

## Breaking Down the Proposed Medicaid Fiscal Accountability Rule

On November 12, the Centers for Medicare and Medicaid Services (CMS) issued a [proposed rule](#) that aims to increase transparency and reporting on state supplemental payments and financing arrangements in Medicaid. In an accompanying [fact sheet](#), CMS stated that the proposed rule will equip the agency with improved oversight and tracking tools, allowing regulators to end state financing arrangements they consider to be impermissible. While we do not expect that most mental health and addiction providers will be directly affected, ultimately, these changes could result in a decrease in overall Medicaid resources available to states.

Note: The National Council’s preliminary analysis of the 200+ page proposal from CMS follows. We will continue to dig into the implications of the proposal and will provide additional updates in the days and weeks ahead.

CMS Administrator Seema Verma noted that the [Medicaid Fiscal Accountability Rule](#) (MFAR) will address states’ increasing reliance on donations, taxes or other financing strategies that CMS perceives “mask or circumvent” current Medicaid rules regarding how states are permitted to generate the state portion of the Medicaid match. The rule comes in the wake of several Government Accountability Office (GAO) and other oversight agency reports that highlighted “vulnerabilities” in Medicaid related to non-federal Medicaid expenditures.

### WHAT’S IN THE PROPOSED RULE?

The proposed rule provides new definitions and specific guidance on what types of state financing arrangements CMS considers to be permissible under the Medicaid program, imposes a renewable sunset period on supplemental payment methodologies and increases reporting requirements. Specifically, the proposed rule covers three key areas:

#### Improve Reporting on Supplemental Payments

- States will be required to report provider-level payment information for Medicaid supplemental payments. This is in contrast to current practices where states report aggregate data across all providers. States must also report provider-level payment information for state plan services and demonstration programs, as well as identify the specific authority and source of the non-federal share for these payments. CMS indicated these changes are intended to yield greater insights into how supplemental payments are administered and whether they are consistent with Medicaid program standards requiring “efficiency and economy” of care.
- States will be required to sunset existing and new supplemental payments after three years, with an option to renew. This renewal request would provide CMS an opportunity to re-evaluate whether supplemental payment initiatives are being implemented in accordance with program requirements after the initial SPA or demonstration approval.
- The proposed rule would mandate the use of Office of Management and Budget (OMB)-approved [templates](#) and [CMS guidelines](#) for acceptable upper payment limit (UPL) calculations. The UPL is a federal limit placed on fee-for-service reimbursement of Medicaid providers. This mandate would require standardized UPL data, allowing CMS to better analyze states’

compliance with payment limits and understand how payments advance Medicaid program goals.

### **Clarify Medicaid Financing Definitions**

- The regulation would establish new definitions for Medicaid “base” and “supplemental” payments, which are not currently defined in federal regulations.
- The rule would also clarify the definitions and processes for the non-federal share of Medicaid spending as well as requirements for upper payment limits.

### **Update Financing Mechanisms**

- Noting the CMS’ concern that complex financing mechanisms are being used to “mask” inappropriate sources of funds for intergovernmental transfers (IGTs), the proposed regulation re-affirms that IGTs must be derived solely from state or local tax revenues. IGTs are a mechanism by which states may leverage funds from another governmental agency (i.e., county or state agency) to produce the state share of the Medicaid match.
- The proposed rule would require that 100 percent of a state’s expenditure claim must be paid to and retained by the Medicaid provider, thus preventing states from reusing Medicaid payments as the source of state financing for additional payments.
- The regulation adds new detail and clarity to the definition of provider donations, with the stated intent of ensuring that any donations used to finance the state’s share of the FMAP are “bona fide.” CMS emphasizes that in no instances may there be a formal or informal “hold harmless” expectation whereby the donor provider is assured of receiving a return on its donation in the form of Medicaid reimbursement.
- CMS would have new authority to examine the net effect of a state’s tax laws on Medicaid providers when determining whether a given tax is an appropriate source of financing for state Medicaid programs. The rule would prevent states from structuring tax packages designed to generate funds for the state’s Medicaid match from entities that are not a permissible class of taxable providers
- The proposed rule would allow health insurers to be considered a permissible tax class, thus modernizing the list of permissible classes.
- The regulation would seek to strengthen oversight of approved tax waivers, specifically to ensure they continue to align with federal requirements.
- The proposed rule would implement new reporting requirements related to Medicaid disproportionate share hospital (DSH) payments and clarify overpayment discovery and redistribution procedures associated with DSH payments.

### **WHO IS AFFECTED?**

Providers who engage with states in any of the previously discussed financing mechanisms may see changes to their revenue or expenditures under this proposed rule, should CMS deem any of their state’s financing strategies to be impermissible if, and when, the rule is finalized. Specifically, the proposed rule could have implications for providers who:

- Receive supplemental payments.
- Participate in upper payment limit demonstrations.

- Receive DSH payments.
- Engage in intergovernmental transfers (IGT) or certified public expenditures (CPE) to produce a portion of the state's share of the match.
- Provide "donations" of money or services to state or local government entities.
- Are subject to provider taxes, including taxes as part of a broader tax package that has a differential impact on Medicaid health providers vs. other entities.

## NEXT STEPS

The proposed rule will be published in the [Federal Register](#) on November 18, 2019, and comments will be accepted through January 17, 2020. The proposed changes will not go into effect until CMS issues a future final regulation. The National Council will continue its detailed review and analysis of the proposed rule and its impact on community behavioral health providers. We welcome any input or concerns about the impact of the proposed regulation on your organization. Please email [RebeccaD@TheNationalCouncil.org](mailto:RebeccaD@TheNationalCouncil.org) with questions or input.

CMS has created a [fact sheet](#) on the proposed rule or read the [full regulation](#).