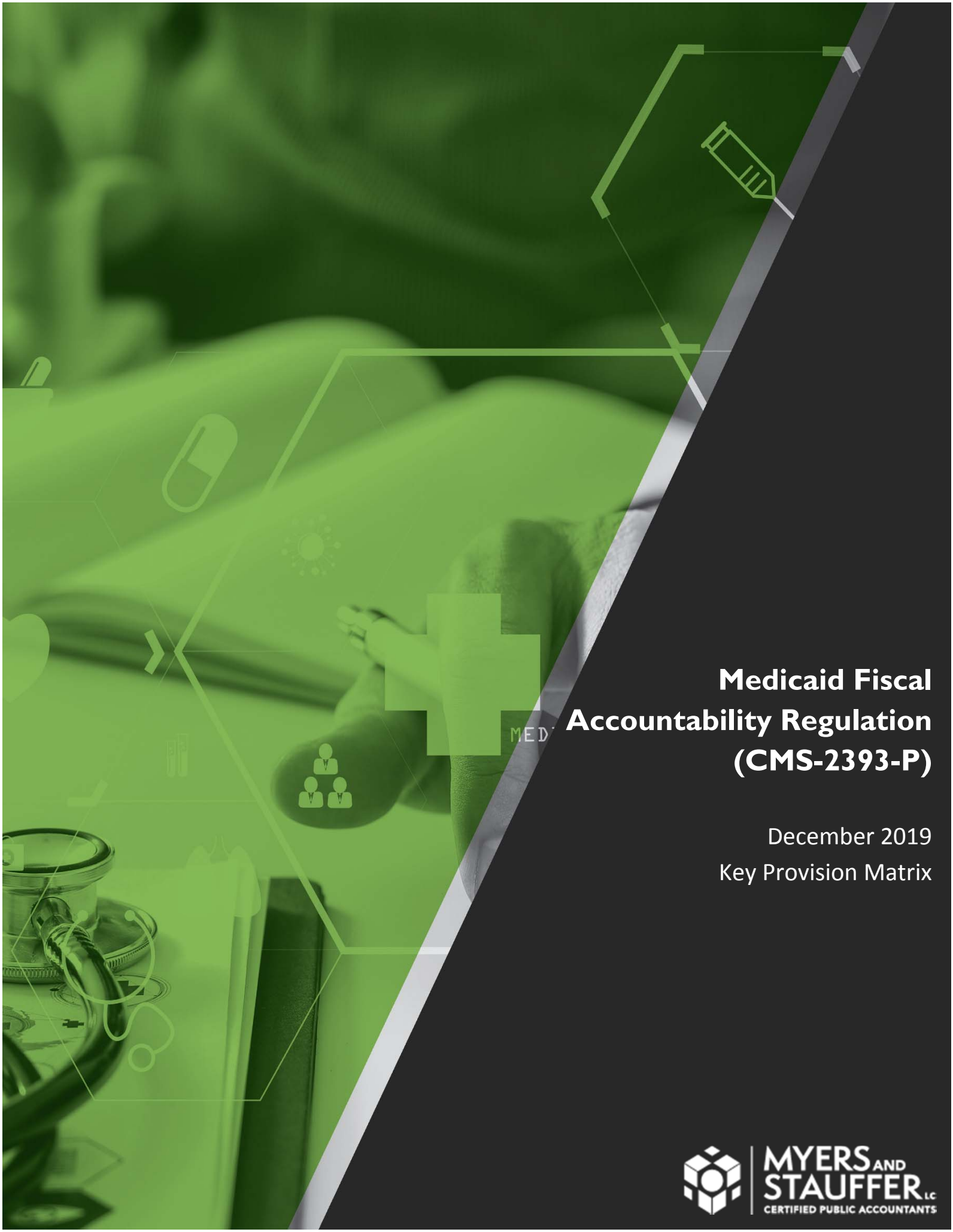

Medicaid Fiscal Accountability Regulation (CMS-2393-P)

December 2019

Key Provision Matrix

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Medicaid Fiscal Accountability Regulation

Medicaid Financial Accountability Regulation Key Provision Matrix	
Provision	**Impact**
42 CFR § 433.51 State Share of financial participation	
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.	Would allow only funds derived from state or local taxes (or funds appropriated to state university teaching hospitals) to be transferred to the state from a unit of government and used as the state share. This is a significant shift in current policy and practice.
42 CFR §447.206 Payments funded by certified public expenditures made to providers that are units of government	
Defines certified public expenditures (CPEs) in regulation and imposes new limitations on a State's use of CPEs including protocols states are to use to identify allowable Medicaid expenditures associated with the use of a CPE as the source of non-federal share. [*Please see "Definitions Applicable to UPL Demonstrations and Supplemental Payments" below.*]	1. Certifying entity must receive and retain the full Federal financial participation associated with the payment. This is a shift from current policy and practice. 2. Payments are limited to reimbursement not in excess of the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries.
42 CFR §433.68(e) Permissible health care-related taxes – Waivers of broad-based and uniformity requirements	
Implements new "undue burden" test for approval of non-uniform and non-broad-based taxes. Demonstrating that a non-uniform or non-broad-based tax is generally redistributive is no longer accomplished solely through mathematical test (B1/B2 or P1/P2). A tax will be considered to impose an undue burden and fail the generally redistributive provisions if providers 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.	If a "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" could be considered by CMS as imposing an "undue burden" and deny a waiver.

Medicaid Financial Accountability Regulation Key Provision Matrix	
Provision	**Impact**
42 CFR §433.68(f) Permissible health care-related taxes – Hold harmless requirements	
Modifies the hold harmless provisions at 42 C.F.R. 433.68(f)(3) to implement a "net effect" standard to determine whether a direct guarantee exists to hold taxpayers harmless. 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. According to CMS, "[t]he fact that a private entity makes the redistribution payment does not change the essential nature of the payment, which constitutes an indirect payment from the state or unit of government to the entity being taxed that holds it harmless for the cost of the tax."	CMS will consider a provider tax to violate hold harmless requirements if there exists arrangements privately or voluntarily between providers where the net beneficiaries of the tax program assist net contributors. This is a departure from previous interpretation and application of federal regulations.
42 CFR §433.72 Waiver Provisions Applicable to Health Care-related Taxes	
Limits provider tax waiver approvals to three year periods. CMS states this is because the data used for the statistical tests changes, and a tax that was generally redistributive when approved may cease to meet that test over time.	Historically, provider tax waivers were approved indefinitely as long as the structure of the tax was unchanged. Provider tax waivers will expire unless the state requests and receives approval for a new waiver every 3 years. This opens up tax programs for routine CMS review and scrutiny.

Medicaid Financial Accountability Regulation Key Provision Matrix	
Provision	**Impact**
42 CFR §447.286 Definitions	
Establishes new regulatory definitions for Medicaid "base" and "supplemental" payments, which are not currently defined. The proposed rule also 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.	1. Defines base and supplemental payments for the first time. 2. Applies stricter definitions on who is eligible to participate in non-federal share of Medicaid such as IGTs and CPEs. 3. Entity's access to and administrative control over state-appropriated funds from the legislature or local tax revenue determines the ability of the provider to supply the non-federal share funds. 4. Proposed definitions would be used to identify the category of provider for purposes of calculating the upper payment limit.
42 CFR §447.252 and §447.302 State Plan Requirements – Medicaid Supplemental Payments	
Limits supplemental payment approval to 3 year periods. To renew a supplemental payment, states must submit a SPA that explains how the supplemental payment is consistent with statutory provisions relative to efficiency, economy, quality of care, includes monitoring and evaluation plans to ensure compliance with the statute, and is accompanied by significant levels of data reporting to CMS relating to qualification criteria, calculation and distribution methodologies, and a UPL demonstration.	1. Historically, supplemental payments were approved indefinitely as long as the methodology was unchanged. Under the proposed rule, supplemental payments will expire unless the state requests and receives approval every 3 years. This opens up supplemental payment programs for routine CMS review and scrutiny. 2. Requesting and receiving approval of supplemental payment programs entails significantly increased administrative burden, including data reporting and implementation of a monitoring plan. 3. States will be required to demonstrate that their supplemental payment programs align with program "efficiency, economy, and quality of care." (Sec. 1902 (a)(30)(A)

Medicaid Financial Accountability Regulation Key Provision Matrix	
Provision	**Impact**
42 CFR §447.272, §447.288, §447.321 Application of Upper Payment Limits	
Establishes in regulation detailed specifications relating to data sources, data time periods, and calculation methodologies for demonstrating compliance with UPL requirements. Eliminates the psychiatric residential treatment facility (PRTF) and clinic UPL requirements.	These changes codify in regulation the approaches and methodologies already deployed by many states, such as cost-based and payment-based methods. However, the proposed rule does not appear to accommodate other reasonable methodologies some states have used that may not conform to the prescribed methodologies but yet generate a reasonable estimate of Medicare payment. This removes state flexibility in meeting the UPL requirements.
42 CFR §447.288 Reporting Requirements for Supplemental Payments	
Requires quarterly and annual reporting to CMS relating to supplemental payments. For each quarterly CMS 64 report on which supplemental payments are reported, States must submit a supplemental schedule that contains provider-level supplemental payment information. On an annual basis, states must submit provider-level information relating to base payments, supplemental payments, and any funds contributed by providers that serve as the non-federal share of a Medicaid supplemental payment.	Imposes substantial additional reporting requirements that has not previously been required.
42 CFR §447.406 Medicaid Practitioner Supplemental Payments	
Prohibits the use of average commercial rate (ACR) data for practitioner supplemental payments. Practitioner supplemental payments would be limited to (1) 50% of the Medicaid FFS base payments; or (2) 75% of the Medicaid FFS base payments for services provided in Health Resources and Services Administration-designated geographic health professional shortage areas (HPSA) or Medicare-defined rural areas.	1. Practitioner supplemental payments will decrease, potentially substantially, given the difference between ACR and 50% or 75% of Medicaid base payments. 2. Non-practitioner supplemental payments utilizing ACR as the upper limit may also be at risk.

Medicaid Financial Accountability Regulation Key Provision Matrix	
Provision	**Impact**
42 CFR §447.201 State Plan Requirements – Medicaid Payment Variation	
The Medicaid state plan may not contain any variation in reimbursement based on a member's Medicaid eligibility category, enrollment under a waiver or demonstration project, or Federal Medical Assistance Percentage (FMAP) rate. The purpose of this provision is to prevent higher reimbursement rates on the basis of higher FMAP rates as in CMS' view this is inconsistent with the principles of efficiency and economy. This is applicable to FFS and managed care.	This rule provision could create issues between the Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) program benefit and Medicaid fee-for-service, where EPSDT rates for the same services may be higher to assure that children receive early detection and care to avert or diagnose and treat as early as possible. Additionally, in some cases managed care plans may reimburse at higher rates in order to enlist participation of a sufficient number of providers. This provision would eliminate that potential for eligibility categories common between fee-for-service and managed care delivery systems. The rule provision could also limit the potential use of alternative payment models or other health care transformation initiatives.
42 CFR §447.299 Disproportionate Share Hospital Payments	
DSH audits must include the total annual amount associated with each audit finding, or the financial impact of audit findings. States and their auditors must quantify the financial impact of any finding, including those resulting from incomplete or missing data.	States and their DSH auditors would be required to quantify all findings, including estimating the financial impact of a finding that was based on lack of data. It is unclear how states and their auditors are expected to quantify an unknown.

Medicaid Financial Accountability Regulation Key Provision Matrix	
Provision	**Impact**
42 CFR §447.286 Definitions Applicable to UPL Demonstrations and Supplemental Payments	
Establishes the following definitions of state government, non-state government, and private provider: • *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 states the new definitions will be used to ensure states and providers do not "manipulate the characterization of providers' ownership to achieve problematic Medicaid financing arrangements." CMS cites supplemental payment programs where providers have been re-designated as governmental in order to supply the IGT for a supplemental payment.