January 30, 2020

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

RE: Proposed Rule: CMS–2393–P, Medicaid Program: Medicaid Fiscal Accountability Regulation (Vol. 84, No. 222), November 18, 2019 and CMS-2393-N (Vol. 84, No. 249) December 30, 2019

Dear Administrator Verma:

Thank you for the opportunity to comment on the proposed Medicaid Fiscal Accountability Regulation (MFAR), Docket #CMS-2019-0169.

The mission of LeadingAge is to be the trusted voice for aging. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, including nursing homes and continuing care retirement communities (CCRCs). We collaborate with 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

The proposed MFAR would have significant impact on how states structure the financing of their Medicaid programs. Critically, if finalized as proposed MFAR could cause states to make cuts to benefits, eligibility and rates/payment to providers. In addition, the proposed MFAR would have serious implications for many nursing facilities in the form of increased state provider taxes. The financial burdens of this proposed rule could very well extend to older adults and the long-term services and supports (LTSS) they require.

The Medicaid program is vital to delivering health and LTSS to older Americans. In fiscal year (FY) 2017, the United States collectively spent $365 billion on LTSS and Medicaid paid for a majority (52%) of that care.[1] For nursing home care, about 6 in 10 (62%) residents are covered by Medicaid. Regulatory changes that affect the financing of the Medicaid program thus has direct implications both for these services and for the people who rely on them to meet their needs. As this letter will discuss, the proposed MFAR jeopardizes this critical care.

At a high level, **LeadingAge recommends that CMS withdraw the proposed MFAR**. As this letter will discuss, many of the key provisions the proposal offers, including changes to provider taxes and supplemental payments, are unworkable as written and would have serious implications for nursing facilities and the residents that live there.

In the absence of a full withdrawal, LeadingAge offers a variety of recommendations for CMS to consider, summarized below and detailed in this letter.

- CMS should exempt nursing facilities as classified in 42 CFR § 433.56 (a)(3) from all changes MFAR proposes.
- CMS should withdraw the proposed 42 CFR § 433.68, or alternatively should either exempt nursing facility provider taxes from the proposed changes entirely and/or include language in a final rule that clearly allows states to continue exemptions/discounts for nursing homes in continuing care retirement communities, small nursing facilities and large nursing facilities.
- 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.
- CMS should put all proposed changes on a five-year implementation timeline if there is a final rule. CMS specifically should not use a one-year timeline for any aspect of this proposal.
- CMS should make revisions to the Regulatory Impact Analysis that includes further detail on the effect MFAR could have on the Medicaid program and the proposal's effect on small businesses.
    - If CMS is not able to conduct the Medicaid impact 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 supplemental payment changes).
    - 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.

The Proposed MFAR Would Disproportionately Affect Nursing Facilities

Recommendation: *CMS should exempt nursing facilities as classified in 42 CFR § 433.56 (a)(3) from all changes MFAR proposes. Alternatively, CMS should delay implementation of the proposed MFAR for nursing homes by at least five years, rather than the proposed three years.*

The proposed MFAR as written would disproportionately impact nursing facilities compared to other types of providers. As mentioned, Medicaid is critical payer for nursing facility care in the United States and covers about 62% of nursing facility residents.

Unlike other classes of providers, Medicaid pays for a larger share of nursing facility care than Medicare or private insurance. Medicare covers nursing facility care in limited capacities, specifically for short-term, post-acute rehabilitation stays. While long-term care insurance products are available, the benefits these policies offer are also limited, and most people do not have them as they do health insurance. If a person needs to go to a nursing facility for a long-term stay, their options are often either out-of-pocket spending or the Medicaid program.

Other classes of providers included in this proposed rule rely on Medicaid in a much more limited capacity. Medicaid covers just 11% of physician services, for example, while Medicare and private insurance collectively account for 2 in 3 dollars covering this care.[2]

Because of this difference in Medicaid payer mixes, different classes of providers will experience the implications of the proposed MFAR if finalized at different extremities. While classes such as physician services would likely be able to fill any gaps in financing as a result of the rule from other payer sources, nursing facilities do not have this capacity and would likely bear the full brunt of the MFAR.

The significant changes MFAR proposes, therefore, could be disruptive to nursing facility provider stability and beneficiary access. LeadingAge research has identified that more than 550 nursing facilities have closed their doors since July 2015.[3] These facilities had similar quality ratings as currently open facilities, and problems with Medicaid financing likely played a role in many of these closures. Further disruption to Medicaid, like this proposed rule would likely cause, could very well lead to further nursing home closures and reduced patient access to nursing facility care among Medicaid beneficiaries. Because of these potentially stark implications for nursing facilities, CMS should consider exempting this class of providers from the proposed MFAR entirely or take a delayed approach to implementation to help minimize disruption to both Medicaid beneficiaries receiving nursing facility care and to providers of these services.

42 CFR § 433.68 - Permissible Health Care-Related Taxes

Recommendation*: CMS should withdraw the proposed 42 CFR § 433.68, or alternatively should either exempt nursing facility provider taxes from the proposed changes entirely and/or include language in a final rule that clearly allows states to continue exemptions/discounts for nursing homes in continuing care retirement communities, small nursing facilities and large nursing facilities.*

About Provider Tax Waivers

The proposed MFAR seeks to change long-standing federal regulation of state provider taxes. 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 tax structures pass statistical tests set forth in current regulation. 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).

Both these statistical tests allow CMS, states and stakeholders a degree of certainty when a state designs provider tax waivers to propose for CMS approval. States can calculate prospective provider tax rates against the prescribed statistical tests and know whether those proposed waivers could receive CMS approval.

The MFAR Proposal for Health Care-Related Taxes is Unworkable as Written

The proposed MFAR does not seek to remove these statistical tests from consideration of state health care-related tax (also referred to as provider taxes) waivers. Instead, it proposes to add an additional set of criteria that provide none of the certainty or predictability allowed by the current 42 CFR § 433.68 (e)(1) and (2) statistical tests.

The proposed additional criteria seek to restrict the use of state provider tax waivers that "burden" the Medicaid program. CMS proposes to consider any provider tax waiver to be a "burden" on the Medicaid program if it meets one of four criteria, proposed 42 CFR § 433.68(e)(3)(i), (ii), (iii) and (iv).

As we describe below, the proposed criterion are unworkable as proposed because they are overly vague and prescribe too much discretion to CMS. Unlike the statistical tests currently in regulation, the proposed language not only fail to give states any criteria under which to design and/or refine provider tax waivers, but also fail to explain how HHS would apply these criteria, which could lead to geographic, or other unexplained differences between states. In doing so, the proposal creates what are essentially discretionary standards for CMS to use in considering state provider tax waivers. States thereby cannot reasonably be expected to craft provider tax structures in compliance with the proposed MFAR.

This could cause states to withdraw from provider tax programs, thereby depriving beneficiaries of critical funds for Medicaid services, and/or structure provider taxes without waivers, which would likely have the effect of raising state taxes on certain providers, which would then likely be passed along to consumers via increased out-of-pocket costs and/or reduced services, regardless of their Medicaid enrollment status. In either scenario, the proposed MFAR would harm Americans in need of care.

In the sections that follow we will explain the problems associated with each of the new criteria under proposed 42 CFR § 433.68(e)(3).

Proposed CFR § 433.68 (e)(3)(i): The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity.
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 higher", 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. Any statistical test or other sub-criteria should be made available for further public comment.**

Proposed CFR § 433.68 (e)(3)(iii): Within each taxpayer group, the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (except as a result of excluding from taxation Medicare or Medicaid revenue or payments as described in paragraph (d) of this section).
This proposed criterion is unnecessary given the other proposed criterion in the section. If a state is taxing Medicaid higher than other types of services, that provider tax structure would likely violate at least one of the other three proposed criterion in addition to this proposed criterion. In addition, a LeadingAge survey of state nursing home provider tax structures did not identify any situation in which Medicaid nursing facility services were taxed at a rate higher equivalent non-Medicaid, non-Medicare (e.g., private pay) services. Therefore, **we question the necessity for CMS to include this criterion in its rulemaking and recommend CMS remove this section from any final rule.**

Proposed CFR § 433.68 (e)(3)(iii): The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group, unless all entities in the taxpayer group with no Medicaid activity meet at least one of the following: (A) Furnish no services within the class in the State, (B) Do not charge any payer for services within the class, (C) Are Federal provider of services within the meaning of § 411.6 of this chapter, (D) Are a unit of government.
This proposed criterion would force states to impose new state taxes. Providers that do not provide Medicaid services and do not receive payment from the Medicaid program by definition are not posing a burden on Medicaid. 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. In nursing facilities in particular, these increased costs would be shouldered by people paying for care out-of-pocket. CMS should not impose regulation that forces states to levy new taxes on non-Medicaid providers and the people they serve. **This proposed criterion should be withdrawn.**

Proposed CFR § 433.68 (e)(3)(iv): The 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 criterion for further public comment.**

The MFAR Proposal for Health Care-Related Taxes Would Harm Nursing Facilities and Residents
In the absence of statistical tests or other calculable criteria in the proposed MFAR, LeadingAge and its members must infer from the proposed new criterions the implications for nursing facilities and provider tax programs for these providers.

Within the nursing facility class, states receive provider tax waivers for all sorts of purposes, including to exempt from taxes or to charge a lower rate to small facilities, larger facilities, continuing care retirement communities (CCRCs) and other types of providers for which a state determined it was in their LTSS system's best interest to pursue a nursing home provider tax waiver. Many of these waivers have been in place for several years.

Specific to CCRCs, most of these communities do not participate in the Medicaid program, and those that do receive only very limited Medicaid funds. CCRCs are a critical component of the aging services system. There are about 2,000 such communities across the country. Collectively, these communities are home to more than 700,000 older Americans who rely on CCRCs to provide them with a full range of housing and services as they age, from dining services and social activity through skilled nursing care. Almost all CCRC residents are older adults, with the average new resident being about 80 years old.[4]

Because the payer mix of these communities are so heavily reliant on out-of-pocket spending, many states have pursued provider tax waivers that exempt CCRCs or provide these communities a discounted rate to avoid them subsidizing the Medicaid program despite largely not participating in it. Thus, neither these communities nor these tax policies pose a burden on Medicaid. LeadingAge has identified eighteen states in which nursing provider taxes provide an exemption or discounted tax rate to CCRCs.[5]

The proposed MFAR poses a serious threat to CCRCs in states with such provider tax waivers. Despite the fact that the nursing facilities in these communities mostly do not participate in Medicaid, the tax exemptions or discounts currently in place could very likely be construed by CMS as being "burdensome" on the Medicaid program. Specifically, if CMS determined CCRCs to be a "proxy group" and/or that these exemptions constitute taxing providers of Medicaid services higher rates, the agency could disallow such exemptions under a final rule.

We are concerned that if the proposed changes to 42 CFR § 433.68 (e)(3) are finalized as written, then states would be forced to assess new state provider taxes on CCRCs and require these communities to

subsidize the Medicaid program even though they largely do not participate in Medicaid and their residents mostly pay out-of-of pocket for nursing facility care.

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. While the exact cost of these new taxes would vary by state and by community, analyses from LeadingAge and our state partners suggest such new taxes as a result of this proposal could easily become a new six- or seven-figure cost each year per community. If those costs were passed onto residents, out-of-pocket costs as a result of taxes this proposed rule would lead to could increase by several hundred dollars each month. In other words, older Americans would likely bear the brunt of the proposed MFAR if finalized.
In addition to CCRC-related tax waivers, many states have provisions that exempt or discount nursing facilities based on size (e.g., exemptions for facilities with less than 45 beds, exemptions for facilities with more than 200 beds). Similar to the CCRC-related discounts and exemptions, these waivers are in place to protect nursing homes from large tax bills that may be unsustainable for their operations. Faced with paying new provider taxes and closing operations, these facilities may be forced to choose the latter and thereby harming residents.

Across the board, the proposed MFAR could lead to an influx of nursing home closures, whether they are small, large and/or in CCRCs, depending on the state and any provider tax waiver(s) they may have for nursing facilities. LeadingAge research has found that more than 550 nursing homes have closed between July 2015 and July 2019. Close to half (44%) of these had 4- or 5- Star CMS Quality Ratings, almost identical to the percent of currently open facilities with such ratings.[6] The implications of nursing home closures can be devastating for residents, their families and their communities. Unfortunately, the proposed MFAR section on health care-related taxes threatens to exacerbate this trend.

Therefore, we **urge CMS to either withdraw the proposed provider tax waiver changes to 42 CFR § 433.68. If CMS must proceed with the proposed 42 CFR § 433.68, it should do so with a specific exemption for nursing facilities and/or include language in a final rule that clearly allows states to continue exemptions/discounts for nursing homes in continuing care retirement communities, small nursing facilities and large nursing facilities.**

The Proposed Hold Harmless Provisions Create Uncertainty and Provide CMS Excessive Discretion
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.

Given the vague nature of this proposed section**, we recommend CMS either withdraw the proposed language and/or propose new language that includes a statistical test or similar criteria and make that language available for further public comment.**

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.**

42 CFR § 447.286 Definitions, 42 CFR § 447.288 Reporting requirements for upper payment limit demonstrations and supplemental payments and 42 CFR § 447.302 State plan requirements

Recommendation*: 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.*

About Upper Payment Limits, Supplemental Payments and the Proposed MFAR

Supplemental payments are an important aspect of Medicaid financing. These are payments made to providers in addition to Medicaid rates, and states can use such payments to incentivize quality improvement and other activities.

According to MACPAC research, nursing facilities receive about 7% of their Medicaid funds from supplemental payments nationally. By state, however, the amount varies significantly. In Indiana, about 38% of Medicaid nursing home dollars come from supplemental payments, for example. [7]

Supplemental payments are limited by the Upper Payment Limit (UPL). Under federal law, Medicaid cannot pay providers more for a given service than Medicare would for that same service. Medicaid can pay up to the amount Medicare pays, through base rates alone or in conjunction with supplemental payments. Historically, states have State calculated their Upper Payment Limits, with CMS approval. Upper Payment Limits generally set aggregate limits by provider and by ownership type. For nursing homes, Upper Payment Limits are generally set for state facilities, non-state government facilities, and private facilities.

Understandably, CMS through this proposed rule seeks to collect additional data on Medicaid supplemental payments to better understand how states are making payments and to the extent to which those payments comport with federal rules. The approach the proposed MFAR takes, however, is not correct path forward. At a high level, **we recommend that CMS withdraw the proposed changes to both aspects of Medicaid financing and pursue data collection before making significant policy changes as proposed in MFAR.**

In the absence of such action, this section of our letter will address many of the proposed changes and include LeadingAge recommendations for moving forward.

CMS Should Take a Data-First Approach to Changing Supplemental Payment Rules

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 collected based on those changes, CMS should take a data-first approach before making such major changes to these rules.

Specifically, CMS should collect the data needed for this proposal, perform analyses and propose changes according to findings from those. There are many ways CMS could approach such collection. For instance, it could convene a Technical Expert Panel and/or propose rulemaking specific to data collection from states on supplemental payments. By doing so, CMS would be better positioned to propose policy changes than it currently is and would be by finalizing the proposed MFAR.

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.

Definitions of Government Units and Payment Types
CMS proposes new definitions in the proposal. We support some of the proposals, including that of base payments. We also have concerns about potential implications of the proposed changes to how governments are defined in Upper Payment Limits.

In the definition for base payments, CMS proposes including "*any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to a particular service provided to the beneficiary, such as payment adjustments made to account for a higher level of care or complexity of services provided to the beneficiary.*" CMS indicated that it considered not including this language in the proposed rule. **Add-ons and similar types of payments are critical in nursing facilities and often allow facilities to serve higher acuity residents, including people living with dementia. CMS was correct to include this language in the proposed base payment definition. LeadingAge supports the inclusion of this language and encourages CMS to retain it if it makes a final rule.**

Currently, the term "non-state government owned or operated" ("NSGO") refers to a nursing facility that is "owned or operated" by a non-state government entity, such as a county or county-owned hospital. This allows a non-state government entity, the ability to operate a nursing facility it <u>leases</u> instead of owns. In addition, it allows the NSGO entity to contract with an experienced management company to run the day-to-day operations of the nursing facility.

In the proposed rule, CMS proposes a new "non-state government provider" (NGSP) definition. As written, the proposed definition would restrict which types of providers qualify as an NGSP for the purposes of Upper Payment Limits and supplemental payments. The proposed narrow definition would prevent most types of public-private partnerships that are critical to the operation of many nursing facilities from being eligible for payment in the non-state government category. These types of partnerships, which can include a county-owned nursing facility contracting management of that facility to an experienced company, can make the difference between nursing homes remaining open versus closing. **We urge CMS to maintain the current government unit definitions and specifically not move forward with the proposed non-state government provider definition.**

Implementation Timeline Concerns

Recommendation*: CMS should put all proposed changes on a five-year implementation timeline if there is a final rule. CMS specifically should not use a one-year timeline for any aspect of this proposal.*

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.
While LeadingAge is opposed to many of the proposals set forth in the proposed MFAR, we do want to make sure that if they are finalized, states, providers and beneficiaries will be provided adequate time for any final rule to be implemented.

Simply put, 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. A rushed timeline like that proposed for this rule could lead to beneficiary harm, be it through facilities closing or through facilities experiencing financial shortfalls and making downward adjusts to staffing and/or services.

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. One year most certainly not for a proposal of this scale. To ensure accurate state data reporting, additional time is needed.

CMS is soliciting feedback on whether other implementation timelines would be more appropriate, specifically mentioning one-year and five-year timelines. In response to that, we recommend that **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.**

Regulatory Impact Analysis Concerns

In addition to concerns related to the proposed policy changes and implementation timeline for those, LeadingAge also has concerns about the lack of detail in the regulatory impact analysis section of the proposed rule.

Impact 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. In the absence of such analysis, CMS should give considerable attention to public comment about the proposal's impact on Medicaid.

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.

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).

Impact on 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 (SBA) 2019 Table of Small Business Size Standards, the small business size standard in millions of dollars for Skilled Nursing Facilities (NAICS code 632110) Continuing Care Retirement Communities (NAICS code 623311) is $30 million in average annual receipts. [8] LeadingAge estimates that the average annual receipts for CCRCs total about $12.2 million[9], and for nursing facilities about $5.8 million[10], both well under the SBA size standards.

Without provider tax exemption/discount protections, small entities like CCRCs and skilled nursing facilities would likely experience state 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.

Conclusion

The Medicaid program is vital to delivering health and long-term services and supports to older Americans. Given the absence of Medicare and private insurance coverage of LTSS, any changes to how states finance their Medicaid programs has direct implications both for these services and for the people who rely on them to meet their needs. LeadingAge therefore cannot support any cannot support any policy proposal that would threaten Medicaid LTSS funding.

The proposed MFAR unfortunately does exactly that via the proposed changes to provider taxes and to supplemental payments. If finalized, it would likely create instability across aging services and threaten the operations of many nursing facilities, thereby harming residents.

While LeadingAge supports efforts to improve the financial integrity of the Medicaid program, the proposed rule is not the correct way forward. We urge CMS to take a consensus, data-driven approach to future activity related to changes to Medicaid financing.

Thank you for considering the feedback in this letter. In addition to a letter from LeadingAge, several of our state partners have submitted comment letters highlighting state-specific implications of the proposal. Several nursing facilities, including those in CCRCs, have also submitted public comment, as have hundreds of residents of these facilities. We urge CMS to strongly consider the feedback from our community.

If you have any questions, please don't hesitate to contact me or have your staff contact Brendan Flinn (bflinn@leadingage.org) of the LeadingAge staff.

Sincerely,

Katie Smith Sloan
President and CEO
LeadingAge
ksloan@leadingage.org

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[1] MaryBeth Musumeci, Priya Chidambaram, and Molly O'Malley Watts, Kaiser Family Foundation, Medicaid Home and Community-Based Services Enrollment and Spending, Exhibit 1, https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/

[2] CMS 2018 National Health Expenditure Data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index

[3] Brendan Flinn, LeadingAge, Nursing Home Closures and Trends, June 2015-June 2019, https://leadingage.org/sites/default/files/Nursing%20Home%20Closures%20and%20Trends.pdf

[4] Life Plan Community (CCRC) Market Snapshot Report 2019, https://www.leadingage.org/sites/default/files/LALS20-0031_eBook_MarketSnapshot_LifePlan_Community_p3b.pdf

[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

[6] Brendan Flinn, LeadingAge, Nursing Home Closures and Trends, June 2015-June 2019, https://leadingage.org/sites/default/files/Nursing%20Home%20Closures%20and%20Trends.pdf

[7] MACPAC, https://www.macpac.gov/publication/medicaid-supplemental-payments-to-non-hospital-providers-by-state/

[8] U.S. Small Business Administration, Size Standards https://www.sba.gov/federal-contracting/contracting-guide/size-standards

[9] Life Plan Community (CCRC) Market Snapshot Report 2019, https://www.leadingage.org/sites/default/files/LALS20-0031_eBook_MarketSnapshot_LifePlan_Community_p3b.pdf

[10] Nursing Home Market Snapshot Report 2019, https://www.leadingage.org/sites/default/files/LALS20-0031_eBook_MarketSnapshot_NursingHomes_p3b.pdf