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February 1, 2020

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Attention: CMS-2393-P

Dear Administrator Verma,

On behalf of ADvancing States, I am writing you to provide feedback on the Medicaid Fiscal Accountability Regulation (CMS-2393-P). ADvancing States (formerly the National Association of States United for Aging and Disabilities, or NASUAD) is a nonpartisan association of state government agencies and represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and persons with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including many state agencies with responsibility for Medicaid long-term services and supports (LTSS). Together with our members, we work to design, improve, and sustain state systems delivering LTSS for people who are older or have a disability and for their caregivers.

We first want to stress that ADvancing States and our members are committed to the financial integrity of the Medicaid program, as well as to ensuring that fraud, waste, and abuse is mitigated. We do not disagree with CMS' intent to ensure that Medicaid financing is consistent with statutory intent and that the program is not funded by inappropriate arrangements. However, we do believe that there are significant challenges associated with the regulation which could seriously impact states' abilities to implement the Medicaid program. Due to the programmatic responsibilities of our members, we will focus our comments on implications for LTSS and state agencies on aging and disabilities. Despite our comments' limited scope, we also want to express our support for the comments submitted by our colleagues at the National Association of Medicaid Directors (NAMD) and we share many of their concerns regarding the rule.

## General Comments Regarding the Rule

We believe that the rule contains an extremely challenging timeline for implementation. As you know, the financial structure of Medicaid frequently involves a number of sensitive issues that impact state and local governments as well as private entities. In many states, implementation of the rules will require complex legislative and regulatory changes and in some cases there will also need to be renegotiation of provider rates in order to meet the new regulatory requirements. This process could be extremely lengthy and, especially in states with biennial legislatures, it may not be feasible to enact legislation, amend state regulations, implement IT system changes, and complete the financial restructuring necessary within the allowed period. We encourage a minimum of five years for states to implement these changes.

We also note that many of the final determinations of compliance are left to CMS discretion. While we agree that there are often specific considerations within each state, we are concerned that this broad Federal discretion will create significant challenges with state implementation. For example, when a state agency provides technical assistance to their legislature on statutory language establishing or modifying a provision that falls under the MFAR regulation, it will be challenging for them to know whether their advice is federally approvable. Similarly, when states request feedback from CMS on a conceptual policy, they may get generalized advice but often cannot receive any tangible response until a written proposal is submitted. This creates a challenging scenario where a state will likely not know whether their policy is acceptable until CMS approves or denies it. Changes in federal leadership could also result in different interpretations or priorities, thus leading to a different decision for the same policy depending upon the current administration's views. A similar problem is possible given the different staff at CMS Regional Offices. States routinely report receiving slightly or substantially different guidance depending upon the regional staff they are in contact with. If this regulation is implemented as written, CMS risks substantial geographic variation in approved payment policy.

Additionally, we are concerned that the new provisions will inadvertently create challenges with state initiatives to expand the availability of home and community-based services (HCBS). For example, we are concerned that several of the policies related to UPLs, IGTs, and provider taxes may inadvertently impact the cost neutrality calculations for 1915(c) waivers given that hospitals, nursing homes, and intermediate care facilities are the provider types most likely to be impacted. Potential shifts in the reimbursement for these providers may limit the ability of states to innovate within their 1915(c) waivers.

Lastly, the substantial reporting requirements created by this rule will establish significant administrative burden on the states and it is unclear whether there will be a resultant

improvement in the quality of care or the overall programmatic integrity. We do agree that HHS has a fiduciary duty for oversight of state finances and that states must ensure they are operating their programs effectively and appropriately. However, this function is already performed through a variety of mechanisms, such as routine audits, OIG investigations, and GAO investigations. We are specifically concerned that the rule's requirements for states to collect and report specific information on individual providers' financing and ownership arrangements will result in a large amount of submitted information that CMS does not have the capacity to analyze and act upon.

### **Other Section-Specific Comments**

#### 42 CFR § 447.252

The amendments to this section raise specific concerns for our membership, particularly as it relates to the role of aging and disability agencies, counties, and other units of government within the aging and disability service network. Our read of the legislation indicates that general fund revenue appropriated to the state aging and disability agency would be allowable. However, it is unclear how the rule would treat instances where counties or other government entities provide a portion of Medicaid LTSS funding to state aging and disability agencies, who in turn serve as the operating agency for Medicaid HCBS waivers or other LTSS options. Similarly, the rule proposes to limit transfers of funds to those derived from state or local taxes. While direct taxes comprise most of the funding within the aging and disability network, we are concerned about states who have implemented innovative financing for LTSS, such as using state lottery funds or surcharges on DUI citations to support services. We request that CMS broaden this provision to ensure that other legitimate forms of revenue from state operating agencies or local governments are allowable sources of Medicaid match.

#### 42 CFR § 447.252

The three-year approval period for supplemental payments runs counter to the broader Medicaid program administration. In general, once CMS approves a state plan provision, the policy remains in effect until the state submits a subsequent amendment. Although states are required to submit amendments when statutory changes result in existing state plans becoming noncompliant, it is the role of the state to initiate any such amendment. We believe it would establish an inappropriate precedent for CMS to regulate arbitrary timeframes and sunset dates for state plan approvals.

We recognize that over the past few years, many states have shifted their UPL policies into waiver arrangements. Such waivers should continue to be approved and renewed according to their statutory timelines.



### **Provider Taxes and HCBS**

Although it is outside the current regulation as written, we wish to emphasize the existing imbalance in rules for LTSS. Currently, states may leverage additional FFP through provider taxes on hospitals, nursing homes, and other institutional providers but are prohibited from establishing similar financing arrangements to enhance HCBS payments. The current workforce shortage in HCBS necessitates creative solutions, which should include additional mechanisms to finance HCBS. Enabling states to utilize provider taxes in HCBS could not only result in increased payments and provider participation, it could also allow states to establish creative incentives, pay-for-performance, and other value-based purchasing arrangements that are currently lacking in many HCBS programs.

We appreciate the opportunity to provide feedback on this important topic. If you have any questions regarding this letter, please feel free to contact Damon Terzaghi at [dterzaghi@advancingstates.org](mailto:dterzaghi@advancingstates.org) or 202-898-2578.

Sincerely,

A handwritten signature in blue ink that reads "Martha Roherty".

Martha Roherty  
Executive Director  
ADvancing States