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Special Bulletin

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CMS Releases Proposed Rule on Medicaid Fiscal Accountability

The Centers for Medicare & Medicaid Services (CMS) Nov. 12 released a comprehensive proposed rule addressing Medicaid fiscal accountability.

The proposed rule is intended to provide greater transparency in Medicaid supplemental payment programs, including Disproportionate Share Hospital (DSH) payments, and how states finance these payment programs, as well as enable greater oversight by the agency. CMS cites numerous reports and analyses by the Government Accountability Office (GAO), Health and Human Services (HHS) Office of Inspector General (OIG) and the Medicaid and CHIP Payment and Access Commission (MACPAC) as evidence for the need to change how it oversees these state payments and funding arrangements. CMS proposes definitional changes to health care-related taxes, bona fide provider donations and public funds. The agency proposes to change the review process for supplemental payment programs and health care-related tax waivers, as well as proposes to codify sub-regulatory guidance issued over the last decade. Several of the proposed policy changes date back to the Bush Administration, regarding the definition of Medicaid costs for government providers.

CMS will accept comments on the rule for 60 days after its publication in the Federal Register.

AHA Take: We understand CMS's interest in increased transparency and oversight of public programs. At the same time, this rule could jeopardize access to critical funding streams that have been put in place precisely because the program has been chronically underfunded. The Medicaid program cannot sustain further erosion in funding. It will be important for member hospitals to work with their state hospital associations, state Medicaid programs and governor's office to assess implications for their state programs.

Highlights of the Medicaid proposed rule follow.

Key Takeaways

CMS proposes to:

- Require states to report provider-level supplemental payments.
- Sunset supplemental payment methodologies after three years, require future approvals, and adhere to standardized templates and calculations.
- Establish new regulatory definitions for Medicaid "base" and "supplemental" payments.
- Clarify definitions for non-federal share financing arrangements and upper payment limit (UPL) ownership categories.
- Clarify how public funds can be used in state financing arrangements.
- Clarify impermissible donations.
- Prohibit imposing higher provider tax rates on Medicaid services.
- Require new reporting for DSH audits that would quantify DSH audit findings by hospital.
- Clarify the procedures for when DSH overpayments are discovered through the audit process and specify procedures to address the overpayments.

HIGHLIGHTS OF THE PROPOSED RULE ON MEDICAID FISCAL ACCOUNTABILITY

Supplemental Payments: The proposed rule address several aspects of state Medicaid fee-for-service (FFS) supplemental payment programs.

- CMS proposes to define supplemental payments as any payment that is not tied to a specific service and is not a base payment or a DSH payment. The agency proposes to define base payments as the fee for the service plus any payment adjustments, add-ons, or other additional payments received by the provider and attributable to a specific service provided to a beneficiary, including those payments made to account for a higher level of care or complexity of services.

- CMS proposes that states report provider-level payment detail to support the already required aggregate reporting for UPL supplemental payments.

- CMS proposes that states report provider-specific payment information for payments received for the services that are identified in the state plan and through any Section 1115 waiver demonstration program. In addition, states would be required to identify the non-federal source of Medicaid funding that support the UPL payments.

- CMS proposes to redefine the existing three UPL ownership categories to be: state government provider, non-state government provider and private provider. The redefinition would eliminate the terms "state or non-state government own or operated." CMS believes the existing terms have created confusion.

- CMS proposes to codify current guidance on the calculation of UPL. UPL is currently set at the aggregate amount that Medicare would have paid for the same Medicaid services using Medicare payment and cost principles. CMS clarifies that states should use the "Medicare equivalent payment," which is meant to be equivalent to Medicaid cost, charge and payment for comparable services and not a reasonable estimate of Medicare.

- CMS proposes to require that states use Office of Management and Budget-approved templates when submitting their UPL calculations for approval.

- CMS proposes to cap Medicaid practitioner supplemental payments to 50% of the FFS base payments or 75% of such payments for services provided in designated health professional shortage areas.

- CMS proposes to sunset supplemental payment methodologies after three years and require states to submit for new UPL approval.

State Financing Arrangements: The proposed rule clarifies policies regarding providers' role in funding the non-federal share of Medicaid, such as Intergovernmental Transfers (IGTs), Certified Public Expenditures (CPE), health care-related taxes, and bona-fide provider donations.

- CMS proposes to clarify that IGTs (funds that government providers transfer to the state to use for federal matching purposes) must be derived only from state or local tax revenues or state funds appropriated to a state teaching hospital.

- CMS proposes to clarify that the use of private provider donations through a contract or other arrangement in order to trigger an IGT is impermissible. In addition, a change of

ownership between a private provider and a government entity to facilitate an IGT would be considered an impermissible provider donation.

- CMS proposes to place limits on what expenditures a state or non-state government provider are allowed to certify for purpose of CPEs. That limit would be the actual incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods.

- CMS proposes that for any provider that certifies expenditures through the CPE process would retain 100% of the Medicaid payment and that payment could not be used for future matching purposes.

- CMS proposes to clarify that a health care-related tax cannot circumvent current law restrictions when the health care-related tax is incorporated into other state tax programs that are not health care related.

- CMS proposes to prohibit a health care tax that would have a higher tax rate for Medicaid services than for non-Medicaid services justifying that a tax of this type would unduly burden the Medicaid program.

- CMS proposes to add health insurers to be included as a permissible tax class.

- CMS proposes greater oversight and monitoring of approved health care-related tax waivers, including limiting any approval to a three-year period.

DSH Payments: The proposed rule addresses issues regarding the DSH audit process, the identification of overpayments through the audit process, and the process to reconcile the DSH overpayment.

- CMS proposes to add a new DSH audit reporting requirement to quantify the financial impact of any finding (including a finding of missing or undocumented data), which may affect a hospitals eligible hospital-specific DSH limit.

- CMS proposes to require that states report to the agency any DSH overpayment of the hospital-specific DSH limit within two years of discovery and report any redistributions on a quarterly basis.

NEXT STEPS

The proposed rule has a 60-day comment period from the date of publication in the Federal Register. Public comments are due to the agency on or about Jan. 15, 2020.

Please contact Molly Collins Offner, AHA director of policy, at mcollins@aha.org with questions.