

What You Need to Know About the Medicaid Fiscal Accountability Rule (MFAR)

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On November 18, 2019, the Trump Administration [released](#) a proposed rule called the Medicaid Fiscal Accountability Regulation (MFAR). The Centers for Medicare and Medicaid Services (CMS) says that the rule would promote transparency by establishing new reporting requirements related to supplemental payments to Medicaid providers and upper payment limits (UPL) on what providers can be paid by Medicaid programs. In addition to new reporting requirements, the rule makes changes to the rules and review of supplemental payments and UPL arrangements as well as changes to financing the non-federal share of Medicaid with new requirements and reviews of state financing mechanisms. The rule was issued as part of the administration's [program integrity strategy](#). The changes proposed are extremely technical and complex but are likely to have significant implications for provider payment rates and state financing of Medicaid by disrupting current arrangements and restricting the future use of such arrangements. This brief provides some context on Medicaid financing, an overview of current state payment and financing rules, the provisions in the rule and potential implications for considerations.

Current Rules. The matching structure of Medicaid creates tension between federal and state financing of the program, giving state flexibility to meet health needs, but also an incentive to maximize federal revenues. The rules around payment and financing are complex. Fee-for-service provider reimbursements include base payments, supplemental payments, UPL calculations and disproportionate share hospital payments (DSH). Financing mechanisms include provider taxes and donations, intergovernmental transfers (IGTs) and certified public expenditures (CPEs).

Proposed Changes. MFAR proposes a number of highly technical changes to supplemental payments and state financing arrangements designed to improve transparency and program integrity including increased reporting, limiting UPL arrangements to 3 years at a time with additional requirements for review, changes to UPLs for physicians, new hold-harmless tests for donations and IGTs, and changes to the definitions and review of health care taxes.

Potential Implications. The proposed rule would codify some current practices, though there are also new provisions. The regulatory impact statement notes that the fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown except for some more narrow provisions. Since all states rely on at least one of these payment or financing mechanisms, the changes could have significant implications for providers and state budgets; but could have vastly different implications across states. Some have noted that it is not clear how CMS will apply some of the new standards and that there is a lot of discretion available to CMS which could leave states facing high levels

of uncertainty about the impact of the changes. Given the magnitude of the potential changes and lack of data to determine the fiscal impact, some are calling for additional data collection prior to implementing the changes. Looking ahead, the proposed rule is open for public comment through February 1, 2020.

Background

The matching structure of Medicaid financing has always [produced pressures](#) and tension between the federal government and the states. The current structure provides states with substantial (though not total) flexibility to address specific state needs and priorities and to make adjustments based on changing needs and demands of the program (i.e. cost of prescription drugs or economic downturns). Due to the matching structure, Medicaid is a significant program in state budgets, accounting for [16.4% of state funds](#) (including general and other); however, Medicaid also accounts for over half of all federal revenue for states.

While states have incentives to control Medicaid costs because states share in the costs of the program, states have also sought to maximize federal Medicaid funds in ways not necessarily intended by Congress by artificially inflating the federal share of Medicaid spending, sometimes using legal financing mechanisms, including DSH payments, supplemental payments, provider taxes as a source of state Medicaid funds, and intergovernmental transfers. [Over time](#), as states have found “loopholes” to maximize federal funding, federal laws and rules were enacted to curtail inappropriate spending. For example, federal laws and rules were enacted in 1991 to impose limits on DSH spending and also to impose rules around the use of UPLs.

Citing goals to promote transparency and program integrity, as well as the rise in the use of supplemental payments, provider taxes and other financing mechanism, CMS has put forth the Medicaid Financial Accountability Rule (MFAR). CMS states that some provisions are codifying existing rules and practices, while some provisions are significantly broadening CMS’s ability to collect data and review and restrict certain payment and financing mechanisms.

What are the current Medicaid provider reimbursement and financing rules?

Current provider reimbursement rules

States have latitude to [determine fee-for-service provider payments](#) so long as the payments are consistent with efficiency, economy, quality, and access rules and safeguard against unnecessary utilization. Within these broad guidelines, provider payments must be sufficient to ensure Medicaid beneficiaries with access to care that is equal to others in the same geographic area. Federal standards generally do not address how states structure the delivery system used to provide services to Medicaid enrollees.

Provider rates are generally comprised of base rates as well as supplemental payments but are subject to aggregate upper payment limits by provider type and class. Base payments are generally

paid for claims for specific services provided to specific Medicaid enrollees in a fee-for-service (FFS) environment. Such payments may vary based on level of care, complexity, and intensity of services. Supplemental payments are payments beyond the base rate that may or may not be tied to specific services. States are limited in making supplemental payments by the Upper Payment Limits (UPL) rules that allow states to make up the difference between a reasonable estimate of what Medicare would pay and Medicaid payments. UPL limits are set in aggregate for the following services: inpatient hospital, outpatient hospital, nursing facilities, intermediate care facilities for persons with intellectual disabilities, (ICFs/ID), and clinics. The UPLs are also calculated by three ownership categories (state government, non-state government, and private). Separate UPLs are used for physician and other practitioner services that are tied to average commercial rates (ACR).

Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.

Within the annual DSH allotments to states and hospital-specific limits, states have considerable flexibility on how to distribute DSH funds. Based on the assumption of increased coverage and therefore reduced uncompensated care costs under the Affordable Care Act (ACA), the law called for reductions in Medicaid DSH payments, originally scheduled to begin in 2014 but they have been delayed and never implemented. The ACA required the Secretary of HHS to develop a methodology to allocate the reductions that must take into account certain factors that would allocate larger percentage reductions on states with the lowest percentages of uninsured individuals and states that do not target DSH payments to hospitals with high levels of uncompensated care. In FY 2018, [DSH payments](#) totaled \$16.5 billion (2.8% of all Medicaid spending).

Current financing rules

Under current law, Medicaid provides a guarantee to individuals eligible for services and to states for federal matching payments with no pre-set limit. Medicaid provides an entitlement to income-eligible individuals. The federal government matches state spending for eligible beneficiaries and qualifying services based on state spending and program need without a limit. The federal share of Medicaid is determined by a formula set in statute that is based on a state's per capita income. The formula is designed so that the federal government pays a larger share of program costs in poorer states. The federal share ([FMAP](#)) varies by state from a floor of 50 percent to a high of 77 percent in 2020, and states may receive higher FMAPs for certain services or populations. There are special match rates for those covered under the ACA's Medicaid expansion, administrative costs, and other services. To participate in Medicaid and receive federal matching dollars, states must meet [core federal requirements](#). However, states may also receive federal matching funds to cover services and populations that are not required by the statute. States also have discretion to determine how to purchase covered services (e.g., through fee-for-service or managed care arrangements) and to set provider payment amounts. Based in part on program flexibility, spending per Medicaid enrollee varies significantly across eligibility groups and states.

States can use provider taxes, IGTs (intergovernmental transfers) and certified public expenditures (CPEs) to help finance the state share of Medicaid. States have some flexibility to use funding from local governments or revenue collected from provider taxes and fees to help finance the state share of Medicaid. Intergovernmental transfers are transfers of public funds between governmental entities. The transfer may take place from one level of government to another (e.g., counties to states) or within the same level of government (e.g., from a state university hospital to the state Medicaid agency). Certified public expenditures are certifications by a government that authorized funds were spent on Medicaid expenses that qualify for federal matching. The federal Medicaid statute explicitly recognizes the ability of states to use IGTs and CPEs for Medicaid financing purposes. There is no state specific data that accounts for how often and the magnitude of Medicaid spending financed through IGTs and CPEs.

Provider taxes used for the state share of Medicaid spending must be broad-based and uniformly imposed (although states can receive waivers of these provisions if certain conditions are met).

Provider taxes cannot hold providers harmless from the burden of the tax (e.g., by increasing reimbursement rates to make up for the tax). Federal regulations create a safe harbor from the hold-harmless test for taxes where collections are 6.0 percent or less of net patient revenues. Federal legislative proposals have considered phasing down the maximum federally allowable safe harbor limit under the “hold-harmless” rule from the current 6 percent level. All states (except Alaska) have at least one [provider tax in place](#) and many states have more than three.

What are the major provisions of the MFAR rule?

Proposed fee-for-service provider payment provisions

Upper Payment Limit (UPL) payments arrangement requirements. The proposed rule would add extensive review and reporting requirements to add or renew supplemental payments, including a detailed description of the methodology to distribute payments, a monitoring plan, and for renewals, an evaluation of how supplemental payments meet economy, efficiency and quality of care requirements. CMS proposes to limit approvals of UPL payments to three years at a time, which could create uncertainty for states and providers. The proposed rule would codify the rules related to the methods of determining the UPL by using Medicare equivalent payments or cost amounts. The rule also provides definitions of the ownership class of providers for the purposes of determining the UPL, which could restrict or change existing provider classes for purposes of determining UPL payments. The rule proposes that states report provider level data on supplemental payments and provider contributions to the non-federal share.

Supplemental UPL payments to physicians. The proposed rule would limit supplemental payments to physicians and other practitioners to 50% of base payments (or 75% of base payments for rural areas and services in designated health professional shortage areas). States are currently able to pay practitioners up to the average commercial rates (ACR). The rule states that some of these supplemental payments have resulted in payments to providers in excess of a reasonable estimate of what Medicare would have paid because ACRs are generally higher than Medicare rates. The proposed rule estimates

that this change could result in a reduction in payments of \$222 million in total computable Medicaid reimbursement.

DSH provisions. The proposed rule requires new reporting requirements for the annual DSH audit reports, specifically that audit findings be quantified. CMS also proposes to allow for publication of the DSH allotments online through the Medicaid.gov website instead of the Federal Register.

Proposed Medicaid financing changes

Health care taxes. The proposed rule adds health insurers as a permissible class of health care items and services for imposing taxes. In addition, the rule broadens the definition of a health-related tax to allow CMS to examine the parameters of the tax and the totality of circumstances to determine if certain taxes are receiving differential treatment and should be subject the health-related tax rules. The rule also would allow CMS to deny waivers of the “broad-based and uniform” requirements if the tax would place a higher burden on the Medicaid program and also limit approved waivers to three years. The rule also would impose a new net effect standard to assess whether providers are held harmless from the effects of a tax. As all states but Alaska use provider taxes to help finance the state share of Medicaid and 35 states have provider tax waivers, changes that would restrict or make it more difficult to impose such taxes or obtain waivers could have broad implications on Medicaid and state budgets.

IGTs and CPEs. The proposed rule would limit permissible IGTs and CPEs to funds from units of governments, state or local taxes or funds appropriated to state university teaching hospitals. Such changes are aimed at addressing financing arrangements involving certain public-private partnerships and could restrict which entities can make IGTs (like public hospitals). The proposed rule would allow CMS to apply new “net effect” standards to determine if certain IGTs involve provider donations that do not comply with hold-harmless rules. To limit the use of CPEs, the rule would limit Medicaid payments to costs and require that providers retain the full amount of all Medicaid payments. In addition, the rules would not allow states to withhold part of a Medicaid payment or require providers to give back part of a payment. This provision could affect the ability of states to enter into certain financing agreements with providers through CPEs. Similar to restrictions with provider taxes, restrictions on states’ ability to use IGTs and CPEs could limit the state share of Medicaid and therefore overall Medicaid funding.

Donations. The proposed rule makes changes to expand how CMS can evaluate if a provider donation is meeting a hold-harmless test. Under the proposed rule, CMS could consider the totality of circumstances to assess if the net effect of a financing arrangement between the state and the provider (or other entity making the donation) results in a reasonable expectation that the provider, provider class, or related entity will receive a return of all or a portion of the donation either directly or indirectly. If existing arrangements are deemed impermissible, and states are not able to use other financing arrangements, states may face reductions in overall Medicaid funding.

Variation based on eligibility category. The proposed rule specifies that states cannot vary fee-for-service payments for Medicaid services based on eligibility or enrollment under a waiver.

What are the potential implications of MFAR?

The regulatory impact statement notes the fiscal impact of the Medicaid program from the implementation of the policies in the proposed rule is unknown except for some narrow provisions related to data reporting and the limit on supplemental payments to physicians. Given the potential of far reaching effects and uncertainty of the implications, [some have called](#) for [collecting additional data](#) before implementing some changes. There is little consistent information available to quantify the range of supplemental payments or financing arrangements that could be effected by the proposed changes. However, it is likely that most if not all states employ some type of arrangement that could be affected under the rule, which would create significant uncertainty in state budgeting. Restricting or limiting state financing mechanisms for Medicaid would mean states would need to dedicate additional state general fund dollars to maintain current programs. Without the state match, states would not be able to draw down the federal matching funds which could result in cuts in reimbursement for providers with [implications for enrollees](#). Some key questions that could influence the effects of the proposed rule include:

- **Overall implications:** What is the fiscal magnitude in terms of provider payment changes and effects on state budgets tied to the provisions in MFAR? How would the implications of the changes vary across states? How would this ultimately affect eligibility, benefits and provider payments and access to care?
- **Changes to supplemental payments:** How will CMS determine if supplemental payments are meeting program objectives? What are the implications of limiting approval for supplemental payment arrangements to three years? To what extent do the requirements of every 3 years create uncertainty in state budgets/provider payments?
- **Changes to financing:** Which states have waivers of certain provider tax provisions that would be subject to new review? How will changes to the definition of ownership classes affect current UPL and IGT arrangements? How will the restriction of the definition of permissible IGTs affect existing arrangements?