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Barriers to Improving Transparency of Medicaid Financing

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Overview

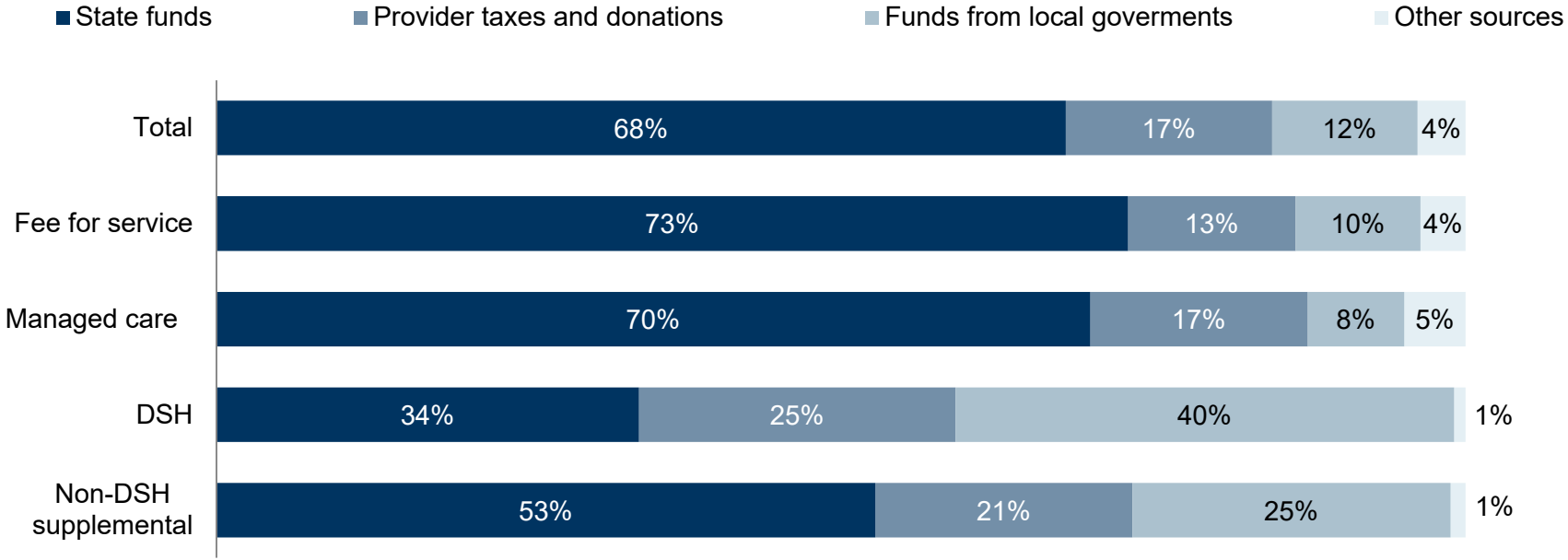
- Background
- Prior MACPAC analyses and recommendations
- Initial themes from expert interviews
  - Goals of improving transparency
  - Transparency of state financing methods
  - Reporting of state-level financing amounts
  - Collecting provider-level financing amounts
  - Using provider-level data to calculate net payments
- Next steps

Background

- The Medicaid statute permits states to finance the non-federal share of Medicaid spending from a variety of sources, including:
  - State general funds
  - Health care-related taxes (often referred to as provider taxes)
  - Intergovernmental transfers (IGTs)
  - Certified public expenditures (CPEs)
- Between state fiscal year (SFY) 2008 and SFY 2018:
  - State general funds declined from 75 to 68 percent of the non-federal share
  - Health care-related taxes increased from 7 to 17 percent of the non-federal share

MACPAC

Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2018



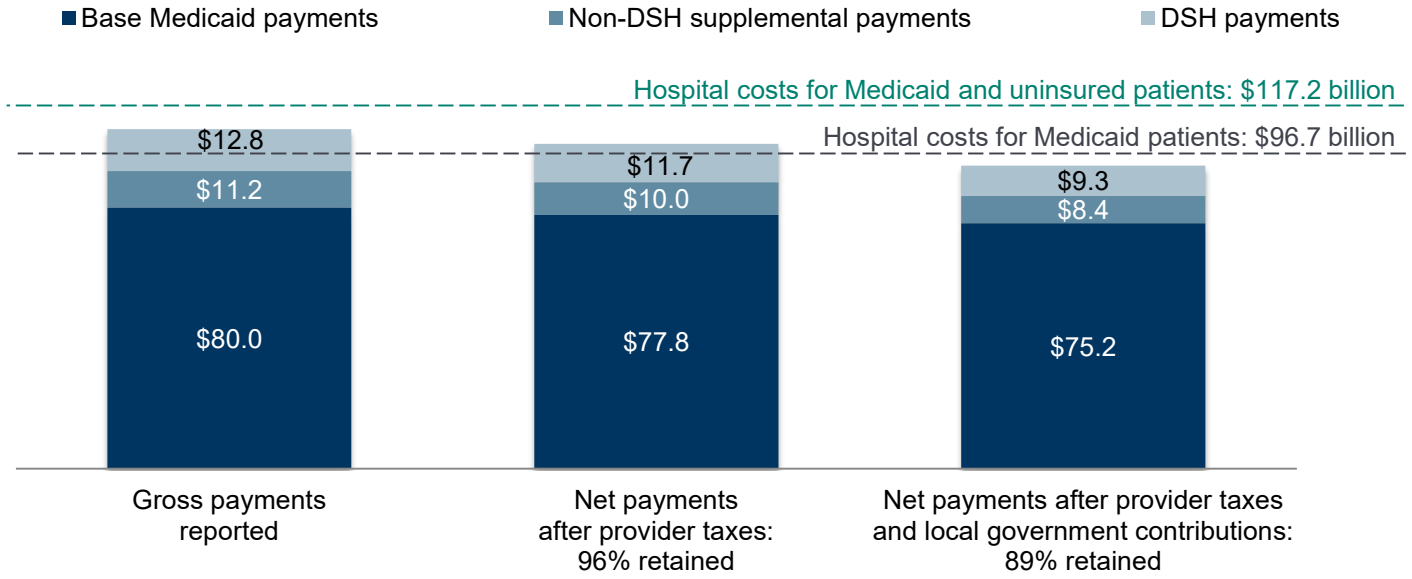
Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Non-DSH hospitals and institutions for mental diseases were excluded from this analysis. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not add due to rounding.

Source: GAO 2020

Prior MACPAC Analyses

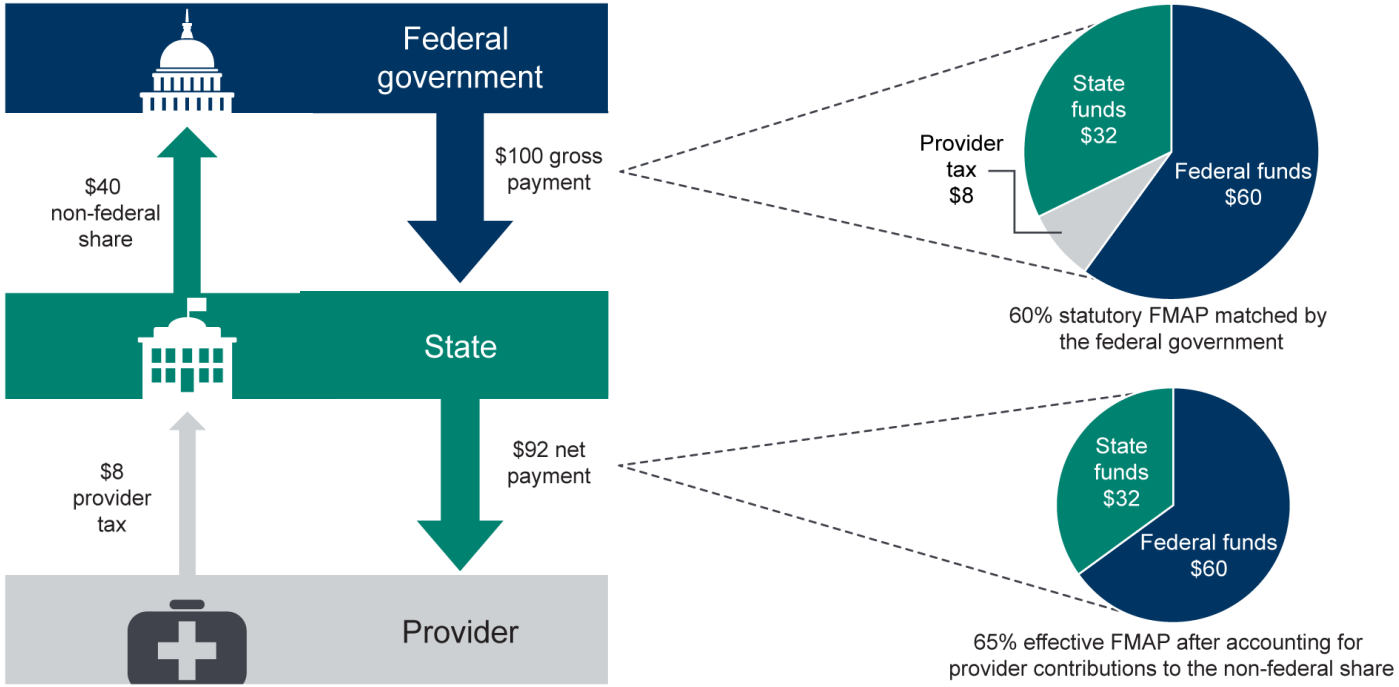
- Supplemental payments are often targeted to providers who finance these payments
- In recent years, there has been a rapid growth in managed care directed payments financed by providers through IGTs or taxes
- Provider contributions to the non-federal share of Medicaid spending reduce the net payments that providers receive
- These arrangements effectively increase the share of federal spending above the federal matching assistance percentage (FMAP)

Gross and Net Medicaid Payments to Disproportionate Share Hospitals, 2011 (billions)



Notes: DSH is disproportionate share hospital. This analysis excludes institutions for mental diseases.
Source: Nelb, R., J Teisl, A. Dobson, et al, 2016, For disproportionate share hospitals, taxes and fees curtail Medicaid payments, *Health Affairs,* 35, no. 12:2277–2281, https://doi.org/10.1377/hlthaff.2016.0602.

Illustration of Provider-Financed Payments that Increase the Effective FMAP



Note: FMAP is federal matching assistance percentage.

Prior MACPAC Recommendations

- MACPAC has recommended that the Centers for Medicare & Medicaid Services (CMS) collect provider-level data on the sources of non-federal share for hospital and nursing facility payments
- These data are needed to calculate net payments and can ultimately help inform assessments of whether payment amounts are consistent with statutory goals
- Prior recommendations did not specify how data should be collected
- These recommendations do not preclude MACPAC from making more comprehensive recommendations about other financing data

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Initial Themes from Expert Interviews

Unclear How CMS Would Use Data

- Recent CMS proposals to limit permissible financing sources have created concerns among stakeholders about financing policy
  - Medicaid fiscal accountability rule (MFAR)
- Experts questioned why CMS would need to improve transparency of sources of the non-federal share if they were permissible
  - Concern that CMS would use data to reduce federal funding instead of supporting providers who finance Medicaid payments
  - Medicaid statute currently sets upper limits on Medicaid payment based on the gross payment amount, not net payments
- Recent CMS guidance on school-based services claiming was cited as a more positive example of CMS working collaboratively with states and providers to clarify financing policies

State Financing Methods and Amounts

- CMS currently collects narrative information about state financing methods when states submit state plan amendments (SPAs) or managed care directed payment pre-prints
  - These data are not publicly available
  - Because of number of SPAs each year, these data may hard to synthesize
- CMS is statutorily required to collect state provider tax amounts
  - In SFY 2018, states reported $29 billion on Form CMS-64.11 but reported $37 billion in provider taxes to the Government Accountability Office (GAO)
  - State-level IGTs and CPEs are not reported to CMS ($26 billion in SFY 2018)
- Experts noted that state budget officers already track financing sources but may have difficulty reporting financing for specific payments

Provider-Level Financing Amounts

- In MFAR, CMS proposed that states reported financing on new provider-level supplemental payment reports
  - Although MFAR was withdrawn, Congress has begun requiring provider-level reporting on supplemental payment amounts (but not financing)
  - Experts noted it may be difficult to attribute financing to specific payments
- Cost reports could be modified to collect provider tax information
  - Medicare cost reports currently include Medicaid provider tax costs but do not distinguish them from other types of taxes
  - Would be difficult to use for non-institutional providers and IGTs/ CPEs
- Texas recently began requiring the state Medicaid agency to report provider-level financing information
  - Collected from local taxing authorities that send IGTs/ CPEs to the state
  - Publicly reported by provider and supplemental payment program

Determining Net Medicaid Payments

- Experts highlighted a number of considerations for using provider-level financing data to calculate net payments to providers
  - Provider taxes, IGTs, and CPEs that are not returned to the provider
  - Challenges of tracking costs and payments within large health systems
  - Challenges identifying the extent to which IGTs come from patient care revenue
  - Contingency fees paid to consultants to develop financing arrangements
  - Private redistribution of payments among providers

Next Steps

- We are continuing to interview state officials and provider associations to learn more about barriers to improving the transparency of Medicaid financing
- We plan to further examine new provider-level financing data in Texas and link it to provider-level supplemental payment data to illustrate how financing data could be used to inform policy
- If Commissioners are interested in developing policy options that could lead to recommendations, staff will return at January meeting
- Plan to include a chapter in June 2024 report to Congress

Policy Questions

- How can CMS, states, and providers reduce concerns about how financing data will be used?
- What types of information about state financing methods would be most useful for informing future policy development?
- Should CMS collect information on financing amounts for all types of Medicaid financing sources?
- Should CMS collect provider-level data on the financing of all types of Medicaid payments?
- How should provider-level financing data be used to assess provider payment rates? What additional information would help policymakers better evaluate net payments to providers?

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