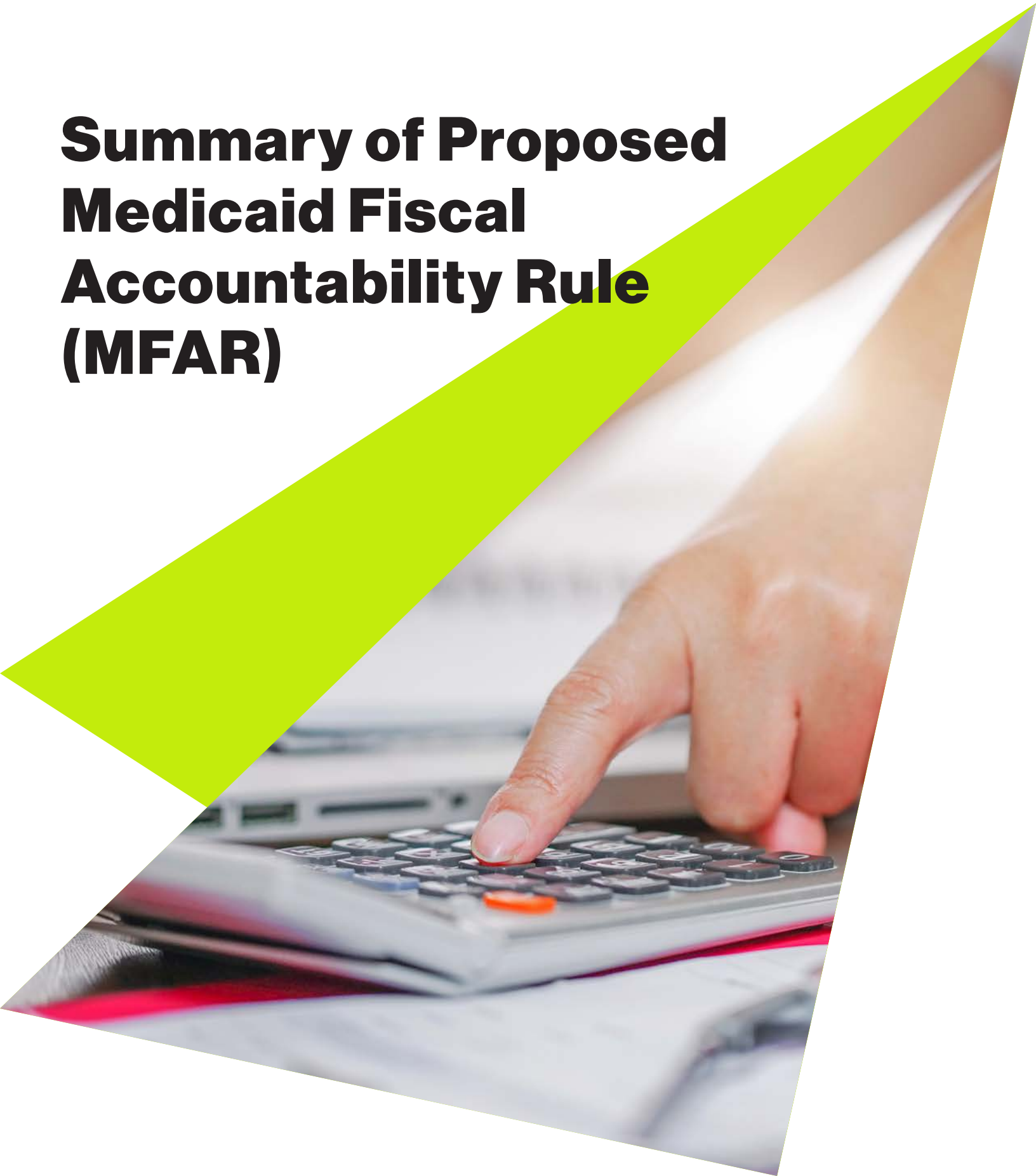
Guidehouse

Summary of Proposed Medicaid Fiscal Accountability Rule (MFAR)



Healthcare

Summary of Proposed Medicaid Fiscal Accountability Rule (MFAR)

I. Introduction and Executive Summary

On Nov. 28, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule entitled "Medicaid Fiscal Accountability Regulation" (MFAR). MFAR is a sweeping proposed rule that focuses on multiple aspects of the fiscal relationship between the federal government and state Medicaid agencies. The most significant changes focus on: supplemental payments under a state plan or demonstration authority (often through a directed payment program (DPP)); state funding sources (intergovernmental transfers, certified public expenditures (CPEs) and provider taxes and donations in particular); disproportionate share payments (DSH); and upper payment limits (UPLs). The proposed rule would impose significant new reporting requirements on all supplemental payments going forward, as it relates to both existing programs and supplemental payment programs established in the future. It would require both high-level reporting and reporting down to provider/claim detail. Because this rule is designed to scrutinize funding arrangements and supplemental payments, and potentially therefore strain state Medicaid budgets and rates, there is already discussion of legal challenges by provider groups.[1]

While having the common themes as described above, MFAR affects six parts of 42 C.F.R.: 430 (Grants to States for Medical Assistance); 433 (State Fiscal Administration); 447 (Payments for Services); 455 (Program Integrity); and 457 (Allotments and Grants to State [for Children's Health Insurance Program (CHIP)]). Below is a summary of the most relevant changes/additions to each part. This is a very high-level summary; however, references are provided to CMS commentary and new proposed rule language.[2]

II. Changes to Part 430 in the MFAR Proposed Rule

CMS proposes the following significant changes to 42 CFR 430 in the MFAR proposed rule:

- **§430.42. State share of financial participation. (Commentary p. 16; rule language p. 55-56[3]).** Amendment to only permit request for reconsideration of a disallowance to be by electronic email.

III. Changes to Part 433 in the MFAR Proposed Rule

CMS proposes the following significant changes to 42 CFR 433 in the MFAR proposed rule:

- **§433.51. State share of financial participation. (Commentary p. 16; rule language p. 55-56) –** Changes to more clearly delineate the state or local funds (formerly "public funds," but change to "state and local" in proposed rule) which may be used as the state share for federal financial percentage matching funds (FFP). Would limit allowable state funding to three types: (1) Legislative appropriations made directly to the state agency; (2) Intergovernmental transfers derived from state or local taxes (or state/local teaching hospitals); and (3) certified public expenditures (CPEs) certified by the giving governmental entity as expenditures being eligible for FFP.
- **§433.52. General definitions. (Commentary p. 17-18; rule language p. 56) –** Create new definitions for the following terms: "Medicaid activity;" "Net effect;" "Non-Medicaid activity;" "Parameters of a tax;" "Provider-related donation."
- **§433.54. Bona fide donations. (Commentary p. 18; rule language p. 56) –** Create "totality of the circumstances" test for determining if there is a guarantee the donation will be returned to the provider.
- **§433.55. Healthcare taxes defined. (Commentary p. 18-19; rule language p. 56-57) –** Clarify when "differential treatment" occurs regarding a healthcare tax (a requirement for one type of healthcare tax). Clarify the measurement of "difference" is as to any other similar providers not subject to tax or any other non-provider entities subject to tax. Also clarify that, in determining if differential treatment exists, CMS will look at the parameters of the tax as defined by the state/local entity implementing it, as well as the totality of the circumstances related to the individuals and entities subject to and not subject to the tax.
- **§433.56. Classes of healthcare services and providers defined. (Commentary p. 19-20; rule language p. 57) –** Add a new broad class of healthcare providers that may be taxed: services of health insurers (other than services of Medicaid managed care organizations).
- **§433.68. Permissible healthcare-related taxes. (Commentary p. 20-21; rule language p. 57) –** In addition to the existing P1/P2 and B1/B2 test for determining whether a tax is redistributive in order to obtain a waiver from the uniformity and broad-based provisions, would

1. See, for example: https://news.bloomberglaw.com/health-law-and-business/trump-plan-to-tame-state-medicaid-finance-schemes-sees-pushback.
2. See link to proposed rule here: https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf. This can be useful if you want to read the actual new rule language, or commentary from CMS on the new rule, as referenced in each bullet.
3. All page references are PDF page numbers from the link in footnote 3.

add four new conditions that must be met, related to not imposing an undue burden on Medicaid services/goods or providers. See §443.68(e)(i) to (iv) to review the detailed conditions. Also add language reflecting statutory language that any guarantee by the state to hold the taxpayer harmless for any portion of the tax is impermissible (reflecting statutory language in SSA 1903(w)(1)(A)(iii)).

- **§433.72. Waiver provisions applicable to healthcare-related taxes (Commentary, p. 22-3; rule language, p. 57) –** Provide limited time frames for broad-based and uniformity waivers for healthcare-related taxes: three years from date of approval; or, if waiver exists when rule becomes final, three years from that date. Any material changes to tax affecting broad-based or uniformity provisions would require a new waiver application.
- **§433.316. When discovery of an overpayment occurs and its significance. (Commentary p. 22; rule language p. 57-58) –** Clarify when an overpayment in a DSH audit is deemed discovered: either the date the state submits the independent certified audit report under §455.304(b); or the earlier of: the date provider notified; the date provider acknowledges; or the date on which state initiates a formal action. Whichever of these dates is earlier controls.

IV. Changes to Part 447 in the MFAR Proposed Rule

CMS proposes the following significant changes to 42 CFR 447 in the MFAR proposed rule:

- **447.201. Payments funded by certified public expenditures made to providers that are units of government. (Commentary p. 22-23; rule language p. 58) –** Clarify that state plan may not pay providers different FFS rates on basis of member's eligibility category, enrollment under a waiver program, or Federal Medical Assistance Percentage available.
- **447.206. Payments funded by certified public expenditures made to providers that are units of government. (Commentary p. 23-25; rule language p. 58) –** Create a new rule section focusing completely on codifying long-standing policies pertaining to CPEs. A lengthy proposed new section, it should be read in its entirety. Among the points of emphasis: CPEs only apply to state or nonstate government-owned providers; cost-allocation principles; use of Medicaid cost reports recommended; documentation and audit protocols; must be a consistent process by which all CPEs process through the Medicaid Management Information System identifying specific enrollees; use most recently filed cost reports, and perform end-of-year final settlement reconciling interim and final cost report; **requires new state plan amendment in §447.206(d).**
- **447.207. Retention of payments. (Commentary p. 25-26; rule language p. 58) –** New section that would require that all payment methodologies permit the provider to receive and retain the full amount of the payment for services under the methodology, and that the state has paid the full non-federal share. Focuses on "associated transactions" not counting toward state share, and cites administrative fees for processing a claim or intergovernmental transfer (IGT) as an example. Commentary discusses the "net expenditure" to the state, and that provider donations are taken into consideration.
- **447.252. State plan requirements. (Commentary p. 26-28; rule language p. 58-59) –** Create new paragraphs added to implement **new requirements for state plans and any Medicaid State Plan Amendments (SPAs) proposing to make supplemental payments to hospital, LTC and ICF/IDD facilities**. Includes a maximum three-year term for any supplemental payment programs (though programs in existence when rule takes effect have more time), and if it is a renewal of a supplemental payment program, detailed aggregate and provider-level reporting as to expenditures under the program. Note: This is probably inapplicable to many or most states, as it only applies to SPAs, not DPPs, and most states have moved to a DPP model.
- **447.272. Inpatient services: application of UPLs. (Commentary p. 28-29; rule language p. 59) –** Changes/additions to improve oversight of upper payment limits (UPLs) on inpatient reimbursement in Medicaid. Establish three new groups for facilities: state government providers; nonstate government providers; and private providers. Clarify that Medicare cost principles apply to establishment of UPL. (Defined in new 447.286). Establish that Medicare cost principles apply (economy, efficiency, quality of care). Specifically references principles in 42 CFR 75 and 2 CFR 200, or as applicable, cost principles in 42 CFR 413. Data elements, methodology parameters, and acceptable UPL demonstration methodologies are in new section §447.288(b). (See below).
- **§447.284. Basis and purpose. (Commentary p. 29-30, rule language p. 59) –** This is the introductory section of a proposed new subpart D in 447 addressing new reporting requirements for all supplemental payments (whether made through state plan or demonstration (DPP, waiver, etc.)).
- **§447.286. Definitions. (Commentary p. 30-32; rule language p. 59-60) –** For purpose of new subpart D, define key terms: base payment, nonstate government provider, private provider, state government provider, and supplemental payment. Definition of supplemental payment is one key term – basically any payment which is not a "base payment" (regular reimbursement per FFS or MCO contract), is not a DSH payment, is not attributed to a particular provider or claim for specific services provided, and is made pursuant to state plan or demonstration authority.
- **§447.288. Reporting requirements for upper payment limit demonstrations and supplemental payments. (Commentary p. 32-37; rule language p. 60-62) –** The key provision of new subpart D, this section would create various new reporting requirements related to upper payment limits and supplemental payments. First, by October 1 of each year, each state must prepare and submit, in a format and manner as determined by the Secretary, a demonstration that UPL is met for the following five service categories: inpatient hospital;

outpatient hospital; nursing facility; Intermediate Care Facilities for Individuals with Mental Retardation; and Institutes for the Mentally Disabled. The section would set forth data standards to be used when creating these demonstrations. The demonstrations could be made through cost-based or payment-based reporting. The section further would create aggregate and detailed provider-level reporting requirements, both quarterly and annually, for all supplemental payments. First, detailed reporting on all supplemental payments must be made concurrent with each quarterly CMS-64, with aggregate and provider-level detail for all supplemental payments made. Additionally, an annual aggregate and provider-level detail reporting for all base and supplemental payments must be made within 60 day of the end of the state fiscal year (SFY). Finally, the section would require, within 60 days of the end of the SFY, aggregate and provider-level detailed reporting for each provider contributing to the state or any unit of local government any funds that are used as a source of non-federal share. This includes the amount of supplemental payments made to any provider paying a provider tax, a certified public expenditure (CPE), donation or an intergovernmental transfer (IGT), and the amount of any provider tax, CPE, IGT, and/or donation the provider makes.

- **§447.290. Failure to report required information. (Commentary p. 37; rule language p. 62) –** This final provision of new subpart D would require the state to always keep available information for UPL and supplemental payment reporting pursuant to 447.288, in the event of an OIG audit. Further, it would provide that if the state does not report the 447.288 information, or does not report it properly, it will be subject to an FFP withhold of the amount CMS estimates the state failed to report properly. Once the state reports properly, the money will usually be released to the state.
- **§447.297. Limitation on aggregate payments for DSHs beginning Oct. 1, 1992. (Commentary p. 37; rule language p. 62-63) –** Amended section would eliminate provision requiring CMS to post annual disproportionate share (DSH) allotments on the federal register; instead they would be posted on the Medicaid Budget and Expenditure System (MBES) and Medicaid.gov.
- **§447.299. Reporting requirements. (Commentary p. 37-38; rule language p. 63) –** This amended section would add a new data element to the current DSH audit process. Specifically, would require the DSH auditors to quantify, or at least estimate, the financial impact of any finding that may affect whether each hospital has received payments for which it is eligible within its hospital-specific DSH limit. Also clarifies the state must return all DSH payments that exceed hospital DSH payment limit.
- **§447.302. State plan requirements. (Commentary p. 38-39; rule language p. 63-64) –** Adding new paragraphs (a) through (d) to implement same state plan requirements for supplemental payments for outpatient hospital services similar to 447.252 for inpatient facilities (hospitals, nursing facilities, and ICF/IDD). Would impose a three-year term for any supplemental payment programs (though programs in existence when rule takes effect have more time), and in the case of a renewal of a supplemental payment program, detailed aggregate and provider-level reporting as to expenditures under the program. Note: Like 447.252, this is probably inapplicable to many or most states, as it only applies to SPAs, not DPPs, and most states have moved to a DPP model.
- **§447.321. Outpatient hospital services: application of UPLs. (Commentary p. 39-41; rule language p. 64) –** Significantly amend 447.321 to improve oversight of Medicaid program FFS expenditures for services subject to the UPL. Major changes include: revising the name of current ownership groups to state government providers, nonstate government providers and private providers; changing UPL standard for outpatient hospital services to "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under..." Medicare payment principles. Also notes that data elements, methodology parameters and acceptable upper payment limit demonstration methodology are defined in proposed new 447.288.
- **§447.406. Medicaid practitioner supplemental payments. (Commentary p. 41-44; rule language Page 64) –** Addition of a new section to place limits on Medicaid supplemental payments to practitioners pursuant to 447.286 and targeted to practitioners pursuant to a specific methodology in the state plan. Does not apply to value-based purchasing. Must meet standards in 447.302 as amended, and also not exceed: (1) 50% of the total FFS-based payments authorized under the state plan; or (2) if provided in a Health Resource and Services Administration-designated underserved or rural area, then 75% of the increase in FFS payment to eligible practitioners in that area.

V. Changes to Part 455 in the MFAR Rule

- **§455.301. Definitions. (Commentary p. 44; rule language p. 64) –** Amend definition of "independent certified audit" in program integrity part to include requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an independent basis, for each hospital. Also amend the same definition to include whether any state DSH payments exceeded a hospital's DSH limit.

VI. Changes to Part 457 in the MFAR Rule

- **§457.609. Process and calculations of state allotments for a fiscal year after FY 2008. [CHIP]. (Commentary p. 44; rule language p. 64) –** Amend this section to eliminate practice of posting state annual CHIP allotments in Federal Register; instead will be published in MBES and on Medicaid.gov.

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