

Summary of AHCCCS Response to the Proposed Medicaid Fiscal Accountability Regulation

On November 18, 2019, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule addressing a variety of issues including Medicaid supplemental payments, methods of financing the non-federal share (including provider taxes and donations) and corresponding State reporting requirements. As proposed, the regulation will have significant implications for the ways in which States finance Medicaid programs and pay for Medicaid services. Below is a summary of the Arizona Health Care Cost Containment System (AHCCCS) comments to the proposed rule.

Proposed Changes to Certified Public Expenditures (CPEs)

- The treatment of CPEs as proposed in the regulations is inconsistent with Arizona’s experience with CPE funding that has been accepted by CMS for years.

- **Section 447.206(b)(4): Retention of Full Amount of FFP Associated With Payments**
 - Proposed section 447.206(b)(4) would require that an entity providing a CPE statement in support of a State’s claim for FFP must retain 100% of the FFP claimed for payments to governmental providers.
 - At 84 FR 63745, the Secretary incorrectly concludes that a State’s retention of any portion of the FFP is inconsistent with provisions of the Act and regulations that do not permit the use of federal funds to be used to match other federal funds.
 - Application of those provisions to the State’s retention of some or all of FFP claimed based on a CPE is unwarranted because the FFP received is the return of a portion of a cost that was initially funded wholly using the revenue of the State and/or its political subdivision.
 - As such, the FFP received is a reimbursement of State or local revenue that the Medicaid program has no authority to restrict.

- **Section 447.206(b)(4): As It Relates to Arizona’s School Based Claiming Program**
 - The proposed regulation seeks to eliminate the State’s flexibility to structure administrative fees based on the amount a provider receives through Medicaid payments.
 - Currently, AHCCCS charges an administrative fee on net new federal funds generated to each Local Education Agency (LEA) based on the amount a provider receives through Medicaid payments.
 - Arizona assumes that, under the proposed regulation, a flat amount charged to each LEA may be an acceptable methodology. However, this may disproportionately harm smaller providers, or in this case LEAs, as the amount of administrative fee charged may exceed the net new federal funds to be received through the CPE or settlement process.

- **Section 447.206(c): Processing All CPE Payments Through MMIS**
 - Proposed section 447.206(c) would require that “all claims for medical assistance (that are funded through a CPE) are processed through Medicaid Management Information Systems [MMIS] in a manner that identifies the specific Medicaid services provided to specific enrollees.”
 - It is not uncommon that disproportionate share hospital (DSH) payments are funded through a CPE. These payments share the same characteristics of supplemental payments in that they cannot be attributed to specific services provided to individual beneficiaries. As such, the State

would not be able to comply with the proposed requirement that those payments be processed through the MMIS.

Proposed Changes to the Permissible Sources of the Non-Federal Share

- Proposed section 433.51(b) would unnecessarily limit the sources of the non-federal share to State or local taxes. The proposed amendment would preclude State use of other legitimate governmental sources that are not derived from taxes, such as patient and operating revenues, collected State university tuition, issued bonds, awarded civil damages, and other such examples.
- For Arizona specifically, this limitation could impact all programs in which the State match share is funded by public universities, tobacco settlement receipts, the State share of drug rebates and the hospital and nursing facility assessments. These programs include, but are not limited to, DSH, Graduate Medical Education (GME), the Access to Physician Services Initiative (APSI), and the Pediatric Services Initiative (PSI).

Proposed “Net Effect” Test

- Proposed section 433.68(F) adds a “net effect” standard to the direct hold harmless guarantee test to explicitly prohibit any arrangement where the state or other unit of government provides for any direct or indirect payment, offset, or waiver that results in holding taxpayers harmless and inserts a more sweeping definition of a hold harmless arrangement; that is, where, considering “the totality of the circumstances,” the “net effect” of an arrangement between the State (or other unit of government) and the taxpayer results in a “reasonable expectation” that the taxpaying provider will receive a return of all or any portion of the tax amount.
- CMS does not define how the agency would interpret or apply this provision which would lead to great uncertainty regarding the validity of provider taxes and would hinder the State Legislature’s ability to plan, adopt, and implement tax structures that would not be deemed by CMS to be an invalid method of funding the program.
- Stated this generally, any health care-related tax that in any way benefits the taxpayer could constitute a reasonable expectation of a hold harmless arrangement. For instance, an assessment on inpatient hospital revenues that is used to cover the cost of all covered services to an expanded Medicaid population could, under this language, constitute an impermissible hold harmless arrangement because hospitals would reasonably expect reduced uncompensated inpatient costs as a result of the eligibility expansion.
- A nursing facility assessment that is used to fund payments to nursing facilities could similarly conflict with the proposed rule.

Proposed “Undue Burden” Standard for Health-Care Related Taxes

- The proposed regulation would not permit the State to use tax revenues to fund the program if the tax imposes an “undue burden” on health care services paid for by Medicaid or on providers of services that are reimbursed by Medicaid. Under the proposal, among other things, a tax is considered to impose “undue burden” if taxpaying providers are divided into taxpayer groups and the tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity.
- The proposed provision deviates from prior CMS practice of acceptance of documentation of compliance with statistical requirements as sufficient.
- For Arizona, this could impact both the hospital and nursing facility assessments, where currently certain providers are excluded, and could also impact all populations/programs funded by those sources of State match dollars. It is unclear how CMS would address variable assessment rates which may be permitted under the proposed regulation “based on genuine commonalities that meet legitimate policy objectives.”
- Vesting CMS with the type of discretion detailed in this proposed regulation may substantially impair the ability of the State legislature to exercise its authority to raise revenues.

Proposed Compliance Provisions and Sunset Period for Tax Waivers and Supplemental Payment Programs

- **Section 433.72(d): Ongoing Compliance of Tax Waivers**
 - Arizona is concerned that proposed section 433.72(d) regarding ongoing compliance does not address the impact of a period of noncompliance and whether States will be afforded any type of grace period.
 - Many factors that could impact continued compliance with the statistical tests are beyond the control of the State Medicaid Agency.
 - Arizona's hospital and nursing facility assessments would be at risk under this proposed section.

- **Section 447.252: Supplemental Payments**
 - CMS is proposing to limit the prospective approval of any and all supplemental payment programs to a period not to exceed three years.
 - Supplemental payments will be subject to a formal evaluation process against the stated goals of the Medicaid supplemental payment program.
 - AHCCCS will have to provide more rationale and policy justification for the continuation of such supplemental payments, as well as articulate how these payments will improve quality or access to care.
 - This opens questions on whether certain supplemental payments will be approved in the future if they fail to achieve their intended policy objectives.
 - The rule should provide for longer approval processes and a defined grace period for supplemental payments.
 - While the definition of supplemental payments in the proposed rule is not clear, payments that could potentially be impacted include DSH, GME, APSI, PSI, Critical Access Hospital (CAH), Rural Hospital Inpatient Fund (RHIF), nursing facility assessment, and Differential Adjusted Payments (DAP).

Proposed Limitation on Practitioner Supplemental Payments (50 percent of the Base Rate or 75 Percent in a HRSA-Designated Provider Shortage Area or Medicare-Defined Rural Area)

- The proposed limit on practitioner supplemental payments to a percentage of the base rates appears to be inconsistent with the stated goals of CMS in the November 14, 2018 Federal Register (83 FR 47264) to "encourage states to continue developing payment models that produce optimal results for their local markets," including using "average commercial rate reimbursement," and to provide corresponding regulatory flexibility.
- On its face, the proposed limit of 50%/75% is a material divergence from the 2017 national average of 93% cited by CMS in the NPRM, and some States and providers would be more significantly impacted than others if they are above the average. No additional supporting data or analysis is provided to support the 50%/75% limit, which therefore appears arbitrary.
- Arizona has implemented an APSI directed payment under 438.6(c), which provides a uniform percentage increase of 85% to otherwise contracted rates for practitioner services furnished by eligible providers. The 85% increase is based on the calculated average commercial rate (ACR) of 188% of the AHCCCS market reimbursement rates for eligible providers in Arizona. Thus the proposed limit of 50%/75% is not consistent with either national or State-specific ACR data that Arizona has reviewed. Implementing such an indiscriminate and arbitrary national standard is not a data driven approach that would effectively account for regional and local variations in both ACR rates and base Medicaid reimbursement rates in the manner needed to truly assess the efficiency and economy of overall Medicaid reimbursement in a localized context.
- Arizona and other States have already addressed these concerns by implementing specific ACR methodologies that require appropriate accounting for facility, non-facility, and modifier factors.

- CMS should instead define the specific technical parameters that States must meet in preparing ACR computations in order to ensure consistency and transparency.

Proposed Prohibition of Variation in FFS Payment for a Medicaid Service

- Proposed section 447.201(c) could be interpreted to prohibit variation in fee-for-service rates based on, among other things, the FMAP available for the services.
- As drafted, the proposed regulatory provision could be understood to prohibit States from making payments to Indian Health Service (IHS) and tribally owned or operated facilities at the all-inclusive rates for inpatient and outpatient services, if other facilities are paid on a different basis. That differentiation in payments is common among States, and it has been the long-standing position of the Department of Health & Human Services that payment to those facilities at the published all-inclusive rate is appropriate for both the Medicare and Medicaid programs.
- In Arizona, this could have significant financial impacts for IHS and tribally owned or operated facilities paid at the all-inclusive rates for inpatient and outpatient services serving the members of Arizona's twenty-two tribes.

Other Proposed Reporting Requirements

- **Section 447 Subpart D: Quarterly and Annual Reporting Requirements**
 - The reporting requirements detailed in the proposed amendment to Part 447 Subpart D will require unprecedented system programming changes to include new data fields for the State plan number or waiver demonstration number to be assigned to individual payments, as well as new provider categories to be reported on at the individual payment level.
 - The analysis of costs in the NPRM significantly underestimates the cost to the States to modify systems, educate providers on new coding requirements, and for ongoing reporting efforts.
- **Section 447.290(b): CMS' Expectations for Supplemental Payment Reporting**
 - Proposed section 447.290(b) penalizes States if reporting requirements are not met, indicating that FFP attributable to payments which the State has not reported properly will be withheld until State comes into compliance.
 - The proposed regulation lacks any standard (much less an objective standard) for how CMS will estimate the amount attributable to payments made to providers as to which the State has not reported properly.
- **Section 447.299(c)(21): Annual Independent Certified Audit of DSH Payments Must Include Estimates of Findings When Available Data Does Not Permit a Specific Finding**
 - The addition of a requirement for the independent audit to quantify the financial impact of any finding, including those resulting from incomplete or missing data, would be a material addition to the scope of work of the auditors and is anticipated to result in a significant increase in administrative costs to the State.