**Medicaid Fiscal Accountability Rule Comment Guide**

**LeadingAge MFAR webpage:** [**www.leadingage.org/MFAR**](http://www.leadingage.org/MFAR)

**Housekeeping items on filing comment letters:**

* Comments to the Medicaid Fiscal Accountability Rule (MFAR) are due on February 1.
* You can read full text of the rule here: <https://www.federalregister.gov/documents/2019/11/18/2019-24763/medicaid-program-medicaid-fiscal-accountability-regulation>
* Note: the link above may mention a due date of January 17. You can ignore those. CMS extended the comment period to February 1.
* Click this link to submit a public comment: <https://www.regulations.gov/comment?D=CMS-2019-0169-0001>
* You may submit comment letters via copy and pasting into the **comment** box and/or by attaching a document where it says, “**Upload file(s)**”. LeadingAge typically attaches PDF documents and writes into the comment box to please see the attachment.
* If you want to provide contact information, check that box and fill in your information.
* If you are submitting on behalf of an organization, such as a CCRC, check that box and write the organization name.
* Click continue in the lower right-hand corner of the web page when you are finished pasting and/or attaching your comments.
* You will be taken to a preview screen. Check that everything is correct, check the box acknowledging you are submitting the comment into an official docket, and then click **submit comment**.
* If you need to make edits, click the “**Edit**” button and repeat above steps.
* After submitting the comment, you’ll have the option to get an emailed receipt of the comment.
* Comments are posted publicly online once they are received and CMS processes them. It may take a few weeks to see it online, but as long as you submit before February 1 you are okay.
* See comments posted to date here: <https://www.regulations.gov/docketBrowser?rpp=50&so=DESC&sb=postedDate&po=0&dct=PS&D=CMS-2019-0169>

**Tips for Effective Comment Letters:**

* Comments letters need to be tailored and include unique content to maximize effectiveness.
* LeadingAge provides in this document template language to draw from in comment letters. A good approach is to integrate this with information specific to your state and/or organization and how the proposal would affect you.
* Form letters are not generally effective. Federal agencies can read a form letter only once regardless of how many people submit them.
* Keep in mind: Comments are not a vote. Federal agencies are required to consider comments but are not bound by comment feedback when making a final rule. That said, the more comments that get submitted, the better our chances are that the agency listens.

**If you submit a comment letter, we’d love to see it! Please send to** [**bflinn@leadingage.org**](mailto:bflinn@leadingage.org)

**These are the key points in the document, all supported with data and other details:**

* + Changes to federal Medicaid financing policy disproportionately affect nursing homes.
  + The proposed provider tax changes could increase state taxes for CCRC nursing home providers.
  + The proposed provider tax language is vague and arbitrary.
  + The proposed rule does not adequately estimate the impact of the rule on Medicaid.
  + The proposed changes to the Upper Payment Limits/supplemental payments are not based on adequate data.
  + The proposed rule is incorrect in saying the proposed rule does not impact small entities/providers.
  + Given the impact of these changes, a three-year implementation/renewal timeline is too short.

**Recommended letter opening:**

(Date of submission)

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS–2393–P

P.O. Box 8016

Baltimore, MD 21244

Docket #CMS-2019-0169

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation (MFAR), Docket #CMS-2019-0169. I am writing today on behalf of (organization name). (Include here information about your organization, including its location, what types of services you provide, how many people you serve, how many older adults you serve specifically, your annual revenues, etc. If you have a mission or vision statement that would fit within the letter, go ahead and add that. LeadingAge typically includes this in our comment letters.)

I am concerned about the proposed MFAR’s potential implications for both the Medicaid program and for continuing care retirement communities/life plan communities (or other provider type if applicable). (Detail your ask here. If you want a withdrawal, say that. If you want changes made either as a direct response OR if CMS does not withdraw the rule, say that and summarize the changes you want here).

**Facts you may want to include about life plan communities/CCRCs**

* Life plan communities/CCRCs are residential communities for older adults that provide independent living and nursing home services, and often provide assisted living and other types of services for older adults.[[1]](#footnote-1)
* There are almost 2,000 life plan communities/CCRCs nationally.
* CCRCs collectively serve almost 750,000 people, the vast majority of whom are older adults.
* About 4 in 5 (79%) CCRCs are nonprofit organizations.
* Most (65%) are faith/religiously-affiliated.
* The average CCRC serves about 290 people and has an average annual budget of $12.2 million.[[2]](#footnote-2)
* About 30% of life plan communities/CCRCs indicated in a 2019 survey that they were planning to reduce the size of their nursing homes- even before the proposed MFAR was announced.[[3]](#footnote-3)

**NOTE: While we and many others use the branding term *life plan communities*, the federal legal term is still *continuing care retirement community*. We recommend using the latter (CCRC).**

**Items to include if you want to write about how changes to federal Medicaid financing policy disproportionately affect nursing homes**

The proposed MFAR as written would disproportionately impact nursing facilities compared to other types of providers.

Medicaid is critical payer for nursing facility care in the United States.

Medicare does not pay for nursing home care beyond short-term/rehab stays, and the private long-term care insurance market is becoming smaller each year. According to the most recent data, Medicaid paid for more than 60% of nursing facility care nationally. (Include the figure in your state here, using this data source: <https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/>).

Other types of providers subject to this rule rely less on Medicaid for financing services. For physician services, for example, just 11% of care is Medicaid-funded and almost 2 in 3 (66%) dollars for physician services come from private insurance or Medicare.[[4]](#footnote-4)

As a result, the MFAR proposal will have a more direct impact on nursing home than other types of providers, and the significant changes proposed could be disruptive to nursing home provider stability and beneficiary access.

**Given the critical role of Medicaid for nursing facility care financing, CMS should exempt nursing facilities from the proposed rule, or delay doing so until it can assess the impact of the proposal on providers of other types of services that rely less significantly on Medicaid.**

**Items to include if you want to write about the proposed provider tax language is vague and arbitrary**

Current Medicaid regulation requires that state provider taxes must be broad-based and uniform. If a state wants to provide an exemption or discount to a group of providers, they may do so if those policies pass statistical tests set for by CMS. Specifically, state provider tax waivers must pass either the B1/B2 test for waivers of uniformity, or the P1/P2 test for waivers of the broad-based requirement. See current 42 CFR § 433.68 (e)(1) and (2).

The proposed rule imposes additional requirements beyond these tests, however the proposed new criteria for provider taxes are overly vague and provide too much discretion to CMS. Because of this, states and providers cannot reasonably determine what types of provider taxes would or would not comply with the proposed rule.

The proposed MFAR as written, particularly proposed 42 CFR § 433.68 (f)(3)(i), (iii) and (iv), are unworkable as detailed below and CMS should not proceed with finalizing these without significant revision.

*Proposed CFR § 433.68 (f)(3)(i): Taxing providers that provide less Medicaid services at lower rates than those that provide relatively more Medicaid services.*

This proposed criterion is overly vague. CMS does not provide any definition or sub-criteria for what would constitute “relatively more” Medicaid services. Without additional guidance on “relatively more”, this proposed criterion would be exceedingly difficult for states to comply with, particularly as payer mixes change over time. **CMS should not move forward with this proposed criterion, however at minimum should provide further information and a reliable statistical test for what constitutes “relatively” more or less Medicaid services.**

*Proposed CFR § 433.68 (f)(3)(iii): Not taxing, or taxing at a lower rate, groups of providers with no Medicaid services compared to other groups (e.g., those that take Medicaid).*

This proposed criterion would force states to impose new taxes. Providers that do not provide Medicaid services by definition are not posing a burden on the Medicaid program. Exempting such providers from a state provider tax thus does not burden the Medicaid program, either. Taxes levied on non-Medicaid providers to fund the Medicaid program would be harmful to non-Medicaid providers and the residents and patients they serve. CMS should not impose regulation that forces states to levy new taxes on non-Medicaid providers. **This proposed criterion should be withdrawn.**

*Proposed CFR § 433.68 (f)(3)(iv): Tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group.*

This proposed criterion is overly vague. CMS does not provide a definition for or process through which it would “reasonably determine” a proxy for a taxpayer group. Further, including a consideration of “the totality of the circumstances” is overly broad. Collectively, these phrases grant CMS undefined and likely excessive discretion toward determining the permissibility of state provider tax structures. Without more clear standards for this proposed criterion, states cannot be reasonably expected to design and/or revise tax structures to comply with the proposed regulation. Further, the lack of specificity for this proposed criterion could cause the rule to be inconsistently and/or arbitrarily applied across states. **Thus, CMS should withdraw this proposed criterion or propose a revised, more specific criteria for further public comment.**

In addition, CMS considered, but did not propose, requiring that provider taxes pass BOTH the B1/B2 test (uniformity) and the P1/P2 test (broad-based requirement). We support not requiring both of these tests and recommends CMS continue to require only one of the two statistical tests.

**Items to include if you want to write about how proposed provider tax changes could increase state taxes for CCRC nursing home providers**

As of January 2020, eighteen states that have provider taxes in place for nursing facilities provide exemptions for nursing homes in CCRCs[[5]](#footnote-5).

If your state has such an exemption or discount, write about it here. How long has it been in place? Why was this exemption or discount granted?

Most CCRC nursing facility residents pay for their care with private funds. Most CCRCs do not participate in the Medicaid program and do not receive Medicaid funds**. Thus, neither these communities nor these tax policies pose a burden on Medicaid.**

As currently written, however, the proposed MFAR could have the effect of disallowing states to continue these types of tax exemptions or discounts. As a result, the MFAR proposal would likely cause states to impose new taxes on these providers by ending the current exemptions and discounts.

Most CCRCs would not be able to absorb these new taxes without cutting services, passing the new costs along to their older adult residents or closing their nursing home operations entirely.

If you have an estimate on how much the tax could cost your community, include that here and explain how you calculated it. If you have a resident-level impact (e.g., higher monthly fees), all the better.

**CMS should not move forward with the proposed provider tax changes given their impact on CCRC nursing homes. CMS should withdraw this section (proposed 42 CFR § 433.68), or at minimum include in final rule language that the regulation does not apply to exemptions or discounts for nursing homes in continuing care retirement communities.**

**Items to include if you want to talk about other types of provider tax exemptions/discounts**

Explain what the tax exemption is designed to do (e.g., exempt small facilities).

Discuss why having this exemption is important to the those exempted, and any financial impact from the proposed MFAR.

Highlight how: there is no certainty as to whether CMS would allow these types of programs to move forward under a final MFAR, and that CMS needs to provide clarity rather than proposing criteria that allows itself excessive discretion.

**Items to include if you want to talk about the proposed hold harmless provisions**

Under current policy, states cannot have provider taxes in which a provider is held harmless for the cost of the tax. There are two current statistical tests that determine this. See 42 CFR § 433.68 (f).

The proposed MFAR proposes to add language allowing CMS to consider the “net effect” of provider tax policies in considering whether they hold providers harmless.

This is overly vague. Rather than continue to use calculable statistical tests to determine hold harmless compliance, CMS is proposing to give itself discretion to pick and choose compliance.

While CMS includes a definition for “net effect,” this definition is also overly broad and provides nothing for states or providers to use toward determining whether their current arrangements comply with the proposed text.

Further, the implementation timeline for this section is too immediate. **States and providers will need time to transition to any final rule, and this section if finalized should be on the same implementation timeline (3 or 5 years) as other sections in this proposal.**

**Items to include if you want to talk about how proposed changes to the Upper Payment Limits/supplemental payments are not based on data**

Open with some discussion about the role of supplemental payments in your organization’s operations and in your state. If there is a specific purpose for these, such as quality improvement, include that here.

As currently proposed, CMS would make substantial changes to how states calculate non-DSH supplemental payments but does not provide data supporting such changes.

Instead, it proposes to limit the types of data used (e.g., from within the last two years) and the methodologies states can employ to calculate the Upper Payment Limit. It also requires states to submit extensive data to CMS on quarterly and annual bases, which would be used to inform future decision making on supplemental payments and Upper Payment Limits.

We believe CMS is taking the incorrect approach to this section of the proposal. Instead of making changes to the supplemental payments and Upper Payment Limit rules and then using data, CMS should take a data-driven approach before making such major changes to these rules.

CMS should collect the data needed for this proposal, perform analyses and propose changes according to findings from those.

**Thus, CMS should not move forward with the proposed changes to Upper Payment Limit calculations or to supplemental payments without first gathering the data needed to do so. The proposed sections should be delayed or withdrawn until CMS has data to justify them, rather than creating new policy and collecting data after the fact.**

**Items to include if you want to talk about how CMS does not estimate the impact of proposed MFAR on the Medicaid program**

In Section V (Regulatory Impact Analysis), Part C (Anticipated Effects), Item 3 (Effects on the Medicaid Program), CMS says “The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown.”

Given the broad scope of the proposal, and its potential implications for beneficiaries and for providers, this is not a sufficient response.

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

In the absence of such analysis, CMS should give considerable attention to public comment about the proposal’s impact on Medicaid. In my state, for example… (talk about the potential implications for your Medicaid program here).

**CMS should delay finalizing this rule until it has the data analysis necessary to support the rule.**

**If CMS is not able to conduct this analysis, it should withdraw the rule entirely and/or the sections for which there is no estimated Medicaid impact (e.g., proposed provider tax changes, proposed non-DSH supplemental payment changes).**

**Items to include if you want to talk about how CMS is incorrect in saying the proposed rule does not impact small businesses and other providers.**

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

This is simply inaccurate. While state Medicaid agencies would be in large part responsible for carrying out the requirements of the proposed rule, they are not the only entity that would be affected by policy changes that would come from this rule’s finalization.

According the U.S. Small Business Administration’s 2019 Table of Small Business Size Standards , the small business size standard in millions of dollars for Continuing Care Retirement Communities is $30 million in average annual receipts. [[6]](#footnote-6) (if you are not a CCRC, follow the source linked below and find your category to determine whether you’d be considered a small entity).

LeadingAge estimates that the average annual receipts for CCRCs total about $12.2 million, well under the SBA size standard.[[7]](#footnote-7)

If your receipts are under the $30M threshold, be sure to emphasize that here. **You are considered a small entity and are affected by the proposed MFAR!**

Without provider tax exemption/discount protections, small entities like CCRCs would likely experience tax increases as a result of this proposal.

CMS cannot reasonably assert that this proposal would not have “a significant economic impact” on small businesses, as its finalization would likely result in state policy changes that adversely affect small businesses and their customers, including CCRCs and the older residents who live there. CMS may not be directly making that change, but the agency would be the underlying cause of them via this proposal.

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

**Items to include if you want to talk about the implementation timeline**

CMS proposes a broad set of changes to Medicaid financing, including but not limited to the proposed changes to provider taxes and supplemental payments.

CMS currently proposes that these changes go into effect two or three years after the date any final rule is published.

Three years is not enough time for states to revise their policies to comply with the proposal, nor is it enough time for providers to recalibrate their financial strategy to prepare for implementation.

In addition, the data required from states in the proposal are complex and most states likely would need significant time and resources to create/augment data systems and to collect data. Three years is likely not enough time to do so.

If your state agency has had problems with Medicaid data collection and/or reporting, highlight that here as evidence of how difficult implementation will be.

CMS is soliciting feedback on whether other implementation timelines would be more appropriate, specifically mentioning one-year and five-year timelines.

**CMS should delay the implementation date entirely for five years. If it does not do so entirely, it should delay the implementation of the proposed provider tax changes for five years.**

**CMS specifically should not use a one-year timeline for any aspect of this proposal.**

**Closing**

To close the letter, summarize the points and the recommendations you make in the letter in a few sentences. Also provide a contact in case there are further questions related to your comment letter.

1. LeadingAge/Ziegler 200 report definition [↑](#footnote-ref-1)
2. Life Plan Community (CCRC) Market Snapshot Report 2019, <https://www.leadingage.org/sites/default/files/LALS20-0031_eBook_MarketSnapshot_LifePlan_Community_p3b.pdf> (Source for bullets 2-6) [↑](#footnote-ref-2)
3. “Right-Sizing” Nursing Care Settings in a Life Plan Community, <https://www.leadingage.org/sites/default/files/%E2%80%9CRight-Sizing%E2%80%9D%20Nursing%20Care%20Settings%20in%20a%20Life%20Plan%20Community.pdf> [↑](#footnote-ref-3)
4. CMS 2018 National Health Expenditure Data, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index> [↑](#footnote-ref-4)
5. LeadingAge, Map of States with Nursing Home Provider Taxes that Exempt or Provide Discounts to CCRCs, <https://leadingage.org/sites/default/files/state%20provider%20tax%20policies%202020%20map.pdf> [↑](#footnote-ref-5)
6. Per SBA, *“This is the “total income” (or “gross income”) plus the “cost of goods sold.” These numbers can normally be found on the business’s IRS tax return forms. Receipts are averaged over a business’s latest three complete fiscal years to determine the average annual receipts. If a business hasn’t been in business for three years, multiply its average weekly revenue by 52 to determine its average annual receipts.”* <https://www.sba.gov/federal-contracting/contracting-guide/size-standards> [↑](#footnote-ref-6)
7. Life Plan Community (CCRC) Market Snapshot Report 2019, <https://www.leadingage.org/sites/default/files/LALS20-0031_eBook_MarketSnapshot_LifePlan_Community_p3b.pdf> (Source for bullets 2-6) [↑](#footnote-ref-7)