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# CMS proposes transformative federal controls on Medicaid fiscal accountability, impacting state flexibility and raising concerns among providers

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Medicaid reimbursement requirements, already under assault in Courts federal courts around the country,[1] will change once again if CMS' new proposed regulation is finalized. On November 18, 2019, in response to rapid growth of the federal share funding the Medicaid program in recent years, the Centers for Medicare and Medicaid Services ("CMS") published a proposed rule overhauling Medicaid fiscal accountability measures at the federal and state levels (the Medicaid Fiscal Accountability Regulation ("MFAR")).[2] MFAR's stated goal is to strengthen the Medicaid program's overall fiscal integrity by focusing on four areas of vulnerability: Medicaid fee-for-service ("FFS") provider payments and supplemental payments, disproportionate share hospital ("DSH") payments, Medicaid program financing mechanisms, and health care-related taxes and provider-related donations.

CMS plans to reach this fiscal integrity goal through increased transparency and enhanced oversight related to states' financing of supplemental and base Medicaid payments through the non-federal share. Oversight agencies including the Government Accountability Office ("GAO"), the Office of Inspector General ("OIG"), and the Medicaid and CHIP Payment and Access Commission ("MACPAC") have independently concluded that expenditures for maximum state Medicaid program payments in the aggregate (the Upper Payment Limit ("UPL")) to hospitals have grown significantly, signaling the need to reaffirm sound stewardship principles. CMS takes the position that it currently lacks sufficient state Medicaid payment and financing data to enable effective oversight, and cannot reliably determine whether states are financing their shares of Medicaid expenditures from permissible sources and using acceptable mechanisms.

If the proposed rule becomes final, the changes to Medicaid financing and supplemental payment structures will be systemic and will likely curtail the many innovations that are currently part of

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[1] See our prior alerts regarding litigation in the D.C. Circuit Court of Appeals, the Supreme Court of the United States, and United States Court of Appeals for the First Circuit.

[2] https://www.federalregister.gov/documents/2019/11/18/2019-24763/medicaid-program-medicaid-fiscal-accountability-regulation

existing state plans. This alert highlights potential impacts on providers, and outlines the proposed rule's features and requirements.

CMS is soliciting public comments on the proposed rule until January 17, 2020. Given Medicaid's joint funding mechanism, the final rule is likely to be controversial. Legal and political efforts to prevent implementation are expected. Providers and their industry associations should consider providing comments—with specific details of anticipated adverse impacts—before the deadline. Such information becomes the record necessary to support any possible legal challenge.

## Potential impacts on providers and states

Since MFAR's announcement, providers have taken public stances against the proposed rule, highlighting the threatened harm to the fragile health care safety net, and to the financial stability and flexibility of state Medicaid programs and their ability to protect patients' access to care. CMS's strongly worded public statements on MFAR accuse states of engaging in "payment arrangements that mask or circumvent the rules" using "shady recycling schemes[.]"[3] CMS Administrator Seema Verma blamed increasing federal Medicaid payments on "self-interested providers, egged on by opportunistic consultants seeking to leverage regulatory loopholes or hide behind a lack of transparency."[4]

These provocative comments do not appear to address the very reasons states have crafted provider taxes and supplemental payment methodologies to begin with: to make up for the fact that Medicaid base rates are insufficient to compensate providers for the cost of services rendered to Medicaid beneficiaries. States are likely to view MFAR as contradictory to the current administration's highly publicized strategy to champion conservative health policy by shifting more decision-making to states given that, rather than encouraging state flexibility in Medicaid plan administration, MFAR's overall result will constrain the states and providers alike by strengthening federal controls over financing and reporting.

## Medicaid FFS provider payments and supplemental payments

MFAR would substantially increase federal visibility into state Medicaid spending and, at the same time, would likely decrease overall federal financial participation ("FFP"). States establish "base payment" methodologies typically with standard payments to providers on a per-claim basis for specifically identifiable services to Medicaid beneficiaries. On top of the base payment system, states can make "supplemental payments" to all or some providers, which are not connected to specific services. The amount of supplemental payments is dependent upon the UPL inpatient and outpatient demonstration requirements. For state Medicaid expenditures in excess of the UPL, no FFP is available.

According to CMS, supplemental payments have grown from 9.4% of total Medicaid spending in 2010 to 17.5% in 2017 as a result of financing mechanisms devised by states to fund their portion of Medicaid programs.[5] Under current reporting, states provide aggregate payment detail for base and supplemental payments—meaning states have tremendous flexibility regarding payment design.

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[3] CMS Administrator Seema Verma's Nov. 12, 2019, Speech to National Association of Medicaid Directors, available at https://www.cms.gov/newsroom/press-releases/cms-administrator-seema-vermas-speech-national-association-medicaid-directors-washington-dc (last accessed 11/24/2019).

[4] *Id.*

[5] MFAR Fact Sheet, available at https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar (last accessed 11/24/2019).

Medicaid UPLs are established by placing providers into ownership group categories, and states are prohibited from paying each ownership group, in the aggregate, more than a reasonable estimate of the amount Medicare would pay for the services furnished by the providers in that group. This application of aggregate UPLs has allowed states to be flexible in determining facility-specific payments up to an overall payment ceiling. At the same time, these aggregate UPL calculations have allowed states to pay certain providers in excess of the reasonable amount that Medicare would pay, as long as the state's aggregate Medicaid payments do not exceed the aggregate UPL for the particular ownership category. CMS suggests that these supplemental payment methodologies may be improper because they selectively target only those providers with the available means to participate in financing the non-federal share funding to substantiate the state's FFP claim.

To ensure states' practices are consistent with federal Medicaid statutes, MFAR would include new definitions for Medicaid "base" and "supplemental" payments, which would allow CMS to better monitor statutory requirements and would require states to disclose provider-level payment detail to further clarify aggregate information used for UPL demonstrations, which CMS suggests will increase transparency and lead to more effective oversight. MFAR would also limit supplemental payment methodologies to three years, and implement Office of Management and Budget- and CMS-approved templates and guidelines for determining UPL calculations.

## DSH payments

States are permitted to make DSH payments to hospitals to help pay for uncompensated care related to serving high volumes of low-income, special needs patients, including Medicaid-eligible and uninsured individuals. DSH payments have distinct statutory authority and are not included in base rate payments or supplemental payments. Pursuant to the Medicare Modernization Act, states must submit independent DSH audit reports. MFAR proposes to revamp this annual auditing process by requiring hospital-specific audit findings and clarifying related reporting requirements. MFAR would add a new data element to DSH reporting, requiring auditors to quantify the financial impact of findings, which may affect eligible hospitals' receipt of DSH payments within the hospital-specific DSH limit. MFAR would also ensure that DSH overpayments are discovered timely and returned to either the Federal government or to other hospitals through redistribution procedures. It would require states to report DSH overpayments and related redistributions, and to return payments in excess of the hospital-specific limit to the federal government by reporting the excess, using Form CMS-64.

## Medicaid program financing

Among other problematic financing mechanisms, MFAR aims to decrease states' reliance on providers to fund the non-federal share. Intergovernmental transfers ("IGT") and certified public expenditures ("CPE") occur when local units of government or non-state governmental entities contribute to fund the non-federal share by transferring their own funds to the state Medicaid agency. To be allowable, IGTs and CPEs must derive from state or local tax revenue or funds appropriated to state university teaching hospitals. They cannot come from impermissible health care-related taxes or provider-related donations. MFAR reaffirms these derivation requirements, and clarifies the sorts of public funds that may qualify for IGT and CPE use. MFAR further requires that Medicaid providers receive and retain the full amounts of these payments, preventing states from recycling Medicaid payments as the source of state financing for additional payments.

Specifically, MFAR would limit IGTs to "[s]tate or local taxes (or funds appropriated to [s]tate university teaching hospitals)" rather than "public funds." Additionally, MFAR would specify that

"[s]tate funds that are provided as an intergovernmental transfer from a unit of government within a [s]tate that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources" would be considered to be a non-bona fide provider-related donation as defined under 42 C.F.R. §§ 433.52 and 433.54.

Under MFAR, all CPE-based claims would need to be processed through the Medicaid claims systems and identify specific services provided to specific enrollees. States would also need to establish interim rates for governmental providers receiving CPE-based payments based on the provider's most recent filed cost reports and subsequently execute final settlement of such interim rates to actual cost within 24 months of the cost report year end.

## Health care-related taxes and provider-related donations

From the mid-1980s, states have used—and Congress has sought to curb the use of—health care-related taxes and provider-related donations to finance the non-federal share of Medicaid payments. Health care-related taxes are those taxes for which at least 85% of the tax burden falls on health care providers. Currently, states can impose broad-based and uniform health care-related taxes without first receiving CMS approval. If the tax is non-broad-based or non-uniform, states must obtain a CMS waiver by demonstrating that the tax passes one of two statistical tests to ensure it is "generally redistributive." Those tests, though, allow states to take advantage of loopholes, which in turn place an undue burden on the Medicaid program (for example, by taxing Medicaid services at higher rates than non-Medicaid).

MFAR would allow CMS to make a determination that a state's tax does not meet generally redistributive standards even though it passes the applicable statistical test. MFAR would give CMS the authority to require that a tax not be structured so as to place greater burden on taxpayer groups with greater levels of Medicaid activity. In order to assist CMS in prohibiting states (or other local governmental units) from incorporating an impermissible tax on health care items or services into a larger, existing tax, or creating a new tax to circumvent federal requirements, MFAR additionally proposes to clarify how differential treatment results in a tax being considered health care-related. Namely, differential treatment would occur if a tax treats certain individuals or entities paying for or providing health care items or services differently than (1) individuals or entities that are providers or payers of any health care items or services not subject to the tax or (2) other individuals or entities that are subject to the tax. CMS has also proposed adding health insurers to the list of taxable classes, and strengthening long-term monitoring of tax waivers, which themselves must be affirmatively renewed after three years.

Provider-related donations are donations or voluntary payments by providers made directly to the state or unit of local government for administration of the state's Medicaid plan. MFAR addresses concerns about non-bona fide provider-related donations, whereby private providers make a direct or indirect donation, and the state returns the value to the providers using only federal funds. These schemes are impermissible because they reduce overall Medicaid expenditures funded with state dollars, while increasing federal funding. MFAR proposes the application of a "net effect" standard for these complex financing arrangements, where any exchange of value from the government to a private entity constituting reimbursement for the private entity's donation must be assessed in terms of its net effect.

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