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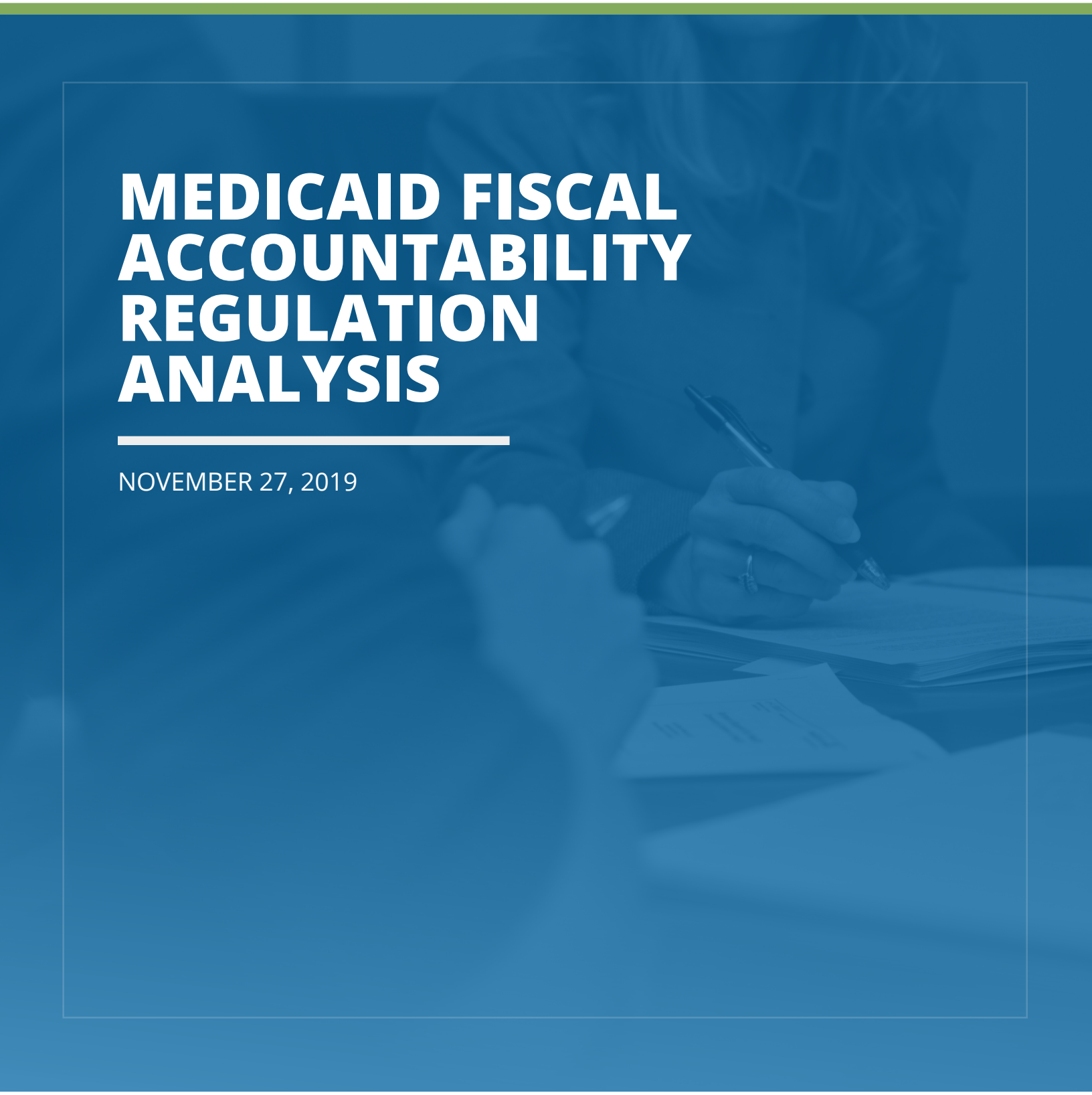

MEDICAID FISCAL ACCOUNTABILITY REGULATION ANALYSIS

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On Monday, November 18th the Centers for Medicare & Medicaid Services (CMS) officially proposed a comprehensive regulation on Medicaid fiscal accountability. The rule addresses a variety of issues including Medicaid supplemental payments, methods of financing the nonfederal share (including provider taxes and donations), and state reporting requirements. As proposed, the regulation will have significant and profound consequences on provider reimbursement, state and local budgets, and possibly access to care.

To facilitate your review of the rule, HMA staff have created an overview of key elements of the proposed regulation and our summary is included in the following pages. Given the breath of issues and concerns addressed in this regulation, the intent of this document is to give readers a framework to analyze the proposal. Although analysis is provided in most sections, the intricacy and uniqueness of local issues may require in-depth policy support.

The Federal Register publication of the rule can be found **here**. To be assured consideration, comments must be submitted to CMS no later than 5 p.m. on January 17, 2020.

The regulations are comprehensive and complex. HMA consults with a variety of clients that have significant interest in the details and implications of the proposed rule. HMA staff have spent considerable time analyzing the regulation and stand ready to help organizations interpret the regulation, evaluate the impact, draft comments, and strategize on possible next steps.

FOR ASSISTANCE PLEASE CONTACT:

Mary Goddeeris
Senior Consultant
Chicago

mgoddeeris@healthmanagement.com
Phone (312) 600-6748

Tom Marks
Principal
Lansing

tmarks@healthmanagement.com
Phone (517) 482-9236

Steve Perlin
Managing *Principal*
Chicago

sperlin@healthmanagement.com
Phone (312) 600-6740

SUMMARY

On November 12, 2019, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule addressing several long-standing concerns about certain Medicaid provider payments and states' methods of financing the nonfederal share. The rule is referred to as the Medicaid Fiscal Accountability Rule (MFAR) and was published in the Federal Register on November 18, 2019. From the **CMS Fact Sheet and press release**:

(The MFAR is intended) *to strengthen the fiscal integrity of the Medicaid program and help ensure that state supplemental payments and financing arrangements are transparent and value-driven. The last several years have seen a rapid increase in Medicaid spending from $456 billion in 2013 to an estimated $576 billion in 2016. Much of this growth came from the federal share that grew from $263 billion to an estimated $363 billion during the same period. Supplemental payments, or additional payments to providers beyond the base Medicaid payment for particular services, have steadily increased from 9.4 percent of all other payments in FY 2010 to 17.5 percent in FY 2017. Independent analysis by oversight agencies including the Government Accountability Office (GAO), the Office of Inspector General (OIG) and the Medicaid and CHIP Payment and Access Commission (MACPAC), has resulted in the observation that expenditures for hospital Upper Payment Limit (the maximum payment a state Medicaid program may pay a certain provider type in the aggregate) supplemental payments increased for Medicaid benefits between 2001 and 2016, resulting in a total of $16.4 billion in supplemental payments for 2016. With this significant growth comes an urgent responsibility to ensure sound stewardship and oversight of the Medicaid program.*

The proposed rule would expand, modify or add 25 different sections of federal Medicaid regulations. At a high level, most of the proposed changes address three broad areas where CMS has raised concerns in recent years:

1	**Ensuring supplemental payments made under fee-for-service are consistently derived and, in some cases, restricting the amounts that can be paid.**
2	**Reducing what CMS refers to as questionable methods of financing of the nonfederal share of Medicaid payments.**
3	**Improving reporting of Medicaid payments and financing sources to increase transparency and permit more effective monitoring by CMS.**

A SUMMARY OF THE MAJOR CHANGES PROPOSED BY CMS IS AS FOLLOWS:

SUPPLEMENTAL PAYMENTS AND DISPROPORTIONATE SHARE HOSPITAL (DSH)

- Supplemental payments are defined as non-claims-based payments, excluding DSH payments, authorized through the Medicaid state plan, a waiver or a demonstration.
- Providers must receive and retain the full amount of all Medicaid payments. States may no longer withhold part of a Medicaid payment or require providers to give back part of a payment.
- Authorization of supplemental payments will expire after three years and states must request a state plan amendment to renew them. Currently, supplemental payment policies are not required to have a time limit. Also, states will be required to monitor these payments continuously for compliance. These changes will increase administrative burden and create additional uncertainty for providers and states.
- States will be required to report an extensive amount of information about supplemental payments annually, including all amounts paid, by provider and the sources of the nonfederal share. States will also be required to provide an extensive amount of information to support each request for a renewal of a supplemental payment policy including monitoring and evaluation plans. This change will increase administrative burden and enable increased monitoring and oversight of these payments by CMS.
- Upper payment limit (UPL) calculations, referred to as demonstrations, must consistently follow CMS guidelines for data sources, time periods and key assumptions used in projections.
- Supplemental UPL payments to physicians and other practitioners will be limited to 50% of base payments for most urban areas, and to 75% of base payments for rural areas and services in designated health profession shortage areas. States are currently able to pay practitioners up to the average payment rates under private insurance. These proposed limits will likely result in large reductions in many states that utilize practitioner UPL payments.
- All findings from annual audits of Disproportionate Share Hospital (DSH) limits must be quantified and if applicable, all associated overpayments must be quantified. Audit reports that cite concerns about missing or improper data must now quantify or estimate the effects.

The proposed changes affect fee-for-service payments, as well as payments made under a waiver or demonstration. These changes do not affect directed payments made by managed care organizations which are subject to separate Medicaid managed care regulations.

PROGRAM FINANCING

PROVIDER TAXES:

- The definition of "health care-related tax" is expanded to include taxes on non-health care items and services collected from providers/payers, if the tax treats some providers/payers differently than others or the tax treats providers/payers differently than non-health care entities that are subject to the tax. These changes are intended to subject more taxes to the health care-related tax requirements and is likely to result in some current tax structures being impermissible for Medicaid financing.
- Waivers of the "broad-based and uniform" requirements will be denied if the exceptions are deemed to impose an undue burden on the Medicaid program. Currently, states may obtain automatic waivers to exclude providers from the tax or use variable tax rates, if the tax meets certain mathematical tests. Meeting these tests will no longer be sufficient if CMS concludes that a tax places undue financial burden on Medicaid. Four conditions are established to define situations where undue burden may exist, including one prohibiting the applications of a higher tax rate for Medicaid services than for non-Medicaid services.
- A new "net effect" standard is added to prohibit arrangements where any provider is held harmless for losses incurred under the tax (i.e. where a provider would experience a loss due to a share of the tax which exceeds its payments financed by the tax). The regulation would prohibit states (or a unit of local government) from directly or indirectly guaranteeing to hold harmless providers for all or any portion of the tax. CMS does not define how the agency would enforce this provision.
- Waivers of the broad-based and uniformity requirements will have a three-year term. Currently, there is no time limit on such waivers. This change will add administrative burden and create additional uncertainty for providers and states.

INTERGOVERNMENTAL TRANSFERS (IGTs):

- IGTs will be impermissible if the transfer is contingent upon or replaced by a provider donation. The CMS position is that an IGT is not permissible when a private provider receives Medicaid payments that are financed by the IGT and directly or indirectly reimburses the public entity making the IGT. CMS has enforced this position inconsistently; however, the public-private transactions targeted by these proposed changes may be currently utilized in many states.
- If a provider assumes a cost or an obligation from a unit of government in connection with an IGT and the provider is not compensated by the unit of government at fair market value, the assumption of the cost or obligation will be considered a non-bona fide donation and may result in a determination that the IGT made by the unit of government is impermissible.
- Definitions of state provider, non-state government provider (NSG), and private provider are established. The new definitions are, in part, intended to address situations where private entities partner with units of government to own, manage or operate health care facilities. The new definition of NSG providers will likely result in some providers being reclassified from NSG to private, and consequently may reduce the number or entities able to make IGTs and increase the number or entities subject to the provider donation restrictions.

CERTIFIED PUBLIC EXPENDITURES (CPEs):

» **Several new requirements for CPE-related payments will be added, including limiting the Medicaid payment to the cost incurred treating Medicaid beneficiaries, specifying the methods for determining allowable cost, and requiring that a retrospective reconciliation be performed after the provider's fiscal yearend to ensure that the CPE did not exceed actual cost.**

The proposed changes are likely to have an impact on all states. At a minimum, the new reporting requirements create an additional administrative burden on state Medicaid agencies, other state agencies, and certain public providers. The effects of the changes in payment and financing policies will vary from state to state. In many cases, CMS says in the preamble that the changes are intended to codify current policy and/or practice. However, CMS has not consistently enforced these policies and practices, and may not have communicated its expectations to many states. Consequently, the changes in any particular regulation may have profound impact in some states and little or no impact in others. The proposed changes will have a greater impact on states which have extensively used these methods for provider payments or Medicaid financing.

The remainder of this report is a summary of the proposed changes in each of the 25 affected sections of the regulations, and in most cases, HMA comments on the meaning and potential impact of the changes. To assist readers, the following table cross-references each of the 25 affected sections with the type of change being proposed.

	AFFECTED SECTION
SUPPLEMENTAL PAYMENTS AND DSH PAYMENTS	9. When Discovery of Overpayment Occurs and Its Significance (§ 433.316) 10. State Plan Requirements (§ 447.201) 12. Retention of Payments (§ 447.207) 13. State Plan Requirements [for Inpatient Services] (§ 447.252) 14. Inpatient Services: Application of UPLs (§ 447.272) 15. Basis and Purpose [for New Subpart D] (§ 447.284) 16. Definitions [Related to Supplemental Payments] (§ 447.286) 17. Reporting Requirements for UPL Demonstrations and Supplemental Payments (§ 447.288) 20. Reporting Requirements [related to DSH Audit Findings] (§ 447.299) 21. State Plan Requirements [for Hospital Outpatient Services] (§ 447.302) 22. Outpatient Hospital Services: Application of UPLs (§ 447.321) 23. Medicaid Practitioner Supplemental Payments (§ 447.406)

	AFFECTED SECTION
PROGRAM FINANCING	2. State Share of Financial Participation (§ 433.51) 3. General Definitions [related to Financing] (§ 433.52) 4. Bona Fide Donations (§ 433.54) 5. Health Care-Related Taxes Defined (§ 433.55) 6. Classes of Health Care Services and Providers Defined (§ 433.56) 7. Permissible Health Care-Related Taxes (§ 433.68(E) and (F)) 8. Waiver Provisions Applicable to Health Care-Related Taxes (§ 433.72) 11. Payments Funded by Certified Public Expenditures Made to Providers that are Units of Government (§ 447.206)

	AFFECTED SECTION
OTHER	1. Disallowance of Claims for FFP (§ 430.42) 19. Limitations on Aggregate Payments for DSHs Beginning October 1, 1992 (§ 447.297) 24. Definitions [of Independent Certified Audit] (§ 455.301) 25. Process and Calculation of State Allotments for Fiscal Year [FY] after FY 2008 (§ 457.609)

SECTION BY SECTION SUMMARY AND ANALYSIS OF THE PROPOSED RULE

1. DISALLOWANCE OF CLAIMS FOR FFP (§ 430.42)

States may request that CMS reconsider a disallowance of claims for Federal Financial Participation (FFP) and currently all such requests must be made by registered mail. This change revises all references to registered mail or to "written requests" to allow reconsideration requests to be made in electronic format.

2. STATE SHARE OF FINANCIAL PARTICIPATION (§ 433.51)

Clarifies the permissible sources of the nonfederal share:

1. State general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency, including funds generated by provider taxes;
2. Intergovernmental Transfers (IGTs) from units of government (including Indian tribes), derived from state or local taxes or funds appropriated to state university teaching hospitals, and transferred to the state Medicaid Agency and under its administrative control, except funds provided as an IGT that are contingent upon or replaced using unallowable sources would be impermissible.;
3. Certified Public Expenditures (CPEs), which are certified by the contributing unit of government as representing expenditures eligible for federal match. There are also new criteria for CPEs in § 447.206 (see 11. Below).

HMA COMMENTS

This is the first of several instances where CMS adds language to codify current guidance related to IGTs and public-private partnerships. CMS' position is that an IGT is not permissible when a private provider receives Medicaid payments that are financed by the IGT and directly or indirectly reimburses the public entity making the IGT. CMS has enforced this position inconsistently; however, the public-private transactions targeted by these proposed changes may be used in many states.

There is also a concern that the statutory language limiting IGT sources derived from "state or local taxes or funds appropriated to state university teaching hospitals" could be too restrictive. In some states, for example, state universities make IGTs and the universities may not own teaching hospitals that receive state appropriations.

Lastly, there is a concern that Medicaid covered services can be administered by multiple state agencies, not just the Medicaid agency, and therefore the proposed language related to general fund appropriations may be too restrictive.

3. GENERAL DEFINITIONS [RELATED TO FINANCING] (§ 433.52)

Establishes five new definitions of terms used in various proposed provisions related to Medicaid financing:

Medicaid activity: any measure of the degree or amount of health care items or services related to the Medicaid program or utilized by Medicaid beneficiaries.

Non-Medicaid activity: any measure of the degree or amount of health care items or services not related to the Medicaid program or utilized by Medicaid beneficiaries.

Net effect: the overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in cash or in kind, among participating entities.

Parameters of the tax: the grouping of individuals, entities, items or services, on which a state or unit of government imposes a tax.

Taxpayer group: one or more entities grouped together based on one or more common characteristics for purposes of imposing a tax on a class of items or services

Under the definition of provider-related donation, new paragraph (2) specifies that a transaction would be considered a donation made indirectly to the governmental entity when a private health care provider or provider-related entity assumes an obligation previously held by a unit of government, and the government entity does not compensate the private entity at fair market value.

HMA COMMENTS

Each of these added definitions are used in subsequent sections, and the implications of the added terms are described there. The new paragraph 2 of the provider-related donation definition is intended to codify CMS' position that IGTs cannot be made under an arrangement whereby the government entity making the IGT is made whole by a private provider or provider-related entity, whether by a direct transfer of funds or indirectly by assuming a cost previously borne by the governmental entity.

4. BONA FIDE DONATIONS (§ 433.54)

Expands the hold harmless test to examine whether the "totality of the circumstances, the net effect of an arrangement between the state (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or related entity will receive a return of all or a portion of the donation either directly or indirectly."

HMA COMMENTS

Existing regulations define whether a provider donation is bona fide and therefore is permissible as a source of state match. This expansion will further tighten the limitations on bona fide donations and gives CMS greater authority to judge whether there is a direct or indirect hold harmless arrangement. This is another instance targeted toward tightening restrictions on public-private partnerships.

5. HEALTH CARE-RELATED TAXES DEFINED (§ 433.55)

Expands the definition of health care-related taxes. A tax may be considered a health care-related even if the tax is not limited to health care items or services, under the following circumstances:

- If the tax includes certain providers/payers but excludes other providers/payers providing or paying for the same or similar services;
- Treats health care providers/payers differently than non-health care entities that are subject to the tax (such as placing a higher tax rate on health care providers/payers).

HMA COMMENTS

Health care-related taxes are already subject to several requirements that non-health care taxes do not have to meet (health care-related taxes must be broad-based and uniform, and redistributive). CMS is concerned that states have created tax structures that circumvent the health care-related tax requirements by taxing certain health care providers and payers with high levels of Medicaid activity under broader, non-health care taxes.

Current regulations say that a tax is health care-related if at least 85% of the tax falls on health care goods and services. The proposed changes in this section would codify current practice and give CMS expanded authority to classify any non-health care tax as health care-related where the agency concludes providers/payers are included selectively or taxed differently, and in particular where the tax targets providers/payers with high Medicaid activity.

6. CLASSES OF HEALTH CARE SERVICES AND PROVIDERS DEFINED (§ 433.56)

Adds a new class of taxable services: health insurers besides those already included in the managed care organizations class.

HMA COMMENTS

This provision codifies existing practice, as some states already have taxes on health insurance. By expressly including this as a new class, states have additional flexibility to generate state/local match. However, if used as a source of Medicaid funds the tax must meet the health care-related tax restrictions. See comments under #7 below.

7. PERMISSIBLE HEALTH CARE-RELATED TAXES (§ 433.68(E) AND (F))

433.68 (E), ADDITIONAL TESTS FOR WAIVERS

States may obtain waivers from the "broad-based and uniformity" requirements if specific mathematical tests are met to demonstrate that the tax does not unfairly target Medicaid (referred to as P1/P2 and B1/B2 tests). 'Broad-based" means all services within the class are taxed and "uniform" means all providers in the class pay the same tax rate. Proposed regulations add that even if a tax passes the P1/P2 or B1/B2 test, a tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid. A tax is considered to impose undue burden under this paragraph if taxpayers are divided into taxpayer groups and any one or more of the following conditions apply:

- The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity.
- Within each taxpayer group, the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (with the exception of excluding Medicare revenue, as permitted).
- The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group (with some exceptions).
- The tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group.

HMA COMMENTS

Currently, waivers of the broad-based and uniformity requirements are automatically granted if the value of the applicable test is 1.0 or more. These revisions would allow for CMS to have more discretion in granting waiver approvals and denying waiver requests.

In the preamble, CMS presented a specific example of taxes on Managed Care Organizations (MCOs) that are structured to meet the P1/P2 and B1/B2 tests but are deemed to place an undue burden on Medicaid. Application of these additional criteria could result in the waiver for such taxes on MCOs to be denied.

Additionally, one or more of these conditions could apply to many other provider tax structures currently in place, and there is significant risk that many tax structures that have been allowed historically would be deemed impermissible in the future.

433.68(F), NET EFFECT STANDARD

Adds a "net effect" standard to the direct hold harmless guarantee test to explicitly prohibit any arrangement where the state or other unit of government provides for any direct or indirect payment, offset, or waiver that results in holding taxpayers harmless for all or a portion of the tax amount. This prohibition applies to any arrangement between the state or unit of government and the taxpayer regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement. The preamble explicitly states that the use of an intermediary does not change the essential nature of the transaction.

HMA COMMENTS

In the preamble, CMS acknowledges that the agency is aware of arrangements that exist where taxpayers may have an expectation for being held harmless by the state or unit of local government for losses incurred under the tax (i.e. where a provider would experience a loss due to a share of the tax which exceeds its payments financed by the tax). The net effect standard is intended to clarify CMS' intent to prohibit such arrangements. CMS does not specifically define how the agency would enforce this provision.

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8. WAIVER PROVISIONS APPLICABLE TO HEALTH CARE-RELATED TAXES (§ 433.72)

Limits broad-based and uniformity tax waivers to a maximum of three-year terms from the effective date of the final rule or from the effective date of a waiver approved after the final rule.

HMA COMMENTS

This provision will add administrative burden to collect data, prepare a demonstration of the applicable statistical test(s), and answer any CMS questions through the review process every three years. Currently, states receive approval once and do not have to resubmit a waiver unless they plan to change the relevant tax structure. In addition, the proposal creates additional uncertainty about the sustainability of Medicaid financing. States will be required to meet the waiver review conditions specified in § 433.68(E) and the net effect standard described in § 433.68(F) with each waiver renewal request, which may result in more denials or changes in tax structures.

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9. WHEN DISCOVERY OF OVERPAYMENT OCCURS AND ITS SIGNIFICANCE (§ 433.316)

Clarifies when the one-year clock starts for repaying any overpayments discovered by the disproportionate share hospital (DSH) payment audits. At the latest, this clock would start when the state submits the certified audit to CMS.

10. STATE PLAN REQUIREMENTS (§ 447.201)

Explicitly prohibits variation in FFS payments based on beneficiary eligibility category (for purposes of maximizing FFP) without the justification of differing costs except when addressing problems in access.

HMA COMMENTS

This provision would prevent states from seeking to take advantage of the higher federal match rate for adult expansion and certain other eligibility groups, by paying higher rates (and drawing down larger federal match) for services to such groups. The proposed regulation codifies current CMS policy.

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11. PAYMENTS FUNDED BY CERTIFIED PUBLIC EXPENDITURES [CPES] MADE TO PROVIDERS THAT ARE UNITS OF GOVERNMENT (§ 447.206)

A new section with several provisions specifying requirements to use CPEs as a source for state match including:

- Limits Medicaid payment to the actual incurred cost of services to Medicaid beneficiaries by the certifying public entity. The cost must be documented by an annual provider cost report, either the Medicare cost report or a state-specific version that follows Medicare cost principles.
- The entity incurring the costs must receive and retain the full amount of the FFP associated with the payment.
- Payments made pursuant to CPEs are estimates (interim payments) based on the most recent cost report available.
- States are required to reconcile the interim payments to actual cost and perform a final settlement no later than 24 months after the end of the cost report year end. If the reconciliation results in actual costs greater than the interim payments, the states may pay the difference to the certifying entity but is not required to do so. If the interim payments exceed actual costs, the state is required to return the federal portion of the overpayment.
- The state plan must specify the protocols applicable to CPEs including the method for determining allowable cost, the interim payment methodology, a list of Medicaid services furnished by each certifying provider, and the reconciliation process.

HMA COMMENTS

CMS says that § 447.206 is needed to codify longstanding practice, but many of these requirements may be new in several states.

In particular, the requirement that the certifying entity receive and retain the full amount of the payment may have consequences for states. CMS notes that in recent years, they have found that states have been drawing down FFP to match CPEs, retaining the federal share. CMS asserts that states may be using these federal funds to make other Medicaid payments, violating the prohibition on using federal funds as a source of state match.

In addition, the requirements for a retrospective reconciliation to actual cost and for documenting the various protocols in the state plan may be new for many states. This will add administrative burden to both providers and the state agency and may result in additional financial uncertainty related to the potential changes in certifiable cost.

12. RETENTION OF PAYMENTS (§ 447.207)

Requires that payment methodologies must permit the provider to receive and retain the full amount of the payment for services furnished under the State plan (or the approved provisions of a waiver or demonstration, if applicable). CMS will determine compliance with this requirement by examining any associated transactions that are related to the provider's Medicaid payments to ensure that the State's claimed expenditure (provider payments) is consistent with the State's net expenditure.

Associated transactions may include, but are not necessarily limited to, the payment of an administrative fee to the State for processing provider payments or, in the case of a non-State government provider, for processing intergovernmental transfers. In no event may such administrative fees be calculated based on the amount a provider receives through Medicaid payments or amounts a unit of government contributes through an intergovernmental transfer.

HMA COMMENTS

The intent of this section is to prevent states from withholding part of a Medicaid payment or requiring providers to give back part of a payment. CMS notes that in some states, participation in a supplemental payment is conditioned on the state receiving a portion of the payment back from the providers. CMS also expresses concerns about administrative fees charged by states to process payments or charged by another governmental agency to process an IGT. CMS' position is that when a portion of the payment is withheld or returned to the state, it has the same effect as a tax on Medicaid revenue, which is an impermissible source of the non-federal match.

13. STATE PLAN REQUIREMENTS [FOR INPATIENT SERVICES] (§ 447.252)

Limits state plan approvals for fee-for-service (FFS) supplemental payments to three years. States may request renewals of expiring supplemental payments using the state plan amendment (SPA) process.

- For supplemental payments approved more than three years before the effective date of final rule, payment authority would expire two calendar years following the effective date of the final rule
- For supplemental payments approved less than three years before the effective date of the final rule, payment authority would expire three years following the effective date of the final rule.

With a SPA to establish or renew supplemental payments, the state must provide:

1. Explanation of how payments are consistent with efficiency, economy, quality of care, and access standards along with the intended effects of the supplemental payments
2. Criteria to determine provider eligibility to receive payment
3. Comprehensive description of the methodology used to distribute payments including:
   - The amount to be paid to each provider or, if distribution is based on a formula, the total amount available to all providers
   - The criteria (service, utilization or cost data) to be used for the calculations
   - The timing of supplemental payments
   - An assurance that the total will not exceed the upper payment limits
   - An upper payment limit demonstration
4. Duration of payment authority (not to exceed three years)
5. Monitoring plan to ensure payments remain consistent with standards and enable evaluation of effects of payments on program
6. If a renewal, an evaluation of the impacts of the payments on the Medicaid program over the most recent approval period

HMA COMMENTS

Currently, there are no restrictions on the length of approval of supplemental payments once approved under a state plan amendment. This provision requires states to provide more transparency related to current supplemental payment arrangements, allows CMS to reassess payments every three years, and imposes new requirements (5) and (6) which require states to continuously monitor payments and justify their necessity.

Items (1), (5), and (6) focus on whether there is value associated with the supplemental payments or if the payments are simply increasing CMS spending.

14. INPATIENT SERVICES: APPLICATION OF UPLS (§ 447.272)

This section establishes the requirement for states to calculate and provide documentation for the fee-for-service inpatient upper payment limit (UPL) of hospitals and nursing facilities. CMS proposes to modify the definitions of provider ownership groups and specify the methods and data sources for calculating and reporting UPLs in new sections § 447.286 and § 447.288, respectively. The changes in this section § 447.272 are to align the new ownership group definitions with § 447.286, clarify the definition of UPL, and reference the new requirements for calculating and documenting UPLs in § 447.288.

15. BASIS AND PURPOSE [FOR NEW SUBPART D] (§ 447.284)

This section simply introduces three new sections, § 447.286, § 447.288, and § 447.290, as described below.

16. DEFINITIONS [RELATED TO SUPPLEMENTAL PAYMENTS] (§ 447.286)

Five definitions are added, for terms that are used in supplemental payment policy:

Base payment: A payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the state plan for FFS or paid to the provider through its participation with a Medicaid managed care organization (MCO).

Supplemental payment: A Medicaid payment to a provider that is in addition to the base payments to the provider, other than DSH payments under part 447, subpart E, made under state plan authority or demonstration authority.

State provider: A health care provider that is a unit of state government or a state university teaching hospital.

Non-state government provider: A health care provider that is a unit of local government in a state, including a city, county, special purpose district, or other governmental unit in the state that is not the state, which has access to and exercises administrative control over state-appropriated funds from the legislature or local tax revenue, including the ability to dispense such funds.

Private provider: A health care provider that is not a state government provider or a non-state government provider.

HMA COMMENTS

Base payments include all amounts paid to providers on a per-claim basis for a specific service including incentive payments and other add-on payments. Distinguishing between base payments and supplemental payments is important under proposed new reporting requirements and CMS plans to more closely monitor provider payments.

The new definitions of state, non-state government, and private providers are relevant for two reasons. First, UPLs are calculated separately for each of these three groups and aggregate payments within a provider group generally cannot exceed the group UPL. The new definition of state provider explicitly includes "state university teaching hospitals", however, some states currently classify such providers as non-state government-owned. This change will shift spending room across UPL classes and could impact the scale of certain supplemental payments to providers.

Second, CMS will use these definitions to establish which providers can make IGTs (state and non-state government) and which providers are subject to the provider donation restrictions (private). It is not uncommon for public/private arrangements to complicate the determination of whether a provider is governmental or private. CMS is concerned that some providers may be classified as governmental to generate local financing opportunities (i.e., IGTs). CMS intends to consider several factors in evaluating whether a provider is governmental or private, including legal and operating authority, how the provider is characterized for purposes other than Medicaid financing, and access to/control over state appropriations and tax revenue.

17. REPORTING REQUIREMENTS FOR UPL DEMONSTRATIONS AND SUPPLEMENTAL PAYMENTS (§ 447.288)

UPL DEMONSTRATIONS

Beginning October 1 of the first year following the year in which the final rule may take effect, each state must submit a UPL demonstration that meets several proposed requirements:

- **Describes the allowable data sources for each UPL calculation component. Certain specific criteria include:**
  - Medicare and Medicaid data must use the same dates of service. For example, if provider Medicare cost reports are used to determine Medicare cost or payment ratios, Medicaid utilization must be obtained that matches the provider Medicare cost report period.
  - Data must be from a time period no older than two years prior to the dates of service covered by the demonstration.
- **Describes the allowable UPL methodology data standards such as the types of utilization and cost trend factors that must be applied.**
- **Describes the allowable UPL demonstration methodologies including cost-based and payment-based methods.**
  - Limits the payment-based methodologies to payment-to-charge and payment-per-day calculations.
  - Requires that UPL demonstration methodologies must be consistent for all hospitals in a class (e.g., private providers).
- **Allows for demonstrations to be calculated on either a retrospective or prospective basis.**

States would no longer be required to submit UPL demonstrations for psychiatric residential treatment facilities and clinics.

HMA COMMENTS

This section largely codifies CMS submission requirements and UPL demonstration guidance described in the March 2013 State Medicaid Director Letter (SMD #13-003). The added methodology requirements appear to align closely with current guidance; however, the payment-based methodologies notably do not include references to payment-per-discharge or Diagnosis Related Group-based calculations that many states utilize today.

Additionally, many states utilize a different methodology for different types of hospitals (e.g., acute care hospitals are calculated based on a different methodology than specialty hospitals). These changes could have a significant impact on the level of spending room available for supplemental payments in many states. The stricter restrictions related to data sources, such as aligned Medicaid data to each hospital's cost report fiscal year, could also result in increased administrative burdens for states.

STATE REPORTING

In addition to outlining the UPL requirements, states must also submit supplementary data reports to CMS on a quarterly and/or annual basis.

States currently must submit quarterly Medicaid statements of expenditures using the Form CMS-64. As a supplement to this form, states will now also need to report detail underlying the supplemental payment amount reported on the CMS-64 with the following components for each provider that receives a supplemental payment.

- Provider's name and complete physical address where services are provided.
- Provider's identification numbers including National Provider Identifier (NPI), Medicaid identification number, and employer identification number (EIN)
- The service type for which the payment was made, the provider specialty (e.g., pediatric hospital), and the provider category (e.g., private provider)
- The specific amount of payments paid to providers by payment authority (e.g., state plan reference)

No later than 60 days after the end of the state fiscal year (SFY), states must also report the following additional information:

- Separately for each eligible provider, the total FFS base payments authorized under the state plan, authorized under demonstration authority, received from Medicaid cost-sharing requirements, received from donations, and received from any other third parties.
- Separately for each eligible provider, the total Medicaid supplemental payments authorized under the state plan and demonstration authority.
- Aggregate total of all payments made.

No later than 60 days after the end of the SFY, states must also report aggregate and provider-level information on each provider contributing funds that are used as a source of non-federal share for any Medicaid supplemental payment. These proposed data elements are intended to be itemized based on all payments to a provider and contributions from the provider, as applicable.

HMA COMMENTS

Currently, states are not required to submit such detailed reporting on supplemental payments, and as a result, CMS has had difficulty tracking supplemental payments and associated financing. These new requirements will create a significant administrative burden to states. The increased visibility of the value of supplemental payments will create additional public scrutiny on providers and they will need to be prepared to respond appropriately.

18. FAILURE TO REPORT REQUIRED INFORMATION (§ 447.290)

If reporting requirements are not met, FFP attributable to payments which the state has not reported properly will be withheld until state comes into compliance.

HMA COMMENTS

Non-compliance with these reporting requirements carries a steep price, and the effective date of these requirements is unclear. It may take states time to collect the necessary elements and establish workflows to develop the reports.

19. LIMITATIONS ON AGGREGATE PAYMENTS FOR DSHS BEGINNING OCTOBER 1, 1992 (§ 447.297)

Eliminates the requirement for CMS to publish DSH allotments for each state in the Federal Register. Instead CMS will publish at Medicaid.gov and in the Medicaid Budget and Expenditure System (MBES) as soon as they are available.

20. REPORTING REQUIREMENTS [RELATED TO DSH AUDIT FINDINGS] (§ 447.299)

Requires auditors to quantify or estimate the financial impact of all findings in annual DSH audits. CMS has received DSH audit reports where issues were identified during the audit, such as missing or improper data, but the effect of the finding on the hospital-specific DSH limit was not determined. States and their contracted auditors would be required to calculate or estimate the impact of each audit finding. In addition, states must report to CMS all overpayments resulting from the DSH audit that are recovered by the state or redistributed to other DSH providers.

HMA COMMENTS

This proposed new requirement is likely to result in an increase in recovered and redistributed DSH payments, as more hospitals will incur reductions in their hospital-specific DSH limit and will be required to return DSH payments in excess of the lower DSH limit.

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21. STATE PLAN REQUIREMENTS [FOR HOSPITAL OUTPATIENT SERVICES] (§ 447.302)

CMS is proposing similar changes in state plan requirements for outpatient supplemental payments as are proposed for inpatient supplemental payments, primarily a three-year time limit for approval of supplemental payment policies and additional documentation and analysis in state plan amendments for new or renewed supplemental payments.

See #13 above concerning § 447.252 for a summary of these proposed changes and HMA comments.

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22. OUTPATIENT HOSPITAL SERVICES: APPLICATION OF UPLS (§ 447.321)

This section establishes the requirement for states to calculate and provide documentation for the outpatient UPL of hospitals. CMS proposes to modify the definitions of provider ownership groups and specify the methods and data sources for calculating and reporting UPLs in new sections § 447.286 and § 447.288, respectively (items 16 and 17 above). The changes in this section § 447.321 are to align the new ownership group definitions with § 447.286, clarify the definition of UPL and reference the new requirements for calculating and documenting UPLs in § 447.288.

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23. MEDICAID PRACTITIONER SUPPLEMENTAL PAYMENTS (§ 447.406)

This new section is proposed to codify and modify existing practice related to physician and other practitioner supplemental payments.

- Limits supplemental payments to practitioners to 50% of base payments for services provided in most urban areas or 75% of base payments for services in a HRSA-designated health profession shortage area or a rural area.
- Quality incentive payments, if claims-based, would be included in base payments if available to all providers but would be considered supplemental payments if targeted to certain types of providers.
- Methodology would have to be outlined in the state plan, consistent with § 447.302 for hospital outpatient supplemental payments, except that states would no longer be required to submit UPL demonstrations for practitioner services.

HMA COMMENTS

Many states have physician and other practitioner supplemental payments that reimburse eligible providers up to a calculated average commercial rate or ACR (the average amount received by the eligible providers from the five largest commercial payers by volume). Medicaid base payments to physicians and other practitioners are often well below Medicare rates, and ACRs are typically well above Medicare rates. Accordingly, a cap on supplemental payments equal to 50% or 75% of base payments could result in very large reductions in these payments.

For states without these programs in place today, the administrative burden associated with establishing these supplemental payments under the new methodology is significantly lower than what is currently required under the ACR methodology. This may seem attractive to states if a source of financing can be identified.

States would have the ability to increase base payments, and accordingly, the limit on supplemental payments would increase. However, identifying a source for the nonfederal share of increased payments may not be practical.

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24. DEFINITIONS [OF INDEPENDENT CERTIFIED AUDIT] (§ 455.301)

Revises the definition of **independent certified audit** to include the requirement for auditors to quantify the financing impact of each audit finding. See #20 Reporting Requirements above.

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25. PROCESS AND CALCULATION OF STATE ALLOTMENTS FOR FISCAL YEAR [FY] AFTER FY 2008 (§ 457.609)

Outlines the process for publishing the state DSH allotments on Medicaid.gov and in the MBES. (See #19 above on Limitations on Aggregate Payments for DSHs Beginning October 1, 1992).

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