

# State considerations regarding Medicaid Fiscal Accountability Regulation proposed by CMS

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## Introduction and background

On November 18, 2019, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule referred to as the “Medicaid Fiscal Accountability Regulation” (MFAR), citing the need for increased transparency of Medicaid supplemental payments and concerns over their financing via non-bona fide provider-related donations.<sup>1</sup> As proposed, MFAR could have significant implications for states and affected parties for both existing and new state Medicaid supplemental payment arrangements. The proposed rule’s public comment period is open as of this writing and is scheduled to conclude on February 1, 2020.

CMS’s proposed rule establishes a definition of “base” payments versus “supplemental” payments in 42 CFR 447.286. Base payments are defined as “standard” payments that can be attributed to identifiable services that have been provided to an individual beneficiary. Base payments can be attributed on a per claim basis inclusive of adjustments, add-ons, or other payments received by the provider. Supplemental payments are defined as “extra compensation to certain providers,” often made to the provider in a lump sum on a monthly, quarterly, or annual basis apart from payments for a provider claim. Supplemental payments therefore cannot be directly linked to a provider claim for specific services provided to an individual Medicaid beneficiary.<sup>2</sup>

This white paper contains a summary of key MFAR proposed changes to supplemental payments that may be impactful to state Medicaid agencies. Given the substantial number of changes proposed under MFAR, this paper is not a comprehensive list, but rather highlights key changes for the consideration of states. If implemented, we anticipate many states will need to revise their Medicaid supplemental payment programs to achieve MFAR compliance.

## Physician supplemental payment upper payment limit

Many states have Medicaid supplemental payment programs for physicians (and other practitioners) at state university teaching hospitals, where the state share of payments is funded through intergovernmental transfer (IGT) arrangements. Currently CMS allows the Upper Payment Limit (UPL) for these physician supplemental payment programs to be based on average commercial rates (ACR), which CMS references being as high as approximately 300% to 400% of Medicare rates.<sup>3</sup>

Citing the need to “establish an appropriate and auditable upper bound to better ensure that practitioner payments are consistent with economy and efficiency,”<sup>4</sup> CMS proposes to reduce the physician UPL in 42 CFR 447.406 such that supplemental payments would be limited to 50% of Medicaid fee-for-service (FFS) base claim payments authorized under the state plan. This limit is increased to 75% for services provided within designated geographic health professional shortage areas or Medicare-defined rural areas. If value-based payments (VBPs), such as pay-for-performance or bundled payment arrangements, are available to all providers as an alternative to FFS payment rates then they qualify as FFS base payments under the proposed rule.

### Applicability to FFS and Managed Care Delivery Systems

MFAR states “the financing requirements in 42 CFR parts 430 and 433 and addressed in this proposed rule are applicable to FFS, managed care, and demonstration authorities.”<sup>5</sup> As such, we believe the proposed changes affecting financing of supplemental payments via healthcare-related taxes, intergovernmental transfers, and public-private partnerships (described later in this paper) would be applicable to both Medicaid fee-for-service (FFS) and managed care. MFAR’s proposed rules on supplemental payment methodologies are generally related to state plan amendments (SPAs) applicable to FFS. Note that it is currently unclear whether MFAR is applicable to state-directed payment arrangements approved under 438.6(c) Preprints, because these payments may not meet MFAR’s definition of supplemental payments. Although not explicitly addressed in the proposed rule, states should be prepared for CMS to apply the considerations proposed under MFAR during the 438.6(c) Preprint evaluation process.

<sup>1</sup> The full text of the proposed rule may be found published in the Federal Register, Vol. 84, No. 222 (November 18, 2019), page 63722.

<sup>2</sup> Ibid, page 63723.

<sup>3</sup> Ibid, page 63763.

<sup>4</sup> Ibid, page 63764.

<sup>5</sup> Ibid, page 63726.

CMS states that, from a fiscal standpoint, the proposed physician UPL reduction “would have the most direct impact on current provider payments” of all proposed changes under MFAR, in the short term.<sup>6</sup> CMS estimates that, for providers who were eligible to receive supplemental payments in 2017, these supplemental payments in composite equaled 93% of base payments. The implementation of this revised payment limit would have resulted in a maximum net decrease of \$222 million, or 22% of these providers’ total payments. Figure 1 provides an illustration of this calculation.<sup>7</sup>

**FIGURE 1: SUPPLEMENTAL PAYMENTS AS A PERCENTAGE OF BASE PAYMENTS (\$ MILLIONS)**

	2017	PROPOSED RULE	IMPACT
Base Payments	\$ 512.0	\$ 512.0	\$ 0.0
Supplemental Payments	\$ 478.0	\$ 256.0	(\$ 222.0)
Total	\$ 990.0	\$ 768.0	(\$ 222.0)
Supplemental as % of Base	93.4%	50.0%	(43.4%)

Notes:

Values reflect both federal and state share of payments.

Base payments only include providers who were eligible to receive supplemental payments.

Under MFAR, states could mitigate decreases in supplemental payments by increasing FFS base rates (and then paying an additional 50% to 75% in supplemental payments). However, such rate increases would have to be authorized through the SPA approval process, which could make it more difficult to continue to focus enhanced payments to affected providers at the same levels. States with currently approved physician supplemental payment programs will be given a three-year transition period to submit a SPA that brings the arrangement into compliance with the UPL outlined in the proposed rule.

## Public-private partnerships

Section 1903(w) of the Social Security Act mandates that a state’s Medicaid expenditures for which federal financial participation is provided shall be reduced by the sum of any revenues resulting from provider-related donations received by the state other than bona fide provider-related donations.<sup>8</sup> Section 1903 defines a bona fide donation as “a provider-related

donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title (Medicaid) to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary.”<sup>9</sup>

Citing concerns over complex financing structures that “mask non-bona fide, provider-related donations used to fund the non-federal share of Medicaid Payments,” CMS proposes to clarify the hold-harmless definition related to non-bona fide provider donations. Specifically, the proposed rule references examples of public-private partnerships where a governmental entity executes an IGT with a state, funded by a “transfer of value” from a private provider through formal or informal arrangements. In this scenario, the state then makes a supplemental payment to the “private donating provider,” which compensates it for the value it transferred to the governmental entity.<sup>10</sup> CMS states that “such an arrangement constitutes a non-bona fide donation because there is a pre-existing hold harmless agreement.”<sup>11</sup>

CMS indicated that MFAR is intended to “Reduce Questionable Financing Mechanisms.”<sup>12</sup> Clarification of the hold-harmless definition is intended to assist in accomplishing this goal. CMS also clarified that ownership changes will undergo heightened scrutiny to ensure that facilities will not receive additional Medicaid payments following ownership transfers in situations where the facility’s operations are generally not changed.

Under MFAR, CMS would clarify the hold-harmless definition related to donations and establish a “net effect standard” for donation arrangements. In 42 CFR 433.54, CMS proposes to look at the overall arrangement and the “totality of circumstances” to determine whether a non-bona fide donation has occurred, regardless of whether a formal public-private

<sup>6</sup> Ibid., page 63773.

<sup>7</sup> Ibid., page 63773. “In 2017, 21 states made approximately \$478 million in physician supplemental payments compared with \$512 million in Medicaid FFS base payments to the practitioners eligible to receive the supplemental payments.”

<sup>8</sup> Ibid., page 63735.

<sup>9</sup> See the full text of this clause at [https://www.ssa.gov/OP\\_Home/ssact/title19/1903.htm](https://www.ssa.gov/OP_Home/ssact/title19/1903.htm).

<sup>10</sup> Previously in State Medicaid Director Letter #14-004, CMS had defined a non-bona fide provider-related donation as a circumstance “in which private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments typically in the form of a supplemental payment”.

<sup>11</sup> MFAR proposed rule, op cit., page 63736.

<sup>12</sup> CMS (November 12, 2019). Fact Sheet: 2019 Medicaid Fiscal Accountability Regulation (MFAR). Retrieved January 6, 2020, from <https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicare-fiscal-accountability-regulation-mfar>.

partnership exists. In 42 CFR 433.52, CMS proposes to define “provider-related donation” to include where a private provider “assumes an obligation previously held by a governmental entity and the governmental entity does not compensate the private entity at fair market value.”<sup>13</sup> As such, states would need to identify any public-private partnerships where the related supplemental payments return any portion of the donation to the private provider, and evaluate the arrangement’s compliance with respect to the proposed rule.

## Healthcare-related tax requirements

Citing concerns over healthcare-related tax waivers and hold-harmless arrangements, under MFAR CMS would implement new criteria to gain approval for waivers of tax requirements. States would need to meet proposed new standards to demonstrate the tax is “generally redistributive” and does not “place an undue burden on Medicaid,” in addition to the current requirements related to passing the B1/B2 and P1/P2 statistical tests.<sup>14</sup>

**B1/B2 test:** Compares the relationship between each provider’s Medicaid-taxable units and the provider’s share of total taxes, assuming a) the tax is broad-based and uniform (B1), versus b) the proposed tax structure (B2). This test is applicable to tax programs seeking to waive both the broad-based and uniform requirements.

**P1/P2 test:** Compares the proportion of the tax revenue applicable to Medicaid, assuming a) the tax is broad-based and uniform (P1), versus b) the proposed tax structure (P2). This test is applicable to tax programs seeking to waive the broad-based requirement only.

Specifically, the proposed rule states that CMS will evaluate the following:

- **“Net effect” standard:** Citing concerns of supplemental payment redistribution agreements where “the taxpayers have a reasonable expectation to be held harmless for all or a portion of their tax amount,” CMS is proposing to add clarifying language to its hold-harmless definition in 42 CFR 433.68. Similar to criteria for non-bona fide donations, CMS would establish a “net effect” standard and review the “totality of the circumstances” to determine whether a hold-harmless arrangement exists (regardless of whether redistribution occurs).<sup>15</sup> CMS proposes to define the net effect as 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.” To enforce this proposed rule, it is not clear whether CMS expects states to identify all private payment redistribution agreements among providers (to which state Medicaid agencies are generally not privy), as well as collect information from providers needed to calculate and report final net impacts after redistribution.
- **Tax exemptions:** Citing concerns over states providing tax relief to provider groups where “the specific basis for the grouping is designed to obscure a true purpose to define the group based on lack of or relatively low Medicaid activity,” CMS is proposing new standards in 42 CFR 433.68 for evaluating the extent to which tax structures are redistributive. Specifically, CMS would not consider tax structures to be generally redistributive when taxpayers are grouped together such that groups with relatively higher Medicaid activity are taxed more heavily, and groups with relatively lower levels are excluded from the tax (or taxed at relatively lower rates).<sup>16</sup> The proposed rule, however, would preserve states’ ability to exclude from taxation or impose lower tax rates on providers “based on genuine commonalities that meet legitimate policy objectives”;<sup>17</sup> however, CMS elected not to list “acceptable commonalities.”<sup>18</sup> As such, states with provider groups exempted from the tax or with lower tax rates would need to evaluate the group definitions and associated Medicaid activity. Note that CMS proposes to maintain its policy that a tax excluding Medicare revenues or payments will be considered uniformly imposed.<sup>19</sup>

<sup>13</sup> MFAR proposed rule, op cit., page 63777.

<sup>14</sup> Ibid., page 63742.

<sup>15</sup> Ibid., page 63735.

<sup>16</sup> Ibid., page 63732.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid., page 63774.

<sup>19</sup> Ibid., page 63741.

CMS is proposing to give states up to three years from the final rule effective date before seeking reapproval of the tax waiver of the broad-based and uniform requirement.

In addition to provider taxes, CMS is proposing to clarify permissible health insurer premium taxes. Currently, 42 CFR 433.56(a) outlines classes of healthcare services that are permissible for tax imposition, which specifically includes services of managed care organizations such as managed care organizations (MCOs), preferred provider organizations (PPOs), and health maintenance organizations (HMOs).<sup>20</sup> CMS proposes to establish services of other types of health insurers as a new permissible class. An important regulatory criterion established for creating this new permissible class of services is that no more than 50% of revenue may come from Medicaid and no more than 80% of revenue may come from all federal programs combined. CMS cites premiums, covered lives, and revenue as mechanisms that could be used to determine tax assessment amounts.

## State plan approval duration

In MFAR, CMS states that a “time-limited supplemental payment” would allow CMS and the state “an opportunity to revisit state plan supplemental payments to ensure that they remain consistent with efficiency, economy, and quality of care.” Specifically, CMS proposes in 42 CFR 447.252 the following limitations on new SPAs for inpatient, outpatient, and long-term care facility services:<sup>21</sup>

- **New SPAs:** The supplemental payment would be approved for no more than three years.
- **SPAs approved three or more years** prior to the final rule effective date: The supplemental payment would expire two years following the final rule effective date.
- **SPAs approved less than three years** prior to the final rule effective date: The supplemental payment would expire three years following the final rule effective date.<sup>22</sup>

It is reasonable to assume that this proposed change would result in CMS requiring modifications to previously approved supplemental payments once the approval period expires. States are familiar with providing details regarding the methodology used to calculate and distribute the supplemental payment amounts. Under the current approval process, CMS informally or formally requests information such as:

- Purpose of the supplemental payment
- Description of how the payment is consistent with the overarching goals of Medicaid
- Criteria utilized to determine which providers are eligible to receive a payment

Under MFAR, states would be subject to new monitoring requirements and would be required to report the following:<sup>23</sup>

- Proposed duration of the authority, up to three years
- Detailed monitoring plan to ensure the payment generates outcomes as intended and its effects are properly evaluated
- Evaluation of the impact of the supplemental payment during the most recent effective period, for those seeking renewal

In the proposed rule, CMS indicates that there are instances where a supplemental payment arrangement may require more time to reasonably achieve its impact on the Medicaid program, and thus the state cannot complete the third requirement above. In these cases, CMS may still approve the renewal application. An important aspect to emphasize is that many states currently resubmit their supplemental payment programs for approval annually, whether due to funding amounts varying as a result of state legislature proceedings or for other reasons. While the new monitoring and evaluation requirements would impact these states, the proposed three-year term approval limit would not.

<sup>20</sup> Ibid., page 63740.

<sup>21</sup> Ibid., page 63747.

<sup>22</sup> Ibid., page 63749.

<sup>23</sup> Ibid., page 63747.

## Reporting requirements

Citing the need “to improve our and states’ abilities to oversee fiscal integrity by requiring transparency through better data reporting,”<sup>24</sup> CMS proposes in 42 CFR 447.288 to require states to report data for supplemental payments, Medicaid payment and utilization, provider contributions of the nonfederal share of supplemental payments, as well as other information.<sup>25</sup>

The new proposed reporting requirements include a total of 42 new metrics, and are as follows:

- **UPL demonstrations:** The proposed rule would eliminate the UPL demonstrations for Psychiatric Residential Treatment Facilities (PRTFs), Clinic Services, and Medicaid Qualified Practitioner Services and Other Inpatient & Outpatient Facility Providers, and would codify the annual UPL demonstration requirement for the remaining provider types.<sup>26</sup>
- **Quarterly reporting of supplemental payments:** The proposed rule would require states to report a summary of expenditures claimed for each supplemental payment at the same time the state submits its quarterly CMS-64, including:
  1. The SPA transaction number or demonstration authority number which authorizes the supplemental payment.
  2. A listing of each provider that receives a supplemental payment, including *eight different provider demographic items*.
  3. The specific amount of the supplemental payment made to the provider.<sup>27</sup>
- **Annual reporting:** The proposed rule would require states to annually report aggregate and provider-level information on base and supplemental payments made under state plan and demonstration authority, by service type, including:
  1. The SPA transaction number or demonstration authority number that authorizes the supplemental payment.
  2. A listing of each provider that receives a supplemental payment, including *nine different provider demographic items*.
  3. The specific amount of Medicaid payments made to each provider, including *eight different metrics* separating base and supplemental payments.<sup>28</sup>
- **Annual nonfederal share reporting:** The proposed rule would require states to annually report aggregate and provider-level information on funds used as a source of the nonfederal share of Medicaid supplemental payments. There would be 17 different provider identifiers and metrics required, including Disproportionate Share Hospital (DSH) payments, certified public expenditures, IGT amounts, taxes collected, provider donations, etc.<sup>29</sup>

<sup>24</sup> Ibid., page 63722.

<sup>25</sup> Ibid., page 63768.

<sup>26</sup> Ibid.

<sup>27</sup> Ibid., page 63783.

<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

## Conclusion

In its proposed Information Collection Requirements (ICRs), CMS estimates that, for all parts of the proposed rule, the average annual administrative burden would be 67 hours per state Medicaid agency.<sup>30</sup> Each state should evaluate the proposed rule to determine its own administrative needs to not only meet MFAR reporting requirements, but also to evaluate how its current supplemental payment programs would be affected. For those programs affected by MFAR, the state would need to develop a strategy to identify the adjustments needed to preserve the program, or to determine alternative initiatives that would sustainably achieve state goals and CMS compliance.



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<sup>30</sup> Ibid., page 63771.