

Medicaid Fiscal Accountability Proposed Rule: Analysis and Potential Implications

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

Agenda

- Background and Context
- Key Provisions and Implications for States
- Q&A

Background and Context

Context for Today

- Medicaid programs increasingly rely on intergovernmental transfers (IGTs) and provider taxes to fund the non-federal share of Medicaid payments, including supplemental payments.
- States financed ~26% in total non-federal share of Medicaid payments via mechanisms at issue in proposed rule (primarily provider taxes and IGTs) in FY2012.
- As supplemental payments have grown, so have federal oversight and calls for the Centers for Medicare & Medicaid Services (CMS) to strengthen its monitoring activities.
- On November 18, 2019, CMS published a **proposed rule*** that focuses heavily on Medicaid financing approaches, and less so on supplemental payments.
- Public comments on the rule are **due February 1, 2020.**

*Proposed rule can be found at: <https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf>

Key Definitions

Non-Federal Share Financing

- **Intergovernmental Transfers (IGTs):** Funds transferred from a “public agency”—which could be a public hospital, public entity or a county/city—to the state
- **Provider Taxes:** A health care-related fee, assessment or mandatory payment imposed by a state where most of the financial burden ($\geq 85\%$) falls on health care providers (e.g., hospitals, managed care plans)
- **Provider Donations:** Voluntary contributions made by private providers to a public entity directly or indirectly through another provider

Supplemental Payments

- **Supplemental Payment*:** Provider payment over and above a base payment, including:
 - Disproportionate Share Hospital (DSH) Payments (*statutorily required*)
 - Non-DSH Supplemental Payments (*permitted but not required*)
 - Upper Payment Limit (UPL) Payments (including graduate medical education payments and other add-on payments)
 - 1115 Waiver Payments (e.g., Uncompensated Care Pools, Delivery System Reform and Incentive Payments)

*Note: The proposed rule generally does not impact pass-through or directed payments in managed care authorized under 42 CFR § 438.6.

Highlights of Proposed Rule

Non-Federal Share Financing

- Substantial changes to rules related to:
 - Provider taxes
 - Intergovernmental transfers (IGTs)
 - Certified public expenditures (CPEs)
 - Provider donations

Supplemental Payments

- Limits supplemental payment amounts to physicians and other practitioners
- Prohibits redistribution of supplemental payments among providers
- Sets vague standards for CMS approval of supplemental payments

Rule also imposes extensive new reporting and oversight requirements for both non-federal share financing and supplemental payments.

Key Takeaways

- ① Limits the ways in which states finance the state share with implications for state budgets and beneficiary access
- ② State internal accounting and budgeting practices may need to change to continue to rely on state-share financing options
- ③ Creates uncertainty as to whether state share financing and supplemental payments comply with the rules
- ④ Reporting requirements impose new administrative burdens on states
- ⑤ Puts financing that supports safety-net hospitals at risk, jeopardizing patient access

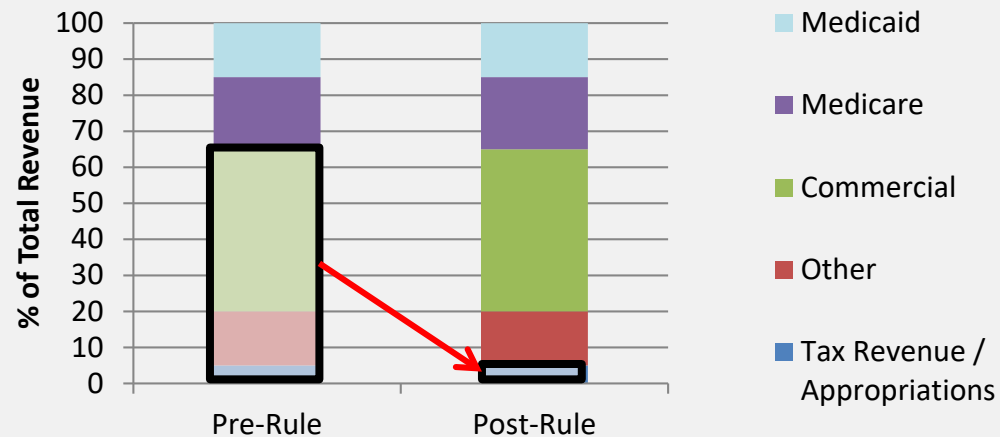
Key Provisions and Implications for States

Limits Use of IGTs

Key Provisions

- Narrows definition of “public provider” eligible to make IGTs
- Reduces maximum size of IGTs (*see graphic for illustrative impact on example provider’s IGT amounts*)

**Proportion of Provider Revenue Allowable for IGTs*,
Pre and Post Proposed Rule**



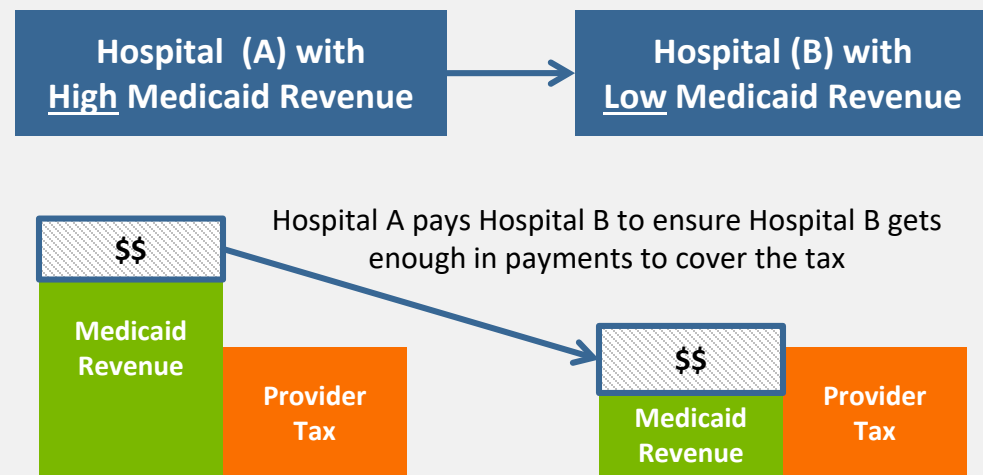
*Note: Percentages are illustrative; not tied to a specific provider nor national averages.

Rule limits states’ ability to finance non-federal share through IGTs, with potential disproportionate effect on safety-net hospitals; possible mitigation strategies exist

Prohibits Pooling Arrangements Linked to Provider Taxes

Key Provisions

- In preamble, CMS states intent to prohibit voluntary pooling arrangements; proposed rule text is ambiguous
- Under pooling arrangements, hospitals move dollars among themselves to ensure participating hospitals receive supplemental payments equal to or greater than the amount they pay in provider taxes (*see graphic*)



If a pooling arrangement exists (even if only among a few hospitals), the pooling arrangement would need to end or the whole tax would be unlawful.

Heightens Standard to Secure a Waiver of Provider Tax Rules

Key Provisions

- Rule would add requirement that states demonstrate that a tax *not* pose an “undue burden” on Medicaid program
- Today, standards for approving a waiver of the broad-based and uniformity requirements on provider taxes are formulaic and approval is automatic if the tax meets the text

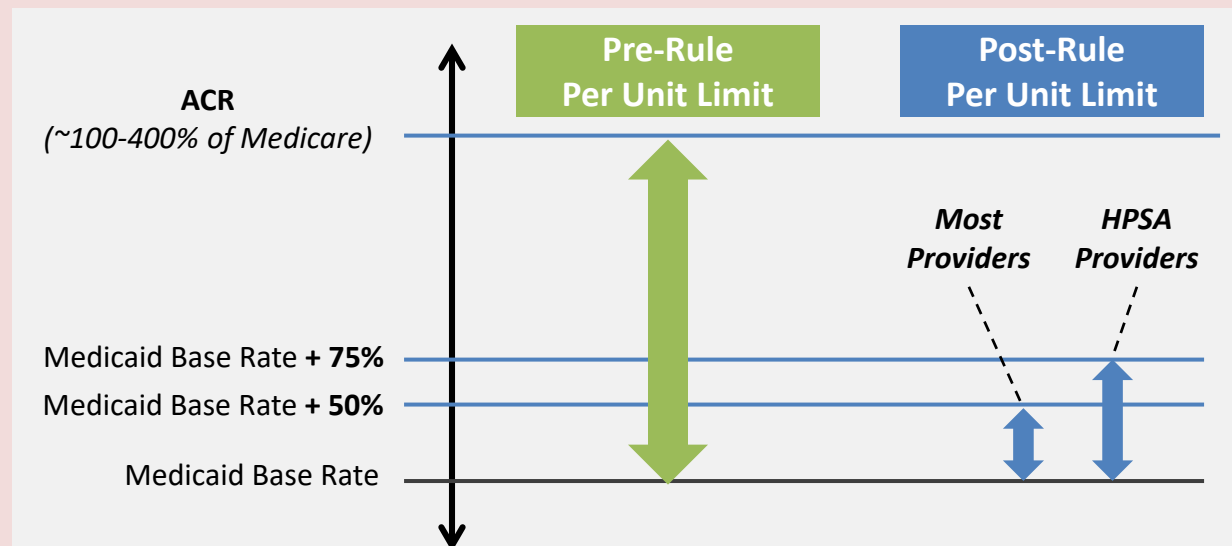
Throws into question current taxing authority, including for example:

- Different tax rates for Medicaid v. non-Medicaid covered lives (for managed care organizations)
- Different tax rates for distinct health insurer types that primarily serve the Medicaid program
- Exclusion of low-Medicaid hospitals (e.g., rehab hospitals)

Limits Amount of Supplemental Payments for Practitioners

Key Provisions

- Limits practitioner supplemental payments to a percentage of base payments rather than the average commercial rate (ACR). New limits vary by provider location:
 - 50% of Medicaid base rate for most providers
 - 75% of Medicaid base rate for those in Health Professional Shortage Areas (HPSA)



States likely to face heightened pressure to increase base rates with no clear source of funding

Requires States to Justify Supplemental Payments Without Clear Standards

Key Provisions

- Rule would require states to explain how their supplemental payments are consistent with “economy, efficiency, quality of care and access,” without stating CMS’s evaluation criteria
- Today, states have flexibility to make supplemental payments as long as they do not exceed an “upper payment limit”

The rule constrains states’ flexibility in how they can distribute supplemental payments, and may disrupt existing arrangements; however, the rule could support states’ value-based payment reforms by encouraging link between payment and service delivery

Imposes New Reporting Requirements

Key Provisions

- Requires renewal of supplemental payment SPAs and provider tax waivers every 3 years
- Requires states to report for each provider the supplemental payments received and provider taxes paid/IGTs made, among other data points
- Allows CMS to penalize states that do not submit timely, complete, and accurate information

The value of the reported data for CMS and states is unclear

Grants CMS Substantial Oversight Discretion

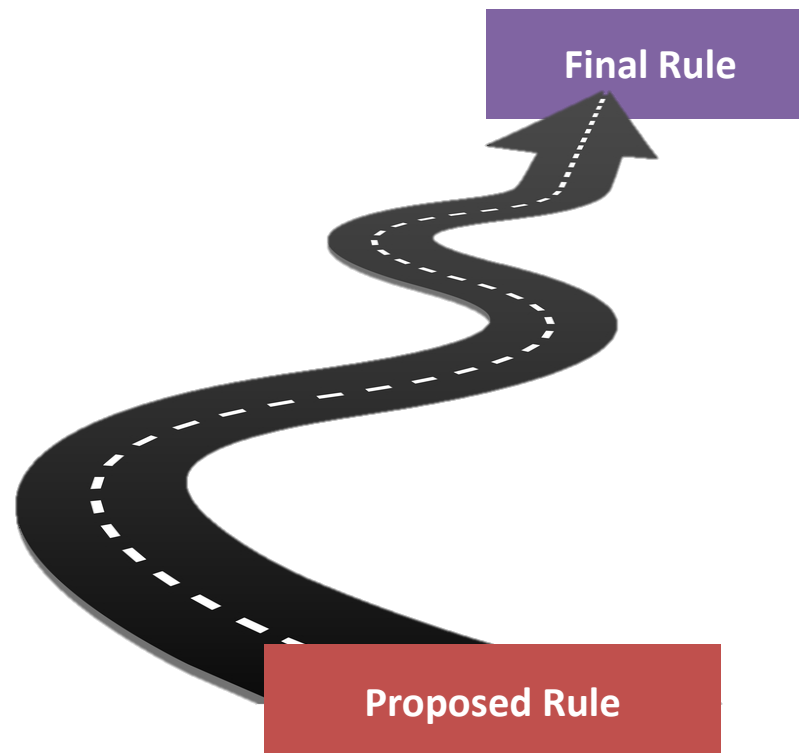
Key Provisions

- Grants CMS considerable discretion in oversight role, implementing either an “undue burden,” “net effect,” and/or “totality of circumstances” standard of review by CMS for many provisions (*see appendix for more detail*)
- CMS does not approve in advance most IGTs or provider taxes, putting states at risk if CMS determines later that those arrangements do not comply with the rules

Unclear standards makes it challenging to know whether payments and financing meet federal requirements

Long Road from Proposed to Final Rule

Given the proposed rule's complexity and the already significant push-back from stakeholders, the final rule may look significantly different than the proposed rules.



Next Steps

- 1 **Evaluate potential effects of the rule**
 - States will want to evaluate the risks to their Medicaid programs, given each state's unique payment and financing arrangements.
- 2 **Public comment**
 - States should consider submitting public comment (due **February 1**) to underscore state-specific impacts.

Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar



Thank You

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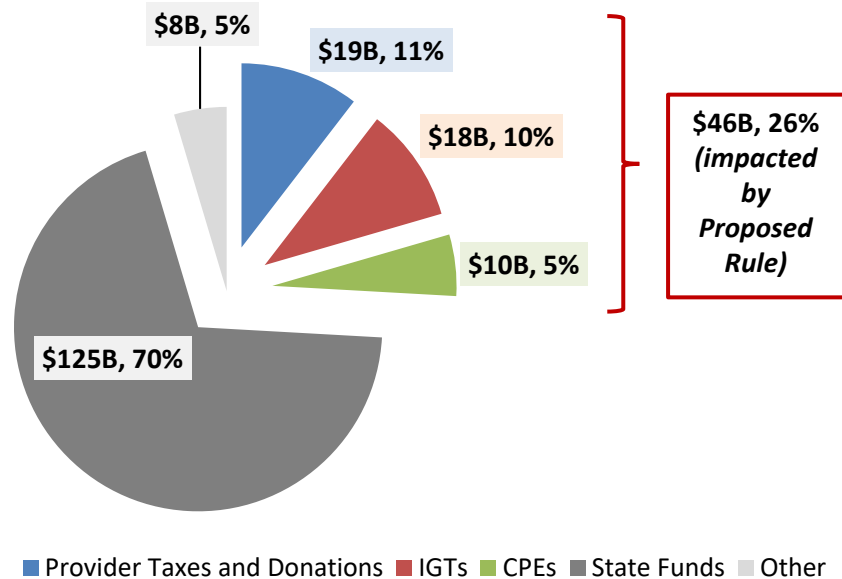
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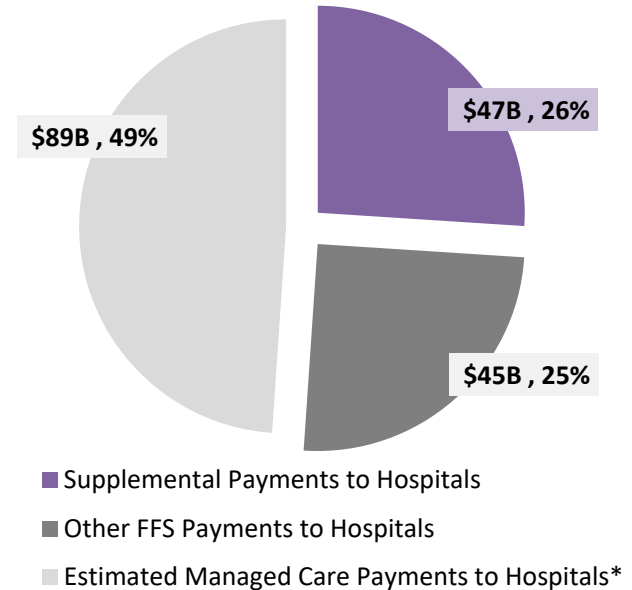
APPENDIX

Medicaid Payments and Financing Statistics

**Non-Federal Share of Medicaid Payments
To All Providers by Source, FY2012**



**Supplemental Payments as a % of
Total Medicaid Payments to Hospitals – FY 2016**



Sources:

¹ States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collections, GAO-14-627, July 2014.

<https://www.gao.gov/assets/670/665077.pdf>

² CMS-64 data submitted by states from MACPAC Report, 2016.

*Estimates derived based on Manatt analysis of MACPAC and National Health Expenditure Survey data.

CMS Review Standards: More Detail

The following provisions would be subject to either an “undue burden”, “net effect”, and/or “totality of circumstances” standard of review by CMS.

Provision	Review Standard for CMS Discretion
Reduce the number of providers eligible to make IGTs (§447.286).	Considers whether an entity qualifies as a state or non-state governmental provider “in the totality of circumstances”.
Prohibit voluntary provider tax pooling arrangements (§433.68).	Considers the “net effect” of whether in the “totality of circumstances” a payment holds harmless the entity paying the tax.
Constrain states’ ability to tax Medicaid utilization at a higher rate despite meeting technical regulatory (i.e., broad-based and uniform waiver) requirements (§433.68).	Considers whether a provider tax imposes an “undue burden” on the Medicaid program.
Give CMS greater discretion to prohibit provider payment transactions that it views as creating impermissible provider donations (§433.54).	Considers the “net effect” of whether in the “totality of circumstances” a provider will receive a return all or a portion of a provider donation.

Effective Dates

Some of the most consequential proposed changes would take effect upon the rule's finalization (typically 30- 60 days from date of final regulation), rather than allowing for a transition period.

Provision	Proposed Effective Date
Reduce the number of providers eligible to make IGTs (§447.286).	Upon final rule effective date
Effectively cap the amount of IGTs governmental providers can make by requiring IGTs be "derived from state or local taxes (or funds appropriated to state university teaching hospitals)" (§433.51)	Upon final rule effective date
Prohibit voluntary provider tax pooling arrangements (§433.68).	Upon final rule effective date
Constrain states' ability to tax Medicaid utilization at a higher rate despite meeting technical regulatory (i.e., broad-based and uniform waiver) requirements (§433.68).	For provider tax waivers already approved, 3 years from final rule effective date
Give CMS greater discretion to prohibit provider payment transactions that it views as creating impermissible provider donations (§433.54).	Upon final rule effective date
Limit practitioner supplemental payments to a percentage of base payments rather than the current upper limit (§447.406).	<ul style="list-style-type: none"> For SPAs approved 3 or more years prior to effective date of the final rule, SPA expires 2 calendar years following final rule effective date For SPAs approved less than 3 years prior to effective date of final rule, SPA will expire 3 calendar years following final rule effective date
Codifies UPL Demonstration requirements and permitted UPL calculation methodologies (§447.288).	Oct. 1 st after final rule effective date
Implements new retrospective reporting requirements on Form CMS-64 and in new annual reporting to CMS, requiring states to report on supplemental payment and non-federal share financing at the provider level (§447.288).	Upon final rule effective date; applies to payments made before the effective date