



February 1, 2020

Seema Verma
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments in response to the proposed Medicaid Fiscal Accountability Regulation (MFAR), [CMS-2393-P]. NAMD supports transparency and accountability for the Medicaid program. Both states and the federal government have a vested interest in ensuring resources are spent appropriately, with the aim of improving health outcomes for Medicaid members in a fiscally responsible manner. Our members stand ready to strengthen the partnership with CMS to efficiently and effectively advance these goals.

That said, several states have significant concerns with the operational ramifications of MFAR as proposed. MFAR as written would impose uniform rules and requirements on states without sufficient consideration to the diversity of state program designs and financing mechanisms. This one-size-fits-all approach will inevitably create challenges for the majority of states. While we support clarifying the parameters of appropriate financing mechanisms, CMS should not do so in a manner that gives the federal government significantly more authority over state decisions or define parameters so tightly that states no longer have necessary flexibility to administer their programs.

Throughout the preamble, CMS discusses examples of practices it finds concerning to the fiscal integrity of the Medicaid program. However, the remedies proposed in MFAR risk introducing unintended consequences for state Medicaid operations. In attempting to address a wide variety of disparate issues in the rule, CMS would create multiple process inefficiencies which could contribute to destabilizing state budget cycles and appropriations processes. CMS would also create an environment of uncertainty for states via significantly increasing the federal agency's discretion to approve or disapprove state financing arrangements, which may limit states' ability to predict what CMS's decisions will be on an ongoing basis.

For these reasons, NAMD encourages CMS to take additional time to open dialogue with states to refine the rule's provisions going forward. We also request, at minimum, a five-year implementation period after a final rule is promulgated to allow sufficient time for states to modify their financing arrangements and reimbursement structures.

The broad impacts of MFAR cannot be overstated. The rule aims to comprehensively update CMS's oversight of virtually all state arrangements to finance Medicaid state share, including health care-related taxes, intergovernmental transfers (IGTs), certified public expenditures (CPEs), and provider donations. MFAR also creates new time limits and evaluation requirements for

supplemental payment programs, which many states use to some degree to achieve specific objectives in their programs. In addition to these changes, MFAR would also increase expected reporting requirements from the states, with detailed and frequent provider-level reports on participation in supplemental payment programs and financing mechanisms.

All told, MFAR represents a significant departure from current state and CMS practice. CMS maintains that in several areas MFAR is codifying current CMS policy, particularly in its treatment of IGTs and CPEs. Many NAMD members do not agree that this is the case. MFAR would give CMS significant leeway to make subjective decisions on what constitutes a permissible state financing mechanism or supplemental payment program. This subjectivity creates uncertainty for states, both in terms of what current programs would remain allowable and what future programs would be approved by CMS. Further, CMS's proposed sunset of supplemental payment programs and health care-related tax waivers means that an initial approval is not a guarantee that an arrangement can be relied on in future years. This poses operational challenges for states as will be discussed below.

While states appreciate the spirit of the proposed regulation, we request that CMS consider a more targeted, deliberative approach. This work should take place over multiple rulemaking cycles, in strong partnership with states to ensure regulatory approaches are both feasible and effective. Advancing the shared goal of transparency, accountability, and integrity for the Medicaid program also requires supporting stable state financing and operations.

NAMD's comments on specific aspects of MFAR follow below. We have segmented our comments by general issue area for clarity and ease of review.

"State and Local Funds" vs. "Public Funds"

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. The focus on specific Medicaid agency appropriations in this definition raises serious operational concerns. We address issues with IGTs and CPEs separately below.

Several states' legislative appropriations processes and general fund accounting practices are inconsistent with CMS's proposals. MFAR's language assumes that specific dollars in a state's general fund are identifiable by source and type and are subsequently utilized for specific appropriations. This is not the case for many states. Once moneys enter a state general fund, whether they originated as a tax receipt, non-tax revenue, federal revenue, or some other source, several states do not characterize those funds as retaining a specific character to be used for a specific purpose. For these states, the general fund cash balance represents available funding for supporting appropriations made by the legislature.

This information is relevant due to CMS's focus throughout MFAR on the appropriate use of federal dollars. First, CMS appears in the preamble to view state earned federal revenues as federal funds, even after they have entered the state general fund; and second, that CMS retains the ability to

direct to states and local government entities how these earned federal revenues may be spent. Many states fundamentally disagree with this view. While CMS's intent to prevent federal matching funds from being used to generate additional federal match is understood and appreciated, CMS taking the stance that it has the authority to dictate how earned federal revenues are spent by a state or a local government strains the state-federal partnership at the core of Medicaid. MFAR would inhibit lawful and appropriate use of these dollars.

Further, the requirement for a general fund allocation specifically to a Medicaid agency would inhibit the role of sister state agencies, such as agencies on aging, intellectual and developmental disabilities, and substance use disorders, in achieving the goals of the Medicaid program. Many states rely on these agencies to administer components of Medicaid to which they are naturally suited. These agencies may also receive their own appropriations from the state legislature that are used to provide or pay for Medicaid services, as specifically authorized by statute in § 1903(w)(6)(A). MFAR's focus on the Medicaid agency appropriation as a source of state share would significantly impact state operations that rely on these sister state agencies. Also, while not units of state government, Tribal governments' participation in Medicaid financing, which is common for states with significant Tribal populations, appears to be precluded by CMS's proposals here.

In order to address these issues, we request that CMS not move forward with the change of "public funds" to "state and local funds." To the extent that CMS is concerned that impermissible sources of public funds are being utilized to finance the Medicaid program, the agency should propose rules which target those specific arrangements.

Intergovernmental Transfers

Many states are concerned that CMS's proposals for IGTs will create substantial barriers to effective use of IGTs as a state share financing mechanism. Further, CMS's IGT proposals appear to not align with the language and spirit of statute.

Specifically, CMS proposes at §433.51(b)(2) that IGTs must be derived from state or local taxes, or be funds appropriated to a state university teaching hospital. While this language is directly included in statute at §1902(w)(6)(A), which states that the Secretary may not restrict state use of funds derived from these sources, MFAR interprets this language as the *only* permissible source for an IGT. MFAR would preclude state use of other legitimate governmental sources that are not derived from taxes, such as patient and operating revenues, collected state university tuition, issued bonds, awarded civil damages in tobacco or opioid settlements, and other such examples. We do not believe CMS has the authority to restrict state use of these legitimate sources of funding. It is also unclear how existing state arrangements, such as funds transferred into a treasury which are subsequently appropriated by the legislature, would be considered under this definition.

Should CMS nonetheless finalize this provision, states and local governments would face challenges in operationalizing it. Many states currently rely on a certification and attestation process under which the transferring government entity attests a transfer is made from a public source. States do

not generally verify the nature of this source and would need to develop new processes for doing so. Developing and implementing these processes will create administrative burdens for the states. The impact on local units of government would also be significant. As noted above, local government-owned providers may have several sources of legitimate funding that are not direct appropriations or derived from taxes. To broadly require local governments to create tax appropriations to support their locally owned providers, even if these providers are able to effectively operate without such an arrangement existing today, creates undue burden for local taxpayers simply to meet CMS's expectations.

MFAR also creates new definitions for "non-state government provider," "private provider," and "state government provider" at §447.286. In the definitions of state government provider and non-state government provider, CMS includes several elements it would rely on to verify a provider's status. We recognize CMS's intent in these definitions is to ascertain whether changes in ownership of a private provider to a unit of government were made solely to generate previously unavailable IGTs. However, it is unclear how CMS intends to obtain all of this information or what the role of the state Medicaid agency is intended to be in this process. Medicaid agencies are generally not privy to specific arrangements and contracts existing between the entities in question.

Certified Public Expenditures

There are a number of challenges with CMS's treatment of CPEs under MFAR. Of these, the most significant is the requirement at §447.206(b)(4) that the certifying entity of the CPE receive and retain the full amount of FFP associated with the payment. While CMS maintains that this is a codification of existing requirements and practice, a number of states disagree with this characterization. These states have long-standing CPE arrangements that CMS has approved and would face immense fiscal challenges if this new requirement were finalized.

Further, these states disagree with CMS's justification of this change by referencing existing statute and regulation prohibiting the use of federal funds to match other federal funds. Retention of FFP from a CPE does not by itself indicate that the retained FFP will be used to draw down additional match; more often the retention is used to fund additional services which advance the goals of the program but for which no match is claimed or received. Additionally, since a CPE is originally sourced entirely from revenue from the state or its political subdivision, FFP received from the CPE is a reimbursement of that revenue. We question whether CMS has the authority to restrict this reimbursement, which is most appropriately characterized as allocation of state and local revenues among the state and its political subdivisions, as authorized under statute at § 1903(w)(6)(A).

An area that needs clarification is CMS's proposal at §433.51(b)(3), which appears to require that all CPEs comply with §477.206. At §477.206(a), CMS indicates that CPE requirements apply only to payments made to providers that are state government providers or non-state government providers. It is unclear if this language would restrict FFP availability only to CPEs that are made by state government providers or non-state government providers. Some states may use CPEs to fund Medicaid administrative activities conducted by sister state agencies, local government agencies, local health boards, and other non-provider entities which are essential to the functioning of the

program. If CMS makes these types of CPEs impermissible, this could result in states having all administrative functions and local funds flow through a Medicaid agency appropriation. The unintended consequence of this approach would be a dramatic increase in state Medicaid appropriations simply to satisfy a federal regulatory change. We do not believe this is CMS's intent and request clarification that FFP would remain available for the types of non-government provider CPEs described here.

At §447.206(c)(1), CMS proposes that all CPEs must be processed through the state's Medicaid Management Information Systems (MMIS) to identify the specific Medicaid services provided to specific enrollees. This would be a departure from current practice for several states and calls into question any supplemental payment programs which use a CPE as their financing mechanism, as well as administrative functions funded by a CPE. By MFAR's definition of supplemental payments, such payments are not attributed to a particular claim for a specific service. Further, some states may make DSH payments using a CPE funding mechanism, which are also not linked to specific claims for specific services. We are concerned at the potential confusion with this requirement and request CMS clarify that the expectation for CPEs processed through the MMIS does not apply to CPE-funded supplemental payments or DSH payments.

Lastly, several states are concerned with the 24-month timeframe at §447.206(c)(3) for final settlement of interim payments made to CPE certifying entities. This is a departure from current practice for several states and would be difficult to perform, especially for states with numerous county-based CPEs. We recommend at minimum a 36-month timeframe for final settlement.

Health Care-Related Taxes

MFAR'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 major concern. Taken together, the net effect and undue burden tests would create an environment of major uncertainty for states around the permissibility of a significant number of current tax arrangements. These tests would be a significant departure from CMS's current use of statistical tests, which provide states with clear parameters around what is and is not permissible for health care-related taxes. Shifting to unclear assessments of the "totality of circumstances" of a tax arrangement gives CMS wide discretion to make compliance decisions, with little ability for states to predict what the outcome of those decisions will be.

The net effect definition at §433.52, applied to the hold harmless test at §433.68(f)(3), hinges on the "reasonable expectation" of the taxpayer based on the "totality of circumstances" to receive a return on any portion of the tax amount. CMS defines this reasonable expectation as constituting a "direct guarantee" of such a return, a reference to the language found at §1903(w)(4) of the Social Security Act. However, it is unclear how a reasonable expectation can be understood to be an actual guarantee within the scope of that statute, how CMS will make the determination that a reasonable expectation exists, or how a state can contest CMS's finding if CMS does deem such an expectation to exist. Without clearer parameters around this test, states face significant fiscal and operational uncertainty. There is clear reason to believe that states which account for provider taxes in their

rate structures and designate health care-related taxes as an allowable cost – all of which has been approved by CMS – would be required to modify their structures under this rule.

The undue burden standard described at §433.68(e)(3) is also an area of concern that presents a substantive departure from current CMS practice. From an operational perspective, states would need significant guidance from CMS regarding audit processes to determine downstream provider use of earned revenue and the situations under which certain uses constitute an undue burden in a totality of circumstances assessment.

More fundamentally, while states recognize CMS's intent to introduce new standards to eliminate outlier scenarios and inappropriate workarounds to the current statistical tests to determine if a tax is generally redistributive, the undue burden standard as proposed introduces an unacceptable amount of subjectivity into CMS's review process. Such subjectivity inappropriately places CMS at the center of state legislative powers to exercise taxation authority. This proposed test also creates an expectation that CMS – and by extension the state Medicaid agency – must regulate inter-provider relationships that exist outside of a direct relationship to Medicaid. It is unclear how this will be accomplished, or if it is reasonable and appropriate to do so. If CMS's primary goal is to eliminate known outliers and workarounds, it should propose tests and parameters that are targeted to those known arrangements instead of granting itself broad and subjective review authority.

Further, the undue burden standard 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 MFAR are focused entirely on the tax rate itself, with no consideration given to associated expenditures.

We request that CMS not move forward with this proposed adoption of the net effect and undue burden standards and a totality of circumstances review process. This review would create too many difficulties for states by removing confidence in their health care-related tax arrangements. These tests, combined with CMS's proposed routine review of health care-related tax waivers, would together remove states' ability to be certain that an arrangement approved for one cycle would be approved ongoing. This dynamic would introduce long-term uncertainty for Medicaid financing. If CMS wishes to address specific arrangements which it views as impermissible, this should be accomplished via more targeted rulemaking that provides clear, quantifiable parameters for states.

Reporting Requirements and Concerns with Enforcement Mechanisms

As noted above, the reporting burden on states envisioned under MFAR is significant. At §447.288(c), CMS describes its quarterly and annual reporting requirements for inpatient and long-term care facility supplemental payment programs. On a quarterly basis, CMS expects states to provide identifying information and total supplemental payment amounts made under a SPA

and/or waiver authority to every provider receiving a supplemental payment. On an annual basis, CMS expects both aggregate and provider-level information on:

- Total FFS base payments made;
- Total supplemental payments made and under which authority;
- Cost-sharing received from Medicaid patients;
- Total DSH payments made;
- Medicaid units of care provided;
- Total of each health-care related tax collected by the state or local government;
- Total of costs certified as CPEs;
- Total amount contributed as IGTs; and
- Total of provider-related donations made.

Any provider receiving a supplemental payment and any provider contributing to any state share financing arrangement at the state or local level for a supplemental payment program would be subject to these reporting requirements.

The volume of information CMS is requesting is substantial. The feasibility for states and local units of government to gather and report this information in a standardized format is an open question. At minimum, states will need to make substantial new investments in reporting systems, which will come with associated costs and strain on state staff and budgets as well as increased federal spending to match state spending in this area. We recommend at least five years for states to make these modifications if CMS moves forward with this level of new reporting. We also recommend CMS eliminate the quarterly reporting requirement and focus only on annual reporting for these programs.

In addition to these specific data elements, CMS also proposes new monitoring plans and evaluations for supplemental payment programs at §447.252(d)(5) and (d)(6). The requirements are not detailed, including only references to generating information to assess effects of the payment on providers and beneficiaries. It is unclear what CMS's expectations for these evaluations would be for long-standing supplemental payment programs. If we assume that CMS will base its monitoring and evaluation expectations on those found under 1115 demonstration waivers or other waivers, there is good reason for states to anticipate significantly increased administrative burden and costs to meet this new requirement.

As an enforcement mechanism, CMS proposes at §447.290(b) to withhold the amount of FFP estimated as attributable to payments made under a supplemental payment program for which CMS deems the state is not meeting its reporting obligations. It is unclear how CMS would make these estimates. Opening the door to FFP withholds based on a state's inability to meet CMS's unrealistic reporting requirements introduces another element of fiscal uncertainty into MFAR. A more reasonable enforcement option is a corrective action plan with flexibility for CMS to respond to the unique circumstances of each situation, similar to other areas where CMS identifies compliance issues in a state's Medicaid program.

Practitioner Supplemental Payment Limits

At §447.406(c), CMS proposes limits on Medicaid practitioner supplemental payments at either 50 percent of the total FFS Medicaid base payment paid to an eligible provider, or 75 percent for services provided in a HRSA-designated health professional shortage area or Medicare-defined rural area. CMS justifies this limit in the preamble by citing identified growth over the past decade in upper payment limits established through an average commercial rate (ACR) calculation. It is unclear whether CMS considers value-based purchasing arrangements made to practitioners to be supplemental payments for purposes of this provision.

Many states disagree with CMS's imposition of arbitrary limits on practitioner supplemental payments based on the Medicaid base payment, nor do they agree with CMS's outright elimination of ACR-based supplemental payment methodologies. Numerous states use ACR-based methodologies today, and this change would undercut many successful programs. CMS does not provide any data justifying its proposal to limit supplemental payments to the levels it does, nor does it offer any consideration for the disruptive effects of removing this option from states that selected it to account for local market conditions. Finally, the removal of ACR methodologies is at cross purposes to CMS's proposed revisions to the Medicaid managed care regulations, where CMS explicitly encourages states to study and adopt commercial rates when the state deems them appropriate.

States acknowledge CMS's interest in eliminating instances of manipulated ACR data to set supplemental payment ceilings that are significantly higher than they would otherwise be. However, the solution to this policy concern is not to eliminate states' ability to use an ACR methodology in designing an appropriate supplemental payment. CMS should instead work individually with states to negotiate new parameters for ACR-based practitioner supplemental payments if the federal agency seeks to address specific outliers. We also encourage CMS to clearly state that value-based purchasing arrangements with providers are not subject to arbitrary caps.

Sunset Periods

For both supplemental payment programs and for health-care related tax waivers, CMS proposes a new maximum approval time period of three years, which would require the state to resubmit the program or waiver for reapproval from CMS every three years. This is a significant change from current practice, under which states do not need to seek CMS reapproval if there are no changes to the payment method or tax structure.

The three-year timeline for these programs and waivers is concerning for states. CMS already has a process in place today – the approval of relevant State Plan Amendments and/or waivers – to assess and approve a state's approach. If states seek to materially alter the parameters of these existing authorities, CMS then has the opportunity to conduct a review of the state's arrangements. We do not believe opening up these arrangements on a routine basis will generate value for the states, particularly when considering the potential for operational and administrative disruption. This is especially true for states with long-standing arrangements which would be newly subject to

CMS review. Should changes to these arrangements be necessary, states would require significant lead time to adjust them. We do not believe the transition periods outlined in MFAR will be sufficient in these instances.

As CMS is aware, states are required to operate balanced budgets in their fiscal cycles, with at least a year of planning and forecasting informing a given cycle. The tax waivers and supplemental payment programs CMS proposes reviewing every three years constitute a significant source of a given fiscal cycle's funding. Should a CMS reapproval not be conducted in a timely fashion, states would experience severe disruption in their budgeting processes and fiscal cycles. States caution CMS that its administrative capacity may not be able to guarantee timely approvals, given delays in existing approval processes for routine items such as managed care rates and contracts.

We encourage CMS to withdraw this proposal, as a need for continual resubmission and reapproval of previously acceptable arrangements creates unnecessary administrative burden on both the states and CMS. If CMS feels that these arrangements must be periodically reviewed going forward, we recommend a minimum approval period of no fewer than five years. Reviews should be subject to an expedited process to minimize the risk of fiscal and operational disruption for state budgeting cycles. Further, reviews should be conducted on a rolling basis, rather than all at once. This approach would provide state staff with sufficient time to address each individual review.

Administrative Fees in Supplemental Payment Programs

At §447.207(a), CMS proposes requiring that supplemental payment methodologies permit the provider to receive and retain the full amount of the payment. CMS will assess compliance with this requirement by reviewing associated transactions, including administrative fees paid to the state. MFAR prohibits these administrative fees from being calculated based on amounts received or amount of contributions made through an IGT. Notably, CMS does not offer a definition an administrative fee, which creates uncertainty for states given these provisions.

These proposals present some challenges for states, particularly the prohibition on differential administrative fees. It appears that CMS intends for administrative fees to be set at a flat amount in the supplemental payment program. If this is the case, states which utilize supplemental payment programs for certain objectives, such as school-based health services or non-emergency medical transportation, could see challenges in setting fee structures that meet the state's administrative costs without becoming financially burdensome for smaller providers or rural entities.

Additionally, states which are leveraging third-party administrative entities or fiscal agents as part of a currently approved payment demonstration may have challenges with the provider retention component of this proposal.

Overall, it is unclear to states what problem CMS is seeking to address with its proposals on supplemental payment administrative fee structures. We request CMS clarify how states can continue to operate programs in the instances discussed above that meet the overall intent of CMS's

goals in this section of the proposed rule, and if necessary, provide a process for exemptions of certain programs from these requirements.

Disproportionate Share Hospital Payments

CMS proposes at §433.316(f) clarifying when a DSH overpayment discovery occurs for purposes of beginning the one-year period for states to recover or attempt to recover the overpayment. States are supportive of this clarification.

CMS proposes amending §447.297 to utilize Medicaid.gov and the Medicaid Budget and Expenditure System instead of the Federal Register process to publish annual final state DSH allotments. States are supportive of this change.

At §447.299(c)(21), CMS proposes incorporating the revised definition of “independent certified audit” at §455.301 and requiring that the annual independent DSH audit must include estimates of findings when available data does not permit a specific finding. Several states anticipate that this requirement will increase state and federal costs of the audit process for potentially little gain. It is our understanding that relatively low percentages of DSH audits each year have significant data quality or completeness issues. We recommend that CMS consider more targeted assistance to states that experience these challenges instead of requiring a finding in the audit.

At §447.299(g), CMS proposes a two-year timeline for states to redistribute an identified DSH overpayment. States support this change alongside a request that CMS clarify that the same timeline applies to overpayment recoupments, with both timelines aligned with the relevant audit timeframe. We also ask that, in the infrequent instance when a state identifies a DSH underpayment to an eligible hospital in the course of its annual independent DSH audit, that the state have the option to make an additional payment to the impacted hospital.

MFAR's Relationship with Other CMS Rulemaking and Precedents

Due to its complexity and far-reaching nature, MFAR has several interactions with existing CMS rules, processes, and procedures that require additional clarification from CMS. We highlight here two such instances, related to 1115 demonstration waivers and issues under the Medicaid managed care regulations.

Several states use 1115 demonstration waivers to operate supplemental payment programs, sometimes as part of a wider effort at advancing value-based care and delivery system transformation. These states have already negotiated the terms of their waiver programs with CMS, with such terms generally being approved for five years. In some cases, states have continually renewed these waivers over multiple cycles, though for any state an 1115 waiver represents a significant investment of resources and staff time. It is not yet clear if CMS intends for MFAR's provisions, if finalized, to apply to these waiver programs. If that is CMS's intent, then the issue of implementation should be uniquely tailored to a given state's 1115 waiver renewal cycle timeline. If a state's renewal is due earlier than the three-year transition period outlined in MFAR, CMS should

grant these states additional time – ideally a full five-year waiver cycle – before requiring compliance.

The relationship between MFAR’s treatment of supplemental payment programs and managed care directed payments is also unclear. For purposes of managed care, MFAR defines the base payment as a payment made to a provider by a Medicaid MCO, documented in the state’s MSIS or T-MSIS system, and include all adjustments, add-ons, or additional payments attributable to a particular service for a beneficiary, including those made to account for a beneficiary’s higher level of care, complexity, or intensity of services. States have the flexibility under §438.6 of the managed care regulations to direct their MCOs to make payments of this type. This reading suggests these directed payments would be considered base payments, and thus MFAR’s provisions on supplemental payments would not apply. We request CMS to clarify that this reading is correct and MCO directed payments made under §438.6 are not required to meet any MFAR supplemental payment requirements.

An additional question emerges around language in the preamble compared to proposed regulatory text regarding inclusion of managed care payments in supplemental payment programs. Specifically, the proposed regulatory text at §447.288(b)(1)(iv)(B) requires states conducting an Upper Payment Limit (UPL) demonstration to “include all actual payments and all projected base and supplemental payments, excluding any payments made for services for which Medicaid is not the primary payer, expected to made during the time period covered by the upper payment limit demonstration to the providers within the provider category, as applicable, during the State plan rate year.” At §447.286, CMS defines “base payment” as “a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the State plan or that is paid to the provider through its participation with a Medicaid managed care organization.” Taken together, MFAR appears to require states to include managed care payments and other non-FFS payments in the UPL calculation. However, in the preamble CMS describes §447.288(b) as specifying “detailed UPL demonstration standards for demonstrating that Medicaid FFS payments are made in aggregate amounts that are less than or equal to the aggregate cost or Medicare payment amounts.” We request CMS to clarify that UPL demonstrations do not include managed care payments.

As CMS continues its work to improve the integrity of the Medicaid program, NAMD thanks it for consideration of state perspectives on these critical issues. We share CMS’s goal of good fiscal stewardship of the program. That said, several provisions in MFAR significantly depart from current understandings of CMS’s authorities and would create uncertainty and operational burdens for states. We encourage CMS to collaborate with states and take a more targeted, defined approach to address the specific outliers and scenarios discussed throughout this NPRM, in order to ensure an effective, operationally feasible regulatory structure that minimizes the risk of disruption for states.



Sincerely,

Kate McEvoy
State Medicaid Director
State of Connecticut
President, NAMD

Beth Kidder
Deputy Secretary for Medicaid
State of Florida
President-Elect, NAMD