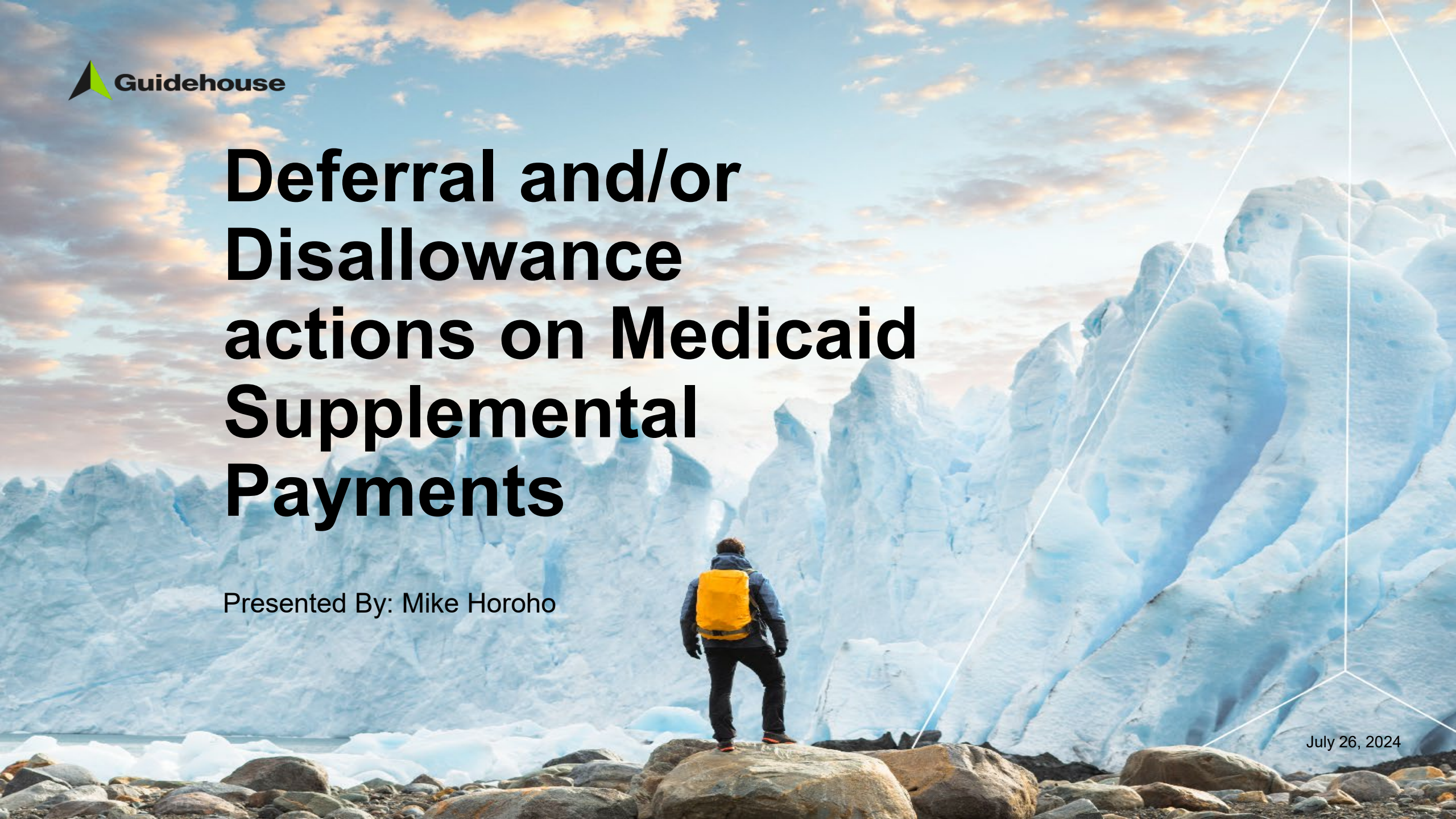

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Deferral and/or Disallowance actions on Medicaid Supplemental Payments

Presented By: Mike Horoho

July 26, 2024

About the Presenter

Michael Horoho

Director

Michael is a seasoned Medicaid financial consultant with more than 20 years of experience in the Medicaid finance and audit industry. Michael and his team specialize in assisting state health and human service finance agencies with expenditure reporting used to support claims for Medicaid/CHIP federal financial participation (FFP). Michael's background and experience include long-term care cost report audits, institutional fee for service rate setting with a focus on Upper Payment Limit (UPL) calculations / Medicaid FFS supplemental payments/State share financing, and Medicaid / CHIP federal expenditure reporting (CMS-64/CMS-37/CMS-21/CMS-21b).

His expertise extends across Medicaid finance/budget, claims/accounting systems, grants management, program management, Medicaid administrative claiming, and provider audit. Michael has successfully navigated clients through complex federal guidance (state plan/waiver authorities, public assistance cost allocation, various federal regulations and guidance), CMS/OIG/state audits, identifying opportunities to increase claims for Medicaid FFP or even identifying/managing any FFP at risk, preparing institutional costing models, and implementing automated technology solutions that increase efficiency and quality in financial reporting.

Before his role at Guidehouse, Michael held senior leadership positions at leading CPA firms providing audit and consulting services to state health and human service agency clients. Michael's team are sought-after professionals with decades of Medicaid finance and regulatory compliance experience. These professionals are former CMS Financial Management branch chiefs and state agency finance leaders. This team is supported by the broader Guidehouse state practice with program and policy experts, Medicaid claims systems professionals, actuaries, former state executive budget officers, former state agency CFOs, Enterprise System Solutions, and former Medicaid provider finance officers.

Agenda

- What is a deferral and disallowance

- Funding Mechanisms used for Medicaid Supplemental Payments
  - Intergovernmental Transfers
  - Provider Taxes

- Medicaid Supplemental Payment Deferrals and Disallowance Case Studies
  - Recycling
  - Non-Bona Fide Donations

What is a Deferral and/or Disallowance Action

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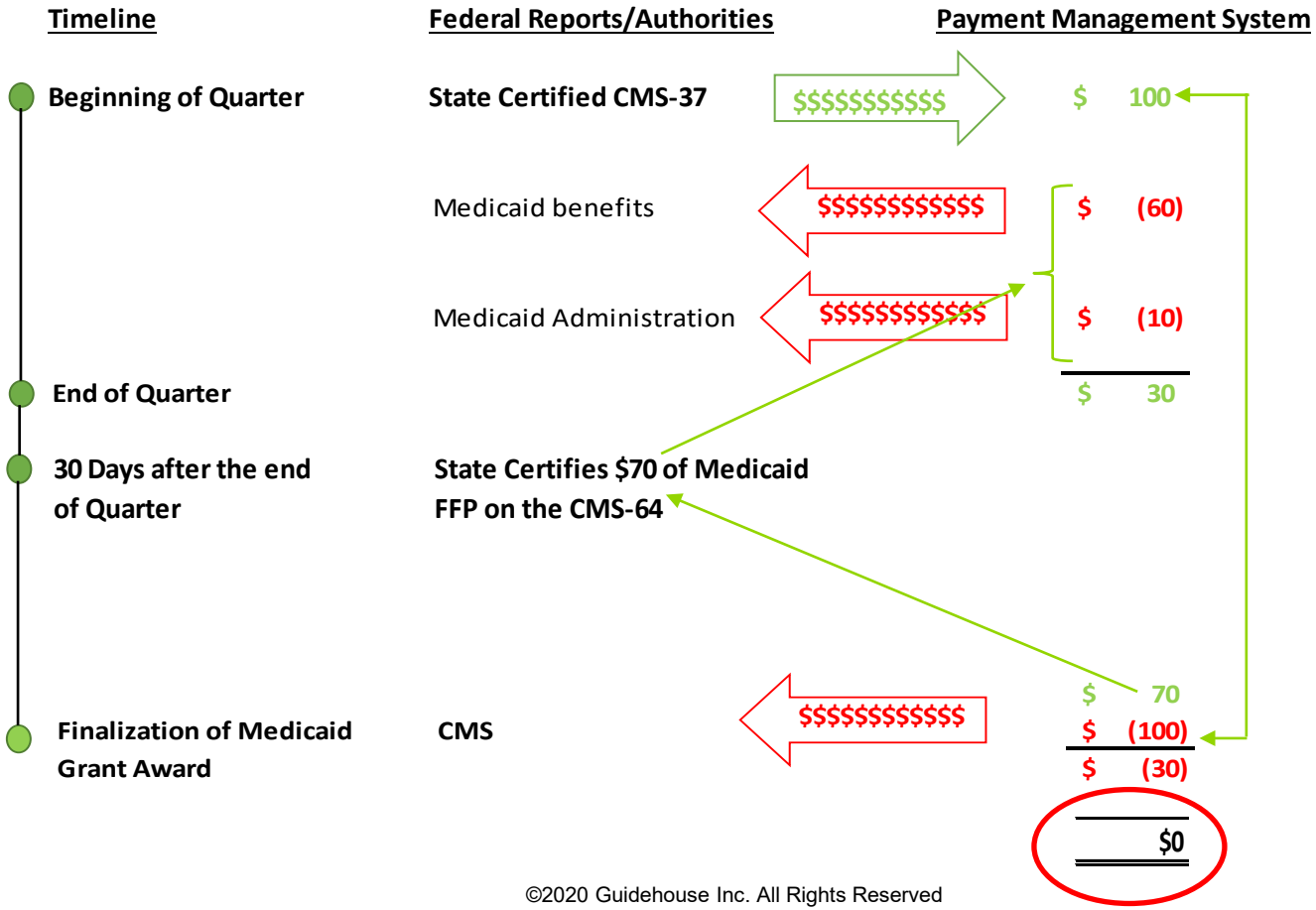
Medicaid Grant Award Finalization

CMS completes their review of the CMS 64 and “finalizes” the Medicaid grant award for that quarter. The finalization award will recover what is initially awarded to the state less what CMS has determined the state has earned in Medicaid FFP (based on the certified CMS 64). If draws from the PMS system equal what is reported on the CMS 64 and no other adjustments were made by CMS in their review, then the balance in PMS for the Medicaid grants would be zero dollars.



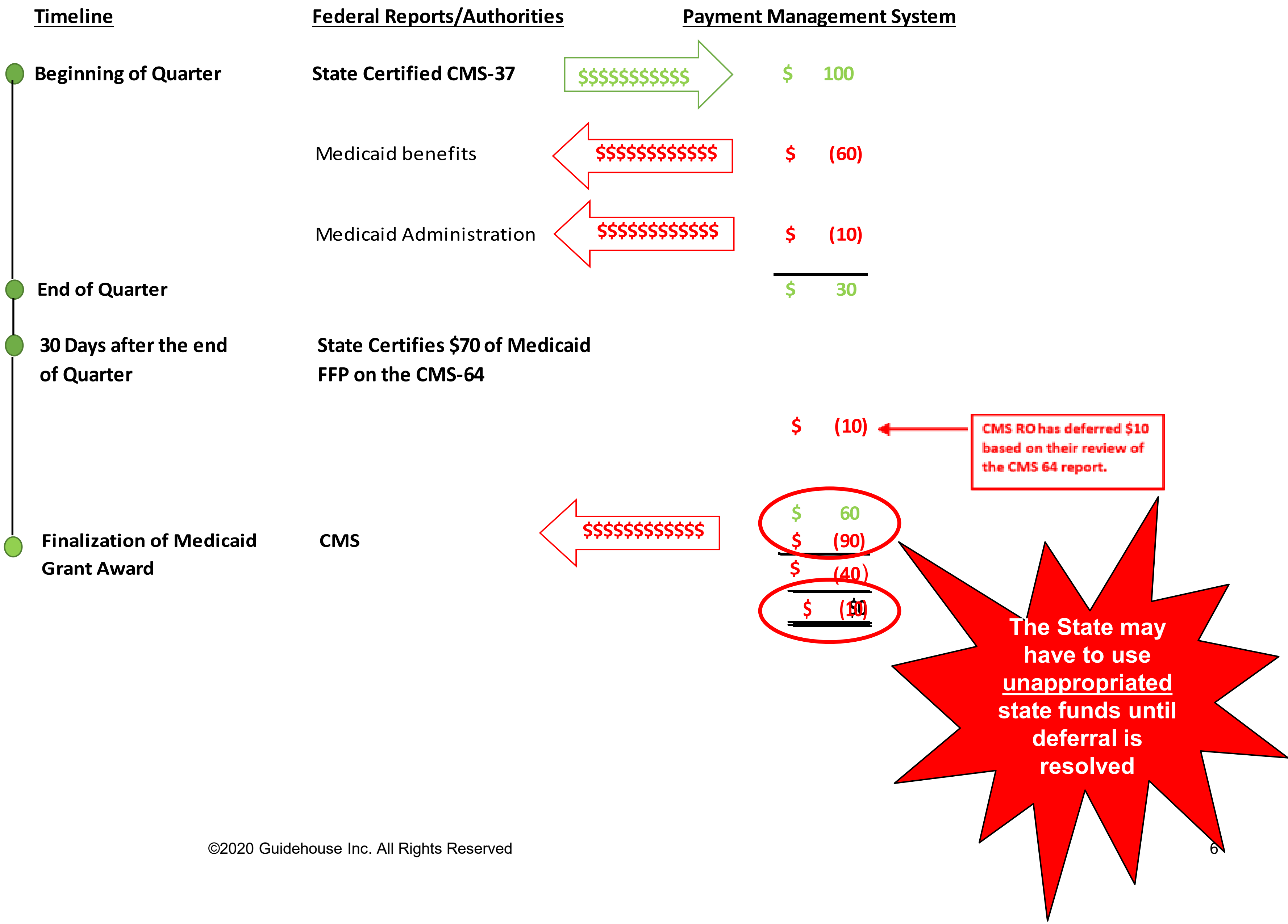
Deferral and Disallowance Action

If during the review performed by CMS the state is unable to adequately explain or support the allowability of an expenditure on the CMS 64, CMS can defer the award of Medicaid federal funds related to that specific expenditure.

In this example CMS has executed a deferral action based on their review of the support for the CMS 64 provided by the state.

If after reviewing the support for the deferred expenditure CMS determines that the state cannot justify the expenditures allowability, then CMS issues a disallowance for that expenditure.

This deferral action is recognized in the grant award finalization and has the below effect on the federal funds being managed in PMS.



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Medicaid Supplemental Payment Deferrals and Disallowance Case Studies

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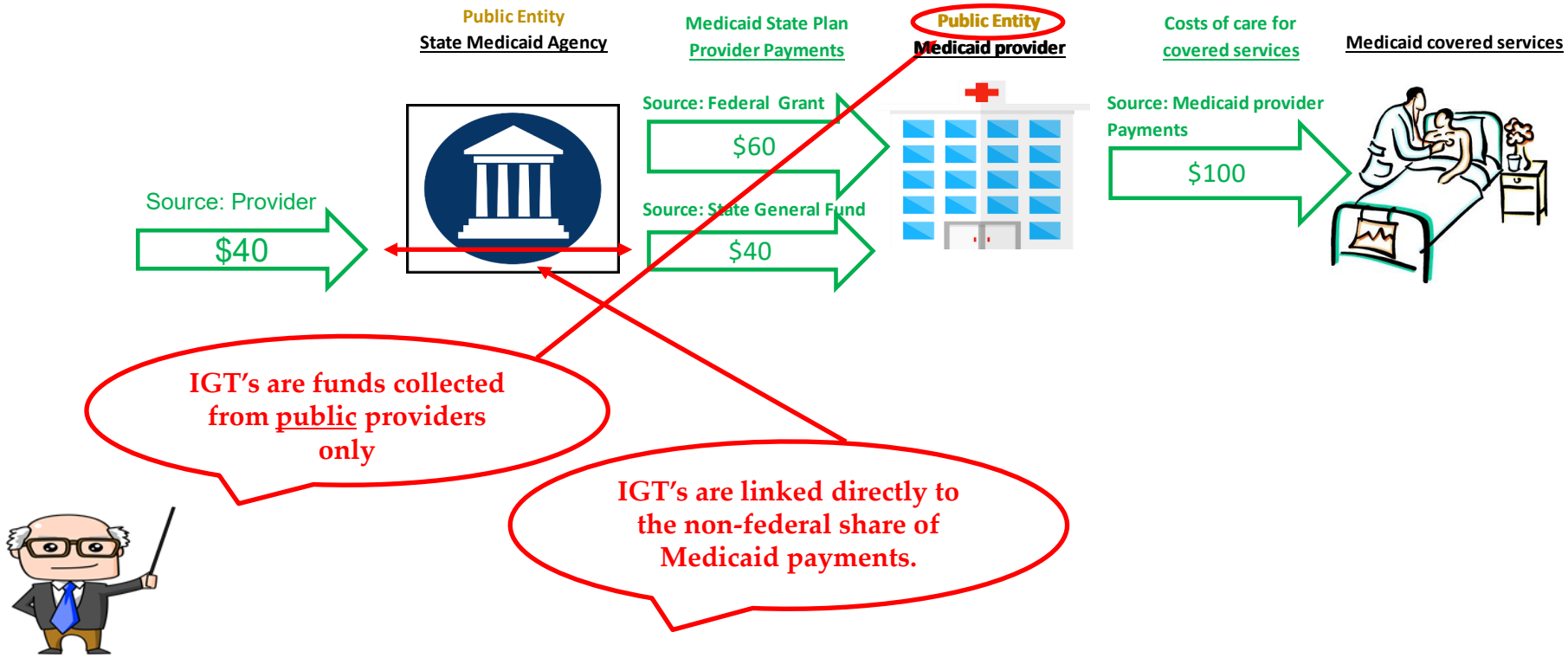
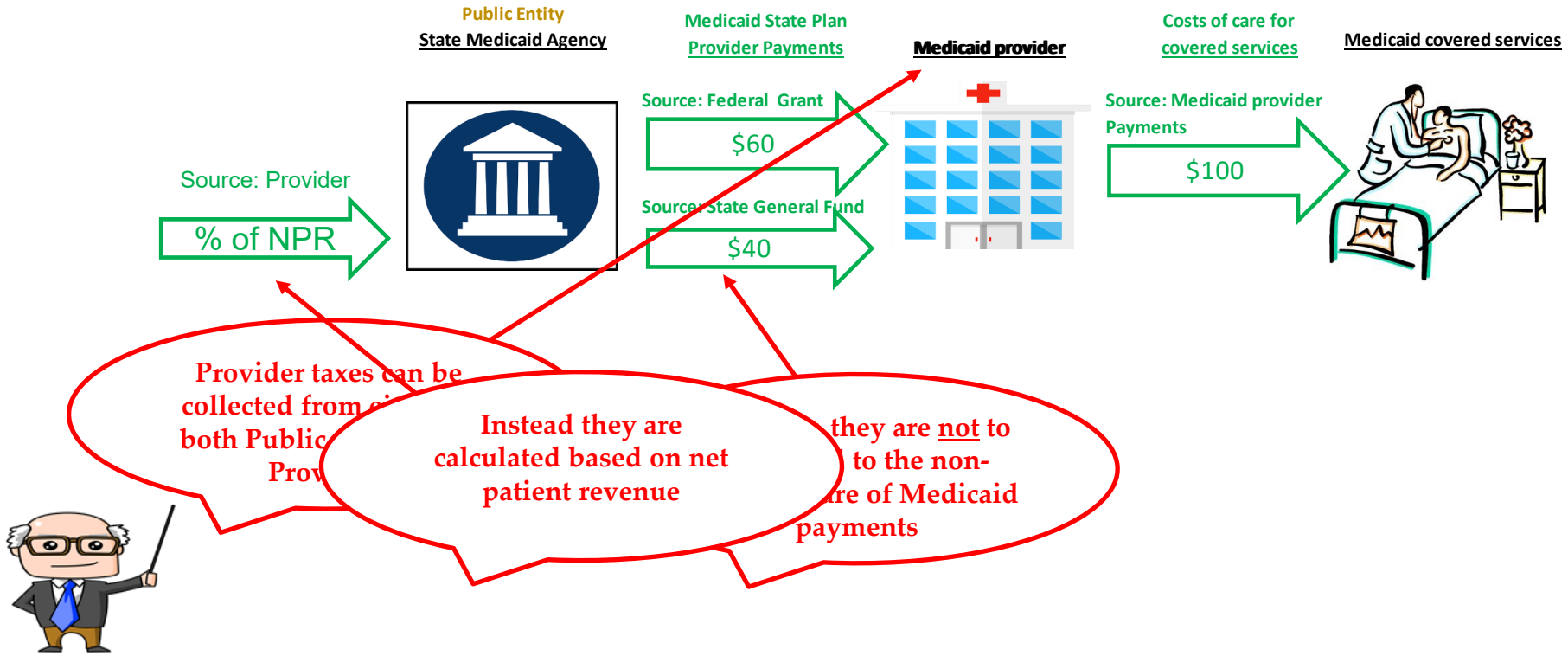
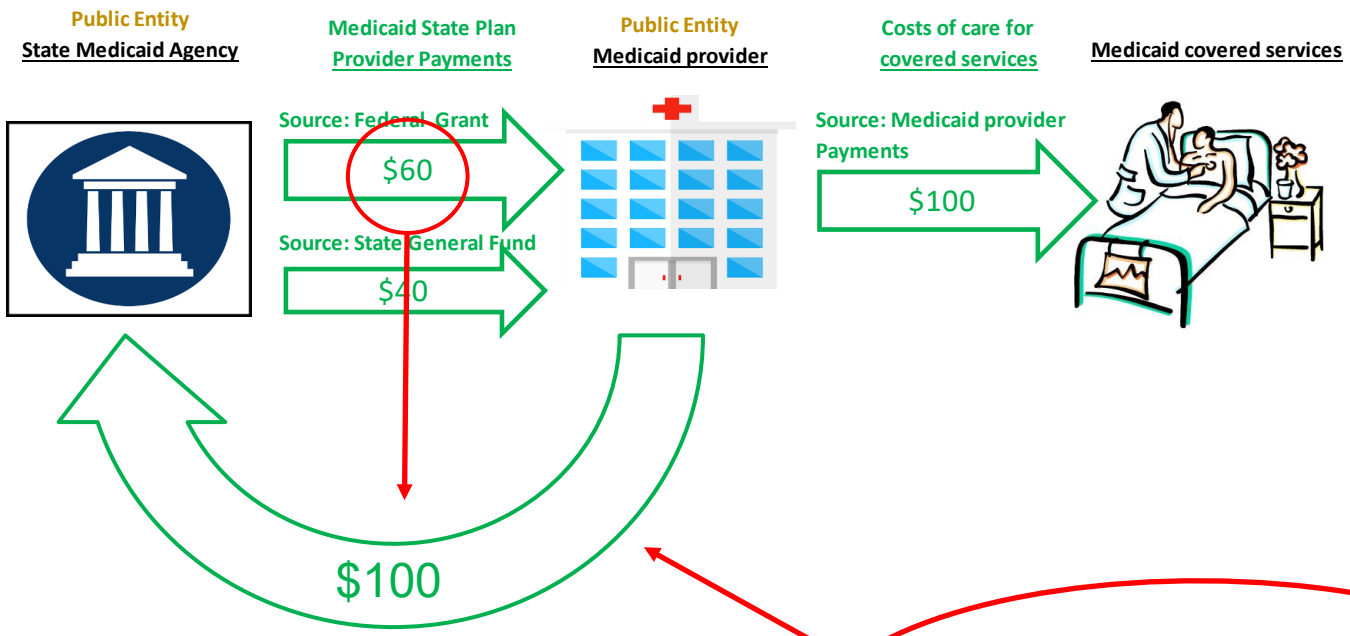
Intergovernmental Transfers (IGT)



Provider Taxes



Recycling



The public provider returns Medicaid payments to the SMA via "IGT." SMA will leverage these dollars to fund state share of other Medicaid payments.

Examples of Recycling Medicaid Supplemental Payments

Transfer of funds after supplemental payment is received

State Medicaid Agency (SMA) paid Nursing Facilities a FFS Medicaid Supplemental Payment. A letter was sent by the SMA to each provider receiving this payment to IGT 90% of this payment to the state. CMS deferred and eventually disallowed the amount of the IGT that was greater than the state share. So if FMAP is 70%, the state share would be 30% and CMS would disallow 60% (90% IGT – 30% state share) of the supplemental payment.

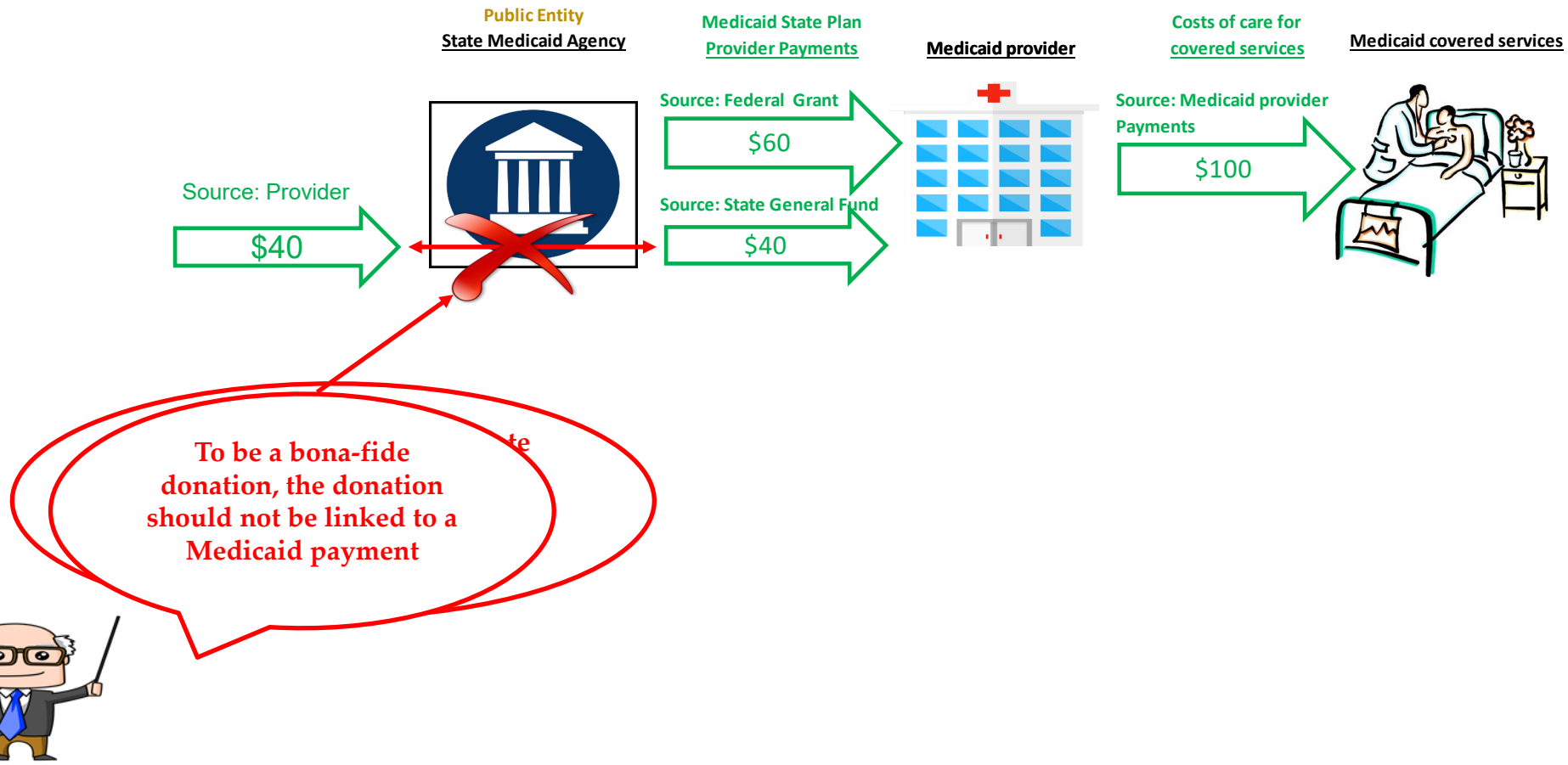
"Admin" Fee

SMA keeps a percentage of an IGT used to fund a Medicaid Supplemental Payment to cover the administrative costs incurred by the state to administer a FFS Medicaid Supplemental Payment Program. The SMA then "grosses up" the remaining percentage of the IGT to payout the Medicaid Supplemental Payment to the provider. CMS defers and eventually disallows this "fee" since the state's administrative costs are already covered by a Medicaid Administrative Grant.

Distributing only the federal share

The SMA assumes that since the SMA and the public provider are both public entities, then the Medicaid Supplemental payment is a "state funds only" interagency transfer (similar to how certified public expenditures (CPE) works). However, the Medicaid state plan clearly requires the state to pay the provider the full amount of the Medicaid supplemental payment. Therefore, CMS disallows any portion of the IGT that was greater than the state share of the actual Medicaid payment made to the provider.

Non-Bona Fide Donations



Examples of Non-Bona Fide Donations funding Medicaid Supplemental Payments

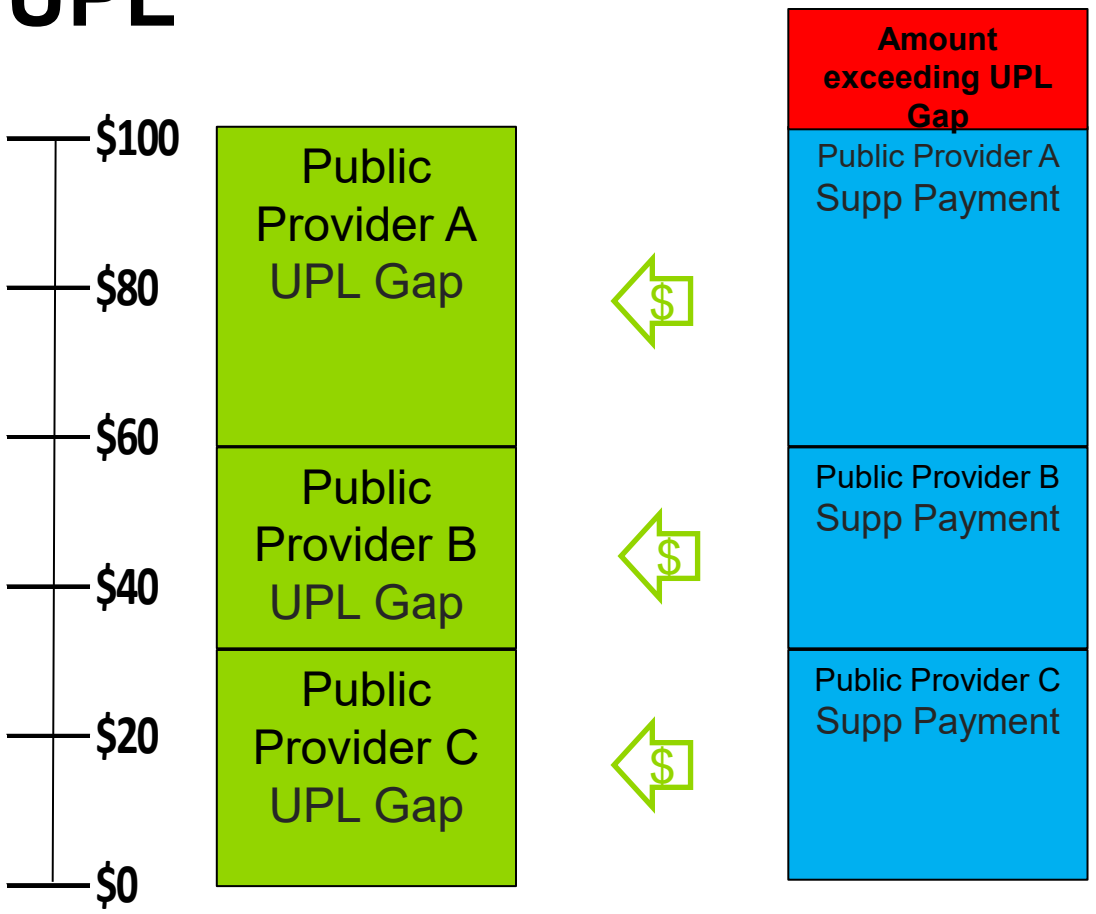
Public/Private Partnerships

A privately owned hospital enters into an agreement with the state to provide services to patients typically treated at a nearby public hospital. In return, the state will pay the privately owned hospital a Medicaid Supplemental payment. The state does not have enough general fund appropriation and the state does not want to create a tax to fund the state share of the Medicaid Supplemental payment. Therefore, the state accepts a "donation" from the privately owned hospital to fund the state share of the Medicaid Supplemental payment. Since there is a direct link between the donation and the Medicaid Supplemental payment, CMS disallows the federal share portion of the Medicaid Supplemental payment.

Redistribution of Medicaid Payments

A State is struggling to maintain access to care for certain Medicaid services within rural areas. As a way to get money to rural providers, a state directs a hospital to distribute a portion of a Medicaid Supplemental payment to these rural providers. Again, since there is a direct link between the Medicaid Supplemental payment and the portion paid to the rural providers, CMS considers this an impermissible donation and disallows the federal share of the amount paid to the rural providers.

Exceeding UPL



[illegible] upper payment limit [illegible] the CMS-64, we recommend taking a look at since there is conflicting guidance on how Medicaid Supplemental payments are to be reported on the CMS-64.

Contact

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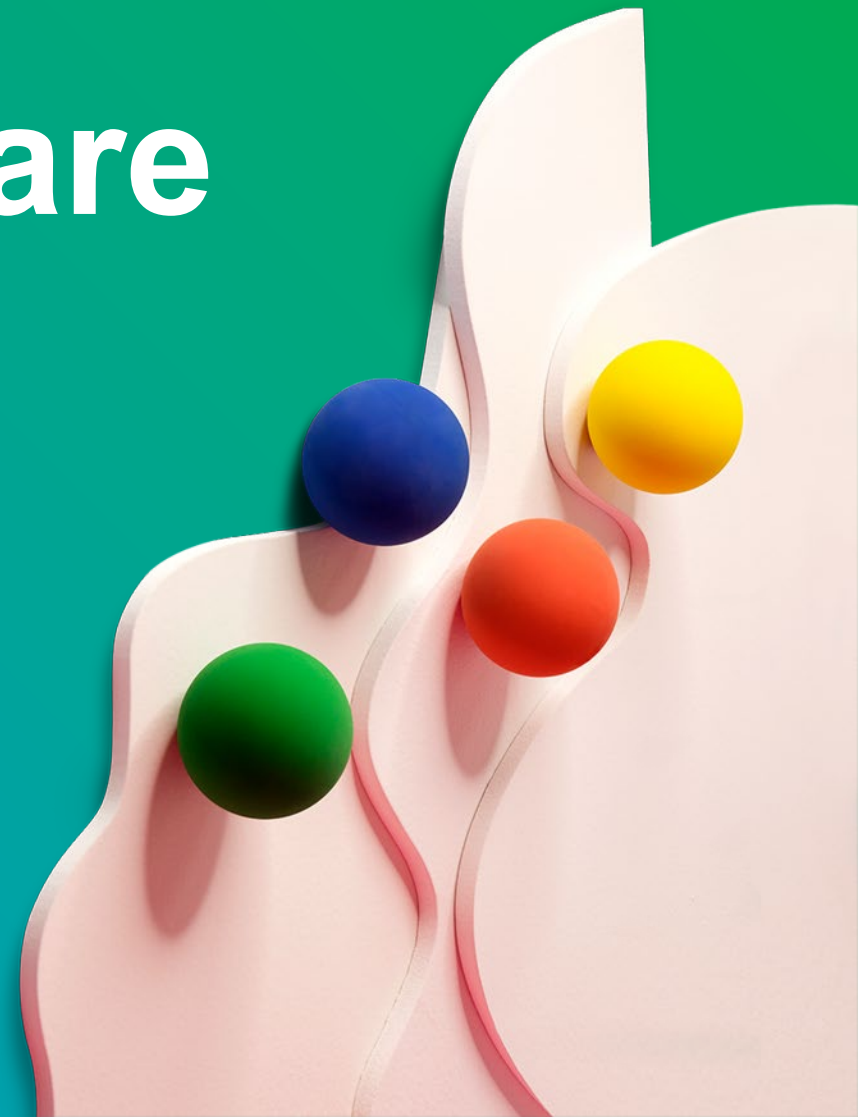
welcome to brighter

Medicaid Managed Care Final Rule

State Directed Payments



August 7, 2024

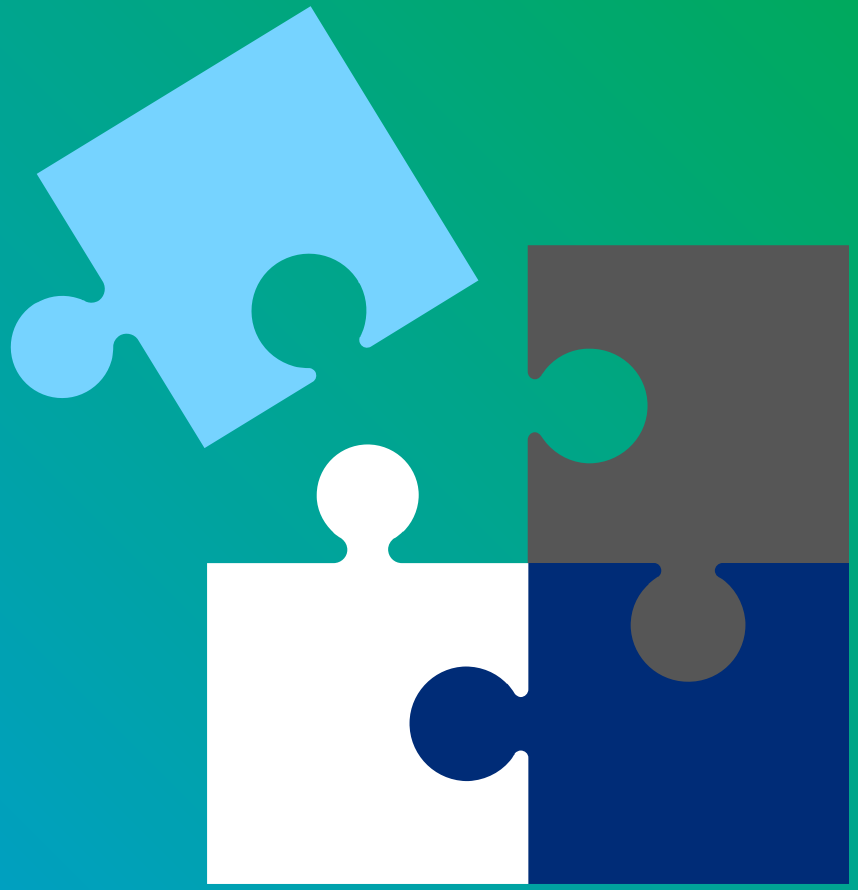
A business of Marsh McLennan

Medicaid Managed Care and FFS Access Final Rules

Overview

On April 22, 2024, Centers for Medicare & Medicaid Services (CMS) released two significant final rules describing new requirements targeted to enhance access to care in Medicaid managed care, as well as fee-for-service (FFS), with an effective date of July 9, 2024, and many provisions being phased in over time:

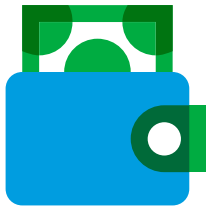
- CHIP Managed Care ("Managed Care Rule"): This rule builds on the 2016 Managed Care Rule with several new requirements and modifications to managed care payment, operations, and evaluation (e.g., SDPs, in lieu of services [ILOS], quality ratings). This rule also requires new access standards for managed care to align with marketplace requirements
- Ensuring Access to Medicaid Services ("Access Rule"): This rule primarily focuses on new CMS requirements for access in FFS, including new requirements for home and community-based services (HCBS) programs and attempts to better align managed care and FFS access policies



Medicaid Managed Care Final Rule

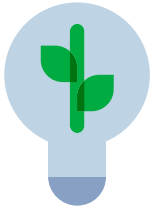
Overview

Access and Rate Transparency



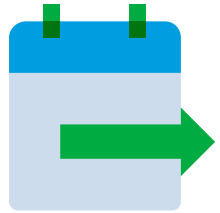
Directed Payments, ILOS, and Medical Loss Ratio (MLR)

Quality Ratings for Plans



Transparency in Managed Care Organization (MCO) Oversight

External Quality Review and Quality Strategies



Implementation Timeline

State Directed Payments

SDPs: The Good, the Bad, the Ugly

The Good

Streamlining

- No preprint if 100% of Medicare

State Appeal Rights

- CMS can disapprove an SDP, but states can appeal to the Departmental Appeals Board (DAB) review (similar to the process for financial disallowances)

Value-Based Purchasing (VBP)

- Removes rules that prohibit states from setting the amount or frequency of the plan's expenditures
- Allows condition- or population-based VBP
- States will be allowed to recoup unspent funds from MCOs
- Allows states to implement stronger and more flexible VBP incentives

Out of Network Providers

- Will be allowed, but not required
- Addresses a barrier states have raised to CMS

SDPs: The Good, the Bad, the Ugly

The Bad

With Certification Reports

- Calculate SDP cost percentages compared to capitation rate
- Two-year submission window
- Actuarially certified
- More administrative paperwork to track

Documentation Requirements

- **Timeframes for preprints submission will change to the prior to the start of the payment** and include standards for complete submission
- Timeframes to document in the contract and rate certification
- Specific documentation standards
- Transformed Medicaid Statistical Information System (T-MSIS) reporting (is SDP encounter-based?)

More Rigorous Evaluation

- Written evaluation *plan* for CMS prior written approval, updated with amendments and renewals
- Evaluation *report* required for SDPs over 1.5% of capitation and optional for others
- At least two measures in plan per preprint
- Evaluation reports must be posted on state website
- CMS commits to considering disapproval of SDP if no improvement
- Permits external quality review organization (EQROs) to complete evaluations for enhanced match

VBP Administration

- No payment unless **maintenance** or improvement so providers may not get payments they feel they deserve

No Post-Payment Reconciliation

- Payment can only be made on current claims and encounters
- Impact on cash flow

SDPs: The Good, the Bad, the Ugly

The Ugly

ACR

- Total Payment Rate for inpatient (IP) facility, outpatient (OP) facility, nursing facility (NF), or practitioner services at an academic medical center cannot be paid more than average commercial rate (ACR)
- Does not permit states to trend forward ACR; must recalculate if updating annually
- CMS continued to include NFs even with strong opposition

No Separate Payment Terms

- CMS will not permit the use of a separate payment term for any directed payment arrangement and will require all SDPs be built into the rates through base data and adjustment to capitation rates

No Retroactive Changes to Capitation Rates

- Retroactive changes to the rate certification for SDPs are no longer permitted unless error
- Changes now must be prospective

Financing and Redistribution

- Requires attestations by most providers in a payment arrangement funded through taxes that the provider will not be held harmless
- Permits some flexibility if a provider will not sign

Implementation Timeline

July 9, 2024 Effective Date–First Impacted Rating Period January 1, 2025

July 9, 2024

- Restricts retroactive adjustment to rates for SDPs
- Streamlining for 100% Medicare
- VBP flexibilities
- State appeal rights
- Out of network

First Rating Period After July 9, 2024

- ACR demonstration
- VBP condition-based payment attribution
- VBP measure selection

First Rating Period After July 9, 2026

- VBP payment requirements
- CMS preprint submission timeframes
- Contract documentation requirements

First Rating Period After July 9, 2027

- No separate payment terms
- No payment reconciliation
- Evaluation plan submission and report requirements

First Rating Period After January 1, 2028

- Provider hold harmless attestation

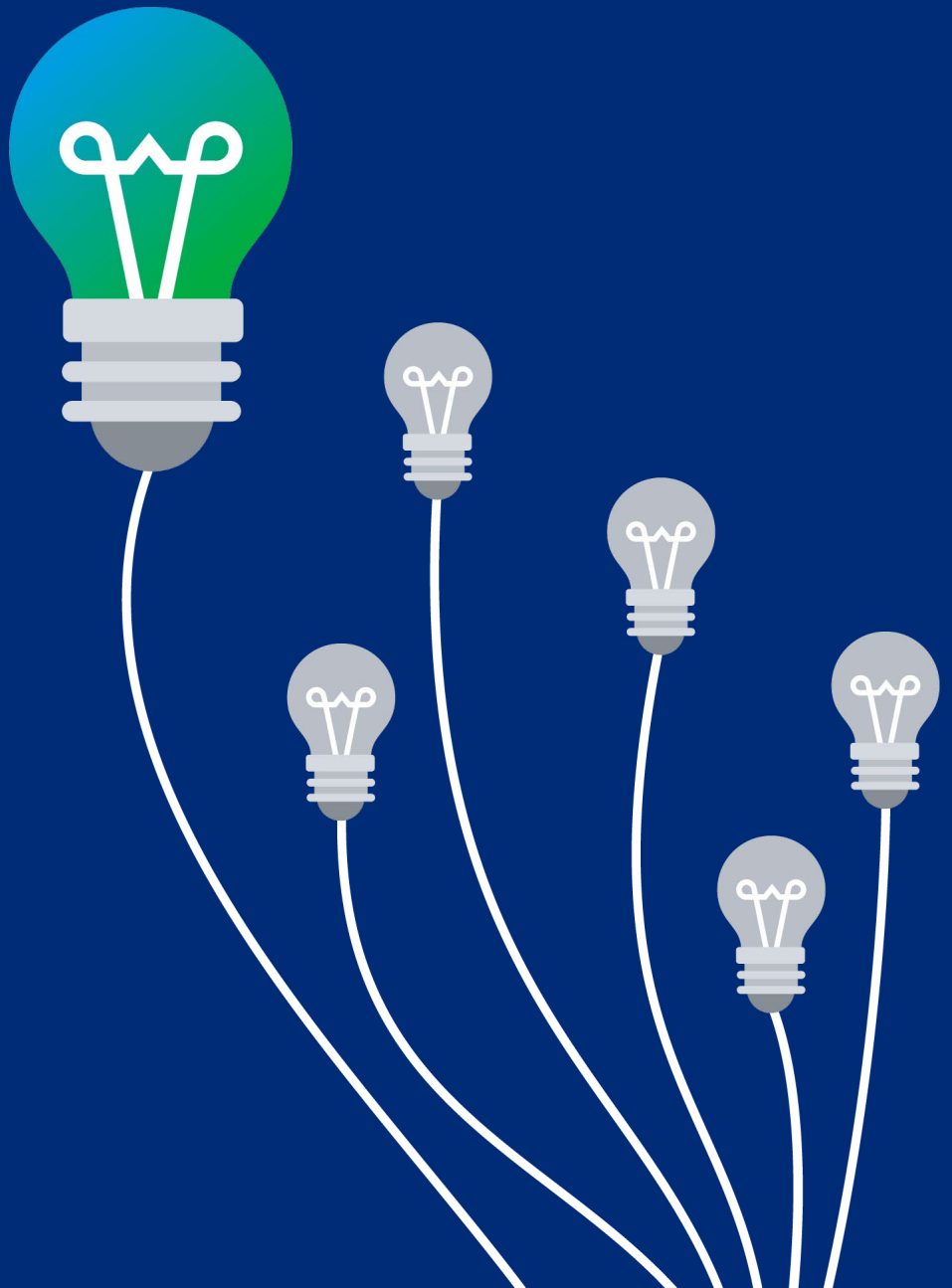
First Rating Period After July 9, 2028

- Timeframes to submit contract and rate certification after start of arrangement

Variable date: SDP T-MSIS reporting will be provided in upcoming T-MSIS guidance

Items States Should Consider with The New Final Rule

- Evaluating different approaches to ACR demonstration
- Review current SDPs for future compliance and determine solutions to non-compliance
  - Includes review of evaluation measures
- Determine a process that considers new SDP preprint and contract submission timelines
- Develop effective solutions for no separate payment term
  - Risk Corridors
  - Other options
- Conduct stakeholder engagement regarding new limitations on use of SDPs
- Communicate with peers on new processes such as provider attestations



Financing and Donations

Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

CMCS Informational Bulletin (February 17, 2023)

- CMS acknowledges the importance of healthcare-related taxes in states funding formula for the non-Federal share of their Medicaid programs
- CMS stated that “Medicaid statute and regulations afford states flexibility to tailor healthcare-related taxes within certain parameters to meet their provider community needs and align with broader state tax policies and priorities for their Medicaid programs.”
- CMS re-stated in stance that “such taxes must be imposed in a manner consistent with applicable federal statutes and regulations, including that they may not involve hold harmless arrangements, to avoid a reduction in the state’s Medicaid expenditures eligible for federal financial participation.”
- CMS presses states and providers to be transparent in any redistribution of funds to prevent circumvention of the hold harmless provisions under the Social Security Act 1903(w)(1)(A)(iii) and (w)(4) of the Act and 42 C.F.R. §433.68(b)(3) and (f)
  - Indirect according to CMS “makes clear that the state or other unit of government imposing the tax itself need not be involved in the actual redistribution of Medicaid payments for the purpose of making taxpayers whole for the arrangement to qualify as a hold harmless.”

Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

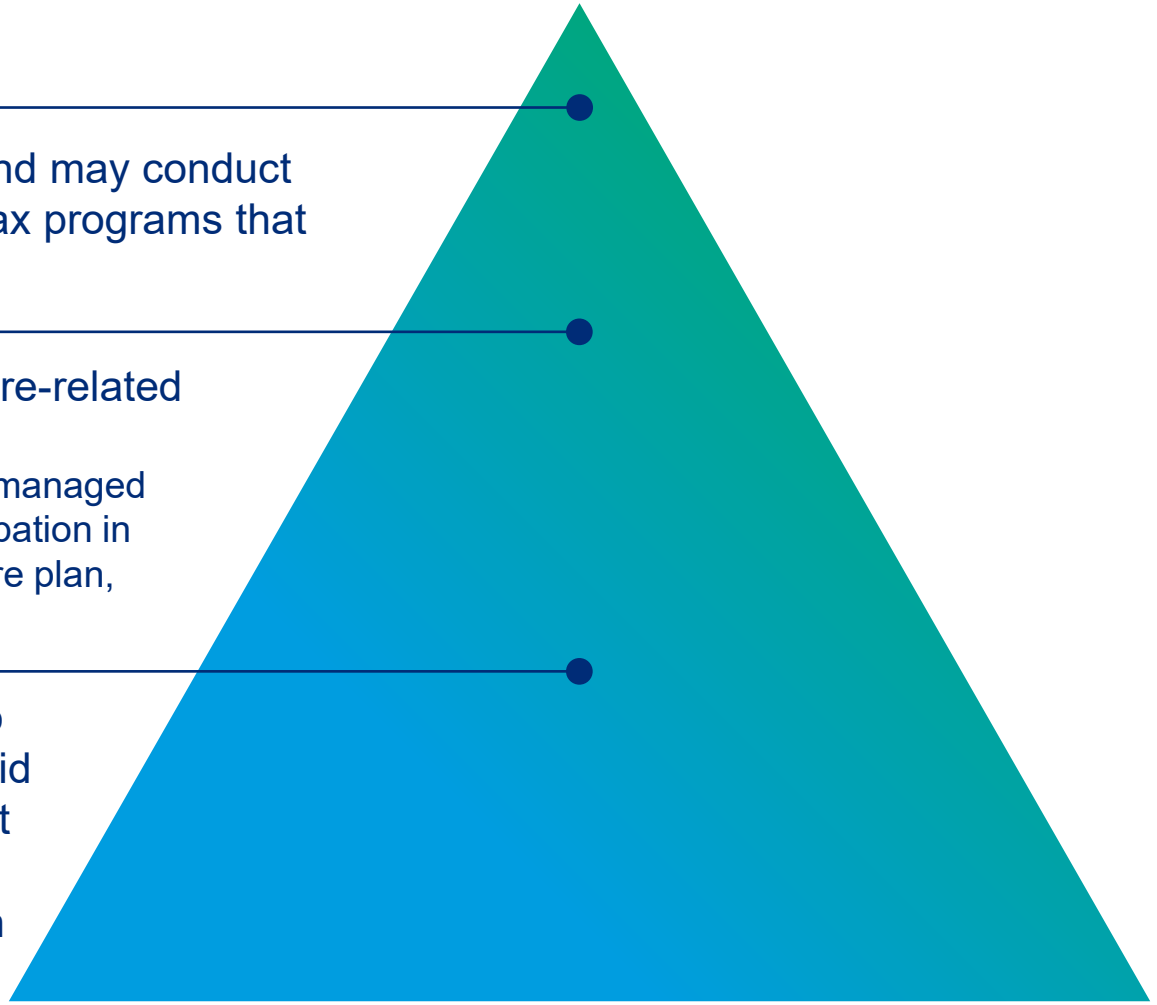
CMCS Informational Bulletin (February 17, 2023)

CMS will “inquire about potential redistribution arrangements and may conduct detailed financial management reviews of health care-related tax programs that appear to include redistribution arrangements.”

States will be required to have detailed information on healthcare-related tax arrangements.

- States “should examine their provider participation agreements and managed care plan contracts to ensure that providers, as a condition of participation in Medicaid and/or of network participation for a Medicaid managed care plan, agree to provide necessary information to the state.”

“Health care-related tax programs in which taxpayers enter into agreements (explicit or implicit in nature) to redistribute Medicaid payments so that taxpayers have a reasonable expectation that they will receive all or a portion of their tax cost back generally involve a hold harmless arrangement that does not comply with federal statute and regulations.”



State Reaction to CMS Bulletin

State of Florida v. Chiquita Brooks-Lasure, et al.,

Florida filed suit against CMS after issuance of the bulletin and a "Notice of Financial Review" (FMR) in regards to the Florida's use of healthcare-related taxes under the s Local Provider Participation Program (LPPF) tax program as a source of the non-federal share of Medicaid payments

Florida argued that, under CMS' previous policy, matching funds were disallowed only when the same governmental unit that imposed the tax also indemnified the taxpayer, but now, as Florida alleged, CMS improperly changed its policy, without engaging in rulemaking, to categorize purely private redistribution arrangements as constituting a prohibited hold-harmless agreement

January 29, 2024 — US Magistrate Judge denied the State of Florida's motion for preliminary injunction and granted CMS motion to dismiss due to the lack of subject matter jurisdiction because the FMR was not the final agency action

State Reaction to CMS Bulletin

State of Texas Health and Human Services Commission v. Chiquita Brooks-Lasure, et al.,

Texas argued that the bulletin exceeds CMS' statutory and regulatory authority, did not go through notice-and-comment rulemaking, and is arbitrary and capricious because it departs from past practice and fails to consider the State's substantial reliance interests

CMS argued that Texas' claims do not fall within the scope of judicial review under the Administrative Procedure Act (APA) because the Bulletin is not "final agency action"

June 30, 2023 — US District Judge granted the preliminary injunction due to the State of Texas demonstrated: (1) a substantial likelihood of success on the merits, (2) a substantial threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that the grant of an injunction will not disserve the public interest

Exercise of Enforcement Discretion until Calendar Year 2028 for Existing Healthcare-Related Tax Programs with Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

CMCS Informational Bulletin (April 22, 2024)

CMS will not take enforcement action until January 1, 2028, against states that, as of the publication date of this CMCS Information Bulletin (CIB), have the type of financing arrangements described in the February 2023 CIB and are prohibited under section 1903(w)(4) of the Act and 42 CFR 433.68(f), regardless of which Medicaid delivery system or type of payment the arrangement supports (e.g., SDPs, FFS payments)

CMS intends to begin routinely asking questions about possible hold harmless arrangements in conjunction with reviews of healthcare-related tax waiver requests and state payment proposals funded, at least in part, by healthcare-related taxes

CMS expects states to transition away from existing provider payment redistribution arrangements and not develop reliance on new redistribution arrangements

Exercise of Enforcement Discretion until Calendar Year 2028 for Existing Healthcare-Related Tax Programs with Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

CMCS Informational Bulletin (April 22, 2024)

Important Things To Remember

#1

- Delay in Enforcement Impacted by Outstanding Texas Lawsuit

#2

- Enforcement Delay is Specifically for Existing Arrangements Only

#3

- New Tax Arrangements will Follow CMCS Informational Bulletin Dated February 17, 2023

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