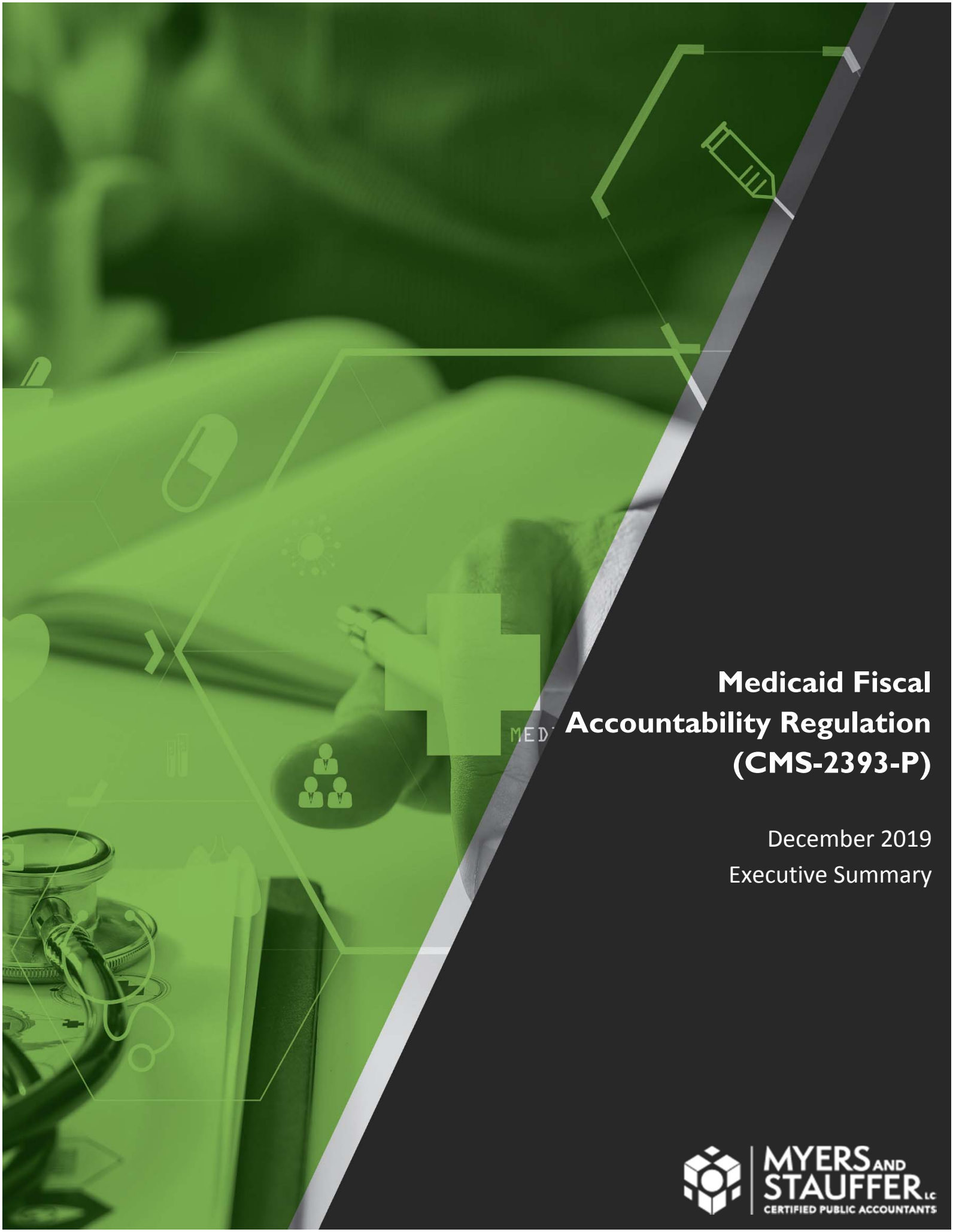

Medicaid Fiscal Accountability Regulation (CMS-2393-P)

December 2019

Executive Summary

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CERTIFIED PUBLIC ACCOUNTANTS

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Background

On November 12, 2019, the Centers for Medicare & Medicaid Services (CMS) issued the proposed Medicaid Fiscal Accountability Rule (CMS-2393-P), which was published in the Federal Register on November 18, 2019. The proposed rule addresses a number of areas involving Medicaid financing, including supplemental payment programs, certified public expenditures, intergovernmental transfers, and health care-related taxes, among others.

By implementing this rule, CMS explains their objective is to strengthen the fiscal integrity of the Medicaid program and improve the oversight, transparency, and value achieved from state supplemental payments. CMS reports a rapid increase in Medicaid spending from $456 billion in 2013 to approximately $576 billion in 2016, primarily driven by the growth in federal share spending for supplemental payment programs. The use of supplemental payments by states has increased to approximately 17.5 percent of all other Medicaid payments during Federal fiscal year (FFY) 2017.

CMS indicates the availability of timely and robust payment information inhibits their ability to effectively monitor these programs. It is also not always possible for CMS to accurately determine the source of the state share of Medicaid expenditures. CMS reports that the insufficiency of data on state supplemental payment programs makes their oversight of such supplemental payment programs vulnerable to speculation.

The proposed rule addresses four broad payment and financing categories:

- *Medicaid FFS Provider Payments*
- *Disproportionate Share Hospital (DSH) Payments*
- *Medicaid Program Financing*
- *Health Care-Related Taxes and Provider-Related Donations*

1. Medicaid FFS Provider Payments

Under the provisions of the proposed rule, CMS is seeking to better understand the relationship between and among supplemental provider payments, the costs incurred by providers, current UPL requirements, state financing of the non-federal share of supplemental payments, and the impact of supplemental payments on the Medicaid program. In doing so, they also considered previously reported findings that identified data limitations regarding lump-sum Medicaid supplemental payments as an impediment to comparing payment levels across providers and states, determining the total amount of Medicaid spending on specific services and populations, and evaluating the impact of Medicaid payment policies.

CMS is proposing to gather additional information to better understand how states distribute supplemental payments to individual providers and whether there are benefits to the Medicaid program resulting from supplemental payments. Currently, states report aggregate payment detail for base and supplemental payments. Under this proposed rule, states would be required to furnish provider-level payment detail to support the aggregate level information received through UPL demonstrations. CMS explains the reporting of provider-level data will aid with transparency as well as support both states and CMS in better oversight of the program.

CMS explains in the proposed rule that they are concerned that certain changes in ownership category appears to be only a device to permit the state to make supplemental payments to a provider and demonstrate compliance with the UPL, rather than reflective of an actual change in the provider's true ownership or operational interests, in view of the apparent continuity of the provider's business structure and activities. CMS continues by describing their belief that this shift in designation has facilitated higher supplemental payments to certain providers, without the state incurring additional cost to fund the non-federal share of payment where the private operator passes funds to the new governmental owner in a manner that is not consistent with the basic construct of the Medicaid program as a cooperative federal-state partnership where each party shares in the cost of providing medical assistance to beneficiaries.

The proposed rule would establish new regulatory definitions for Medicaid "base" and "supplemental" payments, which are not currently defined. Base and supplemental payments, respectively, are defined as:

- *§ 447.286*
  - ***Base Payment.*** *A payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the State plan or that is paid to the provider through its participation with a Medicaid MCO entity ... Base payments …*

include all payments made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries, including any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to a particular service provided to the beneficiary, such as payment adjustments made to account for a higher level of care or complexity of services provided to the beneficiary.

- ***Supplemental Payment.*** *A Medicaid payment to a provider that is in addition to the base payments to the provider, other than DSH payments … made under state plan authority or demonstration authority. Supplemental payments cannot be attributed to a particular provider claim for specific services provided to an individual recipient and are often made to the provider in a lump sum.*

The proposed rule redefines the three provider categories, currently defined as state government-owned or operated facilities; non-state government-owned or operated facilities; and privately-owned and operated facilities as state government provider; non-state government provider; and private provider, respectively. The redefined categories are defined as follows:

- *§ 447.286*
  - ***State Government Provider.*** *A health care provider … that is a unit of state government or a state university teaching hospital.*
  - ***Non-State Government Provider.*** *A health care provider … that is a unit of local government in a state, including a city, county, special purpose district, or other governmental unit in the state that is not the state, which has access to and exercises administrative control over state-appropriated funds from the legislature or local tax revenue, including the ability to dispense such funds.*
  - ***Private Provider.*** *A health care provider … that is not a state government provider or a non-state government provider.*

CMS explains that in determining the ownership category of the provider, the proposed rule would consider the totality of the circumstances, including, but not limited to, the identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider.

In determining whether an entity shares responsibilities of ownership or operation of the provider, CMS' consideration would include, but would not be limited to, whether the entity:

- *§ 447.286*
  - *Has immediate authority to make decisions regarding the operation of the provider;*

- *Bears the legal responsibility for risk from losses from operations of the provider;*
- *Has immediate authority over the disposition of revenue from operations of the provider;*
- *Has immediate authority with regard to hiring, retention, payment, and dismissal of personnel performing functions related to the operation of the provider;*
- *Bears legal responsibility for payment of taxes on provider revenues and real property, if any are assessed; or*
- *Bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or other operations, activities, or assets of the provider.*

Additionally, in determining whether a provider and/or entities other than the provider share responsibilities of ownership or operation is a unit of a state or non-state government, CMS would consider the character of the entity which would include, but would not be limited to, whether the entity:

- *§ 447.286*
  - *Is described in its communications to other entities as a unit of state or non-state government, or otherwise;*
  - *Is characterized as a unit of state or non-state government solely for the purposes of Medicaid financing and payments, and not for other purposes (for example, taxation); and*
  - *Has access to and exercises administrative control over state funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds, based on its characterization as a governmental entity.*

The rule would also require that states report provider-specific payment information on payments received for state plan services and through demonstration programs, as well as identify the specific authority for these payments, and the source of the non-federal share of the total computable.

This proposed rule would mandate the use of OMB-approved templates and CMS guidelines on acceptable UPL calculations. CMS indicates this requirement would ensure standardization of data applicable to UPL demonstrations, allowing the state and CMS to better ensure compliance with applicable payment limits, as well as measure the effect of payments on advancing Medicaid program goals.

The proposed rule also specifies 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 Federal Medical Assistance Percentage (FMAP). CMS explains 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 the Social Security Act and that it would improve consistency across both FFS and managed care.

2. Disproportionate Share Hospital (DSH) Payments

Existing provisions: The "Medicaid Program; Disproportionate Share Hospital Payments" final rule published in the December 19, 2008 Federal Register (the 2008 DSH Rule) requires state reports and audits to ensure the appropriate use of Medicaid DSH payments.

Proposed provisions: The proposed rule will require that the audit report include the total annual amount associated with each audit finding, including those resulting from incomplete or missing data. If it is not practicable to determine the actual financial impact amount, the estimated financial impact should be reported for each audit finding identified in the independent certified audit when it is not already reflected in required data elements.

The proposed rule defines estimated financial impact as the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available.

Existing provisions: FFP is not available for DSH payments that are found to exceed the hospital-specific limit. Amounts in excess of the hospital-specific limit are regarded as overpayments to providers. There are no specific rules for the return of the overpayments determined through the independent certified audit.

Proposed provision: The proposed rule includes specific provisions for overpayment and redistribution reporting processes. DSH payments found to exceed hospital-specific cost limits, as identified in the independent certified audit process, must be addressed as follows:

- *§ 447.299*
  - *Overpayment amounts returned to the Federal government must be separately reported on the Form CMS-64 as a decreasing adjustment which corresponds to the fiscal year DSH allotment and Medicaid State plan rate year of the original DSH expenditure claimed by the State.*
  - *States must report any overpayment redistribution amounts on the Form CMS-64 within two years from the date of discovery that a hospital-specific limit has been exceeded in accordance with a redistribution methodology in the approved Medicaid State plan. The State must report redistribution of DSH overpayments on the Form CMS-64 as separately identifiable decreasing adjustments reflecting the return of the overpayment and*

increasing adjustments representing the redistribution by the State. Both adjustments should correspond to the fiscal year DSH allotment and Medicaid State plan rate year of the related original DSH expenditure claimed by the State.

Existing provisions: The current definition of an independent certified audit does not include a requirement for determining the financial impact of audit findings for each hospital.

Proposed provisions: The definition of Independent Certified Audit is revised by adding a requirement that the audit findings include a determination of whether the state made DSH payments that exceed any hospitals DSH limit and requires reporting of the financial impact of audit findings on a hospital-specific basis.

Existing provisions: CMS publishes DSH allotments via the Federal Register on an annual basis.

Proposed provisions: CMS proposes to make allotment and national expenditure targets available by posting the information on Medicaid.gov and in Medicaid Budget and Expenditure System (MBES) or its successor website or system in lieu of publishing in the Federal Register.

3. Medicaid Program Financing

Current Medicaid financing provisions stipulate that states are required to share in the cost of medical assistance expenditures but are permitted to utilize other units of state or local government to contribute to the financing of the non-federal share of medical assistance expenditures. In the proposed rule, CMS acknowledges the relationship between states and local units of government in financing the Medicaid program through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). However, the proposed rule identifies a concern about the potential for states to establish payment methodologies on the basis of whether a unit of state or local government can provide the non-federal share to support Medicaid supplemental payments.

CMS explains that the proposed rule seeks to address these concerns through a number of strategies, including proposed improvements to reporting that would enable monitoring of changes in non-federal share funding after a SPA is approved. CMS proposes to clarify conditions for hold harmless arrangements by expressly prohibiting certain supplemental payment programs. CMS indicates that proposed new policies, as well as the proposed codification of existing policies will provide better information and guidance to identify existing and emerging financing issues, provide more clarity on allowable financing arrangements, promote accountability, and strengthen the fiscal integrity of the Medicaid program.

For supplemental payments approved three or more years prior to the effective date of the final rule, the proposed rule would expire the state plan authority 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, the proposed rule will expire the state plan authority three years following the effective date of the final rule. States would be required to request a new CMS approval to continue a supplemental payment beyond the maximum three year approved period.

Submission of a state plan or state plan amendment for a supplemental payment would be required to include:

- *§ 447.252(d) and § 447.302(c)*
  - *An explanation of how the state plan or SPA will result in payments that are consistent with efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment;*
  - *The criteria to determine which providers are eligible to receive the supplemental payment;*

- *A comprehensive description of the methodology used to calculate and distribute the supplemental payment to each eligible provider;*
- *The duration of the supplemental payment authority (not to exceed three years);*
- *A monitoring plan to enable evaluation that provides assurances that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and*
- *For a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period.*

States must provide a comprehensive description of the methodology used to calculate and distribute the supplemental payment, including all of the following:

- *§ 447.252*
  - *The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment;*
  - *If applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment;*
  - *The timing of the supplemental payment to each eligible provider;*
  - *Assurances that the total Medicaid payment to a provider will not exceed the applicable upper payment limits.*

In the proposed rule, CMS indicates they are re-affirming the requirement that intergovernmental transfers (IGTs) must be derived from state or local tax revenues, replacing references to "public funds" with "state or local funds" as qualifying for use as the non-federal share of supplemental payments. Act. The proposed rule would limit permissible state or local funds that may be considered as the state share to the following sources:

- *§ 433.51(b)*
  - *State general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency.*

- *Intergovernmental transfer of funds from units of government within a state (including Indian tribes), derived from state or local taxes (or funds appropriated to state university teaching hospitals), to the State Medicaid Agency and under its administrative control.*
- *Certified public expenditures, which are certified by a unit of government within a state as representing expenditures eligible for FFP and meet all other requirements.*

The proposed rule requires that intergovernmental transfers used as the non-federal share of Medicaid expenditures must be derived from state or local taxes (or funds appropriated to state university teaching hospitals) transferred from or certified by units of government.

Certified public expenditures would be specifically defined in regulation, as a result of the proposed rule, as an allowable source of state share in a manner consistent federal financial participation. The rule also describes the protocols states may use to identify allowable Medicaid expenditures associated with the use of a CPE as the source of the non-federal share of the total computable payment.

CMS proposes to require that, for a state to use a CPE as a source of state share, the state must meet the requirements with respect to payments funded by the CPE.

- *§ 447.206*
  - *Such payments, to a provider that is a unit of government, would be limited to the state or non-state government provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods, or as applicable, Medicare cost principles.*
  - *CMS will codify their practice of relying upon the cost allocation principles in federal regulations, and, as applicable, Medicare cost principles as the methods and principles to identify Medicaid program expenditures eligible to support a CPE.*
  - *States must establish and implement documentation and audit protocols, which must include an annual cost report to be submitted by the state government provider or non-state government provider to the state agency that documents the provider's costs incurred in furnishing services to Medicaid beneficiaries during the provider's fiscal year.*
  - *Only the certified amount of the expenditure may be claimed for FFP. The claimed amount is limited because the CPE must only represent amounts that were spent providing the Medicaid services, which authorize federal matching funds for state Medicaid expenditures and allows funds certified by units of government within a state as the non-federal share of expenditures, respectively.*
  - *The certifying entity of the CPE must receive and retain the full FFP associated with the Medicaid payment.*

- *CMS explains the requirement that certifying entities receive and retain the FFP a state claims from CMS is to prevent inappropriate recycling of federal funds and any other potential redirection of federal funds that would be prohibited under the statute.*
- *States would be required to implement processes by which all claims for medical assistance would be processed through the MMIS in a manner that identifies the specific Medicaid services provided to specific enrollees.*
- *States are required to utilize most recently filed cost reports to develop interim payments rates, which may be trended by an applicable health care-related index.*
- *Final settlement will be performed annually by reconciling any interim payments to the finalized cost report for the state plan rate year in which any interim payment rates were made. Final settlement would be required to be made no more than 24 months from the relevant cost report year end, except under certain circumstances.*
- *If CPEs are used as a source of non-federal share under the state plan, the state plan would be required to specify cost protocols in the service payment methodology applicable to the certifying provider, such protocols would be required to meet all of the following criteria:*
    - *§ 447.206(d)*
    - *Identify allowable cost using either a Medicare cost report, or a state-developed Medicaid cost report prepared in accordance with Medicare cost principles;*
    - *Define an interim rate methodology that would be used to pay a provider on an interim basis;*
    - *Describe an attestation process by which the certifying entity would attest that the costs are accurate and consistent with requirements;*
    - *Include, as necessary, a list of the covered Medicaid services being furnished by each provider certifying a CPE; and*
    - *Define a reconciliation and settlement process consistent with requirements.*

The rule specifies that State 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.

The proposed rule requires that providers must receive and retain 100 percent of the payment. The rule specifies 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).

- *§ 447.207*
  - *CMS explains that the proposed rule implements provisions of the Social Security Act that require, among other things, that the state plan for medical assistance provide such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and generally provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise, unless certain enumerated exceptions apply.*
  - *CMS will 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 non-federal share of the payment has been satisfied.*
  - *The term "state's net expenditure" means a state's Medicaid expenditure, less any returned funds or contributions from the provider to the state, related to the Medicaid payment. This view of a return of any portion of a Medicaid payment is consistent with the treatment of provider-related donations in which CMS will deduct the amount of an impermissible provider-related donation from a state's medical assistance expenditures before calculating FFP.*
  - *Consideration for the state's net expenditure would include a review of potential "hold harmless" arrangements, which provides that an impermissible hold harmless practice exists if the Medicaid payment is positively correlated to a donation, varies based only on the amount of a donation (including if payment is conditioned upon the receipt of a donation), or directly or indirectly guarantees to return any portion of a donation to the donating provider (or other party responsible for the donation).*
  - *CMS anticipate that "associated transactions" may include the payment of an administrative fee to the state as a fee for processing provider payments or IGTs. They indicate that in no event could administrative fees be calculated based on the amount a provider receives through Medicaid payments or amounts a unit of government contributes through an IGT as funds for the state share of Medicaid payments. CMS explains that structuring an administrative fee in this way would be tantamount to a Medicaid-only provider tax, which is not allowable. Conversely, if a state charged a flat fee for claims processing that did not vary based on the volume of claims or amount of*

Medicaid payments processed, the payment of such a fee would not be considered an associated transaction.

The proposed rule requires 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 … manner and format specified by the Secretary, each state would be required to submit a demonstration of compliance with the applicable UPL for each of the following services for which the state makes payment: inpatient hospital; outpatient hospital; nursing facility; ICF/IID; and institution for mental diseases (IMD). CMS is proposing to no longer require states to submit UPL demonstrations for psychiatric residential treatment facility (PRTF) and clinic services.

In preparing UPLs, the proposed rule requires states to use the data sources and adhere to the data standards, and acceptable UPL methodologies specified by CMS. CMS explains this provision is necessary "to ensure uniform reporting of UPL data and a full picture of Medicaid payments within each provider category for each category of services subject to a UPL in a given year."

The proposed rule includes specific reporting requirements to identify the individual providers receiving payments, the authority for the payments, and the sum of all payments received by the individual providers. At the time the state submits its quarterly CMS-64, the state would be required to report certain information for each supplemental payment included on the CMS-64. The proposed reporting elements would not be reported on the CMS-64 itself, but would accompany that submission on a separate, supplemental report. These data submission requirements would include provider-level data on base and supplemental payments made under state plan and demonstration authority by service type.

- *§ 447.288*
  - *For each supplemental payment reported on the CMS-64, states would be required to report the SPA transaction number or demonstration authority number which authorizes the supplemental payment; a listing of each provider that received a supplemental payment under state plan and/or demonstration authority, and, for each provider:*
    - *The provider's legal name;*
    - *The primary physical address of the location or facility where services are provided, including street address, city, state, and ZIP code;*
    - *The National Provider Identifier (NPI);*
    - *The Medicaid identification number;*
    - *The employer identification number (EIN);*
    - *The service type for which the reported payment was made;*

- *The provider specialty type;*
- *The provider category (that is, state government provider, non-state government provider, or private provider);*
- *The specific amount of the supplemental payment paid to each provider, including the total supplemental payment made to the provider authorized under the specified state plan or demonstration authority.*

- *On an annual basis, the proposed rule requires states to also report not later than 60 days after the end of the state fiscal year, aggregate expenditure data for all data elements included in above plus the following:*
  - *The state reporting period;*
  - *The specific amount of Medicaid payments made to each provider*
    - *The total FFS base payments made to the provider under the state plan*
    - *The total Medicaid payments made to the provider under demonstration authority*
    - *The total amount received from Medicaid beneficiary cost-sharing requirements, donations, and any other funds received from third parties to support the provision of Medicaid services*
    - *The total supplemental payment made to the provider authorized under the specified state plan,*
    - *The total Medicaid supplemental payment made to the provider under the specified demonstration authority*
    - *The aggregate total of Medicaid payments made to the provider*
- *The proposed rule also requires annual reporting, not later than 60 days after the end of the state fiscal year, of aggregate and provider-level information on each provider contributing to the state or any unit of local government any funds that are used as a source of non-federal share for any Medicaid supplemental payment. This proposed data submission requirement would include all of the data elements listed above, but would also require information related to financial contributions to the state Medicaid program, specifically including the following:*
  - *The total of each health care-related tax collected from the provider by any state authority or unit of local government;*
  - *The total of any costs certified as a CPE by the provider;*

- *The total amount contributed by the provider to the state or a unit of local government in the form of an IGT;*
- *The total of provider-related donations made by the provider or entity related to a health care provider, including in-cash and in-kind donations, to the state or a unit of local government, including state university teaching hospitals;*
- *The total funds contributed by the provider (health care-related taxes, CPEs, IGTs, provider-related donations, and any other funds contributed to the state as the non-federal share of a Medicaid payment).*

For a number of years, states have been making supplemental payments that are targeted to certain practitioners, such as physicians and other licensed professionals, under the Medicaid state plan. Most commonly, states have targeted supplemental payments to practitioners affiliated with and furnishing services in academic medical centers and safety net hospitals. These payments have used what is commonly described as an average commercial rate (ACR) calculation. Predominantly, such ACR payments are funded by IGTs from local government sources or state university teaching hospitals. Under this proposed rule, CMS will end the use of ACR supplemental payments based on their concerns that the payments are not economic and efficient, and that they present a clear oversight risk because they are based on proprietary commercial payment data and thus not verifiable or auditable.

- *§ 447.406*
  - *In proposing these requirements, CMS explains they will establish an appropriate and auditable upper bound to better ensure that practitioner payments are consistent with economy and efficiency by ensuring the supplemental payments have a reasonable relationship to the base rate methodologies that have been approved by CMS.*
  - *The proposed rule defines Medicaid practitioner supplemental payments as an amount that may not exceed the following:*
    - *50 percent 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 HRSA-designated geographic health professional shortage areas (HPSA) or Medicare-defined rural areas, 75 percent 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 indicates they recognize that states may need time to come into compliance with the proposed new limits. For states whose state plans currently provide for Medicaid practitioner supplemental payments, CMS will provide a transition period.*[1]
    - *For state plan provisions approved three or more years prior to the effective date of the final rule, the proposed rule would expire the state plan authority 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, the proposed rule will expire the state plan authority three years following the effective date of the final rule.*
- *By the end of the transition period, a state without an approved SPA bringing the Medicaid practitioner supplemental payment program into compliance with the requirements of this section would not be authorized to continue making the supplemental payments.*
- *States would no longer be required to submit annual ACR demonstrations for the annual UPL submission requirements outlined in the SMDL 13-003 for states that make targeted physician supplemental payments for physician services. Instead, CMS expects that the state plan would include a comprehensive written statement of the Medicaid FFS base payment and Medicaid practitioner supplemental payment methodologies.*

Timely reporting of information to CMS is a requirement of the proposed rule. If a state fails to timely, completely and accurately report information, CMS may reduce future grant awards through deferral by the amount of FFP they estimate is attributable to payments made to the provider or providers as to which the state has not reported properly, until such time as the state complies with the reporting requirements. CMS explains this reporting is necessary to ensure that states comply with applicable federal statutory and regulatory requirements and is necessary for the proper and efficient administration of the state Medicaid plan.

[1] There is some apparent misstatement in the proposed rule. After indicating a transition period will be used under §447.406(d) (see FR 63765), the proposed rule indicates "for Medicaid practitioner supplemental payments that were approved on or before the effective date of any final rule, the state would be required to submit and obtain CMS approval for a SPA to comply with the requirements of this section". The proposed rule further indicates that "Otherwise, the authority for state plan provisions that authorize the Medicaid practitioner supplemental payments that are approved as of the effective date of any final rule would be limited according to the timeframe described in § 447.302(d)." This section is described by CMS as "for state plan provisions approved 3 or more years prior to the effective date of the final rule, we propose that the state plan authority would expire 2 calendar years following the effective date of the final rule. For state plan provisions approved less than 3 years prior to the effective date of the final rule, we propose that the state plan authority would expire 3 years following the effective date of the final rule." § 447.406(d) is not included in § 447.406 (see FR page 63785).

4. Health Care-Related Taxes and Provider-Related Donations

Current Federal statutes permit states to impose a health care-related tax on a permissible class of health care items or services; that it be broad based, meaning that all non-federal, nonpublic providers and all items and services within a class of health care items or services would be taxed; and that it is uniform, meaning that the tax rate would be the same for all health care items or services in a class of providers for such items or services. Furthermore, the statute prohibits hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers. CMS has traditionally waived either the broad based and/or uniformity requirements as long as the state established that the net impact of the tax and associated expenditures was generally redistributive in nature, and the amount of the tax was not directly correlated to Medicaid payments for items and services.

Hold Harmless is currently is defined as the State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. The proposed rule revises the definition as follows:

- *§ 433.68(f)(3)*
  - *A direct guarantee will 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 taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount. The net effect of such an arrangement may result in the return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.*

Current regulation also identifies practices that would constitute a hold harmless arrangement. The "Medicaid Program; Health Care-Related Taxes" (73 FR 9685) published on February 22, 2008 (February 2008 final rule) clarified the direct guarantee test by specifying that a direct guarantee to hold the taxpayer harmless for the cost of the tax through a direct or indirect payment will be found when, "a payment is made available to a taxpayer or party related to a taxpayer" so that a reasonable expectation exists that the taxpayer will be held harmless for all or part of the cost of the tax as a result of the payment. As a result, whenever there existed a "reasonable expectation" that the taxpayer would be held harmless for the cost of the tax, a hold harmless situation would exist and the tax would be impermissible.

CMS proposes to amend regulations to clarify their standard to determine whether a state or other unit of government receiving a donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees the return of any portion of the donation to the provider or other party or parties responsible for the donation, i.e., non-bona fide donation. Specifically, CMS is proposing that a direct guarantee of the return of all or part of a donation would be found to exist where the net effect of an arrangement 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.

- *§ 433.54(c)(3)*
  - *The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other party or parties responsible for the donation). Such a guarantee will 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 a related entity will receive a return of all or a portion of the donation. The net effect of such an arrangement may result in the return of all or a portion of the donation, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.*

For purposes of determining the federal matching funds to be paid to a state, the total amount of the state's Medicaid expenditures must be reduced by the amount of revenue the state collects from impermissible … non-bona fide provider-related donations. Current Federal statutes define a provider-related donation as any donation or other voluntary payment made directly or indirectly to a state or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the state plan. The definition of provider-related donation would be revised under the proposed rule as follows:

- *§ 433.52*
  - *Any transfer of value where a health care provider or provider-related entity assumes an obligation previously held by a governmental entity and the governmental entity does not compensate the private entity at fair market value will be considered a donation made indirectly to the governmental entity. Such an assumption of obligation need not rise to the level of a legally enforceable obligation to be considered a donation, but will be considered by examining the totality of the circumstances and judging the arrangement's net effect.*

The proposed rule defines net effect as follows:

- *§ 433.52*
    - *The overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in cash or in kind, among participating entities. The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities, and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity.*

CMS established the statistical tests used to evaluate requests for waivers of the broad-based and uniformity requirements. In this proposed rule, CMS indicates that subsequent experience has proven that the two mathematical tests do not ensure, in all cases, that proposed taxes that pass the applicable tests are generally redistributive. They indicate that conditions may exist where taxes can pass the statistical test(s) despite an imposition of undue burden on the Medicaid program. The proposed rule would give CMS the authority to determine that the tax is not generally redistributive, despite the fact that it could pass the applicable statistical tests under current regulations, because it places an undue burden on the Medicaid program. CMS provides that the tax may not be structured in a way that places a greater tax burden on taxpayer groups that have a greater level of Medicaid activity than those that have less or no Medicaid activity.

- *In the proposed rule, CMS would consider tax structures not to be generally redistributive when taxpayers are grouped together in a manner that isolates taxpayers with relatively higher or lower levels of Medicaid activity and when taxpayers with relatively higher Medicaid activity are taxed relatively more heavily.*
- *CMS will consider the totality of the circumstances when deciding whether the tax program involves taxpayer groupings that have an effect similar to the sorting of taxpayers by relatively higher or lower levels of Medicaid activity.*
- *The proposed rule would retain the two statistical tests for determining whether or not the proposed tax waiver would be generally redistributive as required by statute. However, in determining whether or not a tax program is generally redistributive, CMS would also examine the totality of the circumstances to determine whether the tax imposes an undue burden on the Medicaid program.*
- *A tax is considered to impose undue burden if taxpayers are divided into taxpayer groups and any one or more of the following conditions apply:*
    - *§ 433.68(e)*

- *The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity.*
- *Within each taxpayer group, the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (except as a result of excluding from taxation Medicare or Medicaid revenue or payments.*
- *The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group, unless all entities in the taxpayer group with no Medicaid activity meet at least one of the following:*
  - *Furnish no services within the class in the State*
  - *Do not charge any payer for services within the class*
  - *Are Federal provider of services*
  - *Are a unit of government*
- *The tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group.*

CMS indicates they are clarifying existing policy that targeting a specific type of health care-related item or service and incorporating it into a larger tax would be considered health care-related, even if 85 percent of the revenue from the tax did not come from health care-related items or services.

While statute and regulation specify that differential treatment results in a tax being considered health care-related, existing law and regulations do not explicitly describe what constitutes differential treatment. Therefore, the proposed rule attempts to clarify what constitutes differential treatment when taxes are health care-related and when they are not. CMS proposes that differential treatment occurs when a tax program treats some individuals or entities that are providing or paying for health care items or services differently than:

- *§ 433.55*
  - *Individuals or entities that are providers or payers of any health care items or services that are not subject to the tax. Tax programs in which some individuals or entities providing or paying for health care items or services are selectively incorporated, but others are excluded; or*

- *Other individuals or entities that are subject to the tax. Differential treatment of individuals or entities providing or paying for health care items or services included in the tax, and other entities also included in the tax.*

- *Items or services within the tax will be considered to be reasonably related if there exists a logical or thematic connection between the items or services or individuals or entities being taxed. When determining whether or not individuals, entities, items, or services are reasonably related, CMS will examine the parameters of the given 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.*

- *Selective incorporation generally occurs when the state or unit of government includes some, but not all, health care related items or services and those items or services are not reasonably related to the other items being taxed and when the state or other unit of government structures the parameters of the tax in such a way that has the effect of such selective incorporation.*

The proposed rule adds a period of validity for tax waivers of the broad-based and/or uniformity requirements, which states that waivers will cease to be effective three years from CMS' approval in the case of tax programs commencing on or after the rule's effective date or three years from the rule's effective date in the case of waivers approved before the rule's effective date.

Contact Us

If you'd like more information, or to further discuss these regulations and how they might impact your program, please reach out to your Myers and Stauffer contact or a member of our leadership team.

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