Federal Funds Information for States
444 North Capitol Street, NW
Suite 642
Washington, DC 20001
www.ffis.org

Issue Brief 19-36, December 27, 2019

Administration Proposes Medicaid Financing Reforms

Trinity Tomsic • 202-624-8577 • ttomsic@ffis.org

Summary

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule to increase the oversight and fiscal integrity of Medicaid by addressing a number of financing structures and mechanisms, including:

- fee-for-service provider payments, particularly supplemental payments
- disproportionate share hospital payments
- sources of the non-federal share

Within each area, the proposed rule would require additional data reporting, clarify definitions and regulatory language, modify state administrative procedures, limit state flexibility, and implement more rigorous requirements. The overarching goal is to reduce questionable financing mechanisms.

This *Issue Brief* summarizes major provisions of the proposed rule. Comments on the proposal were initially due January 17, 2020, but CMS extended the comment period to February 1, 2020.

Background

The proposed rule focuses on areas identified as program vulnerabilities by federal oversight authorities, such as the Government Accountability Office and the Department of Health and Human Services' (HHS) Office of Inspector General (OIG):

- **Medicaid fee-for-service provider payments**. This includes base payments (payments attributed to services provided to an individual) and supplemental payments (additional compensation to certain providers). Supplemental payments are intended to make up the difference between fee-for-service payments and the amount that Medicare would have paid for the same service. Typically, supplemental payments are requested by providers and not funded by state general funds.

  Federal regulations prohibit federal financial participation for Medicaid fee-for-service payments to institutional providers (for example, hospitals and nursing homes) in excess of an upper payment limit (UPL). Specifically, there are limits on the aggregate amount of Medicaid payments that states can make based on provider type. Additionally, separate UPLs apply to three ownership categories (governmentally operated, non-state governmentally operated, and private) for each provider type.

UPLs do not apply to non-institutional providers (for example, physicians and other licensed professionals), but CMS limits those payments to average commercial rates for medical services.

- **Disproportionate share hospital (DSH) payments**. These are payments to hospitals that serve a disproportionate share of low-income patients with special needs (separate from base or supplemental payments). These payments include state-specific caps (annual federal allotments) and hospital-specific limits (cannot exceed the cost of providing uncompensated care).
- **Medicaid program financing**. States finance the non-federal share of Medicaid through state general funds, health care-related taxes, provider donations, and funds from providers that are state or local government entities in the form of intergovernmental transfers (IGTs, transfers of funds to the state Medicaid agency) and certified public expenditures (CPEs, certifications that document Medicaid spending). Federal law requires that states use state general funds to finance at least 40% of the non-federal share each year.
- **Health care-related taxes and provider-related donations**. Provider taxes are a health care-related fee, assessment, or other mandatory payment for which at least 85% of the tax revenue burden falls on health care providers.

  Provider taxes must be broad-based (imposed on all providers within a specified class) and uniform, and providers cannot be held harmless through a direct or indirect guarantee that they will be repaid for taxes they contribute. However, the indirect guarantee test does not apply if the tax rate falls within a safe harbor established under regulations (currently 6% of net patient revenue). States may also request waivers of the broad-based and uniform requirements if they demonstrate that the net impact of the tax is generally redistributive, and the tax amount does not directly correlate to Medicaid payment amounts.

  Provider-related donations are donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a state or local government by a health care provider.

Proposed Rule

The proposed rule makes numerous changes to the financing mechanisms described above, including:

- New reporting requirements for base and supplemental payments (including section 1115 waivers and Medicaid managed care payments), which would require provider-level detail and penalties for failure to submit timely reports
- Three-year sunsets of supplemental payment programs and health care-related tax waivers
- A new requirement that providers receive and retain the full portion of a supplemental payment
- A limit on supplemental payments to practitioners
- A requirement that IGTs be from state and local taxes (or funds

appropriated to state university teaching hospitals), instead of public funds

- New tests/standards for health care-related taxes and donations

The proposed rule does not discuss effective dates for the proposed changes. More details and other aspects of the rule are discussed below.

Supplemental payments. The proposed rule discusses the growing prevalence of supplemental payments, concerns raised by federal oversight agencies, and the inability of CMS to monitor supplemental payments given shortcomings of the data currently collected. As a result, CMS is proposing to gather additional information to better understand how states distribute supplemental payments to individual providers and whether there are benefits to Medicaid resulting from these payments. CMS also proposes changes to limit supplemental payments. Specifically, the proposed rule would:

- Implement new approval requirements for state plans and amendments, including a three-year approval limit (with an option to renew and a transition period for current approvals), payment monitoring during the approval period, and considerable data reporting and evaluation requirements

- Require quarterly and annual reports that detail provider payments (including deferral of federal financial participation for failure to comply) on the following:

    - Data on supplemental payments on each quarterly CMS-64 report

    - Aggregate and provider-level information for all payments by service type, provider specialty type, and provider category (due 60 days after the end of the state fiscal year)

    - Aggregate and provider-level information on each provider contributing to financing the non-federal share (due 60 days after the end of the state fiscal year)

- Limit practitioner supplemental payments to 50% of base payments or 75% of such payments in provider shortage areas and/or rural areas

- Require that providers receive and retain the full portion of supplemental payments (CMS proposes to evaluate this by examining associated transactions and notes concerns with administrative fees based on the percentage of the Medicaid payment or IGT)

DSH payments. Currently, states must submit a detailed annual report on DSH payments, as well as an independent certified audit. Any overpayments (amounts in excess of the hospital-specific limit) identified through annual DSH audits must be redistributed to other qualifying hospitals or the federal share must be returned. CMS notes concerns regarding overpayments, and proposes the following changes to improve the return and redistribution process and to address potential data gaps that result in inconclusive audit findings:

- Incorporate into regulation procedural requirements associated with the return and redistribution of DSH overpayments, including new specifications for the date of discovery of an overpayment

- Require auditors to quantify the financial impact of any finding—including those resulting from incomplete or missing data
- Require states to report overpayments identified through annual DSH audits and related payment redistributions on the CMS-64 (redistributions must be done within two years from the date of discovery)
- Require aggregate reporting of total DSH payments made to the provider and the Medicaid units of care furnished by the provider (part of the annual reports described above)

In addition, CMS proposes to publish the annual DSH allotments on Medicaid.gov and the Medicaid Budget and Expenditure System (MBES), instead of the *Federal Register*, to expedite the release.

Medicaid financing. While CMS employs various oversight mechanisms to review state methods for funding the non-federal share, it notes the lack of reliable mechanisms to track whether the source of the non-federal share changes after a state plan has been approved. CMS identifies several concerns with sources of the non-federal share, including:

- Payment methodologies that favor certain providers solely on the basis of whether they can provide the non-federal share to support Medicaid supplemental payments (Medicaid statute requires states to assure that a lack of funds from local sources will not lower the amount or quality of services, or level of administration.)
- Medicaid financing arrangements designed to increase the federal share of Medicaid without a commensurate non-federal share, including manipulation of Medicaid UPL demonstration calculations and the cost data providers rely on to certify Medicaid expenditures

To address its concerns, CMS proposes to:

- Require additional state reporting of the non-federal share (mentioned above under supplemental payments)
- Specify definitions relevant to Medicaid financing relationships, such as provider designations used to establish the UPL (current categorization is a state decision; according to CMS, this change is to prevent states from re-categorizing providers from private to government to demonstrate compliance)
- Modify how states demonstrate compliance with UPLs, including specifying acceptable methods that require the same methodology per provider type and setting
- Modify the definition of state share of financial participation to replace "public funds" with "state or local funds," defined as including:
    - State general fund dollars appropriated directly to the state or local Medicaid agency
    - IGTs from units of government, including tribes, derived from state or local taxes (or funds appropriated to state university teaching hospitals) and transferred to the state Medicaid agency

(This definition would exclude public hospitals that are currently providing IGTs derived from patient revenue.)

  - CPEs certified by the contributing unit of government as representing expenditures eligible for federal financial participation and reported to the state

- Limit payments funded by CPEs to a provider's actual cost of covered services to Medicaid beneficiaries using reasonable cost allocation methods, require states to implement documentation and audit protocols to document such expenditures, require that the certifying entity receive and retain the full federal financial participation associated with the Medicaid payment, and add several new cost reporting and state plan requirements
- Define an IGT contingent on receipt of funds as an impermissible provider donation

Provider taxes and donations. CMS raises several concerns with this financing mechanism, particularly arrangements that pose an undue burden on Medicaid compared to other entities and services. CMS proposes to:

- Codify current policy regarding hold-harmless arrangements and adopt a "net effect" test (overall impact of tax arrangement) for determining whether such an arrangement exists in a provider-related donation
- Limit and restrict waivers by adding a new "undue burden" standard for determining whether a health care-related tax is sufficiently redistributive (in addition to current statistical tests); for example, CMS would consider a tax an "undue burden" if the state imposes a lower tax on providers seeing fewer Medicaid patients or if the tax varies and is higher on Medicaid items or services
- Limit waiver approvals to three years (with an option to renew) and add new requirements to ensure ongoing compliance with original conditions of waiver approval
- Clarify several terms related to provider taxes, including modifying the definition of provider-related donation to include any transfer of value where a health care provider assumes an obligation previously held by a governmental entity and the governmental entity does not provide fair market value compensation
- Clarify that a tax that has broad application but treats health care providers differently is a provider tax, subject to Medicaid requirements
- Allow health care insurers to be considered a permissible tax class

Other Provisions

The proposed rule also:

- Amends the statute regarding the disallowance of claims reconsideration process to allow states to make requests via email, rather than certified mail
- Explicitly prohibits variations in fee-for-service payments for Medicaid services based solely on federal financial participation (for example, states may not set rates based on beneficiary eligibility group,

enrollment in a waiver or demonstration, or the federal Medicaid matching rate for an eligibility group); a similar provision pertaining to Medicaid managed care was finalized in previous rulemaking

- Discontinues use of the *Federal Register* to publish annual Children's Health Insurance Program (CHIP) allotments (CMS hasn't used this process in several years) and instead codifies use of MBES and Medicaid.gov

Next Steps

The proposed rule is likely to impact states differently and to varying degrees, depending on how states finance the non-federal share and structure supplemental payments. Some states anticipate large financial impacts. According to CMS, the fiscal impact of the proposed rule is unknown.

On December 30, 2019, CMS will publish a notice in the *Federal Register* extending the comment period by 15 days, to February 1, 2020. After comments are received, the next step will be for CMS to issue a final rule.

Copyright © 2019 FFIS Federal Funds Information for States. All rights reserved.