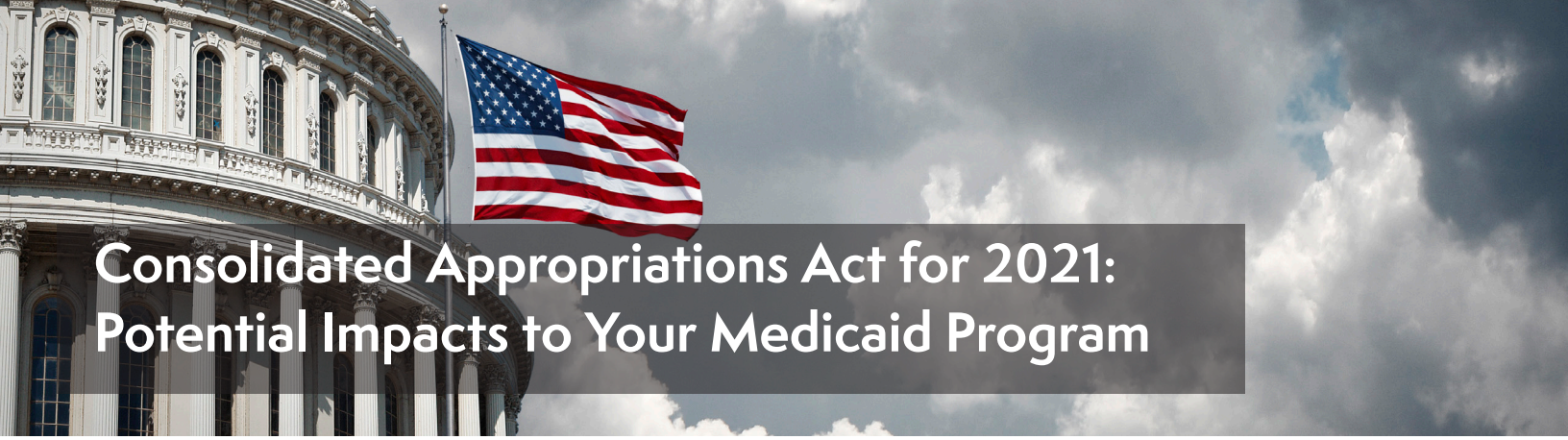

Consolidated Appropriations Act for 2021: Potential Impacts to Your Medicaid Program

On December 27, 2020, President Trump signed the Consolidated Appropriations Act for 2021 into law after it was passed by Congress. In addition to funding the federal government for 2021 and providing $900 billion in COVID-19 relief funds, the legislation includes a number of important provisions impacting states in the areas of Medicaid coverage, reimbursement, and program integrity. Myers and Stauffer is providing this client alert to ensure states are aware of several notable and impactful provisions. For the full legislation, see https://www.congress.gov/bill/116th-congress/house-bill/133.

In summary, the legislation takes the following actions that are discussed in more detail in this alert:

- Delays the Medicaid disproportionate share hospital (DSH) allotment reductions to federal fiscal year (FFY) 2024.
- Imposes new reporting requirements on states related to non-DSH supplemental payments.
- Changes the calculation of a hospital's DSH limit to remove the cost and payments of individuals with Medicare or third-party coverage.
- Allows some hospitals an exception to include dually-enrolled individuals in DSH.
- Clarifies the authority of Medicaid Fraud Control Units (MFCUs) to investigate and prosecute cases of Medicaid patient abuse and neglect in any setting.
- Codifies in legislation the requirement that states cover non-emergency transportation services and requires that states implement certain program integrity measures.
- Establishes a grant program to create and improve state all-payer claims databases.

More information regarding the covered topics are provided below.

DIVISION BB — PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS

Sec. 115. State All-Payer Claims Databases.

- The act creates a one-time grant opportunity for states to either: establish an all-payer claims database if one does not already exist in the state; or, update an existing all-payer claims database if one already exists.
- Grants under this section are $2.5 million over three years: $1 million in year one of the grant; $1 million in year two of the grant; and, $500,000 in year three of the grant.
- Grant funds are available beginning October 2021 (FFY 2022).
- A number of restrictions and requirements accompany the grant, including various confidentiality requirements, prohibitions on attempts to re-identify and disclose individually-identifiable health or financial information, and requirements to provide free non-customized reports.
- The Department of Health and Human Services is required within a year to develop a standardized reporting format for voluntary group health plan reporting of claims, eligibility, and provider data.

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DIVISION CC — HEALTH EXTENDERS TITLE II — MEDICARE EXTENDERS AND OTHER POLICIES

Sec. 201. Eliminating DSH Reductions for Fiscal Years 2021 through 2023.

- The previously-slated Medicaid DSH allotment reductions have been delayed several times in the past. This section extends the annual $8 billion reduction to begin in FFY 2024 and will last through FFY 2027.

Sec. 202. Supplemental Payment Reporting Requirements.

- Beginning October 1, 2021, states are required to report specific information regarding non-DSH supplemental payments as a requirement for any Medicaid state plan provisions permitting these payments. A supplemental payment is defined as a "payment to a provider that is in addition to any base payment made to the provider under the state plan." Examples of non-DSH supplemental payments are upper payment limit (UPL) payments to hospitals, nursing facilities, physicians or other providers in addition to the Medicaid claim payment.
- The new reporting by states to CMS must include the following items:
    - The criteria used to determine provider eligibility for the supplemental payment.
    - A comprehensive description of the methodology used to calculate the amount and distribution of the supplemental payment to each provider.
        - This must include specific criteria (Medicaid service, utilization, or cost data) used as the basis for the calculation amount or distribution methodology and the timing of the supplemental payments to each provider.
    - An explanation of how the state is ensuring such payments adhere to the existing statutory standards of efficiency, economy, quality of care, and access.
    - An explanation of the purpose and intended effects of the supplemental payment.
    - An assurance that total Medicaid payments for inpatient hospital services, including supplemental payments, will not exceed upper payment limits.[1]
    - An upper payment limit demonstration, if not already provided.
- It is important to note that the Medicaid Fiscal Accountability Regulation (MFAR), which was withdrawn by CMS in September 2020, included similar non-DSH supplemental payment reporting requirements.
- The legislation requires CMS to make the information available publicly on the CMS website.

Sec. 203. Medicaid Shortfall and Third Party Payments.

Third Party Payments

- Beginning with the adoption of the 2008 DSH audit rule, the cost of services related to dually-enrolled (Medicare and Medicaid or private insurance and Medicaid) individuals has been included in the DSH calculation of uncompensated care costs. However, the inclusion of the associated Medicare and other third party payments as a reduction to dually eligible costs has been the center of numerous court cases nationwide. The treatment of these payments has undergone several iterations over the years ranging from offsetting all the payments, to offsetting none of the payments, to only offsetting payments on or after June 2, 2017. This act now only allows the inclusion of costs and payments for services for which the Medicaid state plan or waiver is the primary payor for such services. Therefore, the act entirely excludes both the costs and payments for services related to dually-enrolled individuals from

[1] *The legislation does not specify the upper payment limit intended by this provision. However, the withdrawn MFAR rule would have required an assurance that total Medicaid payments will not exceed "the upper payment limits specified in § 447.325". 42 C.F.R. § 447.325 refers to the limitation on reimbursement for inpatient and outpatient facility services to the customary charges of the provider and no more than the prevailing charges in the locality for comparable services under comparable circumstances.*

uncompensated care costs.

- This revised treatment of dually-enrolled individuals closely resembles the approach most states took prior to the release of the DSH audit rule in 2008 and the resulting DSH audits. Most states did not include any of the dually-enrolled individual costs or payments prior to the 2008 DSH audit rule. States that have revised their DSH payment methodologies related to dually-enrolled individuals in recent years will need to evaluate whether this change results in DSH payments being allocated to hospitals that do not meet the state's DSH policy objectives.

Application of Limits for Certain Hospitals

- Some hospitals may still qualify for an exception to continue to include the dually-enrolled individuals (costs and payments) in their uncompensated care costs as is done currently under the Medicaid DSH limit calculations (as of January 1, 2020), if it results in a higher DSH limit.
- To qualify for the exception the hospital must be in the 97th percentile of all hospitals in the number of Medicare supplemental security income (SSI) days or percentage of Medicare SSI days to total inpatient days in its most recent cost reporting period.
- Medicare SSI days are a statistic commonly used in the Medicare DSH payment calculations so hospitals are familiar with this statistic. However, it has not been commonly used in the Medicaid DSH calculations. Medicare SSI days are days where patients were entitled to benefits under Medicare Part A and SSI benefits (excluding any state supplementary benefits paid with respect to such patients).
- The addition of this exception could complicate DSH payment methodologies for states that wish to maximize payments to safety net hospitals during the DSH payment process. There also appears to be a need for additional guidance from CMS related to several issues including clarification of what is meant by most recent cost report period SSI ratio when making DSH payments and performing the DSH examination.
- These DSH amendments take effect on October 1, 2021, and apply to payments made during fiscal years beginning on or after such date. It is not clear at this time whether CMS intends to implement this based on federal fiscal year, state fiscal years, or hospital fiscal years. Further guidance will be needed from CMS related to the effective date and whether a pro-ration will need to be made at the time of the DSH audit.

Sec. 207. Clarifying Authority of State Medicaid Fraud and Abuse Control Units to Investigate and Prosecute Cases of Medicaid Patient Abuse and Neglect in any Setting.

- The Act amends state Medicaid fraud and abuse control requirements to include members/beneficiaries receiving medical assistance under the state plan in a non-institutional or other setting.
- Until this revision, state Medicaid fraud and abuse control units had jurisdiction to investigate matters of patient abuse and neglect in institutional settings, but not non-institutional/other settings. This amendment clarifies that these units have complete jurisdiction to investigate these matters across the Medicaid program.

Sec. 209. Medicaid Coverage of Certain Medical Transportation.

- The Act amends current state Medicaid plan requirements to ensure members/beneficiaries receiving medical assistance under the state plan must receive necessary non-emergency transportation to and from providers of medical services.
- This revision mandates non-emergency transportation services and further requires the Comptroller General of the United States to study and submit a report to Congress regarding Medicaid program coverage of non-emergency transportation services. The report includes:

1. An examination of state safeguards to prevent and detect fraud and abuse within the non-emergency transportation program.
2. An examination of transportation brokers to identify safeguards against fraud and abuse to prevent improper payments for non-emergency transportations.
3. Identification of numbers, types, and outcomes of instances of fraud and abuse in non-emergency medical transportation that state MFCUs have investigated.
4. Identification of trends in non-emergency transportation program integrity to inform CMS non-emergency transportation risk management strategies.

- CMS will convene stakeholder meetings to discuss and share best practices for improving Medicaid non-emergency transportation program integrity.

If you have questions regarding the 2021 Consolidated Appropriations Act, or its associated impact, please reach out to your Myers and Stauffer contact or one of the members of our leadership team.

Jared Duzan, CFE (Principal)
PH 317.815.2925
JDuzan@mslc.com

Ryan Farrell, CFE (Principal)
PH 512.342.0800
RFarrell@mslc.com

Timothy Guerrant, CPA (Member)
PH 317.815.2935
TGuerrant@mslc.com

Robert Hicks, CPA (Member)
PH 816.945.5321
BHicks@mslc.com

Michael Johnson, CPA, CFE (Member)
PH 404.524.0775
MJohnson@mslc.com

Tammy Martin, CPA (Member)
PH 208.378.1400
TammyM@mslc.com

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