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Summary of Nov. 18, 2019, Federal Register DHHS Proposed Regulation For Review and Comment

Healthcare

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Medicaid Program and Children's Health Insurance Plan (CHIP)
Proposed Rule 2019 — Medicaid Fiscal Accountability Regulation (MFAR)
42 CFR Parts 430, 433, 447, 455, and 457

Link to Full Proposed Regulation on Federal Register:
https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf

The rule focuses on four topics: Disproportionate share hospital (DSH) payments; Medicaid program financing mechanisms (healthcare-related taxes, provider-related donations, intergovernmental transfers (IGTs), and certified public expenditures (CPEs)); supplemental Medicaid payments; and upper payment limits (UPLs).

Amended/New Provision	Page Ref. (PDF)	CMS Action	Proposed Revision	Discussion (Summary)
§430.42 Disallowance of claims for FFP. **Amendment**	CMS Commentary: 16 Rule language: 55-6	Proposing changing the methodology for state requesting reconsideration of disallowance of FFP.	• All requests for reconsideration of disallowance of FFP would be sent by "email or another electronic system specified by the administrator [DHHS Secretary]."	Email [or similar electronic system] is preferred form of communication today rather than mail, which was preferred when regulation originally promulgated. Further, email is less expensive, slightly easing administrative burden.

Amended/New Provision	Page Ref. (PDF)	CMS Action	Proposed Revision	Discussion (Summary)
§433.51 State share of financial participation. **Amendment and new paragraph.**	CMS Commentary: 16 Rule language: 55-6	Proposing amending §433.51 to more clearly define the allowable sources of the nonfederal share to more closely align with the provisions in section 1903(w) of the Act.	• Replace the term "public funds" with "state or local funds," and provide specificity as to the type of funds that may be used for the state share. Limit permissible state or local funds that may be considered as the state share to: – State general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency; – 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 as provided in proposed §433.51(d); or – CPEs, which are certified by the contributing unit of government as representing expenditures eligible for FFP and reported to the state as provided in proposed §447.206. (Key §447.206 language (also discussed below) requires for CPE, the funds be limited to the state or other govt. unit-owned provider's actual, incurred cost of providing services). • Add new paragraph (d) clearly indicating funds provided as an IGT from a unit of government but 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 provider-related donation that is non-bona fide under §§433.52 and 433.54.	Lack of clarity and alignment with 1903(w) of the Act as it relates to "public funds" permissible to be used for state share has been causing confusion and state at times attempting to utilize funds not in alignment with parameters of 1903(w) of the SSA. These provisions redefine "public funds" as "state and local funds" and provide clarification regarding the specific types of state and local funds which may be used: (1) State legislative appropriations; (2) IGTs and (3) CPEs — and limitations on them.

Amended/New Provision	Page Ref. (PDF)	CMS Action	Proposed Revision	Discussion (Summary)
§433.52. General Definitions. Amended.	CMS Commentary: 17-18 Rule language: 56	Proposing amending and adding definitions to provide clarifications surrounding provider taxes and donations as a source of state-share funding.	• Add definitions for "Medicaid activity," "non-Medicaid activity," "net effect," "parameters of tax," and "taxpayer group" to provide further clarity related to provider taxes. • Add definitions of "provider-related donation" to include transactions that are not necessarily legally enforceable but based on the totality of the circumstances. • Amend "healthcare-related" to read "provider-related" to align with usage where provider donations are addressed throughout §433, subpart B. • Qualify "the percentage of donations the organization received from the providers during that period" with "that was received as donations from providers or provider-related entities."	CMS is proposing amending and adding some of the definitions in the general definitions section to provide clarity regarding provider taxes and donations. Regarding the clarification of "provider-related donations," CMS states: "This proposal does not represent a new policy, but a clarification of current law designed to aid in preventing and, where they currently may exist, terminating impermissible financing practices involving provider-related donations."
§433.54. Bona fide Donations.	CMS Commentary: 18 Rule language: 56	Proposing amending the provision of the regulations describing what types of provider-related donations are considered "bona fide provider-related donations."	• Amend provider-related bona fide donation to reflect that a direct guarantee of the return of all or part of a donation "would be found to exist where, considering 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."	This clarification is designed to aid in preventing and eliminating complex financing arrangements designed to obfuscate the fact that non-bona fide provider-related donations are the source of the nonfederal share of certain Medicaid payments. This is consistent with our current policy, which we have applied in the past and discussed in SMDL 14-004 on impermissible provider-related donations.

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§433.55. Healthcare-Related Taxes Defined.	CMS Commentary: 18-19 Rule language: 56-7	Proposing amending the provisions of §433.55 related to when a healthcare tax is considered a "healthcare-related tax."	• Amend §433.55(c) by clarifying that differential treatment occurs when a tax program treats some individuals or entities that are providing or paying for healthcare 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 subject to the tax. • Amend §433.55(c) to clarify that CMS examines the parameters of the tax as defined by the state or other unit of government, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject (and not subject) to the tax and at which rate, in determining whether the tax program involves differential treatment as provided in section 1903(w)(3)(A)(ii) of the Act. • Add paragraphs (c)(1) and (c)(2) to §433.55 to clarify when CMS would consider the treatment of individuals or entities providing or paying for healthcare items or services to be different from the treatment provided to other individuals or entities.	CMS is concerned that taxes of the sort described in proposed §433.55(c)(1) and (2) are not consistent with applicable statutory (and current regulatory) requirements because they may include individuals or entities providing or paying for healthcare items or services that receive high levels of reimbursement from Medicaid for such items or services, and that may receive a return of their tax costs in the form of increased Medicaid payments. In particular, CMS is concerned about tax programs that treat healthcare items or services that are mostly reimbursed by Medicaid differently than other healthcare items or services with low Medicaid reimbursement.

Amended/New Provision	Page Ref. (PDF)	CMS Action	Proposed Revision	Discussion (Summary)
§433.56. Classes of Healthcare Services and Providers Defined.	CMS Commentary: 19-20 Rule language: 57	Proposing adding a new class of health-care items and services (services of non-MCO health insurers) to the list of permissible classes of healthcare provider re: healthcare or healthcare-related taxes in §433.56(a). (A new class of providers).	• Revising (a)(19) to add "Services of health insurers (other than services of managed care organizations as specified in paragraph (a)(8) of this section).	CMS became aware that several states may be imposing taxes on health insurers in the form of a tax on health insurance premiums or volume of services. Section 1903(w)(7)(A)(ix) of the Act delegates to the Secretary the power to specify such other classification of healthcare items and services consistent with the paragraph as the Secretary may establish by regulation. CMS is proposing to expand the permissible-class list to provide states with additional flexibility [to tax non-MCO health insurers], while maintaining the fiscal integrity of the Medicaid program by ensuring that the proposed new permissible class would not be limited to items or services that are primarily or exclusively provided or paid for by the Medicaid program.
§433.68. Permissible Healthcare-related Taxes.	CMS Commentary: 20-21 Rule language: 57	Proposing making additions to §433.68 to ensure that a proposed provider-related tax is truly generally redistributive.	• Add §433.68(e)(3) to clarify a provider-related tax must not impose an undue burden on healthcare items or services paid for by Medicaid or on providers of such items or services that are reimbursed by Medicaid. Includes a three-part test for determining whether the tax imposes such a burden. • Amend §433.68(f)(3) to add a "net effect" standard to the direct hold-harmless guarantee for provider-related taxes.	CMS considers taxes that pose an undue burden on the Medicaid program to be inherently not generally redistributive because they impose a higher tax burden on healthcare items or services, or providers of such items and services, that are financed by Medicaid than those not financed by Medicaid, as explained in the preamble to the August 1993 final rule, discussed above. Proposed §433.68(f)(3) aims to thwart efforts by states to skirt hold-harmless provisions by paying supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a healthcare-related tax.

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§433.72. Waiver Provisions Applicable to Healthcare-related Taxes.	CMS Commentary: 22-3 Rule language: 57	Proposing adding provisions regarding the date on which a waiver of the broad-based and/or uniformity provisions for provider-related taxes would be effective and overpayments discovered on DSH audits.	• In §433.72, add new paragraphs (3) and (4) to paragraph (c) to clarify the effective date and term for a broad-based and/or uniformity waiver for provider-related taxes. Sets a term of three years for all such waivers. • In §433.72, add new paragraph (d), to ensure ongoing compliance of tax waivers with the original conditions of the waiver approval. Requires state to ensure the tax program meets the requirements of §433.72(b)(1) through (3) at all times during which waiver is in effect. Also requires state to ask for a new waiver if the state makes changes to the tax affecting uniformity or broad-based aspect of the tax. • Add new paragraph (f) to clarify that in the case of an overpayment identified through the DSH independent certified audit required under §455, subpart D, CMS will consider the overpayment as discovered on the earliest of the date that the state submits the DSH independent certified audit report required under §455.304(b) to CMS, or any of the dates specified in §433.316 (date provider is put on notice; date provider acknowledges; or date formal action commenced against provider).	CMS is proposing to limit waiver approvals to three years because the provider data that states provide to CMS for use in the statistical tests at §433.68 and the providers in the class subject to the waiver change over time. Similarly, the proposed new requirements at paragraph (d) would help ensure that the tax remains generally redistributive while the waiver is in effect, since these changes could affect the determination whether it meets applicable requirements.
§433.316. When Discovery of Overpayment Occurs and it's Significant.	CMS Commentary: 22 Rule language: 57-8	Proposing adding a new paragraph (f) which addresses discovery of overpayments in DSH audits.	• Add a new paragraph (f) in §433.316 to 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 any of the dates specified in §433.316(c)(1)-(3) (date provider notified; date provider acknowledges; or date on which state initiates a formal action). Whichever of these dates is earlier controls.	It is not explicitly clear in the current regulations how the date of discovery is determined when an overpayment is discovered through the annual DSH independent certified audit required under §455.304. Therefore, CMS believes an amendment is appropriate to specify the date of discovery of overpayments as it relates to the annual DSH independent certified audit.

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§447.201. State Plan Requirements.	CMS Commentary: 22-3 Rule language: 58	Proposing adding a new provision to §447.201 to specify that the state plan may not provide for variation in FFS payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan.	• In §447.201, add paragraph (c) stating, "The [state] plan must provide for no variation in fee-for-service payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration project, or Federal Medical Assistance Percentage (FMAP) rate available for services provided to an individual in the beneficiary's eligibility category."	This proposed provision is intended to make clear that variation in payment rates solely on the basis of FFP is prohibited, as it would be inconsistent with efficiency and economy to allow states to pay providers more, only because such payments can be funded by drawing down additional federal dollars at a marginally increased cost to the state (and at net savings to the state, versus the costs the state would incur if the relevant beneficiary population qualified for standard FMAP). CMS believes that this proposed provision is necessary to ensure the proper and efficient operation of the Medicaid state plan, in a manner that complies with the requirements of section 1902(a)(4) and (a)(30)(A) of the Act.

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§447.206. Payments Funded by Certified Public Expenditures.	CMS Commentary: 23-5 Rule language: 58	Proposing adding a new section, 447.206, codifying longstanding policies related to certified public exchanges (CPEs).	• Create §447.206 to address the documentation and other protocols surrounding CPEs. It is an extensive section, but the most crucial points are as follows: – Sub (a) applies only to payment that are state or nonstate govt.-owned providers. – Sub (b) defines generally rules for CPE protocols. Among them: discusses cost allocation principles from 45 CFR part 75 and 2 CFR part 200; recommend use Medicare cost reports where possible; documentation and audit protocols for CPEs; only certified amount may be claimed for FFP match; provider must receive and keep full FFP amount. – Paragraph (b)(1) limits any CPE to actual, incurred costs of provider. – Sub (c) sets forth other criteria for CPEs, including: requires state to implement processes by which all CPE claims would be processed through the Medicaid Management Information System in a manner identifying specific enrollees; requiring state to utilize most-recently filed cost reports to develop interim payment rates; that a final settlement be performed by reconciling interim cost reports to the finalized cost report; and that overpayments must be recovered. – Sub (d) specifies requirements for the state plan for CPEs, which basically requires what is in the new section to be in state plan.	CMS is proposing to add §447.206 to codify longstanding policies implementing the following sections of the statute: section 1902(a)(4) for proper and efficient operation of the state plan; section 1902(a)(30)(A) requiring that payments be economic and efficient; and section 1903(w)(6)(A) permitting states to use CPEs, which are expenditures certified by units of government within a state, as a source of nonfederal share.

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§447.207 Retention of Payments.	CMS Commentary: 25-6 Rule language: 58	Proposing adding a new section requiring that payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved state plan (or the approved provisions of a waiver or demonstration, if applicable).	• Add a new section, §447.207, which provides in sub (a) that "Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved state plan (or the approved provisions of a waiver or demonstration, if applicable). The Secretary will determine compliance with this paragraph (a) by examining any associated transactions that are related to the provider's total computable Medicaid payment to ensure that the state's claimed expenditure, which serves as the basis for federal financial participation, is consistent with the state's net expenditure, and that the full amount of the nonfederal share of the payment has been satisfied. 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 nonstate 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 as funds for the state share of Medicaid service payments."	This provision is intended to implement sections 1902(a)(4) and (a)(32) of the Act. Payment arrangements that comply with an exception in section 1902(a)(32) of the Act and the implementing regulation in §447.10 would not be deemed out of compliance with this proposed provision. The Secretary would determine compliance with this provision by examining any associated transactions that are related to the provider's total computable Medicaid payment to ensure that the state's claimed expenditure, which serves as the basis for FFP, is consistent with the state's net expenditure, and that the full amount of the nonfederal share of the payment has been satisfied.

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§447.252. State Plan Requirements.	CMS Commentary: 26-8 Rule language: 58-9	Proposing adding new paragraphs to §447.252, providing language regarding state plan requirements for payments for inpatient hospital and long-term care facility services, to implement new approval requirements for state plans and any State Plan Amendments (SPAs) proposing to make supplemental payments to providers of these services, and to define a transition period for currently authorized supplemental payments to begin to meet the proposed new requirements.	• Add sub to (d) §447.252, which provides that CMS will apply, pursuant to a SPA, a three-year effective period for any submitted supplemental payment plan. At the conclusion of the three years, the state would have to reapply. Also includes detailed requirements for what needs to be in a supplemental payment SPA. • Add sub (e) to §447.252, for supplemental payment SPAs approved more than three years after effective date of final rule, states would have two years to get approval of new SPA; for such SPAs approved less than three years prior to final rule approval date, states would have three years to get approval of SPA.	A time-limited supplemental payment allows CMS and the state an opportunity to revisit state plan supplemental payments to ensure that they remain consistent with efficiency, economy, and quality of care, as required under section 1902(a)(30)(A) of the Act. As discussed in this section and other sections of this preamble, the proposed revisions to §§ 447.252, 447.288(b), and 447.302 include considerable data reporting requirements that would implement section 1902(a)(6) of the Act, which provide that the state agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. CMS believes the robust payment data CMS proposes to require is necessary to ensure the proper and efficient administration of the plan; to ensure that payments are consistent with efficiency, economy, and quality of care; and otherwise to assist in appropriately overseeing the Medicaid program.

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§447.272. Inpatient Services: Application of UPLs.	CMS Commentary: 28-9 Rule language: 59	Proposing changing §447.272 to improve oversight of Medicaid program FFS expenditures for services subject to the UPL.	• Amend paragraph (a) of §447.272 to revise ownership groups (state government owned or operated, nonstate government owned or operated, and privately owned and operated facilities) used to establish the UPL. Changing to "state-government providers," "nonstate government providers," and "private providers." Then cross reference to §447.286 (including "totality of the circumstances" test). • Amend §447.272(b) by clarifying that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in 42 CFR, chapter IV, subchapter B; or allowed costs established in accordance with Medicaid cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413. The specific data sources, methodology parameters, and acceptable UPL demonstration methodologies are specified in proposed §447.288(b).	Many of the proposed changes to §447.272 would formally codify our current policy in regulation text, while others are newly proposed standards. CMS has long relied upon the UPL requirements in §447.272, and the related review of total inpatient hospital Medicaid payments in relation to a provider's cost or a reasonable estimate of what Medicare payment amounts would have been, as implementing section 1902(a)(30)(A) of the Act, which requires that states assure that payments are consistent with efficiency, economy, and quality of care. (FFP is not available for state Medicaid expenditures that exceed an applicable UPL.)

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§447.284. Basis and Purpose.	CMS Commentary: 29-30 Rule language: 59	Proposing adding a new subpart D to §447 to implement sections 1902(a)(6) and (a)(3)(A) of the Act, which require, respectively, that a state plan for medical assistance must provide that the state agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports, and to assure that payments are consistent with efficiency, economy, and quality of care. Includes §447.284, 286, 288, and 290. This is the section which discusses the basis and purpose.	• New §447.284 (part of new subpart as explained), stating: a. This subpart sets forth additional requirements for supplemental payments made under the state plan and implements sections 1902(a)(6) and (a)(30) of the Act. b. The reporting requirements in this subpart are applicable to supplemental payments to which an upper payment limit applies under §447.272 or §447.321.	In proposed §447.284(a), CMS would specify that proposed new subpart D would set forth additional requirements for supplemental payments made under the state plan and implement section 1902(a)(6) and (a)(30) of the Act. Section 447.284(b) would provide that the reporting requirements in subpart D are applicable to supplemental payments to which a UPL applies under §§447.272 or 447.321.

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§447.286. Definitions.	CMS Commentary: 30-32 Rule language: 59-60	Proposing adding section defining certain terms in the new subpart D (general purpose of subpart D described in §447.84).	• Add a section defining the following terms for the new subpart D of §447: Base payment, nonstate government provider, private provider, state government provider, and supplemental payment.	Clear definitions of these terms are needed so that states and other stakeholders can have a clear understanding of what is required with respect to the proposed reporting requirements for supplemental payments and UPL demonstrations, and to allow us to clearly track supplemental payments and ensure a consistent reporting and UPL demonstration process.
§447.288. Reporting requirements for upper payment limit demonstrations and supplemental payments.	CMS Commentary: 32-7 Rule language: 60-62	Proposing adding §447.88 to define documentation requirements for UPL demonstrations and for states that make supplemental payments.	• Add §447.88(a) to new subpart D of §447 to require that beginning October 1, of the first year following the year in which the final rule may take effect, and annually thereafter, by October 1 of each year, in accordance with the requirements of §447.288 and in the manner and format specified by the Secretary, each state would be required to submit a demonstration of compliance with the applicable UPL for the following service areas: inpatient, outpatient, nursing facility, ICF, IMD. Note: Psychiatric residential treatment facility UPL demonstration no longer required. • Add §447.288(b) to new subpart D of 447 to define UPL demonstration standards. Provides the data sources, data standards, and acceptable UPL methodologies for demonstrating the UPL. • Add §447(c), requires (in addition to the demonstrations discussed in 288(a) and (b)), that the state provide supplemental reports with each CMS-64 regarding provider-level payment information regarding all supplemental payments made to providers. Also requires an aggregate report of the same information. Provider-level DSH payments also required.	CMS believes that these proposed requirements [related to data sources/standards and UPL methodologies] would assist CMS and states in determining the Medicaid inpatient and outpatient facility payment rates are consistent with economy, efficiency, and quality of care under section 1902(a)(30)(A) of the Act. CMS is hopeful these proposed provisions, which, except as noted below, would codify current policy, would enhance states' understanding of acceptable UPL demonstration standards, as well as improve the quality of UPL submissions. This proposed data collection effort [of provider-level supplemental payments] is designed to allow us to conduct efficient oversight of all payments made to providers on an annual aggregate basis.

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§447.290. Failure to Report Required Information.	CMS Commentary: 37 Rule language: 62	Proposing adding §447.290, which puts enforcement mechanisms in place for reporting requirements in §447.288.	• Provide for offset against FFP in amount of estimated or known supplemental payments the state has not reported properly. This includes both not maintaining data as required and not reporting properly when required. State can receive the offset once reports are filed properly.	To effectively ensure that states comply with applicable federal statutory and regulatory requirements, CMS must have adequate enforcement mechanisms in place. The remedy for issues related to state compliance with regulations is often the withholding of federal funds to compel compliance with applicable federal requirements. The enforcement mechanism proposed in §447.290 is similar in structure to the mechanism that applies with respect to the DSH reporting requirements in §447.299(e).
§447.297. Limitations on Aggregate Payments for DSHs Beginning Oct. 1, 1992.	CMS Commentary: 37 Rule language: 62-3	Proposing amending §447.297 to eliminate the requirement to publish annual DSH allotments in a Federal Register notice, and to instead place DSH info in the Medicaid Budget and Expenditure System (MBES) and on Medicaid.gov.	• Change requirement that CMS post annual DSH allotments in a Federal Register notice by April 1 annually, and instead require CMS to post this info in MBES and Medicaid.gov "as soon as practicable."	This process [of posting annual DSH allotments in a Federal Register] is not only administratively burdensome, but is unnecessary as CMS routinely notifies states directly regarding annual allotment amounts and make such information publicly available.

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§447.299. Reporting Requirements.	CMS Commentary: 37-8 Rule language: 63	Proposing creating additional reporting requirements for DSH audits and to clarify guidance on reporting DSH overpayments.	• Create new paragraph §447.299(c)(21) to require an additional data element for annual DSH reporting. Specifically, would require auditors to quantify the financial impact of any finding that may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit. Add new paragraph §447.299(f) to clarify reporting requirements of DSH overpayments identified in the audit process in accordance with part 433 subpart F, including specifying that states must return DSH payments in excess of hospital-specific cost limits to the federal government identified through annual DSH audits through quarterly reporting on the Form CMS-64 as a decreasing adjustment, or redistributed by the state to other qualifying hospitals, if redistribution is provided for under the approved state plan.	To improve the accuracy of identification of provider overpayments discovered through the DSH audit process, CMS is proposing in §447.299 to add an additional reporting requirement for annual DSH audit reporting required by §447.299 and to provide clarifying guidance on the reporting of overpayments identified by the annual DSH audits required under part 455 subpart D.

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§447.302. State Plan Requirements.	CMS Commentary: 38-9 Rule language: 63-4	Proposing adding new paragraphs (a) through (d) to §447.302, establishing new requirements related to supplemental payments made for hospital outpatient services.	• Add a paragraph (a) and (b) to codify existing state plan requirements that the state plan must provide that the requirements of subpart F (related to supplemental payments) are met and that the plan must specify comprehensively the methods and standards used by the agency to set payment rates. • Add a paragraph §447.302(c) that CMS may approve a supplemental payment, as defined in §447.286, provided for under the state plan or a SPA for a period not to exceed three years. A state whose supplemental payment approval period has expired or is expiring may request a SPA to renew the supplemental payment for a subsequent period not to exceed three years, consistent with the requirements of §447.302. • Add a paragraph §447.302(d), for state plan provisions approved three or more years prior to the effective date of the final rule, CMS proposes that the state plan authority would expire two calendar years following the effective date of the final rule. For state plan provisions approved less than three years prior to the effective date of the final rule, CMS proposes that the state plan authority would expire three years following the effective date of the final rule.	As discussed in this section and other sections of this preamble, the proposed revisions to §§447.252, 447.288(b) and 447.302 include considerable data reporting requirements that would implement section 1902(a)(6) of the Act, requiring the state agency to make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. The submission of more robust payment data would assist us in providing proper oversight of the Medicaid program in determining that state Medicaid payments are made in a manner consistent with federal statute and regulations, including section 1902(a)(30)(A) of the Act and applicable UPL requirements. The justification for including the state plan requirements in §447.302 are the same as those justifications and explanations included in the discussion regarding §447.252. CMS is proposing to require states to provide information necessary to determine that the supplemental payments proposed in the state plan are, and remain, consistent with the efficiency, economy, and quality requirements under section 1902(a)(30)(A) of the Act and the parameters concerning permissible sources of nonfederal share under section 1903(w) of the Act.

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§447.321 Outpatient Hospital Services: Application of UPLs.	CMS Commentary: 39-41 Rule language: 64	Proposing amending §447.321 related to FFS expenditures for outpatient hospital services subject to UPL.	• Change title of section to "Outpatient Hospital Services: Application of upper payment limits." • Amend §447.321(a) to revise the current ownership groups (state government-owned or operated, nonstate government owned or operated, and privately owned and operated facilities) used to establish the UPL; and replace these provider designations with "state government providers," "nonstate government providers," and "private providers"; then define these terms. • Amend §447.321(b) to clarify that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in 42 CFR chapter IV, subchapter B, or allowed costs established in accordance with the cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in 42 CFR part 413. The specific data elements, methodology parameters, and acceptable UPL demonstration methodologies are specified in proposed §447.288(b).	To promote improved oversight of Medicaid program FFS expenditures for services subject to the UPL, CMS is proposing changes to §447.321. Some of the proposed changes to §447.321 would formally codify current policy, while others are newly proposed.

Amended/New Provision	Page Ref. (PDF)	CMS Action	Proposed Revision	Discussion (Summary)
§447.406. Medicaid Practitioner Supplemental Payments.	CMS Commentary: 41-4 Rule language: 64	Proposing adding a new section, §447.406, addressing methodology for supplemental payment to certain practitioners.	• Add a new rule section, §447.406, which caps Medicaid practitioner supplemental payments at either 50% of the total fee-for-service base payments authorized under the state plan paid to an eligible provider for the practitioner services during the relevant period; or for services provided within Health Resources and Services Administration -designated geographic health professional shortage areas (HPSA) or Medicare-defined rural areas as specified in 42 CFR 412.64(b), 75% of the total fee-for-service base payments authorized under the state plan paid to the eligible provider for the practitioner services during the relevant period.	CMS is proposing to end the practically unrestricted use of average commercial rate supplemental payments based on concerns that the payments are not economical and efficient, consistent with section 1902(a)(30)(A) of the Act, and that they present a clear oversight risk because they are based on proprietary commercial payment data and thus not verifiable or auditable.
§455.301. Definitions.	CMS Commentary: 44 Rule language: 64	Proposing to amend §455.301 to revise certain definitions.	• Amend §455.301 to redefine "independent certified audit" to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital, per the reporting requirement in §447.299(c)(21) and under section 1923(j)(1)(B) of the Act. • Amend §455.301 to include in definition of "independent certified audit" that a certification of the audit would include a determination of whether or not the state made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid state plan rate year under audit.	Revising the definition is necessary in promoting oversight and integrity of the DSH program and ensuring the audit and report results allow us to calculate accurate hospital-specific limits.
§457.609. Process and Calculation of State Allotments for Fiscal Year.	CMS Commentary: 44 Rule language: 64	Proposing amending §457.609 to revise the method for notifying states and the public of Children's Health Insurance Plan (CHIP) allotments.	• Amend §457.609 to eliminate requirement that CMS publish annual CHIP allotments in Federal Register; instead require them to be published in the Medicaid Budget & Expenditure System (MBES) and CHIP Budget & Expenditure System (CBES) and at Medicaid.gov.	CMS believes that posting the CHIP allotment amounts at Medicaid.gov and in the MBES/CBES is an efficient way to make the information more easily accessible to interested stakeholders and would be less administratively burdensome for CMS.

Contacts

Yelena Barzilla, LL.B., LL.M., CHC
Associate Director
+1-512-493-5402
yelena.barzilla@guidehouse.com

Ryan M. Sims, JD
+1-202-973-3232
Managing Consultant
ryan.sims@guidehouse.com

linkedin.com/showcase/guidehouse-health

twitter.com/GuidehouseHC

guidehouse.com

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