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January 31, 2020

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

Dear Administrator Verma,

Thank you for the opportunity to respond to the proposed Medicaid Fiscal Accountability Regulation (MFAR). As Director of the Oregon Health Authority, which oversees Oregon's Medicaid program, I am committed to ensuring the integrity and stability of the Oregon Health Plan (i.e., Medicaid in Oregon), which provides comprehensive health coverage to nearly 1 million Oregonians. I am writing to express my grave concerns about the proposed MFAR rules: If CMS implements MFAR in the most restrictive interpretation, the rules will devastate health coverage and benefits for one in four Oregonians, especially in rural and frontier counties, as well as jobs across the state.

At a time when CMS is promoting state flexibility, the proposed MFAR rules could dismantle our system of Medicaid financing and deprive Oregon and other states of the flexible, state-level solutions we have devised with the support of federal and state policymakers and partners. At a time when the administration is communicating its commitment to delivering better health care to Americans, losing these funds would destabilize Oregon's health care system that has delivered on its commitment to the federal government to improve health outcomes, improve health care quality and contain costs.

By prohibiting states from using established funding agreements, the proposed rules would:

- Cut more than 60% of state and federal financing for Oregon's Medicaid system by eliminating CMS- and voter-approved provider taxes and severely limiting allowable sources of state funding, including inter-governmental transfers.
- Jeopardize health coverage for more than 300,000 Oregonians covered by the state's Medicaid expansion; threaten Oregon Health Plan benefits such as prescription drugs, mental health services, and dental care that nearly 1 million Oregon children and adults rely on to be healthy.
- Risk more than 23,000 Oregon health care jobs that were created after the state expanded Medicaid in 2014.

The rules proposed under MFAR threaten to undo the decades of work we have committed to shaping the Oregon Health Plan as we now know it. Oregon's dedication to providing health coverage through the Oregon Health Plan has remained consistent for more than two decades,

which has been made possible through our strong, transparent partnership with CMS through every gubernatorial and presidential administration.

Our state first expanded coverage to all Oregonians up to 100 percent of poverty in 1994. Since then, whether during times of plenty and times of famine, we have prioritized maintaining health coverage for those in our state who are most in need. We have done it the Oregon way, with creativity, cooperation and bipartisan support.

- After years of budget constraints, in 2009 Oregon extended health coverage to an additional 20,000 children.
- In 2017 voters approved a spending plan that provided approximately $1 billion in Medicaid funding.
- Just last year, Oregon's plan to fully fund the Oregon Health Plan for the next six years was signed into law.
- We continue to innovate in the area of coordinated care under CCO 2.0 – now a national model – which aims to improve care for Oregon Health Plan members and hold down cost increases.

The proposed rules are a clear overreach that go against the current federal statute as well as current and past CMS practice – and run counter to Oregon's bipartisan consensus to transform health care in our state.

Make no mistake: We support greater transparency and accountability within the health care system. The values of transparency and accountability have guided our work in Medicaid. Yet these proposed rules strengthen neither goal. Instead, they bring dramatic uncertainty to Oregon's current CMS-approved Medicaid finance models.

Moreover, I am deeply concerned about the considerable degree of discretion CMS would have under the proposed MFAR rules, the vague language included in the proposed rules, and the dramatic, negative effects the rules could have on Oregonians.

I urge you to reject the current proposed MFAR rules and instead adopt an approach that allows states to lead.

Sincerely,

Patrick Allen
Director
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Health Systems Division
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January 31, 2020

Seema Verna, Administrator
Center For Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments to Proposed Medicaid Fiscal Accountability Regulation (CMS-2393-P) on behalf of the Oregon Medicaid Program and the Oregon Health Authority

The Oregon Medicaid Program, at the Oregon Health Authority (OHA), appreciates the opportunity to provide formal comment to the proposed rule, Medicaid Fiscal Accountability Regulation (MFAR), [CMS-2393-P]. If implemented as proposed, these regulations will have dire consequences on Oregon's Medicaid program and our ability to provide access to vital health care services on which one in four Oregonians depend. Accordingly, OHA urges CMS not to finalize the MFAR in its current form.

MFAR poses major operational risks to state Medicaid programs

OHA supports CMS's intent to achieve greater transparency and accountability within the health care system. However, we have significant concerns with the operational impact our state will face with the proposed rules and their implications on 60% of the total state and federal financing for Oregon's Medicaid system. Of most concern, the proposed rule substantially limits the sources of Oregon's non-federal funding that have long been available and approved by CMS. In addition, the new time limits and evaluation requirements proposed for our existing programs and financing sources will create significant operational challenges and substantially increase resource needs to support the extensive reporting requirements. OHA has significant concerns with the proposed requirement to deliver provider-level reports on participants in supplemental payment programs.

MFAR rule is too broad and departs from current CMS practice

It is our belief the scope of MFAR is overly broad, too far-reaching, and threatens longstanding and widely used payment arrangements that currently exist in 49 of 50 states (Kaiser Family Foundation.). While CMS's stated intent is to provide clear guidance to states on rules that "have been subject to misinterpretation by states and other stakeholders, or that otherwise could benefit from additional specificity," many parts of the proposed rule such as tests for "net effect" and "undue burden" would give CMS broad discretion to determine whether a particular arrangement will be allowed, thereby making the federal requirements less clear to states, rather than more clear. Given the degree of vagueness in

the proposed rule language as written, we are deeply concerned about the considerable degree of discretion CMS would have to determine if specific funding arrangements will meet MFAR requirements. These ambiguities create significant uncertainty for Oregon's current CMS-approved Medicaid finance models, including Intergovernmental Transfers (IGTs) and health care related taxes.

Oregon does not agree that MFAR, as a significant departure from current state and CMS practice, simply codifies current CMS policy in several areas including the treatment of IGTs and supplemental payment programs. Our concerns about specific provisions are presented below. However, the two issues of most concern to Oregon are the new restrictions on health care related taxes proposed at §433.68, which threatens the viability of our CMS approved hospital tax, and the impact of proposed changes at §447.286, which would impact our CMS-approved IGT arrangement with our state's teaching hospital, Oregon Health & Science University (OHSU).

CMS has not assessed MFAR's impact

It is OHA's belief that CMS failed to assess the full impact of the proposed rule. CMS should collect data and conduct analyses to develop policies that more narrowly target specific arrangements that violate current regulations as opposed to establishing the broad, far-reaching policies of the proposed rule.

The proposed sunsetting of supplemental payment programs and tax waivers creates additional uncertainty for long-term planning. Oregon believes the current approval processes for SPAs and waivers already works correctly as a system of checks and balances. To the contrary, this proposal creates inherent risk of delays in CMS approvals that would inhibit our state budgeting and appropriations processes. Recently, our Governor signed into law a plan to fully fund the Oregon Health Plan for the next six years. This plan included the continued use of provider taxes, IGTs and supplemental payments. A three-year sunset for tax waivers and supplemental payments could put the six-year plan in jeopardy, if the agreements are not renewed or substantially altered. Therefore, Oregon requests a six-year sunset and approval period, given we operate with a biennial budget cycle.

Sweeping scope and devastating impact of MFAR requires transition

Lastly, we believe that if MFAR is finalized as proposed, OHA would require a minimum of eight years to implement these changes including the extensive reporting requirements, given our legislative budgeting process and appropriations. We recommend CMS provide a multi-year transition plan to avoid major disruption in Oregon's longstanding, CMS approved funding for Oregon's Medicaid program.

OHA is committed to ensuring federal and state funds are spent appropriately and responsibly to improve health outcomes for Oregonians. While OHA fully agrees with the goals of strong fiscal integrity and transparency, we do not believe this proposed rule accomplishes either.

OHA's comments on specific elements of MFAR are below. For ease of review, our comments are presented by general and topical issues.

"State and Local Funds" vs "Private Funds"
Based on the proposed new definition of "state share of federal participation" at §433.51(b), Oregon is concerned about potential adverse implications of establishing an upper limit on the amount government providers can IGT to fund state share based on the amount of the provider's state or local tax revenue, or funds appropriated to a state teaching hospital.

This provision would severely limit our state teaching hospital in its ability to make IGTs. While the hospital does not have taxing authority, it is a governmental entity, as established in Oregon Revised Statutes 353.020, and all its funds, whether received by direct state appropriation or by other revenue sources such as commercial insurance and tuition, are the funds of the State of Oregon. The assumption that specific dollars in Oregon's General Fund are identifiable by source and type is inaccurate.

Oregon's insurer assessment also could be impacted by the addition of "health insurers" as a new permissible class for health care related taxes. Oregon currently imposes an assessment of 2.0% on all commercial health insurance and managed care entity premiums.

The expansion and change of definitions of entity types may be difficult to operationalize in Oregon's Medicaid Management Information System (MMIS), given the questions surrounding them. Once finalized there will be a need for extensive updates in the MMIS to include: non-state government owned, state owned, and private as it relates to IGTs.

Intergovernmental transfers
This proposed change to §433.51(b)(2) will effectively cap the amount of the allowable IGT that Oregon's teaching hospital can make, and limit Oregon's use of IGTs as a non-federal share financing source.

The impact of proposed changes to definitions at § 447.286, "government provider, non-state government provider, and private provider" would significantly impact our IGT arrangement with our state's teaching hospital. We do not believe that CMS is best positioned to determine if an entity qualifies as a state or non-governmental provider, given these designations are established by the State of Oregon.

Health care related taxes

Oregon is concerned about the proposed "net effect" test. The state believes it enables CMS to have wide latitude in its approach to prohibit non-federal share financing arrangements CMS believes to be inconsistent with Medicaid statutes and regulation. Oregon is concerned the "net effect" test could impact current hospital taxes and IGT agreements, which provide the state's share of qualified directed payments to Oregon hospitals tied to utilization of CCO-enrolled Medicaid and CHIP Oregon Health Plan members. While Oregon can attest the state is not aware of any written or legally enforceable agreements that would guarantee any specific hospital(s) would be held harmless for health-care related taxes, Oregon is unsure how it could comply with the "net effect" test, which gives CMS the authority to consider the "totality of the circumstances" and unwritten or non-legally enforceable agreements.

As stated above, Oregon is concerned the proposed definition change of "public funds" to "state or local funds" could limit the use of IGTs as a non-federal share financing source. Oregon may need to implement additional safeguards to ensure transfers are being made with allowable funds, such as audits or additional documentation. IGTs with our local and county governmental partners may need to be renegotiated.

Since health care related taxes and an IGT agreement provide the state share for qualified directed payments (QDP) to Oregon hospitals, OHA is uncertain whether these payments would be impacted by the new "net effect" test. OHA is also unclear whether directed payments approved under a 438.6(c) preprint, meet the definition of "supplemental payments." If so, QDPs could be impacted by the proposed rules even if they are not impacted by the proposed changes to provider tax and IGT regulations.

Oregon's current hospital tax arrangement requires a waiver of the broad-based and uniform requirements, so this arrangement would be subject to the "undue burden" standard upon the newly required three-year waiver review in §433.72. The standard would be applied in addition to the current statistical tests to determine if health care related taxes are generally redistributive. Based on the proposed definitions at §433.52, Oregon believes the "undue burden" standard would give CMS broad authority to determine whether a tax structure divides providers into groups that serve as a proxy for Medicaid activity even if such distinctions are not expressly stated. The level of discretion provided CMS in the proposed rule would make it hard for Oregon and other states to know how to comply with the new standard and know whether new or existing health care related taxes are permissible.

Oregon is concerned about the significant deviation from current CMS processes under proposed changes to the undue burden standard at §433.68(e). Oregon appreciates CMS's attempt to eliminate outlier scenarios for the current statistical test. However, the proposed standard subjects states to an inherent amount of subjectivity in the CMS review process. Oregon believes CMS should propose alternate tests to target specific arrangements of concern, rather than the current language that gives broad and subjective review authority.

Oregon has concerns about proposed changes to how classes of health care services and providers are defined. Our state currently imposes a tax on commercial insurance and managed care entity premiums but is unclear whether the addition of "health insurers" as a permissible class in 433.56 would impact Oregon's compliance with health care related tax regulations. The addition of "health insurers" as a new permissible class for health care related taxes creates ambiguity because it is not clear whether some types of insurers not currently covered by the assessment would be included in the new class. If so, the assessment could need a waiver of the broad-based requirement for health care related taxes and need to meet the new "undue burden" standard.

Reporting requirements and concerns with enforcement mechanisms
While Oregon fully supports transparency, we believe this requirement will take a considerable amount of resources to implement and will come with indeterminate costs. Implementation could take several years or more given the need for operational and MMIS changes. Oregon requests that CMS allow a five-year transition period in order to meet the

extensive reporting requirements. Additionally, if this level of detail is required, CMS should amend the proposed rule to require it annually and not quarterly.

Based on the proposed requirement for states to submit an additional annual report disclosing the amount of provider contributions to support the non-federal share, Oregon's MMIS configuration should support being able to provide the report. Additional resources and time will be needed to create, draft, and review the report for accuracy at this level of detail.

In light of the proposed requirements under §447.252 and §447.302 to include new information in SPA submissions, including the duration of supplemental payments, a monitoring plan to ensure payments remain consistent with requirements, and for renewal requests to include a program evaluation from the last approved period, Oregon emphasizes the need for specific criteria for CMS review and approval.

CMS also states in the NPRM that "we are also proposing that the states submit an additional annual report disclosing the amount of provider contributions provided to the state to support the non-federal share of the Medicaid payments along with the total payments received by the contributing providers. The provider contributions include all provider taxes, IGTs, CPEs, and any provider-related donations as described in part 433, subpart B." Oregon notes this additional reporting could be cumbersome and extensive.

The annual reporting should tie to CMS64 but will include Units of Service, and coordination of this requirement may be difficult. Oregon just completed a survey (supplemental reporting) that included Revenue State Fund source detail requirements.

The state "would be required to report certain information for each supplemental payment included on the CMS-64 … These submission requirements would include provider-level data on base and supplemental payments made under state plan and demonstration authority by service type." This reporting could also quickly become cumbersome and extensive.

It is unclear if CMS will be comparing the new reports required in the NPRM to current state reporting requirements for Schedule of Expenditures of Federal Award (SEFA). These would likely not match as accruals are entered and ultimately could be contradictory.

Oregon does not believe it is appropriate to defer the estimated FFP made to providers if the state is deficient in its reporting. The proposed action is punitive to states and the providers who rendered services in good faith. This change would create additional work for states and CMS in reconciling reports. Additionally, CMS has not shown an ability to be timely in reviewing and approving state deliverables such as rate review. This lack of timeliness will dramatically affect state finances. Given the vagueness of the proposed language, Oregon is concerned about how the FFP deferral estimates could be incorrect or incomplete based on a variety of factors and recommends CMS use corrective action plans to remediate deficiencies.

Sunset periods
Oregon believes the current approval processes for SPAs and waivers already works correctly as a system of checks and balances. We believe the proposed changes at §447.252(d)(5) and (d)(6), and 433.72 including the three-year sunset requirement will not add any value for Oregon or other states. To the contrary, this proposal creates inherent risk of delays in CMS approvals that would inhibit our state budgeting and appropriations processes.

Recently, our Governor signed into law a plan to fully fund the Oregon Health Plan for the next six years. This plan included the continued use of provider taxes, IGTs and supplemental payments. A three-year sunset for tax waivers and supplemental payments could put the six-year plan in jeopardy, if the agreements are not renewed or substantially altered. Oregon requests a six-year sunset and approval period, given we operate with a biennial budget cycle.

Administrative fees in supplemental payment programs
Some Oregon supplemental payment programs have state statutory provisions that allow OHA to collect an administrative fee to fund supplemental payment processing costs. Oregon is concerned how CMS may view these in context of CMS assessing compliance with §447.207 by examining any associated transactions that are related to the provider's total computable Medicaid payment. Without the support of administrative fees, Oregon may need to eliminate these programs due to lack of resources to administer them. In some circumstances, state enabling legislation may also include agency authority to levy interest charges on providers who are late in providing administrative fees to the state for program management. Given legislation may include the right for the state to withhold or deduct interest owed from future payments, OHA would want clarification this arrangement conforms with the requirement.

Disproportionate Share Hospital payments
Oregon supports CMS proposal at §433.61(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.

Oregon supports the proposed changes at §447.297 to use Medicaid.gov and the Medicaid Budget and Expenditure system instead of the Federal Register to publish annual final state DSH allotments.

Oregon questions the return on investment of both the state's and CMS's time and resources in revising the definition of "independent certified audit" and requiring annual independent audits at §447.299(c)(21) and §455.301 to include estimates of findings when data is limited, and a specific finding cannot be derived. Oregon asks that CMS provide technical assistance to those states where DSH audits are problematic rather than requiring a finding in the audit.

Oregon supports CMS's proposed changes to §447.299(g) that states redistribute identified DSH overpayments within two years. We recommend that CMS require that overpayment recoupments occur under the same timeline and be aligned during the same audit period.

MFAR and managed care
Oregon asks for clarity and assurances that managed care directed payments are not affected by the proposed changes. We seek confirmation that directed payments will be considered as base payments, and therefore MFAR's supplemental payment provisions would not apply.

Additionally, it is unclear to Oregon whether the intent of MFAR is that states will need to include managed care payments and other non-FFS payments in the UPL calculation under §447.288(g).

Oregon appreciates CMS's efforts to improve the integrity of the Medicaid program and its consideration of our comments on these important issues. Again, we wish to reemphasize our concerns about specific provisions of MFAR overstepping CMS's authority and the potential ramifications in our state. We strongly believe that CMS should take a more targeted approach to identifying specific outliers or discrepancies, instead of implementing broad changes that create new issues for states where they currently do not exist.

Sincerely,

Lori Coyner, MA
State Medicaid Director
Oregon Health Authority