Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
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INDIANAPOLIS, IN 46207-7083

February 1, 2020

Calder Lynch
Acting Deputy Administrator and Director
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Director Lynch:

The State of Indiana appreciates the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation (MFAR), [CMS-2393-P]. We thank the Centers for Medicare and Medicaid Services (CMS) for its ongoing collaboration efforts with state Medicaid programs to develop sound Medicaid policy that promotes state flexibility, supports federal fiscal considerations, and ultimately upholds the promise of the Medicaid program as a critical high-quality health care program for its beneficiaries. We support CMS's stated goals of fiscal integrity, transparency, and accountability for the Medicaid program. However, as proposed, MFAR could have significant implications on Medicaid financing in Indiana. Specifically, the State is concerned with the timeline for implementation of the proposed changes. We will walk through the proposed changes and potential implications in this letter, and we will identify areas where we are seeking clarification or making recommendations for improvement, including, but not limited to, recommending a five-year transition period to afford states adequate time to implement the proposed changes.

The Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) administers vital services to one in five Hoosiers through its Medicaid programs for the State of Indiana, including traditional Medicaid, risk-based managed care, and a variety of waiver services tailored to the needs of specific populations. We were the first state in the country to introduce consumer-driven principles into the State's Medicaid program and have been at the forefront of innovation with our Healthy Indiana Plan (HIP).

But we have more work to do. We are committed to improving the health and wellness of all Hoosiers. In 2018, as part of a collaborative effort with a wide range of stakeholders, including nursing homes, hospitals, Area Agencies on Aging, Adult Day Service providers, housing partners, and our State's health department, we kicked off a comprehensive Long Term Services and Supports (LTSS) system and payment workgroup to analyze, review and ultimately make significant changes to the long term care system in Indiana. The goal is to ensure Hoosiers receive the services they need at home and in the community, and in a timely manner. The concepts addressed by CMS in MFAR certainly are timely with our efforts, and reinforces our need to continue to work closely with stakeholders and federal partners to navigate the shifting landscape. To the extent we can work in a coordinated manner, with appropriate timelines and runway, we are confident we can reform our system in Indiana in a way that continues to meet the goals of this proposed regulation, but also improves the health and wellness of all Hoosiers, by allowing our citizens to age in place with independence, dignity and support.

I want to reiterate that the State appreciates and shares CMS's goal of fiscal integrity, transparency, and accountability for the Medicaid program, and we look forward to working with CMS to mutually achieve this goal. Despite the concerns we raise in this letter, we do want to start and finish by thanking CMS for this opportunity to provide comment on this critically important initiative. We look forward to working collaboratively with CMS and our stakeholders to find a path forward which allows Indiana to continue to meet the needs of Hoosiers and continue its efforts to transform the LTSS landscape. I am enclosing our specific comments and recommendations, organized by CFR section reference. If you have any questions regarding this letter, please contact me at Allison.Taylor@fssa.in.gov. Please also copy Amy Owens, Federal Relations Lead for Indiana Medicaid, at Amy.Owens@fssa.IN.gov.

Sincerely,

Allison Taylor, JD
Indiana Medicaid Director

CC: Jennifer Sullivan, Secretary, FSSA
Paul Bowling, Chief Financial Officer, FSSA
Sarah Renner, Division of Aging Director, FSSA

Comments and Recommendations

Implementation Timeline

A significant part of the State's contention with the proposed regulation is the timeline for implementation due to the time and effort associated with adjusting to the proposed changes. First and foremost, we are concerned about member continuity of care and ensuring no negative member impacts during any transition. Additionally, we will need time and runway to work with stakeholders and members to adjust programming, scale up to meet additional reporting requirements, secure additional funding within our biennial budget cycle in the state, pursue new federal approvals as appropriate, and promulgate any related amendments to the Indiana Administrative Code (IAC). It will take at least 5 years to accomplish these changes.

The additional time and runway is exceedingly important for Indiana, as the State is aggressively working towards transforming the landscape of our Long Term Services and Supports (LTSS) in Indiana. We are committed to the goal of building an LTSS environment where all Hoosiers live in a fully engaged home and community-based setting and reach their greatest emotional, mental, and physical well-being. However, this transformation will require a number of legislative, regulatory, policy, and programmatic changes – without factoring in the changes contemplated in this proposed regulation. As a result, the State would request implementation of the proposed changes be effective five years from the effective date of the Final Rule. This will afford the State adequate time to make legislative, regulatory, policy, and programmatic changes that support the goals of the State's LTSS reform, and balance those with the directives of this regulation.

State Share of Financial Participation (42 CFR §433.51)

CMS proposes replacing the current term "public funds" with "state and local funds." At §433.51(b), CMS defines this term as general fund dollars appropriated directly to the state or local Medicaid agency, an IGT, or a CPE. We understand this modification will limit funds that may be considered as the state share to: (1) state general fund dollars appropriated by the state legislature directly to the State or Medicaid agency; (2) IGTs from units of government, derived from state or local taxes (or funds appropriated to state university teaching hospitals) then transferred to the State Medicaid Agency (SMA); or (3) CPEs, which are certified by the contributing unit of government as representing expenditures eligible for federal financial participation (FFP) and reported to the state.

The proposed modification of language creates a restriction on the State, as it indicates that state appropriated funds must be those made directly to either the State or SMA. Consequently, this could jeopardize State appropriated funds received from other State divisions and agencies, including sister state divisions on aging, intellectual and developmental disabilities, and mental health and addiction. Indiana Medicaid relies on these divisions to administer components of Medicaid to which they are naturally suited. For example, the Indiana Department of Education (DOE) transfers State funding to Indiana Medicaid to pay the state share of administrative and services costs for Individual Education Programs (IEPs), using State appropriations. Additionally, the language indicates that IGTs must come from state and local taxes; however, Indiana's IGT sources are not currently overseen by the Indiana Medicaid agency.

The State would recommend that the allowable appropriations language be clarified to include state general fund appropriations made to other state agencies. Additionally, the State would recommend CMS clarify the requirements surrounding IGTs. Indiana does not currently verify the IGT source and would need to develop new processes for doing so. The State would recommend CMS provide guidance on the requirements for the State to verify IGT sources. Further, the State would recommend implementation of these changes be effective five years from the effective date of the Final Rule.

General Definitions (42 CFR §433.52, 42 CFR §447.286)

CMS is proposing to alter definitions under 42 CFR §433.52 for the following terms: Medicaid activity, non-Medicaid activity, net effect, parameters of a tax, provider-related donation, and taxpayer group. The State is primarily concerned by the definition of net effect and the addition to the provider-related donation definition. As proposed, net effect will mean "the overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in case or in kind, among participating entities." The net effect will be determined by the totality of the circumstances. As proposed, the definition of provider-related donation will be expanded to specify that "any transfer of value where a health care provider or provider-related entity assumes an obligation previously held by a governmental entity, and the governmental entity does not compensate the private entity at fair market value, would be considered a donation made indirectly to the governmental entity. The obligation need not rise to the level of a legal obligation but would be considered by examining totality of the circumstances and the net effect."

The altered definitions will provide CMS with substantial flexibility and subjectivity. As proposed, the State is unable to ascertain clear guidance on the factors contributing to the tests. Without clear guidance, these definitions will provide significant uncertainty to the provider community as to how these determinations will be made. Furthermore, the State would not have access to certain legal documents made by an entity without express rights, which could impact future contract drafting.

The State would recommend CMS clarify the scope of the net effect definition as the State currently understands it to mean a state would be responsible for the actions of private entities outside the scope of any relationship or agreement with the State or Medicaid providers; thus, the State would recommend the definition be limited to agreements between the State and providers. The State would recommend a five-year period to implement necessary changes following the effective date of the Final Rule.

CMS is proposing to alter definitions under 42 CFR §447.286 for the following terms: base payment, non-state government provider, private provider, and supplemental payment. Base payment will mean a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the Medicaid State Plan or paid to the provider through its participation with an MCO. Supplemental payments will mean a Medicaid payment to a provider that is in addition to the base payments to the provider—other than DSH payments—made under Medicaid State Plan authority or demonstration authority. Supplemental payments are any payments to a provider other than base payments or DSH payments. Supplemental payments are lump sum payments made to the provider at various intervals depending on the state program.

Non-state government provider will mean a health care provider that is a unit of local government in a state—including a city, county, special purpose district, or other governmental unit in the state that is not the state—which has access to and exercises administrative control over state appropriated funds from the legislature or local tax revenue, including the ability to dispense such funds. Private provider will mean health care provider that is not a state or non-state government provider. CMS intends the modified definition of private provider to act as a catch-all for remaining health care providers in the state. State government provider will mean a health care provider that is a unit of state government or a state university teaching hospital.

CMS proposes a totality of the circumstances test to determine whether a provider is governmental or private. The State would recommend CMS clarify the timeline for determining if a provider meets the proposed definition of a non-state government provider, as this will affect the timing of the UPL calculation and payment. Further, the State would recommend CMS include an appeals process for these determinations.

In particular, we wanted to point out that the proposed rule does not provide an effective date for the IGT requirement or expressly tie it to the transition period. If adopted as written, we would request that this provision be effective five years from the effective date of the final rule to afford us time to develop proper transitions and ensure continuity of care for our nursing home members.

Permissible Health-Care Related Taxes (42 CFR §433.68(e) and (f))

CMS proposes to provide that a tax must not impose undue burden on health care items or services paid for by Medicaid, or on providers of such items and services reimbursed by Medicaid. CMS also notes that the net effect test would apply to this section.

CMS's proposed incorporation of a "net effect" test on the hold harmless requirements of health care related taxes, combined with the proposed "undue burden" standard for such taxes, is an area of concern for the State. Taken together, the net effect and undue burden tests create uncertainty for the State and the provider community around the permissibility of a significant number of current tax arrangements.

Further, the undue burden test appears to conflict with statutory language in the Act at §1903(w)(3)(E)(ii), which requires the Secretary to approve tax waivers if "the net impact of the tax and associated expenditures" is generally redistribute in nature. CMS's undue burden standard and examples in the proposed rule are focused entirely on the tax rate itself, with no consideration given to associated expenditures. The State would recommend CMS provide clarification on these points.

The State would recommend implementation of these changes be effective five years from the effective date of the Final Rule. In addition, the State would request that hold harmless agreements between providers without direction or agreements from the state should be considered outside the scope of the proposed rule. Furthermore, the State would recommend that CMS provide guidance on the standards of the undue burden provision or remove the provision from the proposed language.

Waiver Provisions Applicable to Health Care-Related Taxes (42 CFR §433.72)

CMS proposes an approved tax waiver will have a three-year run period. In addition, CMS proposes to add that approved tax waivers must meet the outlined waiver provisions at all times; if it ceases to do so, the state or other unit of government must request a new waiver.

While we understand the spirit of this proposed provision, we are very concerned with the concept of giving these tax waivers a "run rate" and re-up period. We would propose that the waiver authority should remain effective until there is a change made to the program. Otherwise, requiring these waivers to be reassessed every three years will pose tremendous uncertainty for the state and providers as degrees of compliance might vary in the minds of reviewers.

The State would recommend that CMS remove the requirement for states to resubmit previously approved Medicaid Waivers. In the alternative, the State would recommend a five-year implementation and renewal timeframe, instead of the proposed three years. This would allow the State the flexibility needed to coordinate waiver submissions with new requirements and afford the State the opportunity to establish appropriate internal monitoring processes.

State Plan Requirements (42 CFR §447.201, §447.252, & §447.302)

At 42 CFR §447.201, CMS proposes to specify that the Medicaid State Plan may not provide for variation in FFS payment for a Medicaid service on the basis of 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. CMS notes this proposed approach would be consistent across FFS and managed care.

In Indiana, services rendered as part of the Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) program are paid at a higher rate; this is not intended to leverage federal dollars, but rather done to assure children receive early detection and care. This section would likely also impact the Healthy Indiana Plan (HIP) since, per state statute dating back to 2008, HIP pays at Medicare rates.

Further, at 42 CFR §447.252 and §447.302, CMS proposes amending Medicaid State Plan payment requirements for inpatient hospital and long-term care facility services and outpatient hospital services, respectively, to implement new requirements and any SPAs proposing to make supplemental payments to providers of these services. CMS proposes limiting approval for any Medicaid supplemental payments to a period of not more than three years and will require states to monitor the supplemental payment program during its approval term, which will require robust data reporting. A state whose supplemental payment approval period has expired, or is expiring, may request a SPA to renew the supplemental payment for a subsequent period not to exceed three years, consistent with the new requirements.

The State would recommend CMS remove the requirement for states to resubmit previously approved Medicaid State Plan Amendments. In the alternative, the State would recommend a five-year implementation and renewal timeframe, instead of the proposed three years. This would allow the State the flexibility needed to coordinate SPA submissions with new requirements and afford the State the opportunity to establish appropriate internal monitoring processes.

Payments Funded by Certified Public Expenditures (CPEs) Made to Providers That Are Units of Government (42 CFR §447.206)

CMS proposes to add §447.206(b) to codify CPE protocols. In addition, CMS proposes to require states implement processes by which all claims for medical assistances would be processed through MMIS in such a way that identifies the specific service provided to the specific enrollee. Furthermore, CMS proposes that reconciliations would be performed by reconciling payments made during the year based on the interim Medicaid payment rates, to the provider's filed cost report for the state plan rate year in which interim payments were made. Finally, CMS outlines four requirements for specification in the Medicaid State Plan when the state proposes to use a CPE to fund a Medicaid payment.

The State would recommend CMS provide further guidance on the limitations and reporting requirements for administrative claiming due to the potential for additional cost reports and payment reconciliations.

Inpatient Services: Application of UPLs (42 CFR §447.272)

CMS proposes to revise the current ownership groups (state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities) used to establish the UPL. CMS proposes to replace these provider designations with state government provider, non-state government provider, and private provider, as defined above. In addition, CMS proposes to codify existing policy regarding two methods of demonstrating the Medicaid UPL: using the Medicare equivalent payment amount or cost amount, and the process for establishing and demonstrating compliance with the UPL in §477.288(b) of the proposed rule, which describes the data sources, data parameters, and methodologies that must be considered and used in demonstrating compliance with the UPL.

As proposed, the new definitions could have a significant impact—potentially disqualifying providers from participation in the DSH and nursing facility supplemental payment programs. The State would recommend CMS provide guidance on the totality of the circumstances test that will be used to determine

ownership groups. In addition, the State would recommend CMS include an appeals process for these determinations. Further, the State would recommend implementation of these changes be effective five years from the effective date of the Final Rule to allow the State to mitigate access concerns.

Basis and Purpose (42 CFR §447.284)

CMS proposes to require states to submit quarterly and annual reports which detail the total provider payments—including base and supplemental payments—authorized under Medicaid State Plan and demonstration authority. In addition, states will be required to submit an additional annual report disclosing the amount of provider contributions provided to the state to support the non-federal share of the Medicaid payments, along with the total payments received by the contributing providers. Provider contributions include all provider taxes, IGTs, CPEs, and any provider-related donations as described in Part 433(B).

The State would need to make substantial new investments in reporting systems, which will come with associated costs and strain on State staff and budgets. Currently, there is no funding appropriated to allow the State to cover the additional cost related to the new reporting requirements CMS is proposing. The State would recommend CMS eliminate the quarterly reporting requirement and focus only on annual reporting for these programs. Further, the State would recommend implementation of these changes be effective five years from the effective date of the Final Rule to allow the State time to cover the additional cost.

We are absolutely supportive of additional transparency and meaningful data and reporting in this area. However, we want to make sure any reporting requirements are quality and purpose driven, and do not simply add to the administrative process.

Reporting Requirements for UPL Demonstrations and Supplemental Payments (42 CFR §447.288)

CMS proposes that beginning October 1 of the first year following the year in which the Final Rule takes effect, and by October 1 of each year thereafter, each state would be required to submit a demonstration of compliance with the applicable 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). However, CMS is proposing to remove the reporting of PRTF and clinic UPLs in the annual reporting requirements.

The State understands CMS's intent to tie payments to individual claims. However, the reporting requirements proposed require access to information that may not be easily accessible to the State, such as the information to determine provider category. The State would recommend CMS provide clarification on this point. Further, the State would recommend implementation of these changes be effective five years from the effective date of the Final Rule to allow for the numerous Medicaid State Plan changes and updates to UPL methodology that the proposed changes would require.

Failure to Report Required Information (42 CFR §447.290)

CMS proposes to specify the avenue of enforcement in the event that a state does not comply with the proposed data reporting requirements for base and supplemental payments. If a state fails to timely, completely, and accurately report information, CMS may reduce future grant awards by the amount of FFP it estimates is attributable to payments made to providers as to which the state has not reported properly until such time as the state complies with reporting requirements.

The State would recommend implementation of these changes be effective five years from the effective

date of the Final Rule. In addition, the State would recommend a format and forum to seek reconsideration or appeal of withheld FFP, particularly during the early years of the program while states and providers are still adjusting practices.