CMS' Proposed Medicaid Fiscal Accountability Regulation

Implications for state Medicaid programs and California's public health care systems

January 3, 2020

On November 18, 2019, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule, the Medicaid Fiscal Accountability Regulation (MFAR), which, if implemented, would dramatically cut Medicaid program funding. As proposed, MFAR could force Medicaid programs, safety-net hospitals, and providers across the country to reduce or eliminate services that support millions of low-income patients.

As a federal-state partnership, Medicaid relies upon federal and state dollars to provide health coverage and care to low-income Americans. For years, and with federal approvals, counties, public health care systems and other safety-net providers have helped finance a significant portion of the State's share of the Medicaid program. As public governmental entities, California's public health care systems use mechanisms known as certified public expenditures (CPEs) and intergovernmental transfers (IGTs) to finance the non-federal share of California's Medicaid program (called Medi-Cal) in order to receive federal matching dollars for patient care. The financing mechanisms allow public health care systems to secure additional federal funding that would otherwise be unavailable. The funding is then used to provide services, thereby improving the health of Medi-Cal beneficiaries.

MFAR would sharply limit the ability of states and other public entities to use these mechanisms to finance the state share (a.k.a. the non-federal) and would impose other requirements and restrictions on critically needed supplemental payment programs. Through these proposed restrictions, the federal government seeks to **drastically restrict state flexibility** in operating Medicaid programs and would **sharply reduce funding for Medicaid**.

1) **The rule would restrict how public health care systems provide the non-federal share, which could lead to a dramatic reduction in Medi-Cal funding and cuts to programs and services.**
   The proposed regulation would require that IGTs be derived from state or local taxes or funds appropriated to state university teaching hospitals, which would dramatically curtail available sources of non-federal share. MFAR would also establish new requirements for taxes on nongovernmental entities that are used to draw down federal Medicaid funds, such as California's Hospital Quality Assurance Fee (HQAF) or the Managed Care Organization (MCO) tax, both of which would need to be restructured or no longer used under the proposed rule.

   As a result of this dramatic reduction in Medicaid funding, states would be forced to impose new taxes to serve as the source of non-federal share, or to make huge cuts to their programs. Such reductions would hinder access to care and result in worse health outcomes for millions of low-income Americans.

2) **The rule would make it more difficult for states to implement and maintain supplemental payments that help preserve access to critical safety-net services.**

The regulation proposes a new level of CMS oversight for state Medicaid programs, including more frequent approvals for existing arrangements that California and other states rely on to fund Medicaid. For example, supplemental payment structures in fee-for-service would be limited to a maximum of three years for each specific supplemental payment program. The rule also makes the approval process much stricter, requiring increased scrutiny of the justification for a given supplemental payment and for which providers were included or excluded from the payment. Existing approvals would not be grandfathered in; instead they would be reauthorized within two or three years of finalization of the rule. These new requirements would cause increased uncertainty for the Medi-Cal program and a number of vital funding streams for public health care systems, both in terms of shorter approval periods (today these funding streams largely have no end date) and greater federal discretion to reduce or deny payment. All of these changes would make it more challenging for public health care systems to maintain funds necessary to provide timely access to high quality care.

3) **Numerous additional requirements in the rule would increase regulatory and reporting burdens on states.**

The rule proposes several new provisions that are vague and inconsistent, creating significant uncertainty for states and providers trying to comply with the requirements. For instance, the definitions of what constitutes a base payment versus a supplemental payment are circular and hard to apply in reality. CMS would also have significant discretion in determining whether a provider qualifies as a public provider, and in understanding whether financial transactions are compliant with rules by looking at "the totality of circumstances." These terms do not help create standards, but rather increase uncertainty, and could destabilize programs by causing them to operate in an excessively cautious manner.

In other areas of the rule, the requirements are so detailed that it would be overly burdensome to come into compliance. In addition to the new requirements noted above, the rule would require that states regularly report supplemental payments at the provider level on both a quarterly and annual basis to CMS. The rule would also expand and accelerate reporting and recoupment of Medicaid Disproportionate Share Hospital (DSH) overpayments to the federal government. Medicaid DSH is a vital program that helps safety-net hospitals cover uncompensated care provided to Medi-Cal and uninsured patients. These extensive reporting requirements would take years to implement and require significant changes and investment in data infrastructure and reporting time by providers, as well as state and federal employees.

Should the rule take effect in its current form, California would be just one of many states across the country to face a serious threat to the sustainability of its Medicaid program. States have designed their Medicaid financing structures over the years to provide care in ways that make the best use of the state-federal partnership. The proposed changes would undermine the core framework of state Medicaid financing structures. As a result, **Medicaid programs, public health care systems, other safety-net hospitals, and providers across the country could be forced to reduce or eliminate services and critical programs for millions of low-income patients**.

CMS is accepting comments on this proposal until February 1, 2020. CAPH is developing comments and will be encouraging public health care system members and partners to submit their own comments informing CMS of the enormous negative consequences this rule could have on access to California's safety-net services and the Medi-Cal program. We are requesting CMS withdraw the proposed regulation in its entirety and work with states and providers to identify other ways to address concerns in Medicaid.