SUMMARY OF PROPOSED RULE — DECEMBER 2019

Medicaid Program — Medicaid Fiscal Accountability Regulation

On November 18, 2019, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule in the *Federal Register* that would impose changes on the Medicaid program, including changing the rules for how states can finance their non-federal share of Medicaid costs and their associated upper payment limit (UPL) calculations and establishing new reporting requirements.

This summary reviews the provisions of the proposed rule and highlights significant changes that could impact California.

Comments should be submitted by 2 p.m. (PT) on January 17, 2020.

For Additional Information

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Overview

The Medicaid program is a federal-state partnership that provides medical assistance to specific groups of eligible individuals. In California, the Medicaid program is known as Medi-Cal. The authority for Medicaid generally lies in federal statute (Title XIX of the Social Security Act (SSA)) and federal regulations. The existing authorities provide states with considerable flexibility in designing their programs.

CMS proposes in this rule to focus on four areas that have drawn scrutiny over the years by federal oversight authorities, including the Government Accountability Office (GAO), the Department of Health and Human Services' Office of Inspector General (OIG), and the Medicaid and CHIP Payment and Access Commission (MACPAC).

Medicaid Fee-for-Service Provider Payments

States are responsible for developing their fee-for-service (FFS) payment rates, which must be consistent with certain statutory parameters and include opportunities for the public to comment. CMS refers to "base payments" as the standard payment per claim that a state makes to a provider for a service provided to a Medicaid beneficiary. Base payments can sometimes include certain payment adjustments or add-ons often related to providing care to a patient at a higher level of complexity or intensity.

In addition to base payments, states can also make "supplemental payments" to providers, which are generally made in a lump sum on a periodic basis. They are not connected to any particular claim and, therefore, cannot be linked to any specific service provided to an individual Medicaid beneficiary.

Section 1903(a)(3)(A) of the SSA requires states to ensure their payments to providers (including base and supplemental payments) are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the same extent that they are available to the general public.

CMS requires that the combination of base payments and supplemental payments does not exceed an upper payment limit (UPL), which is described in existing rules at §§447.272 and 447.321, for inpatient and outpatient settings, respectively. The UPL restricts payments to inpatient hospitals, institutions providing long-term care, outpatient hospitals, and clinic services. For those settings, providers are grouped into "ownership groups"— state government-owned or operated, non-state government owned or operated, and privately owned and operated. For each of those groups, states cannot pay in the aggregate more than Medicare would pay for those services and must demonstrate that to CMS.

States may also make supplemental payments to physicians and other non-facility-based practitioners. Without a regulatory standard to govern those UPLs, however, CMS has permitted states to use the average commercial rate (ACR) in demonstrating that payments are consistent with the UPL.

In the proposed rule, CMS notes that certain practices with respect to supplemental payments have raised concerns. First, CMS observes that states sometimes do not equitably distribute those funds among providers and, instead, target the payments to a small set of providers that can help to finance the non-federal share of those payments. In addition, the use of supplemental payments has grown considerably. Currently, 48 states have at least one type of supplemental payment program. Since reporting began, supplemental payments have almost doubled to 17.5% of all FFS payments to hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and physicians.

Today, CMS collects information on supplemental payments through two mechanisms. States are required to report all Medicaid expenditures, on a quarterly basis, via Form CMS-64. In addition, CMS reviews state plan amendments; each new supplemental payment is reviewed at its start through the state plan amendment review process. CMS notes that neither of those methods provides it with provider-level information on receipt of supplemental payments. The proposed rule is intended to address this.

Disproportionate Share Hospital Payments

Medicaid statute requires states to take into account, in establishing payment rates to hospitals, the hospitals that serve a disproportionate share of low-income patients with special needs. CMS notes that disproportionate share hospital (DSH) payments are separate from base or supplemental payments — but they are also subject to certain limits, and states are provided with an annual allotment that they may not exceed.

To maintain compliance, states are required to submit annually a report identifying DSH payments to providers as well as an independently certified audit of the state's DSH program. In the proposed rule, CMS points out that, even though the audits and annual reports provide a great deal of information, it does not have the information it needs to determine whether an overpayment occurred and why. CMS cites reports from the OIG and the GAO that raise concerns with such overpayments. CMS proposes to expand the audit requirements to address the issue of recovering DSH overpayments.

Medicaid Program Financing

CMS notes that the foundation of the federal-state responsibility for the Medicaid program is the state's responsibility to share in the program's financial burden and risks. Existing federal statutes and regulations provide states with flexibility to fund the non-federal share of program costs through a number of approaches. Financing of the non-federal share via state general funds (SGF) from tax revenue is unrestricted. However, certain federal statutory and regulatory restrictions apply when states raise their share of Medicaid costs using revenue from health care-related taxes, provider-related donations, intergovernmental transfers (IGTs), and certified public expenditures.

In the proposed rule, CMS notes a number of financing arrangements appear to be designed to increase the federal share of Medicaid funding without the required non-federal share. CMS alleges these arrangements sometimes resemble public and private entities working together to mask non-bona fide donations as legitimate IGTs to use as the non-federal share of Medicaid payments. CMS proposes changes to address these concerns about financing arrangements.

CMS also notes that, while it reviews state plan amendments describing states' financing approaches, it is concerned that sometimes a program that complied with all federal rules at the time of approval is later changed. CMS proposes to limit state plan amendment approvals to no more than three years.

Health Care-Related Taxes and Provider-Related Donations

States have used health care-related taxes and provider-related donations for nearly 40 years as a way to finance the non-federal share of Medicaid payments. Since the start, these arrangements have drawn heavy scrutiny by Congress, CMS, and other federal oversight authorities. As result, federal statutory and regulatory changes have evolved over the years, imposing greater oversight and compliance requirements. Existing statute requires health care-related taxes to be imposed on a permissible class of health care items or services and to be broad-based and uniform. The overall tax structure must also prohibit hold harmless arrangements for taxpayers.

Under existing authority, the Secretary may waive broad-based and uniformity requirements if the state can establish that the net impact of the tax and associated spending is generally redistributive, and if the amount of tax is not directly correlated to Medicaid payments. CMS describes the two statistical tests that may be used to evaluate whether a tax is generally redistributive or directly correlated with Medicaid payments. Even though for many years CMS has approved health care-related tax structures when states can demonstrate compliance with these redistributive tests, in the proposed rule the agency expresses concern that they are not sufficient to ensure the taxes are truly redistributive. CMS explicitly states it has concerns with existing structures passing the redistributive tests while placing a greater tax burden on Medicaid. The proposed changes would eliminate the ability for tax structures that place a greater tax burden on Medicaid or by grouping providers that appear to be generally redistributive but that mask the fact these providers are those with low Medicaid activity.

CMS has also identified concerns with states holding harmless the health care providers paying the taxes for the amount they pay and states it is a violation of both statutory and regulatory rules. CMS proposes clarifying language to establish that the "net effect" of such arrangements may not hold providers harmless for the taxes they pay. CMS additionally refers to the "net effect" description for provider donation arrangements where states, localities, and private providers work together to design complex structures to mask impermissible arrangements. Often, those involve a transfer of value from a private provider to a governmental entity — the value of which the state uses to fund its share of the Medicaid program. The state then returns the "donation" to the provider, and the result is to raise federal funding

for Medicaid without the mandatory state share. CMS describes past efforts to curtail such complicated arrangements but proposes additional clarifications to address them.

Significant Proposed Changes

Permissible Health Care-Related Taxes (§433.68(e) and (f))

Existing law and regulations permit states to apply for a waiver of the broad-based requirements and/or the uniformity requirement for a health-related tax if the state can demonstrate that it is generally redistributive in nature. CMS notes that it believes a tax that is not generally redistributive is one in which a higher tax burden is imposed on Medicaid items or services than those not financed by Medicaid. Existing regulations at § 433.68(e) describe certain tests (in (e)(1) and (2)) for demonstrating that a tax is generally redistributive.

CMS explains the tests have been insufficient in determining whether a tax is redistributive in nature and proposes to add that, in requesting a waiver, a state's tax must satisfy those tests as well as a set of conditions that would be specified in new § 433.68 (e)(3) as follows:

- The tax excludes or places a lower tax rate on a group defined by its level of Medicaid activity, and the tax imposed on Medicaid activity is higher than non-Medicaid activity.
- Within a group, the tax rate is higher for Medicaid activity than non-Medicaid activity.
- The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than another taxpayer group, unless all entities in the group without Medicaid activity meet one of the following specifications:
    - Furnish no services within the class in the state
    - Do not charge a payer for services within the class
    - Are a federal provider of services
    - Are a unit of government
- The tax excludes or imposes a lower tax rate on a group defined by any commonality that, considering the totality of circumstances, CMS determines is a proxy for lower or no Medicaid activity.

CMS notes that states would need to comply with these provisions beginning on the effective date of a final rule for waivers not yet approved. For existing waivers, states must comply when they submit a new waiver request. In addition, CMS notes that proposals described below in § 433.72(b) would, if approved, impose a three-year term on such waivers.

CMS seeks comment on any additional conditions that could result in a tax program imposing undue burden on the Medicaid program and, therefore, should be considered as failing to meet the requirements to be redistributive in nature.

Existing § 433.68(f) describes taxpayers considered to be held harmless under a tax program including, as described in § 433.68(f)(3), when the state provides for any direct or indirect payment, offset, or

waiver that directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. CMS proposes to expand the consideration to include the "totality of circumstances" to determine if the taxpayer expects some or all of its tax to be returned. CMS states the changes to this provision are intended to "thwart efforts by states to skirt hold-harmless provisions by making supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a health care-related tax."

State Share of Financial Participation (§433.51; new §447.206)

Intergovernmental Transfers (IGTs) (§433.51)

CMS proposes to replace the term "public funds" with "state or local funds" in existing rules describing the types of funds that states can use as the state share of Medicaid payments. CMS explains that "state or local funds" better conforms with the statutory provisions defining allowable sources of the non-federal share (in section 1903(w)(6)(A) of the SSA). In addition, CMS notes the use of the term "public funds" has raised confusion and has led states to seek permission to derive IGTs from sources other than state or local tax revenues — which CMS states is not permitted under section 1903(w)(6)(A).
In addition, CMS proposes to add the following specificity to § 433.51(b) to describe the state and local funds that may be considered to be a state's share of Medicaid financing:

(1) State general fund dollars appropriated by the state Legislature directly to the Medicaid agency
(2) IGTs from units of government within the state (including Indian tribes) derived from state or local taxes (or funds appropriated to state university teaching hospitals), to the Medicaid agency, except those transfers that are contingent on the receipt of funds by, or replaced in the accounts of, the transferring unit of government from funds from unallowable sources such as provider-related donations
(3) Certified public expenditures (CPEs), which are certified by a unit of government as being eligible for federal matching, and which meet the requirements in proposed §447.206 (which would limit payments to a provider that is a unit of government to the provider's actual, incurred cost of providing services to Medicaid beneficiaries using reasonable cost allocation methods as described below)

CMS proposes to add new paragraph § 433.51(d), establishing that state funds transferred from a unit of government that are contingent on the receipt of funds by, or replaced by funds from unallowable sources, would be considered to be a non-bona fide provider-related donation.

Payments Funded by CPEs Made to Providers That are Units of Government (new 42 C.F.R. §447.206)

CMS proposes a new § 447.206 to codify what it refers to as longstanding policies related to proper and efficient operation of the state plan, requirements that payments be economic and efficient, and states' ability to use CPEs as a source of the non-federal share. The proposed new section would codify the standards for states to document Medicaid expenditures that units of government certify through a CPE for a claim for federal financial participation (FFP). In the proposed § 447.206:

- § 447.206(a) — Applies only to payments made to providers that are state or other government providers whose Medicaid payments are funded by a CPE
- § 447.206(b)(1) — Specifies that CPE-funded payments must be limited to the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods
    - CMS recommends that states use Medicare cost reports as the basis for determining Medicaid cost where available, but since a number of states already use a state-developed cost report, CMS does not propose requiring that states use only the Medicare cost report.
- § 447.206(b)(2) — State requirement to establish and implement documentation and audit protocols, including an annual cost report to the state agency that documents the provider's costs incurred in furnishing services to Medicaid beneficiaries
- § 447.206(b)(3) — Specifies that only the certified amount of the expenditure may be claimed for FFP
- § 447.206(b)(4) — Requires the certifying entity of the CPE to receive and retain the full FFP associated with the Medicaid payment
    - CMS notes it is trying to prevent inappropriate recycling of federal funds. CMS explains that states have been drawing down FFP to match CPEs, retaining the federal share and using these federal funds as the non-federal share for other Medicaid payments.
- § 447.206(c) — Requires additional criteria for states when a CPE is used to fund a Medicaid payment
- § 447.206(c)(1) — State requirement to implement processes by which all claims for medical assistance would be processed through the Medicaid Management Information System (MMIS) in a manner that identifies the specific Medicaid services provided to specific enrollees
- § 447.206(c)(2) — State requirement to use the most recently filed cost reports to develop interim payment rates, which may be trended forward by a health care-related index
- § 447.206(c)(3) — State requirement to create a final settlement annually by reconciling interim payments to the finalized cost report for the state plan year
    - Final settlement within 24 months of the relevant cost report year end, except under circumstances identified in 45 CFR 95.19 (relating to time limits for states to file claims)
- § 447.206(d) — State plan requirements when the state proposes to use a CPE. The state plan would be required to specify cost protocols in the service payment methodology that:
    - Identify allowable cost using either a Medicare cost report or a state-developed Medicaid cost report.
    - Define an interim rate methodology.
    - Describe an attestation process by which the certifying entity would attest that the costs are accurate and consistent with applicable rules.
    - Include, as necessary, a list of the covered Medicaid services furnished by each provider certifying a CPE.

- Define a reconciliation and settlement process.

Retention of Payments (new §447.207)

CMS-proposed new § 447.207 would require that states' payment methodologies permit a provider to receive and retain the full amount of the Medicaid payment for services furnished. CMS explains this provision is intended to ensure compliance with existing rules prohibiting Medicaid payment to anyone other than the person or institution providing the care or service (although there are a limited number of explicit exceptions).

CMS would determine compliance with the provision by examining, in addition to the payments to the providers, any associated transactions. An example of an associated transaction could be an administrative fee required by the state for processing claims. The provision would explicitly prohibit administrative fees calculated based on the amount a provider receives in Medicaid payments.

State Plan Requirements (§447.252)

CMS proposes to add two new paragraphs to existing § 447.252, which addresses state plan requirements for payments for inpatient hospital services and long-term care facility services. The new paragraphs would describe requirements related to approval and continuation of a supplemental payment program. CMS describes the provisions as responding to the GAO and others calling for better oversight of the program. CMS believes that describing the information in these provisions will make oversight more efficient and will enable it to react to problematic programs more quickly. CMS notes that items 1 through 3 (listed below) would codify current practices, while items 4 through 6 would establish new requirements.

In paragraph (d), CMS would approve a supplemental payment program for a period not to exceed three years. A state whose supplemental payment approval has expired or is expiring may request to renew such a program, but CMS notes it would limit approval to the three-year limit. CMS notes that the three-year timeline would present opportunities for it to re-review state programs and ensure that they remain in compliance with applicable rules. It provides the example of a state program that, after approval, was expanded significantly to new providers and incorporated new fund transfers that were impermissible. CMS believes the three-year timeline could help prevent these problems.

Under proposed paragraph (d), states requesting approval for such a program would be required to provide:

1. An explanation of how payments are consistent with 1902(a)(30(A), which requires that states establish payments to providers that are consistent with efficiency, economy, quality of care, and access to care
2. The criteria for providers' eligibility for the supplemental payments
3. A description of the methodology used to calculate and distribute the payments
    a. It would need to include the amounts to be paid to each eligible provider and the total amounts for all eligible providers, specific criteria used as the basis for such calculations,

the timing of payments to each eligible provider, an assurance that payments will not exceed UPLs, and a UPL demonstration required under § 447.272.

4. The duration of the program (which, if finalized, could not exceed three years)
5. A monitoring plan to ensure the program remains in compliance with relevant requirements
6. For renewing supplemental payment programs, an evaluation of the impacts of the supplemental payments on the Medicaid program during prior periods

New paragraph (e) would provide additional detail on the three-year timeline, including a transition plan for states with currently approved supplemental payment programs to come into compliance with the proposed rules.

- For state plan provisions approved three or more years before the effective date of the final rule, the state plan authority would expire two calendar years after the effective date of the final rule.
- For state plan provisions approved less than three years prior to the effective date of the final rule, the state plan authority would expire three years after the effective date of the final rule.

This timeline permits states with existing programs at least two years, and as many as three years, before needing to request renewal or a new approval.

Reporting Requirements for UPL Demonstrations and Supplemental Payments (§447.288)

CMS proposes to establish and specify the requirements for UPL demonstrations in § 447.288. CMS states that most of these provisions would codify current policy except where specifically noted.

UPL Demonstrations

Effective October 1 of the first year following the year the final rule takes effect, and annually thereafter, each state would be required to submit its demonstration of compliance with the applicable UPL for each of the following service types:

- Inpatient hospitals
- Outpatient hospitals
- Institutions for mental diseases
- Nursing facilities
- Intermediate care facilities

Data Sources and Standards for UPL Demonstrations

CMS proposes in § 447.288(b)(1) to describe permitted data sources and establish standards for those data. Sources can include Medicare cost and charge data, Medicaid charge and census data, and Medicaid payment data from a state's billing system. CMS also includes parameters for each of those data sources — for example, Medicare cost data must be from either a Medicare cost report, a report that conforms to Medicare cost reporting principles, or cost allocation requirements. Additionally, data would need to be no more than two years old, be specifically for the services subject to the UPL

demonstration, and be applied consistently to all providers within the category. Medicaid charge data must be provided during the same dates of services as the Medicare data being used or from the most recent state plan year for which 12 months are available. Medicaid data may be trended forward to account for changes in state plan payments.

UPL Methodology

CMS proposes in § 447.288(b)(2) to identify the data standards for the UPL methodology. This includes requiring projected changes in Medicaid enrollment and utilization to be incorporated. Medicare trend factors, if used, must be uniformly applied within a provider category; Medicaid data must incorporate only payments for the Medicaid services within each service type; and health care-related taxes may be incorporated.

CMS proposes in § 447.288(b)(3) to describe acceptable UPL demonstration methods. States will have the ability to submit either a cost-based demonstration or a payment-based demonstration. Each have their own specific requirements.

Supplemental Payment Reporting

Quarterly Expenditure Reports: CMS proposes in § 447.288(c) to require states to submit a quarterly report describing the supplemental payments included on its quarterly Form CMS-64 submission. This supplemental report would provide CMS with provider-level data on base and supplemental payments. It would include, for each provider receiving such payments, the provider's name, address, National Provider Identifier, Medicaid identification number, employer identification number, service type, specialty type, provider category (state government provider, non-state government provider, or private provider), and the amount of supplemental payment.

Annual Base and Supplemental Payments Reports: CMS proposes that, no later than 60 days after the end of each state fiscal year, each state would be required to provide aggregate and provider-level information on base and supplemental payments.

Annual Contributions, Health Care-Related Taxes, and IGT Reports: CMS proposes that, no later than 60 days after the end of each state fiscal year, states would be required to provide a report of aggregate and provider-level information on each provider contributing to the state or any local government all funds that are used as a source of non-federal share for any Medicaid supplemental payment.