

# Greater Transparency of Supplemental Payments Needed



A Senate Finance Committee Majority Staff Report

April 30, 2019

**The following Members of the U.S. Senate Committee on Finance support this report and its call for improved education and transparency surrounding Medicaid supplemental payments:**

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## EXECUTIVE SUMMARY

The Medicaid program, jointly financed by the federal government and states, serves over 70 million Americans each year at a cost of \$600 billion. An important role for Congressional oversight is to review the policy and payment decisions by CMS and states to determine whether additional Congressional action is necessary. Medicaid payments are roughly divided between base payments, which are regularly reported at a granular level, and supplemental payments, which are inconsistently reported at the aggregate level. In 2016, the most recent year for which data is available, these supplemental payments totaled nearly \$50 billion.

This report seeks to increase educational understanding of Medicaid supplemental payments, as well as outline the reporting mechanisms for these payments to ensure adequate stewardship of taxpayer dollars. It is imperative that Congress, and the public, better understand the complex nature of Medicaid payment structures. Whether by the reporting requirements under current law, the differences between the types of supplemental payments, how states raise their share of supplemental payments, or the different interactions between fee-for-service and managed care with supplemental payments, this report offers a clearer lens into one of the most opaque areas of health care financing. The ultimate conclusion, that non-DSH supplemental payment data at the provider level would improve efficiencies and transparency to better inform policy decisions, brings the Medicaid program into the 21st century.

## INTRODUCTION

The U.S. Senate Committee on Finance (Committee) has oversight jurisdiction of the Centers for Medicare & Medicaid Services (CMS) and all of its programs, including Medicaid. In fiscal year 2017, Medicaid spending totaled \$592 billion across all reported federal and state payments.<sup>1</sup> Enrollment in Medicaid and CHIP in fiscal year 2017 totaled 74.8 million individuals. Committee Members have investigated reporting requirements pertaining to supplemental payments made by states to providers. Supplemental payments are typically lump sum payments that are made in addition to states' regular, claims-based payments. Unlike claims-based payments, supplemental payments are not specifically linked to a Medicaid beneficiary. As such, CMS collects payment data from states in the aggregate for provider-type classifications. This reporting requirement offers an impression of the amount a category of providers in a state may receive, but it is insufficient to gain an understanding of payments at a more granular level, such as those at the provider-level.

As the magnitude of supplemental payments increased over time, the Committee began an analysis of the use of supplemental payments to pay providers in order to better comprehend how states allocate their state and federal Medicaid funds. Committee staff examined the types of supplemental payments, how they are financed, and what information CMS collects about them, including the current reporting requirements and its limits. The Committee also examined approaches proposed to increase transparency. This report is a compilation of the Committee's findings on current CMS reporting requirements, and concludes provider-level data is necessary for adequate oversight of the supplemental payments.

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<sup>1</sup> CMS. What are Annual Expenditures for Medicaid & CHIP? Available online at <https://www.medicaid.gov/state-overviews/scorecard/national-context/annual-expenditures/index.html>

Other Medicaid stakeholders have commented on reporting challenges of supplemental payments, and the negative impact of poor quality data on oversight. The House of Representatives Committee on Energy and Commerce, Government Accountability Office (GAO), and Medicaid and CHIP Payment and Access Commission (MACPAC) have also demonstrated an interest in the availability of data supporting how states distribute funds to providers. Greater transparency of supplemental payments could improve how resources are targeted, ensure that federal and state funds are being used in accordance with applicable Medicaid laws, and may improve the delivery of health care to Americans.

### General Medicaid Financing

State Medicaid programs are jointly financed by the federal government and each state's government. On an annual basis, every state has an established rate to determine the degree at which the federal government matches state-generated spending for Medicaid services. The proportion of the federal share is determined based on a number of state specific economic factors, ultimately resulting in the Federal Medical Assistance Percentage (FMAP). The FMAP is applied to total Medicaid spending for most services in a state, and CMS then uses the FMAP to reimburse the state for the federal share of spending.<sup>2</sup>

The FMAP may range from 50 to 83% by law, and is dependent on a state's economic well-being in comparison with the national economy.<sup>3</sup> In practice, FMAPs range from 50.00 to 76.98%.<sup>4</sup> This matching mechanism is generally agnostic to the uses of funds, only barring identified impermissible spending.<sup>5</sup> This structure permits increases in federal spending due to state decisions to raise eligibility levels, outside economic influences, new diseases, medical innovations, or unforeseen events.<sup>6</sup> Medicaid's ability to respond and adapt to the changing needs of low-income populations is an advantage that states may utilize, but also represents a challenge for managing spending levels to ensure taxpayer funds are used most efficiently.<sup>7</sup>

Base rate determinations in Medicaid cover all mandatory and optional services covered by the state under the state plan or amendments or waivers to the state plan. Viewed alone, base rates are usually lower than Medicare or private insurance rates. According to CMS, base rates are provided through a fee-for-service (FFS) fee schedule (19% of total claims, by volume) and managed care

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<sup>2</sup> Government Accountability Office (GAO). *Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods*. [GAO-16-195T](#). November 3, 2015. Page 4.

<sup>3</sup> *Id.* For the Medicaid, FMAP, the formula uses a state's per capita income as the measure of economic well-being.

<sup>4</sup> The Henry J. Kaiser Family Foundation (KFF). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, Timeframe: FY 2017. Available online at <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&selectedDistributions=fmap-percentage&selectedRows=%7B%22nested%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D>

<sup>5</sup> Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid and CHIP. June 2016. Page 45. Available online at <https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

<sup>6</sup> Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid and CHIP. June 2016. Page 44. Available online at <https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

<sup>7</sup> *Id.*

arrangements (81% of total claims, by volume).<sup>8</sup> In a 2017 example outlined by MACPAC, inpatient base rates averaged 78% of Medicare rates.<sup>9</sup> Supplemental payments are additional payments to these base rates.

### Types of Supplemental Payments

State Medicaid agencies make a number of payments to providers, which the federal government matches. A significant amount of Medicaid spending consists of base payments according to a FFS schedule.<sup>10</sup> Beyond these payments for services, states also make additional, supplemental payments that are not linked to specific beneficiaries and are also matched by the federal government—up to specific limits established by the program. These supplemental payments are distributed to providers in addition to the base payments and are comprised of disproportionate share hospital (DSH) payments and non-DSH payments. In FFS, the payments are provided for a group of providers or as lump sums for types of activities or patient mix. In managed care, supplemental payments are referred to as “pass-through” payments, which are add-on payments to the capitated rates to managed care plans. The April 2016 Medicaid Managed Care Rule indicated a desire by CMS to restrict, and eventually eliminate, pass-through payments, but that has not yet occurred.

### *DSH Payments*

Medicaid DSH payments are available to providers through a statutorily mandated methodology and by the discretionary function of the state Medicaid agency. DSH payments can offer an additional source of funding to hospitals delivering services to Medicaid beneficiaries, particularly where there is a higher risk of Medicaid shortfall, which is the difference between a hospital’s Medicaid payments and that hospital’s costs to provide services to Medicaid beneficiaries, and uninsured care costs. State Medicaid agencies are required to include a description of criteria used to determine which hospitals are designated to receive DSH payments in their Medicaid State Plan submitted to CMS, and to articulate the formulas used to calculate the payments. The amount a state may disburse per hospital through DSH payments is limited to the specific hospital’s costs incurred by providing uncompensated care.<sup>11</sup>

Per federal statute, states must make DSH payments to qualifying hospitals that meet one of the following minimum criteria:

1. Medicaid inpatient utilization rate is at least one standard deviation higher than the mean for all hospitals in the state; or
2. Low-income utilization rate higher than 25%.<sup>12</sup>

States may make DSH payments to other hospitals provided they have a Medicaid inpatient utilization rate of at least 1%, among other requirements.<sup>13</sup>

The bulk of how DSH payments are allocated is defined by statute. Qualifying DSH hospitals made

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<sup>8</sup> CMS. Who Enrolls in Medicaid & CHIP? Available online at <https://www.medicaid.gov/state-overviews/scorecard/national-context/enrollment/index.html>

<sup>9</sup> Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Hospital Payment: A Comparison across States and to Medicare. April 2017. Available at <https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf>

<sup>10</sup> The Medicaid program reimburses for delivered services at rates lower than most other insurers. Its number of beneficiaries and stability increase its bargaining power with hospitals to ensure favorable rates for CMS.

<sup>11</sup> 42 U.S.C. § 1396r-4(g)(1).

<sup>12</sup> 42 U.S.C. § 1396r-4(b)(1).

<sup>13</sup> 42 U.S.C. § 1396r-4(d).

up 29% of the hospitals receiving DSH payments in 2011, and received 64% of DSH payments. States allocated the remaining 36% of DSH payments to other hospitals, according to their respective state plans.<sup>14</sup>

Statutorily mandated and discretionary DSH payments are subject to provider-level reporting through annual DSH audits. Federal regulations outline that states must submit to CMS the amount of DSH payments allocated to each “individual public and private provider or facility,” and “present a complete, accurate, and full disclosure of all their DSH programs and expenditures.”<sup>15</sup> The General DSH Audit and Reporting Protocol outlines the measures states and their auditors must comply with to receive the payments.<sup>16</sup> The Protocol’s reporting requirements for specific hospital DSH costs allow increased transparency to the payments. It is worth noting that DSH audits represent annual facility-level reporting for a Medicaid supplemental payment.

### *Non-DSH Payments*

In addition to DSH payments, non-DSH payments encompass other supplemental payments used to finance and direct Medicaid spending between the state Medicaid programs and providers. Categories of non-DSH payments include, but are not limited to, upper payment limit (UPL) payments and Medicaid demonstration supplemental payments. The state sources of financing for these non-DSH supplemental payments are outlined in Appendix A.

### Upper Payment Limit Supplemental Payments

In general, state Medicaid provider payments must comply with the Upper Payment Limit regulations, which establish a ceiling on federal matching funds for Medicaid payments for certain types of services based on an estimate of what Medicare would pay for comparable services. Because the UPL is an aggregate limit on all payments for a particular type of service and does not limit the amount that can be paid to an individual provider, large supplemental payments under the UPL can be paid to a small number of providers.

States typically make UPL payments to compensate for low Medicaid payment rates. However, UPL payments do not have a specified statutory or regulatory purpose by federal law,<sup>17</sup> but are outlined state-by-state according to the applicable state plan.<sup>18</sup> UPL supplemental payments have traditionally been used to offset costs for services provided to Medicaid beneficiaries that claims-based payments may not have covered, as well as counterbalance costs from treating uninsured and low-income patients. This approach requires the HHS Secretary to approve future spending as described in the state plan prospectively. They are not required on the basis of Medicaid services, and may be distributed according to the state plan. Importantly, DSH payments are not included in determining UPL payments.

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<sup>14</sup> Medicaid and CHIP Payment and Access Commission (MACAPC). Overview of Medicaid Policy on Disproportionate Share Hospital Payments. Pages 12-13. Available online at <https://www.macpac.gov/wp-content/uploads/2016/03/Overview-of-Medicaid-Policy-on-Disproportionate-Share-Hospital-Payments.pdf>

<sup>15</sup> 42 CFR 447.299(a)

<sup>16</sup> CMS. General DSH Audit and Reporting Protocol. Available online at [https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/general\\_dsh\\_audit\\_reporting\\_protocol.pdf](https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/general_dsh_audit_reporting_protocol.pdf)

<sup>17</sup> GAO. *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*. [GAO-13-48](#). Page 4.

<sup>18</sup> *Id.* at 8.

Current CMS reporting standards require states to disclose UPL payments based on the service type and ownership classification of providers through the Form CMS-64 Quarterly Expense Report (Form CMS-64). State UPL levels are measured and reported in the aggregate, meaning statewide groups of providers as determined by the reporting requirements are classified together for reporting purposes. Provider-level specificity is not captured in the data collected using the UPL reporting requirement.

UPLs are applied, in aggregate, for three provider ownership categories—local government, state government, and private—and six service categories—inpatient hospital services, outpatient hospital services, nursing facility services, physician and surgical services, other practitioner services, and intermediate care facilities for the developmentally disabled (ICF/DD) services. UPLs theoretically can apply to each of the six service categories within each of the three provider ownership categories. It is worth noting that GAO, the Department of Health and Human Services Office of the Inspector General (OIG), and other government oversight entities historically have had difficulty identifying which UPL service payments are affiliated to which provider ownership category due to poor reporting and the nature of aggregate payments.

The UPLs are reasonable estimates by states of what Medicare would pay for similar services. These limits are then the upper bound of what Medicare would pay a provider and the Medicaid rate.<sup>19</sup> For services where Medicaid and Medicare differ drastically in payment, UPL payments have helped states retain providers for Medicaid beneficiaries. However, because CMS oversight of UPL payments is focused on the aggregate UPLs, it is extremely lax and the predominant mechanism the agency uses for assessing whether payments to providers are economical and efficient, as required by statute.

Data reported using aggregate levels of spending lends itself to less transparency. Information on UPL payments specific to hospitals would provide a more complete representation of how states are distributing supplemental payments. In contrast, aggregate data among a wide breadth of providers permits inconsistent payment distribution for providers with similar levels of Medicaid shortfall or uncompensated care costs.

### Demonstration Supplemental Payments

Section 1115 of the Social Security Act allows the HHS Secretary to waive certain Medicaid requirements and approve expenditures for demonstrations that, in the Secretary's judgment, are likely to promote Medicaid objectives.<sup>20</sup> These waivers must be budget neutral, meaning they do not incur additional federal spending than would have existed without the waiver. However, GAO has found that CMS did not consistently require selected states to report the information needed to assess compliance with the 1115 demonstration spending limits.

The HHS Secretary has broad authority to approve demonstrations promoting the goals of Medicaid.

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<sup>19</sup> GAO. CMS Oversight of Provider Payments is Hampered by Limited Data and Unclear Policy. [GAO-15-322](#).

<sup>20</sup> GAO. *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*. [GAO-15-239](#), April 2015. Page 6. Under CMS policy, these waivers must be budget neutral, meaning they do not incur additional federal spending than would have existed without the waiver. However, GAO has found that CMS did not consistently require selected states to report the information needed to assess compliance with the 1115 demonstration spending limits.

Historically, HHS has not issued specific criteria guiding how these determinations are made and believes it is not in the agency's interest to issue guidelines to the public that may limit its flexibility in determining which demonstrations promote Medicaid objectives. States have used 1115 waivers to test new approaches to delivering care to generate savings, efficiencies, or improve quality and access.<sup>21</sup> If these objectives are not met, CMS has the authority to terminate the waiver, although it has never done so.

States have received approval to make supplemental payments as part of their Medicaid 1115 demonstrations, for example, Delivery System Reform Incentive Payments (DSRIP) and Uncompensated Care Pool payments.<sup>22</sup> Additionally, some states that have shifted to manage care delivery have received approval to use demonstration authority to continue supplemental payments previously made under their state plans, although CMS has more recently questioned whether that should be a facet of the demonstrations or part of a transition to non-fee-for-service care.

## MAGNITUDE AND DISTRIBUTION FOR SUPPLEMENTAL PAYMENTS

Supplemental payments determine current spending patterns for state financing. For example, states use these payments to cover uncompensated care costs, to make provider rates more competitive and comparable to Medicare, and to finance their Medicaid expansion populations. As states have struggled to raise their share of these payments through tax increases or other mechanisms using state general funds, they have turned to supplemental payments, which may not have direct impacts on state budgets, but do cause an increase in federal spending.

### Magnitude of Supplemental Payments

States have used supplemental payments at an increasing rate, meriting further examination into the actual payments made by states. In FY 2016, supplemental payments totaled approximately \$48.5 billion.<sup>23</sup> DSH payments totaled \$19.7 billion (40.6%) and non-DSH payments totaled \$28.8 billion (59.4%).<sup>24</sup> The federal share of supplemental payments was \$27.8 billion (57.3%) of the \$48.5 billion program total. The \$28.8 billion of non-DSH payments is the focus of this report.

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<sup>21</sup> GAO. *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*. [GAO-15-239](#). April 2015. Page 6

<sup>22</sup> CMS may approve demonstration supplemental payments under section 1115 of the Social Security Act, which authorizes HHS to waive certain Medicaid requirements and allow payment for costs not otherwise matchable as long as they are likely to promote Medicaid objectives. DSRIPs are considered to be a type of pool payments.

<sup>23</sup> CMS, Office of the Actuary. 2017 Actuarial Report on the Financial Outlook for Medicaid. Page 56. Available online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf>

<sup>24</sup> *Id.*



Service Category	Total (\$ billions)	Federal (\$ billions)	Nonfederal (\$ billions)
Inpatient Hospital - DSH	16.53	9.41	7.12
Inpatient Hospital – Sup. Payments	19.80	11.43	8.48
Mental Health Facility - DSH	3.13	1.75	1.38
Nursing Facility Services - Sup. Payments	3.04	1.81	1.23
Intermediate Care Facility - Sup. Payments	0.12	0.06	0.06
Physician & Surgical Services - Sup. Payments	1.32	0.78	0.53
Outpatient Hospital Services - Sup. Payments	4.51	2.61	1.90
Other Practitioners Services - Sup. Payments	0.02	0.01	0.01
<b>DSH Totals</b>	<b>19.66</b>	<b>11.16</b>	<b>8.50</b>
<b>Non-DSH Supplemental Payment Totals</b>	<b>28.80</b>	<b>16.69</b>	<b>12.11</b>
<b>Supplemental Payment Totals</b>	<b>48.46</b>	<b>27.86</b>	<b>20.61</b>

**Note: Not all non-DSH supplemental payments can be distinctly identified in CMS-64 data. Non-DSH supplemental payments made by managed care plans, and those made under Section 1115 demonstrations are not included in these totals. Numbers may not add due to rounding.**

**Figure 1.** Financial Management Report Data: CMS-64 Financial Management Report, Net Services, Medical Assistance Payments, Fiscal Year 2016. Relevant services categories relating to supplemental payments extracted from Table 19. See CMS, Office of the Actuary. 2017 Actuarial Report on the Financial Outlook for Medicaid. Page 56. Available online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf><sup>25</sup>

### *Payment Distribution Yields Varying Resources for Providers*

Based on available information on DSH and non-DSH supplemental payments, hospitals were able to recuperate 107% of their Medicaid costs on average.<sup>26</sup> The range of costs covered spans from 81% in the lowest paying state to 130% in the highest paying state, meaning the percentage of costs of Medicaid supplemental payments cover for a hospital varies greatly.<sup>27</sup> This indicates hospitals have contrasting experiences receiving supplemental payments to cover Medicaid care costs. However, this accounting does not include all of the non-DSH supplemental payments made, particularly those

<sup>25</sup> CMS, Office of the Actuary. 2017 Actuarial Report on the Financial Outlook for Medicaid. Page 56. Available online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf>

<sup>26</sup> KFF. Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes. Page 3. Available online at <http://files.kff.org/attachment/issue-brief-understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes>

<sup>27</sup> MACPAC. Improving Data as the First Step to a More Targeted Disproportionate Share Hospital Policy. Page 59. Available online at <https://www.macpac.gov/wp-content/uploads/2016/03/Improving-Data-as-the-First-Step-to-a-More-Targeted-Disproportionate-Share-Hospital-Policy.pdf>

made through Section 1115 demonstrations and supplemental payments made by managed care organizations.

Better health care may be achieved through increased transparency of how states distribute supplemental payments to providers. Increased reporting standards offer a chance to understand how funding decisions are made by gathering statewide payment information on providers classified by ownership and service type. Data is a tool to be harnessed, and it provides an opportunity to ensure a higher quality of care. These data would also assist the Committee in overseeing Medicaid.

Provider-level information on supplemental payments can increase transparency of how states distribute those payments to providers, ensuring that payments are “economical and efficient,” per statutory mandate. Regardless of whether at the provider or facility-level, these data should be reported and transmitted efficiently.

### *Managed Care Rule’s Impact on Supplemental Payments*

The billions of dollars of supplemental payments invested in state Medicaid programs demonstrate the high utilization of these payments in Medicaid. In April 2016, CMS expanded Medicaid managed care regulations, specifically acknowledging pass through payments that were in effect on July 1, 2017.<sup>28</sup> As states transitioned to a managed care delivery system, traditional non-DSH supplemental payments under the state plan were diminished. To continue making non-DSH supplemental payments, states developed pass-through payments, which are payments the state makes to a managed care organization; the managed care organization is then required to pass the non-DSH supplemental payment along to the providers.

Although these payments were generally not permitted under prior Medicaid rules, CMS did not immediately identify their existence. Because pass-through payments are the primary way supplemental payment funding is retained in managed care, their restriction and eventual elimination by 2027 (as required by the April 2016 managed care regulations) will require states to tie any supplemental payments to utilization of services for Medicaid beneficiaries.<sup>29</sup>

Prior to the regulation, total pass-through payments were distributed to providers with consistency from year-to-year. This regularity gave assurances to safety-net and smaller providers with varying utilization levels. Vulnerable providers operating under a managed care model will likely face difficulties if payment is contingent on utilization levels. Notably, Medicaid providers using a FFS arrangement are not subject to this regulation. If providers are unable to sufficiently support their operations with the utilization-based pass-through payments, this carve-out incentivizes providers to opt for some services to be provided under FFS arrangements over managed care.<sup>30</sup> There are concerns that such discrepancy can discourage value-based arrangements in Medicaid. It is also concerning that, while there are circumstances where supplemental payments may be important for safety net and small providers, there is little data to connect the payments to actual utilization data. Therefore, it is difficult for the federal government to ascertain the extent to which the supplemental payments are needed.

Supplemental payments for purposes other than utilization within managed care will face reductions

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<sup>28</sup> Nursing facilities and physicians may receive pass-through supplemental payments through July 1, 2021.

<sup>29</sup> The total allowable amount for pass-through payments is reduced each year for hospitals, and is capped at the difference between Medicare rates and the Medicaid plan, or FFS payment rates excluding pass-through payments.

<sup>30</sup> [http://us.milliman.com/uploadedFiles/insight/2016/2232HDP\\_20160518.pdf](http://us.milliman.com/uploadedFiles/insight/2016/2232HDP_20160518.pdf)

and eventual elimination within a decade under this rule. The Committee advocates that more information on how the payments are distributed to providers should be collected to inform how any reductions are made, as data will be needed to determine if payments are being shifted to other sources or whether an increase in certain population carve-outs from managed care would be a likely result to maintain current spending.

In 2018, CMS updated the April 2016 Managed Care Rule to state that pass-through payments from managed care organizations to providers will be allowed during the first three years that a new population is transitioned to managed care in the state. According to CMS, this will allow FFS incentives to be maintained during the transition to a new payment model.

### Determining the Recipients of Supplemental Payment Funds

States make supplemental payments to providers from these funds, as according their state plan, or applicable state plan amendment (SPA).<sup>31</sup> The state plan is required for all states to be eligible to receive any Medicaid funding. It serves to describe the specific Medicaid program structure and operations, detailing eligibility, covered benefits, and payment mechanisms.<sup>32</sup> States must file a SPA with CMS to modify the state Medicaid program to reflect any policy changes.<sup>33</sup>

SPAs are the primary method used for states to specify their Medicaid programs, but do not provide details on plans to distribute UPL supplemental payments. The HHS Secretary, or a delegate, reviews the state-proposed changes to ensure they are congruent to federal law.<sup>34</sup> However, the absence of formal policy on factors governing the disbursement process lends to a low threshold for approval. This is not a commentary on the appropriateness of such a threshold, but rather acknowledgement of existing flexibility.

SPAs are expected to be forward-looking plans that are approved prior to their implementation. Once a SPA is approved, it is generally not subject to a regular review process to compare actual disbursements made with the elements of the plan. Ratified SPAs are permanent changes that may function without a recurring application, unless a state seeks to amend the policies implemented under the SPA. In some cases, supplemental payment components of SPAs may implement certain payment methodologies for a prescribed period of time, but those will eventually sunset.

The forward-looking nature of SPAs means that they do not identify individual providers that will receive supplemental payments. A SPA is designed to be incorporated into a general state plan and offer information to the class of providers that receive an amount of supplemental payments. SPAs are a medium to understand the wider goals of a state Medicaid program, and are not conducive to oversight of payments made at the provider level.

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<sup>31</sup> GAO. *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*. [GAO-16-108](#). Page 9.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* at 3.

## REPORTING REQUIREMENTS AND THE LIMITATIONS OF THE CURRENT APPROACH

### Reporting Requirements

Reporting requirements for states do not provide information conducive to evaluation. Disclosure forms, state plans, and data tracking systems do not mandate usable and specific provider-level disbursement information from states, obscuring the financial relationship between state Medicaid agencies and providers. These systems have a common goal of accumulating data for the purposes of assessing utilization and valuing the weight of different aspects of the Medicaid program. For supplemental payments, the current system of gathering information does not include transparency measures to adequately oversee state distribution.

One of the Committee's goals is to ensure CMS has the data necessary to conduct an informed prospective analysis based on provider-level information. The reporting requirements for supplemental payments are predictive-in-nature (based on estimates) and most supplemental payments are reported in the aggregate for certain groups of providers. Prospective analysis and retrospective accounting does not prepare CMS to actively monitor how supplemental payments are disbursed, nor does it create opportunities to improve the delivery of health care. The federal government plays a critical role in the administration of the Medicaid program, yet access to complete data continue to present challenges to effective federal oversight of supplemental payments.

### *CMS-64*

States are required to report Medicaid expenditures through the Form CMS-64, which provides information as a statement of expenditures, including invoices, cost reports, and eligibility records.<sup>35</sup> It is required for states to complete, and is the basis by which the federal government matches state spending. The federal government may withhold federal funding from the state if expenditures are not supported and consistent with Medicaid requirements.

The Form CMS-64 provides a partial impression of how states allocate Medicaid spending. With the current form, it does not collect sufficient information to adequately illustrate the distribution of supplemental payments. It collects information in the aggregate, not at the provider level. For supplemental payments, Form CMS-64 requires state Medicaid spending for the following provider categories: 1) inpatient hospital services, 2) outpatient hospital services, 3) nursing facility services, 4) physician and surgical services, 5) other practitioners' services, and 6) intermediate care facility services.<sup>36</sup>

Of these categories, states must fill in their quarterly aggregate amount of funding expended to support that particular classification of providers. The Form CMS-64 groups together a statewide class of providers, and informs CMS of the total amount disbursed through supplemental payments. With data that are only capable of providing a quarterly aggregate of all similarly classified providers based on a service type category, states have the flexibility to allocate supplemental payments with discretion and minimal external regulation. While state flexibility is laudable for implementing the

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<sup>35</sup> CMS. CMS-64 Quarterly Expense Report. Available online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/CMS-64-Quarterly-Expense-Report.html>

<sup>36</sup> Id.

Medicaid program, there is very little accountability for the \$48.8 billion currently spent on supplemental payments.

### *State Medicaid Director Letter and UPL Demonstration*

CMS issued a letter to state Medicaid directors in March 2013 discussing the mutual obligations between the federal government and states to ensure integrity in how federal and state funding are spent.<sup>37</sup> It called for states to submit annual information on UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities.<sup>38</sup> In 2014, the provider categories requiring annual reports were expanded to clinics, physician services, ICF/DDs, private residential treatment facilities, and institutes for mental disease (“IMD”), and in 2017 an additional category was added for durable medical equipment.<sup>39</sup> CMS has not published results from the UPL demonstration, but preliminary communications with CMS have indicated the information helped the agency identify gaps in the current data collection mechanisms on UPL supplemental payments.

CMS guidance materials for the UPL demonstrations do not increase reporting requirements at the provider-level, but generally discuss methodology within the broader aforementioned categories to state Medicaid directors. The guidance materials were designed to be inclusive to varying state practices.

Additionally, the annual submissions for the UPL demonstrations were for the upcoming year, meaning they were predictive. There is no affirmative approval process required for how the actual payments would be disbursed. CMS indicated the aggregate payment projections should be within a reasonable amount of what Medicare would pay, but this directive makes it difficult to collect actual Medicaid spending data that may be used to improve the Medicaid program. Furthermore, the submissions are based on data from preceding years, and the window of time used for the UPL calculations is up to state discretion.

The State Medicaid Director Letter was a step towards collecting standardized information from states by distributing high-level guidance on how states were distributing UPL supplemental payments. Such CMS guidance on methodology for distributing payments is helpful in gaining an understanding of broader program trends. However, the letter and subsequent demonstration did not mandate more specific state disclosures that would offer data at a more detailed level than already in place with the CMS-64. It remains difficult to fully conduct oversight of how the states elected to distribute supplemental payments when the data are not standardized or at a level specific enough to fully analyze how discretionary decisions were made.

### *Medicaid and CHIP Program (MACPro) Portal*

SPAs offer general data that points to how supplemental payments plan to be distributed, if the HHS Secretary approves the modification. MACPro was built as a part of a state-facing system in December 2015 to capture states’ submissions of state plan amendments, waivers, quality measures, and advanced planning documents.<sup>40</sup> The Centers for Medicaid and CHIP Services (CMCS)

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<sup>37</sup>Mann, Cindy. RE: Federal and State Oversight of Medicaid Expenditures. March 18, 2013. Copy of letter available online at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf>

<sup>38</sup>*Id.*

<sup>39</sup>*Id.*

<sup>40</sup>Medicaid. Medicaid and CHIP Data Collection Systems. Available online at <https://www.medicaid.gov/medicaid/data-and-systems/collection-systems/index.html>

constructed this system to help address uniformity challenges of a federal-state partnership and aid CMS in conducting oversight of its current programs.

In the supplemental payment context, MACPro consolidates state plan amendments and is only as specific as the state plans require. While a valuable tool for amassing data on the state Medicaid programs, it can only extract information with as much detail as the contributions permit.

### *MSIS/T-MSIS*

The Medicaid Statistical Information System (MSIS) began as a way to collect, manage, analyze, and disseminate information on eligibility, beneficiary demographics, utilization, and payment under state Medicaid programs.<sup>41</sup> States submitted MSIS reports on a quarterly basis covering eligibility files and adjudicated claims for medical services.<sup>42</sup> CMS has transitioned to a transformed Medicaid Statistical Information System (T-MSIS) starting with a pilot program in 2011, and is now collecting at least some T-MSIS data from all 50 states, the District of Columbia, and Puerto Rico.<sup>43</sup> CMS has ongoing efforts to improve the quality of T-MSIS data and is considering how these data may be used for policy decisions.

T-MSIS data are collected on a monthly basis, and CMS expects it to modernize how states submit data about beneficiaries, providers, claims, and encounters. The potential exists for T-MSIS to identify information relating to the provider expenditure experience that could increase transparency at the provider-level for supplemental payments. Additionally, encounter data collection allows for a single platform for fee-for-service and managed Medicaid data to be compiled. T-MSIS aims to mitigate activities inconsistent with maintaining the integrity of Medicaid.<sup>44</sup>

Specific aspects of T-MSIS, such as provider-specific data, may minimize limitations in the Medicaid data historically reported by states. Challenges exist that delayed the T-MSIS rollout, but as states become more familiar with the T-MSIS Data Dictionary, and develop a common terminology, these challenges may be alleviated. In fairness to state processes, all state Medicaid programs are asked to submit complex data in a new and expanded reporting format. The amount of information T-MSIS generates can be overwhelming for its users, and presents a challenging task to inform the states about quality specific to their work.<sup>45</sup> From the T-MSIS data, it is expected that CMS will develop new guidance to address prevailing issues as states continue to shift more costs to managed care and move more data reporting to a monthly, not quarterly, schedule.<sup>46</sup>

There are both opportunities and challenges that arise from T-MSIS. States are now required to

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<sup>41</sup> CMS. Medicaid Statistical Information Statistics (MSIS). Available online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MSIS/index.html?redirect=/msis/>

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> Mann, Cindy. RE: Transformed Medicaid Statistical Information System (T-MSIS) Data. Copy of letter available online at <https://www.medicare.gov/federal-policy-guidance/downloads/smd-13-004.pdf>

<sup>45</sup> Mathematica. Moving Medicaid Data Forward: Understanding T-MSIS, the Transformed Medicaid Statistical Information System. Presentation. Available at [https://www.researchgate.net/profile/Carol\\_Irvin/publication/311607060\\_Moving\\_Medicare\\_Data\\_Forward\\_Understanding\\_T-MSIS\\_the\\_Transformed\\_Medicare\\_Statistical\\_Information\\_System/links/5853fc7c08ae7d33e01d310d/Moving-Medicare-Data-Forward-Understanding-T-MSIS-the-Transformed-Medicare-Statistical-Information-System.pdf?origin=publication\\_detail](https://www.researchgate.net/profile/Carol_Irvin/publication/311607060_Moving_Medicare_Data_Forward_Understanding_T-MSIS_the_Transformed_Medicare_Statistical_Information_System/links/5853fc7c08ae7d33e01d310d/Moving-Medicare-Data-Forward-Understanding-T-MSIS-the-Transformed-Medicare-Statistical-Information-System.pdf?origin=publication_detail)

<sup>46</sup> *Id.*

identify supplemental payments at the provider level, and by type (DSH and non-DSH). Additionally, for states operating any portion of their programs through managed care, supplemental payments can be delineated between fee-for-service and managed care. Should states submit this information, CMS will be able to understand the policy impacts of different types of non-DSH supplemental payments at a more granular level.

### Limitations of Current Approach

The Committee's oversight of Medicaid payments to hospitals, nursing facilities, and general base payments to providers are hampered by not having access to supplemental payments distributions. It is difficult to gauge policy impacts of new proposals when data on existing payment rates are convoluted, at best, and unreported, at worst. Currently, the reporting requirements and data collection mechanisms are not structured in a way conducive to gaining this insight. Beyond the Committee's needs, CMS's own oversight—and those of GAO and OIG—are also hampered by this lack of information.

The existing approach to collecting information on supplemental payments operates in a way that is generalizable to statewide trends for classifications of providers. It does not inform, from an oversight perspective, how states fund the specific entities supplemental payments are intended to help. Additionally, it is unclear how managed care rates incorporate non-DSH supplemental payments, and the Committee should monitor the use of pass-through payments in the coming years.

Medicaid is a particularly sensitive program with elements including the federal-state relationship, direct constituent impact, income disparity, and many other factors intertwined into the law. For these reasons, the goals of framing a more efficient and economical Medicaid financing model are valuable, and data collection in Medicaid differs from other federal programs. However, transparency can warrant these concerns are acknowledged while ensuring providers receive appropriate supplemental payments in proportion to their need.

States have made a commitment to T-MSIS, and the Committee is optimistic of its continual progress towards full implementation and use in policy decisions.

## CONCLUSION

Supplemental payments comprised over \$48 billion in the Medicaid program in 2016. With over \$28 billion in non-DSH supplemental payments, there is too little focus on the ways in which Medicaid makes supplemental payments that act as an adjustment to its base Medicaid rates for certain providers. It is possible that many of these adjustments are justifiable and made according to the statutory authority provided in the Social Security Act. However, without detailed processes in place, it is also possible that some payments have been made inappropriately.

Additionally, the differences between state mechanisms for raising their share of Medicaid payments, such as provider assessments, certified public expenditures, and fund transfers via intergovernmental transfers (all of which are outlined in greater detail in Appendix A) create confusion amongst policy staff at both the state and federal level seeking to improve the Medicaid program as it furthers its mission to provide high quality care for its beneficiaries. Without oversight of the different federal and state payments and the proper conditions of their use, the Committee is concerned that they can be easily abused.

Furthermore, the data collection systems for non-DSH supplemental payments need to evolve to capture payment information at the provider level, where appropriate, so federal decisions are not based on aggregate numbers. It is impossible to justify base rate increases for providers when net provider rates remain a black box. The Committee continues to watch implementation of T-MSIS and seeks to further the use of data in T-MSIS in policy decisions. When used in combination with Form CMS-64 data, there are opportunities to analyze payment trends based on total payments to providers or facilities, not just state-wide base payment rates.

In conclusion, this report provides a starting point for the Committee to begin a robust conversation on supplemental payments in Medicaid. While the Committee remains interested in future recommendations from MACPAC, GAO, and others, there are currently many unaddressed recommendations (Appendix B) that can be implemented to improve the Medicaid program and its accountability to taxpayers.



## Appendix A: State Financing of Nonfederal Share of Medicaid Payments

### Sources of State Financing

#### *Provider Taxes*

States may tax health care providers as a revenue source for a state nonfederal share of their Medicaid program.<sup>47</sup> Provider taxes, often referred to as provider assessments, are frequently utilized in the Medicaid financing system; about two-thirds of states have three or more provider taxes, while all states but Alaska use provider taxes.<sup>48</sup> Similarly to intergovernmental transfers (IGTs, which are discussed later in this section), provider taxes are a tool of states to minimize budgetary shortfalls. Provider taxes must be broad-based and uniformly applied to all providers within a specific class and without guarantees that providers will be held harmless by receiving their provider tax back, as determined through the guarantee test.<sup>49</sup> The guarantee test states that a provider may impose a provider tax if it is either:

1. Less than six percent of net patient services revenue received by the taxpayer; or,
2. More than six-percent of the net patient services revenue, as long as the state can prove that more than seventy-five percent of taxpayers in the provider class receive at least seventy-five percent of the costs back through Medicaid or state payments.<sup>50</sup>

States have indicated they plan to further utilize provider taxes to confront challenges brought by decreases in federal support from the Medicaid expansion when the federal match drops from 100 to 90% in 2020.<sup>51</sup> A review of current and past expansions approved through 1115 waivers illustrate increased state usage of provider taxes. Moreover, the provider taxes imposed across provider types varies in each state, including hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities. In 2016, there were 152 provider taxes across providers in all 50 states.<sup>52</sup> For additional details, please see Table 1.

#### *Intergovernmental Transfers (IGT)*

IGTs, as applicable to Medicaid, are a transfer of funds between state or sub-state government entities within the same level of government or between different levels of government.<sup>53</sup> For instance, IGTs may occur between local and state government groups, or state-owned hospitals and the state Medicaid agency. They may be made by government entities to finance the state's nonfederal share

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<sup>47</sup> GAO. *Medicaid: Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight*. [GAO-14-817T](#). Page 5.

<sup>48</sup> KFF. *Medicaid Financing: The Basics*. Page 10. Available online at <http://files.kff.org/attachment/Issue-Brief-Medicaid-Financing-The-Basics>

<sup>49</sup> CRS. *Medicaid Provider Taxes*. RS22843. Page 1. Available online at <http://www.crs.gov/Reports/RS22843?source=search&guid=495b9720f42a49988bead63ba668956a&index=0>

<sup>50</sup> This is also known as the “75/75 rule”. *Id.*

<sup>51</sup> KFF. *Understanding How States Access the ACA Enhanced Medicaid Match Rates*. Page 6. Available online at <http://files.kff.org/attachment/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates-issue-brief>

<sup>52</sup> Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2016. <https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/>

<sup>53</sup> GAO. *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. [GAO-14-627](#). Page 8.

of Medicaid payments, which the federal government matches at the applicable rate.

When the state proposes a supplemental payment SPA, CMS asks the state to identify its sources of financing; however, the provider that will receive the supplemental payment is not required to report how that payment was financed.<sup>54</sup> The Committee seeks greater transparency of provider-level supplemental payments and their sources of funding. For additional details, please see Table 1.

### *Certified Public Expenditures (CPE)*

CPEs are another payment mechanism by which states finance their share of Medicaid spending, and receive federal matching funds for spending that the state certifies is eligible for Medicaid coverage but is beyond base rates for providers or services<sup>55</sup>. Unlike IGTs, there is no transfer of funds, but rather the state asserts through a certification process that the funds are being used for eligible Medicaid payments and the state's normal FMAP applies. For additional details, please see Table 1.

### *Graduate Medical Education (GME) Payments*

GME payments in Medicaid have been made in 42 states and D.C., totaling \$4.2 billion in 2015.<sup>56</sup> GME payments are made by CMS to hospitals and other institutions that have committed to training physician residents. States are not required by statute to make GME payments, but states have the flexibility to design and administer how the state allocates GME payments.<sup>57</sup> Payment size to qualifying providers is calculated by the number of residents at the hospital, and is not subject to a material amount of discretion. These payments may be made through FFS or managed care delivery systems, or both.<sup>58</sup>

The data available on how Medicaid GME payments are distributed is limited, as collected through the CMS-64 and the Association of American Medical Colleges (AAMC). The data collected by these two sources both serve distinct purposes, and do not provide a complete picture of the role of GME payments. The CMS-64 data capture is quarterly, but is limited to FFS GME payments.<sup>59</sup> The AAMC conducts its 50-state survey every four years. These sources encompass the information available on the distribution of GME payments. More encapsulating data made in managed care and FFS environments for GME payments, as collected by the CMS with a penalty for noncompliance would promote higher program quality, as well as increase oversight capabilities of the Committee.

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<sup>54</sup> Milliman. Pass-through payment guidance in final Medicaid managed care regulations: Transitioning to value-based payments, delivery system reform, and required reimbursement. Available online at <http://us.milliman.com/insight/2016/Pass-through-payment-guidance-in-final-Medicaid-managed-care-regulations-Transitioning-to-value-based-payments/>

<sup>55</sup> [http://www.csg.org/knowledgecenter/docs/Medicaid\\_Primer\\_final\\_screen.pdf](http://www.csg.org/knowledgecenter/docs/Medicaid_Primer_final_screen.pdf)

<sup>56</sup> American Association of Medical Colleges (AAMC). Medicaid Graduate Medical Education Payments: A 50-State Survey 2016. Page 6. Available online at [http://members.aamc.org/eweb/upload/Medicaid\\_Graduate\\_Medical\\_Education\\_Payments--A\\_50\\_State\\_Survey.docx.pdf](http://members.aamc.org/eweb/upload/Medicaid_Graduate_Medical_Education_Payments--A_50_State_Survey.docx.pdf)

<sup>57</sup> “While no federal guidance speaks to Medicaid GME payments, federal regulations specify upper payment limits (UPLs) for Medicaid payments to hospitals, which prohibit using federal matching funds for Medicaid fee-for-service payments in excess of what would have been paid under Medicare payment principles that include GME payments (42 C.F.R. 447.272).” Congressional Research Service (CRS). *Federal Support for Graduate Medical Education: An Overview*. Page 10. Available online at <https://fas.org/sgp/crs/misc/R44376.pdf>

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<b>Table 1: Federal Statutory and Regulatory Requirements Governing Use and Reporting for Health Care Provider Taxes, Provider Donations, Intergovernmental Transfers, and Certified Public Expenditures Source of funds</b>		
	<b>Federal requirements governing use</b>	<b>Federal reporting requirements</b>
Health care provider taxes <sup>a</sup>	<ul style="list-style-type: none"> <li>• Tax (1) must be broad-based (i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state); (2) must be uniformly imposed (e.g., the tax is the same amount for all providers furnishing the services within the same category);<sup>b</sup> and (3) must not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back)</li> <li>• Taxes that are at or below 6 percent of the individual provider’s net patient service revenues are considered not to have provided an indirect guarantee that providers will receive their tax payments back<sup>c</sup></li> </ul>	<ul style="list-style-type: none"> <li>• States must submit a request if seeking a waiver of the broad-based and uniform requirement</li> <li>• States must report their revenues from provider taxes on a quarterly basis</li> </ul>
Provider donations <sup>d</sup>	<ul style="list-style-type: none"> <li>• Donations must be bona fide. To be bona fide, the donor must not be held harmless<sup>e</sup></li> <li>• If the donations do not exceed \$5,000 for individual provider or \$50,000 for health care organization per year, they are deemed to be bona fide. However, donations may not have a hold-harmless provision that would return the funds, in all or part, to the donor.</li> </ul>	<ul style="list-style-type: none"> <li>• States must report their revenues from provider donations on a quarterly basis</li> </ul>
Intergovernmental transfer (IGT) <sup>f</sup>	<ul style="list-style-type: none"> <li>• Federal law does not restrict states’ use of funds when funds are transferred from local governments<sup>g</sup></li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Medicaid certified public expenditure	<ul style="list-style-type: none"> <li>• Federal law does not restrict states’ use of funds when funds are certified as matchable expenditures by local governments.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Source: GAO analysis of federal laws and regulations. | GAO-14-627

**Note: Centers for Medicare & Medicaid Services (CMS) officials stated that they also request that states provide additional information on the sources of the nonfederal share in certain circumstances. For example under a 2013 policy, states must annually report on provider payments to demonstrate compliance with the UPL. As part of this reporting, CMS asks states to identify the sources of the nonfederal share for these payments which may include provider taxes, provider donations, IGTs and CPEs.**

<sup>a</sup> 42 U.S.C. § 1396b(w), 42 C.F.R. § 433.55-.74. If a tax is imposed by a local government, the tax must extend to all services or providers within a category in the area over which the local government has jurisdiction.

<sup>b</sup> States may seek CMS approval of a waiver of either the broad-based or uniformly imposed requirements. CMS may waive these requirements only if the net impact of the tax is generally redistributive and not directly correlated with Medicaid payments to the providers subject to the tax.

<sup>c</sup> Taxes at or below the 6 percent threshold are automatically determined to comply with the indirect guarantee test, which is one of the three tests required for the hold-harmless requirement. Specifically, the indirect guarantee test ensures that states do not provide a direct or indirect guarantee that providers will receive their tax payments back. However, states still must comply with the remaining hold-harmless provisions. The positive correlation test is violated if a provider paying the tax received a payment that is positively correlated to the tax amount or the difference between the provider’s Medicaid payment and the tax amount. The Medicaid payment test is violated if all or any portion of the Medicaid payment to the provider varies based only on the amount of the total tax payment.

<sup>d</sup> 42 U.S.C. § 1396b(w), 42 C.F.R. § 433.54-.74.

<sup>e</sup> CMS recently issued guidance explaining an application of this requirement. In May 2014, CMS issued a State Medicaid Director Letter that identified arrangements that CMS would find unallowable because under the arrangement, the provider is held harmless for its donation (e.g., provided a direct or indirect guarantee that the provider will receive all or a portion of the donation back).

<sup>f</sup> 42 U.S.C. § 1396b(w)(6).

<sup>g</sup> States are prohibited from using IGTs as the nonfederal share if the funds transferred by the local government were derived from provider taxes or provider-related donations that did not meet federal requirements. 42 U.S.C. § 1396b(w)(6).

## Appendix B: Proposed Approaches to Achieve Greater Transparency

The Committee has compiled this report based on the previous efforts and recommendations of MACPAC, GAO, HHS OIG, CMS program staff, state Medicaid program staff, and Medicaid contractors. A sampling of existing, public recommendations is included below.

### General MACPAC Findings

- MACPAC has stated there is a void of national data available on how supplemental payments are disbursed at the provider level.
- The current data capture mechanisms only determine net payments made to a broader category of providers similar to each other. Net payment to individual providers is not presently possible.
- Further, there is no methodology outlined by CMS to account for a change in billing practices, as the industry is moving towards managed care services from FFS.
- In reference to what approach should be taken to increase the data collected on provider level supplemental payments and improve its quality, MACPAC has acknowledged the differences between collecting or reporting data in comparison with auditing the data.
- MACPAC thinks it is fair to say CMS needs legislative authority to conduct auditing, however the same threshold may not be required for collecting/reporting data. MACPAC stated CMS likely and presently has the authority to report data collected on supplemental payments at the provider level.

### General GAO Findings<sup>60</sup>

- Between fiscal year 2011 and 2015, supplemental payments have grown in usage to at least \$43 billion according to a 2015 GAO study.
- Complete and reliable data in the tens of billions of supplemental payments is lacking from the states, and inhibits possible transparency and oversight.
- The data available are not complete, reliable, uniform, or accessible.
- There is no statutory purpose outlining why non-DSH supplemental payments should and should not be made to certain providers.
- GAO recommended CMS clarify that all Medicaid payments should be distributed on the basis of Medicaid services provided and annual reports should provide payments at the facility-specific level.<sup>61</sup>
- GAO recommended Congress consider requiring CMS to provide guidance on permissible methods for calculating non-DSH payments, in addition to requiring state reports and audits.

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<sup>60</sup> GAO testimony to Congress. <http://www.gao.gov/assets/680/673493.pdf>

<sup>61</sup> GAO. *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*. [GAO-13-48](#).

