MACPAC

Review of Proposed Rule on Supplemental Payments and Financing

Medicaid and CHIP Payment and Access Commission

Robert Nelb and Moira Forbes

Overview

- Background
- Provisions of the proposed rule
  - Payment policy
  - Financing policy
  - Oversight
- Potential areas for comments
  - Alignment with prior MACPAC recommendations
  - General comments about level of federal oversight and potential effects
  - Technical comments

Background: Medicaid Payments

- There are two broad categories of Medicaid payments to providers
  - Base payments
  - Supplemental payments
- In fee for service (FFS), aggregate base and supplemental payments for a class of providers cannot exceed the upper payment limit (UPL)
  - The UPL is based on a reasonable estimate of what Medicare would have paid for the same services
  - If base payments are below the UPL, states can make UPL supplemental payments to make up the difference

Background: Medicaid Financing

- States are permitted to finance the non-federal share of Medicaid payments using a variety of sources, including:
  - State general revenues
  - Intergovernmental transfers (IGTs) from local governments
  - Certified public expenditures (CPEs) by government-owned providers
  - Health care-related taxes

Proposed Rule

- On November 18, CMS issued a proposed rule to increase federal oversight of Medicaid FFS payments and financing policies
- The rule aims to address CMS concerns about arrangements that it views to be inconsistent with Medicaid payment principles
  - Growth in the use of supplemental payments that do not appear to have a clear link to value
  - Financing arrangements that return Medicaid payments to the providers that finance them

Proposed Payment Policies

Review of Supplemental Payments

- CMS proposes to limit approval of UPL payments to three years at a time and adds new review requirements
  - States must describe the Medicaid objectives that UPL payments are intended to address
  - In order to renew UPL payments, states must submit an evaluation of whether the payment met its objectives
- These changes aim to align the rules for UPL payments with the rules for managed care directed payments that CMS added in 2016

New Limit on Physician Supplemental Payments

- CMS proposes a new limit on supplemental payments to physicians and other practitioners
  - Currently, payments to these providers cannot exceed the average commercial rate
  - CMS proposes to limit supplemental payments to 50 percent of base payment rates (or 75 percent in rural or health professional shortage areas)
- CMS estimates that this provision could reduce payments by up to $222 million a year

UPL Calculation Policies

- CMS proposes to codify its existing guidance on ways to calculate the UPL
  - Payment-based method based on what Medicare would have paid
  - Cost-based method based on Medicare cost principles
- CMS proposes to explicitly define the classes of providers for UPL purposes
  - State government owned or operated
  - Non-state government owned or operated
  - Private

Proposed Financing Policies

Current Tax Rules

- Health care-related taxes are any tax on which 85 percent of the burden falls on health care providers or payers
- Health care-related taxes must be broad-based and uniformly applied
  - States can apply for waivers to target taxes to particular providers if they meet certain statistical tests
- States cannot directly guarantee providers are held harmless for the tax that they pay
  - Indirect guarantees are allowed as long as the tax rate is below 6 percent of net patient revenue

Proposed Tax Rules

- Definition of health care-related tax broadened to include insurers and taxes that impose higher rates on health care providers
- CMS proposes a new test to evaluate waivers of the broad-based and uniform standards
  - CMS will evaluate whether the tax places a higher burden on providers with high Medicaid activity
  - The rule also limits tax waiver approvals to three years
- CMS proposes to evaluate hold harmless provisions based on the net effect of any direct or indirect payments

Local Government Financing

- The rule proposes a similar net effect standard to evaluate whether donations from private providers hold IGT entities harmless
  - In-kind provision of services are classified as provider donations
  - This policy has been the subject of ongoing litigation
- The rule codifies CMS's policies for ensuring that CPE-financed payments do not exceed costs

Retention of Payments

- The rule proposes that providers be able to retain the full amount of payments for services
  - Intended to limit the ability of states to charge administrative fees for IGT and CPE transactions
  - Aims to limit associated transactions that return tax or IGT payments to providers, consistent with the proposed hold harmless provisions

Proposed Oversight Policies

Provider-Level Reporting

- The rule proposes that states report provider-level data on supplemental payments and provider contributions to the non-federal share
  - Limited to providers that receive UPL or Section 1115 waiver supplemental payments
  - Allows CMS to withhold federal funds for states that do not submit complete and accurate data
- CMS notes that these data are not available in existing data sources

Payment Data in Current and Proposed Reporting Systems

Type of payment	CMS-64	T-MSIS	DSH audit	Proposed rule
FFS base	Aggregate	Claims-level	Provider-level	Provider-level
DSH	Aggregate	Unclear	Provider-level	Provider-level
UPL	Aggregate	Unclear	Non-DSH supplemental payments in one sum at provider-level	Provider-level
GME	Aggregate	Unclear		Unclear
§1115 supplemental	Aggregate	Unclear		Provider-level
Managed care base	No	Claims-level	Managed care payments in one sum at provider-level	No
Managed care directed	No	Unclear		No

Notes: CMS-64 is a quarterly expenditure report that states submit to claim federal Medicaid matching funds. T-MSIS is the Transformed Medicaid Statistical Information System. DSH is disproportionate share hospital. FFS is fee-for-service. UPL is upper payment limit. GME is graduate medical education. Section 1115 supplemental payments include delivery system reform incentive payments (DSRIP) and uncompensated care pool payments. Managed care directed payments are additional payments to providers authorized under 42 CFR §438.6(c).

Financing Data in Current and Proposed Reporting Systems

Type of financing data	CMS-64	T-MSIS	DSH audit	Proposed rule
Source of non-federal share for payment	Incomplete	Unclear	No	No
Provider contribution towards the non-federal share	No	No	No	Provider-level

Notes: CMS-64 is a quarterly expenditure report that states submit to claim federal Medicaid matching funds. T-MSIS is the Transformed Medicaid Statistical Information System. DSH is disproportionate share hospital.

Recouping DSH Overpayments

- The proposed rule makes it easier for CMS to recoup DSH payments made in excess of hospital uncompensated care costs
  - Requires auditors to better quantify overpayments
  - Streamlines timeline for recoupment
- According to 2014 DSH audits, 419 hospitals received $2.6 billion in DSH overpayments
- Most states redistribute DSH overpayments to DSH hospitals that received payments below their uncompensated care costs

UPL Demonstration Requirements

- The proposed rule codifies CMS's existing guidance requiring states to demonstrate compliance with the UPL annually
- Two options to demonstrate compliance:
  - Prospective estimates of spending
  - Retrospective analysis of actual spending
- There is no process to reevaluate the UPL if actual spending is different from projected spending

Potential Areas for Comments

Alignment with Prior Recommendations

- The proposed rule takes steps to address MACPAC's prior recommendations
  - Provider-level data (March 2014 and February 2016)
  - UPL oversight (March 2019)
- Some aspects are not fully addressed
  - Proposed provider-level payment data will not include data on all payments for all providers
  - Actual UPL spending data will not be used to enforce UPL requirements
  - Payment and UPL data will not be made publicly available

Level of Federal Oversight

- It is unclear how CMS will apply some of the new standards that it proposes
  - Evaluation of whether supplemental payments advance statutory goals
  - Net effect standard for hold harmless provisions
- Additional administrative burden from this proposed rule contrasts with CMS's view about the burden of access monitoring requirements

Effects on Providers

- The rule will result in reductions to Medicaid provider payments
  - Up to $222 million a year reduction in physician supplemental payments
  - Additional reductions are likely because of new payment and financing rules
- To mitigate effects on providers, CMS could:
  - Wait to apply new rules until it collects more data
  - Delay implementation of new requirements
  - Re-affirm requirement for states to review access before reducing payments to providers

Technical Comments

- CMS requests technical comments on several topics that MACPAC has previously examined:
  - Definitions of supplemental payments
  - Potential alignment with existing data systems
  - Rationale for collecting provider-level data
  - Special types of physician supplemental payments
  - UPL calculation methods
  - DSH overpayment recoupment process
  - DSH allotment posting process

Next Steps

- Comments are due January 17
- If the Commission decides to comment, staff will prepare a letter reflecting the discussion at this meeting
- The changes and concepts in this proposed rule may suggest areas for future work

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