from requiring provider-level payment information and requiring states to develop a monitoring plan to ensure compliance with Section 30(A) – unless provider-specific costs information is also required in order to ensure overall payments are adequate to meet the requirements of Section 30(A).

Finally, while we believe CMS should address specific concerns to ensure the fiscal integrity of the program, this must be done with respect to the unique needs and circumstances of a given state. It must not be done using the blunt, one-size-fits-all approach as proposed in this rule.

***To comply with the requirements of Section 30(A), CMS must look at the totality of payments relative to costs.***

As referenced above, seeking provider-level payment information only represents one aspect of the analysis under Section (30)(A). CMS must ensure states demonstrate consistency with all four elements of Section 30(A). Currently, there is no examination of provider-level costs and adequacy of payments in relation to those costs. This is something that neither states nor CMS undertake in a systematic way in state plan development and review. The detailed data CMS is requesting through this proposed rule regarding supplemental payments is meaningless unless it is reviewed in concert with the costs of providing quality services and a determination made as to the adequacy of a combination of base rates and supplemental payments in covering the costs necessary to ensure quality and access to care, along with efficiency and economy.

Studies of nursing facility Medicaid rate adequacy conducted annually by AHCA for almost two decades have demonstrated the inadequacy of Medicaid rates, including supplemental payments, in covering allowable Medicaid costs.<sup>15</sup> Therefore, supplemental payments to nursing facilities funded through provider tax programs present little, if any, risk of non-compliance with Section 30(A). Requiring further detail on these payments on a provider-specific level or requiring states to establish a monitoring plan does nothing to provide greater assurance if CMS does not also take on a more-detailed examination of the cost side of the equation.

***Overstepping its authority on supplemental payments.*** In addition to our broad concerns regarding the data collection CMS has included in its proposed rule, we believe the agency has overstepped its statutory authority by proposing timing-related limitations on existing and new SPAs providing for supplemental payments. Under the proposed rule, existing SPAs providing for supplemental payments will

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<sup>15</sup> Medicaid Shortfall Reports from 2010-2017, available at [https://www.ahcancal.org/research\\_data/funding/Pages/Medicaid-Shortfall-Report.aspx](https://www.ahcancal.org/research_data/funding/Pages/Medicaid-Shortfall-Report.aspx)

expire automatically within a set number of years after the effective date of the final file, while new SPAs establishing supplemental payments may only be approved for up to three years. These proposals, which we refer to collectively as the “Supplemental Payment Sunset Rule,” are unprecedented in Medicaid’s history. The Social Security Act does not give the Secretary authority to, in effect, retroactively amend past SPA approvals by limiting the time those approvals will remain in effect, nor does the Social Security Act authorize the Secretary to impose time limitations on SPA approvals on a going-forward basis. Congress certainly knows how to enact statutory language providing for the latter, as the Social Security Act imposes express time limitations on waiver and demonstration-project approvals by the Secretary.<sup>16</sup>

## **Intergovernmental Transfers (IGTs)**

### ***Key points:***

- Because of their impact on state budgets, CMS must provide at least a five (5) year implementation timeframe for any changes made regarding IGTs. Such changes should also apply to the effective date of any definitional changes.
- CMS has misinterpreted existing statutes by asserting that IGTs must be derived from taxes (the Derived-From-Taxes rule) and by insisting that public entities have taxing authority to make IGTs (the Government-Provider rule). In addition, the agency did not comply with the statutory requirement to consult with the states prior to issuing this rule.

### ***CMS must be thoughtful and deliberate in the way it addresses any concerns with IGTs.***

AHCA/NCAL understands CMS’ concerns with how the use of IGTs has unfolded in certain circumstances. However, as CMS works to ensure the fiscal integrity of the program, given the dramatic changes that cutting these funds quickly would have, we urge CMS to take steps to ensure there is a thoughtful, deliberate process put in place to ensure compliance with any proposed changes CMS ultimately moves forward with so as to not penalize beneficiaries. Because of state budget reliance on this financing mechanism, we believe that a five (5) year implementation would be a

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<sup>16</sup> See, e.g., Social Security Act § 1115(f)(6), 42 U.S.C. § 1315(f)(6) (“An approval of an application for an extension of a [demonstration] waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title.”); Social Security Act § 1915(c)(3), 42 U.S.C. § 1396n(c)(3) (“A waiver under this subsection . . . shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.”); Social Security Act § 1915(d)(3), 42 U.S.C. § 1396n(d)(3) (“[A] waiver under this subsection . . . shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.”); Social Security Act § 1915(h)(1), 42 U.S.C. § 1396n(h)(2) (“No waiver under this section (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) may extend over a period of longer than two years unless the State requests continuation of such waiver”).

more reasonable timeframe for states and providers to come into compliance with any changes that impact the use of this financing mechanism. In addition, the definitional changes that appear to go into effect when the MFAR is finalized—State share of financial participation, Non-state government provider, and language establishing new UPL demonstration methods—must also be on a similar five-year implementation timeline.

***Overstepping its authority regarding IGTs.***

We believe that the Derived-From-Taxes Rule exceeds CMS' statutory authority. Our preliminary assessment of the legality of the Derived-From-Taxes Rule stems from CMS' mistaken assertion that Social Security Act § 1903(w)(6)(A) requires that funds transferred via IGT be derived from taxes. According to CMS: "[T]he term public funds in the regulatory text has created confusion among states, and has led to state requests to derive IGTs from sources other than state or local tax revenue (or funds appropriated to state university teaching hospitals), *which is not permitted under the statute in section 1903(w)(6)(A) of the Act.*"<sup>17</sup> That is the same misreading of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (the 1991 Act) put forward by CMS in its 2007 rulemaking.<sup>18</sup> Numerous states and other stakeholders refuted CMS' assertion during the course of that rulemaking. Read properly and in accordance with its historical context, Social Security Act § 1903(w)(6)(A) as added by the 1991 Act gives CMS discretion to promulgate a derived-from-taxes rule. CMS' reading of Social Security Act § 1903(w)(6)(A) as commanding such a rule misreads the 1991 Act and potentially threatens significant amounts of past federal financial participation paid to numerous states. In addition, we also believe that CMS is mistaken in its view regarding Social Security Act § 1903(w)(6)(A) and its supposed requirement for taxing authority in the Government-Provider rule.

Finally, the MFAR would promulgate a new regulation, 42 C.F.R. § 447.207, stating:

Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable). The Secretary will determine compliance with this [requirement] by examining any associated transactions that are related to the provider's total computable Medicaid payment to ensure that the State's claimed expenditure, which serves as the basis for Federal financial participation, is consistent with the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied.<sup>19</sup>

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<sup>17</sup> Proposed MFAR, 84 Fed. Reg. at 63,737 (emphasis added).

<sup>18</sup> See Medicaid Program; Cost Limit for Providers Operated by Units of Government, 72 Fed. Reg. 29,748 (May 29, 2007).

<sup>19</sup> Proposed MFAR, 84 Fed. Reg. at 63,779 (proposed 42 C.F.R. § 447.207).

The intended purpose of the proposal appears to be to act in conjunction with the Derived-From-Taxes Rule and prohibit IGTs derived from non-tax sources such as provider payments, so we believe that it, too, exceeds CMS' statutory authority. As demonstrated by the 2007 rulemaking record, the 1991 Act authorized the continued transfer of non-tax funds from governmental providers unless and until CMS exercised its discretion to alter the treatment of "public funds."

In this case, CMS has proposed to alter the treatment of "public funds" under the guise that such changes are statutorily required. Furthermore, under the 1991 Act, Congress prohibited CMS (then HCFA) from implementing interim final rules affecting IGTs and required the Secretary to "consult with the States before issuing any regulations under this Act."<sup>20</sup> Such consultation has not occurred.

### **Clarification Regarding Upper Payment Limit Calculations**

#### ***Key points:***

- CMS should clarify that under a payment-based UPL demonstration, states can compute the Medicare UPL by simply dividing Medicare payments by Medicare days for each provider and multiplying the resulting average Medicare per diem payment times each provider's total Medicaid days.
- CMS should modify the UPL calculation to allow exclusion of Medicaid payments that are incentive-based and have no relation to the cost of services provided.

#### ***Background regarding the clarification being sought.***

With regards to the UPL provisions of the proposed rule, § 447.288(b)(3)(ii)(C) indicates:

**A payment-based UPL demonstration using an imputed Medicare per diem payment rate determined by dividing total Medicare prospective payments paid to the provider by the provider's total Medicare patient days, which are derived from the provider's Medicare census data.** Each provider's imputed Medicare per diem payment rate is multiplied by the total number of Medicaid patient days for the provider for the period. The products of this operation for each provider are summed to determine the aggregate UPL. The demonstration must show that Medicaid payments are not excess of the aggregate UPL, calculated on either a retrospective or prospective basis, consistent with the methodology described in paragraph (b)(3)(ii)(A) or (B) of this section, as applicable.<sup>21</sup>

The bolded language appears to indicate that the Medicare UPL can simply be calculated by dividing Medicare payments by Medicare days for each provider and

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<sup>20</sup> 1991 Act § 5(c).

<sup>21</sup> Proposed MFAR, 84 Fed. Reg. at 63,782.

multiplying the resulting average Medicare per diem payment times each provider's Medicaid days. It does not appear that states must attempt to classify Medicaid patients into a Patient-Driven Payment Model (PDPM) category, then determine what Medicare would pay for that category, and then sum those payments for all Medicaid patient days. That is the current methodology if a RUGs-based approach is used. However, Medicaid patients cannot currently be classified into a PDPM group based upon the information available for Medicaid patients through their OBRA assessments. Therefore, we are asking CMS to confirm that the payment-based UPL demonstration process has been simplified so that states can compute the Medicare UPL by simply dividing Medicare payments by Medicare days for each provider and multiplying the resulting average Medicare per diem payment times each provider's total Medicaid days. We are also seeking confirmation that Medicare payments are those prior to sequestration and quality/value-based adjustments.

***Recommendation for exclusion of access and quality payments from UPL calculations.***

We propose that the UPL calculation in § 447.272 be modified to allow exclusion of Medicaid payments that are incentive-based and have no relation to the cost of services provided. Such incentive-based payments would be those that are paid to improve access or for quality performance. There are a few states, primarily those that use a cost-based UPL approach, that are at or near their nursing facility UPL that are considering quality-based incentive programs. They would be unable to do so if these payments are included in the computation of the UPL. They could reduce rates and allocate the reduction to quality, but that defeats the purpose, making providers achieve quality goals with less funding. We therefore propose that incentive-based payments that have no relation to the cost of services provided but are intended to improve quality or access to services for Medicaid beneficiaries, be excluded from UPL computations.

**CMS Has Overstepped Its Authority With the Donation Net Effect Rule**

In addition to the concerns we have raised elsewhere in this letter with areas we believe CMS has overstepped its authority, we believe CMS does not have statutory authority to apply the Donation Net Effect Rule to events that transpired prior to the effective date of a final MFAR. The Supreme Court has held that “if Congress intends to impose a condition on the grant of federal moneys [to states], it must do so unambiguously.”<sup>22</sup> This principle means that neither Congress nor an agency exercising authority delegated to it by Congress can apply new requirements on states retroactively.<sup>23</sup> CMS' assertion that the Donation Net Effect Rule is a mere “clarification”<sup>24</sup> appears to be factually unfounded and self-serving. Furthermore, Texas's recent litigation challenging the DAB decision cited by the proposed MFAR

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<sup>22</sup> *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

<sup>23</sup> *See id.* at 25 (“Though Congress' power to legislate under the spending power is broad, it does not include surprising participating States with postacceptance [sic] or 'retroactive' conditions.”).

<sup>24</sup> Proposed MFAR, 84 Fed. Reg. at 63,739.

raises the question whether CMS can apply such a rule to events occurring before the effective date of a final MFAR.<sup>25</sup>

## **Data & Transparency**

AHCA/NCAL supports the idea of transparency in principle but has concerns with what CMS proposes and the practicality of implementing what is included in the proposed rule. With respect, we raise the challenges related to the implementation of T-MSIS and UPL data currently collected and raise the question of how all of these data are used. This concern regarding the agency's capacity to implement what it is proposing was also noted at the December MACPAC meeting, with commissioners noting the implementations challenges CMS experienced with T-MSIS.<sup>26</sup> Furthermore, we believe the proposed data submissions would be burdensome for both states and providers. States would have to develop methods for collecting the data CMS is proposing to require. Given the specificity of data that CMS suggests it needs, these requirements are likely to take a significant amount of state and provider resources to comply with these new requirements. At the same time, it is not clear that CMS has the capacity to analyze such an influx of data, or for that matter, review all the state plan amendments states would now be required to submit on an ongoing basis. Instead of immediately collecting new data, CMS should build on what information is currently available. In addition, we reiterate that CMS should create a TEP to examine how access will be assessed and what data are needed to achieve CMS' goal of fiscal integrity. Such a group should consist of states and stakeholder groups, including providers and beneficiaries.

## **The Impact of the Proposed Rule on Medicaid Budgets and Economy**

Medicaid plays a crucial role in supporting the nation's health care system and accounts for a significant portion of revenues for health care providers, including hospitals, physicians, clinics, and nursing facilities, as well as home and personal care services. Providers not only deliver services that improve the health of those in their communities, but they are also employers, taxpayers, and consumers themselves. Every dollar spent on Medicaid has a ripple effect that stimulates additional spending for goods and services, supports local economies, and strengthens state economies. In rural areas, which are often disproportionately dependent on Medicaid, the economic effect of the program is particularly significant.

AHCA/NCAL is concerned that the broad, sweeping changes that CMS is proposing will result in draconian cuts to state Medicaid budgets, ultimately having a negative

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<sup>25</sup> See Pl.'s Orig. Compl. ¶ 41, *Tex. Health & Human Servs. Comm'n v. HHS*, No. 3:19-cv-02857 (N.D. Tex. Dec. 2, 2019), ECF No. 1.

<sup>26</sup> MACPAC December 12, 2019 Meeting Transcript.

impact on beneficiaries and their ability to access needed care and services covered under the program.

Across the country, long term care facilities support nearly \$642 billion in state economic activity.<sup>27</sup> Nursing centers employ 1.6 million people nationally, including doctors, nurses, therapists, and administrative staff. The profession represents \$64 billion of all salaries in the U.S.<sup>28</sup>

This proposed rule is especially concerning for providers that care for a majority Medicaid-covered population. At any given time, 62 percent of the people receiving care in a nursing facility are there under a Medicaid stay. Federal policy decisions that impact funding for Medicaid will have a direct impact on the resources available to facilities to provide quality care to beneficiaries. Because Medicaid is a large payor of nursing facility services, it is critical that payment policies support high-quality, efficient care.

AHCA/NCAL supports transparency and appropriate oversight of the Medicaid program. To move in this direction, we believe CMS must first have data, then take time to analyze the information available to fully understand the impact of these changes from the perspectives of providers and beneficiaries, as well as the effect on state and federal economics and quality of care. Only after that analysis should CMS implement financing policy that will result in significant changes for providers and beneficiaries. We appreciate the opportunity to provide comments on the proposed rule, and we look forward to working with CMS to ensure both appropriate fiscal oversight of the program and access to a range of quality services and providers for Medicaid beneficiaries.

If you have any questions about our comments, please contact Caroline Haarmann at [chaarmann@ahca.org](mailto:chaarmann@ahca.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Michael W. Cheek". The signature is fluid and cursive, with a long horizontal stroke at the end.

Michael W. Cheek  
Senior Vice President, Reimbursement Policy

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<sup>27</sup> AHCA analysis using IMPLAN data and software; 2017 Quarterly Census of Employment and Wages; and 2016 County Business Patterns.

<sup>28</sup> [https://www.bls.gov/oes/current/naics4\\_623100.htm](https://www.bls.gov/oes/current/naics4_623100.htm).

## Attachment 1

State	Basis On Which Tax is Assessed	Medicaid Day-Weighted Assessment Rate Under Waiver Model	Assessment Rate on Medicaid Days if Tax Rate Imposed Uniformly Using the Assessment Basis in Column 2	Per Diem Difference in Tax on Medicaid Under the Waiver v. Tax Imposed Uniformly Using the Assessment Basis in Column 2	Percentage That Tax Rate is Higher On Medicaid Days Under the Waiver
Arizona	Non-Medicare Days	\$10.62	\$9.67	\$0.95	9.8%
Colorado	Non-Medicare Days	\$5.29	\$5.08	\$0.20	4.0%
Connecticut	Non-Medicare Days	\$20.08	\$19.74	\$0.34	1.7%
Delaware	Non-Medicare Days	\$12.03	\$11.60	\$0.43	3.7%
Florida	Non-Medicare Days	\$21.97	\$20.99	\$0.98	4.7%
Hawaii	Patient Days	\$10.58	\$10.58	(\$0.00)	0.0%
Indiana	Non-Medicare Days	\$14.13	\$13.62	\$0.51	3.7%
Iowa	Non-Medicare Days	\$8.83	\$8.33	\$0.50	6.0%
Kansas	Beds	\$7.60	\$7.26	\$0.34	4.6%
Kentucky	Non-Medicare Days	\$9.81	\$9.69	\$0.11	1.2%
Maryland	Non-Medicare Days	\$5.97	\$5.59	\$0.38	6.9%
Massachusetts	Non-Medicare Days	\$17.49	\$17.27	\$0.22	1.3%
Michigan	Non-Medicare Days	\$27.28	\$27.10	\$0.18	0.7%
Mississippi	Patient Days	\$13.66	\$13.03	\$0.63	4.8%
Nebraska	Non-Medicare Days	\$3.37	\$3.25	\$0.12	3.7%
New Mexico	Non-Medicare Days	\$17.87	\$17.47	\$0.41	2.3%
North Carolina	Non-Medicare Days	\$7.52	\$7.15	\$0.37	5.2%
Ohio	Beds	\$13.14	\$13.11	\$0.03	0.2%
Oklahoma	Patient Days	\$11.51	\$11.33	\$0.19	1.6%
Pennsylvania	Non-Medicare Days	\$21.70	\$20.39	\$1.31	6.4%
Tennessee	Non-Medicare Days	\$15.46	\$15.32	\$0.14	0.9%
Washington	Non-Medicare Days	\$16.41	\$15.39	\$1.02	6.6%
<b>Medicaid Day-Weighted Average For All 22 states</b>		<b>\$15.52</b>	<b>\$15.01</b>	<b>\$0.52</b>	<b>3.45%</b>

## Attachment 2

State	Basis On Which Tax is Assessed	% of Total Tax Assessed on Medicaid Days Under the Waiver	% of Total Tax Assessed on Medicaid Days If Tax Rate Assessed Uniformly Using Assessment Basis in Column 2	Percentage Points Difference
Arizona	Non-Medicare Days	89.6%	81.6%	8.0%
Colorado	Non-Medicare Days	71.0%	68.2%	2.7%
Connecticut	Non-Medicare Days	81.3%	79.9%	1.4%
Delaware	Non-Medicare Days	69.4%	67.0%	2.5%
Florida	Non-Medicare Days	83.3%	79.6%	3.7%
Hawaii	Patient Days	56.5%	56.5%	0.0%
Indiana	Non-Medicare Days	76.9%	74.1%	2.8%
Iowa	Non-Medicare Days	58.1%	54.8%	3.3%
Kansas	Beds	57.1%	54.6%	2.5%
Kentucky	Non-Medicare Days	78.4%	77.5%	0.9%
Maryland	Non-Medicare Days	78.5%	73.5%	5.1%
Massachusetts	Non-Medicare Days	79.3%	78.3%	1.0%
Michigan	Non-Medicare Days	79.5%	79.0%	0.5%
Mississippi	Patient Days	78.9%	75.2%	3.6%
Nebraska	Non-Medicare Days	60.1%	57.9%	2.1%
New Mexico	Non-Medicare Days	79.9%	78.1%	1.8%
North Carolina	Non-Medicare Days	84.1%	80.0%	4.2%
Ohio	Beds	50.2%	50.1%	0.1%
Oklahoma	Patient Days	68.5%	67.4%	1.1%
Pennsylvania	Non-Medicare Days	87.0%	81.8%	5.3%
Tennessee	Non-Medicare Days	75.5%	74.8%	0.7%
Washington	Non-Medicare Days	82.4%	77.2%	5.1%
<b>Medicaid Day-Weighted Average For All 22 states</b>		<b>75.8%</b>	<b>73.2%</b>	<b>2.5%</b>