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Latest Challenges in Medicaid Payments and Financing

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Eyman Associates

June 23, 2015

Overview

- **Challenges to Non-DSH Supplemental Payments**
  - New (Renewed) Scrutiny of UPL Payments
  - Managed Care Proposed Rule
  - CMS' Evolving Position on Waiver-Based Payments
- **CMS Scrutiny of Provider-Related Donations**

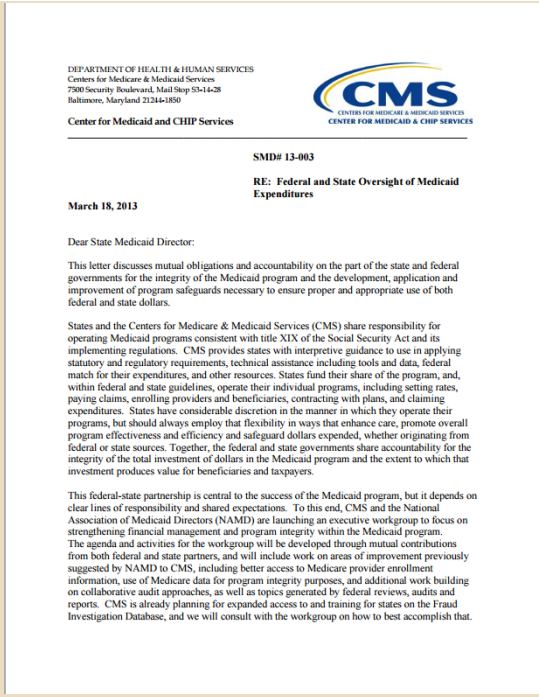
Medicaid Non-DSH Supplemental Payments

Refresher: Rules Governing "UPL" Payments

- Upper Payment Limits
  - Hospital/NF/Clinic UPLs: Aggregate rates must be no greater than **Medicare**
    - 1. State-owned and operated providers
    - 2. Non-state government providers
    - 3. Private providers
  - Professional services: No regulatory UPL
    - CMS policy limits payments to **Average Commercial Rate (ACR) or Medicare**
- Direct pay prohibition for services under managed care contract

CMS Accountability Initiative (2013)

- First time states required to submit annual UPL demonstrations
  - Inpatient & outpatient hospital, nursing facilities, physician/practitioners, clinics, etc.
  - Provider-specific reporting
  - Includes source of non-federal share funding
- First time published CMS guidance on how to calculate the UPLs
- Contractor engaged to organize and analyze the data



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

SMD# 13-003

RE: Federal and State Oversight of Medicaid Expenditures

March 18, 2013

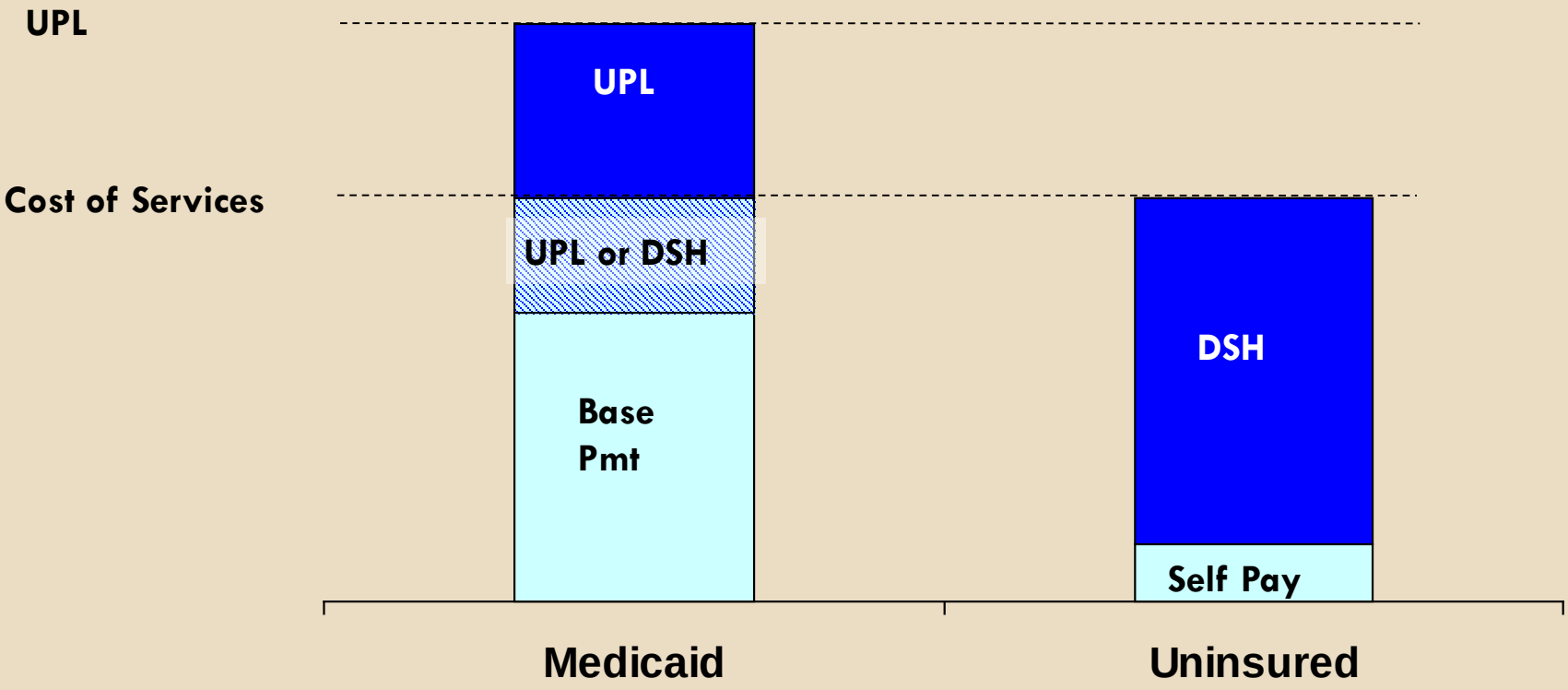
Dear State Medicaid Director:

This letter discusses mutual obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program and the development, application and improvement of program safeguards necessary to ensure proper and appropriate use of both federal and state dollars.

States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act and its implementing regulations. CMS provides states with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, federal match for their expenditures, and other resources. States fund their share of the program, and, within federal and state guidelines, operate their individual programs, including setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures. States have considerable discretion in the manner in which they operate their programs, but should always employ that flexibility in ways that enhance care, promote overall program effectiveness and efficiency and safeguard dollars expended, whether originating from federal or state sources. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers.

This federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. To this end, CMS and the National Association of Medicaid Directors (NAMD) are launching an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. The agenda and activities for the workgroup will be developed through mutual contributions from both federal and state partners, and will include work on areas of improvement previously suggested by NAMD to CMS, including better access to Medicare provider enrollment information, use of Medicare data for program integrity purposes, and additional work building on collaborative audit approaches, as well as topics generated by federal reviews, audits and reports. CMS is already planning for expanded access to and training for states on the Fraud Investigation Database, and we will consult with the workgroup on how to best accomplish that.

Reminder Interaction of UPL & DSH Payments



Medicaid Non-DSH Supplemental Payments

New Agency and Legislative Scrutiny

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

GAO

MACPAC

MACPAC Dissatisfied with CMS Accountability

- **March 2012:** "State Approaches for Financing Medicaid"
- **March 2014:** "Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments"

MACPAC

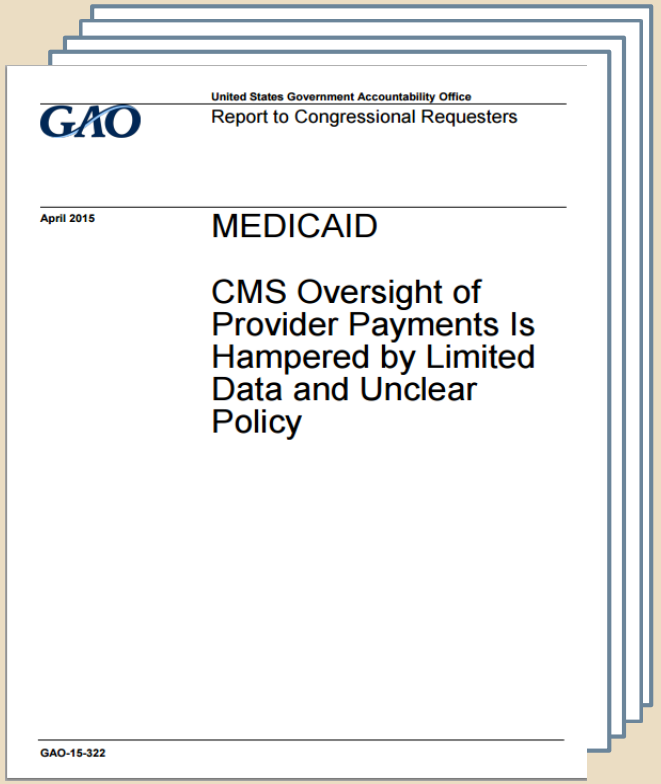
Medicaid and CHIP Payment and Access Commission

Recommendation 6.1

As a first step toward improving transparency and facilitating understanding of Medicaid payments, the Secretary should collect and make publicly available non-DSH (UPL) supplemental payment data at the provider level in a standard format that enables analysis.

Renewed Government Accountability Office (GAO) Scrutiny

- **July 2014/March 2015:** "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection" *(Reps. Issa, Lankford)*
- **April 2015:** "Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives" *(Sen. Hatch, Rep. Upton)*
- **April 2015:** "CMS Oversight of Provider Payments is Hampered by Limited Data and Unclear Policy" *(Reps. Chaffetz, Jordan, Issa, Sen. Lankford)*


United States Government Accountability Office

GAO

Report to Congressional Requesters

April 2015

MEDICAID

CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy

GAO-15-322

GAO Findings, April 2015

Analyzed provider payments in 3 states

- Findings
  - Provider-specific data insufficient
  - Some public hospitals received payments above total (not just Medicaid) operating costs
  - "a small number of government hospitals were receiving high payments that warrant oversight"
  - CMS oversight insufficient
- Recommendations for CMS:
  - Ensure states report provider-specific payment data
  - Develop policy to determine economy and efficiency
  - Develop process to review payments to ***individual providers*** to determine economy and efficiency
    - *Not just aggregate UPL test*

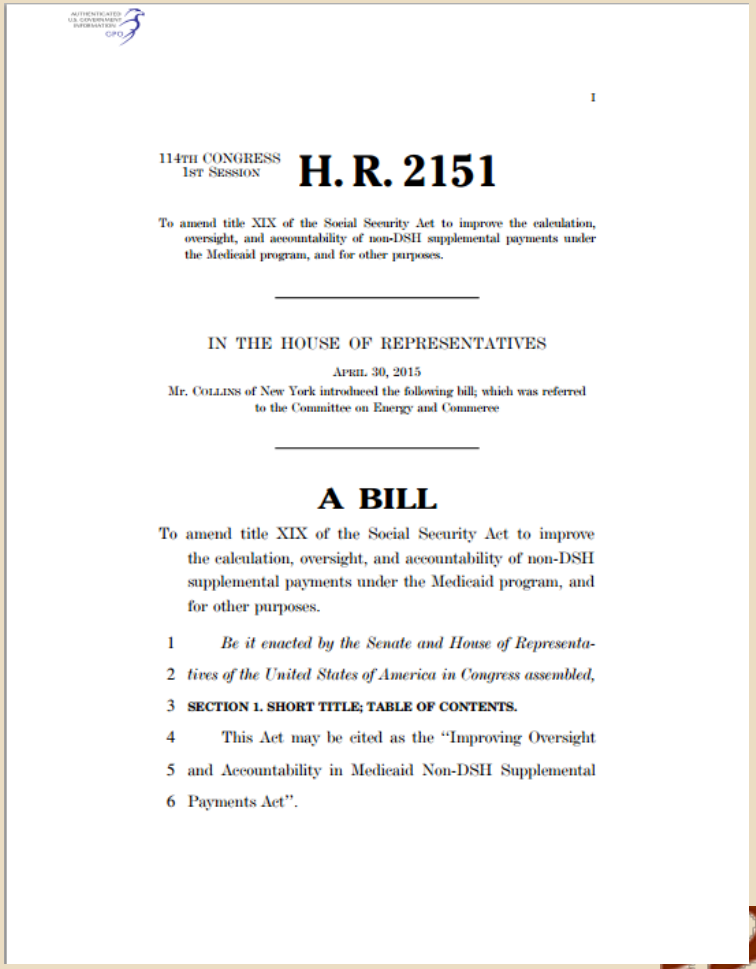
CMS Response

HHS is gathering information from states' annual UPL and DSH audit submissions to better inform individual provider level payment criteria and establish policies and procedures to evaluate whether payments at the provider level are economic and efficient.

CMS Response
GAO Report 15-322 April 2015, Appendix

Renewed Congressional Interest

- Introduction of the "*Improving Oversight and Accountability in Medicaid Non-DSH Supplemental Payments Act*" (H.R. 2151, Rep. Collins (R-NY))
  - Requires DSH-style independent audits of non-DSH supplemental payments
  - Could lead to repayment obligations
  - Application to waiver-based UC payments unclear



114TH CONGRESS
1ST SESSION

H. R. 2151

To amend title XIX of the Social Security Act to improve the calculation, oversight, and accountability of non-DSH supplemental payments under the Medicaid program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 30, 2015

Mr. COLLINS of New York introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XIX of the Social Security Act to improve the calculation, oversight, and accountability of non-DSH supplemental payments under the Medicaid program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

This Act may be cited as the "Improving Oversight and Accountability in Medicaid Non-DSH Supplemental Payments Act".

CMS Working on Supplemental Payments Rule

- CMS Regulatory Agenda includes plans to issue "Medicaid State Payment Adjustment" proposed rule
- New requirements to ensure supplemental payments are economic and efficient
  - Would require "all supplemental payments be distributed proportional to the volume or cost of service delivered or be tied to meeting performance benchmarks"
- Time limit on supplemental payments
- Additional state reporting requirements

Medicaid Non-DSH Supplemental Payments

Implications of Managed Care Proposed Rule

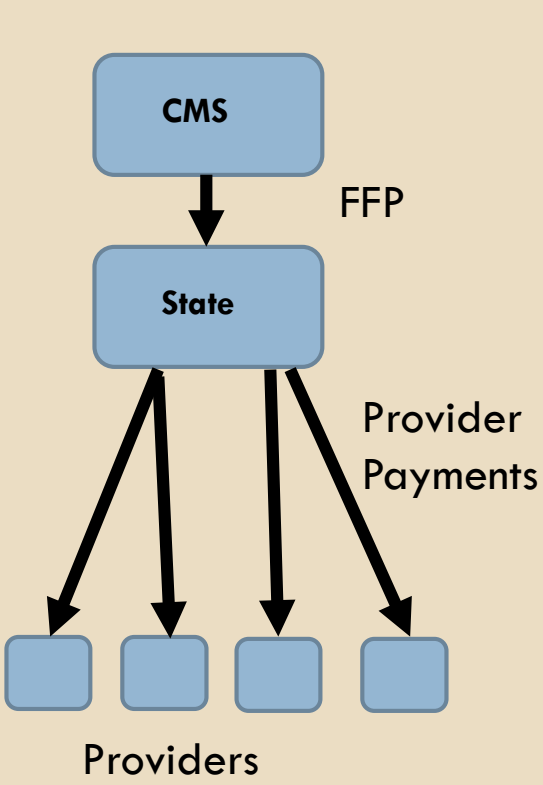
Challenge of Adequate Support Under Managed Care

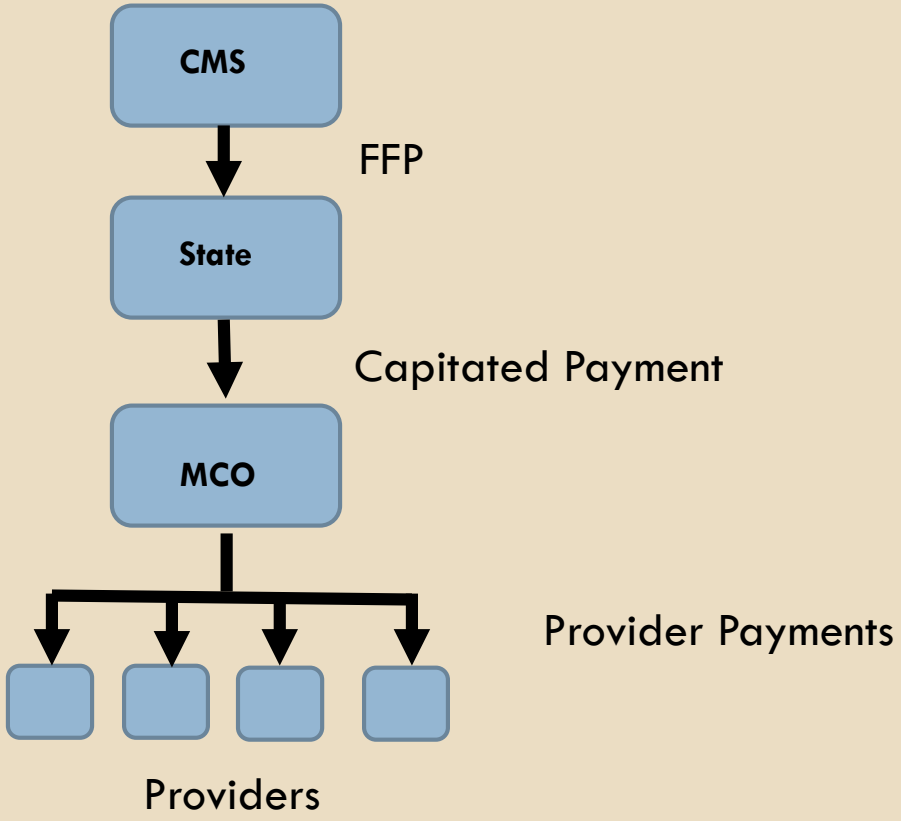
- Direct pay prohibition
  - CMS regulations say states cannot make supplemental payments directly to providers for services under MCO contract
  - Past interpretation limited state indirect payments through plans
- *Exceptions*
  - Statute requires to pay **DSH** directly to providers
  - CMS policy allows states to pay **graduate medical education** directly to providers
  - FQHC wrap-around

State "Workarounds"

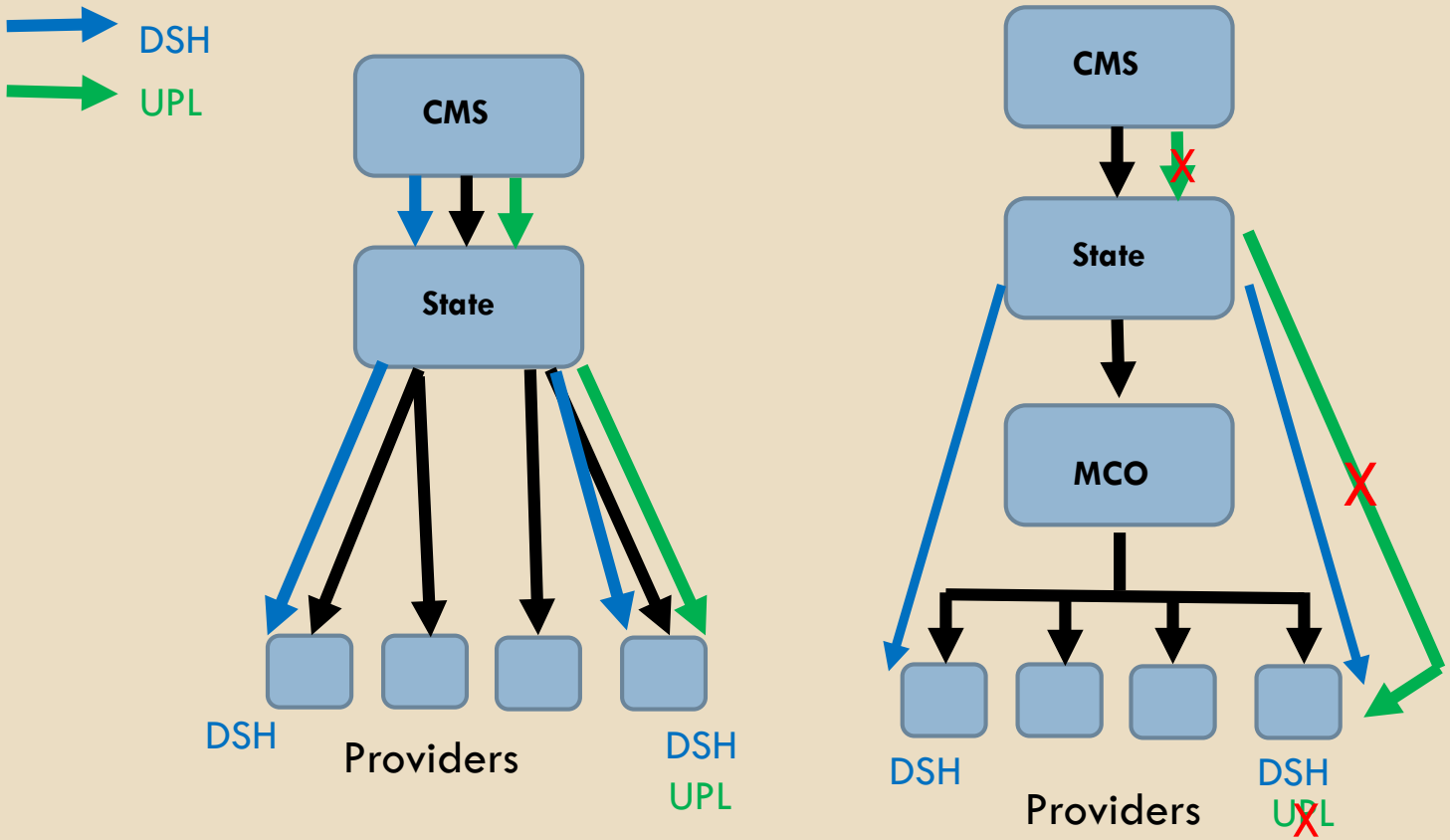
- Services carve-outs
- Waiver-based UC pools
- DSRIPs (in some cases)
- GME payments (may be paid directly)
- Payments through MCOs

Simplified Model FFS vs. Managed Care

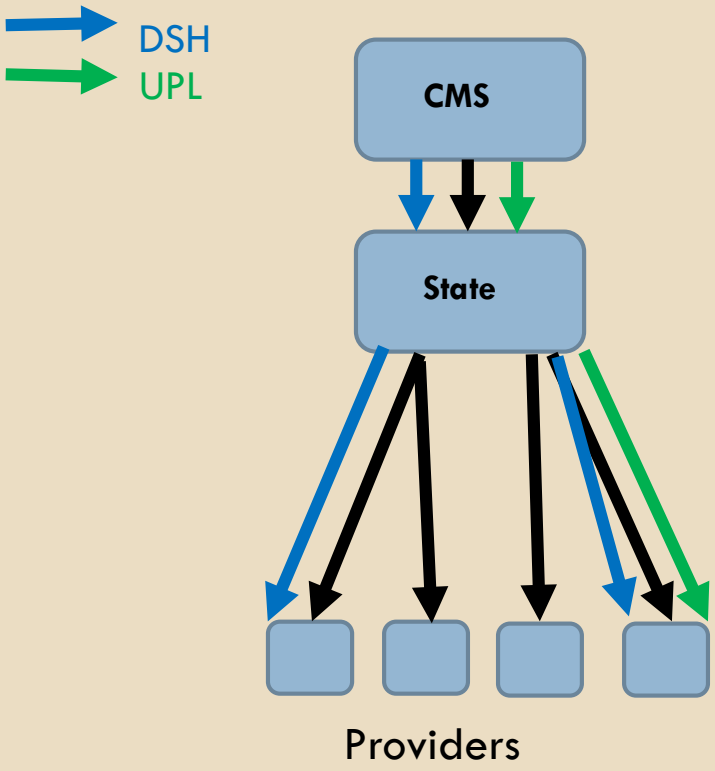


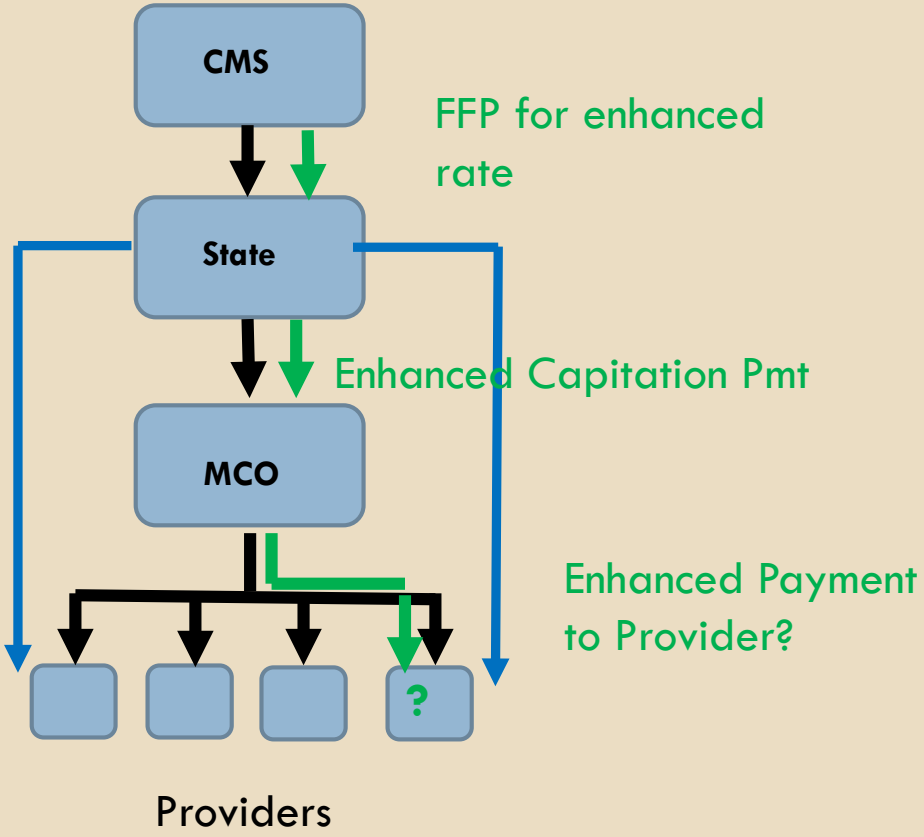


Direct Pay Prohibition



Enhanced Payments through MCOs





How much will CMS let State direct payment to provider?

Prior to Managed Care Proposed Rule

- America's Essential Hospitals Letter to CMS, April 2015

necessarily shared by contracted health plans. In a letter to former CMS Administrator Marilyn Tavenner last fall, we detailed our concerns about the direct pay prohibition and its implementation. Since then, we have been pleased to learn, in meetings with CMS staff, that CMS's policy regarding states' ability to contractually require plans to make specific supplemental payments to specific providers is evolving, and that in certain (unspecified) circumstances, more prescriptive provisions are allowable. Direct supplemental payments from states to providers remain impermissible under the current regulations, but at least that prohibition appears less likely to also ban indirect payments through plans.

Nonetheless, it is still critical that the direct pay prohibition be repealed and states be allowed to make direct payments to providers to meet other state policy goals, beyond the current exceptions for graduate medical education payments, DSH payments and payments to federally qualified health centers.

Proposed Managed Care Rule

- Released May 26, 2015
- Comprehensive overhaul of managed care regulations (first since 2002)
  - Goals include promoting innovation and cost-efficiency, expanding value-based payments, incentivizing use of performance targets
- Retains the direct pay prohibition
- Adds explicit prohibition on directing payments through MCOs

Proposed Rule on Directing Payments through MCOs

State cannot direct MCO payments under contract with plans *except under specified circumstances*:

- 1) requiring implementation of value-based purchasing models,
- 2) mandating participation in a multi-payer delivery system reform and
- 3) requiring the plan to adopt
  - A minimum fee schedule or
  - uniform rate increase for *all* providers of a particular service.

- Troublesome preamble language characterizes as simply codifying "longstanding CMS policy"
  - Significant new constraints compared to current practice
- (Does not impact ability to negotiate higher payment amounts in contract between plan and provider)

Medicaid Non-DSH Supplemental Payments

CMS' Evolving Position on Waiver-Based Payments

CMS' Evolving Position on DSRIPs

- CMS is re-evaluating its DSRIP activity
  - Return on investment
  - Administrative burden
  - New York waiver as preferred approach
  - DSRIP as a means not an end
  - Sustainability a concern

CMS' Evolving position on Uncompensated Care Pools

- CMS disfavors **uncompensated care pools**
  - Will review each state's circumstances individually, as pools expire
  - Requiring independent evaluations
- Principles announced in April 14 letter to Florida, later sent to 8 other states with UC pools:
  1) "…uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion."
  2) "Medicaid payment should support services provided to Medicaid beneficiaries and low-income uninsured individuals."
  3) "…**provider payment rates must be sufficient to promote provider participation and access…**"

Example Waiver Terms

Arizona 1115 Waiver
Special Terms and Conditions

"Arizona must conduct an **independent evaluation** of the use of the SNCP for Phoenix Children's Hospital…An analysis of factors that contributed to the necessity of SNCP payments to PCH including, but not limited to…Provider and diagnosis **payment rates** in the state…An analysis of …the factors that contributed to the necessity of SNCP payments overall as well as specifically for **Medicaid shortfall.**

The state shall submit a **transition plan** describing **movement towards long term payment reforms** and solutions for PCH and away from current payments received through the SNCP…"

Florida 1115 Waiver
Special Terms and Conditions

"Florida will …develop a plan to **reform Medicaid provider payments** and funding mechanisms, with the goal of **developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms** that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding…

…A **report from an independent entity** on Medicaid provider payment in the state…

Significant Challenges to Each Avenue of Supplemental Payment

- Renewed scrutiny and potential proposals to limit FFS UPL payments
- No direct supplemental payments for MC services
- No indirect state direction of enhanced payments through MC plans, except limited circumstances
- Transition out uncompensated care pools
- Uncertain future of DSRIPs
- DSH cuts ahead

Where does this leave you?

- CMS wants states to pay adequate base rates
- But
  - *Armstrong* decision forecloses providers' ability to seek judicial enforcement of adequate rates
  - CMS not yet finalized proposed Equal Access Rule, pending since 2011
    - And question efficacy of proposed form

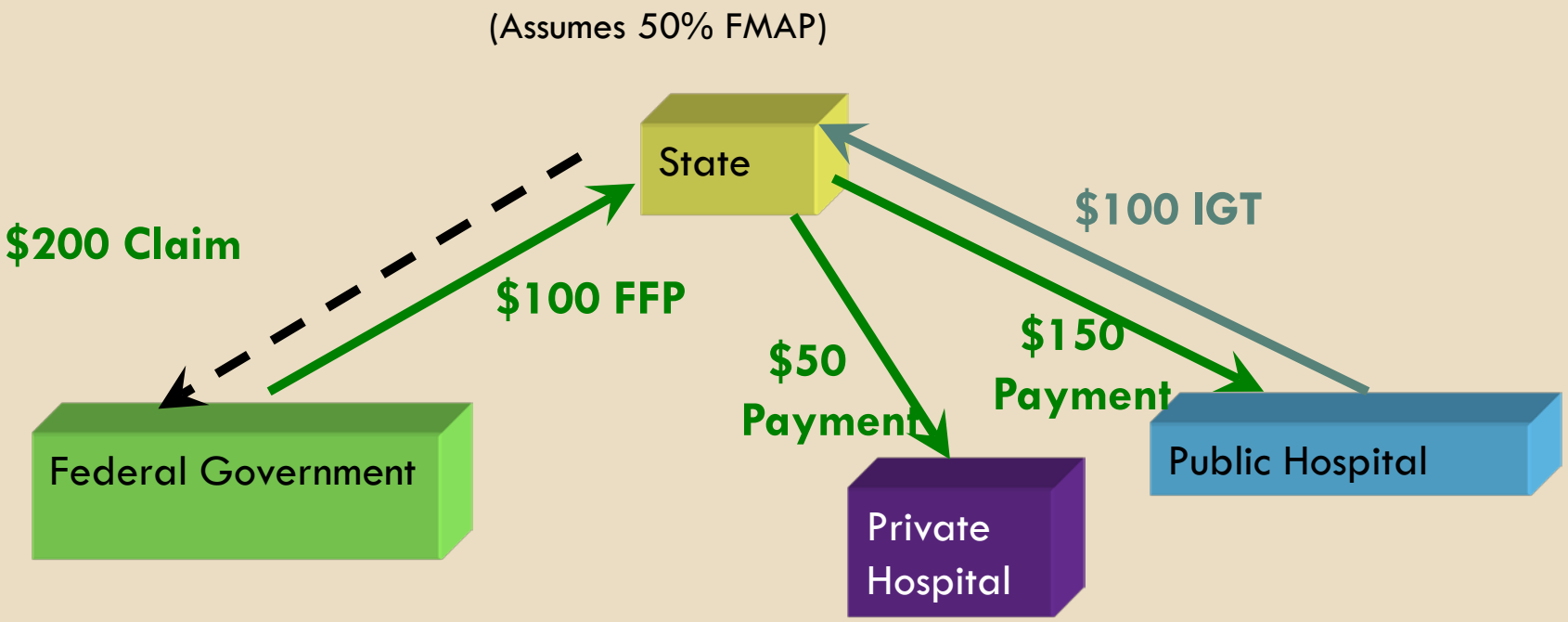
Financing Challenges

Provider-Related Donations

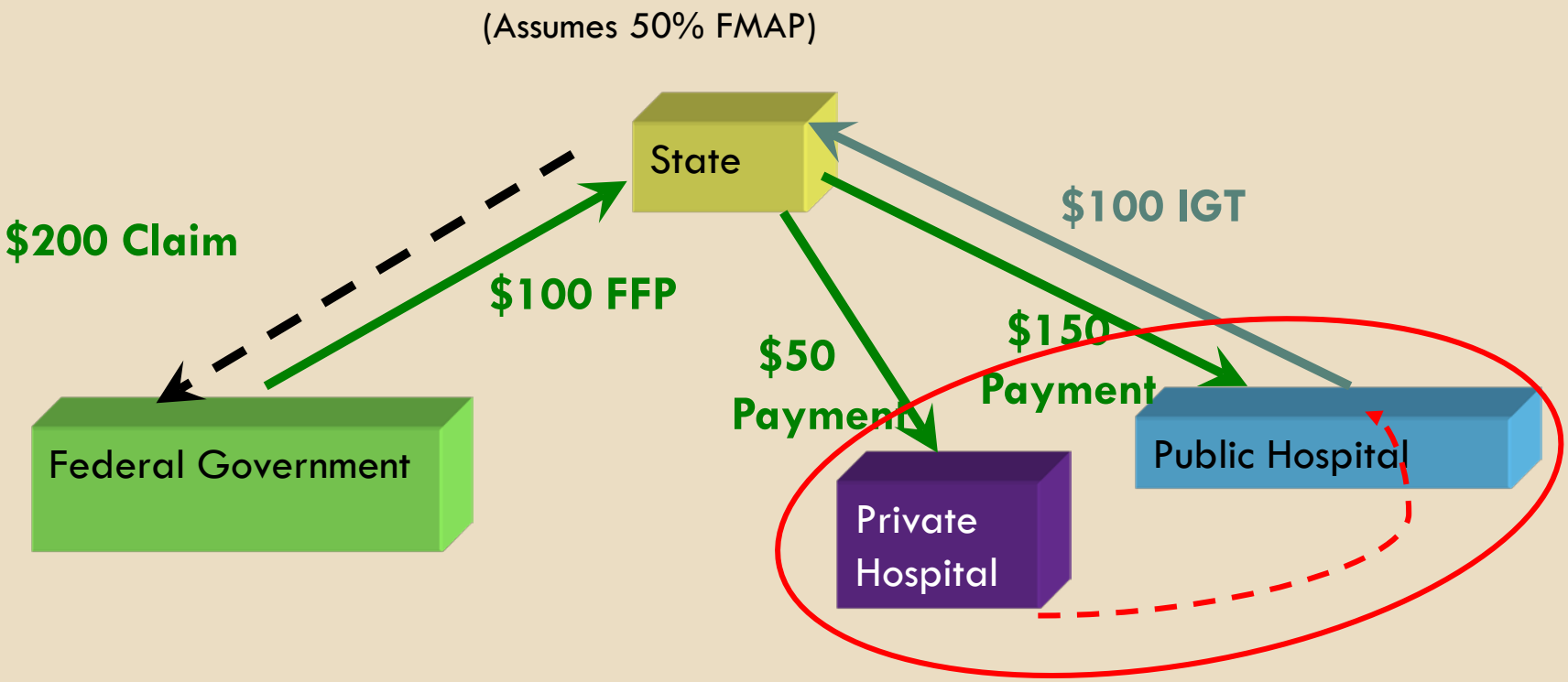
- No federal match for expenditures financed with funds from private provider-related entities
- CMS regulations define as:

> "a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a state or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the state for administration of the state's Medicaid plan"

Recall permissible to fund private hospital payments with IGTS



But IGT cannot be funds from private provider



CMS' Evolving Policy on Provider Donations

- May 9, 2014 State Medicaid Directors Letter
  - Public-private partnerships
  - The provision of a service or in-kind transfer of value by a private provider to "further the purposes of the government entity" may constitute an impermissible provider donation
- Louisiana SPA disapproval
- Texas deferral lifted; must address by end of 2015

Examples of Potential Donations from May 2014 Guidance

- Example 1
  - Private hospital lease space from a government entity at an amount above fair market value
  - Government entity uses lease payments to fund IGTs for the non-Federal share of Medicaid supplemental payments to the private hospital
- Example 2
  - Government entity and private hospital enter public-private partnership arrangement
  - government entity terminate an existing contract with a non-profit organization for certain services
  - private hospital executes the same contract with the same non-profit organization
  - Government entity sends an IGT to Medicaid agency to fund Medicaid payments to the private hospital
  - IGT is in an amount approximately equal to the amount that it would have spent on the now terminated contract

No Payment without Permissible Source of Non-Federal Share

Viable alternatives?

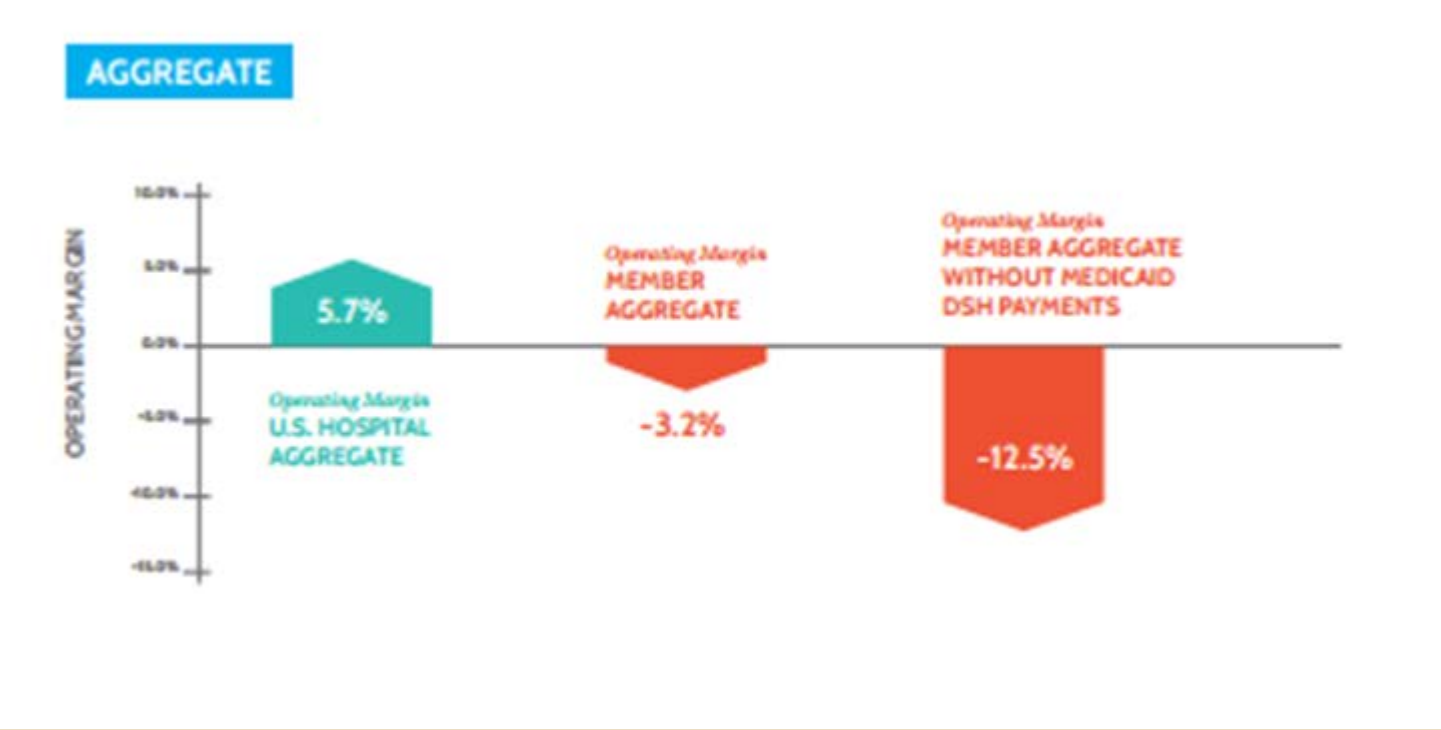
- General Revenues
- Intergovernmental Transfers
  - Without impermissible public/private arrangement?
- Provider Taxes
- Non provider-related donations

Conclusion

The Stakes are High

National Operating Margins

Members of America's Essential Hospitals vs. All Hospitals Nationwide FY2013




UNKNOWN
CONDITIONS
AHEAD

Questions?

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