Appointment

From: Chadwick, Alpheus (CMS/OL) (b)(6) (b)(6)

Sent: 5/4/2023 8:47:41 PM

To: Martino, Maria (CMS/OL) (b)(6) (b)(6); Sanders, Kaylynn (CMS/OL) (b)(6) (b)(6) Kirchgraber, Kate (CMS/OL) (b)(6) (b)(6) Howe, Rory (CMS/CMCS) (b)(6) (b)(6); Khalid, Zunaira (CMS/OL) (b)(6) (b)(6)

Subject: FL Staff Call on Hold Harmless (Provider Tax) Issue

Attachments: RE: RE: FL CMS Call on Informational Bulletin; CMS Bulletin 1-Pgr[2].pdf; Bulletin - MFAR Resurfacing Impact.pdf

Location: https://cms.zoomgov.com/j/1602325294?pwd=cEZ5YlRuWkJzdXB2R2pBQ3NsNUVyUT09

Start: 5/9/2023 5:30:00 PM

End: 5/9/2023 6:00:00 PM

Show Time As: Tentative

Required Attendees: Howell, Cherie (CMS/OL); Martino, Maria (CMS/OL); Sanders, Kaylynn (CMS/OL); Kirchgraber, Kate (CMS/OL); Howe, Rory (CMS/CMCS); Khalid, Zunaira (CMS/OL)

This call is with **staff** from the offices of Rep. Debbie Wasserman Schultz (D-FL) and Rep. Kathy Castor (D-FL), who asked to discuss Florida hospital concerns with the CMS Informational Bulletin regarding hold harmless agreements.

Alpheus Chadwick is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
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This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

Message

From: Powell, Eric (CMS/CMCS) (b)(6)
(b)(6)
Sent: 2/22/2023 8:05:42 PM
To: Todd.Richardson@dss.mo.gov (b)(6)
CC: (b)(6) Howe, Rory (CMS/CMCS) [rory.howe@cms.hhs.gov]; Endelman (he/him), Jonathan (CMS/CMCS) [jonathan.endelman@cms.hhs.gov]; Kimble, Davida (CMS/CMCS) [davida.kimble@cms.hhs.gov]
Subject: Missouri FRA tax review QE 12/31/22
Attachments: FRA Tax Questions QE 12-31-22.docx; mhd-rapid-response-review.pdf

Director Richardson,

As indicated in our July 15, 2022 letter, CMS is committed to ensuring the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section 1903(w)(4) of the Social Security Act and federal regulations at 42 CFR 433.68(f)(3). In that July letter and prior communication with the state including a July 20, 2020 letter, CMS reiterated concerns that CMS the state's Federal Reimbursement Allowance (FRA) tax program appeared to contain a hold harmless arrangement, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 CFR 433.68(f)(3). The July 2022 letter also indicated that CMS intended to conduct a focused review of Missouri's FRA program related to expenditures reported to CMS on the Form CMS-64. We appreciate the state's August 25, 2022 response to our July 15, 2022 letter. After review of the information shared in conjunction with the letter, CMS remains concerned that Missouri's FRA program does not appear to meet federal requirements. Therefore, we are requesting information and supporting documentation to determine if the FRA is in compliance with all federal statutory and regulatory requirements for FRA tax amounts reported on the CMS-64 for the quarter ending December 31, 2022. Request for information and supporting documentation is attached to this email – please provide responses by close of business Friday, 3/10/23.

Eric Powell, CPA | Centers for Medicaid and CHIP Services | FMG/DFO-West Branch B | 312.886.0791

Missouri Federal Reimbursement Allowance (FRA) Tax Questions

As indicated in our July 15, 2022 letter, CMS is committed to ensuring the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section 1903(w)(4) of the Social Security Act and federal regulations at 42 CFR 433.68(f)(3). In that July letter and prior communication with the state including a July 20, 2020 letter, CMS reiterated concerns that CMS the state's Federal Reimbursement Allowance (FRA) tax program appeared to contain a hold harmless arrangement, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 CFR 433.68(f)(3). The July 2022 letter also indicated that CMS intended to conduct a focused review of Missouri's FRA program related to expenditures reported to CMS on the Form CMS-64. We appreciate the state's August 25, 2022 response to our July 15, 2022 letter. After review of the information shared in conjunction with the letter, CMS remains concerned that Missouri's FRA program does not appear to meet federal requirements. Therefore, we are requesting information and supporting documentation to determine if the FRA is in compliance with all federal statutory and regulatory requirements for FRA tax amounts reported on the CMS-64 for the quarter ending December 31, 2022.

Please provide the following information and documentation relating to FRA amounts reported to CMS on the Form CMS-64 for the quarter ended December 31, 2022:

1. The state law(s) that authorize the FRA and that direct the disposition of the revenue raised.

2. A list of each State Directed Payment Preprint and State Plan payment provision for which the non-federal share includes FRA tax revenue.

3. For each provider paying the FRA tax:
    a. Provider name
    b. The applicable FRA tax rate or rates
    c. The basis for the tax rate (e.g., hospital net patient revenues, discharges, etc.)
    d. Amount of FRA tax paid for the quarter ended 12/31/2022
    e. Total amount received in Medicaid payments funded by FRA tax revenue through the State Directed Payments and/or State Plan payments.
    f. Amount(s) paid or contributed to the Missouri Hospital Association FRA Funding Pool
    g. Amount(s) received from the Missouri Hospital Association FRA Funding Pool

4. Please confirm that the FRA assessment is imposed on the two permissible classes, inpatient hospital services and outpatient hospital services, and no other items or services. The term "permissible class" is defined in section 1903(w)(7) of the Social Security Act and 42 CFR 433.56(a).

5. Each permissible class the state taxes under the FRA is subject to the indirect guarantee hold harmless test as specified in 42 CFR 433.68(f)(3)(i)(A) and (B). The state should calculate the test for each permissible class separately. For example, inpatient hospital

services and outpatient hospital services should be calculated separately. Please confirm the total amount of health care-related tax or taxes is less than or equal to 6% of the taxpayers' net patient revenue for inpatient hospital services, and for outpatient hospital services. If the state cannot confirm that the total amount of health care-related tax or taxes is less than or equal to 6% of the taxpayers' net patient revenue for inpatient hospital services, and for outpatient hospital services, please confirm that 75% or more of providers being taxed in the class do not receive 75% or more of their tax cost back in Medicaid or other state payments.

6. An arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 C.F.R. § 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.

   In a document entitled, "Rapid Response Review- Assessment of Missouri Medicaid Program" issued by the Missouri Department of Social Services on February 11, 2019, there is a flowchart entitled "Exhibit 12: Missouri Hospital Association FRA Funding Pool." The document is included as an attachment to this email. According to the flow chart, providers that receive more in Medicaid payments funded by the FRA than the provider pays in tax transfer some of the provider's FRA-funded Medicaid payments to the pool operated by the MHA. If a provider receives less in Medicaid payments funded by the FRA than it pays in tax, the provider receives a payment from the pool consisting of amounts from the pooled Medicaid payments from other providers. The goal is to "net out the FRA paid with the payments received" or, in other words, to guarantee that no taxpayer is financially harmed by the cost of the tax. Is the description found in the PowerPoint issued by the State of Missouri an accurate description of how the pooling arrangement worked for the quarter ended December 31, 2022 with regard to the FRA?

7. Please provide any documentation the state has concerning the operation of these pooling arrangements (including the redistribution of payments) and how they work. This would include any copies of contracts, agreements, letters, call or meeting notes, or other similar materials discussing the arrangements, involving the state, hospitals, the Missouri Hospital Association (MHA), managed care organizations, and/or other parties.

8. If a hospital is a "pool contributor" and receives more in payments than it pays in tax, does it always pay all of the difference into the pool? Do "pool receivers" that pay more in tax than they receive in payments always receive the entire amount back from the pool, or only some of it? How are those payment amounts determined?

9. Please provide any additional detail on the memorandum of understanding (MOU) between the Missouri Hospital Association and Managed Care Organizations, as described in the Rapid Response document, regarding an agreement to attempt to ensure individual hospitals are not financially harmed by the FRA using Medicaid managed care payments. If available to the state, please provide a copy of this MOU as it was in effect during the quarter ended December 31, 2022, and as it is currently in effect, if the MOU instrument is not the same for the periods. Are these expectations reflected in any contract between the state and the MCOs? If so, please provide copies of the relevant MCO contracts, identifying the relevant provisions.

10. Has the state communicated with its providers regarding the statutory and regulatory prohibition of hold harmless arrangements involving provider payment redistributions, including as articulated by CMS in its July 20, 2020 and July 15, 2022 letters? If so, please describe the nature and substance of the communications, providing copies, if available.

11. Please describe what oversight the state conducts to ensure that the state and providers comply with federal requirements related to the financing of the non-federal share of Medicaid expenditures.

12. Based on the responses to these questions regarding possible redistribution arrangements, CMS may ask additional questions and/or make additional requests for information from the state and/or providers, if necessary.

Missouri Department of Social Services

Rapid Response Review – Assessment of Missouri Medicaid Program

FINAL REPORT

February 11, 2019

Contents

Executive Summary

Missouri's Medicaid program is an important safety net for Missouri's most vulnerable populations, providing health care and support for activities of daily living for nearly one million Missourians. Children in low-income families comprise 63.5% of participants, while persons with disabilities comprise the largest share (46%) of spending. In State Fiscal Year (SFY) 2018, total spending for the program was approximately $10 billion, funded 53% by federal funds, 21% by state general revenues, and the balance by provider taxes and other funds.

Analysis of historical trends indicates that the financial sustainability of Missouri's Medicaid program is currently under pressure: Medicaid spending has grown from 17% of state general revenues in SFY2009 to 24% in SFY2018. Based on continuation of these trends, spending could grow to 26% by SFY2023. This number could be even higher (30%) if Missouri were to experience an economic downturn, given the potential for such a downturn to increase Medicaid enrollment while also reducing growth in state general revenues.

Under any of the scenarios described in the pages that follow, significant changes in the structure and performance of Missouri's Medicaid program would be necessary to bring Medicaid spending growth in line with projected economic growth of the state.

Opportunities for Improvement

Since October, a detailed assessment of the Missouri Medicaid program has uncovered a wide range of opportunities for improvement, which may collectively deliver substantial reductions in the rate of growth of Medicaid spending. These opportunities, detailed in the pages that follow, are based on extensive interviews with state agency leaders and staff, detailed analysis of claims- and non-claims data, review of agency operations, and benchmarking against other states as well as Medicaid managed care organizations (MCOs) and other health insurers.

High-level summaries are provided below for each of eight programmatic and functional areas. Further details follow in the report, including descriptions of opportunities (with supporting facts) and potential initiatives that may be considered by the state in shaping its approach to Medicaid transformation. Potential initiatives include possible changes to provider payment methods, care management, and contracting with MCOs and other vendors, as well as improvements in agency and vendor operations. A selection of potential initiatives outlined in the following pages could collectively enable the Medicaid program to achieve significant cost savings while maintaining or improving access to high-quality care, without broad-based cuts in provider rates, or reductions in eligibility or covered services.

Were Missouri to effectively address the opportunities and potential initiatives outlined in this report, total savings to the program (including federal and state share) could total up to $0.5-1.0 billion by SFY2023. This level of savings, while significant, does not represent an absolute reduction in the size of the Medicaid program but rather a meaningful reduction in the rate of growth of Medicaid spending, to bring it more closely in line with growth of the economy. Implementing changes at this scale would make the program more financially sustainable under all future financing scenarios, allowing for the state to continue to make investments to protect the program's essential role in serving the state's most vulnerable populations.

Acute Care Services. Missouri spent ~$4.2 billion in SFY2018 on acute care services, including hospital, clinic, physician, and diagnostics services, across both the managed care and non-managed care populations. (Pharmaceutical services are discussed in a separate section). Provider payment for acute care providers in Missouri is currently almost exclusively fee-for-service. Fee schedules are based on historical costs; in some cases, these are adjusted each

year based on changes in operating costs. Accordingly, the payment methods used offer few incentives for providers to contain costs. A significant proportion of Missouri Medicaid acute care expenditures is associated with potentially avoidable exacerbations and complications (PECs) and inefficiencies in the choice of provider, site, or treatment. In addition, Missouri Medicaid is unique in making "add-on payments" to hospitals for services provided by Missouri hospitals to non-Missouri residents. Potential initiatives to improve incentives and reduce costs include adjusting rate setting methodologies, moving to value-based payment models, and investing in the rural and safety net heath care infrastructure, including primary care and behavioral health. In total, the gross impact of Acute Care initiatives could range anywhere from $250 million to $500 million, depending on choices made by the state.

Long-Term Services and Supports. Missouri spent ~$2.9 billion in SFY2018 on long-term services and supports (LTSS) for approximately 106,000 Medicaid participants accessing these services. LTSS in Missouri consist of institutional services (e.g., nursing homes for frail elderly, intermediate care facilities for individuals with intellectual disabilities), and home and community-based services (both residential and non-residential) covered by the Medicaid State Plan and nine waivers. Nursing facilities are reimbursed using a cost-based, facility-level per diem methodology without adjustments for acuity, quality, or outcomes, and home and community-based services (HCBS) are reimbursed on a fee-for-service basis. LTSS in Missouri are administered by Missouri Medicaid in conjunction with the Department of Health and Senior Services (DHSS) and the Department of Mental Health (DMH), each of which administers HCBS waivers and conducts assessments to determine access to LTSS. The assessment process currently in use by DHSS uses decades-old standards and, as such, may not consistently determine institutional level of care accurately. Potential initiatives include incorporating an acuity adjustment into the nursing home reimbursement methodology, completing and expanding upon revisions currently underway for the state's assessment algorithms, more directly applying assessment results in the care planning process, and improving the consistency of the prior authorization approval process for personal care services. In total, the gross potential impact across LTSS initiatives ranges from $90 million to $275 million, depending on choices made by the state.

Pharmacy. Missouri spent ~$1.5 billion in SFY2018 on pharmaceutical products. This spending is inclusive of all participants as the state carves pharmacy benefits out of its MCO arrangements. The state utilizes a preferred drug list and receives statutory and supplemental rebates to help control costs. The basis for drug ingredient cost reimbursement was recently updated, and Missouri is in the process of updating dispensing fees. Missouri rebate performance is below the average for other states, potentially due to expansive grandfathering. While the state uses a broad range of approaches to ensure appropriate utilization, there is an opportunity to expand it to other high-cost drug classes such as oncology, hemophilia, and IVIG. Potential initiatives include limiting grandfathering, implementing additional utilization management, joining a purchasing consortium to increase supplemental rebate capture, requiring NDC submission on claims for non-J-code HCPCS drugs, and applying for a value-based contracting waiver from CMS. In total, the gross potential impact across Pharmacy initiatives ranges from $35 million to $60 million, depending on choices made by the state.

Program Integrity. Program integrity functions within the state Medicaid agency center serve to: prevent fraud, waste, and abuse; ensure proper participant enrollment and identify third-party resources to pay for medical claims. Numerous divisions within the state help accomplish these goals; however, the separation of divisions leads to siloed data and communication. Potential initiatives include expanding adoption of best practices from the National Correct Coding Initiative, updating certain medical and reimbursement policies to prevent improper payments,

implementing claims edits that would prevent improper billing based on Missouri's current policies, optimizing the state's ability to identify and enroll participants who are eligible for Medicare, and improving third-party liability identification. In total, Program Integrity initiatives could deliver savings between $65 and $100 million, depending on choices made by the state.

Managed Care. Missouri's Medicaid managed care program covers primarily acute care and professional services for non-disabled adults and children. Approximately 75% of Medicaid participants are covered by managed care, whereas approximately 23% of Medicaid expenditures (~$2.2 billion) flow through managed care contracts. Most pharmacy and behavioral health services for the managed care population remain "carved out" of managed care; the Medicaid aged, blind, and disabled (ABD) population is entirely excluded from the current managed care program. Potential initiatives include incorporating additional adjustments to managed care rates to remove inefficient utilization (e.g., inpatient stays that could have been avoided with better outpatient care) from rate calculations, expanding day-one managed care eligibility to streamline participant transitions and reduce residual fee-for-service payments, strengthening key contract provisions and the compliance and performance management relationship between MHD and the MCOs, and altering the scope of the managed care program—for example, including additional services or Medicaid eligibility groups. In total, the gross potential impact of all Managed Care-related initiatives ranges from $175 million to $300 million, depending on choices made by the state.

Federal Financing. Federal Financing focuses on identifying opportunities to optimize federal funding for the state's Medicaid program. Overall, Missouri has been able to capture a significant share of the available federal funding opportunities, capturing funds across Medicaid spending and non-Medicaid spending within DSS, DMH, and DHSS and capturing enhanced match on select categories. However, there remain several opportunities that the state could pursue to capture additional federal funding. These opportunities could include new waiver and grant programs released in the SUPPORT for Patients and Communities Act, enhanced match on substance use disorder (SUD) focused health homes, among others. In total, potential impact from these improvements may be $10 million to $20 million, based on choices made by the state.

Medicaid Management Information System. Missouri's Medicaid Management Information System (MMIS) is a set of ~70 components, partially developed within a mainframe-based system dating from 1979. The system supports a wide range of vital activities within the Medicaid program, but is not positioned to meet both current and future needs. Its limited functionalities underlie several of the opportunities for improvement identified in other topical areas. There is little alignment between program strategy and the MMIS replacement plan, and the Information Systems (IS) group lacks the wide range of capabilities needed to ensure an MMIS replacement trajectory that will deliver the future functionality Missouri needs. The potential initiatives discussed in this section attempt to address these challenges.

Operations. This section analyzes the performance and operational efficiency of three operational functions: participant managed care enrollment, claims processing, and contact centers. These functions are currently executed through a mix of state staff and vendor contracts. In comparison to other states, work processes often appear fragmented, process steps seem poorly integrated and best-practice management principles are variably applied. Potential initiatives include organizational process optimization, automation and digitization, and improved contract management. Adoption of best practices across the different functional areas could liberate up to 15-20% of operational resources, which could be redeployed to improve service levels for participants and for other external and internal "customers" of the different functions.

Implementation Considerations

The potential initiatives described in the following pages are wide-ranging, including operational improvements to bring the program up to date with common practices among other state Medicaid programs, as well as best practices and more transformational changes. Some of the potential initiatives outlined represent alternative ways of achieving similar goals: in some cases, the initiatives could reinforce one another; in other instances, they could be mutually exclusive. Such interdependencies will be highlighted throughout.

Broadly, the state could balance two approaches to controlling spending. One approach commonly adopted by both public programs and managed care would rely primarily on controlling the unit prices paid for services and seeking to curb utilization through broad-based utilization management. Such an approach could reduce costs in the short term. However, on its own such an approach may not provide incentives to improve outcomes. As an alternative approach, the state could seek to adopt value-based payment and care delivery models that reward providers for quality and efficiency of the total care delivered to patients. This approach may support more transformational changes in care delivery, with corresponding improvements in patient outcomes and experience. However, such an approach is likely to require greater commitment of resources and will take longer to generate impact given the need for providers to adopt new capabilities and implement changes in clinical practices.

Aligning the growth of Medicaid expenditures with the state's economic growth may involve a combination of these approaches, with targeted use of utilization management and targeted adjustments in provider rates in the near-term, combined with investments in care management and value-based payment to support sustainable improvements in quality and efficiency. In parallel, there may be a series of operational changes that the state could implement to bring policies and operations up to speed with common practices, such as state-of-the-art program integrity measures and improvements of internal administrative processes. Such changes could generate near-term savings to offset investments in transformation changes.

Any substantial portfolio of initiatives would demand careful planning and execution, as well as investments to support the transformation and build new capabilities. Key requirements for effective design and implementation of Medicaid transformation include: strong and visible executive leadership; effective stakeholder engagement; commitment to fact-based decision making supported by robust data; upskilling of key agency staff; a well-resourced transformation office; and modernization of the program's technological infrastructure.

Overview of Medicaid Program

In State Fiscal Year 2018, Missouri Medicaid was a $10.3 billion program, funded by state general revenue ($2.2 billion), federal funds ($5.5 billion), and other funds ($2.6 billion).[1] The "other funds" consisted primarily of revenue from provider taxes ($1.4 billion).[2]

Since 2009, Medicaid spending has grown in proportion to the total state budget, and in proportion to state general revenues. In 2009, Medicaid spending comprised 17% of state general revenues; in 2018, it was 24%.[3] Without significant changes in the Missouri Medicaid program, spending growth may continue to outpace growth in state general revenues and could comprise 26-30% of state general revenues by 2023.[4]

The following pages provide a brief introduction of the Missouri Medicaid program and a summary of key trends in the larger U.S. healthcare context that influence program spending, as well as state fiscal scenarios that could lead Medicaid spending to represent a greater share of state general revenues.

THE CURRENT PROGRAM

Enrollment and Spending

Missouri Medicaid is a $10.3 billion program that covers predominantly four types of participants: low-income children; parents of low-income children; pregnant women; and aged, blind, or disabled (ABD) individuals.[5] Children comprise the largest eligibility group in Missouri Medicaid, representing 63.5% of enrollees; however, persons with disabilities account for the greatest proportion (46%) of Medicaid spending (see Exhibit 1 and Exhibit 2).

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[1] Missouri DSS, "TSM Expenditures History FY05 to FY18," 2018; Missouri DSS, "Final FY18 Total State Medicaid Expenditures," 2018.

[2] Missouri DSS: see note 1.

[3] Missouri DSS: see note 1.

[4] Analysis based on projections from past trends. Missouri DSS: see note 1.

[5] Missouri DSS, "MO HealthNet enrollees and expenditures," 2018, see: dss.mo.gov/mhd/general/pdf/mhdollars.pdf.

EXHIBIT 1: MEDICAID ENROLLMENT & SPENDING BY ELIGIBILITY CATEGORY, SFY2018[6]

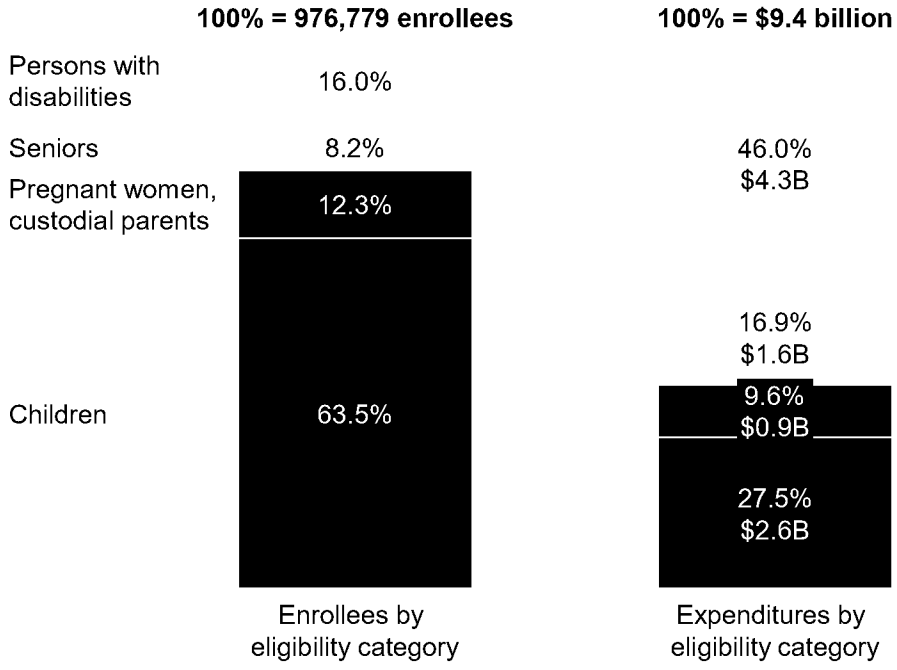
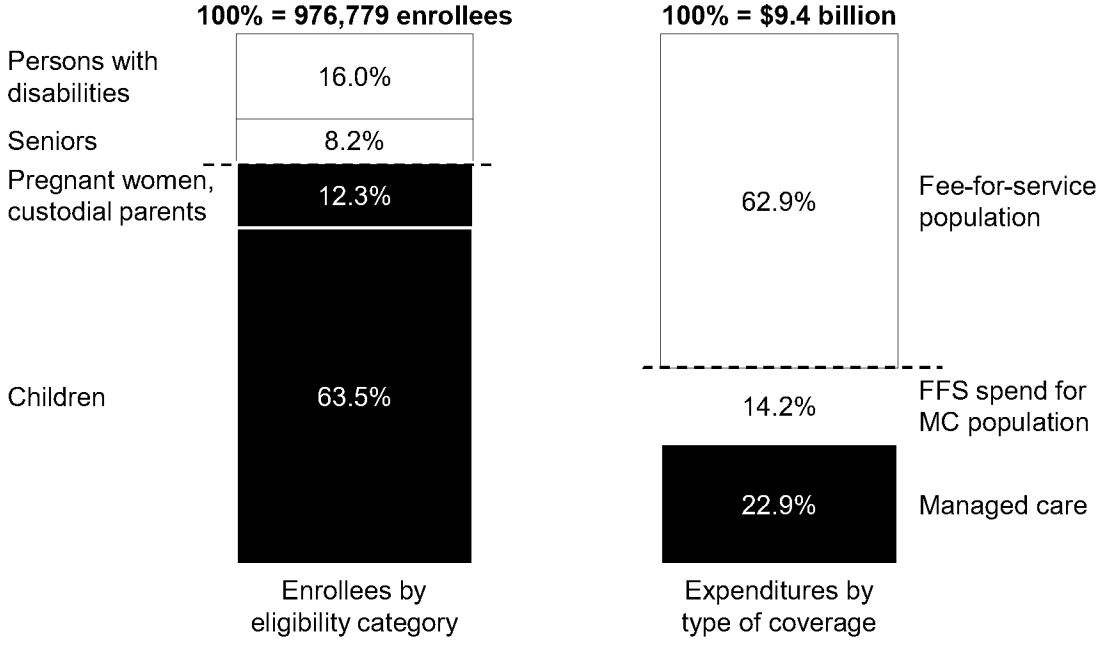


EXHIBIT 2: MEDICAID ENROLLMENT & SPENDING BY TYPE OF COVERAGE, SFY2018[7]



[6] Missouri DSS: see note 5.

[7] Missouri DSS: see note 5.

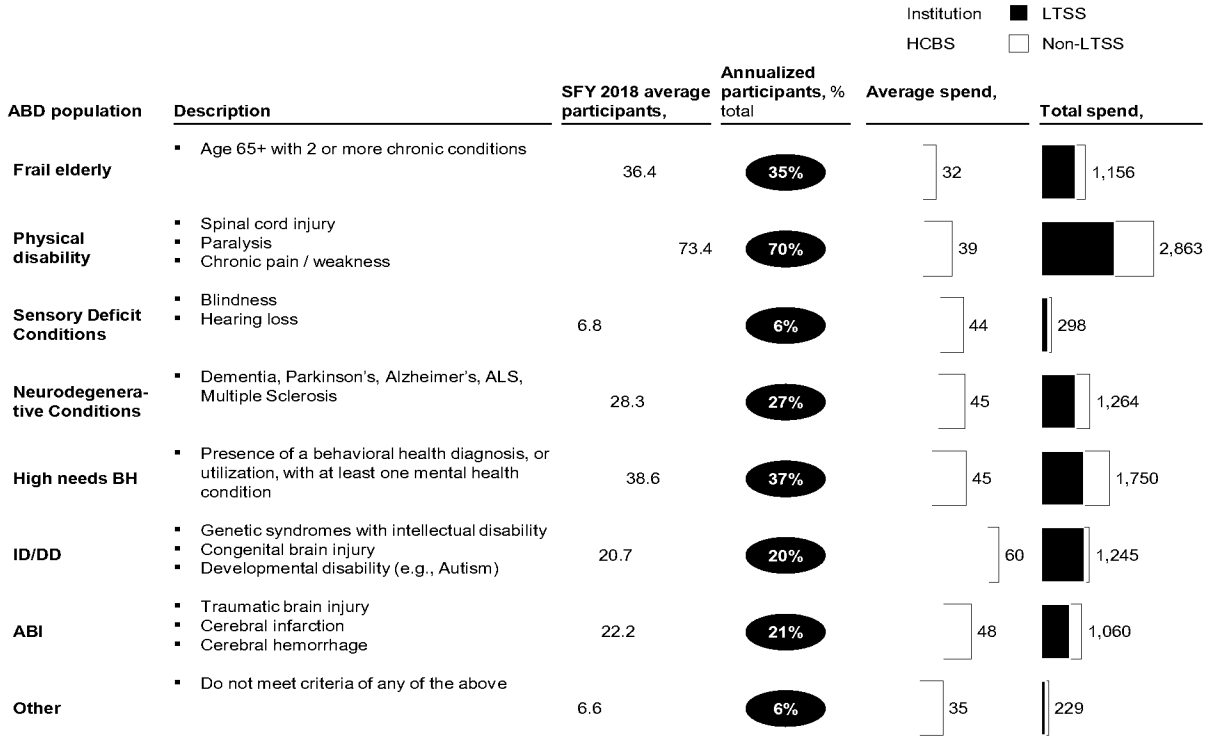
Services for >155,000 persons with disabilities and >80,000 elderly participants (the aged, blind and disabled [ABD] population) are provided through Medicaid fee-for-service, comprising 24.2% of enrollees but 62.9% of total program expenditures. The ABD population includes distinctive subpopulations with different cost patterns: frail elderly, individuals with intellectual and/or developmental disabilities, individuals with severe behavioral health issues, and others.

Non-disabled children, parents, and pregnant women comprise 75.8% of enrollees (about 650,000 in all) but 37.1% of total program costs, of which 22.9% is covered through managed care and 14.2% (pharmacy and behavioral health) is paid through Medicaid fee-for-service.

Exhibit 3 shows one possible categorization of diagnostic groups,[8] including numbers of participants per group, and average per member per month (PMPM) spending per main category (institutional long-term services and supports [LTSS], home and community-based services [HCBS], acute services).

All elderly and 40% of individuals with disabilities are dually eligible for both Medicaid and Medicare. For these participants, Medicare pays for the acute care costs (e.g., hospitals, physicians, drugs); Medicaid pays for long-term services and supports (e.g., home care, nursing homes).

EXHIBIT 3: SUBPOPULATIONS WITHIN THE ABD POPULATION, SFY2018[9]



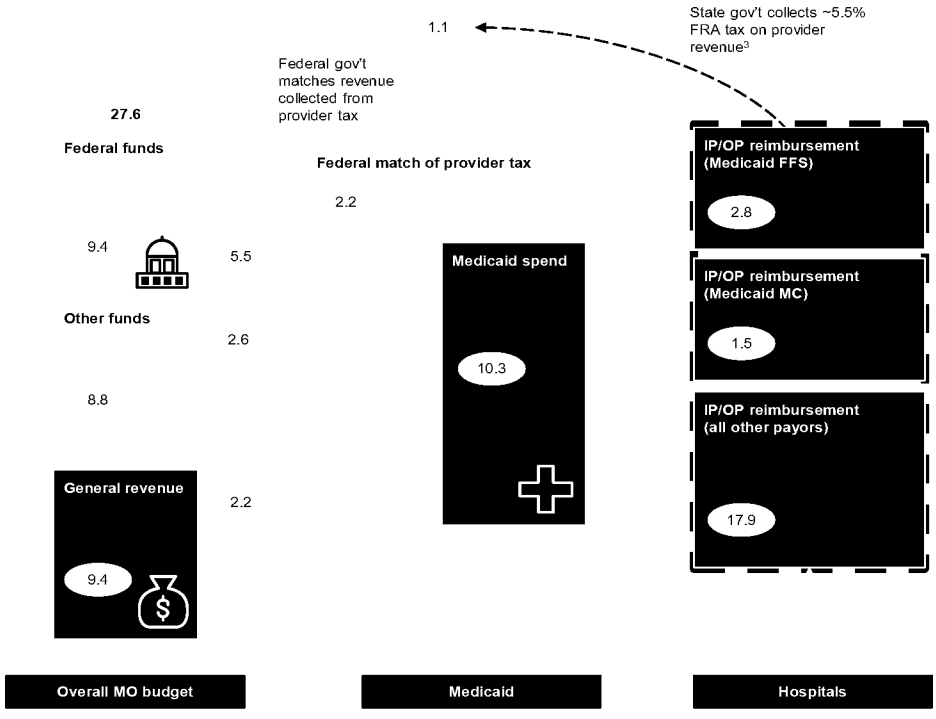
[8] Medical diagnosis, procedure codes and demographic information from Missouri Medicaid claims for SFY2018 were used to develop sub-segmentations of ABD population by diagnosis category. Diagnosis categories are based on claims data only, with the exception of the frail elderly category which is based on age and participant chronicity.

[9] Analysis of Missouri Medicaid claims data, SFY2016-18; participants may overlap across categories.

Financing and Budget

Missouri Medicaid is funded by state general revenue ($2.2 billion), federal funds ($5.5 billion), and other funds ($2.6 billion).[10] The "other funds" are primarily provider taxes ($1.1 billion from hospitals, and $0.3 billion from nursing homes and pharmacies).[11] As these taxes generate federal matching funds (nearly two federal dollars for every dollar generated through provider taxes[12]), they are significant to the financing of the Missouri Medicaid program. Exhibit 4 shows the flow of funds, highlighting the hospital tax and its integration in the Medicaid funding flow.

EXHIBIT 4: MISSOURI MEDICAID FUNDS FLOW (SFY2018, USD BILLIONS)[13]



Organization

Three departments jointly manage parts of the Medicaid program. The Department of Social Services (DSS) operates MO HealthNet (MHD), which is primarily responsible for medical expenses for eligible individuals. This includes both the fee-for-service and the managed care populations. The Department of Mental Health (DMH) administers services for populations with

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[10] Missouri DSS: see note 1.

[11] Missouri DSS, "Provider taxes overview," 2018.

[12] Kaiser Family Foundation (KFF), "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," 2018, see: www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier.

[13] Office of Administration, "The Missouri budget fiscal year 2018 summary," 2018, see: www.oa.mo.gov/sites/default/files/FY_2018_Budget_Summary.pdf; Missouri DSS: see note 1; Missouri DSS: see note 11; Missouri DSS, "Annual_Table 23 and 24_FY18 by Large Group PMPM," 2018; Missouri DSS, "Payments Assessment for SFY 14-18," 2018.

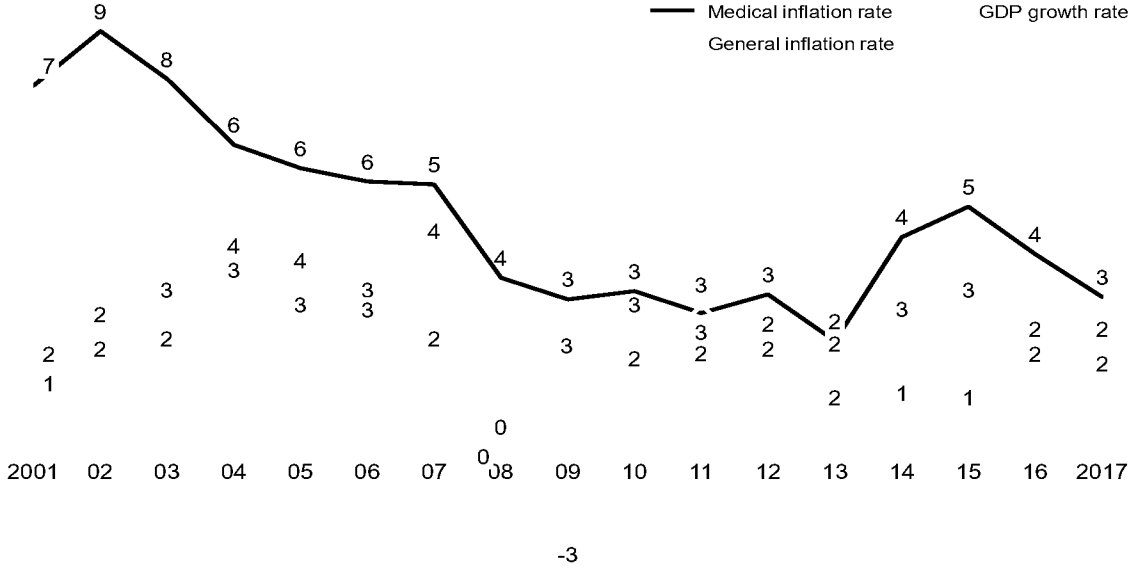
developmental disabilities (both intellectual and physical disabilities, as well as certain learning disabilities), community-based health centers, psychiatric rehabilitation services, comprehensive substance treatment and rehabilitation (CSTAR) services, and health home programs, amongst others. The Department of Health and Senior Services (DHSS) operates the Division of Senior and Disability Services (DSDS), which administers the HCBS benefits for adults 18 and over, and Special Health Care Needs (SHCN), which administers the Healthy Children and Youth benefits for persons with special health care needs up to 21 years of age. DSS is responsible for the largest share of Medicaid spending at approximately $7.9 billion, DMH's share is $1.5 billion, and DHSS' share of Medicaid spending is $0.9 billion.[14]

MAJOR INDUSTRY TRENDS AFFECTING THE PROGRAM

Healthcare inflation rising faster than GDP

The United States faces increasing pressure to contain its rising healthcare costs. In 2017, total U.S. healthcare spending reached $3.5 trillion, marking a 3.9% increase from the previous year, amounting for almost 18% of gross domestic product (GDP)[15]. U.S. health spending per person climbed to over $10,739 in 2017, the third year that the spending has exceeded $10,000.[16] The growth in per-person spending, or medical cost inflation, outpaces the general inflation rate (see Exhibit 5). CMS projects spending to grow 1% faster than GDP to reach $5.7 trillion by 2026.[17]

EXHIBIT 5: MEDICAL INFLATION, GENERAL INFLATION, GDP GROWTH, SFY2001-17, %[18]



[14] Missouri DSS: see note 1.

[15] CMS, "NHE Fact Sheet," 2017, see: www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.

[16] CMS, "The National Health Expenditure Summary including share of GDP, CY 1960-2017," 2017, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

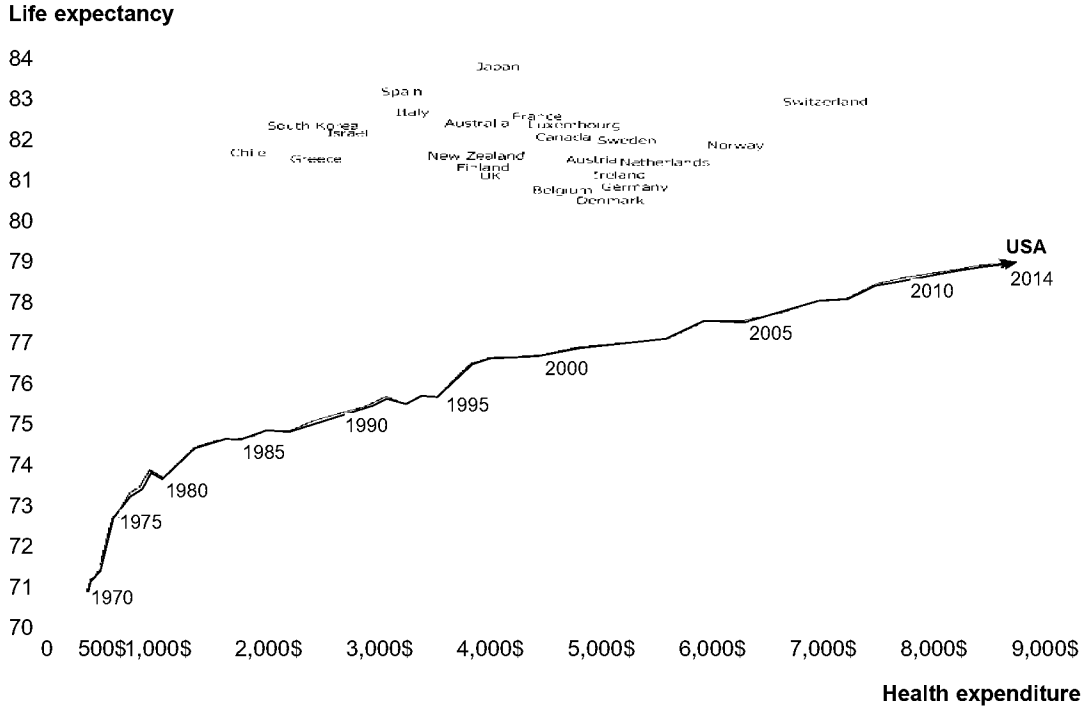
[17] The Balance, "U.S. Inflation Rate by Year from 1929 to 2020," 2019, see: www.thebalance.com/u--inflation-rate-history-by-year-and-forecast-3306093; The Balance, "U.S. GDP by Year Compared to Recessions and Events," 2019, see: www.thebalance.com/us-gdp-by-year-3305543.

[18] The Balance: see note 17.

Costs are rising in Medicare and Medicaid, putting pressure on both federal and state budgets. In addition, rising health care costs create challenges in the commercial market as well. Employees' contribution to health insurance grew almost three times faster than wages between 2010 and 2015,[19] and middle-class Americans' healthcare spending increased 60% over the past 30 years.[20] The growing financial burden of healthcare has been a significant factor in the low growth in purchasing power of the middle class in the U.S. over the past two decades.[21]

While rising health expenditures are not unique to the U.S., its spending exceeds that of other countries even after adjusting for differences in average wealth. While outcomes of U.S. healthcare exceed those of other countries for some catastrophic illnesses and other complex conditions (e.g. breast and colorectal cancer), outcomes lag other countries for most chronic conditions.[22] Chronic conditions, in particular, account for a significant portion of healthcare spending growth, underscoring concerns that increased levels of investment in healthcare have not translated to proportional improvements in life expectancy or quality of life (see Exhibit 6).

EXHIBIT 6: LIFE EXPECTANCY AND HEALTH EXPENDITURE ACROSS COUNTRIES[23]



[19] KFF, "2015 Employer Health Benefits Survey," 2015, see: www.kff.org/health-costs/report/2015-employer-health-benefits-survey.

[20] Hamilton Project, "Where Does All the Money Go: Shifts in Household Spending Over the Past 30 Years," 2016, see:www.hamiltonproject.org/papers/where_does_all_the_money_go_shifts_in_household_spending_over_the_past_30_y.

[21] Pew Research, "For most U.S. workers, real wages have barely budged in decades," 2018, see: www.pewresearch.org/fact-tank/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades/.

[22] Peterson-Kaiser Health System Tracker, "How does health spending in the U.S. compare to other countries?" 2018, see: www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries; www.kff.org/slideshow/how-does-the-quality-of-the-u-s-healthcare-system-compare-to-other-countries/.

[23] Our World in Data, "Link between health spending and life expectancy: US is an outlier," 2017, see: ourworldindata.org/the-link-between-life-expectancy-and-health-spending-us-focus.

CMS taking steps to reduce federal spending on health care

The Centers for Medicare & Medicaid Services (CMS) have undertaken a series of initiatives to reduce federal healthcare costs for Medicare, ranging from attempts to reduce what it pays for drugs and outpatient visits in Medicare to limiting cost growth in Medicare Advantage plans. [2 4] As the federal government will pay for 50% to 78% of Medicaid costs through federal match in 2019 (65% in Missouri)[25], federal spending on Medicaid is similarly assessed for cost reduction opportunities: CMS has announced its intention to increase the level of scrutiny of Medicaid waiver expenditures.[26] In addition, CMS has described its intention to increase audits of state claims for federal matching funds and beneficiary eligibility determination, among others.[27]

Public and private payors are migrating to value-based payment

There is a broad consensus that one of the key drivers of waste and inefficiency in U.S. healthcare is the fee-for-service (FFS) payment model that characterizes most provider payments. FFS stimulates volume rather than coordination of services, and there are no inherent incentives to achieve optimal outcomes nor to deliver care in an efficient manner.[28] Both public and private payors are transitioning from FFS to value-based payment (VBP), using Alternative Payment Models (APMs) to reward providers for delivering high-quality care at lower cost. Research suggests that well-designed APMs improve the quality of care and can meaningfully reduce the cost of care if implemented across the full spending base.[29]

PROJECTED SPENDING WITHOUT SIGNIFICANT COURSE CORRECTIONS

Over the last 10 years, Medicaid spending growth has outpaced growth in state general revenues. For example, in 2009, 17% of state general revenue funds were directed toward Medicaid; however, in the wake of the Great Recession, Medicaid grew to 22% of state general revenue by 2012 and, in 2018, reached 24% (see Exhibit 7). Although Medicaid enrolment has fluctuated over this timeframe, total Medicaid spending growth has outpaced growth in state general revenues when measured over any five-year timeframe, due to the increase in spending per participant enrolled in the program. Notwithstanding reductions in Medicaid enrollment observed since the beginning of SFY2019, program spending is likely to occupy a greater share of state general revenue over the coming five years, absent changes in program performance.

In this section, we consider three scenarios as a method for gauging the level of fiscal pressure that may arise from Medicaid spending growth. In Scenario 1, Medicaid spending as a share of state general revenues continues to grow at a pace similar to the last five years; in Scenario 2,

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[24] CMS, "CMS-1695-P: Hospital Outpatient Prospective Payment- Notice of Proposed Rulemaking (NPRM)," 2019, see: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-P.html; CMS, "Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage," 2018, see: www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf.

[25] The percentage varies by state; for Missouri the match rate in FY2019 is 65.4%.

[26] CMS, "Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects," 2018, see: www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD18009.pdf.

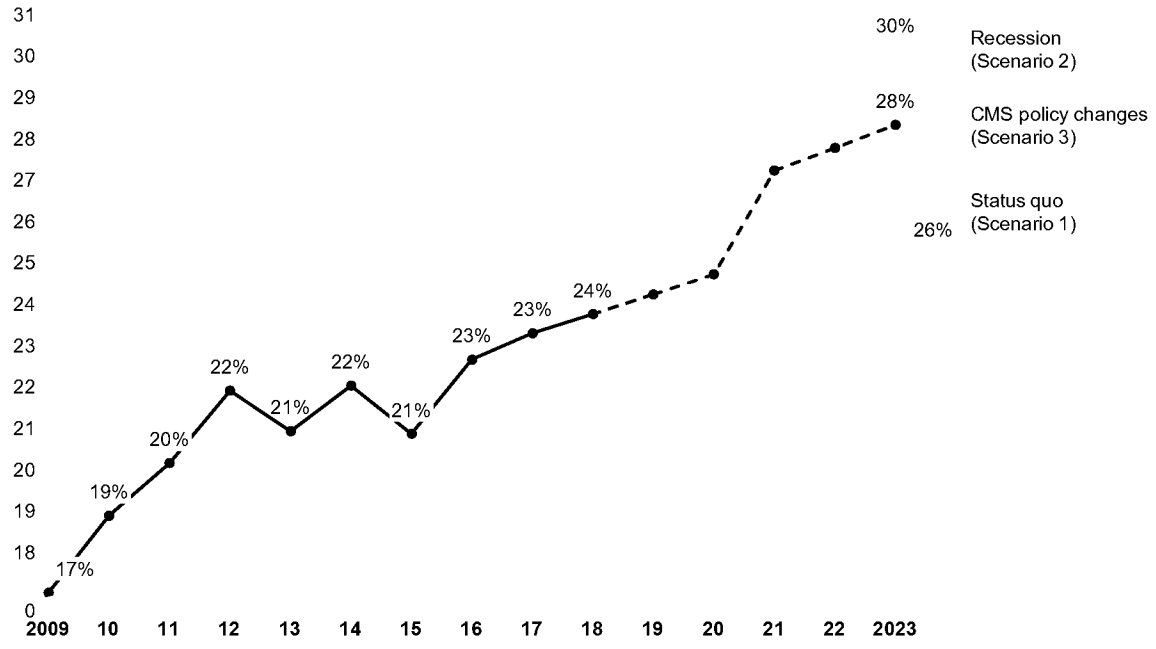
[27] CMS, "CMS announces initiatives to strengthen Medicaid program integrity," 2018, see: www.cms.gov/newsroom/press-releases/cms-announces-initiatives-strengthen-medicaid-program-integrity.

[28] Health Care Learning and Action Network, "Alternative payment model (APM) framework. Updated version 2017," 2017, see: hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[29] McKinsey, "The seven characteristics of successful alternative payment models," 2019, see: www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-seven-characteristics-of-successful-alternative-payment-models.

an economic downturn accelerates the growth of Missouri Medicaid spending while reducing the growth of state general revenue; in Scenario 3, the trends from Scenario 1 are exacerbated by potential changes in CMS policies that would reduce federal revenue for Missouri.

EXHIBIT 7: MEDICAID SPENDING AS PERCENT OF GENERAL REVENUE, SFY2009-23[30]



Scenario 1—Continuation of Recent Trends: Spending on the program increased from 21% of state general revenue in 2013 (36% of total state spending) to 24% (40% of total spending) in 2018.[31] In the first scenario illustrated in Exhibit 7, the assumption is that growth of both Medicaid spending and total state spending continue at the pace observed over these past five years. Under this scenario, total Medicaid spending would increase to $12.8 billion by 2023, while the state's total spending would grow to $29.2 billion (growing 2.5% annually) by 2023. In 2023, Medicaid spending would comprise 44% of the overall state spending and 26% of state general revenues.

Scenario 2—Potential Impact of Economic Downturn: In the second scenario, a severe economic downturn (comparable to the recession that began in 2008) affects both state general revenues and Medicaid enrollment. Based on analyses by Moody's, an economic downturn occurring within the next four years could reduce total general revenue by approximately 12% over a two-year period. This reduction in general revenue will likely coincide with an increase in Medicaid enrollment, as individuals lose jobs and incomes fall, resulting in an estimated increase in Medicaid spending by 1.9% in total over the course of two years.[32] These changes could translate to Medicaid spending growing to comprise 51% of total state spending and 30% of state general revenues in 2023.

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[30] Medicaid expenditures have continued to outpace economic growth. Missouri DSS: see note 1.

[31] Missouri DSS: see note 1.

[32] Moody's, "Stress-Testing States," 2017, see: www.economy.com/getlocal?q=91a42834-85af-4773-b408-5da811028c00&app=eccafile.

Scenario 3—Potential Changes in CMS Policies: In the third scenario, no recession occurs, but CMS policy changes could lead to reductions in federal funds for the state's Medicaid program and, consequently, to greater pressure on the state budget. A 3.5% drop in net federal funds could reduce federal funding by approximately $200 million in SFY2023.[33] If the Medicaid program's total spending were to remain unchanged, the loss of federal funds may need to be offset by a similar increase in funding from state general revenues. This could increase the program's share of state general revenues to 28% in SFY2023.

Savings needed to keep spending growth in line with State General Revenues

Under any of the scenarios described above, significant changes in the structure and performance of Missouri's Medicaid program would be necessary to bring Medicaid spending growth in line with projected economic growth of the state. Following are estimates of the reductions in Medicaid program spending that would be necessary to maintain spending at 24% of state general revenues through SFY2023, under each of the three scenarios.

- In Scenario 1 (continuation of recent historical trends), Missouri would need to reduce the growth rate of Medicaid spending by approximately 2 percentage points to bring it in line with the growth of state general revenue, to maintain spending at 24% of state general revenue. In SFY2023, this would equal approximately $735 million savings to total Medicaid spending, or approximately $260 million savings to state general revenues.
- In Scenario 2 (occurrence of a recession similar in magnitude to that experienced 10 years ago), it would be necessary to reduce Medicaid spending by nearly $1.7 billion, or $590 million in spending from state general revenues, to maintain spending at 24% of state general revenues.
- In Scenario 3 (continuation of historical trends, exacerbated by CMS policy changes), it would be necessary to reduce total program spending by approximately $1.3 billion, or $460 million in spending from state general revenues to maintain spending at 24% of state general revenue.[34]

The funding gap implied by the above scenarios is meant to provide context for understanding the estimated $0.5 billion to $1.0 billion in cost savings associated with the opportunities and potential initiatives detailed in the pages that follow. Maintaining spending at 24% of state general revenues may not necessarily represent the state's policy objective and may not be feasible in all future scenarios. In all scenarios, however, implementation of initiatives such as those outlined in the pages that follow could help the Medicaid program to reduce fiscal pressure on the state budget while maintaining or improving access to high-quality care, without broad-based cuts in provider rates, or reductions in eligibility or covered services.

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[33] As outlined in the section on acute care services, existing risks to the state's federal match revenue exist (e.g. inpatient UPL calculations, planned federal reduction of DSH payments, DSH payments-related legal developments, federal scrutiny of existing provider tax pooling arrangements, federal initiatives to reduce the provider tax safe harbor, and so forth). $200 million is a low estimate of the impact of any combination of two to three of these risks becoming reality.

[34] Assumes a corresponding $120 million decrease in provider tax and $80 million decrease in other cuts to federal funding (e.g., DSH payments). The savings would bring the percentage of Medicaid spending of state general revenue to SFY2018 levels.

Opportunities and Potential Initiatives

Without significant changes, Medicaid spending may increase from 24% of state general revenues in SFY2018 to comprise 26% to 30% of state general revenues by SFY2023. Significant cost savings would be necessary to bring growth of Medicaid spending in line with the level of economic growth of the state, while preserving access to care for participants.

The Missouri Department of Social Services, MO HealthNet Division (MHD) commissioned a rapid, in-depth independent assessment of its programs and operations to identify potential opportunities and strategies to transform the Missouri Medicaid program, including evaluation of which functions the Department is performing well in, what activities or practices could be improved, and what priorities could be considered for future investment.

Overall, the Missouri Medicaid program is currently outdated in most aspects compared to other peer states, and significant opportunities exist relative to industry best practices:

- Dollars spent in the program are not well aligned with value received from delivery system;
- Specifically, methods to pay providers lack incentives to contain costs or enhance quality;
- Approaches to utilization management; eligibility management; fraud, waste, and abuse; and third-party liability are limited, partially due to the limitations of the MMIS (see below);
- Programs for special needs populations are fragmented;
- There is no substantial measurement nor transparency of outcomes of care; and
- Service levels to consumers and providers could also be improved, including reductions in average wait times for handling questions, as well as increased service channels.

Leaders and staff in DSS, DMH, and DHSS are aware of these challenges and highly motivated to modernize the program. However, the foundational operational capabilities to do so are equally outdated, hampering opportunities for improvement: the existing technology infrastructure (MMIS) is antiquated; data quality needed for program management is suboptimal; and access to key management information is absent.

Detailed findings from the assessment conducted over the past several months are outlined in the pages that follow, organized into eight project areas which collectively address sixteen performance opportunities prioritized by DSS at the outset of this assessment. For each topical area, potential opportunities for improvement have been identified and evaluated through interviews with functional leaders and subject matter experts within the relevant departments, analysis of claims- and non-claims data, review of activities and operations, assessment of supporting infrastructure and analytics, and benchmarking against other state Medicaid programs, Medicaid managed care organizations (MCOs), or other private health insurers.

Based on these opportunities, a wide range of potential initiatives have been outlined for further consideration by the Department. Depending on the selection of initiatives the state chooses to pursue, total gross savings to the program (including federal and state share) could total up to $0.5 billion to $1.0 billion by SFY2023. These estimated savings would be net of reinvestments in the delivery system (e.g., in primary care, rural health, and the safety net; as well as rewards for providers that generate savings under value-based payment models) and in the Medicaid program's operations to improve service levels to participants and providers.[35]

[35] One-time investments as well as MMIS replacement investments are not included.

Many of the opportunities for improvement could require changes in policies and contracts requiring cooperation of local providers, support from the state legislature, and in some cases federal approval. Potential initiatives outlined in this report are not meant to represent advocacy for specific policies, nor conclusions yet reached by DSS. The state retains sole responsibility for decision making over which of these potential improvement initiatives (or others) to pursue, and in what form, in compliance with applicable laws, rules and regulations.

ACUTE CARE SERVICES

Missouri spent ~$4.2 billion in SFY2018 on acute care services, including hospital, clinic, physician, and diagnostics services, across both the managed care and non-managed care populations. Including pharmaceutical services, the total is ~$5.7 billion.[36] Hospitals are paid through a combination of base rates and "add-on payments", updated periodically based on changes in hospital operating expenses. This approach offers minimal incentives for providers to contain costs, making it an outlier among states. Uniquely, Missouri Medicaid makes add-on payments to hospitals for services provided to non-Missouri, non-eligible residents.

Physicians and behavioral health providers are also paid per service (fee-for-service [FFS]). Compared to other states, physicians' reimbursement is low. Also, total spending on non-hospital acute care services (physicians, Federally Qualified Health Centers [FQHCs], clinics, and rural health services) is lower than other, comparable states.

The overall value of care delivered (dollars spending vs outcomes for participants) varies significantly across counties. In general, >15% of Missouri Medicaid acute care expenditures may be associated with potentially avoidable exacerbations and complications (PECs), which includes costs of PECs associated with the prevention and treatment of opioid use disorder (OUD). In addition, 5% to 10% of expenditures may be associated with inefficiencies, such as a site of service or choice of therapy that might be more expensive without adding quality.[37]

Potential initiatives to improve incentives and reduce costs range from adjusting rate setting methodologies, moving to value-based payment models and investing in the rural and safety net heath care infrastructure, including primary care and behavioral health. In total, the impact of the acute care initiatives could range from $250 million to $500 million, net of potential reinvestments in the delivery system, depending on the state's choices.[38] To achieve the higher end of this range, the state may need to pursue a combination of initiatives, striking the balance between initiatives primarily focused on rates with initiatives focused on value-based payment (VBP) and investments.

The state could build on its providers' broad experience with Medicaid, Medicare, and Commercial Alternative Payment Models (APMs). Missouri has significant experience with Patient Centered Medical Homes (PCMH) and Health Homes in Medicaid, which aim to integrate physical, behavioral, and substance use disorder (SUD) care for patients with, or at risk of, multiple chronic conditions.

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[36] Pharmaceutical services are discussed in a separate section. The projected savings are not likely to overlap between these sections.

[37] Analysis of Missouri Medicaid claims data, SFY2016-18.

[38] Analysis of Missouri Medicaid claims data, SFY2018; Interviews with Medicaid program staff and analysis of state data, 2018.

This section will first describe the current reimbursement methodologies and the experience with and impact (where quantifiable) of VBP models in Missouri. Subsequently, it will highlight the opportunities to bend the cost curve and improve the value of care for Missourians and present an associated range of initiatives.

Current situation

This section gives an overview of Missouri's current methodology of hospital outpatient reimbursement, inpatient reimbursement, utilization management, out-of-state payments, hospital tax, physician reimbursement, behavioral health reimbursement, and acute care value-based payment initiatives.

Population served, and services provided

For Medicaid, the providers discussed in this section serve both the managed care population (children, parents, and pregnant women) as well as those participants in the disabled population that are not dually eligible.[39] Exhibit 8 shows the breakdown of the total Medicaid costs by service for these populations.

EXHIBIT 8: BREAKDOWN OF ACUTE CARE COSTS BY SERVICE CATEGORY, SFY2018[40]

	Acute care service category	Total acute care spend, $M	Share of total acute care spend	Average beneficiaries, 000	Share of total acute care beneficiaries
Hospital and ED	Hospital inpatient care	1,166	20%	139	12%
	ED care	517	9%	408	35%
	Hospital outpatient care	709	12%	419	36%
Office	Office and clinic care	484	8%	762	66%
Pharma-ceuticals	Prescription drugs	1,488	26%	753	65%
	Specialty pharma	65	1%	103	9%
Diagnostics	Lab and pathology	66	1%	383	33%
	Radiology	55	1%	262	23%
Other	Ancillary services	273	5%	45	4%
	DME and supplies	19	0%	24	2%
	PT/OT/ST	12	0%	21	2%
	Other locations	550	10%	172	15%
	Other types of care	240	4%	370	32%
	Ambulance and transportation	130	2%	130	11%
		Total spend = $ 5,683M		**Total pop = 1,173K beneficiaries**	

In the managed care population, costs are driven by mental illness diagnoses (including substance use disorders) and by perinatal care (pregnancy care, delivery, post-delivery care,

[39] Dually eligible participants receive their acute care services through Medicare.

[40] Analysis of Missouri Medicaid claims data, SFY2016-18; does not include beneficiaries who have no eligibility during any given month, as well as beneficiaries who are dually eligible or have third party liability; beneficiaries may overlap across categories.

and newborn care) (see Exhibit 9). In the non-dual disabled population, mental illness diagnoses drive more than one-third of the total costs, followed by cardiovascular diagnoses (see Exhibit 10). In these exhibits, substance use disorders (including opioid use) are included in the mental illness diagnostic category.

EXHIBIT 9: MEDICAL COSTS BY DIAGNOSIS GROUP FOR MANAGED CARE POPULATION, SFY2018[41]

Medical spend by diagnosis groups for adult and child claimants, SFY2018

Mental Illness	18%
Certain conditions originating in the perinatal period	11%
Complications of pregnancy; childbirth; and the puerperium	10%
Diseases of the respiratory system	8%
Injury and poisoning	6%
Diseases of the nervous system and sense organs	6%
Diseases of the digestive system	4%
Diseases of the musculoskeletal system and connective tissue	3%
Congenital anomalies	3%
Diseases of the circulatory system	3%
Endocrine; nutritional; and metabolic diseases and immunity disorders	2%
Neoplasms	2%
Other	24%

[41] Analysis of Missouri Medicaid claims data, SFY2016-18.

EXHIBIT 10: MEDICAL COSTS BY DIAGNOSIS GROUP FOR NON-DUAL DISABLED POPULATION, SFY2018[42]

Medical spend by diagnosis groups for non-dual disabled claimants, SFY2018

Mental Illness	34%
Diseases of the circulatory system	13%
Diseases of the nervous system and sense organs	7%
Diseases of the musculoskeletal system and connective tissue	7%
Diseases of the respiratory system	6%
Injury and poisoning	6%
Neoplasms	5%
Endocrine; nutritional; and metabolic diseases and immunity disorders	5%
Diseases of the digestive system	4%
Congenital anomalies	1%
Complications of pregnancy; childbirth; and the puerperium	<1%
Certain conditions originating in the perinatal period	<1%
Other	13%

Inpatient reimbursement

For inpatient (IP) care, Missouri uses a hospital-specific per diem, based on historical cost reports up to two decades old. The base per diem is not differentiated by type of services provided nor patient characteristics. In SFY2018, $540 million of inpatient payments were paid to hospitals. In addition, add-on payments are made. $817 million "direct Medicaid" add-ons compensate providers for differences between the base per diem and trended costs as determined by more recent cost reports. In addition, direct Medicaid payments help offset provider tax payments.[43] Other add-ons include disproportionate share hospital (DSH) payments ($759 million) and graduate medical education (GME) payments ($139 million) (see Exhibit 11).

The state uses a vendor to manage utilization of inpatient services. The vendor conducts six types of reviews: prospective (pre-admission), admission (initial), continued stay review, retrospective (post-discharge), and ongoing validation reviews. All review determinations are made using Milliman Care Guidelines® and pertinent medical information received from the attending physician or hospital regarding the patient's condition and planned services.

[42] Analysis of Missouri Medicaid claims data, SFY2016-18.

[43] Missouri Foundation for Health, "Briefing Book for Missouri Medicaid," 2016, see: mffh.org/wordpress/wp-content/uploads/2016/04/Medicaid-Financing.pdf.

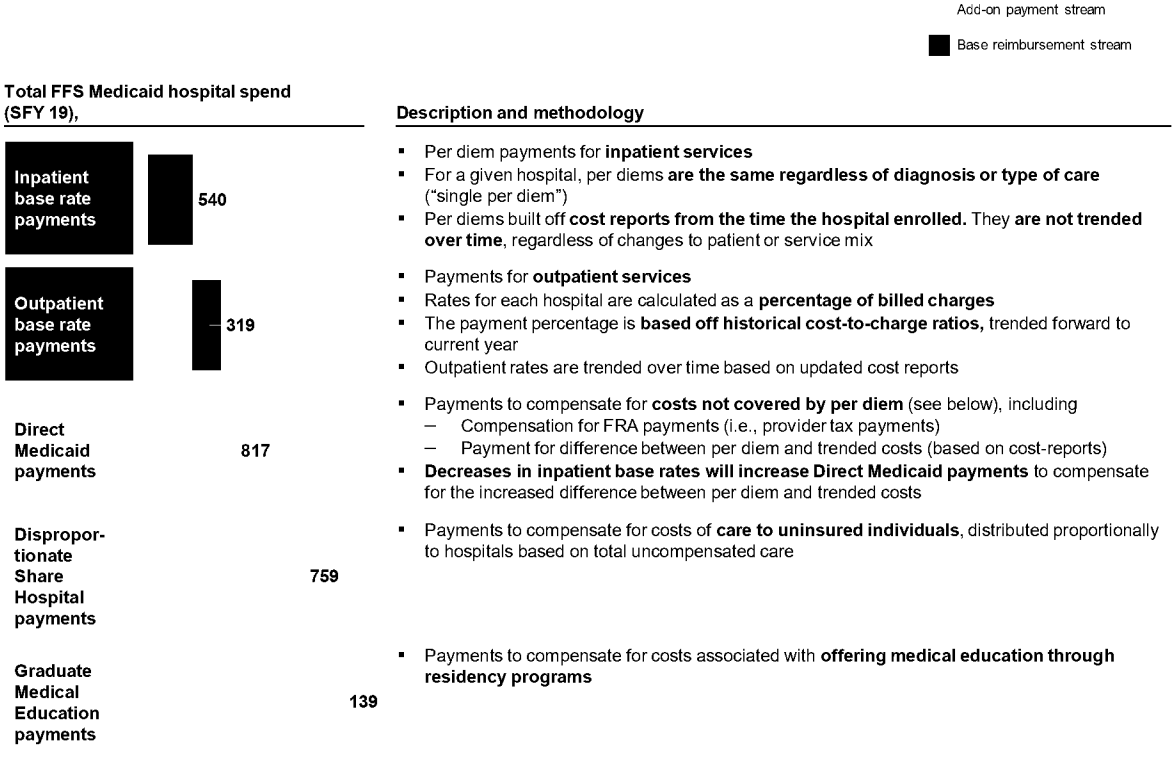
MHD covers up to 24 hours of observation services, ordered for patients who require significant periods of treatment or monitoring before a decision on admission is made. Only one observation code per stay can be billed, capping the reimbursable portion to 24 hours.

Outpatient reimbursement

For outpatient (OP) FFS reimbursement, Missouri pays a percentage of charges for individual services. The percentage is based on analysis of historical cost reports trended to the current state fiscal year. Currently, the state is transitioning towards a Medicare-based outpatient fee schedule model. In SFY2019, hospitals received $319 million in outpatient base rate payments. In addition, add-on payments are made to further help offset provider taxes (these are included in the "direct Medicaid" add-ons, see Exhibit 11).[44]

The state uses a vendor to conduct prior authorizations for advanced imaging (CT/CTA, MRI/MRA, and PET) and select cardiac procedures (cardiac nuclear medicine and cardiac catheterization).

EXHIBIT 11: HOSPITAL REIMBURSEMENT BREAKDOWN, MEDICAID FFS, SFY2019[45]



Provider tax

Like other states, Missouri taxes hospitals and uses these revenues to fund Medicaid and draw down federal funds at the Missouri federal match rate of 65.4% (see Exhibit 4). Missouri's hospital tax rate is higher than most other states (greater than 5.5%).[46] Missouri compensates

[44] Missouri DSS, "FRA 19-3 – 10 24 18 – FINAL," 2019; UPL analysis, Missouri DSS, 2018-19.

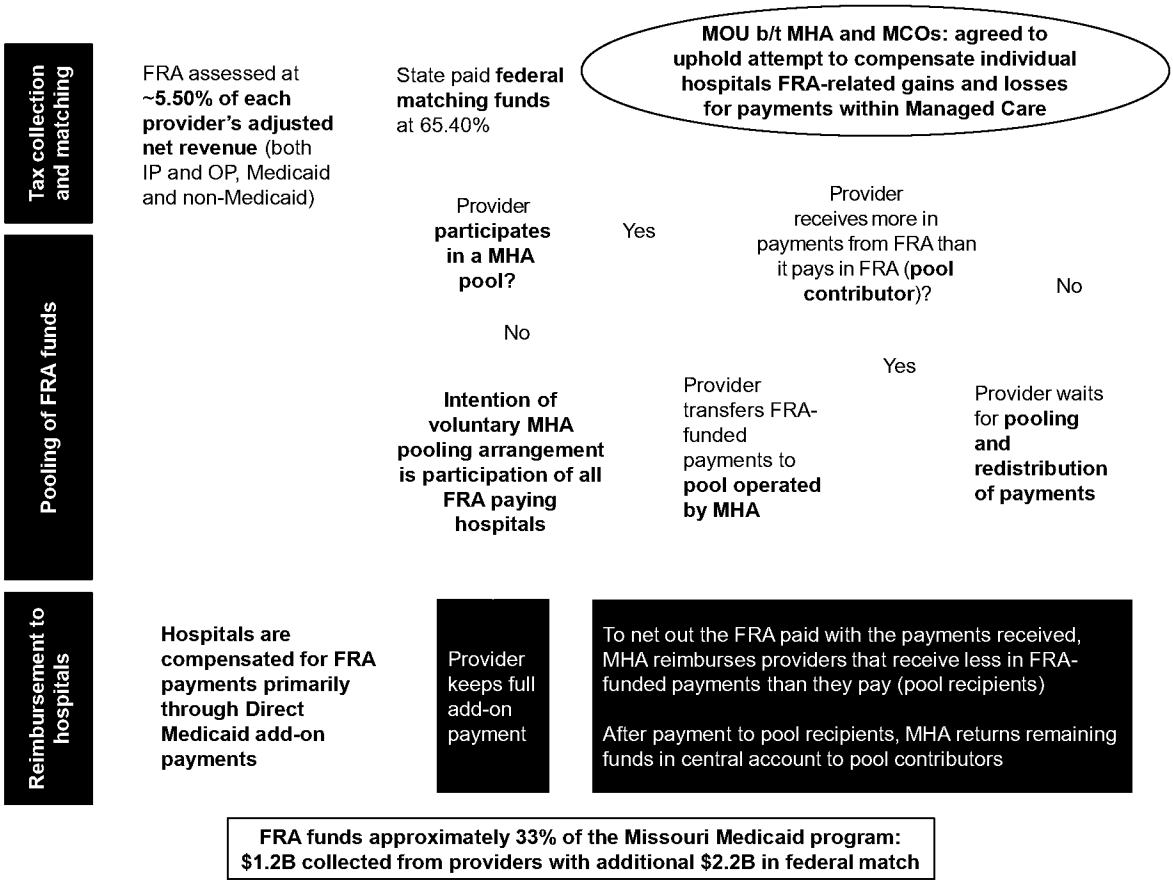
[45] Missouri DSS, see note 44; uses FY18 data for outpatient base rate payments.

[46] KFF: see note 12.

hospitals for these Federal Reimbursement Allowance (FRA) payments through the FFS add-on payments. To attempt to make the tax closer to budget neutral for hospitals, the Missouri Hospital Association (MHA) operates a pooling mechanism (see Exhibit 12).[47]

Since 2017, when managed care was implemented statewide, the state includes a portion of add-ons (primarily to offset provider taxes) in the managed care capitation rate. Through a Memorandum of Understanding, the MCOs and the MHA have agreed to uphold efforts to compensate hospitals for their costs attributable to the FRA assessment.[48]

EXHIBIT 12: MISSOURI HOSPITAL ASSOCIATION FRA FUNDING POOL[49]



Physician reimbursement

Physicians are reimbursed through a fee schedule based on a percentage of what Medicare pays for the same services. Once fees are set (e.g., when fees are initially calculated as a percentage of Medicare's rates for a certain procedure code), they are static until the state legislature changes them. Physicians who are organized in clinics can bill the services provided

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47 Missouri Hospital Association, "How the FRA funds are used," 2014, see: web.mhanet.com/FRA%20Tutorial.pdf.

48 MHA Management Services Corporation, "MSC Health Plan MOU and Amendment," 2017.

49 Missouri Hospital Association, "Missouri's Hospital Provider Tax Pooling Arrangement," 2016, see: web.mhanet.com/article/4387/Missouri8217sHospital-Provider-Tax-Pooling-Arrangement.aspx?articlegroup=2663. Missouri DSS: see note 1. KFF: see note 12.

through their clinics, for which reimbursement rates are generally higher than they are for physicians.

Behavioral health reimbursement

Behavioral health services are covered by both DMH and MO HealthNet. DMH covers Community Psychiatric Rehabilitation services, which include intake and annual evaluations, behavioral health assessment, psychosocial rehabilitation, and day treatment for youth.[50] DMH also covers Comprehensive Substance Treatment and Rehabilitation (CSTAR) services. MO HealthNet covers other behavioral health services, such as various psychotherapy services (e.g., family and group therapy, individual psychotherapy), services in a school setting, applied behavioral analysis, and selected telehealth services, among other covered services.[51] Behavioral health services not covered by Medicaid include housing supports, drug screens, transportation, and occupational therapy for adults. Behavioral health services are reimbursed on a fee-for-service basis, determined by relevant information (e.g., charge information from providers across the state, recommendations from the State Medical Consultant) and current appropriated funds.

Value-based payment (VBP)

There is significant experience with VBP in the state, both within Medicaid and across other payors, although many of these models are not yet fully mature or at scale. The initiatives in Medicaid are primarily focused on PCMHs and health homes (both within the FFS and through the managed care local community care coordination program [LCCCP]), through which providers may receive additional payments to improve the value of the care delivered. The impact of some initiatives can be quantified.

- *Local community care coordination program (LCCCP)*. Missouri contracts require MCOs to develop a LCCCP to be approved by the state in which MCOs are to develop VBP contracts (such as ACOs, PCMHs, primary care case management programs [PCCM]) with providers. Provider participation should have reached 10% in June 2018, with 20% of participants enrolled in the LCCCP by the end of the contract period. The program has recently started; no results are yet available.
- *Accountable care organizations (ACOs).* In addition to the LCCCP initiatives, there are at least 13 ACOs in Missouri, concentrated in St. Louis, Kansas City and Springfield, of which 11 are Medicare ACOs, and two are commercial ACOs. The six Medicare ACOs for which the number of participants has been published jointly serve >184,000 Missourians. At least three of these ACOs have risk-based contracts; one reported $8.9 million in earned savings in 2017.[52]
- *Patient-centered medical home (PCMH)*. There are currently 419 NCQA accredited PCMHs in Missouri,[53] contracting with MCOs through the LCCCP program and with commercial plans. Fifty-three practices participate in CMS' Medicare Comprehensive Primary Care Plus Initiative (CPC+), in which Blue Cross Blue Shield of Kansas City and

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[50] MO HealthNet Community Psych Rehab Program Manual. http://manuals.momed.com/collections/collection_cpr/print.pdf.

[51] MO HealthNet Behavioral Health Services Manual. http://manuals.momed.com/collections/collection_psy/print.pdf.

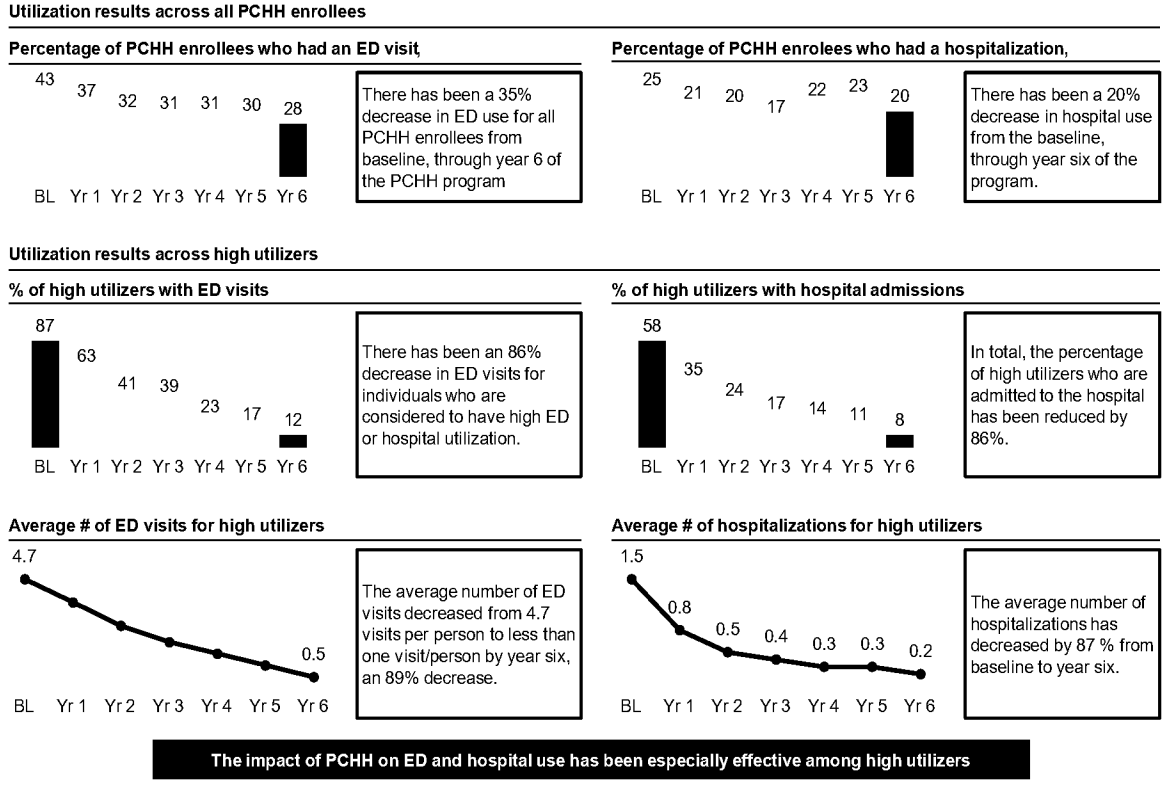
[52] CMS, "Shared Savings Program Accountable Care Organizations (ACO) Public-Use Files," 2017, see: www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/index.html.

[53] National Committee for Quality Assurance, "Practices," see: reportcards.ncqa.org/#/practices/list?state=Missouri.

UnitedHealth also participate; these practices receive care management fees and quality- and efficiency bonus payments. No Missouri-specific results have been published.

- *Health homes*. Missouri was one of the first states to create health homes. Health homes must meet specific quality criteria and receive a per member per month (PMPM) payment for care management and other dedicated health home services. Primary care health homes (PCHH) focus on patients with at least two physical chronic conditions, such as diabetes, cardiovascular disease, or substance use disorder. As of 2017, PCHHs received $63.72 PMPM for health home services; of the 38 PCHHs, 25 are federally qualified health centers (FQHCs), 11 are hospital affiliated providers, and two are clinics. In 2018, 24,580 Medicaid participants were receiving care from PCHHs. According to evaluations published by the state, PCHHs saved $98.35 PMPM, compared to baseline in 2016 (see Exhibit 13).[54] Lower actual and risk-adjusted PMPM costs for the PCHH population are partially driven by lower inpatient costs (see Exhibit 14).[55]

EXHIBIT 13: IMPACT OF PRIMARY CARE HEALTH HOMES: HOSPITAL USE, SFY2012-18[56]



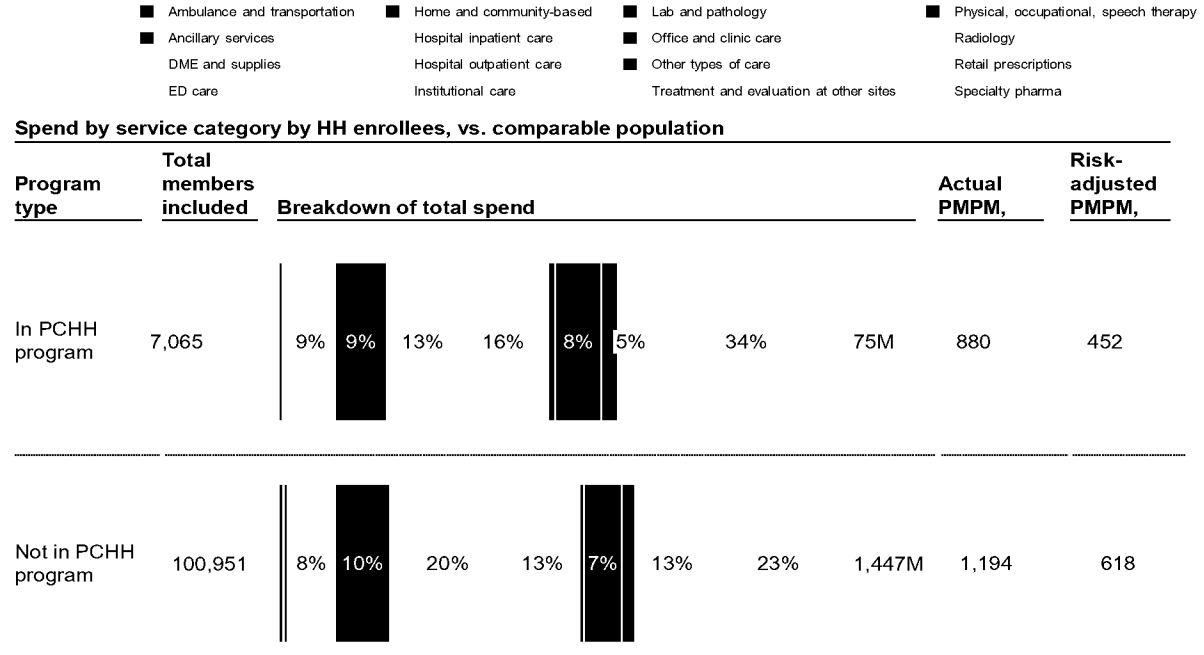
[54] Missouri DSS, "Paving the way," 2017, see: dss.mo.gov/mhd/cs/health-homes/pdf/pchh-paving-the-way.pptx; Missouri DSS, "MO HealthNet PCHH Progress Report 2014-2017 FINAL 07192018," 2018, analysis of Missouri Medicaid claims data, SFY2016-18.

[55] Analysis of Missouri Medicaid claims data, SFY2016-18.

[56] Missouri DSS: see note 54.

EXHIBIT 14: COMPARISON OF EXPENDITURES IN PCHH PROGRAM WITH NON-PCHH PARTICIPANTS WITH COMPARABLE RISK-PROFILE (MANAGED CARE), SFY2018[57]

SFY2018



Spend by service category by HH enrollees, vs. comparable population

Program type	Total members included	Breakdown of total spend								Actual PMPM,	Risk-adjusted PMPM,
In PCHH program	7,065	9%	9%	13%	16%	8%	5%	34%	75M	880	452
Not in PCHH program	100,951	8%	10%	20%	13%	7%	13%	23%	1,447M	1,194	618

Community mental health center health homes (CMHC HH) focus on patients with (serious) mental illness and/or substance use disorder. CMHCs receive $85.23 PMPM to support the infrastructure needed to deliver CMHC HH services; of the 28 CMHCs, 22 are clinics and six are hospital affiliated providers (15 of these CMHCs have become certified community behavioral health clinics [CCBHCs; see below]). As of January 2017, 24,844 participants were enrolled in CMHC HH. An evaluation by the state concluded that in 2016, CMHC HHs saved $284.94 PMPM compared to baseline (see Exhibit 15 for additional results).[58] To compare participants served by CMHC HHs with participants with comparable conditions and co-morbidities, individuals with high behavioral health needs were identified within the CMHC HH population as well as in the non-HH population.[59] In this comparison, participants in the non-dual disabled population show similar nominal PMPM costs but lower risk-adjusted PMPM costs for the CMHC population. As in the PCHH analyses, these results were driven partially by higher pharmacy costs and lower inpatient costs in the CMHC

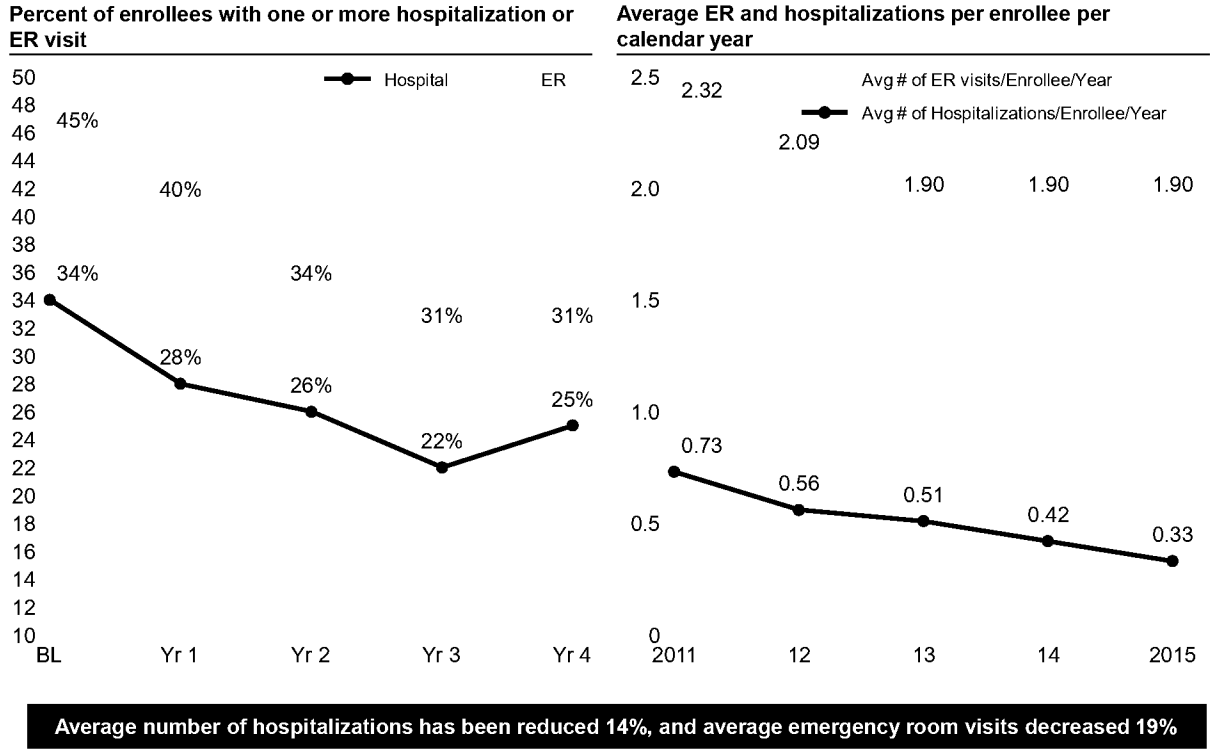
[57] Analysis of Missouri Medicaid claims data, SFY2016-18.

[58] Missouri DMH, "DMH CMHC Healthcare Homes progress report," 2016, see: dmh.mo.gov/mentalillness/provider/docs/cmhchchprogreport16.pdf.

[59] In these analyses, participants were flagged as having high behavioral health needs if they either (1) have diagnoses of schizophrenia, bipolar disorder with psychosis, major depression w/ psychosis, attempted suicide or self-injury, homicidal ideation, or substance use with pregnancy or one year postpartum OR (2) have one or more behavioral health-related utilization of inpatient hospital visit, crisis unit visit, residential facility visit, rehab facility visit, medication-assisted treatment, ED visit, or injection antipsychotics AND presence of bipolar disorder without psychosis, major depression without psychosis, other depression, PTSD, substance use, conduct disorder, personality disorder, psychosis, ODD, or eating disorders.

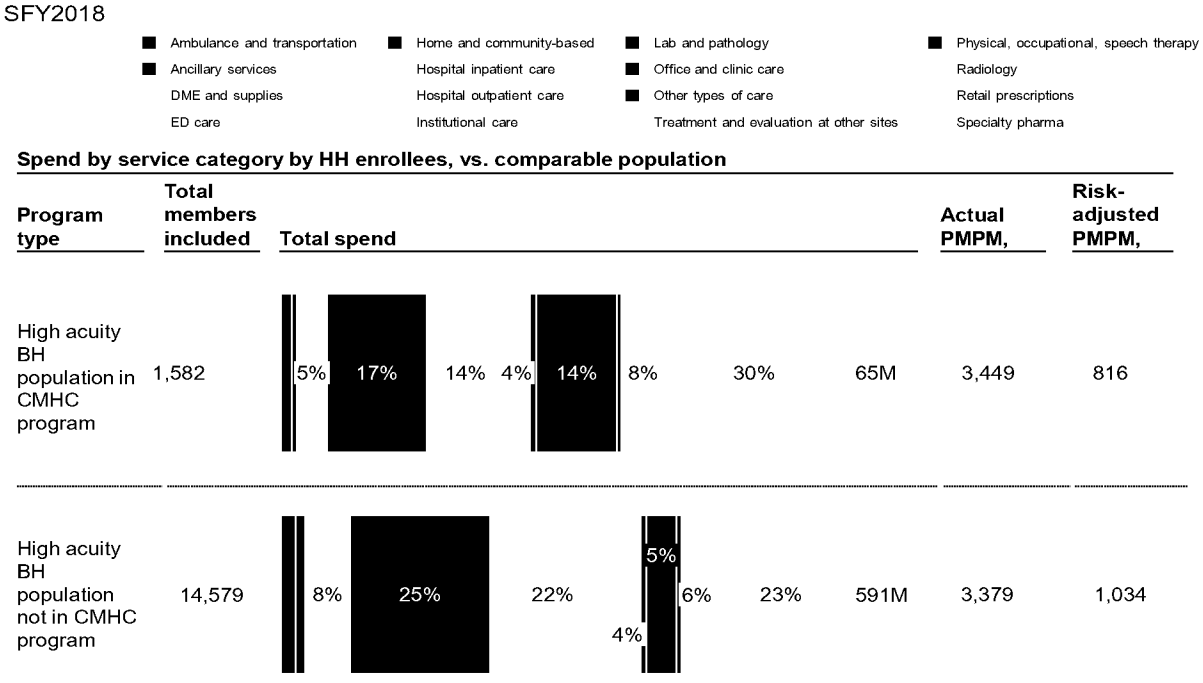
population. This comparison could indicate that the CMHC is cost-effective, improving the care for these patients (including utilization of needed drugs) and reducing potentially avoidable hospital admissions (see Exhibit 16). (The results for the managed care population, mostly children, did not show a comparable difference.)

EXHIBIT 15: IMPACT OF COMMUNITY MENTAL HEALTH CENTER HEALTH HOMES ON HOSPITAL USE, SFY2011-2015[60]



[60] Missouri DMH: see note 58.

EXHIBIT 16: COMPARISON OF PARTICIPANTS WITH SEVERE BEHAVIORAL HEALTH NEEDS IN CMHC PROGRAM WITH NON-CMHC PARTICIPANTS WITH SEVERAL BEHAVIORAL HEALTH NEEDS (NON-DUAL DISABLED POPULATION), SFY2018[61]



Certified Community Behavioral Health Clinics (CCBHC), a new initiative started in 2017, focus on a similar patient population as CMHCs, and can also provide Health Home services. Of the 28 CMHCs mentioned above, 14 have become CCBHCs (and one new CCBHC has been created). As of November 2018, CCBHCs HHs served ~16,650 Medicaid participants (largely participants who were enrolled in CMHC HHs before).[62] CCBHCs are reimbursed using a prospective payment system, in which health home payments are included. No results have yet been published.

– *Bundled Payments.* There are currently seven participating healthcare facilities in CMS' Medicare Bundled Payment for Care Improvement (BPCI) Advanced program, which have selected between one and 19 episodes, including sepsis, hip/knee replacement, and spinal fusion surgery.[63] Additionally, 36 hospitals participated in CMS' Medicare Comprehensive Care for Joint Replacement (CJR) program in 2016-2017, earning savings of on average ~$2 million.[64]

[61] Excludes health home PMPM payments; analysis of Missouri Medicaid claims data, SFY2016-18.

[62] Interviews with Medicaid program staff.

[63] CMS, "BPCI Advanced," 2018, see: innovation.cms.gov/initiatives/bpci-advanced/.

[64] CMS, "Comprehensive Care for Joint Replacement Model," 2018, see: innovation.cms.gov/initiatives/cjr.

Durable Medical Equipment

- The state follows a CMS fee schedule for most DME products (with exceptions such as speech generation software and accessories, and certain types of hospital beds, which use negotiated rates on a case-by-case basis). Total SFY2018 costs were $52 million, of which 27% were for respiratory DME, 27% were for bulky DME (such as wheelchairs and lift chairs), 14% were for orthotics and prosthetics, and the remainder were for other DME categories such as incontinence products and infusions.[65]
- Utilization management techniques are in place for DME products. Prior authorization, precertification, or meeting medical necessity criteria is required for most high-cost/high-utilization products such as power wheelchairs and other bulky DME.

Potential opportunities for improvement

This section identifies potential opportunities to improve Missouri's current approach to hospital and physician reimbursement, as well as regulatory and stakeholder risks. The opportunities are not intended to be mutually exclusive: opportunities for savings or improved outcomes may overlap.

- **The cost-based, single per diem payment method for hospital inpatient care provides limited incentives to contain costs and improve quality**. An outlier among states, Missouri's use of a single per diem lacks a direct connection between payments, actual care provided, and types of patients served. This lack of incentive for efficiency is exacerbated by the tight coupling between the reported cost of delivery and the level of the per diem: increased costs lead to higher per diems. Most state Medicaid programs (similar to Medicare and most commercial health insurers) currently use Diagnosis-Related Groups (DRGs), which make a fixed payment for the entire stay in the hospital, creating cost-containment incentives while also accounting for patient mix and severity.[66]
- **There is no inpatient readmissions policy.** While Missouri spent $160 million on hospital readmissions in SFY2018, it has no policies in place to address potentially avoidable readmissions. CMS, MCOs, and other state Medicaid agencies have extensive experience with such policies.
- **The cost-based, outpatient payment method also contains limited incentives for cost containment.** Proactive outreach to avoid exacerbations of depression or inefficiencies in diabetes care is not part of the standard fee schedule; in fact, reducing ER visits or hospital (re-)admissions reduces revenue for providers in a FFS payment system.[67] In addition, providers tend to have no access to data about the overall costs and outcomes of the care they provide, making it difficult to fully mobilize to prevent potentially avoidable complications and inefficiencies.

  Most states use outpatient fee schedules that are indexed to Medicare's fee schedule or ambulatory payment group models.[68] Missouri has started to move towards a comparable,

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65 Analysis of Missouri Medicaid claims data, SFY2016-18.

66 MACPAC, "State Medicaid Payment Policies for Inpatient Hospital Services," 2018, see: www.macpac.gov/publication/macpac-inpatient-hospital-ayment-landscapes.

67 Krupka, DC et al., "The Impact On Hospitals Of Reducing Surgical Complications Suggests Many Will Need Shared Savings Programs With Payers," 2012, Health Affairs, 31: 2571-78.

68 Such as Enhanced Ambulatory Patient Groups (EAPG) or Ambulatory Payment Classification (APC) methodologies.

Medicare-based outpatient fee schedule model, but has not yet completed that transition. For SFY2020, the state currently estimates this transition to be budget-neutral.[69] Expansion of this approach could generate savings over time as hospitals improve operational efficiencies. Savings could be realized more quickly depending on the approach taken to setting prices under the new fee schedule.

- **Several categories of high-cost outpatient services do not require prior authorization.** Prior authorization (PA) is limited to advanced imaging and select cardiac procedures. Other states and MCOs incorporate measures to ensure appropriate utilization on other OP procedures such as sleep studies, radiation therapy, and arthroscopies.
- **Providing add-on payments to hospitals for non-Missouri residents served is a unique feature of the Missouri Medicaid program.** Throughout the U.S., hospitals serving out-of-state Medicaid patients will be paid by the patient's home state according to that state's Medicaid regulations. In Missouri, the state provides additional add-on payments (estimated at approximately $177 million in SFY2019) to its hospitals for services provided to persons eligible for Medicaid from Kansas, Illinois or elsewhere.[70]
- **Managed care payments to hospitals are set at a higher rate than FFS payments**. Excluding compensation for provider taxes, current MCO inpatient base payments are approximately 30% higher than FFS per diem payments.[71] An estimated >$100 million of MCO payments to hospitals are at rates above 120-130% of FFS payments.[72]
- **Variability in reimbursement levels between hospitals is significant.** Excluding the Medicaid portion of each hospital's provider tax assessment, the difference between the Medicaid payments hospitals received and their individual UPLs varied between <50% and >150% of their hospital-specific UPLs in SFY2016.[73] The variation in outpatient procedure fees is currently being reduced through the introduction of the Medicare-based outpatient fee schedule.
- **Physician reimbursement is lower than in most other states.** Physicians are paid based on a fee schedule that is historically linked to Medicare but is not regularly updated. Reimbursement rates are less than in other states: Missouri Medicaid pays 79% of the national average (ranked 46th); for primary care, the state pays 81% (ranked 42th). Compared to Medicare fees, Medicaid pays 60% for overall physician services (ranked 44th) and 55% for primary care services (ranked 41th).[74] Spending on non-hospital physician services, including Federally Qualified Health Centers (FQHCs), clinics, and rural health services, is lower than other comparable states: In SFY2016, Missouri spent 5% of

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69 Missouri DSS, "MHD – FY 19 Core exercise," 2018.

70 Third-party analysis provided by MHD, 2018.

71 Third-party analysis provided by MHD, 2018.

72 Missouri DSS, "20181119 Medicaid Update," 2018.

73 Missouri DSS, FY2016 UPL analyses; AHA Hospital Cost Report Files (HCRIS): CMS.Gov Case Mix Index Data; Missouri DSS, FY2016 FRA schedule; FRA share of Medicaid revenue calculated by multiplying each hospital's FY2016 Medicaid revenue, the FRA tax rate (5.95% in FY2016), and the percentage of FRA payments from FFS (91%, per the FRA schedule).

74 KFF, "Medicaid physician fees," 2016, see: www.kff.org/state-category/medicaid-chip/medicaid-physician-fees/.

total expenses on non-hospital physician services, as opposed to 9% in comparable states.[75]

- **>15% of Missouri Medicaid acute care expenditures may be associated with potentially avoidable exacerbations and complications (PECs).** A PEC is any event that negatively affects the patient and is potentially controllable by the health care delivery system: an ER visit for an asthma exacerbation, a hospital readmission for a post-surgical wound infection, or an emergency admission for a patient with a depression. PECs are an inherent part of health care: a patient with bronchitis can develop a pneumonia, and post-surgical complications will likely never be completely eradicated. But improving the coordination and quality of care can significantly reduce the volume and costs of PECs.[76]

  As mentioned earlier, the current FFS reimbursement method does not reward coordination of care or adequate care management. Likewise, preventing PECs tends to negatively impact provider economics. Reducing such events, however, is an important source of value for payors and patients alike: addressing PECs means reducing total costs of care through improving outcomes for patients.

  In Exhibit 17, the risk-adjusted total costs of care for the Medicaid managed care population[77] are shown per county and mapped against the percentage of total costs that are associated with PECs. The percentage of costs associated with PECs per county is highly variable, ranging from <10% to >23%. (For persons with disabilities, the variability is comparable; percentages range between 6% and 14%.)[78] Reducing PECs by 20% would amount to ~$170 million in savings or opportunities for reinvestment.

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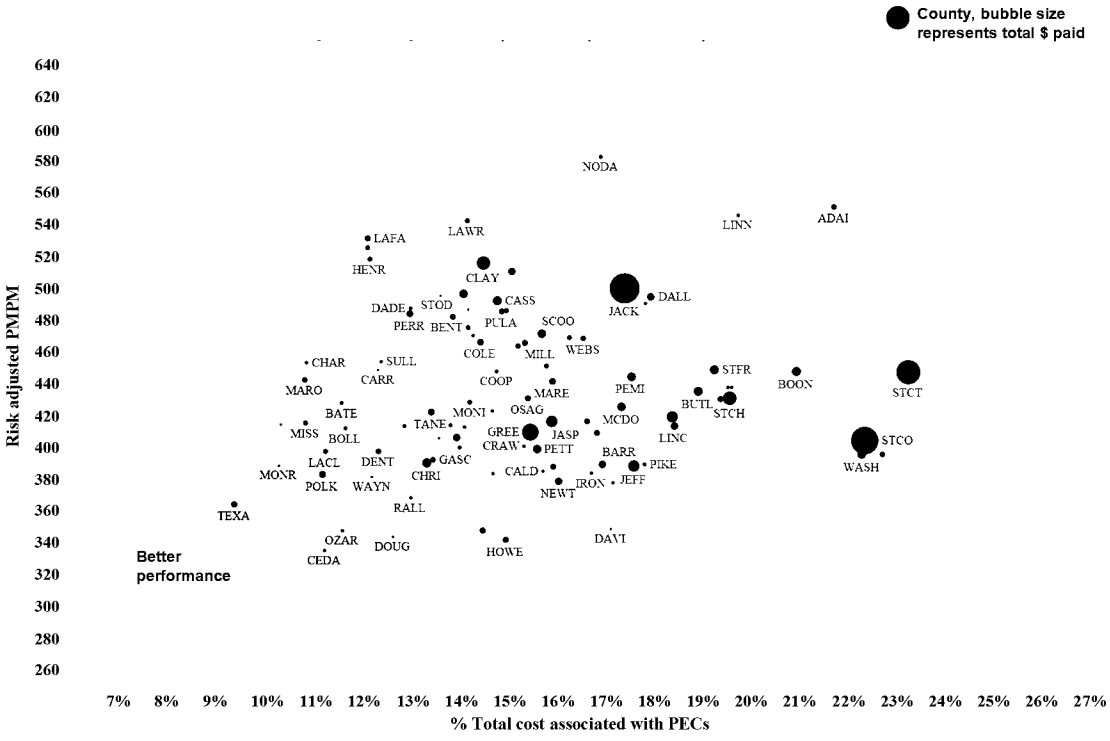
[75] FMR, 2016; comparable states are other states with enrollment in managed care of 30% or less (Alaska, Arkansas, Alabama, Colorado, Connecticut, Idaho, Massachusetts, Montana, North Carolina, North Dakota, Oklahoma, South Dakota, Vermont, and Wyoming).

[76] De Brantes, F, A Rastogi, and M Painter, "Reducing potentially avoidable complications in patients with chronic diseases," 2010, Health Serv Res, 45: 1854-71.

[77] Excluding dually eligible beneficiaries.

[78] PECs percentages are lower for this population as a larger proportion of the spending is LTSS spending, which is not included in PECs.

EXHIBIT 17: POTENTIALLY AVOIDABLE EXACERBATIONS AND COMPLICATIONS AND RISK ADJUSTED SPENDING BY COUNTY, MANAGED CARE POPULATION[79]

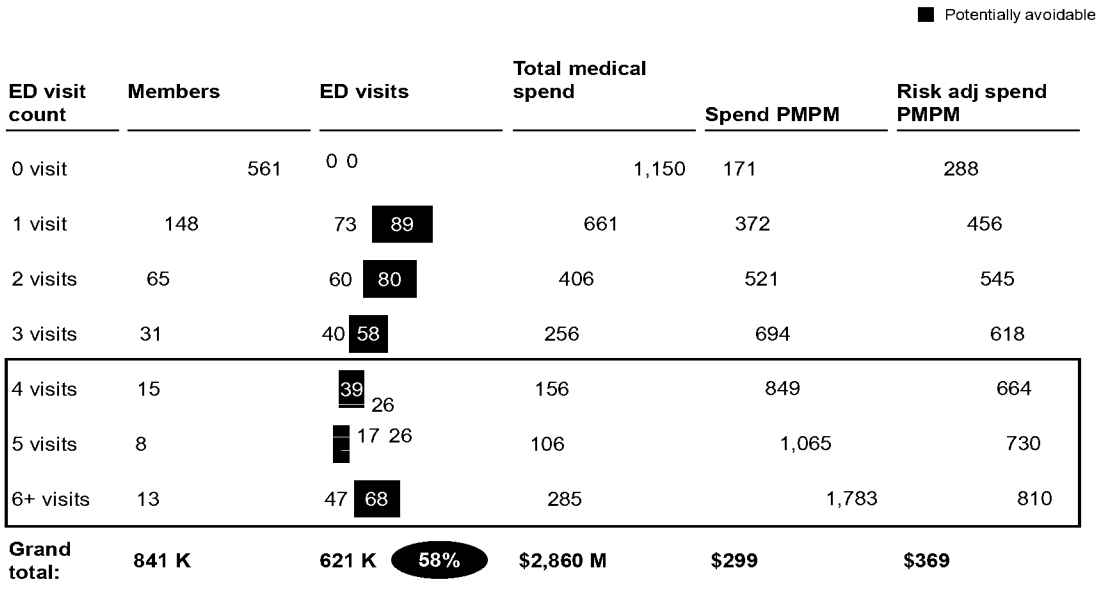


There are several ways value-based payment could support reducing PECs: incentivizing high quality, integrated primary care; rewarding a focus on high-cost patients who cycle in and out of ERs and hospitals (for persons with disabilities, 4% of participants account for nearly one-third of all ER visits) (see Exhibit 18); and strengthening the role of behavioral health care throughout the care cycle (mental health and substance use are the main reasons for hospital admissions amongst the individuals with disabilities, and – after maternal and newborn care – the second main reason in the children and adults population). See Exhibit 19 for the admissions for mental health diagnoses in the non-dual disabled population.[80]

[79] Analysis of Missouri Medicaid claims data, SFY2016-18; excludes counties <15,000 member-months. "Managed Care Population" refers to those individuals eligible for managed care: children, parents, and pregnant women.

[80] Analysis of Missouri Medicaid claims data, SFY2016-18.

EXHIBIT 18: 4% OF MANAGED CARE PARTICIPANTS ACCOUNT FOR ALMOST ONE-THIRD OF ED VISITS, OF WHICH >50% ARE POTENTIALLY AVOIDABLE[81]



ED visit count	Members	ED visits	Total medical spend	Spend PMPM	Risk adj spend PMPM
0 visit	561	0 0	1,150	171	288
1 visit	148	73 89	661	372	456
2 visits	65	60 80	406	521	545
3 visits	31	40 58	256	694	618
4 visits	15	39 26	156	849	664
5 visits	8	17 26	106	1,065	730
6+ visits	13	47 68	285	1,783	810
Grand total:	**841 K**	**621 K** **58%**	**$2,860 M**	**$299**	**$369**

EXHIBIT 19: HOSPITAL ADMISSIONS IN THE NON-DUAL DISABLED POPULATION[82]

Members by DRG for members with mental diseases admission, SFY2018

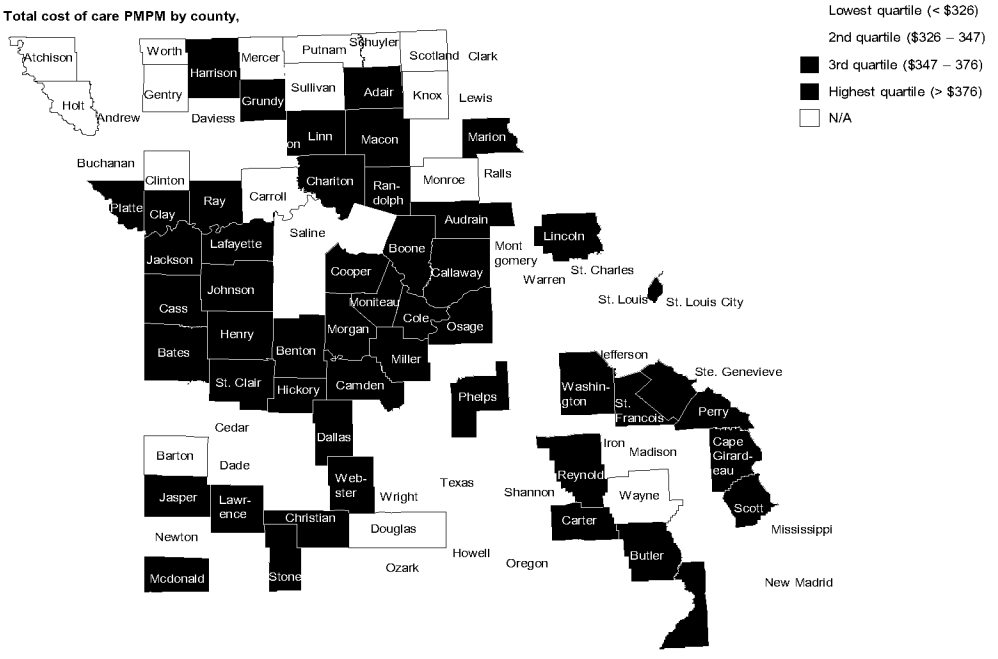
	Annualized members captured by category (members can be in multiple categories)	Total spend,	PMPM spend. .
Major Depressive Disorders & Other/Unspecified Psychoses	2,038	[illegible]	[illegible]
Bipolar Disorders	[illegible]	101M	4,315
Schizophrenia	[illegible]	[illegible]	4,989
Alcohol Abuse & Dependence	669	38M	4,756
Depression Except Major Depressive Disorder	499	26M	4,329
Opioid Abuse & Dependence	35[illegible]	18M	4,271
Other Drug Abuse & Dependence	33[illegible]	14M	3,679
Adjustment Disorders & Neuroses Except Depressive Diagnoses	248	14M	4,650
Acute Anxiety & Delirium States	193	12M	5,506
Disorders Of Personality & Impulse Control	167	12M	5,831
Cocaine Abuse & Dependence	160	10M	5,37[illegible]
Drug & Alcohol Abuse Or Dependence, Left Against Medical Advice	151	10M	5,385
Organic Mental Health Disturbances	124	[illegible]M	7,519

[81] Analysis of Missouri Medicaid claims data, SFY2016-18.

[82] Analysis of Missouri Medicaid claims data, SFY2016-18; excludes top and bottom 2.5% of episodes by cost.

- **5-10% of Missouri Medicaid acute care expenditures may be associated with the location where services are provided and the choice of diagnostics and interventions.** FFS does not incentivize efficiency considerations in making diagnostic or therapeutic decisions, nor does it stimulate providers to select the most cost-effective location to perform these services. Serving people in the ER is costly compared to serving them in a doctor's office; opting for an MRI scan where a CT scan could suffice is similarly inefficient. The risk-adjusted variation in spending per county is ~100%, driven partially by differences in hospital admissions that do not appear to be due to differences in overall differences in risk score per county (see Exhibit 20 and Exhibit 21). In general, across all payors, Missouri's hospital utilization is high compared to that of other states (see Exhibit 22). Analyzing spending per episode of care shows similar variability in expenditures: Exhibit 23 illustrates that perinatal care costs also vary ~100% for perinatal care between high-volume zip codes.[83] As with PECs, some efficiencies may be unavoidable: the MRI may simply be available faster, or the primary care practice – as an alternative to the ER – might be closed. Yet reducing these inefficiencies tends to be feasible. Reducing these inefficiencies by 20%, without negatively impacting the quality of care, would amount to $55 million to $110 million in savings or opportunities for reinvestment.[84]

EXHIBIT 20: RISK ADJUSTED SPENDING BY COUNTY, MANAGED CARE, SFY2018[85]



[83] Analysis of Missouri Medicaid claims data, SFY2016-18. Some of these admissions and costs may be due to PECs.

[84] Calculation: 20% of 5-10% of $5.7 billion (total acute care spending) = $55-110 million (rounded).

[85] Analysis of Missouri Medicaid claims data, SFY2016-18; not calculated for counties with fewer than 1,000 managed care-eligible Medicaid-enrolled residents ("N/A").

EXHIBIT 21: INPATIENT ADMISSIONS BY COUNTY, MANAGED CARE, SFY2018[86]

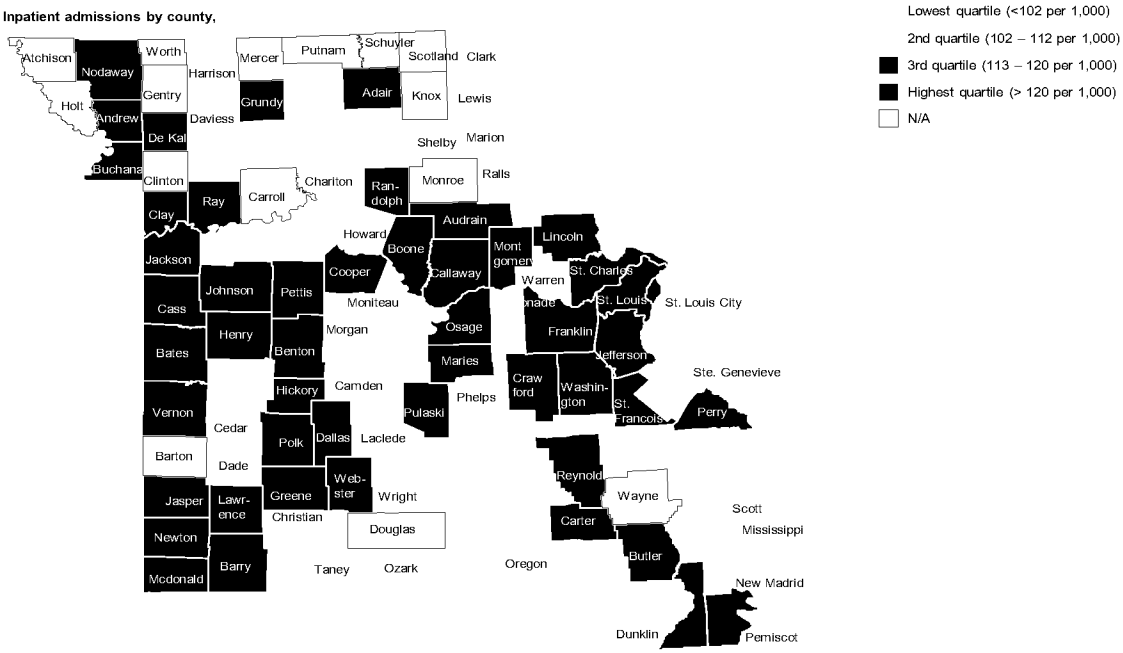
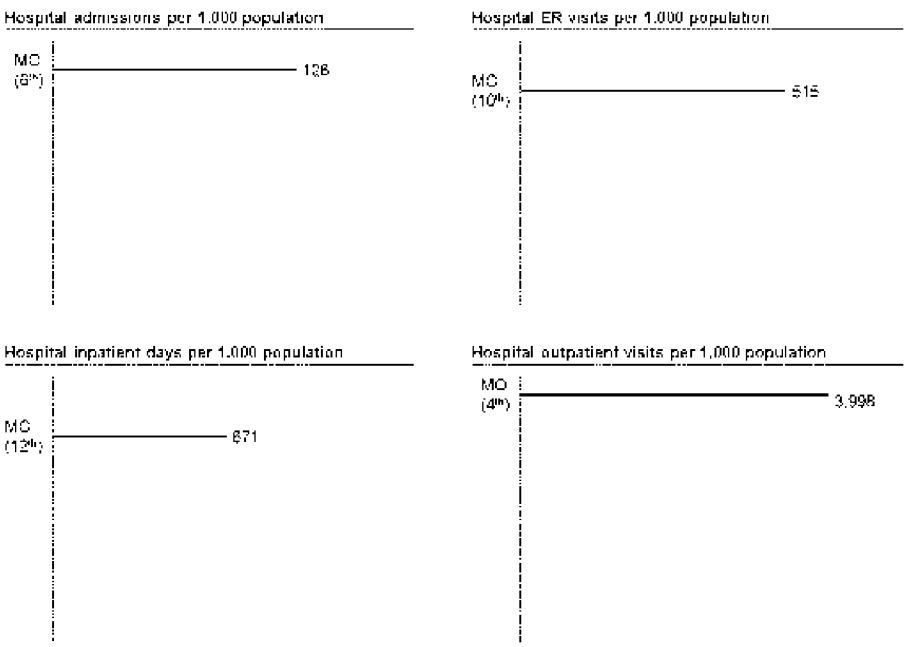


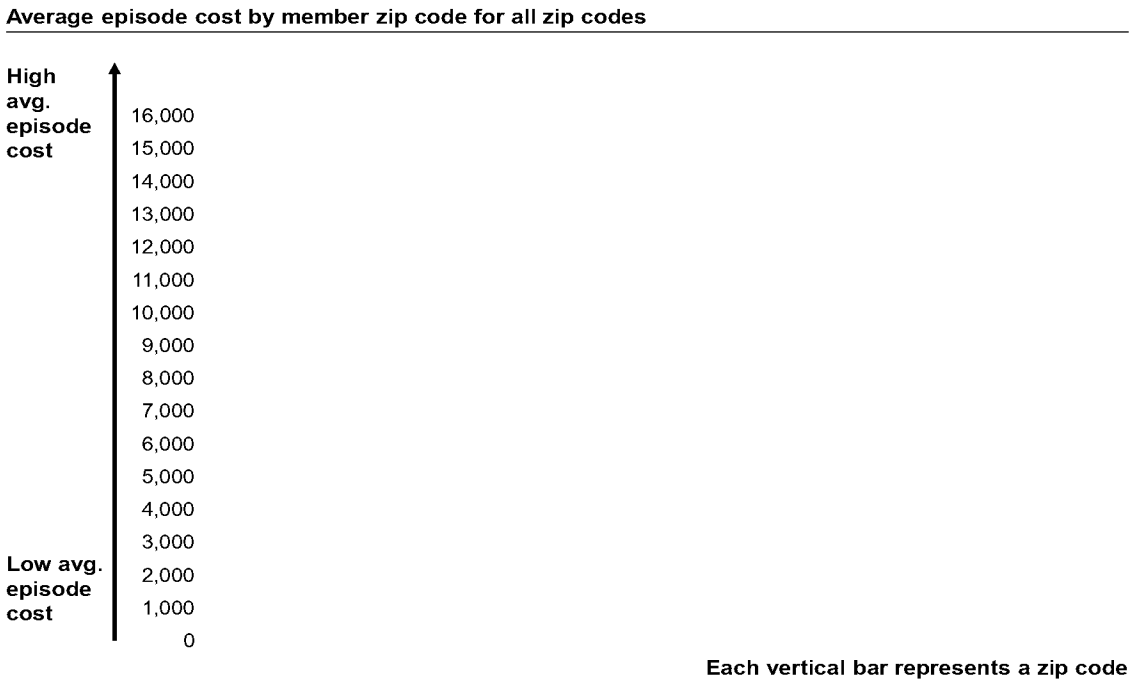
EXHIBIT 22. HOSPITAL USE COMPARED TO OTHER STATES (ALL-PAYORS)[87]



86 Analysis of Missouri Medicaid claims data, SFY2016-18; not calculated for counties with fewer than 1,000 managed care-eligible Medicaid-enrolled residents ("N/A").

87 KFF, "Hospital Outpatient Visits per 1,000 Population by Ownership Type," 2016, see: www.kff.org/other/state-indicator/outpatient-visits-by-ownership.

EXHIBIT 23: VARIATION IN HIGH-SPEND EPISODES: PERINATAL, SFY2018[88]



- **There is little to no transparency of outcomes of care in Medicaid.** Available data (e.g., external quality reviews of the MHD managed care program)[89] covers a limited range of performance measures. There is no readily publicly accessible information about the outcomes of care delivered per (sub)population or condition and per (groups of) provider. This limits consumer choice, accountability, and the opportunity and incentive for provider self-improvement.
- **The incentives embedded in several existing programs can be made stronger and aimed more explicitly at the outcomes of care that matter most to participants**. There are opportunities to build upon the success of the primary care initiatives, Accountable Care Organizations (ACOs), bundled payments, and health homes: increasingly link upside incentives to the outcomes of care, and tie the rewards received to the amount of savings realized. By reducing PECs by 1 percentage point in a Missouri managed care population, a PCMH, health home or ACO with 50,000 attributed lives could receive $1.5 million[90] in savings shared to further invest in improving their care (assuming 50% shared savings). Sharing in the savings could also help these providers to focus even more on the social determinants that may drive up PECs.

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88 Analysis of Missouri Medicaid claims data, SFY2016-18; figures are based on total claims-based expenditure associated with a perinatal episode triggered by live birth diagnosis and delivery procedure code. The top and bottom 2.5% of episodes by cost were excluded in analyses of variation.

89 Behavioral Health Concepts, "2016 MO HealthNet Managed Care Program External Quality Review: Report of Findings," 2016, see: dss.mo.gov/mhd/mc/pdf/2016-external-quality-review-report-mohealthnet-managed-care.pdf.

90 Estimate based on a 500 PMPM average spending of which 18% is associated with PECs.

- **There are physician shortages in many parts of the state, particularly rural areas.** 80% of Missouri counties are considered physician shortage areas, and only 10% of new physicians enter rural primary care. At 267, the state falls below the national average physician to patient ratio of 272 physicians per 100,000 people; for primary care, the state has 87 PCPs per 100,000 people, compared to 91.7 nationally. In rural areas, these issues are particularly challenging: of the 101 rural counties, 99 are Primary Medical Health Professional Shortage Area (HPSAs), 97 are Mental Health HPSAs, and 95 are Dental HPSAs.[91] This may contribute to system inefficiencies and the incidence of PECs: these services tend to be key to avoiding PECs and can lead to institutional care when community care might have been preferable. Creating innovative delivery or reimbursement models fitting the challenges of rural healthcare is difficult within the limits of the FFS fee schedules.[92]
- **The financial viability of many rural and safety net providers is precarious.** Some rural and safety net providers are financially frail, with year over year negative results. Approximately 90% of safety net hospitals and ~60% of rural hospitals had negative margins in SFY2016.[93] Without a rural health care infrastructure that is viable and meets local community needs, access to care for rural Missourians could be threatened. This could in turn lead to higher downstream costs due to missed (secondary) prevention opportunities.

In addition to the previously outlined potential opportunities, there are regulatory and stakeholder challenges which may impact current reimbursement approaches:

- Recent changes in CMS IP Upper Payment Limit (UPL) calculations may result in inpatient payments exceeding the UPL and thus a corresponding loss of federal funds. UPLs limit state Medicaid FFS spending on specific provider classes (e.g., hospital inpatient) to what Medicare would have paid for these services. For IP, both FFS base payments, out-of-state payments, and add-on payments count against the IP UPL. FFS payments that exceed the UPL are not eligible for federal match. CMS has recently introduced a new template to calculate the inpatient UPL, leading to Missouri's inpatient payments to possibly exceed the UPL by $16 million.[94]
- Missouri's tax rate is currently within the federal safe harbor limit (6%), but regulatory scrutiny of exact mechanisms used to compensate hospitals for tax payments could increase. Alternatively, CMS may reduce the current 6% provider tax limit below which it has so far allowed comparable payment arrangements in several states to e.g. 5% or even 3%.[95]
- Provider tax compensation arrangements in FFS and managed care are under pressure as hospitals that are net contributors to pooling mechanisms may opt out.[96] Under the existing MHA pooling mechanism, participating providers who receive more in estimated

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[91] Association of American Medical Colleges, "2017 State Physician Workforce Data Report," 2017, see: members.aamc.org/eweb/upload/2017%20State%20Physician%20Workforce%20Data%20Report.pdf.

[92] Missouri DHSS, "Health in Rural Missouri Biennial Report 2016-2017," 2017, see: health.mo.gov/living/families/ruralhealth/pdf/biennial2017.pdf.

[93] AHA Hospital Cost Report Files (HCRIS); CMS.Gov Case Mix Index Data.

[94] UPL calculation, Missouri DSS, January 2019.

[95] KFF: see note 12.

[96] MHA: see note 49.

FRA-related add-on payments than their provider tax payments contribute to the pool so that other hospitals can be compensated. If pool contributors withdraw from the voluntary transfers, the pool would become less able to compensate pool recipients, thus exacerbating the concern of some hospitals with the provider tax.

- In SFY2016, Medicaid made $19.7 billion in DSH payments nationally ($8.5 billion in state funds and $11.2 billion in federal funds). A reduction of $4 billion is planned for 2020, with the reduction increasing to $8 billion for each year from 2021 to 2025.[97] This could lead to a substantial reduction in available federal DSH funding for the state.
- CMS may recoup parts of DSH payments made to hospitals from previous years' allotments. Many states and hospitals have operated under the assumption that third-party payments did not have to be included in Medicaid DSH payment calculations and audits. In 2017, however, CMS issued a final rule stating that inclusion was needed, which has since been contested in several courts. If CMS prevails, this could lower hospital-specific DSH limits, creating, for example, a potential risk for Missouri hospitals of $96 million from 2011 and 2012 allotments alone.[98]
- Missouri's DME rates are higher than CMS' DME fee schedule across most product categories. Commercial payors, MCOs, and some state Medicaid agencies set DME rates significantly below CMS' DME rates (between approximately 65% to 75%); Missouri's DME fee schedule is currently priced at over 100% of CMS' DME rates. The variance between current pricing and pricing at 70% of CMS' DME rates is >$10 million.[99]

Potential initiatives

The following is a wide range of potential initiatives that Missouri Medicaid may consider, either in combination or as alternatives for improving the financial sustainability of the program. In total, the gross impact of the hospital, physician and behavioral health reimbursement initiatives outlined below could range from $250 million to $500 million, depending on choices made by the state. This excludes the impact on provider tax revenues (see the section on federal financing).

Potential initiatives to improve incentives and reduce costs include adjusting the inpatient (IP) and outpatient (OP) base rate methodologies and the add-on payments for out-of-state patients. Following other states, Medicare and commercial plans, Missouri could also consider transitioning further to value-based payment models and transparency of care costs and outcomes, which would maximize incentives for providers to deliver high-quality care while lowering costs. Through the latter, the state could work to address the significant costs associated with potentially avoidable exacerbations and complications (PECs) as well as other inefficiencies. In addition, value-based payment models could facilitate investments in the rural and safety net heath care infrastructure, including primary and behavioral health.

To achieve the higher end of the estimated impact range, the state would likely need to combine a focus on adjusting hospital reimbursement rates and utilization management with a broader

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97 MACPAC, "Disproportionate share hospital payments," see: www.macpac.gov/subtopic/disproportionate-share-hospital-payments.

98 Modern Healthcare, "CMS appeals Missouri court decision stopping DSH clawback," 2018, see: www.modernhealthcare.com/article/20180416/NEWS/180419941.

99 Analysis of Missouri Medicaid claims data, SFY2016-18; CMS, "DME18-A," 2018, see: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule-Items/DME18-A.htm.

value-based payment program in which providers could share in the savings realized across the total cost of care or in episodes of care. The state could choose its preferred balance between these approaches, which would imply choosing between those initiatives that address similar opportunities in different ways. The list below is intended as an outline of potential options for the state, providing the state with the opportunity to decide on both sizing and timing of the potential implementation of a selection of initiatives.

1. **Implement an inpatient hospital readmissions policy.** Inpatient hospital readmission policies are used by commercial payors, MCOs, other state Medicaid programs, and CMS to not only ensure appropriate utilization of services but also to improve quality. This policy could be modeled after policies that MCOs have today and further refined by the state. This could help ensure safe and appropriate discharge of participants and would also provide important feedback to hospitals. Operationally, this initiative would require modest policy and MMIS changes.
2. **Expand prior authorization (PA) to additional outpatient procedures.** PA policies are likewise used by commercial and other payors. This initiative could add select categories to the current PA list, and it could potentially make changes to the approach used in the existing outpatient PA process. This may require additional system edits and updates to current vendor contracts.
3. **Adjust outpatient base rate methodology.** Missouri could consider further anchoring outpatient base rate payments to a percentage of Medicare fee schedule rather than a percentage of charges across all outpatient services. This could allow Missouri to improve alignment between payments and services provided, increase predictability of outpatient expenditures, and be better able to compare rates both within the state and with other states. In addition, the Medicare fee schedule evolves with changes in the science and practice of medicine, thus ensuring the appropriateness of the payment methodology over time. As this transition has already been set in motion, the implementation complexity of this initiative would be limited.
4. **Adjust inpatient base rate per diem methodology.** To increase provider incentive for cost containment, Missouri could adopt a stratified per diem for inpatient services, offering different per diem rates for different types of patients (e.g., medical, surgical, maternity, neonatal, psych). Rates could be set in one of two ways: 1) based on current payment levels using a state-set trend factor, which would build off current price-setting methodology; or 2) based on regional average costs for each per diem category. Both approaches would likely improve alignment between payments and services offered, but they would not maximize cost containment incentives given the pay-per-service setup. The second approach, basing rates on regional average costs, may better improve alignment between payments and services as it eliminates link to historical costs. But additional risk adjustment would likely be necessary to capture within-region variations across hospital types (e.g., safety net hospitals may not incur the same costs as non-safety net). While it would not be challenging to implement the change from a regulatory respective, redesigning the per diem methodology – including ensuring a smooth transition without disruptive impact on reimbursements of individual hospitals – is not a well-standardized approach and is likely to be complex from a technical and operational standpoint.
5. **Consider case rate methodology for inpatient and/or outpatient services.** Missouri could move away from per diems and payments for individual outpatient services toward a case rate-based reimbursement model. Such models employ a grouping mechanism that varies for inpatient and outpatient services and are in use in many other states. For

outpatient, widely used grouper options are Enhanced Ambulatory Patient Groups (EAPG) and Ambulatory Payment Classification (APC). For inpatient, the standard is Diagnosis-Related Groups (DRG). Like the stratified per diem method above, pricing could be based on regional average costs or historical pricing with forward-looking trend factors set by the Medicaid program. Although payments are no longer determined at the individual service level, this payment methodology would still be volume-focused and hence would still limit cost containment incentives. The implementation complexity will likely be significant: in particular, the change from single inpatient per diem payments will require a thorough rebasing effort so that the transition is within the planned inpatient expenditures, remains predictable, includes the needed add-ons, and does not create financial disruptions for individual providers. In addition, the current MMIS is not currently equipped to handle case rate-based reimbursement models. Workarounds through additional DRG grouping applications exist, but these would have to handle all payments to hospitals.

6. **Reevaluate add-on payments for out-of-state (non-MO) residents.** Missouri could reduce or eliminate the reimbursements it makes to hospitals for treating out-of-state patients. Out-of-state payments are concentrated in a limited set of hospitals. The technical implementation complexity of this initiative is likely to be low, but the impact on affected providers may be significant.
7. **Modify Direct Medicaid payments methodology.** The Direct Medicaid payments (one component of the add-on payments) attempt to bridge the gap between base rate payments and the hospitals' costs to serve the Medicaid population. The state could consider limiting the reliance on cost reports so that reduced utilization or reductions in payments due to other initiatives are not compensated by increased Direct Medicaid payments.
8. **Apply UPL caps to individual hospitals.** The state could consider applying hospital-specific outpatient and inpatient UPL caps. Currently, consistent with federal regulations, the state applies UPL caps to the total of payments made within the applicable service category, but it does not apply individual hospital's UPL caps. As the UPL in Missouri is significantly impacted by the OOS payments, reducing them would affect the UPLs of the recipients of OOS payments.
9. **Adjust MCO hospital payments.** The state could cap MCO hospital payments at a fixed percentage of Medicaid FFS payments.[100] This initiative would require a modification of MCO contracts.
10. **Improve physician and behavioral health reimbursement.** For physicians, not only has the methodology for establishing rates (e.g., as a percentage of Medicare) not been updated, but once set, the rates do not change. As a result, physician reimbursement is low. It is likely that increasing reimbursement could help reduce provider shortage. Likewise, there is a shortage of behavioral health providers. The state could consider integrating this initiative in an overall VBP program.
11. **Re-examine payment levels for financially vulnerable rural and safety net providers.** To the extent that other initiatives are undertaken that could reduce revenue to hospitals generally, the state could consider re-examining the effects of the initiatives on financially vulnerable rural and safety net providers in particular to determine whether adjustments in payment levels, value-based payment structures, or other changes are necessary to mitigate the potential for erosion of access to care.

[100] Missouri DSS: see note 72.

12. **Transition to value-based payments.** In line with the healthcare industry trend led by other states, Medicare, and commercial plans, Missouri could consider moving from its current FFS payment methods to value-based payment (Alternative Payment Models, or APMs). In VBP, providers do not miss or lose revenue by increasing efficiencies and reducing potentially avoidable care services, as they tend to do in FFS. Rather, APMs allow providers to be rewarded if they reduce hospital (re-)admissions and nursing home admissions. This creates a strong business case for providers to invest in primary care, care coordination, integration of physical and behavioral health care, and home health care. In addition, if investing in social determinants of health creates net savings in Medicaid expenditures, shared savings or other VBP payments can be leveraged to fund those services.

    Some forms of value-based payment could be implemented without changing the underlying architecture of the current FFS payment methods by overlaying rewards (and in some cases penalties) on top of FFS payment streams. This would facilitate implementation, as current administrative and billing processes, including the role of the MMIS, would require little change. The additional analytical capabilities required for VBP tend to be delivered by vendors, requiring limited interaction with the MMIS. With a combination of models, building upon current, successful initiatives, Missouri could include most Medicaid participants in VBP initiatives:

    – *Population-based models.* Advanced Primary Care models (APCs) build on the PCMH model but increase accountability for improved outcomes of the total attributed population and total cost of care. Improvement in these parameters leads to higher bonus payments and a share in the savings realized. Accountable care organizations (ACOs) take this responsibility for the total costs and outcomes of care for a population one step further. If the ACO manages to reduce total costs of care below a target budget (usually based on the historical costs of care of the ACO's population), they receive up to 50% of the savings. ACOs can be upside-only (e.g., only savings are shared), or they can include up- and downside risk (e.g., both potential savings and losses are shared). As risk-based APMs reduce the payor's risk for losses, they can share significantly higher percentages of the realized savings (up to 100%) with the providers. ACOs can be led by primary care organizations, hospitals, and (virtually) integrated groups of providers, amongst others.

      For specific high-need subpopulations (e.g. individuals with co-morbidity, severe mental illness, and/or substance use disorder), the existing health home model(s) could be leveraged to further improve outcomes.

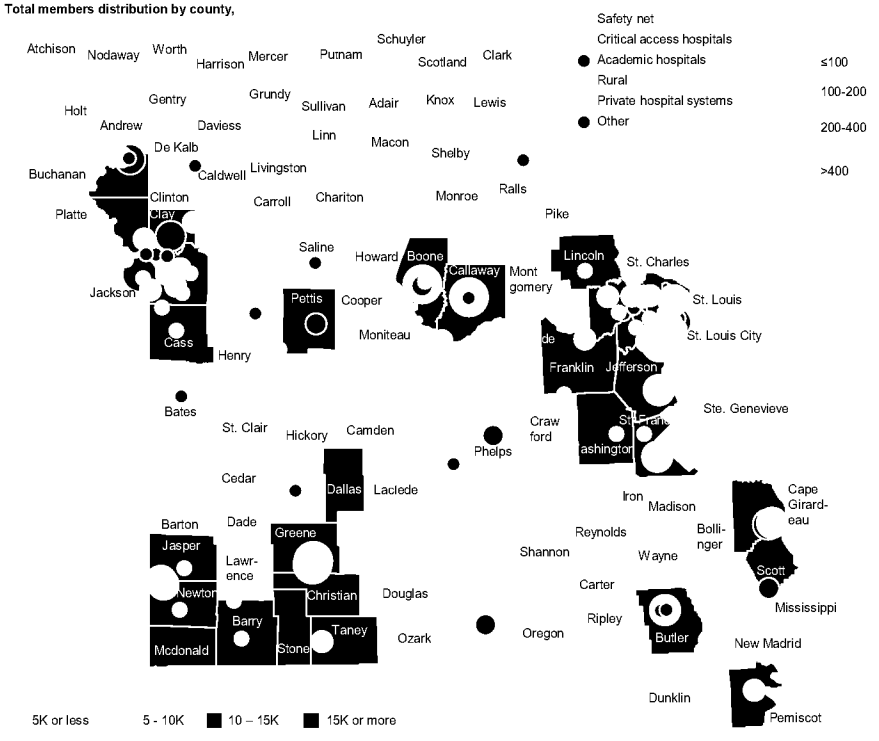
      Population-based models stimulate a focus on prevention and the management of chronic disease and individuals with severe comorbidities: avoiding the need for (institutional) care (including many PECs) is the most cost-efficient way to realize savings.

    – *Bundled payments or episode-based models*. In episode-based models, providers assume responsibility for the costs and outcomes of a set of services to treat a certain clinical condition or conduct a certain procedure. Like an ACO, episodes have target budgets, and they can be upside-only or risk-based. Episode-based models stimulate the creation of patient-centered care pathways across organizational boundaries. PECs and the inefficient utilization of care services are addressed through care coordination. Episodes tend to achieve impact faster as population-based models, as the opportunities for improvement tend to be clear and specific. Several private and public payors have combined population- and episode-based payments to create a "best-of-

both-worlds" mix of incentives for population health and high-value condition-specific care.

– *Global budgets for rural hospitals.* In rural areas, the state could consider global hospital budgets. Sixty-seven percent of Missouri counties have less than 5,000 managed care Medicaid participants. Access to primary care physicians and hospital facilities can be difficult, and the financial viability of many rural hospitals is under pressure. For such hospitals, global budgets (based on the expected cost of the hospital services for an attributed population) could create financial stability and facilitate transformation to a care delivery model aligned with local community needs. The establishment of regional ACOs or advanced primary care models with, for example, performance-dependent PMPM care management fees could further help to mature these geographies' regional care infrastructure.

EXHIBIT 24: MEDICAID ENROLLMENT PER COUNTY, DISTRIBUTION OF BEDS, SFY2016[101]



Share of total members[1] (%)

	Annualized members	Cum.
Jackson	140	12
St. Louis	139	24
St. Louis city	114	34
Greene	50	38
St. Charles	32	41
Clay	30	44
Jefferson	24	46
Jasper	24	48
Buchanan	20	50
Callaway	18	51
Christian	18	53
Franklin	17	54
St. Francois	16	56
Butler	15	57
Pettis	14	58
Cass	14	59
McDonald	14	60
Washington	14	62
Cape Girardeau	14	63
Pemiscot	13	64
Boone	13	65
Barry	13	66
Scott	12	67
Platte	12	68
Lincoln	12	69
Other	355	100
Grand total	**1,156 K**	

13. **Create transparency for outcomes of care.** Providing transparency of outcomes for (sub)populations and key conditions/procedures is a prerequisite of any health care system oriented towards value. Juxtaposing these outcomes to the risk-adjusted costs of care shines light on the performance of the healthcare delivery system and provides the information providers, payors, participants, and policymakers require to make informed choices and focus improvement efforts. As the collection point of all Medicaid claims

[101] Analysis of Missouri Medicaid claims data, SFY2016-18.

data, the state could publish such information on the total costs and outcomes of care per county or (group of) provider(s).[102]

14. **Include MCOs in a VBP program to maximize impact and align incentives for providers across the total Medicaid population.** The majority of Medicaid program participants are enrolled in MCOs.[103] To create the volume for providers to be sufficiently incentivized to participate, both FFS and managed care participants may need to be included, and the APMs across MCOs and Medicaid FFS may need to be adequately aligned. If some MCOs implement bundles and others carve out ACO subpopulations in different ways, providers cannot (and will not be motivated to) make the investments to change their business models. In addition, without alignment between APM definitions, the measurement of outcomes and financial performance will likely not be statistically feasible. Following the example of an increasing number of states, Missouri could consider working with its MCOs to facilitate this alignment and change MCO contracts accordingly.
15. **Explore multi-payor VBP alignment.** To further increase the potential impact of value-based payment, the state could consider collaborating with non-Medicaid payors in the state to align APMs and set collective goals. To significantly increase impact (see previous initiative), multi-payor models are becoming increasingly widespread: CMS' Comprehensive Primary Care models (CPC and CPC+) are an example. Two options the state could explore are, first, alignment with the other main state government payor, the Missouri Consolidated Health Care Plan (MCHCP).[104] Second, the state could consider engaging with CMS to facilitate mutual alignment between the existing and forthcoming Medicare APMs and the Missouri VBP strategy.[105]
16. **Update the DME fee schedule**. Missouri could update its DME rates to match those of other state Medicaid agencies and MCOs, which could potentially be supported by competitive procurements in specific categories. Operationally, this would require a change in the fee schedule, potential procurements, and efforts to ensure access.

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[102] Transparency of costs and outcomes requires a minimum number of attributed participants to allow comparisons; individual professionals, for example, may not see sufficient participants to be meaningfully compared to others.

[103] To optimally align incentives between the state, the MCOs and providers in APMs, Missouri could consider carving in pharmacy and behavioral health for the MCO population.

[104] Including MCHCP would add approximately 100,000 lives. See: http://www.mchcp.org.

[105] This could be relevant for both duals (who make up a disproportionately large share of both Medicaid's as well as Medicare's total spending) as well as for non-duals (where alignment between APMs would increase impact in the same way as alignment with other payors would).

LONG-TERM SERVICES AND SUPPORTS

Certain elderly populations and others with disabilities are eligible to receive long-term services and supports (LTSS) to assist with activities of daily living and otherwise support greater independence. Before receiving LTSS, Medicaid-eligible individuals undergo an assessment process, which determines eligibility but does not impact placement, type, or intensity of services to be provided. Once individuals are deemed eligible, the services they may receive fall into two categories: 1) institutional services and 2) home and community-based services (HCBS, which can be split into residential and non-residential services). Nursing facilities are reimbursed using a cost-based payment methodology without adjustments for acuity, quality of care, or outcomes. As a result, there are minimal incentives for these facilities to provide differentiated care to high-needs patients, or to transition lower-needs participants back to their homes or the community. HCBS are provided through a combination of State Plan and waiver programs; HCBS providers are not held accountable for nursing home (re-)admission rates.

Opportunities to improve quality and control costs of LTSS are primarily to be realized from increasing the proportion of LTSS recipients that receive services at home or in the community rather than in more costly institutional settings, and improving care planning and care management of members regardless of their setting of care.[106] Potential initiatives include improving utilization management, adjusting the nursing facility reimbursement methodology to an acuity-based system, completing and expanding upon planned improvements to the assessment algorithm and process, expanding current grant- or waiver-funded programs to cover services that support individuals in the home or community, and shifting to value-based payment. In total, the gross impact of the LTSS initiatives could range from $90 million to $275 million, net of potential reinvestments in the delivery system, depending on choices that the state may make in the selection, design, and implementation of initiatives.[107]

Current situation

This section gives an overview of the population receiving LTSS in Missouri, the assessment and service authorization process, institutional services, and HCBS.

LTSS population and services

In SFY2018, approximately 106,000 individuals received LTSS in Missouri, representing 39% of the state's total aged, blind, and disabled (ABD) population.[108] However, spending for recipients of LTSS, which was approximately $2.9 billion in SFY2018, represented 71% of the state's total spending on the ABD population. 53% of Medicaid elderly and 33% of persons with disabilities receive LTSS (see Exhibit 25).[109]

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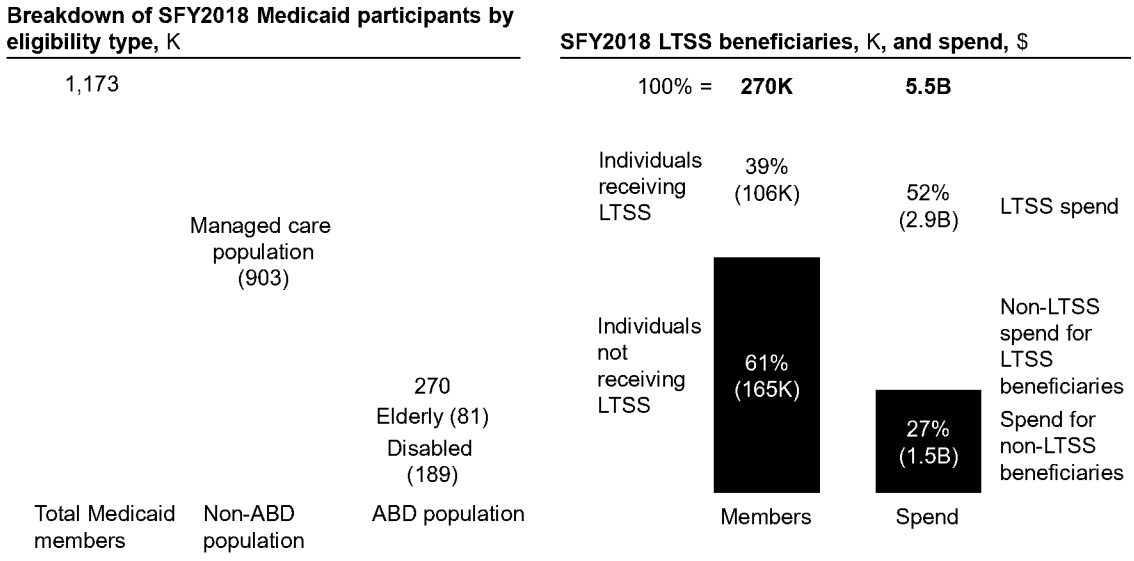
[106] IBM Watson Health, "Medicaid Expenditures for Long-Term Services and Supports in FY 2016," 2016, see: www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.

[107] AARP, Commonwealth Fund, SCAN Foundation, "Long-Term Services & Supports State Scorecard," 2018, see: longtermscorecard.org/databystate/state?state=MO; IBM Watson Health: see note 106.

[108] Analysis of Missouri Medicaid claims data, SFY2016-18.

[109] Analysis of Missouri Medicaid claims data, SFY2016-18.

EXHIBIT 25: LTSS PARTICIPANTS ~40% OF ABD POP'N, 70% OF COSTS, SFY2018[110]



- LTSS analysis is focused on 270K participants in ABD population that make up 23% of total Medicaid enrollment
- Across the elderly and disabled beneficiaries, we found that individuals receiving LTSS services make up ~40% in enrollment but ~70% of total spend

There exist several publicly available reports and datasets that compare performance of the LTSS system across states. These sources reveal several insights about the current performance of Missouri's system. For example, Missouri is ninth in the country on the performance of its No Wrong Door system, which is a national program to streamline access to new LTSS options, improving the patient experience and potentially reducing cost of care.[111] In addition, the state is near the top quartile of states when ranked by the share of LTSS expenditures that goes towards HCBS. In SFY2018, approximately 61% were for home and community-based services (see Exhibit 25). The national average of the HCBS proportion of total LTSS spending was 57% in SFY2016.

In other areas, Missouri performs below the national average. For example, the state ranks 49th in the country in the percentage of nursing home residents that have low care needs (24% vs. the national average of 11%), suggesting opportunities for a greater share of LTSS recipients to be supported within the home and/or community.[112] Furthermore, Missouri ranks 42nd in the country in the employment rate (19% vs. the national average of 22%) for adults with Activities of Daily Living (ADL) disabilities, relative to those without them.

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[110] Analysis of Missouri Medicaid claims data, SFY2016-18; Validation checks performed against Table 23 suggests a total of 1.04 million beneficiaries after inclusion of Women's Health Services (977k not including Women's Health Services). There is ~12% gap in enrollment due to differences in participant accounting (e.g., exclusion of non-claimants).

[111] AARP, Commonwealth Fund, SCAN Foundation: see note 107.

[112] AARP, Commonwealth Fund, SCAN Foundation: see note 107.

Non-institutional services with the highest overall spending are residential services and personal care.[113] Residential services are covered exclusively by DMH's Comprehensive Waiver (see "HCBS" section for additional details on this waiver). Personal care is covered by both the State Plan and almost all the waivers. The State Plan pays for the personal care for the majority (58%) of LTSS participants.

See Exhibit 26 for a breakdown of the LTSS spending by service category and the number of participants receiving services in each category.[114]

EXHIBIT 26: BREAKDOWN OF LTSS SPENDING BY SERVICE CATEGORY, SFY2018[115]

	LTSS service category	Total LTSS spend, $M	Share of total LTSS spend	Average participants,	Share of total LTSS pop.
Institutional	Skilled nursing facility	1,041	36%	29.8	28%
	Intermediate care	84	3%	0.4	0%
	Adult day care / day habilitation	182	6%	6.1	6%
	Career and financing	10	0%	5.8	6%
	Community services	5	0%	1.5	1%
	Counseling and therapy	5	0%	1.2	1%
Waiver HCBS	Residential services	661	23%	6.8	6%
	Personal care	63	2%	3.4	3%
	Private duty nursing	16	1%	0.2	0%
	Respite care	4	0%	0.4	1%
	Targeted case management	58	2%	13.3	13%
	LTSS Other	27	1%	15.0	14%
State plan HCBS	Personal care	701	24%	61.7	58%
	Private duty nursing	20	1%	0.3	0%
	Targeted case management	9	0%	6.0	6%
		Total spend = $ 2,886M		**Total pop = 105.2K participants**	

Assessment and service authorization

Individuals can receive LTSS through either DHSS or DMH. DHSS follows different authorization procedures for adults and for children. For adults, personal care services can be either agency-directed (e.g., where a state agency is responsible for managing participants' personal care, including selection and supervision of personal care assistants) or consumer-directed (e.g., where the participants manage their own services by selecting, hiring, and supervising their own personal care assistants). For adults, LTSS can also include institutional care (nursing homes). DHSS uses the interRAI HC assessment (commonly used nationally) to

[113] Analysis of Missouri Medicaid claims data, SFY2016-18.

[114] Analysis of Missouri Medicaid claims data, SFY2016-18.

[115] Analysis of Missouri Medicaid claims data, SFY2016-18; participants may overlap across categories.

determine need for institutional level of care. For children, personal care services – which must be agency-directed – can be authorized through the Bureau of Special Health Care Needs and are renewed every six months. For these children, the criterion for care is medical necessity rather than institutional level of care needs. Meanwhile, DMH has multiple assessments and determines which to use primarily based on the age of the individual (e.g., the MOCABI[116] for adults; the Vineland assessment or another age-appropriate[117] substitute for children).

The department conducting the assessment then processes the results of the assessment to determine whether the individual is eligible to receive LTSS. DHSS uses a points-based system: individuals who receive a score of 24 points or above are eligible for institutional level of care, which makes them eligible for LTSS offered through DHSS. On the other hand, if DMH determines that the individual has two or more (three or more for waivers) functional limitations, the assessor completes a Level of Care form to demonstrate the need for intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

Once an individual is deemed eligible for LTSS, the departments then engage in person-centered care planning, in which case managers work directly with individuals to determine setting, level, and type of care to be provided. For services provided through DHSS (except for those provided through the Independent Living Waiver), person-centered care planning is performed by regional assessors. For the Independent Living Waiver, person-centered care planning is provided through targeted case management (TCM) providers covered under the waiver. For services provided through DMH, care planning is performed by TCM providers covered by the Medicaid State Plan. The care planning process does not consistently use the results of the assessment to inform the setting, level, or type of care authorized. Rather, assessors are trained to use an HCBS manual (for DHSS services) or an Individual Support Plan (ISP) guide (for DMH services) to inform what, where, and how much of each service can be authorized, but unlike many other states, Missouri does not require that the assessor follow these guidelines.

Institutional services

Nursing facilities are reimbursed using a cost-based per diem methodology at the facility level. While not uncommon among states, this methodology does not take into account patient acuity, intensity of service, quality, or outcomes in determining nursing facility payment levels. As a result, nursing facilities are not necessarily incentivized to provide cost-efficient or appropriate levels of care. Furthermore, the per diem rates are based on historical cost reports that can date back over two decades; yearly incremental adjustments are determined by the state legislature. In total, Missouri's nursing facility payments fall well below the nursing facility Upper Payment Limit.[118]

Approximately 40% of the funds used to pay nursing facility reimbursement is derived from the Nursing Facility Federal Reimbursement Allowance (NFFRA).[119] Like other states, Missouri taxes nursing facilities and uses these revenues to fund Medicaid and draw down federal funds at the Missouri federal match rate of 65.4%.[120]

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116 Missouri Critical Adaptive Behaviors Inventory.

117 Interviews with Medicaid program staff members.

118 UPL analysis, Missouri DSS, 2018.

119 Missouri DSS, "SFY 2014-2019 Rate by Funding Source & Cost Component – 9-28-18," 2018.

120 KFF: see note 12.

For individuals with intellectual and/or developmental disabilities, the state operates four public ICFs/IID known as habilitation centers, which collectively house 315 participants, and contracts with a number of private ICFs/IID, which house another 82 individuals, totaling 397 participants in 2018 (down from 435 in 2017).[121] This number will likely continue to trend downward, as the state plans to reduce admissions in Missouri ICFs/IID further.

HCBS

Missouri covers HCBS through a combination of State Plan and waiver programs. State Plan services include targeted case management, personal care, and private duty nursing. For these services, individuals who exhaust the maximum amount allowed by the State Plan may then access additional allotment of these services through waivers, which cover care beyond what the State Plan is able to fund. Waivers can include a broad range of services, such as personal care and residential services. These waivers do not qualify for enhanced federal match, and each waiver has an expiration date, at which point the state can elect to renew the waiver or allow it to expire.

There are nine HCBS waivers, four of which are administered in coordination with DMH and five of which are administered in coordination with DHSS. While these waivers use various rate-setting mechanisms, they are fundamentally cost-based. Most individuals can only be on one waiver at any given time. HCBS are split between residential and non-residential services. Residential services, which include shared living and group home services, serve over 6,800 individuals, primarily through the DMH Comprehensive Waiver.

The set of waivers[122] includes the following (see Exhibit 27 for a summary of trends in costs and participant count in these waivers):

- **Aged and Disabled Waiver (DHSS through the Department of Senior and Disability Services / DSDS, served 15,200 individuals in Waiver Year [WY] 2016):** For individuals age 65 years and older (or 63 and older if they have disabilities) that have impairment and unmet needs. Services covered include homemaker and chore services, home-delivered meals, respite, and adult day care.
- **Adult Day Care Waiver (DHSS through DSDS, served 1,588 individuals in WY16):** For individuals age 18 to 63 years with impairments and unmet needs. This waiver exclusively covers adult day care services.
- **Independent Living Waiver (DHSS through DSDS, served 190 individuals in WY16):** For individuals age 18 to 64 years with cognitive and/or physical disabilities but also the ability to self-direct. This is the only one of the nine waivers that covers targeted case management; part of the waiver's purpose is to serve as a continuation of State Plan targeted case management.[123] It is also the only one of the five DHSS waivers that explicitly covers self-directed personal care.
- **Comprehensive Waiver (DMH, served 8,882 individuals in WY15):** For individuals with intellectual and/or developmental disabilities. This is the only one of the nine waivers that

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[121] Missouri DSS, "State Operated Habilitation Centers," 2018.

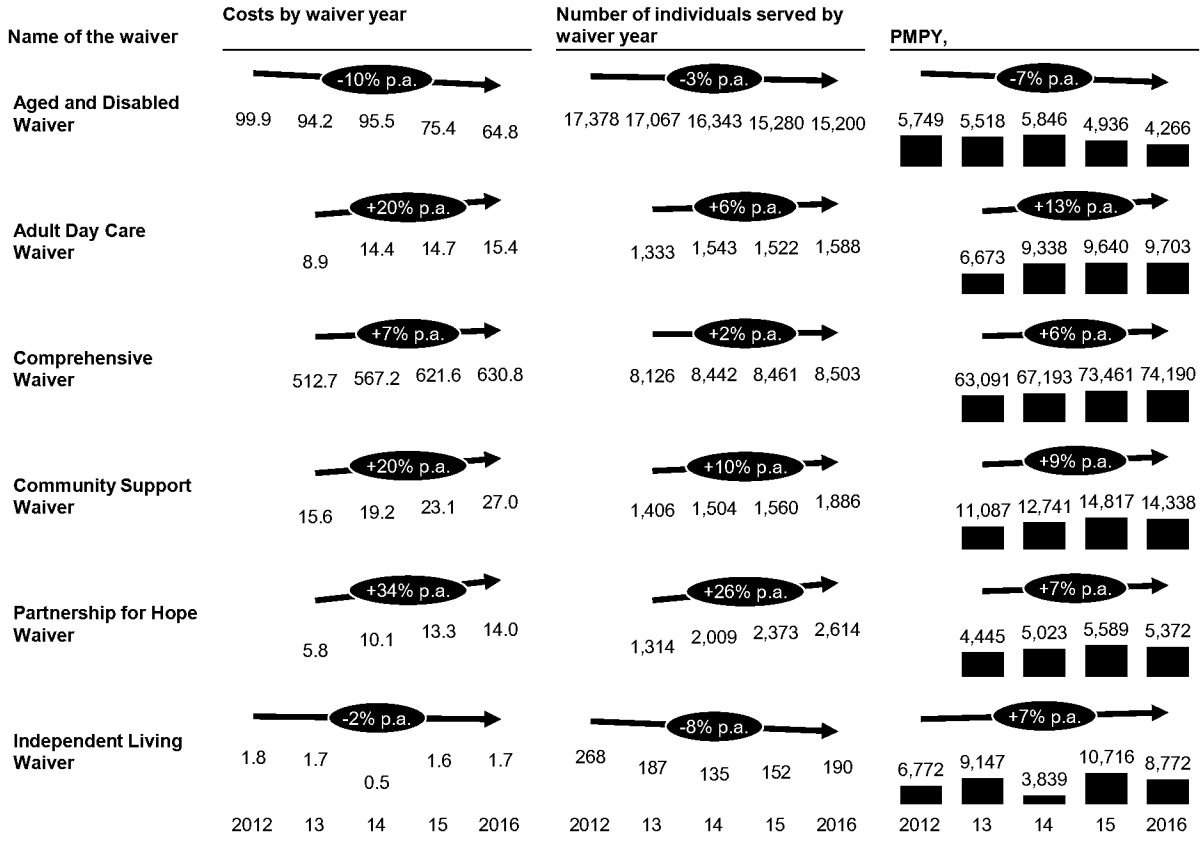
[122] DHSS waivers with < than 400 individuals served (number served in WY16): AIDS Waiver (90), Medically Fragile Adult Waiver (166). DMH waivers with <400 individuals served (number served in WY15): MO Children with Developmental Disabilities Waiver (320).

[123] Interviews with Medicaid program staff members.

covers residential services (e.g., group home, shared living, individualized supported living; see Exhibit 28), but it also covers a range of other services, including personal care.

- **Community Support Waiver (DMH, served 1,886 individuals in WY15):** For individuals with intellectual and/or developmental disabilities who already have a place to live in the community. Given that requirement, residential services are not covered by this waiver, but it otherwise covers the same range of services as the Comprehensive Waiver. It has an annual per capita cost cap of $28,000.
- **Partnership for Hope Waiver (DMH, served 2,614 individuals in WY15):** For individuals with intellectual and/or developmental disabilities who reside in one of 104 Missouri counties plus St. Louis City. It covers the same set of services as the Community Support Waiver – in addition to others, such as dental services – and it has an annual per capita cost cap of $12,362.

EXHIBIT 27: COST PATTERNS FOR THE LARGEST LTSS WAIVERS[124]



[124] Missouri DHSS, "HCBS Waivers DHSS," 2018; Missouri DMH, "HCBS Waivers DHS," 2018.

EXHIBIT 28: SERVICES COVERED ACROSS LTSS WAIVERS[125]

Operated by DHSS ■ Operated by DMH

Waiver	Service category: Adult day care/day hab	Career and financing	Community services	Counseling and therapy	Residential services	Personal care	Private duty nursing	Respite	Supplies and technology	Targeted case management	Other[1]
Aged and Disabled		✕	✕	✕	✕		✕		✕	✕	
Independent Living	✕		✕	✕	✕		✕	✕			✕
Adult Day Care		✕	✕	✕	✕	✕	✕	✕	✕	✕	✕
Medically Fragile Adult	✕	✕	✕	✕	✕			✕		✕	✕
AIDS	✕	✕	✕	✕	✕			✕		✕	✕
Comprehensive waiver							✕			✕	
Community Support					✕		✕			✕	
MOCDD		✕			✕		✕			✕	
Partnership for Hope					✕		✕			✕	

While Missouri Medicaid covers a range of HCBS, the plurality of spending is for personal care, covered by both the State Plan and every waiver except for the Adult Day Care Waiver.

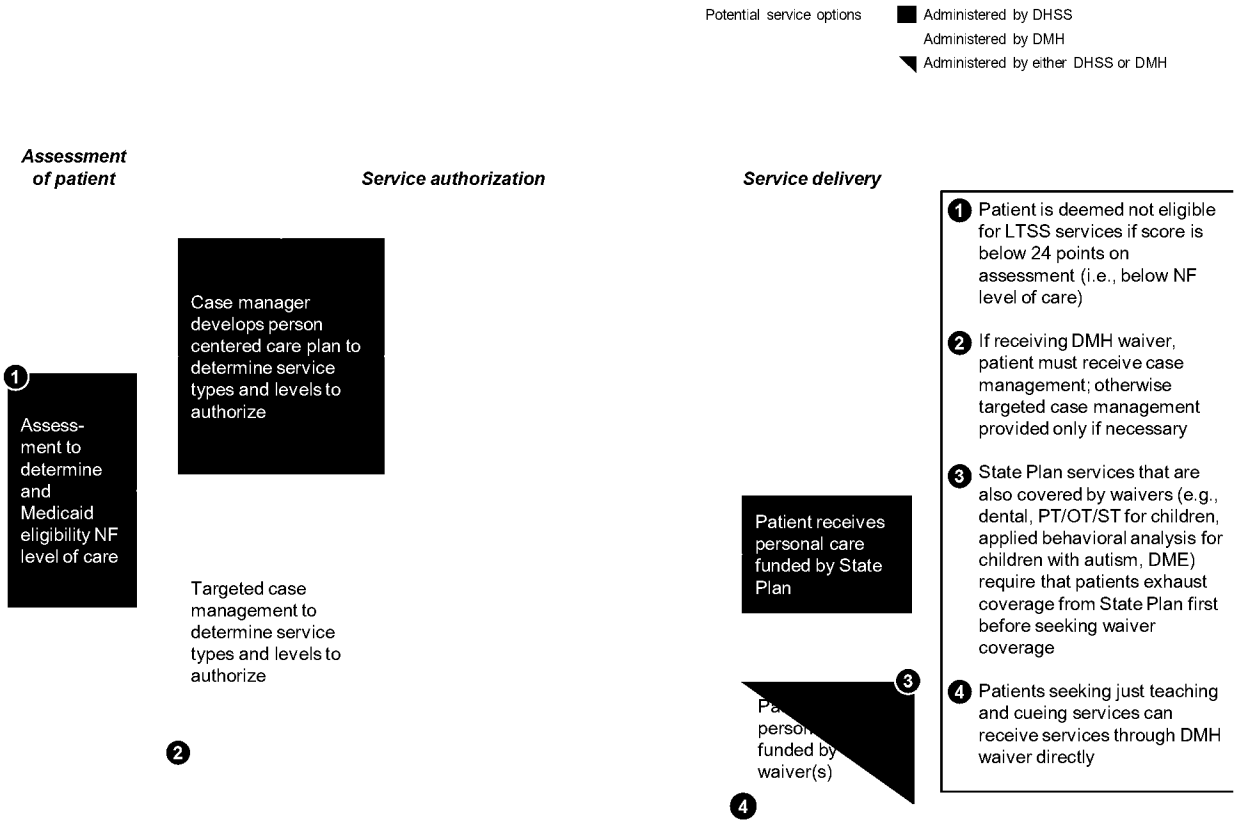
Potential opportunities for improvement

This section identifies potential opportunities to improve Missouri's current approach to LTSS. The opportunities are not intended to be mutually exclusive: cost savings opportunities identified in individual opportunities may overlap with those identified in others. When compared to experiences and practices in other states, the following observations can be made:

- **The patient journey to get access to LTSS can be complex.** Three state agencies (DSS, DHSS, and DMH) play a role in the process of determining eligibility for LTSS and planning care for LTSS recipients. As a result, while Missouri has adopted the principle of "no wrong door" for eligibility and access to LTSS, the participant journey (see Exhibit 29) can be complex and can vary widely depending on the participant's condition and entry point into the system.

[125] Missouri DMH and DHSS: see note 124.

EXHIBIT 29: LTSS PATIENT-CENTERED PROCESS FLOW[126]



- **The DHSS assessment process to determine need for institutional level of care uses decades-old standards and, as such, may not consistently determine institutional level of care needs.** DHSS is currently considering changes to the algorithm it has used to determine nursing facility level of care. Although the state has changed the threshold scores for determining LTSS eligibility, the algorithm has not meaningfully changed since 1982.[127]
- **Assessment results are not consistently used to inform setting of care, type, or intensity of services authorized.** The care planning process currently does not consistently use the results of the level of care assessment to inform the plan of care. As a result, the setting of care, services, and service levels participants are authorized to receive may not be consistent across programs or care planners, and the care provided may not match participants' needs.
- **Personal care services are administered inconsistently depending on the channel through which they are received.** For example, utilization of consumer-directed

126 Interviews with Medicaid program staff members.

127 Missouri DSS, "Rules of Department of Health and Senior Services, Division 30-Division of Regulation and Licensure, Chapter 81-Certification," 2018, see: www.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-81.pdf.

personal care services is almost two times higher than the agency-directed model.[128] Currently, so long as a given participant is eligible to receive consumer-directed care, she may elect to choose it (e.g., participants are not allocated to one or the other). The difference in utilization does not appear to be correlated with participant mix or participant risk. In addition, average reimbursement rates vary depending on whether they are provided through DMH or through DHSS; while these rates have converged in recent years, there remain differences in rates, primarily due to funds available for each department's waivers.[129]

- **Nursing facility rates are based on historical costs, and they do not reimburse based on patient acuity or create incentives for quality or outcomes**. While there are yearly adjustments to the per diem rates, the rates are based on cost reports from SFY2001 (trended to SFY2005).[130] Although these per diems are intended to cover nursing facilities' costs, the reimbursement methodology does not necessarily reflect their current costs. Additionally, there is little correlation between nursing facility per diem rates and either patient acuity or facility quality (see Exhibit 30: darker bubbles represent facilities that experience higher patient acuity on average, while bubbles on the right represent facilities with higher Star ratings).[131] Currently, per diem rates vary from $135.08 to $175.41 by facility, meaning the facility with the highest per diem rate receives approximately 30% more than the facility with the lowest per diem rate.[132] Finally, per diem rates do not incentivize facilities to discharge residents or attempt to avoid admissions where feasible.

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[128] Analysis of Missouri Medicaid claims data, SFY2016-18.

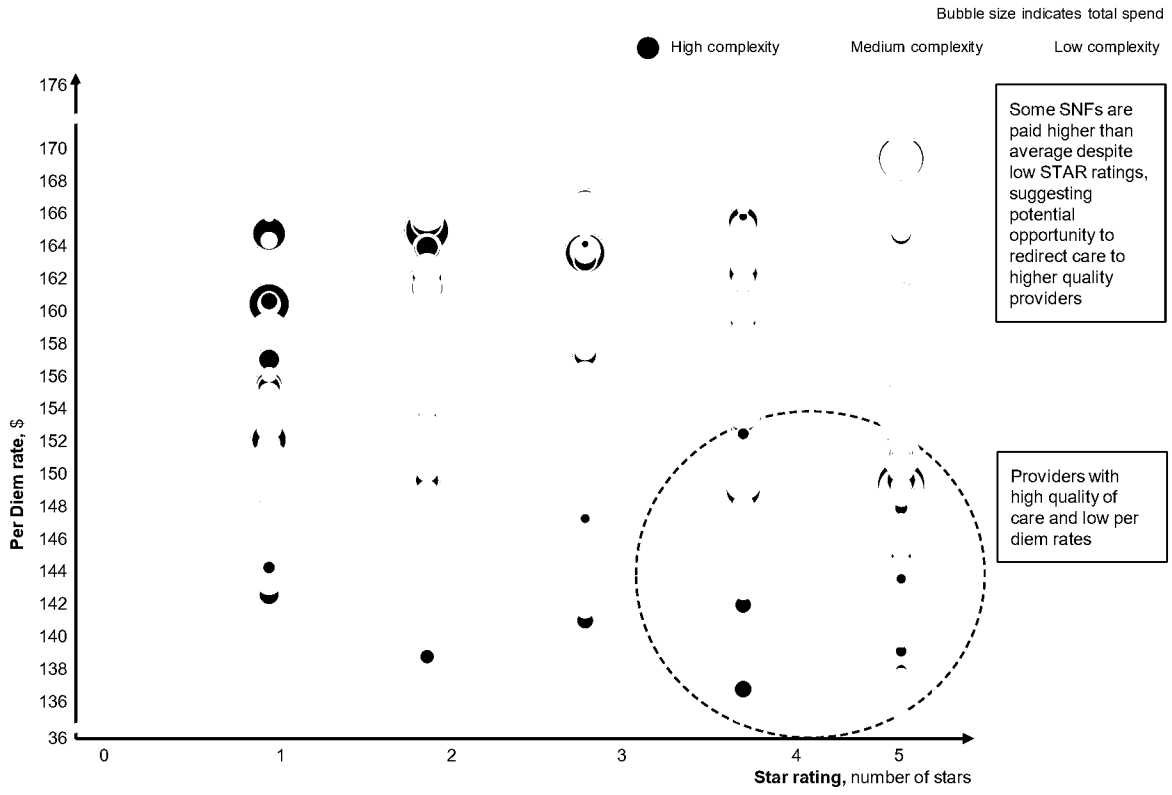
[129] Missouri DSS, "Adult Day Care Waiver," 2018; Missouri DSS, "Aged and Disabled Waiver," 2018; Missouri DSS, "Aids Waiver," 2018; Missouri DSS, "Community Support Waiver," 2018; Missouri DSS, "Comprehensive Waiver," 2018; Missouri DSS, "Independent Living Waiver," 2018; Missouri DSS, "Medically Fragile Adult Waiver," 2018; Missouri DSS, "MOCDD Waiver," 2018; Missouri DSS, "Partnership for Hope Waiver," 2018; Missouri DSS, "Private Duty Nursing," 2018; Missouri DSS, "State Plan Personal Care," 2018; Missouri DSS, "Targeted Case Management," 2018; interviews with Medicaid program staff members.

[130] Missouri DSS, "Rules of Department of Social Services, Division 70-MO HealthNet Division, Chapter 10-Nursing Home Program," 2018, see: www.sos.mo.gov/CMSImages/AdRules/csr/current/13csr/13c70-10.pdf.

[131] Analysis of Missouri Medicaid claims data and MDS data, 2016-18.

[132] Missouri DSS, "Nursing Facility Rate List," 2018 (updated 7/1/2018), see: dss.mo.gov/mhd/providers/pages/nfrates.htm.

EXHIBIT 30: SKILLED NURSING FACILITIES BY PER DIEM, STAR RATING, SFY2018[133]



- **Nursing homes have a relatively high number of low-acuity Medicaid residents.** In Missouri, 23.7% of nursing home residents have low care needs (e.g., could potentially be adequately served through HCBS services) compared to the national median of 11.2%.[134] Diverting participants with low care needs to HCBS to reach the level of median state performance could yield a reduction of spending of up to $90 million.[135]
- **Occupancy rates in nursing facilities are relatively low.** With an average nursing facility occupancy rate of 72%, Missouri ranks 43rd amongst other states, with the top 12 at occupancy rates of 88% or higher.[136] With further reductions likely, the inefficiencies inherent to low occupancy rates will increase, and some nursing homes may not be able to maintain their current business model.
- **Additional waivers or grants could provide key services to certain subpopulations.** For example, the Money Follows the Person (MFP) program is set to expire. Extending it or substituting it with a waiver may help ensure that individuals transferring from nursing

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[133] Acuity measured as average score on 10 MDS functional status questions (e.g., Section G0110) on most recent 25 days of information retained by the state. Providers with fewer than 15 data points excluded. High complexity refers to SNFs with average ADL score of 4+; low with an average score of 2 or less; analysis of Missouri Medicaid claims data and MDS data, 2016-18.

[134] AARP, Commonwealth Fund, SCAN Foundation: see note 107.

[135] IBM Watson Health: see note 106.

[136] KFF, "Certified Nursing Facility Occupancy Rate," 2016, see: www.kff.org/other/state-indicator/nursing-facility-occupancy-rates.

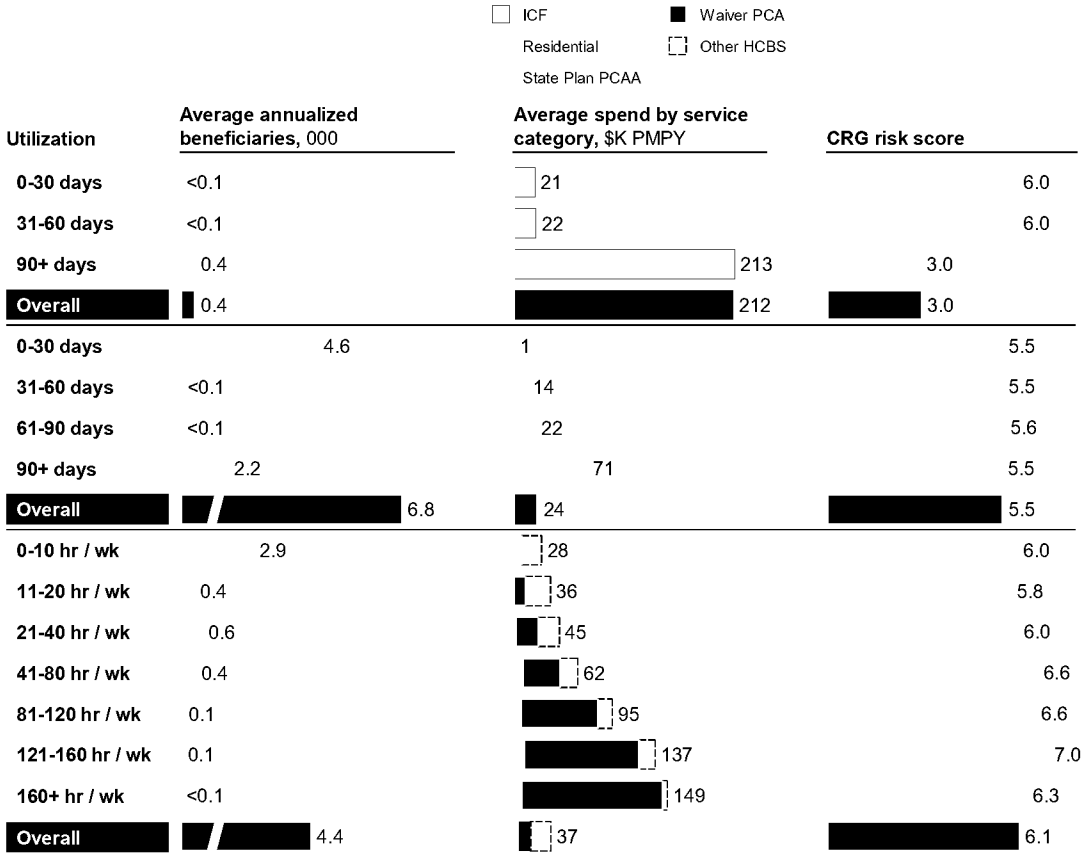
facilities or habilitation centers have access to the resources they need to facilitate their transitions. By shifting more people from institutional settings back to the community, this change could result in savings of $12.5 million to $14 million.[137] Additionally, the state could consider following through on discussions to implement a waiver that covers children with developmental disabilities who do not require habilitative services, which would cover the cost of care for children who do not qualify for Medicaid because of their parents' income. Currently, children need to be hospitalized for a certain period before they can be considered eligible for Medicaid regardless of parental income; this may result in children being hospitalized even if it does not suit the level of care they require.

- **There may be additional opportunity to provide care for participants in less intensive and restrictive settings even across the continuum of HCBS services.** Though a substantial amount of rebalancing from institutional to residential and other HCBS (waiver and State Plan) services has taken place, there may be opportunity to transition members receiving residential services in congregate care settings away from their homes to less intensive and restrictive settings within the continuum of HCBS services. See Exhibit 31 for a breakdown of LTSS spending based on utilization levels of different services.[138]

[137] Interviews with Medicaid program staff members and analysis of state data, 2018.

[138] Analysis of Missouri Medicaid claims data, SFY2016-18.

EXHIBIT 31: LTSS UTILIZATION FOR LTSS ADMINISTERED BY DMH, SFY2018[139]



- **There are limited incentives connecting reimbursement of HCBS providers and outcomes of care**. Reimbursement of HCBS providers is not tied to their success in keeping their clients out of nursing homes (or other forms of residential care). Likewise, as payment is based on units of care delivered, there is no economic incentive to stimulate participants' independence from care. Payments to provider groups that aim to relocate participants from nursing homes or residential care facilities to their homes could be tied to their success rate, for example. Sharing in the savings could also help these providers to focus even more on the social determinants that often stand in the way of successful transition.
- **There is little to no transparency of outcomes of care in LTSS.** While available data on the performance of LTSS in Missouri show mixed results, there is little or no publicly accessible information about the outcomes of care delivered per (sub)population or condition and per provider (or group thereof). This limits consumer choice, provider accountability, and the information necessary for provider self-improvement.

[139] Only considers population receiving services from administered by DMH; analysis of Missouri Medicaid claims data, SFY2016-18; residential services include individual supported living, group home, and shared living services; CRG stands for Clinical Risk Group.

Potential initiatives

Based on a review of Missouri's current approach, interviews with functional leaders and subject matter experts within the relevant departments, and analysis of other states' activities, this section discusses potential initiatives Missouri could consider to improve the value of LTSS in the state, which include reducing costs and, through increasing the number of participants that would be able to remain in their own homes and/or in the community, possibly improving participant experience, quality, and outcomes. In total, the gross financial impact of LTSS initiatives ranges from $90 million to $275 million, depending on choices made by the state.

1. **Include an acuity adjustment in the nursing home reimbursement methodology.** Missouri could consider adding an acuity adjustment to the current per diem methodology. By using an acuity adjustment such as a resource utilization group (RUG)-based grouper, Missouri could categorize patients based on need and reimburse nursing facilities accordingly, using a stratified set of per diem rates. This shift would enable allocation of resources based on need. Additionally, it may encourage further rebalancing from institutional care to HCBS.
2. **Rationalize rates for similar HCBS services provided through different programs and funding authorities.** For services provided through multiple waivers or through a combination of State Plan and one or more waivers (e.g., personal care services), Missouri could consider standardizing rates independent of the funding source for the service. Without standardization, providers may be reimbursed different amounts for care provided to patients with similar needs and acuity levels, which may encourage them to participate selectively in certain programs while not participating in others. This may result in access issues in certain programs and/or geographic areas, eroding patient experience and outcomes. DHSS has engaged an external vendor to conduct a rate study to determine the validity of the reimbursement rates for services covered in their waivers, which may reveal further opportunities to rationalize rates.
3. **Complete and expand upon revisions currently underway to assessment algorithm and process**. The state recently announced changes to DHSS' algorithm to assign points using the interRAI HC assessment instrument, which represent the first major changes since 1982. These revisions could improve the accuracy of the level of care assessment process. The state could also consider further streamlining and strengthening the assessment process across populations, programs, and departments (e.g., improving capture of personal care data with review on a per-reviewer and per-physician basis, especially in the consumer-directed program).
4. **More directly employ assessment results in care planning process.** In addition to improving the assessment process as is currently planned, Missouri could consider incorporating additional functionality into the assessment instrument. First, it could be used to determine eligibility for services. Second, it could more closely tie results of assessment to the care planning process. For example, DHSS has previously considered using a case rate-based system, using a RUG-based grouper mechanism layered on top of the current interRAI HC assessment. This could include more consistently using assessment results as a standardized basis for setting of care determinations and the types and intensity of services to be provided. Third, the assessment instrument could be used to determine payment levels for care. Fourth, the assessment results could serve as an auditing mechanism: care planners and/or providers could be flagged if they are providing a level of care that is inconsistent with the results of the assessment.

5. **Improve the consistency of the approval process for personal care services**. The state could better capture personal care (PCA) PA data digitally and review it on a per reviewer and physician level to ensure consistency in implementing assessment tools and appeals processes. This would be especially important in the consumer-directed program, as different PA approvers may be inconsistent in the type and degree of services they authorize for different individuals with similar care needs.

6. **Extend Money Follows the Person (MFP) through a new grant or waiver.** On average, MFP in Missouri has helped 206 individuals each year to transition back to their communities.[140] The quality of life of individuals living at home may be much higher than it may be for those living in an institution; in addition, the cost of a year of nursing home care is $45,000, versus ~$8,300 for home-based care. According to experts interviewed, if the state includes a rent subsidy for those in the MFP program, it could double the number of transitions per year, to approximately 400 per year.

7. **Implement additional waivers (e.g., waiver for children with developmental disabilities who do not require habilitative services) or expand current waivers.** Implementing such a waiver would allow children who are ineligible for Medicaid because of their parents' income to receive Medicaid services without hospitalization. This would not only allow children to receive care from the comfort of their homes, if they do not require more intensive care, but would also potentially reduce the cost of care.

8. **Missouri could consider introducing Alternative Payment Models (APMs) for LTSS services.** The main value opportunity for LTSS services is moving care from a nursing home or residential services to care in the participant's home where possible. The costs of this care are generally less than half the cost of intuitional care and living at home tends to be highly preferable.[141] Improving care planning and management for this population can also be a significant source of value. An Accountable Care Organization model, specifically designed for LTSS, may be one option to incentivize providers to create this value. Yet for those providers most likely to do so – home care providers – taking on the financial responsibility for nursing home costs is a large risk and is likely not feasible for many smaller providers. Alternatively, such providers could be incentivized by tying a part of their reimbursement to the key outcomes that matter to participants, such as the extent to which they can be successful in delaying or avoiding nursing home admissions, improving self-determination, encouraging independence at home, etc.

9. **Create transparency of the outcomes of care.** Providing transparency of outcomes for (sub)populations is a prerequisite of any healthcare system oriented towards value. Juxtaposing these outcomes to the risk-adjusted costs of care shines light on the performance of the healthcare delivery system and provides the information providers, payors, participants, and policymakers require to make informed choices and focused improvement efforts. As the collection point of all Medicaid claims and assessment data, the state could publish such information on the total costs and outcomes of care per county per provider, or per group of providers.

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[140] Missouri DSS, "Money follows the person," 2018.

[141] Missouri DSS: see note 140.

PHARMACY

In SFY2018, Missouri Medicaid spent ~$1.5 billion on pharmaceutical products.[142] Missouri is one of four states that carves pharmacy out of its managed care arrangements.[143] This carve-out gives the state complete responsibility for paying for and managing the utilization of drugs for all participants. To ensure appropriate utilization and control spending, the state has established a preferred drug list (PDL), which requires prior authorizations, step therapy, and quantity limits for select drugs. Through its process of "grandfathering" treatment, Missouri does not require participants that are established on a non-preferred drug to switch to a preferred drug. In addition to the PDL, Missouri receives statutory and supplemental rebates from pharmaceutical manufacturers as means of cost containment. The state uses a vendor to help it maintain its PDL and to assist in supplemental rebate negotiations.

The state pays for retail drugs in two ways: an ingredient cost and a dispensing fee. In terms of reimbursement for the ingredient cost, Missouri, like other state Medicaid agencies, has converted to an average actual cost methodology. The state is in the process of revising its dispensing fee.

Potential initiatives for Pharmacy include the elimination of grandfathering of drug selection, implementing additional utilization management, joining a purchasing consortium to increase supplemental rebate capture, requiring NDC submission on claims for non-J-code HCPCS drugs, establishing a preferred specialty pharmacy, and applying for a value-based contracting waiver from CMS. When combined, the potential impact of Pharmacy initiatives could range from $35 million to $60 million, net of ongoing operational costs.[144] This savings opportunity is variable and dependent on decisions that are made with respect to initiatives discussed in the managed care and acute care services sections (e.g., including pharmacy as an MCO-covered benefit).

Current situation

This section gives an overview of Missouri's current pharmacy in terms of spending and structure, reimbursement methodology, utilization management (UM) practices, clinical guidelines and (for pharmacy) rebate capture.

Program spending and structure

In SFY2018, 25 drugs accounted for ~25% of Missouri's $1.5 billion pharmacy spending, while 4141 drugs accounted for the other 75%. Total pharmacy costs have grown 5% over the last three years. Treatment for attention-deficit/hyperactivity disorder (ADHD), hepatitis C, behavioral health conditions, hemophilia, rheumatologic conditions, diabetes, asthma, growth deficiency syndromes, and pain are the main drivers of pharmacy spending and growth (see Exhibit 32).[145]

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[142] Analysis of Missouri Medicaid claims data, SFY2016-18; only includes pharmaceutical products billed as separate pharmacy claims.

[143] KFF, "States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019," 2018, see: www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-pharmacy-and-opioid-strategies.

[144] Analysis of Missouri Medicaid claims data, SFY2016-18; interviews with Medicaid program staff members.

[145] Analysis of Missouri Medicaid claims data, SFY2016-18.

EXHIBIT 32. 25 DRUGS ACCOUNT FOR ~25% OF PHARMACY SPENDING, SFY2018[146]

Drugs	SFY2018 Spend,	SFY2017 to SFY2018 spend trend	SFY2017 to SFY2018 utilization trend
LATUDA	36.0	3%	
MAVYRET	28.9	New to the market in SFY2018	
INVEGA SUSTENNA	28.8	22%	65%
HUMIRA PEN	20.7	16%	5%
METHYLPHENIDATE ER	20.6	13%	
VYVANSE	20.6		
PROAIR HFA	18.9	6%	
LYRICA	18.4	9%	
ADVAIR DISKUS	16.6		
LANTUS SOLOSTAR	16.5		
NORDITROPIN FLEXPRO	15.9	18%	14%
SYMBICORT	15.0	6%	
SPIRIVA	12.8		
ADDERALL XR	12.6		
ARIPIPRAZOLE	12.2		
FLOVENT HFA	11.9	16%	16%
NOVOLOG FLEXPEN	11.7	12%	
SYNAGIS	10.8		
OXYCONTIN	10.4		
KOGENATE FS	10.1	110%	52%
METFORMIN HCL ER	9.7	55%	
PALIPERIDONE ER	9.1	13%	3%
ONFI	8.8	17%	13%
SUBOXONE	8.5	39%	37%
GENVOYA	8.5	31%	26%

Missouri carves pharmacy benefits out of its managed care program. Missouri's SFY2018 spending of $1.5 billion was paid on a fee-for-service basis. All pharmacy program operations, including utilization management, are the responsibility of MHD. Missouri also utilizes a preferred drug list vendor. This vendor assists the state with supplemental rebate negotiation and updating/reviewing the state's PDL. Finally, the state has an open pharmacy network, including an open specialty network. An open network allows participants to use any pharmacy of their choice.

Reimbursement

Missouri uses a recently modified hierarchy method to determine reimbursement for drug ingredient costs. Missouri reimburses covered drugs by applying a hierarchy method that starts with National Average Drug Acquisition Cost (NADAC), followed by Missouri Maximum Allowed Cost (MAC), and Wholesale Acquisition Cost (WAC). Missouri uses the usual and customary (U&C) charge submitted by the provider if it is lower than the chosen price. Reimbursement for covered drugs for 340B providers who carve-in for Medicaid was modified by applying the following method: WAC-25% or the U&C charge submitted by the provider if it is lower.[147]

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[146] Analysis of Missouri Medicaid claims data, SFY2016-18.

[147] Missouri DSS, "State of Missouri Pharmacy Manual," 2019, see: manuals.momed.com/collections/collection_pha/print.pdf.

Missouri also has structured fees for reimbursement rates for pharmacy dispensing fees. The state currently pays $9.55 in base dispensing fee to all pharmacy providers, and $4.82 in enhanced dispensing fee to in-state pharmacy providers. In addition, $5.00 in preferred generic product incentive fee is paid for each multi-source product to in-state pharmacy providers. In addition to the retail fees, an additional $0.50 in long-term care dispensing fee is paid per claim under specific circumstances. Outpatient physician-administered drugs are reimbursed as a percentage of billed charges for hospital providers. These fees are under active review with CMS.[148]

Utilization management practices and clinical guidelines

Utilization management protocols are in place for a range of drug classes but lacking in some. Prior authorization (PA), step therapy, and quantity limits are used across the PDL. However, these UM techniques are lacking in certain drug classes (e.g., hemophilia, oncology). Newly approved drugs are automatically placed on the PA list for the first six months after launch. Additionally, Missouri uses an automated PA system for first-level clinical reviews. The system can match participant diagnosis codes to approval criteria to generate automated approvals/denials.

Rebate capture

The state collects both federal and supplemental rebates. Missouri's SFY2018 federal and supplement rebate capture rates were 52.4% and 3.0% of total pharmacy spending, respectively.[149] All claims for physician administered drugs with "J" prefixed HCPCS codes are required to be submitted with an NDC so that rebates can be captured.

The state's PDL vendor negotiates supplemental rebates on its behalf. The state collects supplemental rebates in various therapeutic categories such as: growth hormones, anti-virals to treat hepatitis C, ADHD therapies, and drugs used to treat rheumatologic conditions.

The process for rebate invoicing to manufacturers is highly manual. This process involves using different computer systems to compare claims and invoices. Additionally, it takes the effort of multiple FTEs to convert data from one system to another, do quality checks, send invoices to manufacturers, and review any appeals that come back from the manufacturers.

In Missouri, providers may choose to either carve-in to or carve-out of 340B. The state follows the guidelines set forth by the Health Resources and Services Administration (HSRA). All covered entity providers are identified as such by the state and rebates are not collected on these drugs.

Potential opportunities for improvement

This section identifies potential opportunities to improve Missouri's pharmacy program. When compared to the practices of other states, the following observations can be made:

- **Missouri's expansive grandfathering practice limits the state's ability to shift utilization to the lowest net cost drug.** While some states allow grandfathering for specific drug classes, most require participants to follow changes to the PDL.
- **For certain high-cost drug classes (such as oncology, hemophilia, and IVIG), there are no medical necessity policies.** MCOs and some state Medicaid agencies have

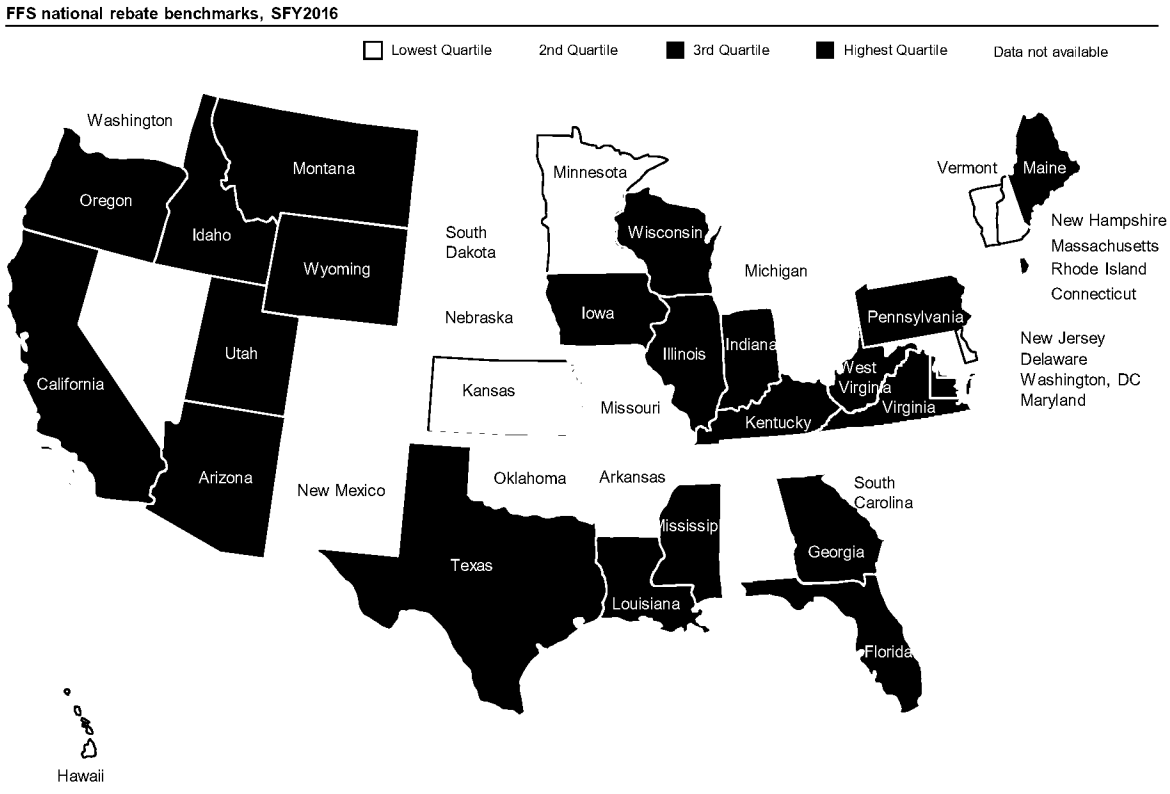
[148] Missouri DSS, "Missouri MoHealthNet Provider Bulletin Volume 39 Number 52," 2017, see: dss.mo.gov/mhd/providers/pdf/bulletin39-52_2017april14.pdf.

[149] Analysis of Missouri Medicaid claims data, SFY2016-18.

medical policies and often use utilization management levers such as PA, step therapy, and quantity limits to ensure appropriate utilization in these high-cost drug classes.[150]

- **Missouri's rebate capture rates are below the national average.** While federal rebate capture has improved from 43.4% to 52.4% between SFY2016 and SFY2018, Missouri is still below the weighted national average of 55.5% (see Exhibit 33) and further below the highest-performing quartile. Additionally, the state's SFY2018 supplemental rebate capture rate of 3.0% also falls below the weighted national average of 3.8%.[151] These deviations from the mean may be in part due to grandfathering practices or PDL design.

EXHIBIT 33: STATE-BY-STATE, FEDERAL REBATE CAPTURE IN SFY2016[152]



- **Missouri does not currently participate in any value-based contracts with pharmaceutical manufactures.** Value-based contracting is becoming more popular with commercial and MCO players. Recently, CMS approved waivers for Oklahoma and Michigan to negotiate value-based contracts with pharmacy manufacturers.

150 Missouri DSS: see note 147.

151 Medicaid.gov, "Expenditure Reports from MBES/CBES," see: www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html; analysis of state data, 2018.

152 Medicaid.gov: see note 151.

Potential initiatives

Based on review of Missouri's current approach, interviews with functional leaders and subject matter experts, and analysis of other states' activities, this section has identified six potential initiatives Missouri could consider for improvements to its pharmacy program. These initiatives build on the existing progress made by the state and could result in a reduction of total Medicaid expenditures from $35 million to $60 million, depending on state choices.

1. **Implement medical necessity guidelines and prior authorizations in drug classes that do not have such policies.** The state could implement new medical necessity policies for oncology, hemophilia, IVIG, and other select high-cost physician-administered therapies. This could not only bring Missouri in line with other states and MCOs but could also require that participants are receiving care based on accepted clinical guidelines in the proper clinical sequence. A vendor could be utilized to handle this process, or the process could be done in-house.
2. **Reduce grandfathering.** Missouri could consider only targeted use of grandfathering for specific drug classes (e.g., antipsychotics) based on an review of clinical need. Operationally, some requirements would include proper notification to participants and providers to ensure that all stakeholders are aware of pending changes and to avoid any impact on access.
3. **Join a purchasing consortium to increase supplemental rebate capture.** There are three supplemental rebate consortiums that state Medicaid programs utilize today: the National Medicaid Pooling Initiative (NMPI), the Optimal PDL Solution (TOPS) and the Sovereign States Drug Consortium (SSDC). Missouri would need to consider how these consortia fit with their current approach and PDL vendor. Additionally, the state would need to submit a State Plan Amendment to CMS.
4. **Require NDC submission on claims for non-J-code HCPCS drugs.** This initiative could ensure that rebates are captured on all physician administered drugs. Operationally, some requirements would include provider notification and modest MMIS system edits.
5. **Consider whether to contract with a specialty pharmacy.** The state could establish a preferred specialty pharmacy which may provide lower prices for certain specialty drugs, and potentially better care management and improved clinical outcomes for participants. Before doing this, the state would need to determine whether such an approach would be consistent with any willing provider regulations. Additionally, the state would likely have to go through the required procurement process.
6. **Apply for a value-based contracting waiver from CMS.** The state could apply for a value-based contracting waiver from CMS, which would allow the state to negotiate drug prices with manufacturers based on clinical outcomes. CMS approval of a State Plan Amendment would be required, as would negotiation with manufacturers to determine the optimal drug(s), outcome(s), and pricing.

MANAGED CARE

In 2017, Missouri's managed care program for children and families was expanded statewide under three capitated managed care organizations (MCOs).[153] The state has taken several steps to improve the performance of the managed care program and ensure its value, and the current managed care contracts attempt to create an environment that fosters innovation through incentive programs and specialized care coordination programs. Nevertheless, both the managed care contracts and rates can be improved to further increase efficiency, eliminate ambiguity in contract language, and lay the foundation for improved MCO performance and state-of-the-art performance management. Finally, the state could consider increasing the scope of managed care and carving in pharmacy and behavioral health services for the current managed care populations. The state could also consider introducing managed care for (parts of) the ABD population or continuing to improve management of those populations outside of the managed care program.

The total potential impact across these initiatives ranges from $175 million to $300 million, net of recurring investments.[154] While there are opportunities to improve the performance and efficiency of the current managed care program, the largest component of this potential impact could be achieved through the inclusion of additional services (e.g., behavioral health, pharmacy) and populations (e.g., ABD) in managed care. If managed care were expanded to the ABD population, MCOs could realize savings partially through implementing similar initiatives as described in the LTSS section above. As a result, there is natural overlap in the potential impact of these areas; if services for the ABD population – including LTSS – are fully carved into managed care, then the aforementioned total potential impact would overlap with the $90 million to $275 million from the LTSS section (and eliminating any incremental savings from it).

Current situation

Scope of managed care

The managed care program encompasses children, parents, and pregnant women, and it excludes most pharmacy and behavioral health services[155] (see Exhibit 34). Medicaid ABD populations are entirely excluded from the managed care program. Children in foster care or in subsidized, post-adoption or guardianship programs are included on an opt-out basis. Total managed care spending is ~$2.2 billion (see Exhibit 35; children, parents, and pregnant women comprise ~67% of Medicaid enrollees but drive only 23% of the spending, excluding FFS spending for that same population).[156]

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153 Analysis of state data, 2018; Missouri Foundation for Health, "Missouri Medicaid Basics," 2017, see: mffh.org/wordpress/wp-content/uploads/2017/03/MedicaidBasics2017.pdf.

154 Missouri DSS, "Annual Table 23 and 24 for FY18," 2018; Analysis of state data, 2018.

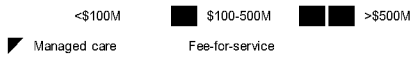
155 Missouri Foundation for Health: see note 153.

156 Missouri DSS: see note 5.

EXHIBIT 34: CURRENT BEHAVIORAL HEALTH COVERAGE

MO HealthNet Covered Benefits	Foster Children (Ages 0-20); Independent Former Foster Adolescents (Ages 21-25)	All other MC eligibility groups: Adults (21+), Pregnant Women, Children COA 1, CHIP Exp, CHIP Separate
Outpatient "clinic option" services	FFS	MC
Inpatient Behavioral Health Admissions	FFS	MC
Inpatient Admission with both Behavioral and Physical Diagnoses	MC	MC
Applied Behavior Analysis for Autism Spectrum Disorder	FFS	FFS (under 21)
Tobacco Cessation Counseling - psychologists, LPCs, LCSWs	FFS	FFS
CPR (Comprehensive Psychiatric Rehab - DMH)	FFS	FFS
CSTAR (Comprehensive Substance Treatment and Rehab - DMH)	FFS	FFS
TCM (Targeted Case Management - DMH)	FFS	FFS
Waivers	FFS	FFS

EXHIBIT 35: MHD ENROLLMENT, MANAGED CARE AND FEE-FOR-SERVICE SPENDING BY ELIGIBILITY GROUP AND CATEGORY OF SERVICE, SFY2018[157]



	Members Thousands	Expenditures, $ Millions: Medical	Rx	Behavioral Health	LTSS	Rehab & specialty	EPSDT	Other
Children	590	1556M / 162M	368M	146M	<1M	7M	62M	<1M
Foster children	34	71M / 46M	52M	131M	<1M	2M	28M	<1M
Custodial parents	94	401M / 72M	155M	26M	6M	2M	<1M	<1M
Pregnant women	22	131M / 42M	23M	5M	1M	1M	1M	<1M
Seniors	81	141M	46M	114M	1076M	106M	<1M	114M
Disabled	156	1183M	751M	1226M	866M	139M	32M	138M

[157] Missouri DSS: see note 154; "children" excludes eligibility groups associated with foster care; "foster children" includes foster care, child welfare; estimated share of Title XIX HDN population attributable to subsidized child

Managed care rate setting

Missouri's MCO rate-setting methodology encourages efficiency, adjusts payments based on risk, and manages non-benefit expenses. Efficiency adjustments have been implemented to avoid payments for some avoidable emergency department (ED) and inpatient (IP) services (e.g., low-acuity non-emergency adjustment for ED utilization that could have been diverted to other settings, potentially preventable hospital admissions adjustment for inpatient utilization). A risk-adjusted efficiency adjustment process is also used to address differences in claim levels among MCOs within a region after adjusting for the underlying risk profile of each MCO's population. Furthermore, a general ledger review of MCO administrative costs has been performed recently, and target MCO profit margins (i.e., underwriting gains) were adjusted to account for lower corporate taxes in Calendar Year 2018.

Contracting, compliance, and performance management

Current managed care contracts establish minimum standards for MCO performance and attempt to create an environment that fosters innovation. Contract provisions cover areas including care management, utilization management, provider payment, program integrity, provider network, grievances and appeals, among others. For care management, Missouri requires initial screening within 90 days of enrollment, with shorter timelines for pregnant women, children with elevated blood lead levels, and members with diseases. The current contracts contain provisions to stimulate innovation and value in the managed care program, through the Local Community Care Coordination Program (LCCCP) as well as member and provider incentive programs.

The performance management regime established through current contracts relies primarily on performance withholds, liquidated damages and sanctions. The performance withhold program is under revision based on negotiation between MHD and the MCOs, with an intention to use predominantly HEDIS measures going forward.[158] Liquidated damages for contract compliance infractions cover a broad set of potential operational issues, with penalties ranging from $100 per day for failure to submit a report to $10,000 per month for failure to adhere to claims processing standards.

The performance management relationship between MHD and MCOs centers on ensuring basic contract compliance and rectifying performance issues. MHD requires 24 distinct reports from MCOs in addition to submission of encounter data and other information. To date, MHD activities have focused on improving and validating the quality of the information submitted by MCOs.

Potential opportunities for improvement

- **The rate-setting methodology could be further strengthened.** While the current methodology employs several strong elements to ensure managed care rates account for all reasonable, appropriate, and attainable costs, opportunities remain to further enhance the rates. Additional efficiency adjustments are available for each of the major categories of expenditures to remove inefficient utilization (e.g., inpatient stays that could have been avoided with better outpatient care) from rate calculations.[159] Steps could also be taken to simplify the rate cell structure by combining small, high-cost rate cells to reduce potential

welfare programs, and independent foster children ages 18-26; "custodial parents" excludes independent foster children ages 18-26.

158 Interviews with Medicaid program staff members.

159 Interviews with Medicaid program staff members; analysis of state data, 2018.

volatility in capitation payments. Finally, as discussed in the acute care section, the state could consider capping MCO hospital payments at a fixed percentage of Medicaid FFS payments, while simultaneously adapting overall MCO capitation rates accordingly.

- **Day one MCO eligibility and/or passive MCO enrollment could be implemented for additional populations**. Except for foster children, new participants eligible for managed care will remain in fee-for-service for some time before either choosing or being automatically assigned to an MCO. States such as Ohio have adopted day one eligibility with passive enrollment for individuals eligible for Medicaid managed care, while still preserving a participant's ability to actively choose or switch MCOs for a period of time.[160] In such states, individuals may be enrolled in an MCO retroactively to the first day of the month in which Medicaid eligibility is determined. In such states, there is no fee-for-service period before MCO enrollment occurs. This can reduce the administrative burden and financial risk to the state and accelerate the process of availing participants to care management and coordination.

- **Operational contract provisions could be further strengthened to improve program performance, increase efficiency and improve member and provider experience.** Timeliness standards for key processes (e.g., provider payment, prior authorization, grievances and appeals) can be further specified. Program integrity requirements (including fraud, waste, and abuse) can be further elaborated to define overpayments to be investigated and clarify roles (e.g., between the state and MCOs) in preventing, detecting, recovering and retaining overpayments. The state may also have an opportunity to revisit provider network and network adequacy requirements, especially considering CMS' November 8, 2018 notice of proposed rulemaking on Medicaid and CHIP managed care.[161]

- **Care management requirements can be further elaborated and appropriately enforced.** The contracts do not clearly specify standards for risk stratification and identification of participants for care management, the proportion of participants the state expects to receive care management, case load standards for care managers, or care management activity requirements once participants are enrolled in care management programs. While the contracts allow MCOs to coordinate care management activities with providers including health homes, it does not set forth a clear expectation or requirement for them to do so. In addition, initial steps to increase healthcare value (e.g., member incentive programs, provider incentive programs and LCCCPs) have not seen broad uptake and MCO progress in implementing these programs and realizing their potential for impact has been uneven.[162]

- **For a subset of health home enrollees, the state pays both MCOs and health homes for care management services.** Approximately 6,500 MCO members are enrolled in a Primary Care Health Home (PCHH), and 5,500 members are enrolled in a Community Mental Health Center Healthcare Home (CMHC HH) or Certified Community Behavioral Health Clinic Health Home (CCBHC HH).[163] In addition to their regular payments from

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[160] Ohio Medical Assistance provider agreement for managed care plan. Ohio Department of Medicaid, 2018.

[161] CMS, "CMS Proposes Changes to Streamline and Strengthen Medicaid and CHIP Managed Care Regulations", 2018, see: www.cms.gov/newsroom/press-releases/cms-proposes-changes-streamline-and-strengthen-medicaid-and-chip-managed-care-regulations.

[162] Interviews with Medicaid program staff members.

[163] Interviews with Medicaid program staff members.

MCOs, Missouri health homes receive additional care management payments directly from the state. Some behavioral health services provided by health home providers are carved out of managed care, but the responsibility for care management and coordination with other services is attributed to both the MCO and the health home.

- **The state has not fully leveraged the available levers for incentivizing MCO performance or disincentivizing MCO underperformance.** Additional levers are available to the state to create positive incentives for MCO performance on, for instance, operational or quality metrics. At present, the auto-assignment algorithm used to assign participants to MCOs only takes into consideration the level of MCO enrollment in each region (subject to minimum and maximum enrollment levels for each MCO). Other states have incorporated operational or quality metrics (e.g., encounter data submission or provider payment operational measures; HEDIS quality measures) into the auto-assignment algorithm to reward better performing MCOs with additional participants.[164] Pooled rewards, bonuses, or public report cards could also be considered as additional performance management levers. Furthermore, while the MCO contracts specify a broad set of liquidated damages or sanctions for performance infractions, the state could revisit the structure and magnitude of these penalties to ensure their efficacy, and clearly communicate to MCOs which areas of performance will be most closely monitored. Exhibit 36 shows the incentive and disincentive levers currently used in Missouri against a broader set of levers observed in other states, highlighting several opportunities for new levers to encourage MCO compliance and performance.

[164] KFF, "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016," 2015, see: www.kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016.

EXHIBIT 36: MCO COMPLIANCE AND PERFORMANCE MANAGEMENT LEVERS[165]

✓ Observed in other states Used by MO

Lever	Contract dimensions: Member experience	Cost/ efficiency	Quality	Network	Pharmacy	Contract perform-ance	Data sub-mission	Program integrity	APM / innovation
Increase auto-enrollment priority		✓	✓	✓			✓	✓	✓
Use pooled rewards	✓		✓	✓		Build encounter data quality and timeliness into auto-enrollment algorithm	✓	Offer bonuses to drive APM and innovation	✓
Offer bonuses		✓	✓	✓			✓		✓
Report health grades	Report publicly on how MCOs are doing at participation in their member and provider incentive programs		✓	✓			✓		
Increase transparency			✓	✓		✓		✓	
Use withholds		✓	✓			✓	✓	✓	
Enforce fines/penalties	✓	✓	✓	✓	✓	✓	✓	✓	
Require corrective action plans		✓	✓	✓	✓	✓	✓	✓	
Decrease auto-enrollment priority			✓	✓		✓	✓	✓	
Freeze enrollment		✓	✓	✓	✓	✓	✓	✓	
Termination		✓	✓	✓	✓	✓	✓	✓	

- **Reporting requirements for MCOs can be improved, reducing administrative burden and improving the value of the information received.** Current required reporting includes seven financial data reports (e.g., unaudited and audited financial statements, copies of administrative services contracts and management agreements), and 17 operational data reports (e.g., contact center reports, provider network reports, care management logs).[166] The state does not appear to be fully processing the volume of detailed data contained in these reports and providing concise, aggregated analysis and feedback that can drive MCO performance improvement. In addition, in several cases, ambiguity or disagreement over the type of information required, granularity, or frequency at which it must be reported have made it difficult to yield reliable data and produce meaningful insights. These issues have led to challenges in establishing the preconditions for optimal performance dialogues between the state and MCOs.
- **The poor quality of the encounter data limits adequate performance management.** The state's MMIS system is not able to take in some encounters or encounter data variables. The quality of MCO encounter data submissions is variable, in part because encounters are being held back due to issues the MMIS system has in processing encounters. The result is that the state has neither a complete, accurate set of encounter data, nor a full understanding of which encounters are not being submitted. Consequently, the state does not appear to be performing certain analyses on spending or spending

[165] Based on review of approximately 15 publicly available managed care contracts across states from 2013-2018.
[166] Missouri DSS, "Managed Care Contracts," 2018, see: dss.mo.gov/business-processes/managed-care/.

trends, for example, or adequately comparing performance between plans, in ways that could be beneficial to the management of the Medicaid program, as a whole, and the managed care program specifically.

- **The performance dialogues between the state and the MCOs could be more focused on the value of the care delivered.** The amount of and reliance on detailed process measures and the poor quality of the encounter data lead to a lack of focus on key outcomes in the performance dialogues between the state and the MCOs. Recent interactions between the state and MCOs have focused on improving the timeliness and validity of information reported, rather than MCO performance on improving quality, outcomes, and experience for the population. Performance dialogues could be advanced to cover more substantive, outcome-, and improvement-oriented conversations. This could be consistent with and supportive of the implementation of value-based payment programs and reimbursement models that reward quality and outcomes as discussed elsewhere in this document (e.g., in the Acute Care Services and LTSS sections). The state also has an opportunity to codify the cadence and approach to performance dialogues with MCOs, establishing its agenda and priorities for these conversations rather than reacting to MCO priorities. Exhibit 37 provides a conceptual illustration of the evolution of the relationship between the state and its MCOs, highlighting potential priorities for more sophisticated levels of state/MCO collaboration.

EXHIBIT 37: EVOLUTION TOWARD MORE ADVANCED COLLABORATION WITH MCOS

	Shift to managed care *Transactional Sourcing*	Maturing managed care *Strategic Sourcing*	Advanced managed care *Supplier Collaboration*
Description	▪ RFPs scored on a set rubric and awarded to MCOs with most points ▪ Meets **mandatory requirements** ▪ **Ad-hoc improvement** initiatives ▪ **Compliance-based** performance conversations	▪ Greater focus on **quality, outcomes and member engagement** ▪ Improved integration of care across **behavioral and physical health** ▪ Comprehensive and **deliberate sourcing** strategy ▪ Fact-based, **holistic performance** conversations	▪ Openness to **joint innovation and collaboration** ▪ Partnership to **improve care coordination and integration** ▪ **Cost and investment transparency** to support shared prioritization ▪ Attention to **MCO capability development** ▪ Payment for **quality, value and outcomes**
Characteristics	▪ Focused on **monitoring contractual compliance** ▪ Dominated by **"firefighting" on unexpected issues** ▪ **Basic KPIs**/performance management processes	▪ **Structured sourcing** and contract negotiations ▪ **Effective program integrity**/ performance management ▪ Management of **complex categories** ▪ Established path to **program-wide payment innovation**	▪ **Performance-based partnerships** ▪ **Advanced analytics** to improve quality and efficiency ▪ **Active management** across MCO portfolio ▪ Partner to address **non-core Medicaid policy goals**

- **The scope of services covered under managed care for children, parents, and pregnant women is narrower than that in many other states.** For the managed care population, most prescription drugs and certain behavioral health services are carved out.[167] A significant majority of managed care states include pharmacy benefits in their managed care contracts (though different approaches exist to managing rebates, formularies, and preferred drug lists), and a growing number include a comprehensive set of behavioral health services. In light of the increasing emphasis on the need to integrate physical and behavioral health services (including substance use), many states have decided that a coordination barrier between physical and behavioral health may hamper the realization of optimal outcomes for patients. Carving in these services can create additional value (in efficiency, quality, and experience) through integrated care management across a more comprehensive continuum of services for covered participants. In addition, moving to value-based payment may also be facilitated by carving in these services as MCOs would otherwise have different incentives than VBP providers in making drug or behavioral health treatment choices.
- **The state could consider including (a portion of) the ABD population in managed care.** In Missouri, the Medicaid ABD populations remain in traditional (FFS) Medicaid. While the multiple improvements to efficiency, quality of care and outcomes discussed in the preceding sections (e.g., care management, rebalancing of the LTSS system, reimbursement based on quality and outcomes) could be achieved through multiple models, managed care represents one potential approach to support these efforts. A transition to managed care could be accomplished through a Medicaid managed care model that includes only the Medicaid benefits for dual or non-dual eligible ABD beneficiaries and/or through one of the several available models for integrating Medicare and Medicaid benefits. Recent guidance from CMS has signaled a renewed focus on programs that integrate Medicare and Medicaid benefits.[168] As shown in Exhibit 38, a majority of states now include at least part of this population in managed care.[169] This may be due to a belief that managed care models present opportunities to improve care management and thus improve quality, outcomes and experience for this population, while increasing the efficiency of the program by better managing medical cost trends over time. While the body of empirical evidence across states to support these claims remains nascent, several studies that have focused on specific subsegments of the ABD population (e.g., LTSS recipients or participants with high behavioral health needs) have shown evidence of the potential for well-designed and implemented managed care programs to improve program performance.[170]

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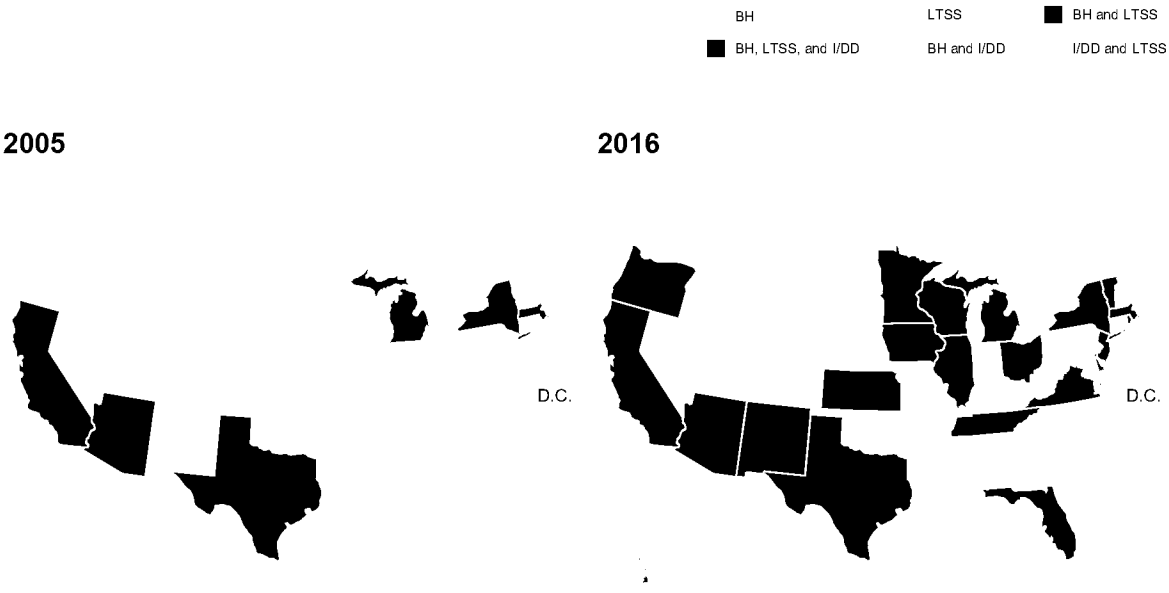
[167] Missouri DSS: see note 166.

[168] Medicaid.gov, "Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare," 2018, see: www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf.

[169] McKinsey, "Next-generation contracting: Managed Medicaid for individuals with special or supportive care needs," 2016, see: healthcare.mckinsey.com/next-generation-contracting-managed-medicaid-individuals-special-or-supportive-care-needs.

[170] McKinsey: see note 169; McKinsey, "Improving care delivery to individuals with special or supportive care needs," 2016, see: healthcare.mckinsey.com/improving-care-delivery-individuals-special-or-supportive-care-needs.

EXHIBIT 38: MANAGED CARE FOR SPECIAL OR SUPPORTIVE CARE NEEDS[171]



Potential initiatives

Based on a review of Missouri's current approach, interviews with functional leaders and subject matter experts within the relevant departments, and analysis of other states' activities, this section has identified 12 potential initiatives Missouri could consider to improve managed care in the state. The total potential impact across these initiatives ranges from $175 million to $300 million, which may include the savings from the LTSS section depending on whether the state fully carves in services for the ABD population

1. **Incorporate additional efficiency measures into the managed care rate-setting process.** Three efficiency adjustments have been put into place in the current managed care rate-setting methodology: 1) removing claims for potentially preventable inpatient admissions, 2) removing emergency department claims that could have been avoided, and 3) conducting an overall adjustment for risk-adjusted efficiency. These efficiency adjustments can be continued. In addition, there are several other efficiency adjustments available that have not yet been employed, covering spending areas such as short-stay admissions, readmissions and maternity care (e.g., inpatient stays that could have been avoided with better outpatient care). These additional adjustments would need to be examined for potential overlap with the adjustments current in place (e.g., risk-adjusted efficiency, a more broad-based adjustment, may already capture some of the value that could be captured through new adjustments), but they have the potential to create additional cost savings for the program.
2. **Implement stop-loss provision and combine small rate cells.** The current rate structure contains several small but high-cost, potentially volatile rate cells (e.g., a rate cell for participants in neonatal intensive care units). The state could consider implementing a stop-loss provision and combining smaller, more volatile rate cells with larger, more stable ones.

[171] McKinsey: see note 169.

This could increase the predictability of state outlays for managed care capitation payments and simplify administration of the rate structure.

3. **Expand day one managed care eligibility and passive enrollment to additional populations.** Day one MCO eligibility and passive enrollment could be expanded beyond foster children to additional populations. Passive enrollment, while still allowing participants to choose or switch MCOs as required by federal regulations, can streamline participant transitions, increase access to care management for participants by requiring it at the time of Medicaid enrollment, and reduce the burden on the FFS system.
4. **Further specify contract provisions regarding key operational processes and timelines.** Contract requirements laying out the process and required decision timelines for prior authorization, provider payment, and resolution of grievances and appeals could be clarified and strengthened. In addition, program integrity language can be further elaborated to set expectations and clarify roles between the state and MCOs for eliminating overpayments due to fraud, waste, and abuse. These improvements to the MCO contract could remove ambiguity and improve MCO performance and the state's ability to monitor and manage MCO performance against these requirements.
5. **Clarify and strengthen care management requirements.** The state could enhance care management requirements by adding specificity around risk stratification and participant identification, the proportion of participants to receive care management, case load standards for care managers, and/or care management activity requirements for MCOs. The state could consider further clarifying expectations for MCOs to collaborate and/or formally delegate care management requirements to health homes or other care management entities. This could ensure clarity of roles and prevent against payment by the state for duplicative care management efforts by multiple parties (e.g., MCOs and health homes).
6. **Clarify and strengthen incentive programs and programs intended to encourage adoption of value-based payment.** The state could engage in a focused effort to collaborate with and manage MCOs in designing and rolling out member incentives, provider incentives, and LCCCP programs. Depending on the choices the state makes in its approach to value-based payment, it could incentivize or require MCOs to align or integrate their efforts with the state's strategy and include definitions for Alternative Payment Models in MCO contracts and/or performance management.
7. **Deploy additional levers to incentivize MCO performance on key metrics.** In addition to the revisions to the withhold program currently underway, the state can consider additional levers such as MCO prioritization in the auto-assignment algorithm based on performance, pooled rewards, bonuses, or public report cards. Expanding the levers in use can enable the state to incentivize performance across a broader set of metrics covering operational performance, quality, and healthcare value (e.g., encounter data submission, member/provider incentive program participation, LCCP or VBP program participation, care management). If the state were to prioritize improving data submission, it would need to ensure that remaining obstacles in the state's encounter data intake process are resolved.
8. **Optimize financial penalties to better regulate MCO performance on key metrics.** The state could revisit the structure and magnitude of the sanctions and liquidated damages set forth in the contract to ensure their efficacy. The state could also more clearly communicate to MCOs which areas of performance will be most closely monitored in a given time period.
9. **Streamline MCO reporting requirements and improve accuracy and timeliness of information reported by MCOs; establish cadence for performance management**

dialogues. Accuracy and timeliness of information reported by MCOs could be improved to enable more informed, focused performance management discussions. This could include further streamlining of MCO reporting requirements, shifting from a focus on processes to outcomes based on collaboration between MHD and each of the MCOs. A cadence for performance management dialogues between the state and MCOs could be established along with clear priorities and expectations for the topics to be covered in each discussion.

10. **Carve in additional services to managed care for the current managed care population.** The scope of services covered under managed care for the current managed care population could be broadened to include pharmacy benefits and additional behavioral health services (e.g., those under DMH-administered programs). Including these services could enhance the MCOs' ability to manage the overall health and total cost of care for the managed care population as well as VBP programs, which could help improve quality, outcomes, and participant experience while increasing program efficiency.
11. **Transition to a single-MCO model with specialized capabilities for the foster care population.** The structure of the managed care program for children in foster care or in subsidized, post-adoption, or guardianship programs could be modified to place this population into a single MCO offering specialized capabilities, experience and expertise with this population, potentially procured through a more tailored procurement process. This could avoid the sometimes-fragmented nature of current services for this vulnerable population, ensure the application of focused expertise and experience within one MCO and optimally leverage its infrastructure to meet this population's needs. Relying on the expertise of one MCO may also improve the ability of the state to conform to the regulatory requirements associated with serving this population (e.g. the management of psychotropics).
12. **Expand the scope of the managed care program to include the ABD population (in whole, in part, or on a phase-in basis).** Expanding managed care to portions of the ABD population represents one potential approach to achieving the improvements to efficiency, quality of care, and outcomes discussed in the preceding sections, among alternatives such as improved state-led care management programs or meaningful adoption of alternative payment models. Expanding managed care to this population would likely require statutory change and could take many forms given the heterogeneity of the ABD population and the services required by its various subpopulations. In general, MCO capabilities in serving the ABD population – and state experience in operating managed care programs for this population – vary widely by subsegment of the population and associated services. Managed care programs covering the core medical, behavioral, LTSS, and pharmacy benefits of non-dual eligible ABD participants are becoming increasingly common, as are managed care programs focused on covering the LTSS services for dual-eligible beneficiaries. Meanwhile, managed care programs for persons with intellectual and/or developmental disabilities (whether residing in an institutional setting or on an HCBS waiver) remain relatively rare. Any potential consideration of managed care for the ABD population may take into consideration the diverse and nuanced characteristics and needs of the various subsegments of this population. Finally, through enrolling elderly and/or dually eligible participants with disabilities in Medicaid managed care plans, the state could take advantage of the increased opportunities recently provided by CMS to improve integrated care for dually eligible populations through, for example, Dual Eligible Special Needs Plans (D-SNPs) or Medicare Advantage Medicare-Medicaid Plans (MMPs).[172]

[172] Medicaid.gov: see note 168.

PROGRAM INTEGRITY

To maintain the functional integrity of the state's Medicaid organization, Missouri has divisions that prevent fraud, waste, and abuse (FWA) and ensure proper payments. Fraud, waste, and abuse detection and prevention are largely the responsibility of Missouri Medicaid Audit and Compliance (MMAC) and the Welfare Investigations Unit (WIU), but multiple other agencies within DSS conduct or enable investigations or enforcement. The WIU is responsible for preventing participant fraud, while MMAC is responsible for enrolling, auditing, investigating, and sanctioning providers.

The Cost Recovery Unit administers cost avoidance and a recovery program to offset expenditures for the state Medicaid agency. This unit ensures that appropriate third-party resources (including but not limited to Medicare, commercial insurers, workers' compensation, probate-estate recoveries, and others) are utilized as the primary source of payment prior to the state paying for services. Enrollment of eligible participants into Medicare is especially important for the state as this population typically has more limitations of average daily living, poorer health, and higher medical expenditures.

When combined, the potential initiatives could save $65 million to $100 million or more, net of recurring investments, depending on decisions made by the state.[173] Potential initiatives include enhancing the quality and quantity of FWA claims-based analytics, increasing coordination between MMAC and relevant internal and external stakeholders, optimizing the identification and enrollment of Medicare-eligible participants, and improving the implementation of certain pre-payment edits.

Current situation

This section provides an overview of Missouri's current FWA organizational structure and functionality, third-party liability (TPL) identification, Medicare Buy-In, and estate recoveries.

Organizational structure and functionality

There are multiple divisions responsible for conducting investigations or performing compliance duties within the state. These divisions include Missouri Medicaid Audit and Compliance (MMAC), the Division of Legal Services (which includes the Welfare Investigations Unit [WIU] and the General Assignment Unit), Family Support Division, Division of Youth Services, Children's Division, and the Division of Finance & Administrative Services.

Missouri handles Medicaid participant fraud through the WIU. WIU deters participant fraud, prosecutes offenders, and collects money lost to the state because of fraud. The WIU currently has 18 investigators.

Missouri handles provider fraud and abuse through MMAC. In SFY2018, MMAC produced about $40 million in savings for the state.[174] MMAC is responsible for enrolling, auditing, investigating, and sanctioning providers. MMAC is currently appropriated 76.5 FTEs, including twenty-nine FTEs dedicated to provider audits and participant lock-in and eight investigators. MMAC works with an analytics vendor and the CMS Unified Program Integrity Contractor to identify opportunities to improve program integrity. Through its investigations, MMAC provides feedback to the policy teams within MHD, another unit within DSS.

TPL identification

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[173] Analysis of Missouri Medicaid claims data, SFY2016-18; interviews with Medicaid program staff members.

[174] Analysis of state data, 2018; interviews with Medicaid program staff members.

TPL information is obtained at the time a participant is enrolled. Family Support Division (FSD) specialists obtain TPL information primarily during the MHD eligibility determination process. Supplementing this initial contact are data matches with both private and public entities, edits within the claims processing system, direct inquiries to participants, non-custodial parents and other potential liable parties. MHD uses a vendor to perform data matches between participant claims' data and external sources of third-party coverage.

TPL identification for participants enrolled into MCOs is the responsibility of the MCO. CMS recommends states use one of four options to ensure that they meet the coordination/TPL requirements: (1) exclude individuals with known sources of TPL from enrollment in MCOs; (2) enroll individuals with known sources of TPL in MCOs, with the state retaining responsibility for COB/TPL; (3) enroll individuals with known sources of TPL in MCOs and contractually require that the MCO assume responsibility for COB/TPL; or (4) exclude individuals with commercial managed care coverage from enrollment in MCOs but enroll individuals with other types of third party coverage in the MCOs.[175] Missouri uses the third option, and as such, MCOs act as agents for the state for coordination of benefits and third-party reimbursement in the following circumstances: workers' compensation, tortfeasors, motorist insurance, and liability/casualty insurance. The state's MCOs are required to report their identified savings and the future capitation payments are adjusted accordingly.

Dual enrollment and Medicare Buy-In

Missouri is one of nine 209(b) states. At least one of Missouri's income eligibility criterion is more restrictive than the SSI program, thus making it one of nine states that are considered 209(b) states (see Exhibit 39).[176] States that elected this option may not use more restrictive standards than those in effect in January 1, 1972, and must provide for deductions of incurred medical expenses from income through Medicaid spenddown so that individuals may reduce their income to the income eligibility level. As a result of being a 209(b), the participant enrollment process is separate from the SSD/I determination.

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[175] Medicaid.gov, "Medicaid Third Party Liability & Coordination of Benefits," see: www.medicaid.gov/medicaid/eligibility/tpl-cob/index.html.

[176] Social Security Administration, "SI 01715.020 List of State Medicaid Programs for the Aged, Blind and Disabled," 2016, see: secure.ssa.gov/poms.nsf/lnx/0501715020.

EXHIBIT 39: MEDICAID-SOCIAL SECURITY ELIGIBILITY AND ENROLLMENT[177]

There are three classifications for states' eligibility and Medicaid enrollment	Description
1634 states	▪ Have the same eligibility criteria as SSI ▪ Eligibility determinations are made by SSA
209(b) states	▪ Have at least one eligibility criterion more restrictive than SSI ▪ Must allow for Medicaid spenddown ▪ Eligibility determinations are the responsibility of the state
SSI States	▪ Have the same eligibility criteria as SSI ▪ Eligibility determinations can be made by SSA or the state ▪ States may require separate enrollment process

State by state eligibility determination classification

Missouri identifies Medicare leads through three main sources. As a cost-saving measure, Medicare premiums are paid for participants of Old Age Assistance, Permanently and Totally Disabled, Aid to the Blind, Temporary Assistance for Needy Families, Specified Low Income Medicare Beneficiary, and Qualified Medicare Beneficiary programs who meet the criteria for Medicare coverage. Staff verifies Medicare leads through reports produced from files sent by CMS, the Social Security Administration, or the TPL/Medicare contractor through a data match.[178] In addition, the state has a policy that mandates participants apply for Medicaid, and they must also apply for Medicare.

Estate recoveries

Missouri identifies estate recoveries through data matches from various organizations. The state uses data from the DHSS' Vital Statistics, FSD county office staff, and cooperation of other public and private groups. When cases are established, TPL staff verifies expenditure documentation and assembles data for evidence. The TPL staff appears in court to testify on behalf of the state and to explain MHD policies and procedures.

Potential opportunities for improvement

This section identifies potential opportunities to strengthen the state Medicaid agency's program integrity. When compared to common practices in other states, the following observations can be made:

- **Improved coordination across multiple agencies could help improve fraud, waste, and abuse (FWA) efforts.** Each division may have its own computer system, eligibility criteria, provider and participant enrollment service authorizations, service delivery, payments, audits, investigations, and compliance functions. In addition, divisions with

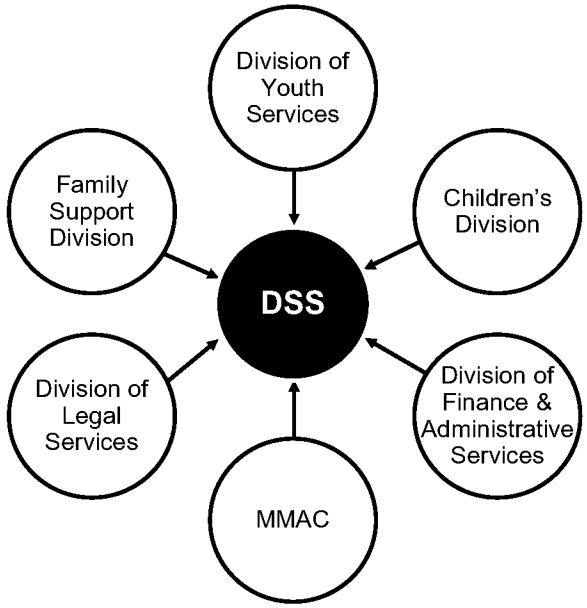
[177] Social Security Administration: see note 176.

[178] Missouri DSS, "Third Party Liability," see: dss.mo.gov/mhd/general/pages/about.htm#tpl.

primary fraud and abuse functions are dependent on staff within the other divisions to detect potential fraud or abuse situations and make a referral in an acceptable format with supporting documentation (see Exhibit 40). However, MHD has recently established an interdisciplinary taskforce to improve coordination of FWA activities.

EXHIBIT 40: DIVISIONS INVOLVED IN FWA EFFORTS AND ASSOCIATED CHALLENGES

Numerous divisions within DSS either conduct FWA tasks or enable other divisions to do so



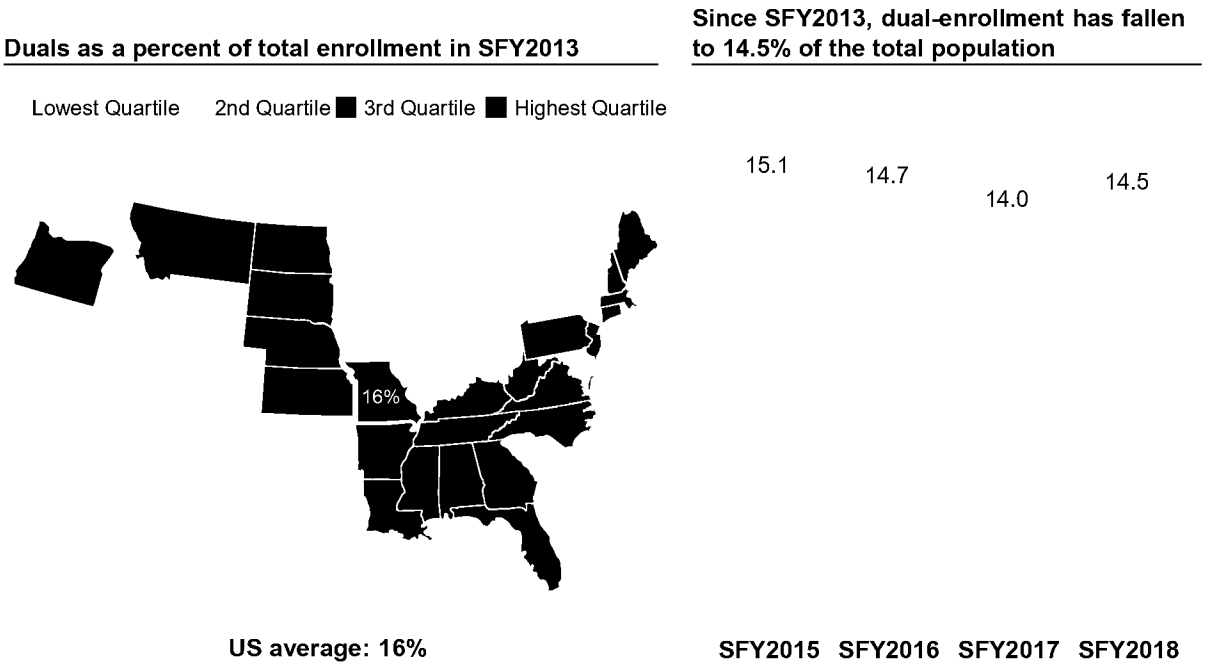
Challenges with this model

- Each division may use unique software and databases for determining:
  - Eligibility
  - Provider and participant enrollment
  - Service authorizations
  - Service delivery
  - Payments, audits
  - Investigations
  - Compliance functions
- Divisions with primary fraud and abuse functions are dependent upon staff within the other divisions to recognize a situation could be fraud or abuse and make a referral in an acceptable format with their supporting documentation
- Ability to work with data across divisions

- **MMAC could increase collaboration with relevant clinical policy teams.** A closed-loop communication system between FWA and clinical policy teams – meaning whenever FWA is identified, the situation is communicated to the clinical staff – could help shape corresponding policy changes in a timely fashion. This might also require additional capacity within the clinical policy teams.
- **The analytical capacity and capability, and the range of FWA concepts tested in Missouri could be increased in line with other Medicaid programs and commercial plans**. The internal analytics function – currently two FTEs – could benefit from additional capacity. MMAC's analytics vendor currently tests for between 25 to 40 program integrity opportunity areas; this funnel could be greatly expanded using a prioritized subset of opportunity concepts adopted by other programs.
- **Ensuring access to a larger set of higher quality data could improve Program Integrity (PI) performance.** MHD current faces challenges in the quality of MCO encounter data as well as some aspects of FFS data. Approaches to improve this data quality are described in other parts of this document. In addition, MHD could work with CMS to access other data sources directly (e.g., Medicare claims) that might be helpful in PI opportunity identification.
- **The state's enrollment of dual-eligible participants into Medicare is lower than historic state and national averages**. In SFY2013, 16% of Missouri's participants were

dually enrolled in Medicare and Medicaid, which was consistent with the national average at the time. In SFY2018, the state's dual-eligible enrollment as a percentage of total participants was 14.5% (see Exhibit 41).[179] The decrease in dual enrollment appears to be more prominent in the disabled population that is less than 65 years of age.

EXHIBIT 41: CHANGES IN DUAL ENROLLMENT AS PERCENTAGE OF TOTAL MEDICAID ENROLLMENT



- **Missouri could increase the number of sources it currently uses for TPL identification**. Other state Medicaid agencies and CMS have pharmacy claims databases to identify primary payors. Using pharmacy claims databases typically allows states to identify an additional cohort of participants who have TPL at a faster rate because of the faster typical timing of pharmacy claims.

Potential Initiatives

Based on review of Missouri's current approach, interviews with functional leaders and subject matter experts, and analysis of other states' activities, this section includes five potential initiatives Missouri could consider improving program integrity. In total, the financial impact of Program Integrity initiatives could range from $65 million to $100 million, depending on state choices.

1. **Expanding the national correct coding initiatives (NCCI) coding edits that the state has in place.** CMS developed the National Correct Coding Initiative to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in claims. There are two broad classifications of NCCI edits: Procedure-to-Procedure edits, which prevent improper payment when incorrect code combinations are

[179] KFF, "Dual Eligibles as a Percent of Total Medicaid Beneficiaries," 2013, see: www.kff.org/medicaid/state-indicator/duals-as-a-of-medicaid-beneficiaries; analysis of Missouri Medicaid claims data, SFY2016-18; interviews with Medicaid program staff members.

reported, and Medically Unlikely edits, which prevent improper payments when services are reported with incorrect units of service. Missouri has implemented some of these edits but has not implemented the full suite of edits. This initiative would require changes to the MMIS system to implement the full suite of codes, among other requirements.

2. **Create an experimental, investigation, and unproven (EIU) medical procedure policy to prevent improper payments.** This agency policy would identify devices or procedures that have not been proven to be medically effective. This initiative would require the state's clinical staff to identify these procedures and review the procedure on annual basis. Additionally, the initiative would require feasible changes to the MMIS system.
3. **Expand the analytical funnel to identify additional improper payments that can be prevented using claims edits and pre-pay changes or can result in recoveries.** As an example, for given procedure codes, Missouri has set billing limits that the state only reimburses hospital observation stays for up to 24 hours. The state could ensure that the claims system is preventing payment for procedures after the allotted 24-hour period. Opportunities that take the form of edits would require feasible changes to the MMIS system.
4. **Optimize the state's ability to identify and enroll participants who are currently and may become Medicare eligible.** The state could implement (either internally or through a vendor) new claims-based technology that would allow the state to identify participants who are currently Medicare-eligible or may become eligible. Missouri staff could then help notify participants about this benefit. This would require medium-complexity changes to the MMIS system and potentially a new vendor.
5. **Improve TPL identification.** Missouri could begin to utilize additional sources (e.g., pharmacy claims data) to increase TPL identification rate. To do this, the state could contract with a vendor that would add additional sources of data.

FEDERAL FINANCING

Missouri has captured a significant share of the federal funding it is eligible for, but there may be additional opportunities to capture federal revenue through new federal programs, both through grants and enhanced match. The state also could consider evaluating the use of inter-governmental transfers (IGT) as an alternative or supplemental financing approach. The total federal financing opportunity is expected to be $10 million to $20 million in grant funding and additional enhanced match.[180]

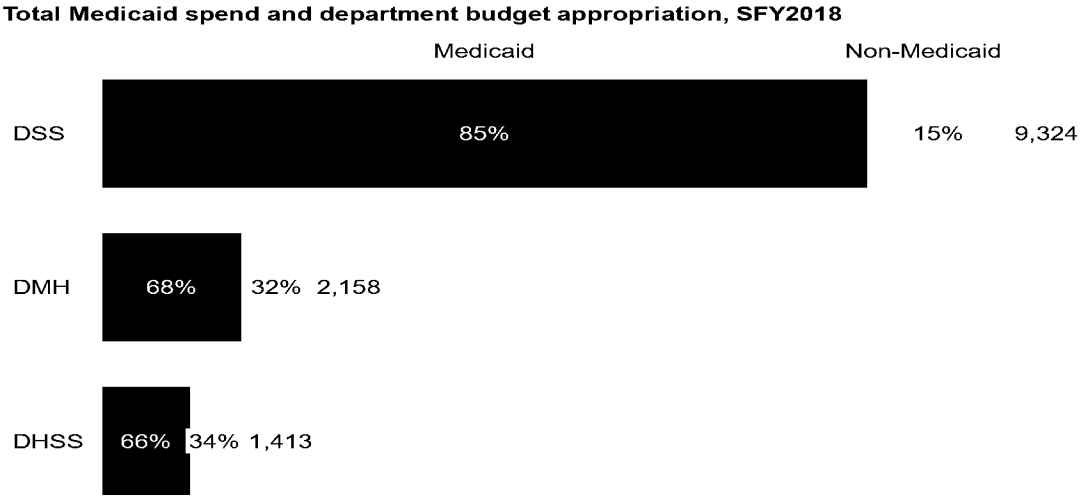
This section will describe the current state of federal financing in Missouri, observed opportunities for improvement, and potential initiatives for the state to consider.

Current situation

Overall Medicaid spending across departments

Medicaid spend represents over 80% of the budget for DSS and approximately two-thirds of the budget for DHSS and DMH (see Exhibit 42).[181] The largest areas of Medicaid spending include managed care, pharmacy reimbursement, hospital and nursing facility reimbursement, physician reimbursement, and community programs. Nearly all these funds receive some form of federal match based on the category of spending (see Exhibit 43). Federal funds represent approximately 65% of the total spending across top Medicaid spending categories.

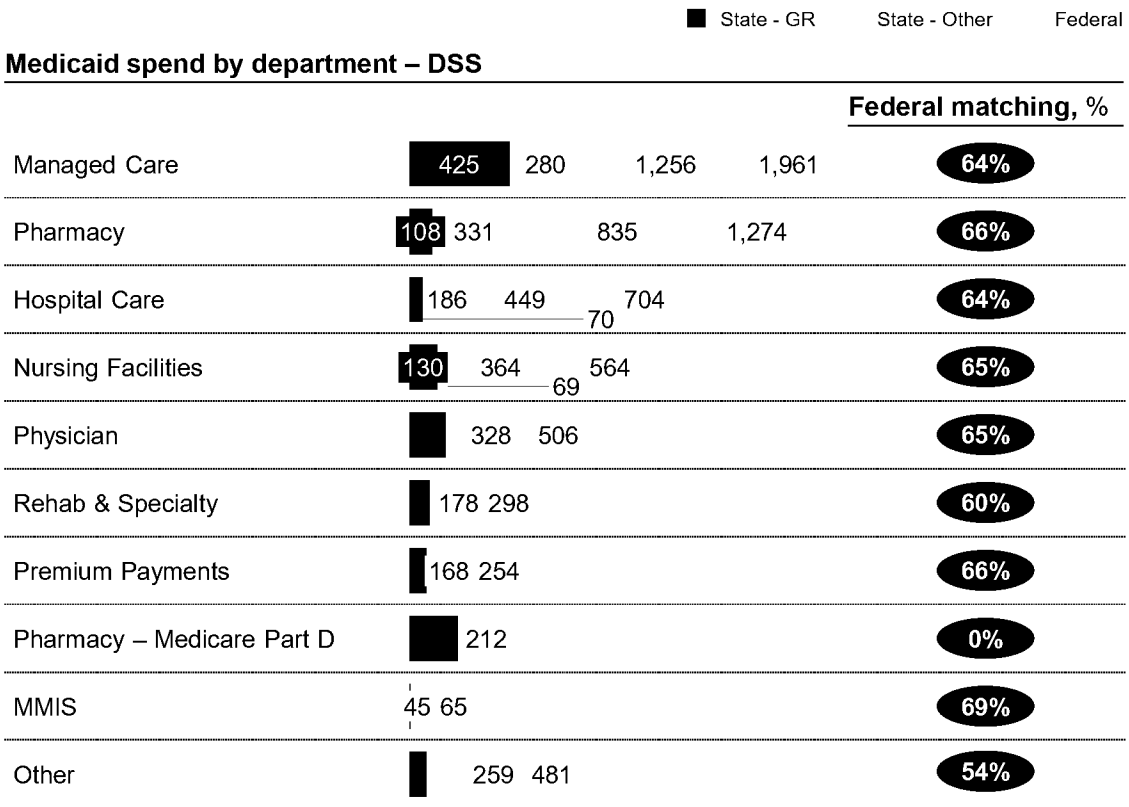
EXHIBIT 42: MEDICAID SPENDING BY DEPARTMENT



[180] U.S. Congress, "H.R.6- SUPPORT for Patients and Communities Act," 2018, see: www.congress.gov/bill/115th-congress/house-bill/6; CMS, "Maternal Opioid Misuse (MOM) Model," 2018, see: www.cms.gov/sites/drupal/files/2018-10/10-23-2018%20Fact%20Sheet%20Maternal%20Opioid%20Misuse%20%28MOM%29%20Model%20%28FINAL%29.pdf; CMS, "Integrated Care for Kids (InCK) Model," 2018, see: www.cms.gov/newsroom/fact-sheets/integrated-care-kids-inck-model.

[181] SFY2018 available appropriations: Office of Administration, "Fiscal Year 2019 Budget Priorities," 2019, see: oa.mo.gov/sites/default/files/FY_2019_Budget_Summary.pdf; Medicaid spend: Missouri DSS, see note 1.

EXHIBIT 43: DSS MEDICAID SPENDING[182]



Unmatched spending across departments

In DSS, only a handful of narrow categories do not receive federal funds. Some examples of these categories are Medicare buy-in, through which the state helps pay Medicare premiums for Medicare Part A and Part B for qualified individuals; state-only assistance, which includes social services block grants; Temporary Assistance for Needy Families (TANF) grants; and State General Fund. In addition, DHSS and DMH have more categories of unmatched spending, although the value of unmatched dollars is a small percentage of the total spending across the departments. Within DHSS, there could be potential to receive additional match for Alzheimer's services and communicable diseases, and within DMH, opportunity exists in autism spending, crisis intervention services (24-hour hotline and mobile outreach for psychiatric patients, although only outreach could be eligible for match), and some emergency room enhancements (ERE).

Other state funds

Provider taxes contribute $1.4 billion to the state Medicaid program, of which $1.1 billion is derived from hospital taxes and $0.3 billion from nursing homes and pharmacies. The hospital tax (>5.5%) and nursing home tax ($13.40 per patient day) rates are both high compared to other states.[183] The use of intergovernmental transfers (IGTs) is limited.

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[182] Office of Administration and Missouri DSS: see note 181; Missouri DSS, "MHD-FY 18 MMIS Expenditures Final 8-13-18," 2018; interviews with Medicaid program staff members.

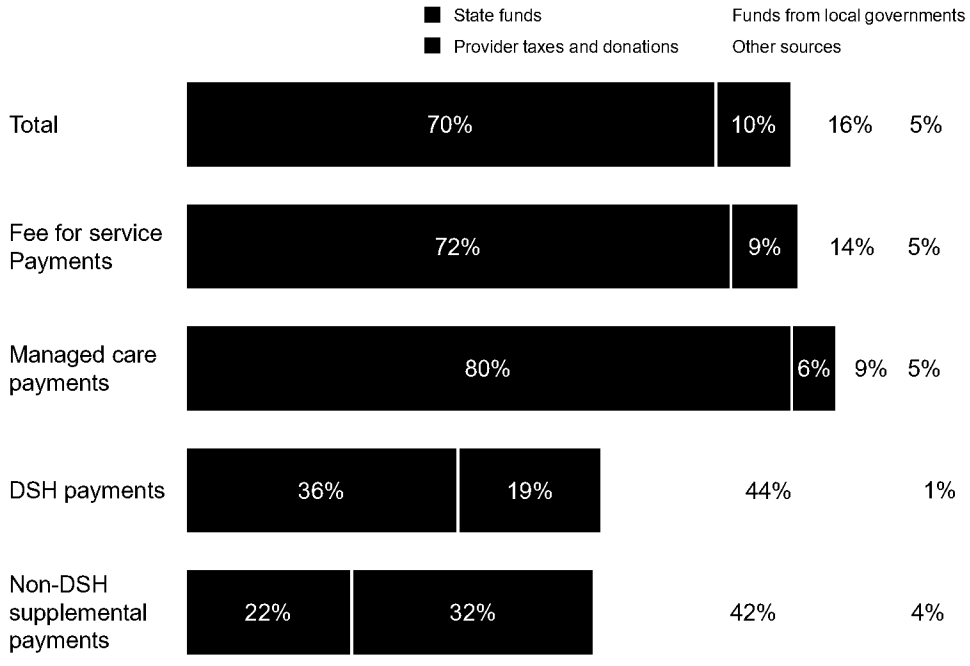
[183] Missouri DSS, see note 11.

Potential opportunities for improvement

This section identifies potential opportunities to improve Missouri's current approach to federal financing. The opportunities are not intended to be mutually exclusive: potential savings identified in individual opportunities may overlap with those identified in others.

- **Missouri could consider leveraging new federal programs that provide federal funding for innovative Substance Use Disorder/Opioid Use Disorder (SUD/OUD) and behavioral health models.** A variety of new funding opportunities have recently been made available to states, including CMMI grants for the design of alternative payment models, guidance from CMS on additional demonstration opportunities that grant increased flexibility in how Medicaid funds are used, and the wide-ranging funds made available to a variety of agencies through the SUPPORT for Patients and Communities Act (SUPPORT Act). Exhibit 44 contains a breakdown of different sources of non-federal funds for Medicaid payments.

EXHIBIT 44: SHARE OF NON-FEDERAL FUNDS FROM DIFFERENT SOURCES[184]



Potential initiatives

The state could consider several potential initiatives to improve its federal financing. The total opportunity could be $10 million to $20 million in grant funding and additional enhanced match, depending on decisions made by the state.[185] These initiatives address overlapping populations and provide different types of funding (grants, enhanced match, regular match for new sets of services). The state could consider strategically combining initiatives to maximize efficiency and

[184] MACPAC, "The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending," 2017, see: www.macpac.gov/wp-content/uploads/2017/07/The-Impact-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf.

[185] U.S. Congress, CMS: see note 180.

generate funding to support the design, development, and implementation of the models as well as the associated care delivery costs.

1. **Access enhanced match by strengthening SUD focus in health homes.** While Missouri has exhausted the eight quarters of enhanced match for the health home program, the SUPPORT Act allows for the creation of a new SUD-focused SPA that would cover 10 quarters of enhanced match for individuals with SUD not previously covered under a health home. There are three groups of individuals whom the state could potentially consider as part of a new SUD-focused SPA: (a) participants with SUD who meet the existing health home criteria but were never successfully engaged (e.g., no payment occurred for those participants); (b) participants with SUD who are newly eligible and meet the existing health home criteria; and (c) participants who are not eligible under the current criteria but would be eligible if the state created additional eligibility pathways for the SUD population (e.g., making receipt of MAT a qualifying factor, creating an eligibility pathway for pregnant women with OUD). The state would need to meet reporting requirements outlined in the SUPPORT Act (e.g., quality of care reporting, reporting of costs of individuals in health homes).[186]
2. **Pursue a State Plan Amendment to access federal funds for SUD services provided in IMDs.** Missouri may be able to leverage the Amendment to the IMD Exclusion to use federal funds to pay for treatment services in residential settings that qualify as IMDs. To access the funds, Missouri would need to design a program emphasizing quality and value. Missouri could consider working with CMS to develop a State Plan Amendment (SPA) initiating the program; this SPA could potentially be effective as early as October 1, 2019. As the services currently are not provided, this initiative would be an investment which the state could consider as part of a value-based program, for example, to reduce total cost of SUD care.
3. **Apply for the Serious Mental Illness/Severe Emotional Disturbance (SMI/SED) demonstration through a Section 1115 Waiver.** The SMI/SED demonstration allows states to use federal funds to pay for treatment services in residential settings that qualify as IMDs for individuals with SMI/SED.[187] To access the funds, Missouri would need to design a program emphasizing quality and value that meets budget neutrality requirements for a Section 1115 Waiver. Missouri would be expected to achieve a statewide average length of stay of 30 days for participants receiving care in IMDs. Additional analysis would be required to understand the net budgetary impact of funding for SMI/SED services provided in IMDs.
4. **Apply for CMMI grant funding through the Maternal Opioid Misuse (MOM) and Integrated Care for Kids (InCK) Models.** The models provide states with federal funds to help the state fund programs to combat OUD in pregnant and postpartum Medicaid participants and improve behavioral health care for children up to 21 years.[188] MOM provides up to $64.5 million nationally for implementation, transition, and milestone funding distributed across up to 12 states; InCK provides $16 million[189]. The state could consider applying for these grants, which could be (but need not be) seen as two sides of the same coin. The Notices of Funding Opportunity (NOFO) for both programs are expected in early 2019; applications for funding are likely to be due early in 2019 and funds awarded in late 2019.

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[186] U.S. Congress: see note 180.

[187] U.S. DHHS, "Section 1115 Demonstration Process Improvements," 2017, see: www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf.

[188] CMS, see note 180.

[189] CMS, see note 180.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

The current MMIS is a set of ~70 integrated components that plays a fundamental role in most of functions of the Missouri Medicaid program. Its "core" is a 1979 mainframe system, maintained and operated by Wipro; a set of additional components are maintained and operated by Conduent. Three main improvement opportunities were identified. First, while the level of spending on technology is not misaligned with the needs of a Medicaid system of Missouri's size, the functioning of the technology does not meet current or future needs. Its limited functionalities and the antiquated architecture underlie several of the program's performance challenges identified throughout this report. Second, there is an opportunity to increase alignment between program strategy and the Information Systems group's (IS) strategy. The current MMIS replacement plan does not include the specificity required to ensure that the forthcoming modules will meet future needs. Third, the IS group lacks the range of capabilities needed to ensure an MMIS replacement trajectory that will deliver that future functionality.

Within this context, the IS group has taken important steps, such as the creation of an outline of a strategic plan for modular replacement and the prioritization of an Enterprise Datawarehouse (EDW) and Business Intelligence System (BIS). However, the state could consider a concerted, integrated effort to set up the MMIS for success. A full end-to-end plan could further define the current roadmap for modular replacement based upon the functionalities most needed from the perspective of the future Medicaid program, including prioritization and specified use cases. If the state would decide to take such an approach, it could consider integrating strategic program priorities, operating models, capabilities, governance, and environment (e.g., procurement, FMAP) into the updated end-to-end plan.

Current situation

This section describes the MMIS, the in-flight initiatives and the plans for future improvements and its costs.

MMIS definition

MMIS includes the Core system operated by Wipro, the Clinical Management Services & System for Pharmacy Claims & Prior Authorization (CMSP), and the Program Integrity solution operated by Truven. The MMIS is not managed by the Information Technology Services Division (ITSD) of the Office of Administration but rather by MHD, with a few notable exceptions: Financial Cycles and Federal Financial Reporting is managed by Division of Finance and Administrative Services (DFAS), HCBS Assessment is managed by DHSS, and Provider Enrollment and Program Integrity is managed by MMAC. The Eligibility Determination systems (managed by Family Support Division [FSD], Division of Youth Services [DYS], and Children's Division [CD]) and Claims Pre-Processing and Adjudication (managed by DMH and DHSS) were excluded from the analysis.

The "MMIS" refers to a disparate range of technologies that are integrated. The components tend to be named for the function they support, and they can include staff or vendor staff activities associated with the technologies. There are also components that largely consist of (vendor) staff activities rather than technology, as when for example several components are managed by the same vendor. This broad definition can and does cause confusion in strategic and tactical discussions, where what "MMIS" means may vary amongst those involved.

Functional and Technical

Missouri's MMIS consists of a collection of technologies that include ~70 components supporting a broad range of administrative functions of the Missouri Medicaid Program. These

components are supported by three vendors. Wipro manages the core MMIS IBM mainframe-based system, programmed in COBOL (~7 million lines of code)[190], originally installed in 1979. Conduent manages the as-a-service CMSP system[191] which is heavily interconnected with the Core and supports Care Quality Solutions (inpatient certification, reporting, and provider web tool), Prescription Delivery (clinical decisions for claims processing and clinical edits), and the Health Information Exchange. Truven manages the current Program Integrity system[192] which is interconnected with the Wipro system.

Some of the components are managed by a single vendor while others have shared vendor responsibilities. Given the architecture and history of the system, many of the 'components' are not partitioned, distinct subsystems but may be highly intertwined within the COBOL code. To help the planning for future modular replacement, the Information Systems groups has classified the existing components into the below 11 functional categories.

1. Core Claims / Encounter Processing (administered by MHD): supports core Medicaid functions such as FFS claims processing, participant web portal, and financial management (e.g., calculation and transmission of payments, provider specific taxes and reimbursements, financial summaries). Wipro manages the majority of this functionality while some components are maintained by ITSD (Medicare buy-in and premium collections and spend down) and Conduent (participant web portal).
2. Pharmacy and Drug Rebate (administered by MHD), operated by both Conduent and Wipro. Pharmacy, clinical adjudication, and preferred drug list are operated by Conduent. These components include pharmacy functions such as managing participant pharmacy benefits, maintaining and applying the drug formulary, and performing pharmacy pre-certification. Wipro operates several functions including drug rebate processing and initial claims validation and pricing.
3. Pharmacy Administration (administered by MHD): primarily manages the drug formulary and setting supplemental drug rebate amounts. These services are operated primarily by Conduent.
4. Provider Enrollment (administered by MMAC): is responsible for enrolling, screening, and monitoring both FFS and managed care providers. It is maintained by Wipro, which subcontracts parts of this work to LexisNexis.
5. Managed Care Enrollment Broker (administered by MHD): these components are responsible for the enrollment of managed care participants in plans through a web portal, associated physical mailings, auto-assignment, and a contact center. The web portal and auto-assignment system are maintained by ITSD, while the contact centers and any physical mailings are operated by Wipro.
6. Contact centers (administered by MHD): supports both the provider relations, participant, and prior authorization contact centers. The provider contact center covers inquiries from providers around program policies, claim assistance, and claim processing instructions, while the participant contact center covers inquiries from participants about eligibility, spenddown, and covered services. The prior authorization contact centers support prior authorizations over the phone. The Contact centers category is operated by Wipro and includes the phone system and contact documentation software.

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[190] This system is hosted by Wipro in a data center in Omaha, NE.

[191] This system is hosted by Conduent in data centers in East Windsor, NJ; Sandy, UT; and Richmond, VA.

[192] This system is hosted by Truven in a private cloud.

7. Data, Analytics, and Reporting (administered by MHD): supports the Medicaid program's needs to access, analyze, and report on data stored in the MMIS. The current system is primarily focused on providing the required outputs to Transformed Medicaid Statistical Information System (T-MSIS)[193] federal financial reporting, and program reporting. Both Wipro and Conduent manage various analytics and reporting components, aligned with their business functions.
8. Program Integrity (administered by MMAC): supports the detection of potential Medicaid fraud, waste, and abuse (FWA) through the analysis of claims data. It is currently operated primarily by Truven Health Analytics and consists of Data Pro (which runs state-defined algorithms to detect possible FWA and provides ad hoc reporting) and Truven Advantage Suite (which provides dashboard reporting). Additionally, the surveillance and utilization review components are operated by Wipro.
9. Health Information Network (administered by MHD): covers the connection of MMIS to various Health Information Networks (HINs). The platform, maintained by Conduent, is in place but is currently not connected to any HINs, pending contract negotiations between the state and HIN(s).
10. Prior Authorization (administered by MHD): encompasses the automated PA system, the PA web portal, participant case management, and the processing of various prior authorizations. The web portal is operated exclusively by Conduent and the case management and prior authorization processing is handled by both Wipro and Conduent, with the exception of dental, physician, audiology, and out-of-state services, which are handled by Wipro.
11. Ancillary / Supporting Services (administered by MHD): these include cross-cutting components that support other components, such as printing and mailroom, help desks, and project management. These services may be shared across functions and vendors.

Current replacement plans

CMS has issued guidance for the replacement of MMIS, outlining the criteria for which states can be eligible for 90/10 federal match of MMIS replacement initiatives.[194] These guidelines emphasize a modular approach to the acquisition of MMIS modules to encourage reuse, reduce the need for customization, stimulate and expand the vendor landscape, grow adoption of shared services, and reduce overall MMIS cost. To meet the CMS criteria, the 11 categories outlined above are identified as the modules in which Missouri has organized the ~70 functions of its current MMIS.

As an overall business strategy for the Missouri Medicaid program is not clearly defined and integrated with IS' plans, the detailed three- to five-year end-to-end approach for MMIS modular replacement (e.g., the timing and requirements for specific modules beyond currently planned initiatives) has not yet been fully determined.

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[193] T-MSIS is a data set that CMS requires states to submit which includes data such as: utilization and claims data, enhanced information on beneficiary eligibility, managed care data, and Medicaid and CHIP expenditure data, see: www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html.

[194] CMS, "Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding," 2016, see: www.medicaid.gov/federal-policy-guidance/downloads/smd16004.pdf; CMS, "Mechanized Claims Processing and Information Retrieval Systems – APD Requirements," 2016, see: www.medicaid.gov/federal-policy-guidance/downloads/smd16009.pdf; CMS, "CMS-2392-F Mechanized Claims Processing and Information Retrieval Systems – Modularity," 2016, see www.medicaid.gov/federal-policy-guidance/downloads/smd16010.pdf.

The state has started the replacement process with two modules identified as priorities. CMS has approved the Advance Planning Documents (IAPDs) and contracts have been awarded in April/September 2018 for a Program Integrity solution and a Business Intelligence Solution/Enterprise Data Warehouse (BIS/EDW). To support a Medicaid transformation effort, providing access to MMIS data in a timely and efficient way is considered important. The BIS/EDW, therefore, is considered a foundational module[195]. The Program Integrity solution has been contracted to replace current functionality and facilitate incremental improvements.

Cost

Total SFY2019 projected MMIS spending is $85 million, comprised mainly by two main contractors: Wipro and Conduent ($51 million [60%] and $17 million [20%], respectively).[196] IS project spending is set to increase from $65 million (SFY2018) to $93 million (SFY2020)[197], driven primarily by net-new spending, such as Truven spending on BIS/EDW and PI (the start of the modular replacement), a managed care pilot, T-MSIS, Health Information Network connection, Electronic Health Records, and HCBS support. Current system costs for MMIS and CMSP remain stable. Projected MMIS spending from SFY2018-SFY2020, by vendor, by funding source, and by spend type is shown in Exhibit 45.

The SFY2019 weighted average federal match is 73%, up from 69% in SFY2018, and it is projected to increase to 75% in SFY2020, driven by increased match on implementing new MMIS modules.[198] In SFY2019, this is projected to split into 90% match for design, development, and implementation activities (DD&I) ($20 million, or 24% of total); 75% match for maintenance and operations activities (M&O) ($48 million, or 56% of total), and 50% match for administrative activities ($17 million, or 20% of total). When the implementation activities have been completed, funding for components will shift to 75/25. Overall spending on these items is expected to decrease as the activities shift from DD&I to M&O. From SFY2018-SFY2020, administrative costs are projected to remain stable, thus decreasing as percentage of total cost as total cost increases.

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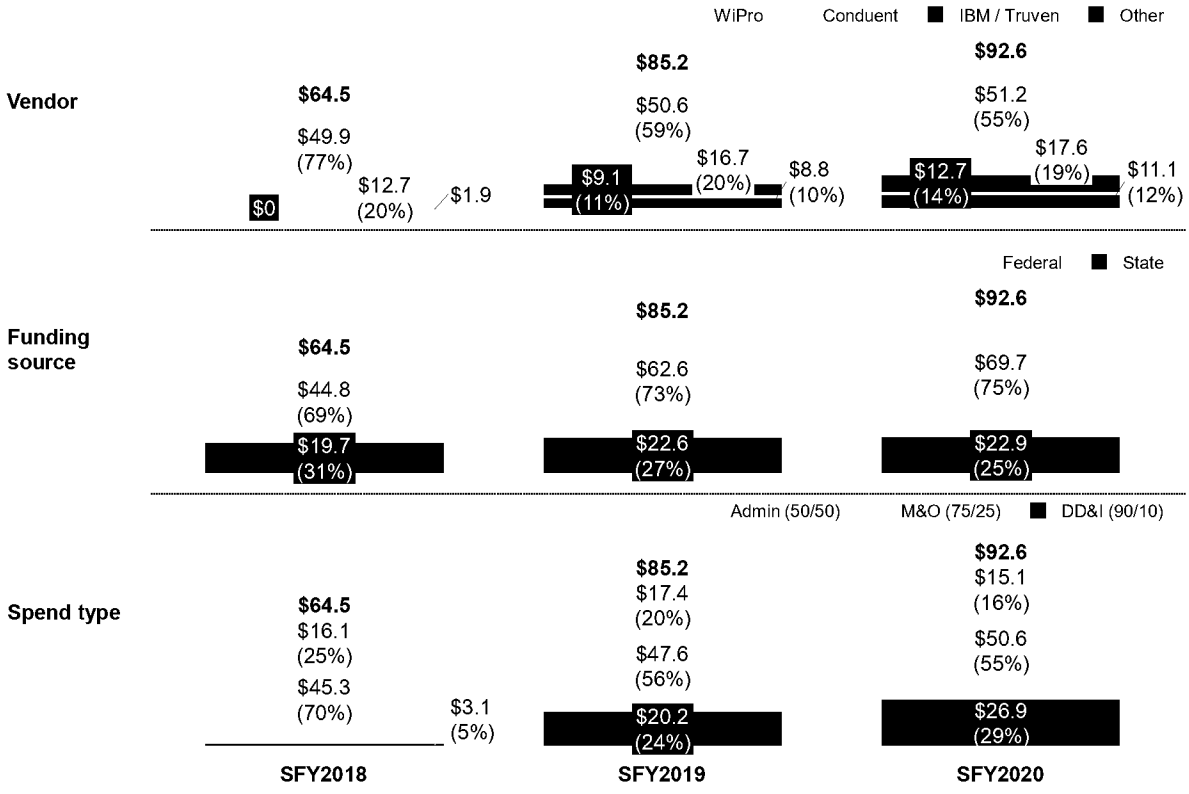
195 Interviews with Medicaid program staff members.

196 Missouri DSS, "MHD – FY 18 MMIS Expenditures FINAL 8-13-18," 2018; Missouri DSS, "MHD – FY 19 MMIS Expenditures 10-31-18," 2019.

197 Missouri DSS, "MMIS Spend Plan FY20 Compare to FY19," 2019.

198 Missouri DSS: see note 197.

EXHIBIT 45: PROJECTED MMIS SPENDING THROUGH SFY2020



Potential opportunities for improvement

This section highlights observations based on a high-level assessment of the current state.

- **The current MMIS is insufficient for current and future needs, and the antiquated mainframe technology poses a risk to the program.** The limitations of the current systems prevent Missouri Medicaid from operating at maximum efficiency. Examples surfaced in other areas of this assessment of the Medicaid program include the following: the MMIS system rejecting certain MCO data submissions resulting in incomplete MCO data; incomplete encounter data limiting the effectiveness of MMAC audit reviews; difficulty in transferring MCO encounter data into MMIS likely resulting in increased error rates; multiple-format data entry required for pharmacy rebate information increasing rebate processing time; challenges in eligibility determinations with MEDES data for MCOs impacting participants' ability to enroll; difficulty in adding new data fields to the proprietary layout; and challenges to identifying certain eligibility categories reducing ability to correctly identify CHIP-eligible children.

  To support new initiatives coming from other topical areas, changes would be required in the MMIS, sometimes with difficult tradeoffs. Generally, there are three categories into which new initiatives fall.

  — *Narrow configuration / code changes*, where system changes to support an initiative can be directly made in the current system with minimal disruption. Examples include additional clinical edits to allow for pharmacy policy adjustments, automation of claim adjudication driven by lab testing diagnoses, or modifications to MCO auto-assignment and lock-in logic to expand day-one managed care eligibility and passive enrollment.

- *Limited workaround*, where workarounds may exist separate from the system that can be implemented to support new or updated functionality with relatively few changes made in the current MMIS system. These workarounds range from a separate software/service to support VBP analytics, a standalone data intake system to augment current encounter data, to a supplemental submission flow for X12 data.
- *Extensive workaround or rebuild*, where a workaround is theoretically possible, but may involve altering so much of the existing MMIS system that it is worthwhile considering rebuilding the functionality in a modular replacement instead. Changes this intensive include drug-level pricing for 340B drugs, DRG classification and payment processing, and additional rate cells for MCO ABD carve-in.

The state could consider prioritizing the first two categories, as the return on investment of making these changes is likely better than for the third category. Changes in the third category could involve a tradeoff between a temporary, possibly costly and higher-risk investment in the current system while the desired functionality could also be implemented as part of a forthcoming modular replacement.

Additionally, the decades-old mainframe technology poses a risk to future Missouri Medicaid success. It is increasingly difficult to maintain the aging core mainframe technology, as the needed expertise and talent in the marketplace are decreasing. Depreciating technology is supported by fewer and fewer vendors due to market trends.

Monolithic mainframe systems lead to a lack of agility to make changes in one part of the system without risking impact to others, as it is especially difficult to fully trace the impacts of changes in a non-modular system. Ultimately, the risk of mainframe impact inhibits the ability to quickly make system changes. For example, to make a small update, code changes may be required in another 50+ locations which may not be simple to edit.

Current MMIS module offerings (such as an off-the-shelf Pharmacy Benefits Management solution) are built on more modern generations of technology or delivery models (virtualized, containerized data centers, or cloud services), further risking interoperability between the old MMIS and new modules.

- **Lack of alignment and coordination between Information Systems (IS) and the Medicaid program.** Interviews with IS staff indicate that there is currently no structural process to incorporate IS in strategic program decisions or to maintain adequate program awareness of IS challenges and opportunities. In addition, the IS department's strategic plan does not appear to be well aligned with program strategic priorities and outcomes, as these have not been well established, resulting in a lack of detail and prioritization of program initiatives.[199] The lack of alignment may limit the ability of IS to create MMIS-related procurements with specific, precise program goals.
- **MHD's IS organization does not map to the needs of a next-generation, modular MMIS**. Based on discussions with IS staff as well as expert interviews across different states, Missouri's IS organization appears to not be appropriately staffed and structured to handle both the day-to-day maintenance and operation of the present MMIS as well as the planning, implementation, and certification of a new, modular MMIS. Across four areas, staff and interviewees noted that the IS department lacks key capabilities to support the new requirements of a modular MMIS.

[199] Interviews with Medicaid program staff members.

- *Technology:* Covers the capability to define a technical architecture both between and across vendors, manage several simultaneous procurements and implementations, and sufficiently understand business process implications on the IS group. Lack of capabilities within the technology area can result in systems which are not built toward a centralized architecture, interruptions in current system maintenance, and delays in the procurement and certification processes. IS currently has one dedicated technical resource and does not appear to have resources to cover the additional activities currently slated for the modular replacement. Examples of positions that may provide these capabilities include technical architects, system operations managers, and technical managers / project managers.
- *Data:* Covers the capability to articulate a data governance strategy, align data management strategy to program goals, and translate between program requirements and data environment. Missing these capabilities can lead to issues with data quality, management, and governance. IS does not currently have any resources dedicated to data capabilities. Positions that could provide these capabilities might include data architects, and data scientists / engineers.
- *Contract management:* Covers capabilities such as technical assessment of bid responses, alignment between RFP/contract outcomes to program goals, and certification of multiple modules simultaneously. Without these capabilities, contracts may lack conciseness and precision, risking suboptimal functionality. Additionally, certification cycle time may increase without appropriate certification resources. IS currently does some limited contract management through OA and its project managers, but OA does not currently have dedicated resources to compose xAPDs (PAPDs, IAPDs, and OAPDs). Example positions that could provide these capabilities include: contract managers, xAPD writers/budget managers, and dedicated resources for various contracts and certification tasks.
- *Vendor management and accountability:* Covers capabilities such as holding vendors accountable to contract and program outcomes/deadlines and facilitating cross-vendor cooperation. Without these capabilities, the risk of vendors delivering suboptimal or incompatible functionality, or failing to meet milestone deadlines, is increased, especially as the number of vendors is likely to increase. IS currently has a limited number of project managers but does not appear to be sufficiently resourced to support upcoming modular replacement activities. Additional project managers and a clear governance structure (including who is making decisions regarding areas such as infrastructure, policy, or participant interactions) is an industry best practice without which vendors may not be able to align to a unified vision and work cohesively.

Potential initiatives for consideration

1. **Improve alignment between IS and program.** Missouri could consider adopting the following industry best practices in place in many other states.

   The state could include an integrated perspective across both IS and the program in both strategy development / planning and day-to-day operations. This would include having IS representation at key program meetings to advise on technical implications and feasibility of various program decisions. In this way, IS would be able to inform and advise on implications of program decisions, introduce novel ideas, provide insights in IS-driven needs as well as opportunities ahead of time. Additionally, it would allow IS to keep business informed about in-flight initiatives to take into account during program decision-making.

Additionally, the state could conduct joint planning exercises to ensure that IS timelines are in accordance with program-desired outcome delivery dates of both technical and functional requirements. These exercises could also help IS explain the choices that the program may have to make and the implications of those choices. These decisions, which tend to be made by the program, will impact the delineations between modules as well as the sequencing of module implementation. Holding these planning exercises may help tighten the feedback loop for IS to explain the choices that the program may have to make and the implications thereof.

Lastly, the state could consider including specific desired functional/program outcomes in procurement documents (e.g., RFPs, vendor contracts) such that vendors are operating against both technical specifications required by IS and functional specifications required to drive targeted, prioritized program outcomes. The additional specificity may help ensure that IS day-to-day tactical actions are more closely aligned.

2. **Evaluate the current modular replacement strategy and define an updated strategy informed by clear strategic direction from the program and reflecting better alignment to the market, other states, and CMS.** First, Missouri could reevaluate the structure of modules used in the current replacement plan, realign it closer to the modules recommended by CMS and those utilized in other states further along in their MMIS modernizations, and map to solutions offered in marketplace. Additionally, finalized modules may be aligned to program priorities (e.g., the decision to carve pharmacy in or out of managed care would alter the future Pharmacy module). To create an illustrative example of a potential module alternative, several interviews were conducted with experts both in Medicaid and in the MMIS industry to understand the common module structures and market offerings. In Exhibit 46, a sample alternative module option is displayed, along with Missouri's current module structure as well as the common marketplace modules.

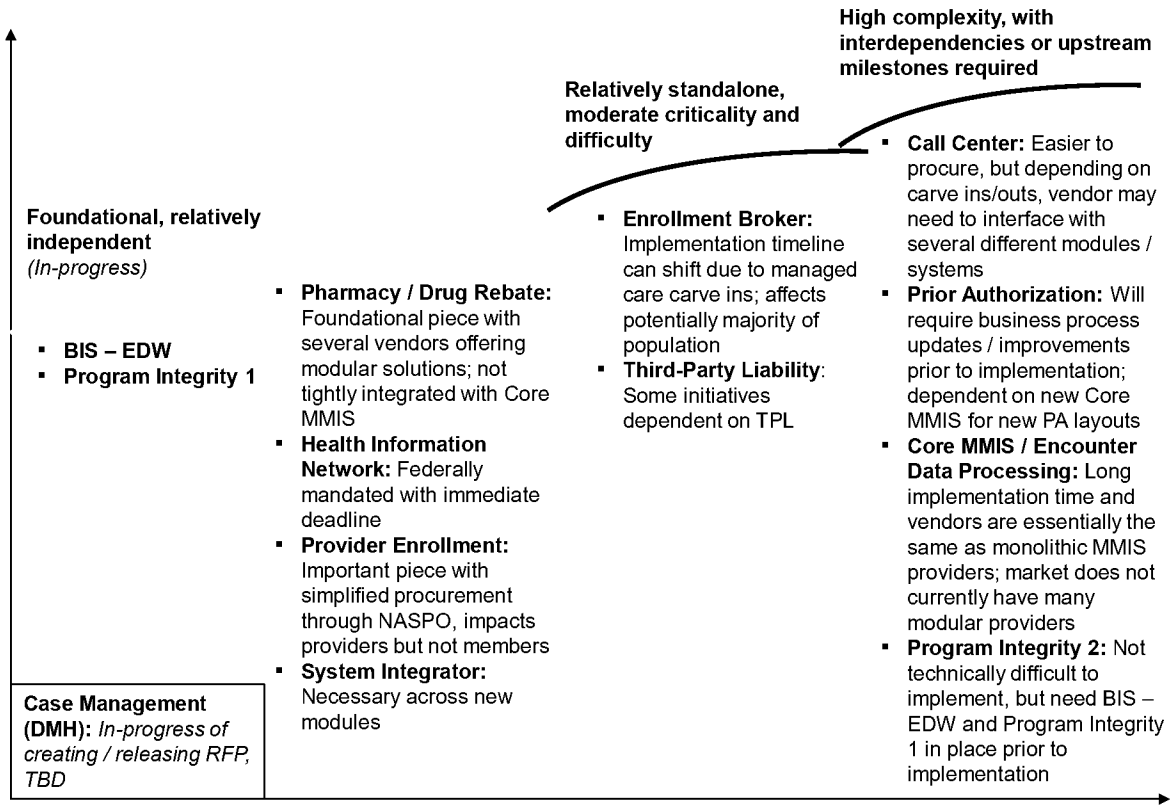
EXHIBIT 46: ILLUSTRATIVE EXAMPLE OF ALTERNATIVE MODULES

MO Modules	Commercially available vendor solutions	Potential Alternate	Potential Alternate Rationale
Core MMIS/Encounter	**Core MMIS/Encounter**	**Core MMIS/Encounter**	***Third-Party Liability:*** *Consolidated standalone solutions exist*
Prior Authorization	**Financial Man.**	**Third-Party Liability**	
Pharm./Drug Rebate	**Third-Party Liability**	**Care Management**	***Care Management:*** *off-the-shelf integrated solutions available, split from Prior Authorization*
Pharm. Admin	**Care Management**	**Prior Authorization**	***Pharmacy:*** *Best practice across states to have single pharmacy module*
Enrollment Broker	**Prior Authorization**	**Pharmacy**	
Provider Enrollment	**Pharmacy**	Enrollment Broker	***Program Integrity 2:*** *Next-generation capability added in a new module separate from Program Integrity 1 module*
Program Integrity	Enrollment Broker	Provider Management	
BIS – EDW	Provider Management	**Program Integrity 1**	***Call Centers:*** *Best practice is to have member call center outsourced and provider call center bundled with claims processing or provider management*
Health Info Network	**Program Integrity**	**Program Integrity 2**	
Call Centers	BIS – EDW	BIS – EDW	***System Integrator:*** *Future requirement due to increase in vendor complexity*
Ancillary Services	Health Info Network	Health Info Network	
	Call Centers	**Member Call Center**	***Ancillary Services:*** *Services not directly related to technology which should be handled separately*
	System Integrator	**System Integrator**	
		Ancillary Services	

Next, the state could conduct further rigorous planning to help create a roadmap aligned to program priorities with IS input on feasibility. Four sample evaluation criteria were created that could be used to develop a heatmap of module priorities: program priority/value/service delivery strategy (e.g., impact of module and functionality on program priority and service delivery strategy, specific program outcomes driven by the module, and urgency and criticality of value unlocked by module), solution availability (e.g., maturity and competitiveness of marketplace, variety of marketplace solutions available), resources (e.g., available resources to dedicate, potential upfront and ongoing costs), and complexity (e.g., dependencies on upstream, downstream, other modules, or other departments and change required).

Through a sample planning exercise conducted with IS staff, each module from the potential alternative module option was evaluated against the sample criteria, considering factors such as updated vendor landscape information, incompletely defined program decisions, populations affected by module change, and ongoing procurements in other departments. The preliminary illustrative roadmap created (shown below in Exhibit 47) could be updated as program priorities are clarified and strategic decisions (e.g., pharmacy carve in/out, additional managed care population carve-in) are made by the program. Additionally, any roadmap could be validated at multiple levels and pressure-tested for feasibility, with many dependencies (e.g., vendor responses, CMS approvals).

EXHIBIT 47: ILLUSTRATIVE MODULE SEQUENCING



Based on clarified program priorities and a value assessment of the current modular replacement strategy, the state could then define their clear, updated, end-to-end strategy.

3. **Strengthen IS capabilities through hiring, partnering for talent, and retraining/upskilling.** DSS could consider prioritizing upskilling IS to complement the currently available skill sets with capabilities focused on technology, data, contract management and vendor management and accountability. Training, hiring, or outsourcing individual expertise are all possible routes towards this goal.

4. **Optimize insourcing vs. outsourcing.** Increasingly, Medicaid leaders across the country are confronted with the need to make informed decisions about what MMIS activities to keep in-house and what to outsource. This decision is particularly critical given that most agencies are making greater use of managed care, implementing value-based purchasing at scale, and/or replacing the business information system platforms they use for eligibility determinations, claims processing, and provider management. All these changes have significant impact on the component's required functionalities. CMS guidance would suggest that a best practice is to keep policy and infrastructure-related decisions in house, allowing for additional oversight and agility. Other activities, such as handling participant interactions may be more efficiently outsourced or delivered through a hybrid model. To make this determination, the state could evaluate factors such as strategic priorities, existing talent, and vendor availability.

OPERATIONS

The Family Support Division (FSD) and MHD are responsible for critical participant- and provider-focused functions for the Medicaid program such as eligibility determination, participant enrollment, provider enrollment, prior authorizations/medical management, claims processing, and general participant and provider queries and escalations. Cross-cutting support functions, such as contact centers and data and analytics, support these customer-focused tasks. The functions are executed through a mix of staff and vendor contracts.

In this section, the performance and operational efficiency of three functions identified by state staff as having relevant opportunities for improvement are discussed: managed care enrollment, claims processing, and contact centers.[200]

Compared to other states and viewed from the customer-focused functional level (the integrated process of participant enrollment from eligibility determination to MCO enrollment, for example), actual work processes often appear fragmented, process steps seem poorly integrated and best-practice management principles are variably applied. Individual staff participants tend to have deep knowledge about their own responsibilities but much less insight into the overall processes and responsibilities therein. Perceived inefficiencies in handoffs between different parts of the organization (such as manual rework) are often accepted as "inevitable" or "unavoidable." Currently, outsourced roles do not appear to be optimally integrated or managed to ensure high performance of functions.

Potential initiatives identified, if employed, may help improve suboptimal service provided to participants and providers, create efficiencies in deployment of scarce staff, reduce frustrations in the workforce, and realize savings while improving vendor performance. Initiatives could include process optimization, with redesign starting from the perspective of the client(s); automation improvements and improved contract management. Improvements made to address the gap with best practices across the different functional areas could lead to up to 15% to 20% improvements in productivity. This may create staff capacity that could be redeployed for other purposes, to improve program effectiveness and workforce satisfaction.[201]

Current situation

Participant managed care enrollment

Participant enrollment processes within MHD aim to enroll children and pregnant women found eligible by FSD into the managed care program.[202] Once a participant is found to be MCO-eligible, the Information Technology Services Division (ITSD) passes that information to the Enrollment Broker (EB). The information the EB sends is determined based on whether the applicant is a "state care and custody" individual, a pregnant woman, and/or "all other" individuals. "State care and custody" applicants are auto-assigned to a Medicaid plan. They receive letters with this information, additional information about switching plans if they wish, and enrollment guides. Pregnant women and all other individuals receive a welcome letter with an enrollment form and an enrollment guide. Pregnant women also receive a health risk assessment. If they do not decide within seven days, they are auto-assigned to an MCO. All other MCO-eligible participants have 15 days to choose an MCO before they are auto-assigned.

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200 Interviews with Medicaid program staff members.

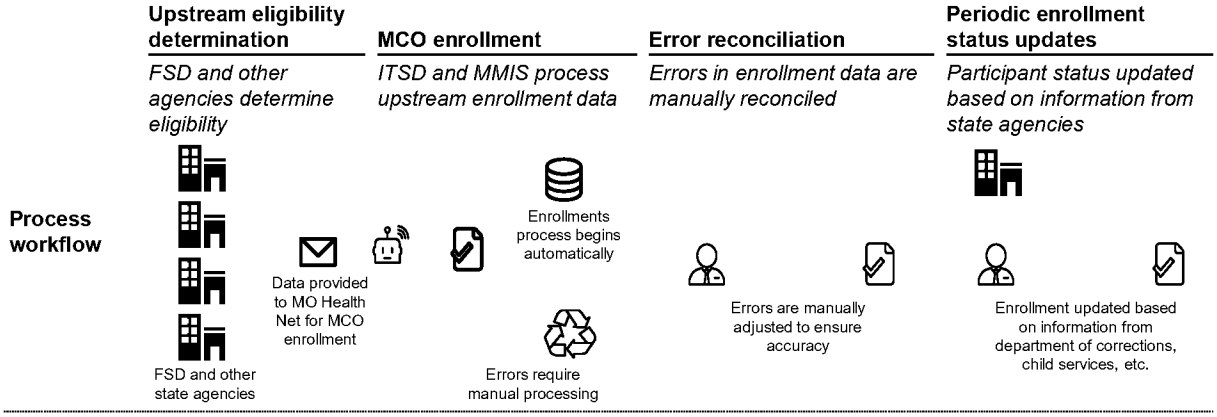
201 Analysis of DSS data versus industry benchmarks.

202 Interviews with Medicaid program staff members; for participants not in managed care no additional enrollment is required. Once found eligible, notices are triggered, and these participants are covered as long as they keep up to date on any premium payments, spend downs, etc.

While the majority of process steps are automated, errors with inbound data feeds and interactions with other state agencies drive manual interventions to ensure participant enrollment is accurate and timely. Communications with several other state agencies take place and are coordinated by the MHD team over email and phone correspondence.

The participant enrollment function serves as a critical interface with FSD. The process consists of four steps (see Exhibit 48). Eligibility determination is performed within FSD, and managed care enrollment is performed as a downstream process within MHD through an enrollment broker. The function relies heavily on upstream FSD systems for data and information feeds. MHD receives enrollment information from five systems, with the majority of volume driven by FSD systems. MEDES, the primary system for managed care eligibility, supplies participant information such as age, income, pregnancy status, etc. Once automated processes have run, any exceptions and errors are handled within MHD participant enrollment staff through manual intervention and communication with other state agencies such as FSD.

EXHIBIT 48: PARTICIPANT ENROLLMENT WORKFLOW



The function also engages other state services: Information feeds from the Department of Corrections, DSS, and the Children's Division are received monthly for manual enrollment updates. Information supplied contains data on incarceration dates, status in foster home programs (flagged as runaway), etc.

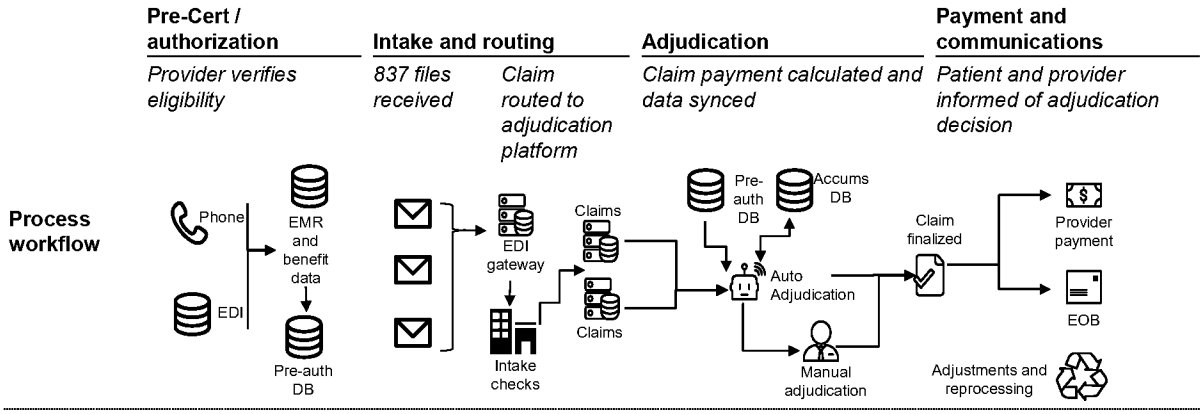
Claims operations

Claims operations include processes from intake of claim files, prior authorizations, claim adjudication and finalization.[203] Claims operations involve multiple stakeholders across claims

[203] Interviews with Medicaid program staff members.

operations, IT, and vendor resources. These operations are both largely automated and outsourced, in line with industry best practices (see Exhibit 49).

EXHIBIT 49: CLAIMS INTAKE, ADJUDICATION, AND PAYMENT PROCESSING WORKFLOW



Process description	▪ Pre-authorizations are received electronically or manually ▪ Processed both internally and by vendors ▪ Process is largely automated but some manual decision making is required	▪ Intake includes both receipt and preparation of claims for adjudication ▪ Process is largely automated with specific claim types such as out of state claims triggering manual intervention ▪ Vendors engaged for mailroom and OCR activities	▪ Clean claims are passed to adjudication system for finalization ▪ Edits built into system appropriately adjudicate claims as to be paid or denied ▪ Small portion of claims are pended requiring manual adjudication	▪ After claim adjudication, finalized claims are passed to payment processes ▪ Appropriate payments and notifications are triggered to both participants and providers

The claims operations function cuts across core claims operations, IT systems (MMIS), and other adjacent processes such as prior authorization. The claim intake is largely digital with limited need for OCR or manual intake in MMIS. The sources of manual intake include out-of-state provider claims, some drug claims, and some DME claims. Various labor-intensive process steps such as manual adjudication and prior authorization have been outsourced and MHD staff focus on issue resolution with vendors and providing expertise to allow vendors to adjudicate claims appropriately. Although the MMIS system is outdated (see previous section), its core FFS claim processing functionality has over the years become well-aligned with current work processes and needs. The system yields high auto adjudication rates, reducing manual work and improving accuracy for participant and provider stakeholders.

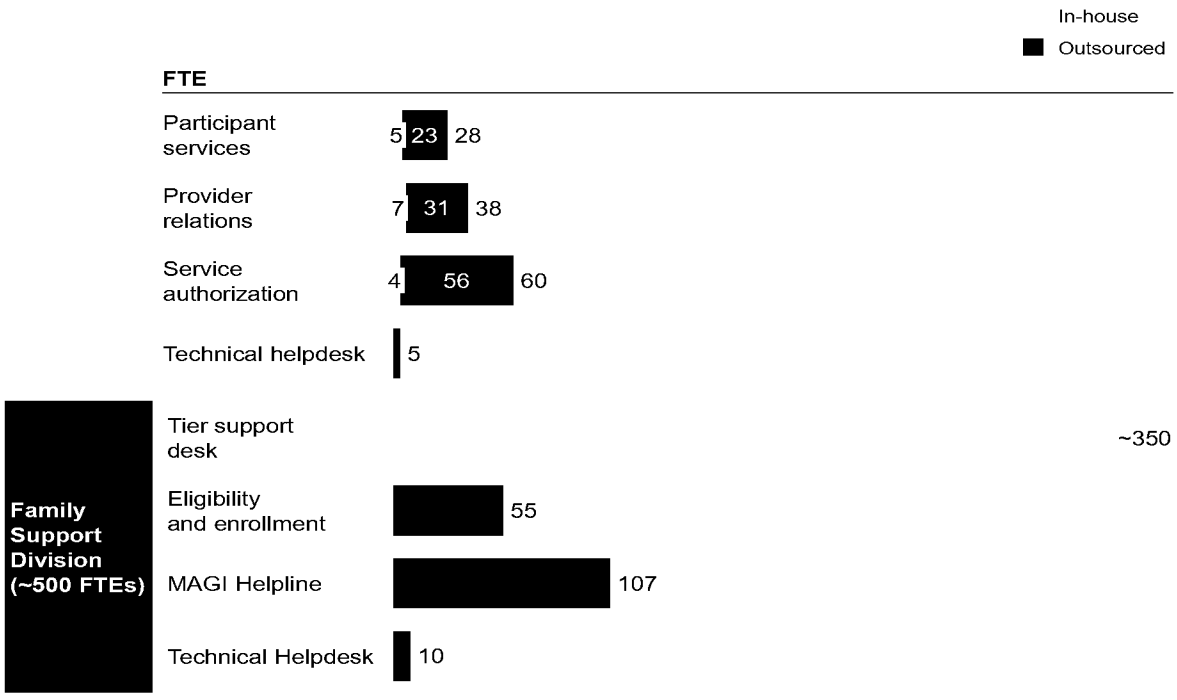
Claims operation processes are largely outsourced: vendors are utilized across almost all process components, including exception adjudication and medical record review.

Contact Centers

DSS manages two large clusters of contact centers. Some contact centers are outsourced; the largest, internal FSD contact centers are composed of ~350 FTEs. FSD contact centers handle calls related to food stamps, health care, child care, and child support for families. Internal contact centers employ full-time state staff members, many of whom served as case workers before the state moved away from the practice of assigning recipients case workers. The internal center within FSD handles queries related to food stamp benefits and processing in addition to a dedicated tier of agents who conduct interviews for food stamp and child care

eligibility, while outsourced FSD contact centers handle MAGI-related requests. The FSD contact centers handled 3.2 million calls in 2018.[204] The constituent health services (CHS) contact centers are largely outsourced. Both internal and external contact centers handle queries related to the state-run Medicaid program for participants and providers.[205] See Exhibit 50 for a breakdown of staff members across DSS contact centers.

EXHIBIT 50: MISSOURI DSS CONTACT CENTERS BREAKDOWN[206]



Incoming calls to FSD contact centers are routed to one of five tiers based on call reason. ~50% of FSD incoming calls are classified as Tier 1 (family support helpline): basic information requests, queries about outbound communication (annual review letters) and case status requests. ~30% of FSD incoming calls are classified as Tier 3 (food stamp interviews), which handle mandatory food stamp interviews. The remaining ~20% of calls are routed to Tier 2, 4, or 5 and are requests for live case-processing over the phone (e.g., for issuance of food-stamp benefits) or MAGI hearing requests (see Exhibit 51). Wait times average ~10 minutes but can reach over an hour for each tier.[207]

[204] Analysis of state data, 2018; interviews with Medicaid program staff members.
[205] Interviews with Medicaid program staff members.
[206] Analysis of state data, 2018.
[207] Analysis of state data, 2018.

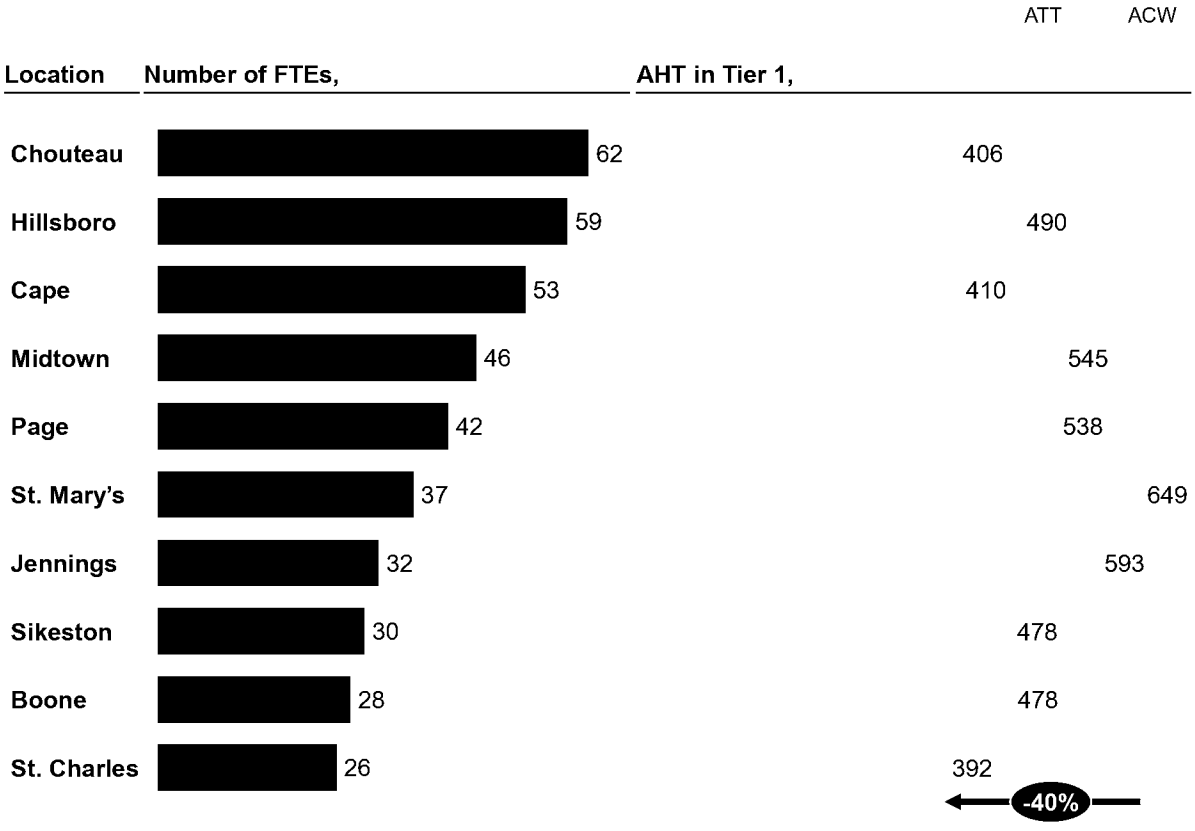
EXHIBIT 51: OVERVIEW OF FSD CALL TYPES[208]

Call type	Description	% of calls	FTEs in each tier	AHT Per Tier (mins)	Average wait times (mins)	Max wait times (mins)
Tier 1	▪ Basic questions about applications, eligibility, minor system changes, and SS updates	53%	67	10.0	13.0	67.0
Tier 2	▪ Case processing for food stamps and MHABD	11%	38	15.3	10.9	62.2
Tier 3	▪ Interviews for programs including food stamps and child support	30%	160	29.2	8.0	60.9
Tier 4	▪ Hearing request for MAGI	3%	33	23.3		
Tier 5	▪ Case processing for temporary assistance, childcare, and food stamps of specific participant groups (e.g., disabled)	4%	32	16.0	9.0	61.5

Internal FSD contact center operations are spread across 10 contact centers located throughout the state. These average a size of ~30-50 FTEs in each location; training, hiring and other support functions are centralized and require staff member travel. Exhibit 52 shows the number of staff members as well as the average handle time (AHT) per location.

[208] Interviews with Medicaid program staff members; analysis of state data, 2018.

EXHIBIT 52: FTE BREAKDOWN BY LOCATION – FSD INTERNAL CONTACT CENTERS[209]



The AHT varies across locations: there is a 40% variation between the location with the highest and lowest handle times. Workforce management practices are limited across the centers. Each location operates for ~12 hours, leading to support ratios of one supervisor to eight frontline agents and one manager to 45 frontline agents.

Outsourced operations deliver several key services to the Missouri Medicaid program: MHD participant and provider communications, which handles incoming calls related to participant and provider queries related to the Medicaid program (e.g., premiums, cost estimates); service authorizations; and the technical helpdesk for the MHD program.[210]

In addition, within FSD, the outsourced contact center specializes in MAGI enrollment and the eligibility helpdesk, including calls related to program eligibility, enrollment of new participants into the Medicaid program, inquires related to MAGI and case updates for the existing MAGI programs.

Potential opportunities for improvement

This section identifies potential opportunities to improve the efficiency and outcomes of Missouri's operations functions.

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[209] Analysis of state data, 2018. ATT: average talk time. ACW: after call work (avg. time for the agent to wrap up call-related tasks).

[210] Analysis of state data, 2018.

Participant managed care enrollment and claims operations

- **Limited KPI tracking and dashboarding:** There is limited tracking of Key Performance Indicators (KPIs) across key functions. Also, compared to best-in-class payors, contract management could be improved in areas such as claim handle time, adjustment rate, and timeliness of payment at a granular level.[211]

- **Staff members, particularly those involved in the participant enrollment process, perform a significant number of repetitive manual tasks:** Some of these tasks include incarcerated participant disenrollment, runaway children closeouts in ITSD (while they remain eligible), immediate enrollment of women who have just given birth, and error reconciliation.[212] Significant manual intervention is required to ensure enrollment information is correct and up to date.

  For claims operations, the need for manual and resource intensive interventions is limited primarily to medical record review and claims adjudication. The adjudication of complex claims typically requires manual intervention to ensure the right amount is being paid for relevant/appropriate services provided to participants. In some cases, this implies requesting medical records, that may be reviewed by clinicians, to ensure that services provided conform to existing policies. Such cases can require significant time as multiple records are received piecemeal from providers and only a subset may be matched to the correct claim. Even if the medical record was available, the content/document management process is not always able to link the record with the corresponding claim.

- **Upstream processes and outputs drive errors and limit scope for process automation:** Challenges with the quality of data received from upstream systems drives manual intervention (e.g., duplicate DCNs, deceased eligibility, >9 months pregnancies). The information received can be erroneous and needs to be manually resolved by MHD staff.[213] Resolutions involve review of data received (e.g., re-coding a pregnant participant as female instead of male) and communication with agencies providing data to gain clarifications (e.g., managing multiple DCNs). Data updates for participants are often received through email and must be manually inputted or modified within enrollment systems including ITSD and MMIS. Several of these issues are currently being addressed by FSD.

- **Participant correspondence processes are not integrated across FSD and MHD:** Parallel communication with participants drives repeat, out-of-order, and therefore potentially confusing communication to participants. For example, participants receive eligibility notices and premium notifications separately from both FSD and MHD. FSD notifications do not inform individuals that they might have to pay a premium and instead only inform them that they are eligible for Medicaid. Subsequently, secondary premium notifications from MHD may go unnoticed, resulting in poor response rates and potential disenrollment.

- **Staff members perform significant tasks within participant enrollment:** Compared to those at best-in-class payors, staff members perform a significant number of tasks across processes such as managed care enrollment, disenrollment, and error correction, which in other state Medicaid programs are often managed by vendors. Currently, therefore,

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211 Interviews with Medicaid program staff members.

212 Interviews with Medicaid program staff members.

213 Interviews with Medicaid program staff members.

internal staff spend much of their time performing tasks that could potentially be outsourced instead of, for example, focusing on quality assurance of the processes.

Contact centers

- **In the FSD internal contact center, current non-phone self-service options are limited, leading to a high number of live contacts and high wait times:** Limited alternative self-service options (e.g., chat or SMS bots) are available for answering basic questions, which creates high call volume in Tier 1. In addition, no status notification systems are in place to inform the participants about the status of food stamp applications or document requests, leading to requests for over-the-phone case processing and status updates. The combination of these factors leads to high incoming call volume in Tier 1, leading to high wait times and sub-optimal customer and staff member experience (e.g., waiting 60 minutes for a 1-minute answer to a question). Addressing the above opportunities could drive a 15% to 25% reduction in incoming call volume while significantly enhancing participant experience during the food stamp interview process. [214] In addition, the self-service options could reduce call volume in Tiers 2, 3, 4, and 5 through notification and tracking of claims processing, scheduling hearing requests via email or chatbots, and alerting an individual when their application is ready for interview via SMS or email. Self-service options require thoughtful design, as suboptimal website and chat bot design may reduce participant experience rather than improve it.
- **FSD outbound communications (e.g., letters, review requests) and applications highlight live customer support options that result in high wait times in FSD contact centers:** Many communications focus on providing customer support via phone and do not guide participants to alternate resources such as the website or clarify the frequently asked questions in the communication. For example, the Missouri food stamp application form bolds the customer support number and asks a participant to call as soon as possible, even though the participant needs to wait 24 hours after submission for the form to be uploaded in the system. [215] In comparison, Florida food stamp application forms more clearly explain the processing window and guide participants to resources on the web (see Exhibit 53).[216] Missouri could adopt a combination of these approaches to improve participant access to timely support.

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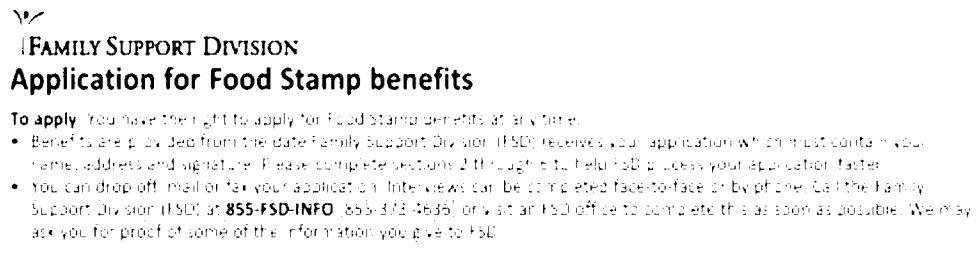
[214] Analysis of state data, 2018.

[215] Missouri DSS, "886-0460 (9-16) Application for Food Stamp Benefits," see: dss.mo.gov/fsd/formsmanual/pdf/fs1.pdf.

[216] Florida state government, "Access Florida Application," 2016.

EXHIBIT 53: FOOD STAMP APPLICATION EXAMPLE[217]

Missouri example



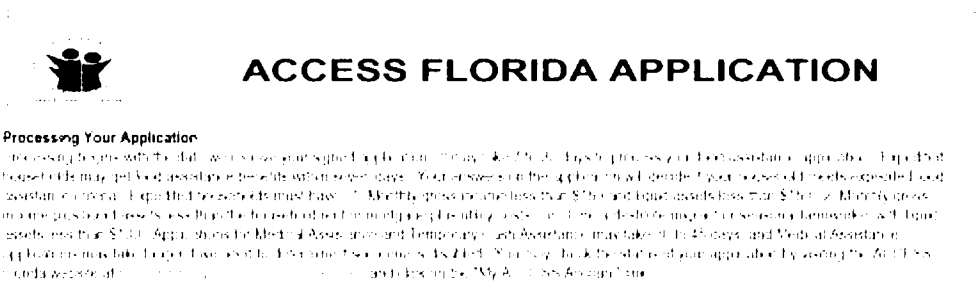
FAMILY SUPPORT DIVISION

Application for Food Stamp benefits

To apply You have the right to apply for Food Stamp benefits at any time.

- Benefits are provided from the date Family Support Division (FSD) receives your application which must contain your name, address and signature. Please complete sections 2 through 5 to help FSD process your application faster.
- You can drop off, mail or fax your application. Interviews can be completed face-to-face or by phone. Call the Family Support Division (FSD) at **855-FSD-INFO** (855-373-4636) or visit an FSD office to complete this as soon as possible. We may ask you for proof of some of the information you give to FSD.

Florida example



ACCESS FLORIDA APPLICATION

Processing Your Application

- **Customer experience is impacted due to both variability in average handle time for calls and high wait times**: In each tier, bottom-quartile agents require 1.7 times longer to handle an average call in comparison to the top-quartile agents. For example, in Tier 3 top-quartile agents handle an interview in ~18 minutes, while bottom-quartile agents take ~30 minutes (see Exhibit 54).[218] Top-performing agents may handle a call in ~30-40% lower handle time compared to lower-performing agents.[219] This could indicate gaps in training and coaching processes, which prevent delivery of a consistent experience. In addition, in the internal contact centers, workforce management practices are not deployed to match incoming call volume to expected staffing of agents in each tier; this likely leads to high wait times in certain tiers during peak times (e.g., >60-minute wait time in Tier 1 on Monday mornings). Currently, Tier 1 has 67 dedicated agents; although analysis indicates at least 100 agents may be required to meet demand. Conversely, Tier 5 has 32 agents although only 15 may be required to meet demand.[220]

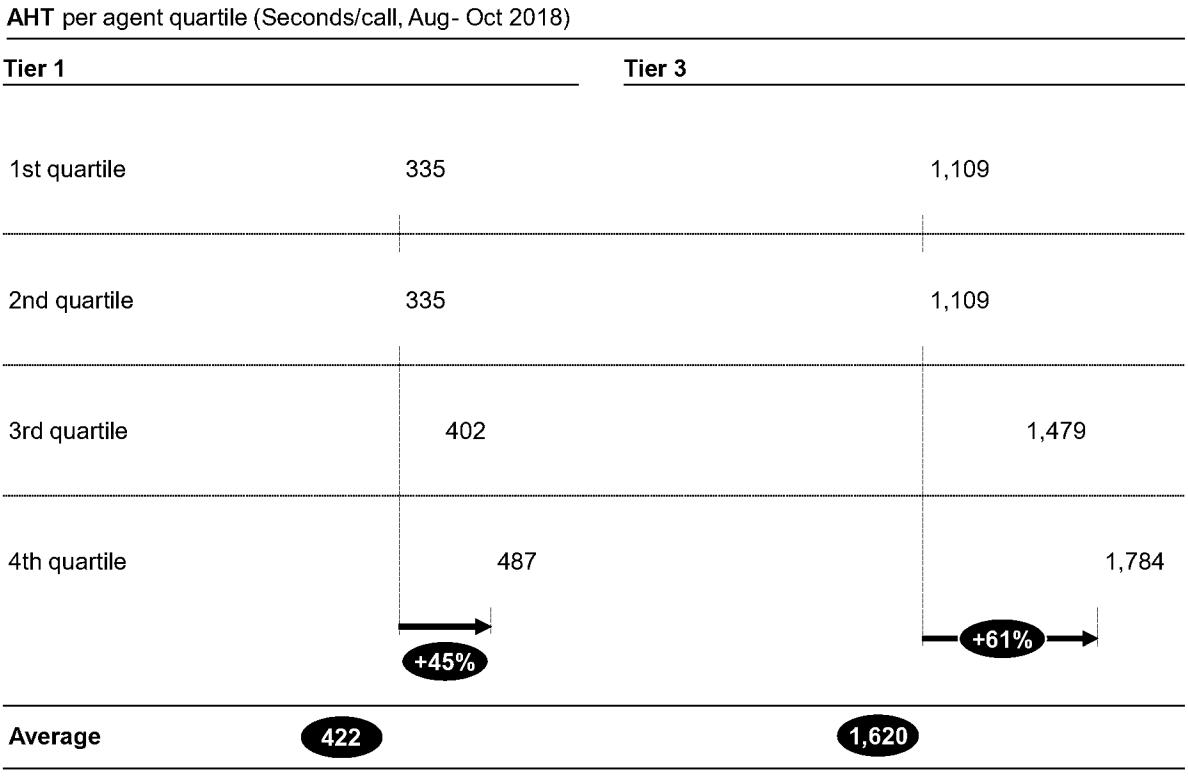
217 Missouri DSS and Florida state government: see note 215 and note 216.

218 Analysis of state data, 2018.

219 Analysis of state data, 2018.

220 Analysis of state data, 2018.

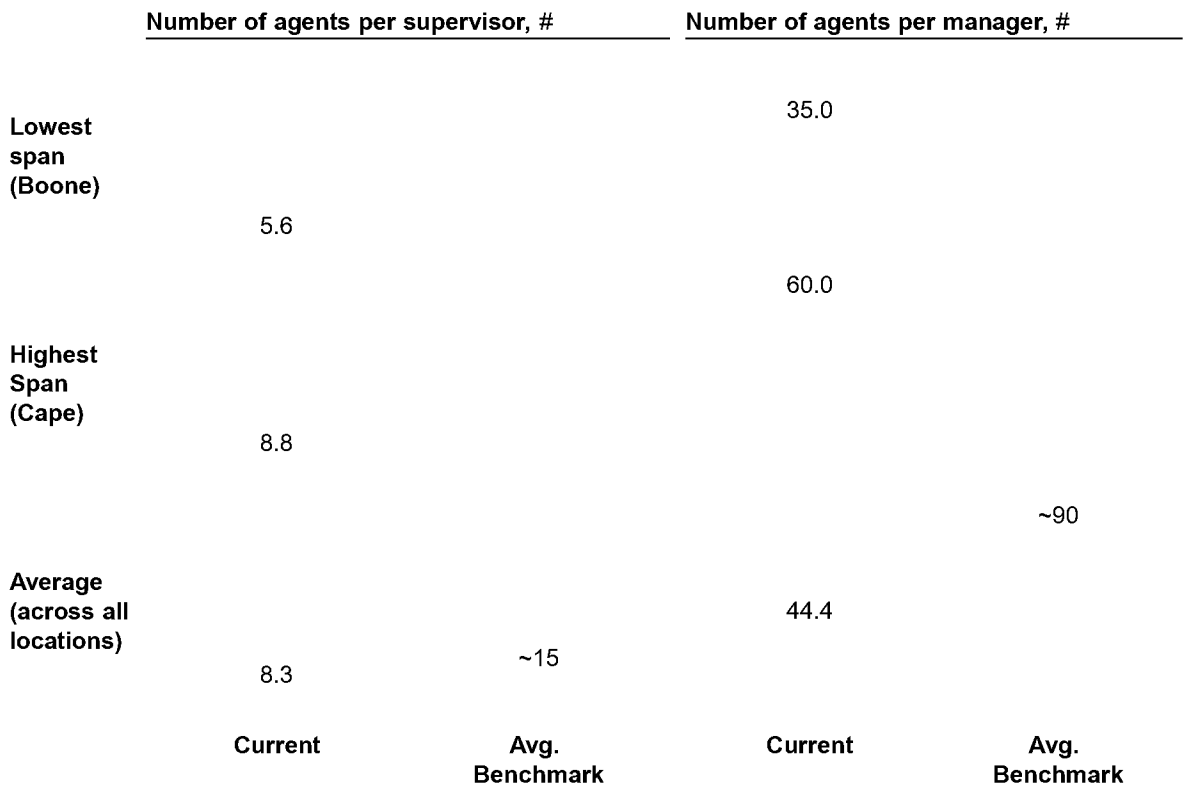
EXHIBIT 54: AVERAGE HANDLE TIME VARIABILITY – FSD INTERNAL CONTACT CENTER



- **In the internal contact centers, multiple locations limit the efficiency of support functions:** Many locations operate at low scale which leads to performance variability, challenges in support services, and underutilization of facility space.[221] Several locations have significantly lower management spans in comparison to the industry benchmark ratio of 15 frontline agents per supervisor (see Exhibit 55).[222] Multiple locations not only lead to higher cost to serve but also to diminished staff member experience due to reduced scale. For example, staff members receive less training because of the need to travel to a central location, and there is inconsistent operating experience in centers.

[221] Internal contact center site observations; Interviews with Medicaid program staff members.
[222] Analysis of state data, 2018.

EXHIBIT 55: AGENT, SUPERVISOR, AND MANAGER STAFFING LEVELS



- **Policies governing the outsourced contact center operations lead to rework for internal state staff members**: In MAGI contact center operations, policies prohibit outsourced contact centers from submission of MAGI case updates in case of change of coverage. This tends to lead to a case transfer to internal case processing teams, who rework the case from the beginning, doubling work and increasing processing time, as well as potentially frustrating customers. Currently, 38% of calls to the MAGI contact center must be transferred for internal processing.[223] Similarly, a policy to transfer calls from MHD reception for internal escalation as opposed to directly to the vendor leads to disruptions in workflow for internal agents and could potentially be simplified to improve customer and staff member experience.
- **Dual operating environment of in-house and outsourced operating model:** The state currently manages both in-house and outsourced operations in its current contact center operations. Currently, Missouri's state in-house operations and outsourcers have similar operating costs. The state has approximately the same set of resources dedicated to managing in-house operations and for contracts for outsourced operations. This may lead to a dual focus of administrative resources and limited opportunity to focus and hone expertise in either of the skillsets.

[223] Analysis of state data, 2018.

Potential initiatives

Based on observations and engagement of Missouri's leaders and functional process owners, potential initiatives spanning organizational process optimization, automation and digitization, and sourcing optimization have been identified.

Implementation of outlined initiatives could drive opportunity for MHD across the following axes:

- **Enhanced customer experience**: Automation, digitization and process improvement could drive improved experience for participants and reduce pain points.
- **Improved staff utilization and satisfaction**: Elimination of repetitive, manual processes and reduction of error corrections could help staff contribute to other high value processes. FTE capacity created could potentially be used to address limited staffing in other core operations functions.
- **Optimized vendor spending**: Assessment of current vendor contracts and management of existing work types could help reduce administrative expense and vendor performance.

Initiatives that deal with technological improvements and capabilities should likely be considered in conjunction with the initiatives discussed in the section on MMIS.

Potential organizational process optimization initiatives

1. **Develop process guides for staff member efficiency improvement and error reduction:** Currently, a limited number of job guides exist to guide staff member on best practices for repetitive tasks. The creation of such guides could drive improved efficiency, reduce errors, and greatly shorten time to ramp up new staff members on core manual processes. Specifically, the enrollment process has many potential tasks that could benefit from the creation of a guide, such as incarcerated disenrollment and error reconciliation. Guides that provide step-by-step instructions on how to complete these tasks could be readily created and may be greatly beneficial.
2. **Develop job aides for high-volume tasks:** High-volume tasks that are currently performed through experience and on-the-job learning have the potential to be standardized and expedited through the creation of job aids. (Job aids are basic decision trees, checklists, planning tools that support work and activity by guiding or directing tasks at hand.) For example, within claims operations, the team could create job aids who provide algorithmic guides specifically for top edits and manual adjudications.
3. **Implement workforce management:** In contact centers, for example, shifting staff members across tiers and optimizing staffing in each tier could achieve reduced wait time on the phone (i.e., average speed of answer of less than 60 seconds against current average of over 10 minutes). To achieve this reduction in wait time, potential solutions include moving agents from Tiers 3, 4, and 5 to Tier 1 and ensuring the right shrinkage factors (e.g., absenteeism) are factored into the staffing model. Workforce management principles could also improve efficiencies within claims processing by further aligning staff members to specializations by skill level and claim type. This could improve processing times and staff productivity.
4. **Adopt performance management practices**: In contact centers, the state could coach toward behaviors that drive high talk-time and quality and reduce variability in average handle time across each tier to achieve a ~10% to 12% reduction in average handle time in each tier and improve customer experience. The state could adopt best-in-class

performance management practices, including defining clear agent goals and KPIs and increasing structured coaching and uniform meeting cadence. To help define clear goals and a holistic set of KPIs, scorecards could be updated with realistic goals against important KPIs. (See Exhibit 56 for typical measurements that are leveraged in contact center environments and shared across contact centers to hold individuals/teams accountable for their role in creating a positive participant experience.) With clearer scorecards and KPIs, coaching could become more structured and efficient, driving better customer experience and lower wait time through reduction in average handle time.

KPIs and dashboarding could be equally essential in participant enrollment and claims processing (see Exhibit 57 for typical KPIs). In the claims tracking process, for example, organizational leadership could increase its effectiveness if it could have access to critical KPIs such as auto-adjudication rate, adjustment rate, percentage of claims paid as billed, rate of denial by denial reason code and denials overturn rate.

EXHIBIT 56: EXAMPLE BEST PRACTICE CONTACT CENTER KPIS

Key KPIs

Dimension	Category	Metric	Typical definition
Service/ Quality	▪ Speed of answer	▪ Service level	▪ % of intervals that achieve the target service level
		▪ Avg. speed of answer	▪ Total wait time/ Total number of answered calls
	▪ Abandoned rate	▪ Abandoned rate after the IVR	▪ Calls dropped after it reaches an CSR/Calls offered
		▪ Abandoned rate during the IVR	▪ Calls dropped during IVR, before it reaches an CSR (excluding self-serve calls)/Calls offered
	▪ Transactions quality	▪ Quality score	▪ Call monitoring score(%) (average score on call monitoring/maximum score)
		▪ Critical accuracy score	▪ % of monitored calls without any fatal errors
	▪ Resolution rate	▪ Repeat transaction rate	▪ % SR requests/calls with a repeat call/SR within 24 hours
		▪ FCR	▪ % of calls resolved during the first call
	▪ CSAT	▪ End-user satisfaction	▪ On a scale of 1-5, % of customers that have rated 4 or 5 (satisfied/ very satisfied)
		▪ End-user dissatisfaction	▪ % of customers choosing "dis-satisfied (2)" or "very dissatisfied (1")
		▪ TNPS	▪ Promoters – Detractors
	▪ On time (for deferred transactions)	▪ Service level	▪ % of transactions processed within targeted cycle time
		▪ Average time late	▪ Average time late of transactions which are outside of targeted cycle time.
Volume	▪ Escalation & transfer	▪ Escalation and transfer rates	▪ % of answered calls escalated /transferred to Tier 2/ other departments/desks
	▪ Volume	▪ Transactions offered	
Efficiency	▪ Utilization	▪ Utilization	▪ (Talk+Hold+ACW)/ Total paid time
		▪ Occupancy ratio	▪ Talk and wrap time divided by logged time
	▪ Availability	▪ Attendance	▪ CSR showing up for work on their scheduled day
		▪ Schedule adherence	▪ Time CSR is available / time they are scheduled to work
	▪ Average handle time	▪ Average handle time	▪ (Talk+Hold+ACW)/ Total number of answered calls. Average processing time for deferred transactions

EXHIBIT 57: EXAMPLE PARTICIPANT ENROLLMENT AND CLAIMS PROCESSING KPIS

Payor value chain function	Metric subcategory	Specific metric
	Summary metrics	▪ Enrollment cost per total transaction ▪ Total enrollment transactions per FTE per year ▪ Total automated electronic transactions as a % of total member transactions
Participant enrollment	Average enrollment processing days	
	Enrollment accuracy	
	ID cards	▪ Percent of participants that received cards before effective date
	Billing	▪ Total number of bills sent per participant
	Summary metrics	▪ Suspended (manual) claims processed per FTE per year ▪ Cost per suspended (manual claim) ▪ Claims processed per claims FTE per year ▪ Cost per claims processed
	Claims type rates	▪ Total suspension rate ▪ Total claims auto-adjudication rate ▪ Total adjustment rate ▪ Denied claims rate
Claims	Speed of processing	▪ Average payment period in days ▪ Average inventory in days
	Percent of claims processed within the following days of receipts	▪ 0-14 days ▪ 15-30 days ▪ 31-60 days ▪ > 60 days
	Timing of claims	▪ Claims turnaround time (TAT)
	Quality	▪ Dollar accuracy percent ▪ Frequency accuracy percent

5. **Within the participant enrollment flow, integrate mailer and correspondence process with FSD:** The state could implement process change to integrate correspondence of premium notices with FSD eligibility notices to drive improved response rate. This could require a simple process change to implement the inclusion of the first premium notice in the same envelope as the eligibility notice. This may significantly reduce non-responses to premium notices.
6. **Improve medical record matching to reduce incorrect denials in participant enrollment:** Matching medical records to appropriate claims to minimize inaccurate denials could drive significant improvement in enrollment accuracy and reduce downstream rework.
7. **Improve accumulator accuracy to help manage spend down errors:** Spend down inaccuracy drives significant billing errors and inbound inquiries. The state could consider setting up a team to minimize spend down on out of sync scenarios, which could help minimize errors.
8. **Assess prior authorization (PA) list for high pass rate codes and optimize through quarterly refreshes:** State staff could conduct analysis to identify drivers of manual PAs and ensure quarterly list refreshes. This could minimize manual PAs for high pass rate codes.
9. **Redesign root-cause drivers (e.g., participant communication & notification) to reduce call volume to contact centers:** The state could institute ongoing processes to

address root-cause drivers currently leading to increased call volumes. There are several near-term initiatives that could lead to the reduction of call volume. For example, the state could consider redesigning forms and letters to guide to digital channels and highlight additional communication resources available. This communication could provide clear and updated guidelines on when to call the contact center after application submission. In the case of interviews, the state could consider asking the applicants to wait 24 hours to allow for the appropriate processing time before calling.

10. **Revise policy guidance on MAGI helpdesk to avoid rework:** The state could review internal policies that currently prohibit outsourced MAGI helpdesk agents from completing case updates in situations when a change of coverage occurs (currently, these changes must be completed by an internal agent). Also, the state could consider updating policies to enable MHD staff members to transfer to Wipro, when applicable, to reduce downstream rework in internal case processing team.

Potential automation and digitization process optimization initiatives

11. **Implement macros and automation to replace repetitive manual tasks:** The state could identify repetitive manual tasks and build simple macros/automation to reduce manual intervention. Batch enrollment corrects or incarcerated participants disenrollment could be executed automatically, for example. Implementation would require both macro development and inbound data manipulation. Creating macros or process automation routines that utilize database queries and pre-set algorithms to perform defined tasks such as participant information updates or error reconciliation could significantly reduce the manual intervention required. Engaging vendors to identify and build use cases for automation could drive efficiency gains: in some quick-win cases, technologies like optical character recognition (OCR) could be implemented within 6 to 12 months, while more complex implementations (e.g., machine learning to improve auto adjudication rates) could take 12 to 24 months.
12. **Improving upstream systems to help reduce manual rework:** Erroneous information feeds drive significant rework within MHD processes. Engaging FSD leadership to drive changes in these upstream systems (especially MEDES) could significantly reduce rework within participant enrollment function. Improved data formats (e.g., pipe-delimited flat files rather than email-based information) could provide basis for rapid system updates, eliminating manual processes.
13. **The state could engage inbound data stream owners to align on data feed formats:** Currently, data from various other state agencies is primarily received via email. Convening leaders to align on unified and simple data exchange formats (some best-in-class payors use pipe-delimited files) could allow for easy and automated intake into ITSD systems. This could reduce manual workarounds and potential for error.
14. **Invest in improvement of auto adjudication rates:** The state could conduct detailed analysis to assess current drivers of manual adjudication – such as edits, medical policies, system issues – and inbound data issues, in addition to implementing improvements in the claims systems to improve auto-adjudication rates. For example, the state could consider identifying top edits that trigger manual adjudication and determining modifications to edits that could drive claims to be auto-adjudicated. For example, if an edit requires an assessment of a particular attachment or medical record and it is found that such claims are paid with a high pass rate, removing that requirement could eliminate need for manual intervention.

15. **Implement issue and project tracking system:** Currently, issue and request management is done through email. The state could consider transitioning to a ticket-based management system that provides real time tracking, escalation paths and pan-organizational transparency.

16. **Build digital participant engagement platform:** Transitioning traditional communication channels to a digital medium for high-impact communications such as premium notices (e.g., e-pay functions), ID cards, or explanation of benefits (EOB) delivery could drive improved participant engagement. The state could consider investing to get ahead of developing participant digital preference trends and drive adoption for new enrollees over a five-year horizon.[224] Some of these participant engagement practices could help promote self-service and reduce call volumes for the contact center and save on costs incurred due to existing communication using traditional channels, such as printed ID cards and EOBs. Given the proliferation of different modes of communication, it could also be helpful to note/flag the preferred method of communication during the enrollment process.

17. **Provide self-service options for Tier 1 calls to reduce live calls and wait times:** The state could consider investing in new self-service channels for the resolution of simple issues like status of cases or food stamp eligibility through alternative channels to reduce call volume by ~15% to 20% in Tier 1. This could ease the load and reduce the current peak wait time for 60 minutes significantly. The state could consider potential quick wins like website-based self-service options and SMS-based notifications and bots to provide quick answers to simple requirement questions. Likewise, chatbots in the website could potentially answer queries on case status and document uploads (e.g., an AI-based chat service with limited human intervention).

Sourcing optimization initiatives

18. **Evaluate engaging additional vendors:** The state could consider engaging a vendor for improved participant address management. Significant correspondence challenges stem from dead or out-of-date addresses. Engaging vendors to conduct address reconciliation and quality improvement is a best-in-class payor practice and can help better engage participants. Ensuring mail is sent to correct participant addresses could also drive cost savings by reducing rework and through postage and printing cost reduction.

    In addition, the state could consider engaging vendors to maximize value added work performed by the department's participant enrollment team. MHD could consider the potential to outsource enrollment correction processes and assess the current reliance on participant enrollment team to solve routine and complex enrollment issues.

19. **Define future operating model for state contact centers to balance in-house vs outsourcing options:** As part of future review of the state's contact center operation, the state could consider three options for future operating model for contact centers:

    - Focus on operations excellence and operate contact centers internally with only strategic outsourced vendor partners as required
    - Focus on contract excellence and move to a primarily outsourced model with retention or strategic contact center operations in-house

[224] McKinsey, "Healthcare's digital future," 2014, see: www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/healthcares-digital-future.

- Continue blended operating model with focus on operations excellence with internal center and focus on contract excellence for outsourced operations with adequate resources to manage in-house operations and outsourced operations

All options could facilitate providing best-in-class contact center services to participants and providers. In the first two options, the state could choose to dedicate its resources to focus on either on operational excellence or contract excellence; in a blended model, the state would likely need to ensure that appropriate resources are dedicated to each area against a shared resourcing model with dual focus. To determine the best fit option for the long term, the state could evaluate each of these options in view of cost, quality of service, strategic fit, administrative priorities, and operational agility to determine the best choice going forward.

Implementation Considerations

Without significant changes, Medicaid spending may comprise 26% to 30% of state general revenues by 2023. To bring growth of Medicaid spending in line with the level of economic growth of the state while preserving access for participants and avoid reducing eligibility or coverage, significant savings would be necessary. In the preceding pages, eight programmatic and functional areas were analyzed, and descriptions of the current state, potential opportunities for improvement, and potential initiatives were provided.

Were Missouri to fully and effectively address the opportunities and potential initiatives outlined in this report, total gross savings to the program (including federal and state share) could total up to $0.5 billion to $1.0 billion by SFY2023 (net of potential reinvestments in the delivery system and in the Medicaid program's operations). These potential savings are not meant to represent an absolute reduction in Medicaid program spending but rather a meaningful reduction in the growth rate of the program to bring it in line with economic growth of the state. In addition, many initiatives focus on reducing cost growth through improving participant outcomes and experience. Adopting such a transformation agenda could make the program more financially sustainable and reduce fiscal pressure that may arise in the event of a recession or changes in federal financing.

Potential initiatives are wide-ranging, including operational improvements to bring the program up to date with common practices among other state Medicaid programs, as well as implementing best practices and more transformational changes. The following entails some of the choices the state may consider in selecting the portfolio of initiatives that will comprise Missouri's approach to Medicaid transformation. Also outlined below is a summary of the key requirements for implementation.

Approach to Portfolio Selection

Broadly, the state could balance two approaches to controlling spending. One approach commonly adopted by both public programs and managed care would rely primarily on controlling the unit prices paid for services and seeking to curb utilization through payor decisions regarding clinical necessity. This approach could reduce costs and drive efficiency across provider types, readily realizes savings, with limited associated technical complexity. Yet this approach may lead to provider resistance and does not provide an incentive to improve patient outcomes. Finally, mainly focusing on rates and volume would likely be only a temporary solution: as one of the root causes of the problem – the underlying FFS payment mechanism – would not be addressed, fragmentation and growth of volume may continue to exist, potentially leading to the need for further rounds of budgetary tightening.

In the second approach, the state would seek to adopt innovative value-based payment and care delivery models that reward providers for quality and efficiency of the total care delivered to patients. This approach may support more transformational changes in care delivery, with corresponding improvements in patient outcomes and experience. A key focus would be reducing costs through improved outcomes for participants: strengthening primary care, integrating behavioral and physical care, emphasizing independent living at home (with community support where needed), and addressing social determinants of health. This approach would pay for the outcomes that matter to participants rather than volume and would stimulate the transparency of provider performance. The approach is likely to require greater commitment of resources and longer to generate impact, given the need for providers to adopt not only the new payment models but also to adopt new capabilities and implement changes in clinical practices.

To align the growth of Medicaid expenditures with the state's economic growth could require a combination of these approaches, balancing and prioritizing shorter- with longer-term needs and strategic goals. Regardless of the balance chosen, there is a range of "no regret," operational initiatives that the state may consider bringing policies and operations up to speed with common practices, including state-of-the-art fraud, waste, and abuse (FWA) as well as third-party liability (TPL) methodologies, targeted use of utilization management, as well as improvements in contact centers and other internal administrative processes. Adoption of common and leading practices in these areas will address outlier practice patterns and inefficiencies, generate near-term savings, improve customer experience, increase workforce satisfaction and reduce pressure on the rest of the system while longer-term, more transformational changes are being implemented.

Any substantial portfolio of initiatives would demand careful planning and execution, and investments to support the transformation and build new capabilities. Key requirements for effective design and implementation of Medicaid transformation include: strong and visible executive leadership; effective stakeholder engagement; commitment to fact-based decision making supported by robust data; upskilling of key agency staff; a well-resourced transformation office; and modernization of the program's technological infrastructure.

Requirements for Implementation

Whichever approach the state adopts, any substantial portfolio of initiatives will demand careful planning and execution, and thoughtful investments in new capabilities. Many states underestimate the resources needed and the challenges that may be encountered in the implementation process.

The assessment of the state's Medicaid program revealed that the Departments responsible for the Medicaid program are aware of many of the opportunities identified and would embrace an ambitious transformation plan. Yet both leadership and staff are also acutely aware of the challenges the state will face in effecting changes. While there is significant institutional knowledge that will greatly benefit the state's efforts, few have experience with managing large-scale transformations. In addition, many of the potential initiatives will require technical knowledge based on experiences outside Missouri. Finally, most initiatives will require building upon operational processes that themselves were identified as needing improvement, as well as outdated technology and data and analytics infrastructure.

Based on our experience, key requirements for successful implementation would include strong executive leadership, a detailed and objective fact base, and extensive stakeholder engagement. In parallel, significant attention to upskilling key agency staff and improving technical abilities (ranging from MMIS functionality to data and analytics to the digitization of key operational bottlenecks) will be necessary to ensure success and sustainability of improvements. The following briefly describes these key requirements in turn.

Strong and visible executive leadership. Successful transformation of the Medicaid program will require active and visible leadership from the Governor's Office, the Medicaid Director, and other agency leaders and senior staff across DSS, DHSS, and DMH, as well as additional support from the Office of Administration. In most states, the Medicaid Director would be the owner of the overall transformation and regular Steering Group meetings, which could include other agency directors/commissioners, the Medicaid CFO, and Governor's Office representative(s), for example. Such a steering group could lead not only through decision-making but also through role-modeling for senior staff, creating a sense of urgency, adopting creative solutions to problems, and communicating a compelling change story.

The planning and execution of the individual initiatives could be grouped into workstreams which could be owned by agency leaders or senior staff ("sponsors") responsible for the areas impacted by the workstream. The exact configuration of this group will be highly state-specific, but a portfolio derived from this current assessment could require sponsor roles of the Medicaid COO, CFO, and CIO, in addition to the Managed Care Director, the Value-Based Payment lead, and the Program Integrity lead, among others. Not allocating sufficient time to these roles is one of the most frequent reasons for implementation failure. In other states, sponsors will spend 20% to 30% of their time for several years per workstream. The Medicaid Director will likely have to commit to an on-the-ground leadership role in the transformation for the majority of his/her time.

A well-resourced transformation office. To realize the implementation of an ambitious portfolio of initiatives, a well-resourced transformation office (TO) has proven to be essential. The TO commonly sits outside of the normal line organization and explicitly operates with a with a clear – and bold – mandate of the executive leadership. The function of the TO goes well beyond the traditional Project Management Office to help the executive leadership, the steering group, and the workstreams to achieve their goals by fulfilling several core roles:

- Drive action, help clarify goals, balance priorities and coordinate between initiatives
- Help create and execute the initiative- and workstream specific implementation plans
- Create, maintain, report on, and further develop the fact base for initiatives per workstream
- Perform advanced data and analytics functions for the workstreams
- Support the stakeholder engagement process in its different forms
- Manage resources, timelines, internal- and external meetings and realization of the targets
- Facilitate training of agency staff

To fulfill all these roles, a TO will need sufficient resources. Successful states draw on talented agency staff as well as on subject matter experts who may bring knowledge of best practices from other states, payors, or industries to build the TO. The TO also requires rigorous project management and in-depth experience with all the dimensions of the change process. The TO should be led by a full-time, sufficiently senior member of the senior leadership with experience in change management.

Upskilling of key agency staff. The Missouri Medicaid program benefits from agency staff who are not only committed to the performance and sustainability of the program, but who collectively possess significant institutional knowledge. At the same time, staff and leadership realize that the future state (and the change process needed to get there) will require knowledge and skills that are currently absent or in short supply. Without these new capabilities, no change efforts can hope to be sustainable.

The more ambitious the agenda, the more critical it is that Medicaid agencies develop strong, end-to-end talent capabilities – including the ability to attract, develop, deploy, reward, and retain top talent. Key skills and roles that would require investment (in number of individuals and/or level of skills) are, for example:

- Project management
- Lean or other business process redesign
- Vendor contracting

- Data and analytics
- Performance management
- Outcomes transparency
- Payment innovation
- Communication
- Technical and data architects
- Data scientists / engineers
- Technical and systems operations management
- Contract management

Best practices in other states include optimally building on existing talent, investing in training (including on-the-job), redeployment, and re-training, as well as recruitment of new leaders and staff. As several of the initiatives address the optimization of the Department's own operations, staff may become available for new organizational roles.

Detailed and objective fact base. A firm footing in data is necessary to set measurable goals, and track progress and ROI. In addition, a solid base of objective facts is the foundation for effective decision making. The opportunities outlined in this report are based on a breadth of research and analysis conducted over the past three months. Going forward, detailed design and implementation of initiatives will demand an even richer fact base to

- Determine the improvement opportunities per initiative in more detail and set goals (including financial targets, outcomes of care, customer experience);
- Analyze options for granular initiative design decisions, ranging from the clinical criteria to be incorporated into new medical policies for utilization management; methods for adjusting new payment models for patient risk and severity; planning internal contact center redesign; or rebasing reimbursement rates;
- Apply risk adjustment, set target budgets, calculate shared savings/losses, quality outcomes and bonus payments;
- Forecast and track possible impacts on provider finances from changes in reimbursement;
- Forecast and track possible impacts of relevant initiatives on rural health and the safety net (financial, access and quality); and
- Create transparency of care costs and outcomes (value) per subpopulation, key conditions, regions and other relevant dimensions;

Stakeholder engagement. Each of the potential initiatives discussed in this report has the potential to affect participants, providers, and other stakeholders, placing a premium on transparency and proactive communication. Certain initiatives – chiefly those associated with reimbursement, value-based payment, and possible changes in the scope of managed care – pose more significant implications for stakeholders and therefore likely demand a collaborative process for design and implementation of changes. Without adequate stakeholder engagement, those impacted by the planned changes are more likely to experience change as something happening to them rather than as something that was co-shaped by them as partners in the change process. Also, without adequate stakeholder engagement, initiatives

may fail to be adequately grounded in the reality of care delivery and payment, and the experience of participants.

Effective stakeholder engagement will take different forms, ranging from a statewide working group consisting of stakeholder leaders, committees focused on specific initiatives or cross-cutting topics ("regulatory issues," or "APM quality measures"), a clear communication plan, interactive web-based discussion forums, informative webinars, regional stakeholder conferences, and training opportunities.

Experience has shown that successful stakeholder engagement starts with a shared narrative about the need for change, and a strong fact base underpinning key decisions. Clarity of goals is essential. Subsequently, initiatives should be fleshed out and design decisions and the implementation plan should be discussed with stakeholders. Stakeholder engagement should continue during the implementation itself as well as during the first year(s) of rollout, and progress toward goals should be jointly monitored. As the implementation and go-live of initiatives always run into unforeseen issues, obstacles, and opportunities, having the ability to jointly address these is a great benefit.

Technology

The existing MMIS poses one of the key challenges for any substantial portfolio of initiatives the state may want to implement. Many of the initiatives will require functionalities that the current MMIS does not offer. If the planning and implementation does not take these limitations sufficiently into account, these initiatives may fail to achieve their intended goals. That said, the current state of the MMIS does not have to hamper achieving ambitious goals. Functional limitations can be addressed in three ways:

1. *Limited configuration or code changes.* For many of the utilization management or pharmacy initiatives, for example, or the further modernization of hospital outpatient FFS reimbursement, minor changes to the existing MMIS will suffice. These can be incorporated in the initiative's implementation plan and – after ensuring that the combination of required MMIS changes is feasible – executed.
2. *Adding new, rapidly deployable functionalities with high program but low system impact.* A cross-cutting need for the transformation process as well as the program, as a whole, is improved access to the claims data, improvement of data quality and the analytical capabilities needed to generate the fact base mentioned above. This ranges from the identification of improvement opportunities, monitoring of APM spending, risk adjustment, calculation of shared savings, creation of reports for stakeholders to the tracking program transformation goals. Vendors that support large-scale transformation processes in Medicaid programs tend to be able to ingest states' data (and potentially and quickly deploy the analytics required. In addition, using state-of-the-art, off-the-shelf technology and agile design, high-impact digitization of key operational bottlenecks can be achieved at limited cost.
3. *Planning the initiative as dependent on the MMIS replacement process.* Some functionalities are difficult to realize without significant program and system impact. The current MMIS, for example, cannot support DRGs or drug-level pricing for 340B drugs, which are both potential initiatives. Although analytical capabilities to create DRGs and identify these drugs could be rapidly deployed, these functionalities would have to go much beyond analyses: providers would have to be paid using DRGs and different drug payment schedules, and existing program integrity algorithms (such as claims edits) would need to be changed. Such cases could lead the state to delay or deprioritize the initiative or opt for an alternative

initiative to achieve the goal (in this case, help reduce inpatient spending) with less system impact. As highlighted in the section on MMIS, the state could reassess the MMIS replacement strategy and module requirements in the light of the prioritized initiatives, thus simultaneously solving some of the MMIS' key limitations and facilitating the transformation's success.

□ □ □

As described, the Missouri Medicaid program faces significant fiscal pressure, assuming continuation of historically observed increases in program spending, outpacing growth with state general revenues, with the potential for further exacerbation based on both economic and regulatory risks. There are opportunities for Missouri to dramatically improve the effectiveness and efficiency of the program. The potential range of initiatives as previously outlined are ambitious in scale and scope. Addressing these opportunities and initiatives will require a thoughtful approach to portfolio selection and investment of significant resources. However, with sufficient leadership and commitment to long-term change, Missouri has the potential to dramatically improve the quality and efficiency of its Medicaid program and in so doing protect the financial sustainability of the program for future generations.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 29, 2020

Todd Richardson, Director
MO HealthNet Division
Department of Social Services
Broadway State Office Building
PO Box 6500
Jefferson City, Missouri 65102-6500

Dear Director Richardson:

Thank you for your letter dated August 2, 2019 communicating your position as to why the Federal Reimbursement Allowance program in Missouri does not violate federal hold harmless provisions. I appreciate your feedback and continued engagement on this important issue.

As you are aware, during the most recent actuarial review of Missouri's Medicaid managed care capitation rates, the Centers for Medicare & Medicaid Services (CMS) became aware that Missouri is using revenues derived from its Federal Reimbursement Allowance (FRA) tax program as the source of the non-federal share for its rates. Consistent with our July 19, 2019 telephone conversation, CMS is concerned that those funds may constitute an impermissible source of the non-federal share.

As we understand the arrangement, Missouri imposes a tax of less than 6 percent of net patient revenues on hospital services (inpatient and outpatient). These revenues provide the state with the source of funding for the non-federal share of payments for hospital services and increased managed care capitation rates that support increased payments to hospitals. A voluntary FRA pool program operated by the Missouri Hospital Association (MHA) then redistributes tax collections among the participating hospitals. While we appreciate the information provided in your August letter, we remain concerned that this pool arrangement appears to ensure that participating hospitals are held harmless for all or a portion of their FRA tax, which would violate section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3).

As discussed in our July 2020 phone conversation, you indicated that the state will ensure that the current pooling arrangement ends by the end of the contract rating period ending June 30, 2021 and that all hospital reimbursement is financed and paid in accordance with all applicable federal requirements. We appreciate the state's commitment and, accordingly, do not intend at this time to utilize our limited financial review resources to conduct an in-depth examination of the pooling arrangement to quantify any possible overpayments through contract rating year 2020 (ending June 30, 2020). However, please note that nothing precludes CMS from

recovering the federal portion of any overpayments from Missouri, including for contract years through 2020, should CMS or another oversight entity (such as the Department of Health and Human Services Office of Inspector General or the Single State Auditor) quantify overpayment amounts relating to Missouri's Full Medicaid Pricing arrangement or FRA tax.

CMS is also in the process of publishing additional guidance on state directed payments, parts of which are expected to further clarify some provisions of guidance published in the November 2017 Informational Bulletin on state-directed payments. Therefore, CMS requests that the state revise future contracts and rate certifications to transition the increased funding for Medicaid hospital stays under the current Full Medicaid Pricing arrangement into a state-directed payment. CMS is committed to providing technical assistance on this topic as discussed during recent calls between our staff.

I want to again thank you for your commitment to resolving longstanding concerns and for your collaborative approach in finding a workable solution moving forward that ensures the Full Medicaid Pricing arrangement and FRA tax meet federal requirements. Should you have additional questions, please contact Rory Howe for tax issues at 410-786-4878, and Alissa DeBoy for managed care issues at 410-786-1699.

Sincerely,

(b)(6)

Calder Lynch
Deputy Administrator and Director

Message

From: Giles, John (CMS/CMCS) [redacted]
Sent: 7/15/2022 3:01:27 PM
To: Richardson, Todd [Todd.Richardson@dss.mo.gov]
CC: Marissa.Crump@dss.mo.gov; Tony.Brite@dss.mo.gov; Connie.M.Sutter@dss.mo.gov; Rebecca.L.Logan@dss.mo.gov; Tameka.Whitney@dss.mo.gov; Kelly.Connell@dss.mo.gov; Howe, Rory (CMS/CMCS) [rory.howe@cms.hhs.gov]; Maccarroll, Amber (CMS/CMCS) [amber.maccarroll@cms.hhs.gov]; Silanskis, Jeremy (CMS/CMCS) [jeremy.silanskis@cms.hhs.gov]; Bonelli, Anna (CMS/CMCS) [anna.bonelli@cms.hhs.gov]; Deboy, Alissa (CMS/CMCS) [alissa.deboy1@cms.hhs.gov]; Smith, Carrie (CMS/CMCS) [carrie.smith@cms.hhs.gov]; CMS State Directed Payment [statedirectedpayment@cms.hhs.gov]; CMS MMCratesetting [mmcratesetting@cms.hhs.gov]; Giles, John (CMS/CMCS) [john.giles1@cms.hhs.gov]; Gibson, Alexis (CMS/CMCS) [alexis.gibson@cms.hhs.gov]; Burch Mack, Rebecca (CMS/CMCS) [rebecca.burchmack@cms.hhs.gov]; Snyder, Laura (CMS/CMCS) [laura.snyder1@cms.hhs.gov]; Loizias, Alex (CMS/CMCS) [alexandra.loizias@cms.hhs.gov]; Caulder, Tara (CMS/CMCS) [tara.caulder@cms.hhs.gov]
Subject: Approval Package - MO_Fee_IPH_New_20220701-20230630 and MO_Fee_OPH_New_20220701-20230630
Attachments: MO_Fee_IPH_New_20220701-20230630 Approval Package.pdf; MO_Fee_OPH_New_20220701-20230630 Approval Package.pdf; MO Richards 4.18 Letter Signed.pdf; MO Companion Letter 7.15.22.pdf

Good Morning Director Richardson –

CMS is pleased to share the attached approval package for MO_Fee_IPH_New_20220701-20230630 and MO_Fee_OPH_New_20220701-20230630, state directed payments submitted under 42 C.F.R. § 438.6(c) for the rating period covering July 1, 2022 through June 30, 2023 (Missouri's SFY 2023 contract rating period). In addition, CMS is granting Missouri's request for an additional one-year period to align all Medicaid managed care contract requirements with the January 2021 State Medicaid Director Letter ("SMDL") #21-001 regarding Medicaid managed care contract requirements that are considered state directed payments per the federal regulations at 42 C.F.R. § 438.6(c) and (d). Specifically, CMS will permit Missouri to maintain the Full Medicaid Pricing (FMP) program for Missouri's SFY 2022 contract rating period. As a result of this extension, CMS will officially withdraw Missouri's preprint submissions for state directed payments for the SFY 2022 contract rating period per the state's request.

Finally, also included in this approval package, CMS is providing a companion letter to the approval of Missouri's state directed payment preprints. CMS remains concerned that the state's use of revenues derived from its Federal Reimbursement Allowance (FRA) tax program as a source of Missouri's non-federal share for these preprints may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act and implementing regulations in 42 C.F.R. § 433.68(f)(3). CMS is committed to providing technical assistance on this issue and is available to continue discussions with Missouri to ensure its sources of non-federal share meet all applicable federal requirements.

If you have any questions or concerns about this approval package, please don't hesitate to reach out to me directly. Thank you again for your partnership on these matters, and we look forward to our continued work together.

John Giles, MPA
Director, Division of Managed Care Policy
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Phone: [redacted]
E-mail: John.Giles1@cms.hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 15, 2022

Todd Richards, Director
Missouri HealthNet Division
Missouri Department of Social Services
P.O. BOX 6500
Jefferson City, MO 65102-6500

Dear Director Richards:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Missouri's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 1, 2022. The proposal was originally given a control name of MO_Fee_IPH_Renewal_20220701-20230630, and the control name has since been updated to MO_Fee_IPH_New_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Minimum and maximum fee schedules established by the state for inpatient hospital services for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

CMS appreciates the information provided to date by the state regarding the non-federal share sources relating to this state directed payment program. To the extent CMS later discovers (either through further CMS review or review by a third party such as the HHS OIG or state auditor) that the non-federal share sources relating to this state directed payment program violates section 1903(w) of the Social Security Act (the Act) and implementing regulations in 42 CFR Part 433, CMS may enforce compliance by initiating deferrals and/or disallowances of federal financial participation.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the

Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

If you have questions concerning this approval or state directed payments in general, please contact Alex Loizias, Division of Managed Care Policy, at (410) 786-2435, alexandra.loizias@cms.hhs.gov.

Sincerely,

John Giles

Digitally signed by John Giles
Date: 2022.07.15 10:42:26 -04'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2022 through June 30, 2023
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
   July 1, 2022
3. Identify the managed care program(s) to which this payment arrangement will apply:
   MO HealthNet Managed Care Program General Plan and Specialty Plan effective July 1, 2022.
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment:
   a. Identify the estimated federal share of this state directed payment: $1,076,090,509
   b. Identify the estimated non-federal share of this state directed payment:
      $393,151,422

      Note that the estimated dollar amounts are based on FMAP percentages effective FFY 2022 and do not reflect the enhanced 6.2% FMAP from the Families First Coronavirus Response Act due to the uncertainty of the end date.

Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☒ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:
   a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
   b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.
      i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

   c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
      ☐ Payment Type Change
      ☐ Provider Type Change
      ☐ Quality Metric(s) / Benchmark(s) Change
      ☐ Other; please describe:

      ☐ No changes from previously approved preprint other than rating period(s).
7. ■ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

MHD developed a minimum and maximum fee schedule that will be used for reimbursement of inpatient hospital service utilization by MO HealthNet managed care enrollees. The minimum and maximum fee schedule will be directly compared to the approved State Plan fee-for-service (FFS) total payments for inpatient hospital services. The negotiated rates within the minimum and maximum fee schedule will be the basis for reimbursement of inpatient hospital services utilized beginning July 1, 2022.

   a. ■ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
   b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Attached are the reimbursement pages for inpatient reimbursement from the state plan.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer[1]**	**Baseline[2] Year**	**Baseline[2] Statistic**	**Performance Measurement Period[3]**	**Performance Target**	**Notes[4]**
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ■ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ■ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☐ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ■ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

The alternative fee schedule for the inpatient directed payment is the approved State Plan FFS total payments for inpatient hospital services. These total payments include the inpatient hospital per diem reflective of hospital costs from 2019 and direct Medicaid add-on amounts that bring total FFS payments to current hospital cost levels. MHD developed a minimum and maximum fee schedule based on this alternative fee schedule that will be used for reimbursement for utilization of inpatient hospital services to MHD managed care enrollees.

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

The minimum and maximum fee schedule was developed using a comparison of current managed care inpatient hospital reimbursement to the alternative fee schedule by hospital class. Health plans can contract with hospitals within the established minimum and maximum percentages applied to the approved State Plan FFS total payments associated with the applicable hospital class. MHD compared the projected reimbursement levels under this directed payment by hospital provider class to the estimated total FFS payments. Additionally, the projected reimbursement levels were compared to estimated Medicare cost levels (inclusive of the Medicaid portion of the FRA provider tax) and Average Commercial Reimbursement levels.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Please refer to the below table that compares anticipated projected reimbursement to Medicare costs and FFS total payment levels.

Class	Expected SFY 2023 Directed Payment Reimbursement	Estimated SFY 2023 Medicare Costs	Expected Payments as % of Estimated Medicare Costs	Estimated SFY 2023 FFS Total Payments	Expected Payments as % of FFS Total Payments
Children's Hospitals	$529,666,793	$456,420,899	116%	$329,898,158	135%
Federal CAH's	$13,474,440	$10,128,422	133%	$13,369,041	101%
Specialty Hospitals	$32,331,298	$28,054,416	115%	$28,570,909	113%
Teaching Hospitals	$598,980,120	$760,601,835	79%	$473,574,007	126%
1-100 Licensed Beds	$41,999,560	$53,074,732	79%	$38,127,747	110%
More Than 100 Licensed Beds	$252,789,720	$337,254,196	75%	$230,304,916	110%

Note that the Expected SFY 2023 amounts reflect SFY 2019 managed care utilization and reimbursement by hospital trended to SFY 2023, including an adjustment applied to these projected payments to account for increasing managed care enrollment (and utilization) compared to SFY 2019 levels due to economic conditions to align with projected expenditures included in response to Question 4. Note that information is not available to project changes in utilization between hospitals and was not considered as part of the impact of increasing enrollment.

In addition, Mercer performed an ACR analysis for the three hospital classes that are expected to be reimbursed above Medicare (Children's Hospitals, Federal CAHs and Specialty Hospitals). To perform this analysis, Mercer received data from the Midwest Health Initiative and Missouri Consolidated Health Plan (MCHP), representing the state employees' health plan. Mercer blended the data based on actual units from each data source and compared the average commercial per diem to the average Medicaid per diem for inpatient hospital services for each of the three hospital classes. The ACR results are presented in the table below where the Medicaid per diems are approximately 64% of the commercial per diems, on average, across the three hospital classes. The expected Medicaid payments for the Children's Hospital and CAH classes compare similarly to the overall ACR (66.3% and 68.2%, respectively). The Specialty class shows expected Medicaid reimbursement to be a much lower percentage of commercial (48.3%). This appears to be driven by no utilization of Rehab Specialty Hospitals in the commercial networks as compared to Medicaid, where the average reimbursement per day is low for these hospitals compared to other hospitals in the Specialty class.

Hospital Class	Expected Medicaid Per Diem Under Directed Payments (Weighted Avg)	Weighted Avg Commercial Per Diem	Expected DP Medicaid Payment as % of Commercial
Children's	$ 5,209.68	$ 7,858.94	66.3%
Specialty	$ 1,135.69	$ 2,353.33	48.3%
CAHs	$ 2,201.61	$ 3,228.91	68.2%
Total	**$ 4,223.39**	**$ 6,582.09**	**64.2%**

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☒ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO,

PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

The minimum and maximum fee schedules were established by hospital class to account for differing hospital characteristics and potential contracting obligations. Given that the maximums are established above current approved FFS Total Payment levels and are based on current managed care reimbursement levels, it is not expected that existing contract obligations for hospitals would necessitate reimbursement at levels higher than the maximum reimbursement level by hospital class established by this directed payment. However, if a hospital and health plan need to request an exemption from the maximum reimbursement level, MHD will evaluate the requested reimbursement level compared to the hospital's costs, FFS reimbursement levels, other reimbursement levels within the applicable hospital class, and other reimbursement levels contracted by the health plan for inpatient hospital services in other lines of business such as commercial.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

No exemptions are anticipated for the current rating period for the reasons described in the above response.

ii. Granted in past years of this payment arrangement

Not applicable

d. Describe how such exemptions will be considered in rate development.

As no exemptions are anticipated, there will be no impact to the rate development process.

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ■ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above.)

MHD developed provider classes for hospitals with similar characteristics that follows the below hierarchy. Hospitals will be attributed to only one provider class based on the hierarchy.

The provider classes are defined as:

1. Children's Hospitals: defined based on the Missouri hospital's Medicare number starting with 2633

2. Federal Critical Access Hospitals (CAHs): defined based on the Missouri hospital's Medicare number starting with 2613

3. Specialty Hospitals: defined based on the Missouri hospital's Medicare number starting with either: 2620, 2621, 2622, 2630, 2641, 2642, 2643, or 2644

4. Teaching Hospitals: defined based on Missouri hospitals receiving GME payments

5. 1-100 Licensed Beds: defined based on licensed bed information listed on the Missouri Department of Health website and from FYE 2017 cost report information.

6. More Than 100 Licensed Beds: defined based on licensed bed information listed on the Missouri Department of Health website and from FYE 2017 cost report information.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The provider classes are not defined in the State Plan and intergovernmental transfers (IGTs) are not the source of the non-federal share of this directed payment. MHD developed a provider class hierarchy for in-state hospitals, as listed in Question 20b, where each hospital is assigned to only one class. The hierarchy follows the order listed above. For example, a hospital would first be reviewed to see if it meets the criteria for the "Children's Hospital" class and then "Federal CAH", and so on. To determine the hospital classes, MHD reviewed the characteristics of each hospital to identify similarities in services provided and populations served, in the comparability of overall costs, and in the comparability of projected payments compared to Medicaid cost levels using Medicare cost reporting principles.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

MHD developed a minimum and maximum fee schedule that will be used for reimbursement for utilization of inpatient hospital services to MHD managed care enrollees. The minimum and maximum fee schedule directly compares to the approved State Plan FFS total payments for inpatient hospital services. Each hospital within a class is subject to the same minimum and maximum fee schedule. The percentages outlined below are applied to the alternative fee schedule for each class to develop the minimum and maximum fee schedules.

Class	Minimum Applied to Alternative Fee Schedule	Maximum Applied to Alternative Fee Schedule
Children's Hospitals	100%	142%
Federal CAH's	100%	102%
Specialty Hospitals	100%	130%
Teaching Hospitals	100%	146%
1-100 Licensed Beds	100%	118%
More Than 100 Licensed Beds	100%	118%

Upon approval by MHD, health plans may utilize Alternative Payment Models that are more advanced in the provider risk continuum than paying on a per diem basis. Overall pricing levels for these arrangements must be consistent with the directed payment. Such arrangements would not result in adjustments in the rate development process as the overall pricing levels are to be consistent with the directed payment. This process is distinct from the exemption process (described in response to Question 18b) to exceed the maximum reimbursement level by hospital class established by the directed payment.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☒ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be complete distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a.					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☐ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Not applicable

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

See response to Question 17b.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

The state will be submitting the newly awarded RFP in June 2022. The identifier of the contract action will RFP #S30034902200777. The state directed payment will be captured in Section 2.7.22.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

The certifications for the MO HealthNet Managed Care Program General and Specialty Plans will be submitted in June 2022.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Not applicable

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☒ State general revenue
- **b.** ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☒ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☒ Other, specify: Healthy Families Trust Fund & Life Sciences Research Trust Fund (Tobacco Settlement Funds), Health Initiative Funds, Premium Funds, Uncompensated Care Funds

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Federal Reimbursement Allowance	Hospital	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategyonline beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://dss.mo.gov/mhd/mc/pdf/2021-quality-stra
- **b.** The effective date of quality strategy. July 1, 2021

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy:
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Promote wellness and prevention	Promote Women's Health Improve management of behavioral health and substance use disorder	28
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The State is establishing a minimum and maximum range of reimbursement for inpatient hospital services that is consistent with total FFS reimbursement for such services. Maintaining parity of reimbursement across delivery systems supports the goal of ensuring appropriate access to inpatient services for Medicaid managed care enrollees.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assurethe State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes).

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Follow-Up After Hospitalization for Mental Illness (30 days)	CY 2021	TBD - MY2021 HEDIS rates will be available in June 2022	Increase by one percentage point or reach the national median (where national benchmarks are available), the percentage of managed care participants, ages 6 and above, that receive a follow-up visit within 30 days after discharge from a mental health hospitalization.	
ii. Prenatal and Post-Partum Care - Timeliness of Prenatal Care	CY 2021	TBD - MY2021 HEDIS rates will be available in June 2022	Increase by one percentage point or reach the national median (where national benchmarks are available), the percentage of deliveries that received a prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	
iii. Prenatal and Post-Partum Care Postpartum Care	CY2021	TBD - MY2021 HEDIS rates will be available in June 2022	Increase by one percentage point or reach the national median (where national benchmarks are available), the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s)and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Not applicable

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 15, 2022

Mr. Todd Richards
Director
Missouri HealthNet Division
Missouri Department of Social Services
P.O. BOX 6500
Jefferson City, MO 65102-6500

Dear Director Richards:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) policy in the January 2021 State Medicaid Director Letter ("SMDL") #21-001 about Medicaid managed care contract requirements that are considered state directed payments per the federal regulations at 42 C.F.R. § 438.6(c) and (d).

CMS intends to continue working with states on implementing Medicaid managed care payment policies that promote access to care and value for Medicaid beneficiaries, improve the fiscal integrity of the Medicaid managed care program, and ensure the actuarial soundness of Medicaid managed care rates. However, we appreciate the specific concerns raised by the Missouri Department of Social Services during a meeting on April 11, 2022 about the timeline for transitioning these existing contract requirements to state directed payments in alignment with the January 2021 guidance for the state's fiscal year 2022 contract rating period beginning on July 1, 2021.

To avoid any disruption to the state's safety-net Medicaid providers and critical services provided to Medicaid managed care enrollees, CMS is granting the state an additional one-year period to align all Medicaid managed care contract requirements with the January 2021 guidance. This one-year delay will provide the state additional time to develop and implement state directed payments for the state's fiscal year 2023 contract rating period that begins on July 1, 2022. Further, notwithstanding this one-year delay, the state understands and agrees that the capitation rates must comply with the requirements at 42 C.F.R. §§ 438.4 through 438.8 for all Medicaid managed care capitation rates to be actuarially sound. Approval of the state directed payments do not constitute approval of any Medicaid managed care plan contracts or rate certifications, or any specific Medicaid financing mechanism used to support the non-federal share of the provider payment arrangement.

CMS is committed to providing technical assistance to Missouri during this transition period. Our CMS team will continue working directly with your Missouri team to find solutions that are workable for the state on this issue. I believe that our teams working collaboratively together can resolve the issues raised in your letter and ensure that critical Medicaid funding remains available for safety-net Medicaid providers during this transition period for these payments.

Thank you again for your letter, and for taking the time to share your views on this complex issue. Should you have additional questions or concerns, please contact John Giles, Director of the Division of Managed Care Policy, at 240-904-2341, or by e-mail at John.Giles1@cms.hhs.gov.

Sincerely,

(b)(6)

Daniel Tsai
Deputy Administrator and Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 15, 2022

Todd Richardson, Director
MO HealthNet Division
Department of Social Services
Broadway State Office Building
PO Box 6500
Jefferson City, Missouri 65102-6500

Dear Director Richardson:

The Centers for Medicare & Medicaid Services (CMS) is providing this letter as a companion to the approval of Missouri's state directed payment preprints, MO_Fee_IPH_New_20220701-20230630 and MO_Fee_OPH_New_20220701-20230630. CMS is concerned that the state's use of revenues derived from its Federal Reimbursement Allowance (FRA) tax program as a source of Missouri's non-federal share for these preprints may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act (the Act) and implementing regulations in 42 CFR 433.68(f)(3).

As we understand the FRA tax program arrangement, Missouri imposes a tax of less than 6 percent of net patient revenues on hospital services (inpatient and outpatient). These revenues provide the state with the source of funding for the non-federal share of payments for hospital services and increased managed care capitation rates that support increased payments to hospitals. A voluntary FRA pool program operated by the Missouri Hospital Association (MHA) then appears to redistribute Medicaid payments among the participating hospitals using a formula that ensures hospitals paying more in tax than they receive in Medicaid payments are not harmed by the tax. Such an arrangement appears to ensure that participating hospitals are held harmless for all or a portion of their FRA tax, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 CFR 433.68(f)(3).

As discussed in a July 20, 2020 letter from CMS to the state, CMS understood that the state would ensure that the pooling arrangement would end for contract rating periods after June 30, 2021 and that all hospital payments would be financed and paid in accordance with all applicable federal requirements. However, based on various communications between CMS and the state relating to referenced state directed payments, it appears the state does not intend to ensure that the FRA pooling arrangement has ended consistent with CMS's understanding articulated in the July 20, 2020 letter.

CMS takes its responsibility for financial oversight of the Medicaid program seriously to ensure its long-term health and financial stability. CMS remains committed to ensuring that the non-federal share of Medicaid expenditures comply with all applicable federal requirements, including section 1903(w)(4) of the Act and federal regulations at 42 CFR 433.68(f)(3). At this time, CMS intends to conduct a focused review of the state's FRA program relating to expenditures for the quarter beginning July 1, 2022, which the state would typically report to CMS on the Form CMS-64 in October 2022. Should CMS determine that the FRA tax program involves a hold harmless arrangement, we intend to initiate formal action to reduce the state's medical assistance expenditures

before calculating federal financial participation (FFP), as required by section 1903(w)(1)(A)(iii) of the Act, on a quarterly basis.

Although CMS intends to focus its review on the FRA tax on expenditures for the quarter beginning July 1, 2022, please note that CMS may also seek to recover FFP for earlier periods based on the results of this review, another CMS review, or review by another oversight entity (such as the Department of Health and Human Services Office of Inspector General or the Single State Auditor).

If the FRA-related hold harmless arrangements described above no longer exist or if Missouri has initiated action to end those arrangements, such as informing providers to cease the pooling and redistribution of Medicaid payments, please provide a detailed description of any actions taken by the state and/or participating hospitals to this end.

CMS is committed to providing additional technical assistance on this issue and is available to continue discussions with Missouri to ensure its sources of non-federal share meet all applicable federal requirements.

Sincerely,

Rory C. Howe -S

Digitally signed by Rory C. Howe -S
Date: 2022.07.15 08:46:25 -04'00'

Rory Howe
Director
Financial Management Group
Center for Medicaid and CHIP Services

Message

From: Richardson, Todd [Todd.Richardson@dss.mo.gov]
Sent: 3/21/2023 7:43:27 PM
To: Powell, Eric (CMS/CMCS) [eric.powell@cms.hhs.gov]
CC: Howe, Rory (CMS/CMCS) [rory.howe@cms.hhs.gov]; Endelman (he/him), Jonathan (CMS/CMCS) [jonathan.endelman@cms.hhs.gov]; Kimble, Davida (CMS/CMCS) [davida.kimble@cms.hhs.gov]; Bray, Kimberlyn [Kimberlyn.R.Bray@dss.mo.gov]; Luebbering, Patrick [Patrick.Luebbering@dss.mo.gov]; Brite, Tony [Tony.Brite@dss.mo.gov]; Vitale, Desiree [Desiree.Vitale@dss.mo.gov]
Subject: CMS FRA QE 12/31/2022 Inquiry
Attachments: FRA Tax Questions QE 12-31-22.docx; #2-FRA Payments to Hospitals 3(e).xlsx; #1 - CMS Qtrly FRA Update - Scott Cover Letter with Attachment.pdf; #3 - MPP.pdf; #4 - Richardson Lttr to Tsai 8-24-22.pdf; #5 - SFY 2022 B1-B2 Hospital Final.xlsx; #6 - Preliminary SFY 2023 B1-B2 Using Sched 23-3 to MHD 7-20-22.xlsx; #7 - Inpatient FMP Directed Payments_111920 pp.pdf; #8 - MSC Health Plan MOU and Amendment.pdf

Mr. Powell,

Please see the attached updated response in FRA Tax Questions QE 12-31-22 document and updated exhibit #2-FRA Payments to Hospitals 3(e) document related to your question from February 22, 2023. There are no changes to the other exhibits.

Thank you,

Todd Richardson
Director
MO HealthNet

Missouri Federal Reimbursement Allowance (FRA) Tax Questions

As indicated in our July 15, 2022 letter, CMS is committed to ensuring the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section 1903(w)(4) of the Social Security Act and federal regulations at 42 CFR 433.68(f)(3). In that July letter and prior communication with the state including a July 20, 2020 letter, CMS reiterated concerns that CMS the state's Federal Reimbursement Allowance (FRA) tax program appeared to contain a hold harmless arrangement, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 CFR 433.68(f)(3). The July 2022 letter also indicated that CMS intended to conduct a focused review of Missouri's FRA program related to expenditures reported to CMS on the Form CMS-64. We appreciate the state's August 25, 2022 response to our July 15, 2022 letter. After review of the information shared in conjunction with the letter, CMS remains concerned that Missouri's FRA program does not appear to meet federal requirements. Therefore, we are requesting information and supporting documentation to determine if the FRA is in compliance with all federal statutory and regulatory requirements for FRA tax amounts reported on the CMS-64 for the quarter ending December 31, 2022.

Please provide the following information and documentation relating to FRA amounts reported to CMS on the Form CMS-64 for the quarter ended December 31, 2022:

1. The state law(s) that authorize the FRA and that direct the disposition of the revenue raised.

Sections 208.453, 208.455, 208.457, 208.459, 208.461, 208.463, 208.465, 208.467, 208.469, 208.471, 208.473, 208.475, 208.477, 208.478, 208.479, 208.480, RSMO, 13 CSR 70-15.110, and CCS SS SCS HCS HB 3011 (2022), which can be found at [HYPERLINK "https://www.house.mo.gov/billtracking/bills231/hlrbillspdf/3011H.06T.pdf"].

2. A list of each State Directed Payment Preprint and State Plan payment provision for which the non-federal share includes FRA tax revenue.

Attachment 4.19A – Prior to Approved SPA MO 22-0004

1. **Inpatient Per Diem**
2. **Disproportionate Share Hospital (DSH) Payment**
3. **Direct Medicaid Payment**
4. **Upper Payment Limit (UPL) Payment**
5. **Graduate Medical Education (GME) Payment**

Attachment 4.19A – Approved March 1, 2023

1. **Inpatient Per Diem**
2. **Acuity Adjustment Payment**
3. **Poison Control Payment**
4. **Stop Loss Payment**
5. **Disproportionate Share Hospital (DSH) Payment**
6. **Medicaid Graduate Medical Education (GME) Payment**

7. Upper Payment Limit (UPL) Payment

Attachment 4.19B – Current

1. Outpatient Simplified Fee Schedule (OSFS) Payment

2. Outpatient Direct Medicaid Payment

Section 1115 waiver – Gateway to Better Health Waiver

Managed Care Directed Payments

1. MO_Fee_IPH_New_20220701-20230630

2. MO_Fee_OPH_New_20220701-20230630

Administration Costs

Medicaid Administrative Grant

3. For each provider paying the FRA tax:
    a. Provider name
    b. The applicable FRA tax rate or rates
    c. The basis for the tax rate (e.g., hospital net patient revenues, discharges, etc.)
    d. Amount of FRA tax paid for the quarter ended 12/31/2022
    e. Total amount received in Medicaid payments funded by FRA tax revenue through the State Directed Payments and/or State Plan payments.
    f. Amount(s) paid or contributed to the Missouri Hospital Association FRA Funding Pool
    g. Amount(s) received from the Missouri Hospital Association FRA Funding Pool

The information responsive to (a), (b) and (d) is provided quarterly to CMS in the Quarterly FRA Assessment Report. The information for the quarter ending 12/31/2022 was provided to CMS on January 6, 2023. A copy of that report is attached as Exhibit 1.

The information requested in (c) is set forth in state regulation at 13 CSR 70-15.110. The rate was 5.4% in the quarter ending 12/31/2022.

Attached as Exhibit 2 is the information responsive to item (e) for fee-for-service outpatient hospital payments, GME, DSH and supplemental payments made in the quarter ending 12/31/2022. These are claims that we can identify by provider from the FRA fund. There are some claims that are paid using a mixture of FRA and other state share funds, which are not identifiable at the provider level. For inpatient hospital payments made in quarter ending 12/31/2022, MHD is having quality control issues, and will provide that information to item (e) as soon as available. DSS does not have information specific to hospital services paid through managed care except as part of the capitation rate.

Updated State Response 3/21/23: Attached as Exhibit 2 is the updated information responsive to item (e) which now includes the fee-for-service inpatient hospital payments, outpatient

hospital payments, GME, DSH and supplemental payments made in the quarter ending 12/31/2022. These are claims that we can identify by provider from the FRA fund. There are some claims that are paid using a mixture of FRA and other state share funds, which are not identifiable at the provider level. DSS does not have information specific to hospital services paid through managed care except as part of the capitation rate.

Pursuant to the Partnership Plan which CMS and Missouri agreed to in 2002, and again in 2008, DSS annually provides CMS with information regarding the Missouri Hospital Association (MHA) redistribution pool. A copy of the 2008 Partnership Plan is attached as Exhibit 3; Director Richardson's letter of August 2022 to Director Tsai setting forth the history of the Partnership Plan is attached as Exhibit 4. The Partnership Plan requires this information to be provided "on an annual basis."

Please find attached as Exhibit 5, the most recent information response to (f) and (g), which was previously provided to CMS for state fiscal year 2022 in July 2022. Please also find attached as Exhibit 6, the projected redistributions for state fiscal year 2023, which was also provided to CMS in July 2022. Because the Partnership Plan requires an annual demonstration, DSS does not have the information requested for (f) and (g) specific to the quarter ending 12/31/2022, nor does DSS know MHA's distribution timing or schedule.

4. Please confirm that the FRA assessment is imposed on the two permissible classes, inpatient hospital services and outpatient hospital services, and no other items or services. The term "permissible class" is defined in section 1903(w)(7) of the Social Security Act and 42 CFR 433.56(a).

Yes, the FRA assessment is applied separately on inpatient hospital services and outpatient hospital services. The hospital's total FRA assessment is the sum of the two. *See* 13 CSR 70-15.110.

5. Each permissible class the state taxes under the FRA is subject to the indirect guarantee hold harmless test as specified in 42 CFR 433.68(f)(3)(i)(A) and (B). The state should calculate the test for each permissible class separately. For example, inpatient hospital services and outpatient hospital services should be calculated separately. Please confirm the total amount of health care-related tax or taxes is less than or equal to 6% of the taxpayers' net patient revenue for inpatient hospital services, and for outpatient hospital services. If the state cannot confirm that the total amount of health care-related tax or taxes is less than or equal to 6% of the taxpayers' net patient revenue for inpatient hospital services, and for outpatient hospital services, please confirm that 75% or more of providers being taxed in the class do not receive 75% or more of their tax cost back in Medicaid or other state payments.

The FRA is imposed at a rate of 5.4% on inpatient adjusted net revenue and outpatient adjusted net revenue and thus is less than 6% of taxpayer net revenue.

6. An arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 C.F.R. § 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.

   In a document entitled, "Rapid Response Review- Assessment of Missouri Medicaid Program" issued by the Missouri Department of Social Services on February 11, 2019, there is a flowchart entitled "Exhibit 12: Missouri Hospital Association FRA Funding Pool." The document is included as an attachment to this email. According to the flow chart, providers that receive more in Medicaid payments funded by the FRA than the provider pays in tax transfer some of the provider's FRA-funded Medicaid payments to the pool operated by the MHA. If a provider receives less in Medicaid payments funded by the FRA than it pays in tax, the provider receives a payment from the pool consisting of amounts from the pooled Medicaid payments from other providers. The goal is to "net out the FRA paid with the payments received" or, in other words, to guarantee that no taxpayer is financially harmed by the cost of the tax. Is the description found in the PowerPoint issued by the State of Missouri an accurate description of how the pooling arrangement worked for the quarter ended December 31, 2022 with regard to the FRA?

DSS is aware of CMS's position that a private redistribution "may be" a hold harmless arrangement, but in the Partnership Plan, CMS and the State agreed, after CMS's extensive review of the FRA, that the tax on inpatient hospital services and the tax on outpatient hospital services would "be recognized as permissible funding sources" subject to an "annual demonstration" that "there is no explicit hold harmless in state law, regulation, or policy" and "the tax program structure at issues meets the B1/B2 standard of 1.0 or above . . . after taking into account the redistribution arrangement." The annual demonstration for state fiscal year 2022 and the projected redistribution for state fiscal year 2023 both demonstrate that the tax program structure meets the B1/B2 standard after taking into account the redistribution arrangement. Thus, under CMS's longstanding position as expressed in the Partnership Plan, there is no hold harmless.

The document that CMS attached entitled "Rapid Response Review" was prepared by an independent consultant, and it appears to be based on MHA materials that were once publicly available but which no longer are. To DSS's knowledge, the consultant did not otherwise obtain information from MHA. The focus of the Rapid Response Review was an overall picture of the Missouri Medicaid program; the hospitals' funding agreements were only a tangential aspect of the overall review. Of the documents referenced in the footnotes to Exhibit 12 of the Rapid Response Review, DSS has only the MOU, which is no longer operative.

DSS does not know the extent to which the description in the Rapid Response Review was or is accurate except that: (a) according to the most recent redistribution information provided to DSS

by MHA, and shared with CMS, there are 27 hospitals that do not participate in the MHA pool, which appears to be contrary to the suggestion in the Review; (b) the MOU was not renewed after July 2020. DSS has confirmed with MHA that no MOU is currently in place or was in place for the Quarter ending 12/31/2022.

7. Please provide any documentation the state has concerning the operation of these pooling arrangements (including the redistribution of payments) and how they work. This would include any copies of contracts, agreements, letters, call or meeting notes, or other similar materials discussing the arrangements, involving the state, hospitals, the Missouri Hospital Association (MHA), managed care organizations, and/or other parties.

DSS is not involved in the pooling arrangement and does not have any documents describing how it works (other than the MOU between MHA and managed care organizations after CMS alerted MHD to it).

However, under the Partnership Plan that DSS has had with CMS since 2002, and renewed in 2008, DSS does require MHA to provide it with a summary of the pooling results to ensure that any redistribution meets the "generally redistributive" standard set forth at 42 C.F.R. § 433.68(e). DSS shares that analysis with CMS on an annual basis, showing the final redistribution for the prior fiscal year, and a projected redistribution for the current fiscal year. Exhibits 5 and 6 are the most recent analyses that were provided to CMS in July 2022. We are happy to provide the analyses from previous years but believe they are all readily accessible to CMS.

8. If a hospital is a "pool contributor" and receives more in payments than it pays in tax, does it always pay all of the difference into the pool? Do "pool receivers" that pay more in tax than they receive in payments always receive the entire amount back from the pool, or only some of it? How are those payment amounts determined?

DSS does not know the answer to these questions; DSS is only aware of the net amounts paid into the pool and out of the pool (see Exhibits 5 and 6) by participating hospitals, and has already reported these amounts to CMS. DSS does not know which payments are pooled, and the Partnership Plan has not required DSS to ask for this information.

9. Please provide any additional detail on the memorandum of understanding (MOU) between the Missouri Hospital Association and Managed Care Organizations, as described in the Rapid Response document, regarding an agreement to attempt to ensure individual hospitals are not financially harmed by the FRA using Medicaid managed care payments. If available to the state, please provide a copy of this MOU as it was in effect during the quarter ended December 31, 2022, and as it is currently in effect, if the MOU instrument is not the same for the periods. Are these expectations reflected in any contract between the

state and the MCOs? If so, please provide copies of the relevant MCO contracts, identifying the relevant provisions.

DSS's contracts with its MCOs has never had a provision requiring or encouraging the MCOs to enter into an MOU with MHA. Prior to July 2022, DSS contracts with its MCOs did require the MCOs to pay "Full Medicaid Pricing" to hospitals for services provided under the contract. That provision was deleted effective July 1, 2022 and replaced with a directed payment methodology, which CMS has approved.

Exhibit 8 is the MOU that was previously in place between the MCOs and MHA through June 30, 2018. Our understanding of the MOU was that it sought to ensure that hospitals received Full Medicaid Pricing for the services provided through managed care plans, i.e., that the payments were comparable to what the hospitals would have received as claims payments and Direct Medicaid payments if the services had been provided fee-for-service. (Direct Medicaid payments are the difference between the per diem and the hospital's cost of providing services to Medicaid patients; their calculation includes the FRA as a cost but otherwise are not tied to the hospital's FRA assessment in any way). We have not identified any provision in the MOU that sought to require the MCOs to reimburse hospitals for the cost of the tax, and DSS believes CMS has misinterpreted its intent. Regardless, DSS informed the MCOs in 2019 that the State was moving away from Full Medicaid Pricing to directed payments, and we have confirmed with MHA that no MOU was in place in the quarter ending December 31, 2022.

10. Has the state communicated with its providers regarding the statutory and regulatory prohibition of hold harmless arrangements involving provider payment redistributions, including as articulated by CMS in its July 20, 2020 and July 15, 2022 letters? If so, please describe the nature and substance of the communications, providing copies, if available.

DSS met with MHA in November 2020 to discuss the move from Full Medicaid Pricing to Directed Payments in which it noted CMS's concerns with the MOU. See Exhibit 7 (PowerPoint from meeting). On September 1, 2022, DSS provided MHA with copies of the two CMS letters referenced above.

11. Please describe what oversight the state conducts to ensure that the state and providers comply with federal requirements related to the financing of the non-federal share of Medicaid expenditures.

DSS has operated under the Partnership Plan ever since CMS extensively reviewed the FRA and the hospital redistribution in the early 2000s. DSS has made clear to MHA that the FRA will only be permissible if its redistribution for participating hospitals is generally redistributive under the test laid out at 433.68(e). MHA must provide the results of the redistribution, including the B1/B2 regression analysis, on both a retrospective and prospective basis. DSS in

turn provides these results to CMS to review for compliance with the terms of the Partnership Agreement.

12. Based on the responses to these questions regarding possible redistribution arrangements, CMS may ask additional questions and/or make additional requests for information from the state and/or providers, if necessary.

Provider Name	IP FRA State	OP FRA State
Audrain Community Hospital	0.00	0.00
BARNES JEWISH WEST COUNTY HOSPITAL	167,247.77	75,444.26
BARNES-JEWISH HOSPITAL	6,266,391.03	1,059,725.01
BARNES-JEWISH ST PETERS HOSPITAL	96,228.93	60,585.90
BATES COUNTY MEMORIAL HOSPITAL	12,228.39	40,781.25
BELTON REGIONAL MEDICAL CENTER	247,422.90	82,715.75
Black River Medical Center	0.00	0.00
BOONE HOSPITAL CENTER	416,685.39	88,334.14
BOTHWELL REGIONAL HEALTH CENTER	152,031.77	122,074.55
CAMERON REGIONAL MEDICAL CENTER INC	60,702.94	39,935.27
CAPITAL REGION MEDICAL CENTER	212,658.01	141,919.28
CARROLL COUNTY MEMORIAL HOSPITAL	6,965.47	43,322.45
CASS REGIONAL MEDICAL CENTER	48,387.38	56,814.19
CEDAR COUNTY MEMORIAL HOSPITAL	11,096.61	15,088.55
CENTERPOINT MEDICAL CENTER	1,031,071.82	195,224.60
CENTERPOINTE HOSPITAL	25,371.81	(181.56)
CENTERPOINTE HOSPITAL OF COLUMBIA LLC	119,171.44	0.00
CHILDRENS MERCY HOSPITAL	1,307,562.72	639,093.69
CHRISTIAN HOSPITAL	1,303,916.91	303,291.33
CITIZENS MEMORIAL HOSPITAL	82,984.30	194,076.07
COMMUNITY HOSPITAL-FAIRFAX	17,904.05	5,652.41
COX BARTON COUNTY HOSPITAL	30,434.24	22,873.06
COX MEDICAL CENTER BRANSON	303,165.55	140,453.87
COX MONETT HOSPITAL	41,794.68	50,289.64
ELLETT MEMORIAL HOSPITAL	736.91	5,398.62
EXCELSIOR SPRINGS HOSPITAL	15,362.21	23,103.32
FREEMAN HEALTH SYSTEM	887,977.28	503,223.47
FREEMAN NEOSHO HOSPITAL	48,822.62	47,262.57
GOLDEN VALLEY MEMORIAL HOSP	91,820.27	134,262.27
HANNIBAL REGIONAL HOSPITAL	298,116.09	131,149.85
HARRISON COUNTY COMMUNITY HOSPITAL	1,388.50	18,230.99
HEARTLAND BEHAVIORAL HEALTH	12,797.71	0.00
HEARTLAND LONG TERM ACUTE CARE HOSPITAL	159,977.99	0.39
HEARTLAND REGIONAL MEDICAL CENTER	1,284,527.49	517,819.24
HEDRICK MEDICAL CENTER	54,977.90	44,438.51
HERMANN AREA DISTRICT HOSPITAL	2,488.93	5,410.70
I-70 Medical Center	0.00	0.00
IRON COUNTY MEDICAL CENTER	1,653.79	37,903.05
JOHN FITZGIBBON MEMORIAL HOSPITAL INC	116,070.68	90,907.65
KINDRED HOSPITAL NORTHLAND	556,982.31	0.00
KINDRED HOSPITAL ST LOUIS	491,207.74	0.00
LAFAYETTE REGIONAL HEALTH	68,842.74	44,606.42
LAKE REGIONAL HOSPITAL	236,937.64	219,040.94
LAKELAND BEHAVIORAL HEALTH SYSTEM	12,339.10	0.00
LANDMARK HOSPITAL OF CAPE GIRARDEAU LLC	109,924.51	0.00
LANDMARK HOSPITAL OF COLUMBIA LLC	43,536.49	0.00

LANDMARK HOSPITAL OF JOPLIN LLC	225,860.97		0.00
LANDMARK REHABILITATION HOSPITAL OF COLU	0.00		0.00
LEES SUMMIT MEDICAL CENTER	286,015.72		38,538.42
LESTER E COX MEDICAL CENTERS	2,443,746.57		783,431.86
LIBERTY HOSPITAL	443,431.78		113,114.85
MADISON MEDICAL CENTER	7,304.34		14,285.95
MERCY HOSPITAL AURORA	27,646.53		38,348.34
MERCY HOSPITAL CARTHAGE	17,941.74		83,339.28
MERCY HOSPITAL CASSVILLE	18,701.46		31,887.88
MERCY HOSPITAL JEFFERSON	902,024.57		174,496.95
MERCY HOSPITAL JOPLIN	1,023,231.82		246,991.41
MERCY HOSPITAL LEBANON	78,615.59		128,573.88
MERCY HOSPITAL LINCOLN	53,254.66		62,452.11
MERCY HOSPITAL SOUTH	1,452,895.00		238,530.20
MERCY HOSPITAL SPRINGFIELD	3,157,452.05		772,773.08
MERCY HOSPITAL ST LOUIS	2,328,855.56		573,187.21
MERCY HOSPITAL WASHINGTON	305,044.64		153,111.00
MERCY REHABILITATION HOSPITAL SPRINGFIEL	222,010.18		0.00
MERCY REHABILITATION HOSPITAL ST LOUIS	63,873.40		0.00
MERCY ST FRANCIS HOSPITAL	5,391.49		29,943.30
MISSOURI BAPTIST HOSPITAL OF SULLIVAN	235,914.44		112,076.06
MISSOURI BAPTIST MEDICAL CENTER	493,290.78		181,331.23
MISSOURI DELTA MEDICAL CENTER	547,376.07		149,429.80
MOBERLY REGIONAL HOSPITAL	28,177.93		38,162.79
MOSAIC MEDICAL CENTER ALBANY	0.00		8,785.05
MOSAIC MEDICAL CENTER MARYVILLE	37,375.70		28,662.26
NEVADA REGIONAL MEDICAL CENTER	156,701.02		30,222.71
NORTH KANSAS CITY HOSPITAL	917,651.87		188,152.71
NORTHEAST REGIONAL MEDICAL CENTER	51,635.27		43,616.25
OSAGE BEACH CENTER FOR BEHAVIORAL HEALTH	62,949.05		0.00
OZARKS MEDICAL CENTER	248,972.56		278,737.99
PARKLAND HEALTH CENTER	170,656.77		158,272.90
PARKLAND HEALTH CENTER BONNE TERRE	560.80		29,469.07
PEMISCOT MEMORIAL HOSPITAL	28,086.71		35,498.85
PERIMETER BEHAVIORAL HOSPITAL OF SPRINGF	39,700.64		0.00
PERRY COUNTY MEMORIAL HOSPITAL	30,053.85		46,570.78
PERSHING MEMORIAL HOSPITAL	4,547.43		15,225.55
PHELPS HEALTH	579,949.69		169,130.19
PIKE COUNTY MEMORIAL HOSP	11,032.56		19,834.57
POPLAR BLUFF REGIONAL MEDICAL CENTER	1,043,960.43		297,317.54
PROGRESS WEST HOSPITAL	95,884.54		27,401.98
PUTNAM COUNTY MEMORIAL HOSPITAL	2,699.62		10,527.64
RANKEN JORDAN PEDIATRIC BRIDGE HOSPITAL	709,658.37		9,162.98
RAY COUNTY MEMORIAL HOSPITAL	(2,539.45)		7,877.58
RESEARCH MEDICAL CENTER	2,562,732.89		352,056.04
ROYAL OAKS HOSPITAL	84,715.00		0.00
RUSK REHABILITATION HOSPITAL	283,734.87		0.00

SAINT FRANCIS MEDICAL CENTER	723,134.78		306,875.83
SAINT LUKES EAST HOSPITAL	547,268.86		103,919.73
SAINT LUKES NORTH HOSPITAL	362,934.40		95,995.83
SALEM MEMORIAL DISTRICT HOSPITAL	18,728.83		27,298.95
SAMARITAN HOSPITAL	4,913.07		13,660.10
SCOTLAND COUNTY MEMORIAL HOSPITAL	20,270.66		8,981.98
SELECT SPECIALTY HOSPITAL ST LOUIS	44,849.04		0.00
SELECT SPECIALTY HOSPIT-SPRINGFIELD INC.	432,691.88		0.00
SHRINERS HOSPITALS FOR CHILDREN	0.00		1,140.05
SIGNATURE PSYCHIATRIC HOSPITAL	2,833.01		0.00
SOUTH CITY HOSPITAL	551,446.57		63,114.89
SOUTHEAST BEHAVIORAL HEALTH	35,678.28		210.67
SOUTHEAST HEALTH	471,024.01		300,885.35
Southeast Health Center of Ripley County	0.00		0.00
SOUTHEAST HEALTH CENTER OF STODDARD	99,607.16		44,166.15
SSM HEALTH CARDINAL GLENNON CHILDREN'S	202,203.60		112,701.62
SSM HEALTH DEPAUL HOSPITAL ST LOUIS	1,371,745.82		454,466.04
SSM HEALTH ST CLARE HOSPITAL - FENTON	268,232.77		132,204.40
SSM HEALTH ST JOSEPH HOSPITAL	235,966.22		139,428.88
SSM HEALTH ST JOSEPH HOSPITAL -	469,540.32		130,557.73
SSM HEALTH ST MARYS HOSPITAL	447,110.67		100,690.98
SSM HEALTH ST MARYS HOSPITAL ST LOUIS	869,358.16		444,244.04
SSM SELECT REHABILITATION ST LOUIS, LLC	580,720.74		2,168.52
SSM-SLUH INC	2,826,362.39		605,862.60
ST JOSEPH MEDICAL CENTER	312,745.09		57,468.17
ST LOUIS CHILDRENS HOSPITAL	957,684.85		421,818.81
ST LUKES DESPERES EPISCOPAL PRESBYTERIAN	57,635.59		13,997.94
ST LUKES HOSPITAL OF KANSAS CITY	1,622,218.13		377,631.22
ST LUKES HOSPITAL WEST	187,904.55		71,233.61
ST LUKES REHABILITATION HOSPITAL	11,875.41		0.00
ST MARYS MEDICAL CENTER	102,860.36		27,365.51
STE GENEVIEVE COUNTY MEMORIAL HOSPITAL	22,793.74		35,555.26
SULLIVAN COUNTY MEMORIAL HOSPITAL	2,748.26		7,490.06
TEXAS COUNTY MEMORIAL HOSPITAL	25,009.11		35,072.03
THE REHABILITATION INSTITUTE OF ST LOUIS	381,479.58		0.00
Two Rivers Psychiatric Hospital	0.00		0.00
UNIVERSITY HEALTH LAKEWOOD MEDICAL CENTE	529,803.58		315,173.31
UNIVERSITY HEALTH TRUMAN MEDICAL CENTER	2,878,784.90		1,496,159.51
UNIVERSITY OF MISSOURI HEALTH CARE	3,634,447.82		1,126,834.65
WASHINGTON COUNTY MEMORIAL HOSPITAL	29,179.97		46,458.36
WESTERN MISSOURI MEDICAL CENTER	106,459.61		103,121.58
WRIGHT MEMORIAL HOSPITAL	16,120.82		35,200.22
	59,413,063.10		18,179,954.52

Supp Pmts FRA State	GME FRA State	DSH FRA State
0	0	61,641
56,668	21,504	324,921
4,923,887	1,995,188	5,630,704
12,756	170	0
6,595	0	272,761
24,582	0	409,848
0	0	74,803
87,601	0	48,217
48,717	2,838	366,489
7,397	0	261,008
134,830	16,104	0
10,979	0	44,135
11,059	0	333,579
3,381	0	121,109
318,872	245	1,049,468
30,012	0	0
42,770	0	0
6,621,778	642,145	0
350,644	3,169	2,636,274
61,199	0	394,386
1,625	0	28,263
3,249	0	170,200
184,329	0	631,579
11,874	0	(261,188)
1,629	0	111,457
2,228	0	113,629
375,825	46,453	1,110,160
6,045	0	106,596
53,634	0	408,523
82,374	0	434,143
3,604	0	157,014
87,080	0	8,525
16,317	0	(392,597)
120,181	0	3,162,377
13,330	0	216,457
1,225	0	60,944
0	0	(114,397)
5,110	0	20,880
60,910	0	195,706
3,416	0	0
40,948	0	0
8,220	0	299,784
28,463	0	352,016
0	0	0
27,191	0	0
19,402	0	0

16,889	0	0
(10,931)	0	0
9,203	3,468	337,777
755,949	70,709	2,887,641
18,641	0	349,811
1,879	0	110,373
4,468	0	(362,686)
5,508	0	(492,166)
7,453	0	138,830
190,046	0	1,019,494
245,887	0	(2,689,882)
56,971	0	(1,183,620)
6,651	0	266,907
188,216	0	1,625,112
2,309,382	0	(5,950,728)
385,425	373,290	0
120,981	0	(2,521,145)
0	0	(200,535)
0	0	56,667
5,485	0	83,529
21,154	0	480,658
205,275	3,697	677,603
20,510	0	715,281
17,695	0	0
2,240	0	137,895
12,735	0	319,108
32,406	0	(50,543)
84,957	0	1,815,756
10,573	90,547	0
31,994	0	0
43,451	0	630,704
35,391	0	501,882
1,779	0	0
6,755	0	189,573
240,520	0	58,362
6,413	0	23,783
3,409	0	78,666
86,144	0	808,085
2,886	0	163,331
63,598	15,610	0
10,805	0	356,465
1,705	0	76,977
1,280,586	0	0
3,167	0	0
836,926	136,785	3,191,302
676,636	12,360	0
13,984	3,982	0

272,024	0	730,479
23,259	0	262,014
61,698	0	960,753
5,139	0	52,834
2,901	0	100,689
1,395	0	(8,262)
35,179	0	0
0	0	0
140,909	0	307,409
0	0	0
19,763	1,309	802,104
757	0	0
63,220	0	956,642
0	0	50,642
12,425	0	297,778
2,876,026	1,110,383	0
66,828	55,550	1,804,650
78,601	0	383,632
186,378	0	117,912
46,591	0	1,157,478
251,208	0	65,227
1,011,894	353,728	0
19,566	0	0
1,371,162	1,250,370	6,035,437
183,531	0	(307,033)
3,753,894	692,063	0
56,729	7,834	231,472
309,599	231,733	978,688
38,283	19,280	137,985
0	0	0
6,056	3,528	249,368
6,819	0	156,215
1,175	0	36,050
21,653	0	285,672
167,928	0	0
0	0	12,485
227,053	535,683	(946,157)
2,274,619	818,386	2,438,042
2,059,887	1,279,844	0
7,836	0	143,555
44,189	0	408,846
12,298	0	167,501
37,702,205.00	9,797,955.00	40,569,787.00

Missouri Department of
SOCIAL SERVICES

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MO HEALTHNET DIVISION
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January 6, 2023

James G. Scott
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
Federal Office Building, Room 235
601 East 12th Street
Kansas City, MO 64106

Dear Mr. Scott:

Pursuant to the Centers for Medicare and Medicaid Services' (CMS) request for the quarterly Federal Reimbursement Allowance (FRA) assessments by hospital, attached is a copy of the FRA, the Missouri Hospital Tax schedule.

This schedule is an update to the one provided to CMS during the review of the hospital provider tax. This information includes the hospital tax for the period October 1, 2022 – December 31, 2022.

If you have additional questions, please contact Christina Jenks, Director of Hospital Policy and Reimbursement at 573-526-4749.

Sincerely,

(b)(6)

Todd Richardson
Director

TR:cj

Attachment

bcc: Christina Jenks
Nate Percy
Tony Brite

Provider Name	9/30/2022 Balance	SFY 2023 - 2ND QUARTER REPORT Actual Recoupment Oct - Dec 2022	Payments for Assessment Oct - Dec 2022	Recoupment From Other Hospitals Oct - Dec 2022	FRA Assessment Oct - Dec 2022	Assessment Adjustment Oct - Dec 2022	Difference Oct - Dec 2022	Balance AS OF 12/31/2022
Signature Psychiatric Hospital	(324,550)	33,014	345,301		357,564		20,751	(303,798.63)
Mercy Rehabilitation Hospital Springfield	(0)	392,964			360,108		32,856	32,855.85
Osage Beach Center for Cognitive Disorders		66,156			66,156			
CenterPointe Hospital of Columbia LLC	(13,186)	209,696			222,882		(13,186)	(26,372.00)
Landmark Rehabilitation Hospital of Columbia		(26,980)			(30,414)		3,434	3,434.00
Perimeter Behavioral Hospital of Springfield		104,466			104,466			
Southeast Behavioral Hospital		47,236			42,138		5,098	5,098.00
Mercy Hospital Springfield		11,221,854			11,221,854			
Madison Medical Center		96,174			96,174			
Mercy Hospital Jefferson		2,709,600			2,709,600			
SSM Health Cardinal Glennon Children's Hospital		4,574,160			4,574,160			
St. Joseph Medical Center - Kansas City		1,980,966			1,980,966			
Texas County Memorial Hospital		264,888			264,888			
Mosaic Life Care at St. Joseph		7,145,238			7,145,238			
Perry County Memorial Hospital		433,002			433,002			
Bothwell Regional Health Center		1,342,674			1,342,674			
Carroll County Memorial Hospital		346,410			346,410			
Mosaic Medical Center - Albany		177,780			177,780			
Capital Region Medical Center	(79,602)	2,506,999			2,530,872		(23,873)	(103,475.33)
Callaway Community Hospital								
St. Francis Medical Center - Cape Girardeau		5,416,734			5,416,734			
Mercy Hospital South		6,765,630			6,765,630			
Putnam County Memorial Hospital		65,160			65,160			
SSM Health St. Mary's Hospital - Jefferson City		1,706,982			1,706,982			
University Health Truman Medical Center		4,605,720			4,605,720			
Harrison County Community Hospital		221,742			221,742			
SSM Rehabilitation Hospital, Bridgeton		1,495,344			1,465,362		29,982	29,982.05
Research Medical Center		7,470,858			7,470,858			
Freeman Neosho Hospital		302,442			302,442			
Sullivan County Memorial Hospital		60,276			60,276			
Cedar County Memorial Hospital		115,698			115,698			
Scotland County Hospital		181,458			181,458			
St. Luke's Hospital of Kansas City		10,663,302			10,663,302			
SSM Health St. Mary's Hospital - St. Louis		4,718,346			4,718,346			
Audrain Community Hospital								
Hannibal Regional Hospital		2,053,158			2,053,158			
SSM Health St. Clare Hospital - Fenton	0	2,484,088			2,446,968		37,120	37,120.07
Southeast Hospital		4,179,864			4,179,864			
SSM Health St. Joseph Hospital - St. Charles		2,816,790			2,816,790			
Macon County Samaritan Memorial Hospital		215,130			215,130			
Mercy Hospital Cassville		165,768			165,768			
Missouri Delta Medical Center		1,009,830			1,009,830			
Nevada Regional Medical Center		346,842			346,842			
Phelps Health		2,955,504			2,955,504			

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Missouri Baptist Medical Center		3,434,496		(5,100,000)	3,434,496	(5,100,000)		
L.E. Cox Medical Center		12,290,436			12,290,436			
Mercy Hospital Lincoln		373,578			373,578			
Hermann Area District Hospital		128,502			128,502			
Western Missouri Medical Center		972,246			972,246			
Cox Barton County Hospital		204,678			204,678			
Excelsior Springs Hospital		211,332			211,332			
Christian Hospital		3,871,530			3,871,530			
St. Luke's Des Peres Hospital	(17,868)	1,185,084			1,202,952		(17,868)	(35,736.00)
Mercy St. Francis Hospital		154,662			154,662			
Ray County Memorial Hospital	(134,150)	98,888			208,962		(110,074)	(244,224.68)
Ste. Genevieve County Memorial Hospital		371,550			371,550			
Mercy Hospital Lebanon		1,064,466			1,064,466			
Ozarks Healthcare		1,639,914			1,639,914			
Wright Memorial Hospital		435,870			435,870			
Community Hospital Association		203,730			203,730			
Ellett Memorial Hospital		80,088			80,088			
Cass Regional Medical Center		807,858			807,858			
SSM Health DePaul Hospital - St. Louis		5,528,184			5,528,184			
Mosaic Medical Center - Maryville		586,590			586,590			
Mercy Hospital Joplin		2,726,124			2,726,124			
Missouri Baptist Sullivan Hospital		725,976			725,976			
Freeman Health Systems		5,876,112			5,876,112			
University of Missouri Hospital and Clinics		13,435,716			13,435,716			
Golden Valley Memorial Hospital		1,004,262			1,004,262			
North Kansas City Hospital		6,424,578			6,424,578			
Mercy Hospital St. Louis	(63,330)	16,383,192			16,446,522		(63,330)	(126,659.84)
St. Luke's Hospital West	(4,002,893)	2,027,809	3,378,096		6,030,702		(624,797)	(4,627,690.13)
University Health Lakewood Medical Center		1,424,190			1,424,190			
Lafayette Regional Health Center		357,498			357,498			
Liberty Hospital		2,894,100			2,894,100			
Mercy Hospital Aurora		204,780			204,780			
Hedrick Medical Center		686,946			686,946			
Salem Memorial District Hospital		245,952			245,952			
Pershing Memorial Hospital		161,514			161,514			
Northeast Regional Medical Center		810,726			810,726			
South City Hospital		547,662			547,662			
Boone Hospital Center	(1,064,213)	3,740,073			4,342,494		(602,421)	(1,666,634.16)
Cameron Regional Medical Center		538,704			538,704			
Fitzgibbon Memorial Hospital		557,850			557,850			
Mercy Hospital Washington	(69,025)	2,528,951			2,597,976		(69,025)	(138,050.76)
Parkland Health Center		1,342,674			1,342,674			
St. Luke's North Hospital		2,268,000			2,268,000			
Centerpoint Medical Center of Independence		4,940,568			4,940,568			

Provider Name	9/30/2022 Balance	SFY 2023 - 2ND QUARTER REPORT Actual Recoupment Oct - Dec 2022	Payments for Assessment Oct - Dec 2022	Recoupment From Other Hospitals Oct - Dec 2022	FRA Assessment Oct - Dec 2022	Assessment Adjustment Oct - Dec 2022	Difference Oct - Dec 2022	Balance AS OF 12/31/2022
Mercy Hospital Carthage		281,664			281,664			
Cox-Monett Hospital		377,610			377,610			
Lake Regional Hospital		2,000,658			2,000,658			
SSM Health St. Louis University Hospital		8,293,350			8,293,350			
Bates County Memorial Hospital		352,146			352,146			
Southeast Health Center of Stoddard County		342,534			342,534			
Barnes-Jewish Hospital		40,950,780		7,272,000	40,950,780	7,272,000		
Pike County Memorial Hospital		147,234			147,234			
Washington County Memorial Hospital		198,114			198,114			
Lee's Summit Medical Center		1,732,176			1,732,176			
St. Louis Children's Hospital		11,693,784			11,693,784			
Children's Mercy Hospital		16,791,000			16,791,000			
Cox Medical Center Branson		2,217,978			2,217,978			
Pemiscot Memorial Hospital		206,562			206,562			
Lakeland Behavioral Health System	(242,435)	43,062			234,150		(191,088)	(433,522.97)
Moberly Regional Medical Center	(257,857)	514,816			712,446		(197,630)	(455,486.94)
St. Mary's Medical Center - Blue Springs		1,185,360			1,185,360			
Poplar Bluff Regional Medical Center		3,335,802			3,335,802			
Citizens Memorial Healthcare		1,297,146			1,297,146			
Ranken Jordan		735,984			735,984			
CenterPointe Hospital	(144,188)	276,964			337,302		(60,338)	(204,525.85)
Heartland Behavioral Health Services		161,862			161,862			
Barnes-Jewish St. Peter's Hospital		627,612		(1,320,000)	627,612	(1,320,000)		
SSM Health St. Joseph Hospital - Lake St. Louis		2,406,413			2,392,266		14,147	14,147.27
Royal Oaks Hospital		206,388			206,388			
Barnes-Jewish West County Hospital		1,361,490		(840,000)	1,361,490	(840,000)		
Kindred Hospital St. Louis		452,316	594,009		452,316		594,009	594,008.79
Rehabilitation Institute of St. Louis		722,358			722,358			
Parkland Health Center - Bonne Terre		54,096			54,096			
Select Specialty Hospital - St. Louis	(528,683)	364,574	209,459		549,738		24,295	(504,387.87)
Belton Regional Medical Center		1,136,550			1,136,550			
St. Luke's East Hospital	(277,726)	3,990,530			4,137,924		(147,394)	(425,119.74)
Kindred Hospital Northland		311,154			311,154			
Mercy Rehabilitation Hospital St. Louis	(267,171)	429,352	190,643		696,522		(76,528)	(343,698.04)
Landmark Hospital of Joplin		189,264			189,264			
Select Specialty Hospital - Springfield	0	334,539			299,838		34,701	34,701.20
St. Luke's Rehabilitation Hospital	(220,535)	45,703	89,682		266,238		(130,853)	(351,388.30)
LTAC Hospital, Mosaic Life Care at St. Joseph		184,740			184,740			
Landmark Hospital of Columbia	(31,481)	150,463			181,944		(31,481)	(62,961.90)
Shriner's Hospitals for Children - St. Louis		111,252			111,252			
Rusk Rehabilitation Center, LLC		348,618			348,618			
Progress West Hospital	(26,171)	1,193,872		(12,000)	1,206,792	(12,000)	(12,920)	(39,090.96)
Iron County Medical Center		115,476			115,476			
Landmark Hospital of Cape Girardeau		226,815			207,108		19,707	19,707.00

Provider Name	9/30/2022 Balance	SFY 2023 - 2ND QUARTER REPORT Actual Recoupment Oct - Dec 2022	Payments for Assessment Oct - Dec 2022	Recoupment From Other Hospitals Oct - Dec 2022	FRA Assessment Oct - Dec 2022	Assessment Adjustment Oct - Dec 2022	Difference Oct - Dec 2022	Balance AS OF 12/31/2022
Center for Behavioral Medicine		191,127			191,127			
Hawthorn Children's Psychiatric Hospital		142,137			142,137			
Northwest Missouri Psychiatric Rehabilitation Center		311,233			311,233			
Fulton State Hospital		1,172,907			1,172,907			
Southeast Missouri Mental Health Center		837,877			837,877			
St. Louis Psychiatric Rehabilitation Center		609,839			609,839			
Open Hospitals Subtotal	(7,765,064)	310,505,883	4,807,189	0	316,869,778	0	(1,556,706)	(9,321,770)
Pinnacle Regional Hospital								
Twin Rivers Regional Medical Center								
Ripley County Memorial Hospital								
Two Rivers Psychiatric Hospital								
I-70 Community Hospital								
Black River Medical Center								
Metropolitan St. Louis Psychiatric Center								
Closed or Merged Hospitals Subtotal	0	0	0	0	0	0	0	0
Grand Total	(7,765,064)	310,505,883	4,807,189	0	316,869,778	0	(1,556,706)	(9,321,770)

MEDICAID PARTNERSHIP PLAN (MPP)

This plan between the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services ("DHHS"), and the State of Missouri, through the Director of the Department of Social Services ("DSS" or "the State"), renews the Medicaid Partnership Plan (MPP) currently scheduled to expire on June 30, 2008. The terms and conditions of this renewal shall govern the financial arrangements between CMS and DSS for the State's MO HealthNet program as of July 1, 2008. The Missouri-Specific Transition Agreement is also hereby renewed on the terms set forth below.

The purposes of this MPP are to:

A.) Establish a stable funding mechanism for the State's MO HealthNet program that embodies accountability while assuring the availability of financial resources to provide needed health care to the program's beneficiaries.

B.) Establish a process whereby CMS and Missouri engage during upcoming State fiscal year (SFY) budget development to determine the permissibility of the funding sources proposed to be used by the State for its share of the MO HealthNet program in upcoming SFY. This proactive approach is not intended to impede the State's ability to structure and manage the financing of its MO HealthNet program. Rather, it is intended to provide guidance to the State to assure the financing structure meets applicable Federal requirements.

The parties seek to assure prospective predictability and public confidence in the MO HealthNet program and its financing processes.

I. Explanation of the Yearly Medicaid Partnership Agreement (MPA) and State Funding Sources

A. For each year beginning with state fiscal year 2009 (July 1, 2008 – June 30, 2009), a yearly Medicaid Partnership Agreement (MPA) will be developed covering all financial aspects of the State's MO HealthNet program, including both services and administration. The MPA will be based on the State's budget as adopted by the General Assembly and approved by the Governor, as augmented by other sources of MO HealthNet expenditures.

1. The MPA will include the Medical Assistance Budget (projected Federal and non-Federal shares) of estimated total computable expenditures with details on projected non-federal funding sources, specifying: (1) amounts that are budgeted to be paid from General Revenues appropriated to the MO HealthNet Division and the Family Support Division, (2) estimated Medicaid expenditure budgets of other State agencies whose expenditures are the basis for Medical Assistance claims (3) estimated expenditures of non-state governmental units that form the basis for Medical Assistance claims.

2. Administrative costs included in the MPA include estimated direct and indirect costs of the State agency for plan administration, including costs allocated to the Medical Assistance program under applicable approved cost allocation plans and, consistent with the principles of OMB Circular A-87, operating agreements with other governmental agencies that are similarly limited to actual costs.

B. "State funding sources" refers to all sources relied upon by the State to provide the non-Federal share of MO HealthNet expenditures. "State revenue sources" refers to any source of revenue for the State or any governmental unit in the State, whether or not it is used as a State funding source. State funding and revenue sources can include all sources consistent with section 1903(w) of the Social Security Act (the Act). The State shall provide information on all funding sources and revenue sources that meet the definition of a health-care related tax or a provider-related donation under section 1903(w) of the Act utilized by Missouri.

II. Submission and Review of the MO HealthNet Budget and State Funding Sources

A. On or before February 1 prior to the commencement of a state fiscal year, the State will submit to CMS its preliminary proposed MO HealthNet Budget to the extent formalized by the Governor for the year and a listing and estimated amounts of all of the state funding sources to be relied upon to provide the non-Federal share of expenditures pursuant to the MO HealthNet Budget.

1. The State agrees to provide information outlined in Attachment I. The State will provide a summary of the annual Medicaid budget, including both projected expenditures and each projected funding source (e.g. Federal Funds, General Revenue, other state funds including provider taxes, certified public expenditures and intergovernmental transfers). The state will provide a table that reflects the annual budget by fund source in the first column. Subsequent columns will reflect changes from the previous SFY that result from caseload growth, inflation, new programs, and new decision items (Attachment II).

2. The State does not have to report on all State revenue sources that are not non-federal share funding sources, except when the state revenue source meets the definition of a health-care related tax or a provider-related donation under section 1903(w) of the Act. For each such proposed health care related tax and/or donation, the State must provide a detailed demonstration that each such source complies with the requirements of section 1903(w) of the Act and the implementing regulations. The State shall report to CMS changes to the tax structure that have been made to any existing health care related taxes that are used as a funding

source for the non-Federal share of MO HealthNet expenditures. If any changes, including changes to the tax rate, tax base, or other aspects of the taxing structure, are made the State must detail in writing the changes made and provide new broad based and/or uniformity waiver tests to CMS if applicable. The treatment of existing health-care related taxes is addressed in the Missouri-Specific Agreement.

3. Upon request, the State will provide additional documentation requested by CMS in a timely manner to facilitate its review of the State's submission.

4. The State will provide update reports to CMS on the status of the budget process within ten working days of the conclusion of action by the Governor, the House of Representatives, by the Senate, and as finally enacted by the General Assembly, notifying CMS of the budget changes occurring between actions. The information to be submitted by the State shall be on the attached forms.

5. When the final state budget is adopted, the State will submit a final MO HealthNet Budget for CMS review, including the estimated amount of each funding source and a description of each of the funds and funding sources expected to finance the non-Federal share of the MO HealthNet expenditures in the applicable SFY.

B. CMS will advise the State no later than 45 days after receipt of the State's submission of any proposed State funding source for which CMS needs additional information to ensure compliance with federal law and regulations.

1. CMS and the State will meet and discuss issues raised with respect to any funding source that CMS asserts is not in compliance with federal law.

2. Once a state funding source has been reviewed and accepted by CMS, continued use of the funding source will be included in the annual submission of the MPA. It is the State's responsibility to notify CMS of any changes to the funding sources subject to review under this Agreement.

C. The State will respond to CMS' request for additional information no later than 45 days after receipt of the request from CMS.

D. If after review and negotiation CMS adheres to a determination that a state funding source is not compliant with federal law and regulations, the State will not utilize the funding source (without prejudice to its right to appeal under paragraph H, below) and it will either provide substitute funding sources that are

acceptable to CMS or will modify the MPA as necessary so that sufficient accepted state funding sources are available to cover the non-Federal match for all budgeted expenditures.

E. In the event of an appeal that results in a ruling that a questioned state funding source is compliant with federal law, the State will be entitled to utilize that funding source to fund expenditures under the MO HealthNet Budget subject to Section I, Explanation of the Yearly Medicaid Partnership Agreement (MPA) and State Funding Sources.

F. As part of its review of the State's MPA, CMS will provide the State with a written determination of any proposed expenditure which it believes lacks outstanding state plan authority, waiver authority or other authority for federal financial participation (FFP), or that the expenditure is otherwise not subject to FFP. If, after negotiation, the State continues to believe that there is authority for the proposed expenditure and that it is subject to FFP, the State may retain the expenditure in the MO HealthNet Budget, but as to that expenditure CMS will be free to utilize any authority in statute or regulation to question or withhold FFP without regard to the following provisions of this Agreement.

G. In the event the MPA is not approved before the beginning of the State fiscal year, the State will be entitled to draw federal funds at the approved level based on the CMS 37 and CMS 21B forms that are submitted by the State and approved by CMS.

H. If CMS takes any formal action as described in paragraph F above, the State may seek a ruling from the Office of the Secretary or, the Secretary's designated appeals board. If the State receives an unfavorable decision, the State may exercise all additional appeal rights allowable under Federal law.

I. The MO HealthNet budget, as adjusted in accordance with the foregoing paragraphs, shall be considered the approved budget for the State's MO HealthNet program for the fiscal year, subject to modifications in accordance with Section III below. This will not limit CMS' authority to review proposed changes to the MO HealthNet program through the State plan amendment (SPA) process. The State will not claim expenditures or drawdown Federal funds for SPAs that may be included in the State's budget prior to approval by CMS.

III. Modifications to the Yearly MPA

A. The State shall submit to CMS a supplemental budget amendment to the MPA to incorporate any previously unbudgeted expenditure. The State's submission will also show the funding sources from which the non-Federal share of the cost of the increased expenditures will be obtained. CMS will review the non-Federal funding sources to ensure compliance with applicable federal law and transition agreement.

1. The supplemental budget amendment may be submitted at any time but would normally be expected to be submitted at the same time that a supplemental budget request is made to the State legislature.

2. CMS will approve any supplemental budget amendment as long as it covers allowable MO HealthNet expenditures and the State has demonstrated a valid funding source for the non-Federal share of the expenditures. The provisions of paragraph II B above shall apply to CMS' review of a state funding source.

3. The amendment will be deemed approved unless CMS advises the State, within 30 days of the submission (or such other period that the parties agree to), that it requires additional information to ensure the proposed State funding source is in compliance with federal law or regulations. The State will respond to CMS' request for additional information regarding the supplemental budget no later than 30 days after receipt of the request from CMS. If the parties are unable to resolve the issue, the processes described in paragraphs II D through H will apply.

4. A supplemental budget submitted because of a state plan amendment or waiver is effective consistent with the effective date requirements governing state plan amendments and waivers. Federal expenditures are available consistent with the effective dates approved under the state plan amendment or waiver.

B. In the event that program expenditures are increased above the amount contained in the MPA (including any approved amendments)as a consequence of litigation, the State will proceed to comply with the order and a supplemental budget amendment with any new funding source for the non-Federal share of the payments will be submitted to CMS as soon as practical. The state and federal governments will participate in accordance with the applicable statutory match rate in any allowable expenditures required as a result of litigation.

IV. Process for Drawing Federal Funds and Reporting Expenditures

A. The approved MPA under the MPP (including any approved amendments) will establish the framework for allowable expenditures for purposes of FFP. Federal grants will be predicated on estimated expenditure amounts submitted as part of the quarterly CMS 37 and CMS 21B budget reporting process.

B. The current process for grant awards, draws of federal funds, and reporting expenditures shall continue to be employed. However, the State will not draw any federal funds to cover expenditures not included in the MPA, including those that would require a new state plan amendment, waiver amendment or new

contracts, unless and until the expenditures are approved and the state funding sources are accepted through the supplemental budget process and the applicable state plan or other federal authorization process.

C. Current federal cash management protocols will be applicable to the State's draw and use of federal funds.

V. Subsequent Year MO HealthNet Budgets

The process described above will be followed for each state fiscal year during which the MPP is in effect, subject to section XI.

VI. Changes to the State Medicaid Plan

A. The state plan submission process contained in existing statutes and regulations will be utilized where the State seeks to make changes to services authorized by the state plan, or to make changes to those persons authorized to receive services by the state plan, or to make changes to the reimbursement to providers authorized by the state plan. However, CMS will make every effort to review such proposals and respond to the State on an expedited basis rather than in the 90-day framework of the existing regulations. The supplemental budget process will be used for the State to amend its MPA and to submit the funding sources to cover the non-Federal share of the additional expenditures. The State will not claim expenditures under any State plan amendments until they are approved by CMS.

B. The State remains free to pay for services covered by pending State plan amendments with state-only funds, pending approval of the plan amendment by CMS and approval of the MO HealthNet Budget amendment, at which time the State will be entitled to draw federal funds for the federal share of all expenditures covered by the approved amendment from the time of its approved effective date.

VII. Policy on Challenges to State Expenditures

A. The parties acknowledge that the yearly MPA process established by this MPP limits the amount of federal funds available to the State annually to the levels contained in approved budgets, in return for assuring funding sources that, by virtue of their advance approval, are more stable and predictable. In that context, the parties recognize the desirability of avoiding, where possible, challenges to state expenditures that could result in retroactive recoveries of previously-spent federal funds or that are based on technical grounds rather than on substantive federal law limitations.

B. Accordingly, when issues arise, through audits, financial review, or otherwise, as to the entitlement of the State to federal financial participation ("FFP") for MO HealthNet program expenditures that have been made, CMS reserves the right to question the entitlement of the State to receive FFP for any

expenditure, and to apply any determination as to the availability of FFP, irrespective of whether or not such expenditure(s) was included in the expenditure estimates submitted under the annual budget review process. The State reserves the right to exercise any rights available to it under federal law or regulations in the event CMS takes any deferral, disallowance or other action with respect to a claim for FFP in MO HealthNet expenditures.

C. Furthermore, where any question arises as to the meaning or application of the State's Medicaid State Plan to any particular expenditure, CMS will defer to the State's interpretation of the plan, as long as the State can demonstrate that it's interpretation of the state plan is supported by the State's historical interpretative, spending and claiming practices.

VIII. Missouri Specific Transition Agreement

A. Pending audits, reviews or other FFP issues that are described in the Missouri-Specific Transition Agreement (appended hereto as Addendum A) will be addressed as described in that Transition Agreement.

IX. Waivers and Demonstration Projects

A. Expenditures under 1115 demonstrations and 1915 waivers will be included in the MO HealthNet budgeting process established by this Agreement.

B. The budget neutrality and cost effectiveness provisions of all current waivers and demonstration projects shall remain in effect subject to their terms and the Transition Agreement.

X. Changes in Federal Law

A. The State shall, within the time frame specified in law and regulations, come into compliance with any changes in federal law and regulations affecting the MO HealthNet program that occur after the date of this MPP. To the extent that compliance with the change in federal law and regulations would affect State MO HealthNet spending, CMS and the State will reflect such change in affected MO HealthNet budgets.

XI. Duration and Termination

A. This MPP shall remain in effect until such time as either party shall terminate the agreement as specified by this MPP.

B. Either CMS or the State may propose amending the terms of this MPP at any time. Any such change shall take effect at the beginning of the next state fiscal year, unless the parties agree otherwise. The party seeking to amend the terms of the agreements must provide the other party with written notice of its proposal at least 180 days in advance of the start of the fiscal year in which the

amendment shall take effect, and the other party shall respond within no more than ninety (90) days from receipt of the proposal.

C. Either CMS or the State may terminate this MPP effective at the end of a state fiscal year. The party electing to terminate this agreement must provide the other party written notice of its intent to terminate at least 180 days prior to the start of the state fiscal year in which the agreement shall terminate. In the event of termination, the MPP will govern the entitlement of the State to FFP for the period of time up to the effective date of termination.

XII. Miscellaneous

A. Except as specified in this MPP, the parties reserve all of their rights under laws and regulations governing the MO HealthNet program. Specifically, except as set forth above, neither CMS nor the State waives any rights under the federal regulations in 42 CFR Part 430.

(b)(6)

For the Centers for Medicare
And Medicaid Services

Dennis G. Smith, Director
Center for Medicaid and State Operations

Date: April 10, 2008

(b)(6)

For the State of Missouri
Department of Social Services

Deborah E. Scott, Director
Department of Social Services

Date: April 8, 2008

MISSOURI PARTNERSHIP PLAN
STATE FISCAL YEAR 2009 BUDGET
ATTACHMENT I

1) Identify any new funding sources for the non-Federal share of MO HealthNet expenditures for SFY 2009.

2) Identify all CPE or IGT funding process arrangements that will be in effect for SFY 2009 and the related MO HealthNet program expenditures in the aggregate.

3) Summarize any MO HealthNet expenditure amounts and the source of non-Federal share coming from state agencies outside of the Department of Social Services.

4) Identify every health care related tax or provider donation, and the total estimated amount that will be collected for each one.

5) Identify significant changes affecting MO HealthNet expenditures for FY 2009 (see Excel spreadsheet Attachment II).

MO HealthNet Budget Worksheet -- Attachment II
FY 2009
DRAFT

Funding Sources	SFY 2009 Budget Request Sample Numbers	New Funding or Funding Changes: Caseload Growth - Page 1	Pharmacy Inflation & Utilization - Page 16	Managed Care Rx Inflat & Medical Utiliz - Page 27	Other Budget Decision Items/Changes *
General Revenue	$ 1,007,003,288	$ 5,230,913	$ 37,077,290	$ 27,374,764	$ 37,379,043
Federal Funds	$ 2,758,076,956	$ 8,387,709	$ 62,916,260	$ 45,381,681	$ 12,956,754
Hospital FRA	$ 652,104,148				
Pharmacy Reimb Allowance	$ 24,289,549				
Nursing Facility Reimb Allowance	$ 218,253,564				
Managed Care Reimb Allowance	$ 48,989,634				
Pharmacy Rebates	$ 37,506,075		$ 3,000,000		
Health Initiative Fund	$ 20,541,199				
Healthy Families Trust Fund-Health Care Account	$ 50,959,100				
Premium Fund	$ 13,637,940				
Uncompensated Care Fund	$ 91,000,001				
IGT	$ -				
Third Party Liability Fund	$ 23,157,822				
Nursing Facility Quality of Care Fund	$ 86,171				
Missouri Rx Plan Fund	$ 24,509,456				
Healthcare Technology Fund	$ 4,950,000				
Life Sciences Research Trust Fund	$ 38,500,000				
Certified Public Expenditures	$ 112,550,000				
Intergovernmental Transfers	$ 1,894,667				
TOTALS	$ 5,128,009,570	$ 13,618,622	$ 102,993,550	$ 72,756,445	$ 50,335,797

* Page numbers refer to the printed and bound Budget Books that include all of the detail and write-ups for each item:
FMAP change - $14,201,450 - page 35
Medicare Part D Clawback Rate Increase - $17,856,600 - page 194
Medicare Part A and Part B Premium Increases - $15,016,474 - page 239
Hospice Rate Increase - $521,786 - Page 281
NEMT Rate Increase - $2,739,487 - Page 294

ADDENDUM A
TO MEDICAID PARTNERSHIP PLAN

MISSOURI-SPECIFIC
TRANSITION AGREEMENT

This Missouri Specific Agreement between the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services, and the State of Missouri, through the Director of the Department of Social Services ("DSS" or "the State"), is entered into contemporaneously with the Medicaid Partnership Plan (MPP). This Missouri specific transition agreement entered into between CMS and DSS is intended to facilitate the MPP by reducing audit and financial management burdens related to past activities and focusing such resources on the ongoing operations of the MPP.

I. Treatment of health-care related taxes:

(A) All existing and new health care related taxes must meet all Federal Medicaid statutory and regulatory requirements.

(B) Inpatient and Outpatient Hospital Services Taxes. The tax on inpatient hospital services and the tax on outpatient hospital services, which are considered separate health care-related taxes for purposes of compliance with section 1903(w), will continue to be recognized as permissible funding sources, subject to annual demonstrations described in paragraph II. For purposes of imposing and collecting the taxes, the State will utilize the methodology described in Attachment 1 of this Addendum to ensure that only the inpatient hospital service revenues are assessed under the inpatient hospital service tax and that only outpatient hospital service revenues will be assessed under the outpatient hospital service tax.

(C) The State's tax on nursing facility services will continue to be recognized as a permissible funding source subject to paragraph I(A) and subject to an annual demonstration of the redistribution arrangement described in paragraph II of this Addendum.

(D) The State's tax on MO HealthNet managed care organizations will expire on September 30, 2009 in compliance with the transition period allowed under the Federal Deficit Reduction Act of 2005.

(E) The State's tax on outpatient prescription drugs will be recognized as a permissible funding source provided that the tax structure is imposed in a broad based and uniform manner with no hold harmless provisions and, if applicable, subject to an annual demonstration of the redistribution arrangement described in paragraph II of this Addendum.

(F) Any new health-care related taxes enacted by the State must be expressly approved by CMS.

(G) Section 403 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432) revised the percentage threshold from 6 percent of net patient service revenue to 5.5 percent under the first prong of the indirect hold harmless test. The State will be expected to comply with this provision as of its effective date of January 1, 2008.

II. In those instances where providers subject to an otherwise valid health-care related tax have an agreement for redistribution of Medical Assistance payments received from the State, the redistribution arrangement will be subject to CMS review and approval. CMS will accept the taxes as a valid state funding source if: 1) there is no explicit hold harmless in state law, regulation, or policy, and 2) the tax program structure at issue meets the B1/B2 standard of 1.0 or above contained in the federal regulations at 42 CFR 433.68(e), after taking into account the redistribution arrangement. Such demonstration must be provided on an annual basis for each health care-related tax program to which redistribution is applicable.

A. Any change in the taxes or tax structures will subject the tax to a new review by CMS under the MPP. Such changes include any change to the tax rate(s), tax base or any other aspect of the taxing structure. Such changes must be included in the annual B1/B2 analysis to be submitted to and approved by CMS before the tax can be recognized as a permissible funding source for the non-Federal share of MO HealthNet expenditures.

B. For purposes of applying the B1/B2 standard to the tax on inpatient hospital services and the tax on outpatient hospital services, facilities can be treated individually or by commonly controlled industry systems in similar geographic locations. Separate analyses shall be performed for the tax on inpatient hospital services and the tax on outpatient hospital services.

C. Submission of the B1/B2 Demonstration Pursuant to the MPP. DSS represents that it is not involved in any way in the redistribution of Medical Assistance payments among providers and does not have access to the information involving redistribution. Therefore, the B1/B2 analyses required to be submitted pursuant to this paragraph shall be prepared in the first instance by the entity or entities that administers a redistribution program. However, the State shall work with such entity to supply and verify the data used as the MO HealthNet statistic, and the State shall be responsible for submitting the B1/B2 analyses to CMS. CMS shall direct any questions regarding the B1/B2 analysis to the State, except that questions as to the redistribution arrangement or the amounts redistributed shall be forwarded to and answered by the provider entities. The State will work with the providers to assure access to records and documentation as necessary to facilitate CMS' review of the analysis.

D. In any circumstance in which the assessed health care providers are required by federal laws, regulations or policies to identify revenues or costs of patient care, the State shall assure that the redistribution of medical assistance payments shall not be taken into account in determining revenues or costs (an assessed health care provider must consider as Medicaid patient care revenues the full amount received from the Missouri program, and may not consider redistribution to be a cost of patient care).

III. Certified Public Expenditures (CPE)

To the extent that the State continues to use certified public expenditures (CPEs) as a source of non-federal share, the State shall (a) use a cost reimbursement methodology; (b) require each provider that certifies expenditures to submit annually a cost report, according to a protocol approved by CMS, that reflects the provider's costs of serving MO HealthNet participants during the year; (c) reconcile payments in each year to the finalized cost report for that year; and (d) provide the results of such reconciliation to CMS and credit the Federal government with any overpayment amount.

(b)(6)	(b)(6)
For the Centers for Medicare And Medicaid Services	For the State of Missouri Department of Social Services
Dennis G. Smith, Director Center for Medicaid and State Operations	Deborah E. Scott, Director Department of Social Services
Date: April 10, 2008	Date: April 8, 2008

ATTACHMENT I
To ADDENDUM A
To the Missouri Medicaid Partnership Plan

HOSPITAL REVENUES SUBJECT TO ASSESSMENT
Third Prior-Year Medicare/Medicaid Cost Report

MO HealthNet Division proposes to determine hospital revenues subject to taxation in the following manner:

1. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3, of the most recent Cost Report that is available for a hospital. Charges shall exclude revenues for Physician Services. Charges related to activities subject to the Missouri taxes assessed for Outpatient Retail Pharmacies and Nursing Facility Services shall also be excluded.

   Gross Total Charges will be reduced by the following:

   a. "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6.

   b. "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1

   c. "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report.

      (Note: To the extent that the Gross Hospital Charges, as specified in #1 above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility and other long-term care providers based at the hospital that are subject to the State's provider tax on nursing facility services.)

   d. Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2

   e. "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7.

   f. "Home Health Charges" from Worksheet G-2, Line 19, Column 2

   g. "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50-63.59.

   h. Other Non-Hospital Component Charges from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24.

2. Obtain "Net Revenue" from Worksheet G-3, Line 3, Column 1. The State will ensure this amount is net of bad debts and other uncollectible charges by survey methodology.

3. Adjusted Gross Total Charges will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

    a. Divide "Net Revenue" by "Gross Total Charges"

    b. "Adjusted Gross Total Charges" will be multiplied by the result of 3. a. to yield Adjusted Net Revenue

4. Obtain "Gross Inpatient Charges" from Worksheet G-2, Line 25, Column 1, of the most recent Cost Report that is available for a hospital.

5. Obtain "Gross Outpatient Charges" from Worksheet G-2, Line 25, Column 2, of the most recent Cost Report that is available for a hospital.

6. Total Adjusted Net Revenue will be allocated between Net Inpatient Revenue and Net Outpatient Revenue as follows:

    a. Gross Inpatient Charges will be divided by Gross Total Charges

    b. Adjusted Net Revenue will then be multiplied by the result to yield Net Inpatient Revenue

    c. The remainder will be allocated to Net Outpatient Revenue

7. Trend Indices will be applied consistently with approved state plan amendment, Sections III B. and XV B. 2.(a)

Missouri Department of
SOCIAL SERVICES

MICHAEL L. PARSON, GOVERNOR • ROBERT J. KNODELL, ACTING DIRECTOR
TODD RICHARDSON, DIRECTOR
MO HEALTHNET DIVISION

August 24, 2022

Dear Director Tsai:

The Missouri Department of Social Services ("DSS"), MO HealthNet Division ("MHD") is responding to the attached "companion letter" (Attachment 1) that we received from the CMS Financial Management Group on July 15, 2022. The letter, which accompanied CMS's approval of managed care inpatient and outpatient hospital directed payments for the period July 1, 2022 through June 30, 2023, announced a "focused review" of Missouri's hospital tax for the quarter beginning July 1, 2022. The letter threatens a potential disallowance that would amount to hundreds of millions and potentially billions of dollars should CMS conclude that a private redistribution arrangement among some Missouri hospitals has resulted in a "hold harmless" arrangement in violation of Section 1903(w)(4) of the Social Security Act (SSA) and implementing regulations in 42 C.F.R. § 433.68(f)(3).

We understand that the CMS had distributed copies of the companion letter to the Missouri Hospital Association and to our congressional delegation, all of whom we are copying here.

We are concerned that the letter makes no mention of the long history of Missouri's discussions and negotiations with CMS regarding the hospitals' private redistribution arrangement or the celebrated partnership that the state and federal government agreed to, with the full support of Missouri's congressional delegation, in 2001. While DSS has referenced the "Partnership Plan" in our prior discussions with CMS staff, we are taking this opportunity to provide the full context and history of that agreement, which predates your tenure at CMS. We are including documentation to demonstrate that the companion letter raises issues and asserts a position that the parties already fully addressed and resolved more than 20 years ago.

Just as in the July 15, 2022, companion letter, in September 1999, CMS (then known as the Health Care Financing Administration) informed Missouri DSS that it was initiating an audit of Missouri's hospital provider tax (known as the Federal Reimbursement Allowance, or FRA) and a "redistribution of medical assistance payments" through the Missouri Hospital Association that CMS was concerned resulted in a violation of the statutory "hold harmless" provisions. See Attachment 2.

DSS was provided with a copy of the draft audit in late 2001. The draft audit laid out the history of the FRA tax and the mechanics of the redistribution arrangement as it was then conducted by the Management Services Corporation ("MSC"), a subsidiary of the Missouri Hospital Association ("MHA"). *See* Attachment 3. The audit tentatively concluded that:

> [T]hrough the redistribution arrangement, the State of Missouri indirectly guarantees to hold hospitals harmless for all or a portion of the tax cost. Specifically, the DSS was authorized to impose and collect a tax on most hospitals in the State of Missouri. The DSS also agreed to make Medicaid hospital payments to [the Management Services Corporation (MSC) operated by the Missouri Hospital Association] (either directly or to individual hospital accounts at one bank, where MSC had authorization to access the accounts). MSC then redistributes the Missouri Medicaid hospital payments (via check or electronically) by transferring Medicaid payments from hospitals that have Medicaid payments in excess of the tax assessment to hospitals that have assessments that exceed Medicaid payments. This arrangement effectively holds harmless the hospitals for all or a portion of the tax and means that the full burden of the tax falls only on the Medicaid program. In other words, through the MSC redistribution arrangement, the State of Missouri makes Medicaid payments that indirectly hold hospitals harmless for a portion of the tax cost.

On October 30, 2001, Senators Bond and Carnahan made statements on the floor of the Senate alleging that the CMS position was putting "form over substance," that it represented "bureaucracy run amok," and urging HHS and CMS to "come to a resolution that meets CMS's concerns but protects the integrity of the Missouri Medicaid program." Other Senators joined in the call for the parties to work together to reach resolution. See Attachment 4.

On November 29, 2001, CMS Administrator Tom Scully wrote a letter to then-Governor Holden requesting an "urgent response" to a "critical Medicaid funding issue" and told the Governor that the State had thirty days to respond to the draft audit. The letter noted that if the draft audit was finalized, CMS would be required to take a disallowance and that "Justice and the Department of Treasury would become involved in the recoupment effort." Among other things, Mr. Scully noted that in 1991, "as a White House staffer," he "personally negotiated" the terms of the 1991 law on health-care related taxes with the National Governor's Association and that it was "abundantly clear then, and under this draft audit, that a tax like Missouri's is inconsistent with the statute."

On December 12, 2001, Governor Holden responded to Mr. Scully. See Attachment 5.

Subsequently, CMS and the State entered into a year-long negotiation to address CMS's concerns. In the course of discussions, CMS took the position that even though the FRA itself was broad-based and uniform, the pooling arrangement and redistribution meant that different hospitals paid different effective rates of tax, which is not permissible. However, CMS acknowledged that its rules permit a non-uniform tax as long as it is "generally redistributive" according to the "B1/B2" analysis described in CMS's regulations at 42 C.F.R. § 433.68(e)(2). CMS's regulations provide that "[i]f the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1, CMS will automatically approve the waiver request." CMS agreed that its regulations would be satisfied if any redistribution arrangement was "generally redistributive" in accordance with its regulations.

Ultimately, in December 2002, the parties agreed to and signed the Missouri Partnership Plan. See Attachment 6. The purpose of the plan was to "establish a stable funding mechanism for the State's Medicaid program that embodies accountability while assuring the availability of financial resources to provide needed health care to the program's beneficiaries." The Partnership Plan requires the State to disclose all of its funding sources to CMS annually to determine their permissibility. *See id.* at 1. In a special addendum addressing health-care related taxes, the Partnership Plan provided that:

> In those instances where providers subject to an otherwise valid health-care related tax have an agreement for redistribution of Medical Assistance payments received from the State, the redistribution arrangement will be subject to CMS review and approval. CMS will accept the taxes as a valid state funding source if: (1) there is no explicit hold harmless in state law, regulation, or policy, (2) the tax program structure at issue meets the B1/B2 standard of 1.0 or above contained in the federal regulations (42 CFR 433.68(e)), after taking into account the redistribution arrangement; and, (3) the proceeds of the taxes do not exceed the tax revenue generated from the hospital tax and nursing facility tax in effect as of June 30, 2002, [subject to inflation.]

See id. at Addendum, p. 1 [page 9 of pdf]

When the Agreement was announced in 2002, CMS issued a press statement in which Administrator Scully described the agreement as "restor[ing] the spirit, and the structure, of the management partnership that was always intended to exist in the federal/state Medicaid relationship" and stating his hopes that "this will be a model for other states." See Attachment 7. With respect to the State's provider taxes, the CMS Press Statement states that:

> [T]oday's Memoradum of Understanding will resolve more than $2.2 billion in potential reimbursement under review over the last decade relating to the existence of a tax on hospitals and nursing homes that potentially 'held harmless' participating providers. **After a detailed review of the state tax procedures, CMS has determined that, with modest changes, the tax structure could have met, and in the future will meet, the tests of CMS regulations. . . .**
>
> With the cooperation of the state, **CMS has spent over a year thoroughly reviewing Missouri's program and determined that with minor changes, it is compliant with federal law.** As a result, through this agreement, CMS has entered into a new cooperative Medicaid budget under which Missouri will make the needed modifications to its provider tax system and the federal and state partnership will be able to focus on the challenges of ensuring current health services for needy Missouri residents.

Id. (emphasis added).

Beginning in State Fiscal Year 2004, consistent with the terms of the Partnership Plan, DSS has annually shared with the CMS regional office both a prospective and retrospective demonstration for any health care related tax that involves a private redistribution arrangement, including the hospital taxes at issue in the companion letter. As far as we are aware, no other State has been as transparent with CMS as to the existence of a private pooling arrangement or the results of the redistribution, or held its providers to a "generally redistributive" standard.

Each year, these annual demonstrations have established – as the CMS regional office can confirm – that any private redistribution arrangements have met and continue to meet the B1/B2 test for a generally redistributive tax that meets the standards for automatic approval under CMS regulations. We note that the most recent B1/B2 for the hospital tax shows a number of hospitals that pay more in taxes than they receive in Medicaid reimbursement. We also are aware that there are a number of hospitals that do not participate in the pooling arrangement; whether to participate is a decision of each hospital individually.

CMS's July 15 companion letter does not point to any change in law or regulation that would require or permit CMS to abandon its prior interpretation of its rules as set forth in the Partnership Plan. We are aware that in 2008 CMS changed the wording in the hold harmless regulations from the State providing "directly or indirectly" for a payment to taxpayers to the State providing for a "direct or indirect" payment, *see* 73 Fed. Reg. 9685, 9699 (Feb. 22, 2008), but we are confident that such a change would not support a different interpretation of CMS rules as applied to Missouri's situation. Among other things, we note that the rulemaking said nothing about private redistributions and that, in 2009 – after publication of the 2008 rule – CMS renewed the Missouri Partnership Plan, after the initial one expired by its own terms after five years.

Further, we note that in its comment response to the 2008 final rule, CMS specifically disavowed the notion that the new rule was "expanding the test for determining when an impermissible hold harmless exists." *Medicaid Program; Health Care-Related Taxes*, 73 Fed. Reg. 9690 (Feb. 22, 2008) (comments and responses to the revisions to 42 C.F.R §433.68(f)).

"We are not aware of any state tax programs that would have been permissible under the Secretary's prior interpretation of the rules, but are no longer permissible under the new rule." *Id.*

The 2009 version of the Partnership Plan, which unlike the 2002 plan does not have an expiration date and continues in place today, provides that that "the tax on inpatient hospital services and the tax on outpatient hospital services . . . will continue to be recognized as permissible funding sources" subject to an "annual demonstration" that "there is no explicit hold harmless in state law, regulation, or policy" and "the tax program structure at issues meets the B1/B2 standard of 1.0 or above . . . after taking into account the redistribution arrangement." *See* Attachment 8, Addendum, page 2 [page 12 of pdf]. The 2009 Partnership Plan does not place a cap on the revenue that can be raised through the hospital and nursing facility tax.

With that background, it appears to us that the position taken in the companion letter is inconsistent with the Partnership Plan, which CMS agreed to back in 2002 and again in 2009, as well as the history of the how the Agreement came to be, and with the public statements from the CMS Administrator in 2002 stating that Missouri's tax program is compliant with federal law. To the extent we have misunderstood CMS's intent in auditing the tax program and the hospitals' redistribution arrangements, we would appreciate it if CMS could provide greater clarity on the purpose of its financial review.

Finally, the companion letter references more recent conversations between the State and CMS, including the letter sent from CMS to Missouri on July 29, 2020. I have also attached for your reference a letter sent from the state to CMS in 2019. (CITE Attachment XX) At that time, we understood CMS to have two primary concerns that were holding up approval of our managed care rates. First, CMS questioned the structure of our FMP payments. Second, CMS raised concerns with a Memorandum of Understanding between our health plans and MHA. We did agree to work with CMS to resolve those concerns. We agreed to submit a proposal to convert our FMP payment into an approved directed payment and we agreed to direct our contracted heath plans to stop executing the MOU with MHA.

As a part of those conversations, we also acknowledged that if CMS finalized the Medicaid Fiscal Accountability Regulation (MFAR) the voluntary pooling arrangement would likely have to change or be eliminated. As MFAR was withdrawn, it remains our strong belief that our tax structure, and the Partnership Plan comply with Federal law and CMS regulation.

I hope that a recounting of this history and the attached materials will negate the need for a financial review. However, in light of the amount of funding at issue and the devastating consequences to the State

Medicaid program were there to be a disallowance, we ask for a response as to whether CMS intends to proceed with a financial review and on what basis, so that we can fully evaluate our options.

Respectfully,

(b)(6)

Todd Richardson
Director
Mo HealthNet

Cc: Rory Howe, CMS Financial Management Group
Missouri Hospital Association
[Congressional delegation]

MISSOURI HOSPITAL PROGRAM
STATE FISCAL YEAR 2022
B1/B2 CALCULATION

Schedule 22-3 Annual Calculations	Inpatient						Outpatient					
5.48% FRA Rate		Inpatient	State's	Inpatient	Inpatient	Effective		Outpatient	State's	Outpatient	Outpatient	Effective
	Medicaid	State's	Tax	Pooling	Effective	Tax	Medicaid	State's	Tax	Pooling	Effective	Tax
Hospital Name	Revenue	Tax	Share	Adjustment	Tax	Share	Revenue	Tax	Share	Adjustment	Tax	Share

Audrain Community Hospital	613,468	(309,104)	0.0005	(35,585)	(344,689)	0.0006	1,961,687	(1,302,632)	0.0020	(179,152)	(1,481,784)	0.0022
Bates County Memorial Hospital	423,204	(302,991)	0.0005	(75,763)	(378,754)	0.0006	2,250,946	(1,130,690)	0.0017	(316,256)	(1,446,946)	0.0022
Boone Hospital Center	7,040,162	(9,597,443)	0.0155	1,990,935	(7,606,508)	0.0123	5,168,490	(8,290,579)	0.0125	2,325,363	(5,965,216)	0.0090
Bothwell Regional Health Center	3,319,691	(1,633,344)	0.0026	(181,962)	(1,815,306)	0.0029	10,924,859	(4,078,088)	0.0062	(540,982)	(4,619,070)	0.0070
Callaway Community Hospital	137,553	(199,888)	0.0003	(595)	(200,483)	0.0003	253,359	(267,829)	0.0004	1,027	(266,802)	0.0004
Cameron Regional Medical Center Inc.	1,234,522	(626,320)	0.0010	(58,089)	(684,409)	0.0011	4,097,727	(1,790,472)	0.0027	(197,235)	(1,987,707)	0.0030
Capital Region Medical Center	3,953,630	(2,588,641)	0.0042	289,724	(2,298,917)	0.0037	12,703,005	(7,300,668)	0.0110	1,998,368	(5,302,300)	0.0080
Carroll County Memorial Hospital	93,202	(149,649)	0.0002	(97)	(149,746)	0.0002	3,451,353	(1,199,760)	0.0018	391,988	(807,772)	0.0012
Cass Regional Medical Center	657,354	(531,017)	0.0009	(4,940)	(535,957)	0.0009	5,495,101	(2,860,427)	0.0043	28,503	(2,831,924)	0.0043
Cedar County Memorial Hospital	89,828	(69,551)	0.0001	(23,028)	(92,579)	0.0001	1,215,096	(360,951)	0.0005	(135,412)	(496,363)	0.0007
CenterPointe Hospital	1,594,274	(1,026,908)	0.0017	221,667	(805,241)	0.0013	609,011	(704,198)	0.0011	186,188	(518,010)	0.0008
CenterPointe Hospital of Columbia	1,026,559	(413,051)	0.0007	-	(413,051)	0.0007	48,409	(23,032)	0.0000	17,112	(5,920)	0.0000
Children's Mercy Kansas City	350,759,820	(36,936,145)	0.0596	(9,969,781)	(46,905,926)	0.0757	227,842,134	(26,741,644)	0.0403	(444,447)	(27,186,091)	0.0410
Citizens Memorial Hospital	2,942,523	(1,186,562)	0.0019	(76,980)	(1,263,542)	0.0020	12,844,824	(4,718,259)	0.0071	(440,304)	(5,158,563)	0.0078
Community Hospital, Fairfax	264,206	(165,579)	0.0003	(945)	(166,524)	0.0003	882,707	(608,878)	0.0009	38,171	(570,707)	0.0009
Cox Barton County Hospital	188,756	(155,682)	0.0003	(39,376)	(195,058)	0.0003	1,914,627	(688,381)	0.0010	(162,659)	(851,040)	0.0013
Cox Medical Center Branson	5,249,538	(3,112,854)	0.0050	(103,671)	(3,216,525)	0.0052	11,066,083	(6,177,559)	0.0093	(295,261)	(6,472,820)	0.0098
Cox Monett Hospital Inc.	1,266,911	(226,475)	0.0004	(5,980)	(232,455)	0.0004	4,277,124	(1,561,534)	0.0024	507,661	(1,053,873)	0.0016
CoxHealth	40,687,728	(18,027,271)	0.0291	(688,426)	(18,715,697)	0.0302	65,416,627	(31,818,303)	0.0480	(1,508,118)	(33,326,421)	0.0503
Ellett Memorial Hospital	20,967	(52,775)	0.0001	(35,584)	(88,359)	0.0001	662,208	(241,145)	0.0004	(173,885)	(415,030)	0.0006
Excelsior Springs Hospital	86,760	(104,826)	0.0002	(14,684)	(119,510)	0.0002	1,244,627	(600,727)	0.0009	(75,894)	(676,621)	0.0010
Fitzgibbon Hospital	1,465,074	(613,306)	0.0010	(92,664)	(705,970)	0.0011	3,797,561	(1,677,291)	0.0025	(251,890)	(1,929,181)	0.0029
Golden Valley Memorial Healthcare	1,687,315	(590,245)	0.0010	(107,807)	(698,052)	0.0011	8,679,471	(3,052,479)	0.0046	(631,896)	(3,684,375)	0.0056
Hannibal Regional Hospital	4,125,888	(2,992,858)	0.0048	(172,831)	(3,165,689)	0.0051	10,871,597	(5,078,413)	0.0077	(425,173)	(5,503,586)	0.0083
Harrison County Community Hospital	121,538	(125,418)	0.0002	(10,433)	(135,851)	0.0002	1,702,650	(768,236)	0.0012	(77,248)	(845,484)	0.0013
Heartland Behavioral Health Services	7,641,431	(654,400)	0.0011	(164,016)	(818,416)	0.0013	-	-	-	-	-	-
Hedrick Medical Center	1,585,507	(629,397)	0.0010	(4,825)	(634,222)	0.0010	5,888,762	(2,448,442)	0.0037	633,573	(1,814,869)	0.0027
Hermann Area District Hospital	57,720	(138,967)	0.0002	(19,528)	(158,495)	0.0003	573,059	(325,828)	0.0005	(50,767)	(376,595)	0.0006
Iron County Medical Center	78,302	(81,533)	0.0001	(6,771)	(88,304)	0.0001	1,249,234	(368,541)	0.0006	(28,126)	(396,667)	0.0006
Kindred Hospital Northland	5,984,685	(1,084,613)	0.0018	-	(1,084,613)	0.0018	-	(9,354)	0.0000	9,326	(28)	0.0000
Kindred Hospital St. Louis	1,786,962	(1,555,169)	0.0025	856,642	(698,527)	0.0011	-	(2,102)	0.0000	1,168	(934)	0.0000
Lake Regional Health System	5,573,531	(2,754,575)	0.0044	(68,243)	(2,822,818)	0.0046	13,029,615	(6,145,228)	0.0093	(321,661)	(6,466,889)	0.0098
Lakeland Behavioral Health System	8,172,679	(952,727)	0.0015	-	(952,727)	0.0015	-	-	-	-	-	-
Landmark Hospital of Cape Girardeau	2,295,056	(720,696)	0.0012	-	(720,696)	0.0012	-	-	-	-	-	-
Landmark Hospital of Joplin	1,167,166	(660,620)	0.0011	-	(660,620)	0.0011	-	-	-	-	-	-
Liberty Hospital	5,854,575	(4,760,309)	0.0077	(6,764)	(4,767,073)	0.0077	7,697,116	(6,419,580)	0.0097	263,588	(6,155,992)	0.0093
Madison Medical Center	123,349	(92,224)	0.0001	(34,642)	(126,866)	0.0002	820,357	(262,925)	0.0004	(118,480)	(381,405)	0.0006
Mercy Hospital Aurora	1,335,427	(201,063)	0.0003	(7,133)	(208,196)	0.0003	2,954,193	(777,557)	0.0012	(1,129)	(778,686)	0.0012
Mercy Hospital Cassville	127,412	(97,296)	0.0002	(9,989)	(107,285)	0.0002	2,322,988	(652,914)	0.0010	(68,659)	(721,573)	0.0011
Mercy Hospital Lebanon	2,096,545	(823,586)	0.0013	(2,575)	(826,161)	0.0013	11,906,328	(4,097,654)	0.0062	(995)	(4,098,649)	0.0062
Mercy Hospital Springfield	63,195,050	(22,303,879)	0.0360	(3,312,450)	(25,616,329)	0.0413	60,968,401	(27,304,244)	0.0412	(4,559,075)	(31,863,319)	0.0481
Mercy Rehabilitation Hospital Springfield	2,946,826	(1,437,252)	0.0023	247,340	(1,189,912)	0.0019	-	-	-	-	-	-
Mercy Rehabilitation Hospital St. Louis	3,005,568	(2,588,184)	0.0042	1,494,828	(1,093,356)	0.0018	-	-	-	-	-	-
Mercy St. Francis Hospital	155,819	(108,911)	0.0002	(20,151)	(129,062)	0.0002	1,998,840	(591,207)	0.0009	(119,603)	(710,810)	0.0011
Missouri Delta Medical Center	4,632,936	(1,570,307)	0.0025	-	(1,570,307)	0.0025	6,867,341	(2,734,020)	0.0041	-	(2,734,020)	0.0041
Moberly Regional Medical Center	1,690,097	(1,212,169)	0.0020	475,079	(737,090)	0.0012	6,168,820	(1,756,834)	0.0027	-	(1,756,834)	0.0027
Mosaic Medical Center - Albany	70,161	(138,214)	0.0002	(27,074)	(165,288)	0.0003	1,227,701	(563,443)	0.0009	(124,090)	(687,533)	0.0010
Mosaic Medical Center - Maryville	1,915,920	(578,325)	0.0009	(65,580)	(643,905)	0.0010	3,104,233	(1,817,518)	0.0027	(122,145)	(1,939,663)	0.0029
Nevada Regional Medical Center	2,578,100	(542,929)	0.0009	(165,807)	(708,736)	0.0011	3,488,404	(1,107,187)	0.0017	(280,605)	(1,387,792)	0.0021
North Kansas City Hospital	17,457,747	(14,713,037)	0.0237	(1,160,474)	(15,873,511)	0.0256	10,886,835	(11,861,425)	0.0179	(986,366)	(12,847,791)	0.0194
Northeast Regional Medical Center	4,340,927	(1,666,118)	0.0027	-	(1,666,118)	0.0027	6,782,793	(2,190,235)	0.0033	-	(2,190,235)	0.0033
Osage Beach Center for Cognitive Disorders	2,396,478	(287,021)	0.0005	-	(287,021)	0.0005	-	-	-	-	-	-
Ozarks Healthcare	5,620,742	(2,080,787)	0.0034	(17,571)	(2,098,358)	0.0034	14,513,461	(5,052,428)	0.0076	(22,093)	(5,074,521)	0.0077
Parkland Health Center -- Bonne Terre	-	(8,946)	0.0000	5,382	(3,564)	0.0000	1,413,034	(566,483)	0.0009	252,775	(313,708)	0.0005
Parkland Health Center -- Farmington	4,381,382	(1,269,776)	0.0020	(213,129)	(1,482,905)	0.0024	13,288,084	(3,882,527)	0.0059	(812,185)	(4,694,712)	0.0071
Pemiscot Memorial Health Systems	1,317,014	(335,992)	0.0005	(66,419)	(402,411)	0.0006	2,629,592	(600,762)	0.0009	(84,760)	(685,522)	0.0010
Perimeter Behavioral Hospital of Springfield	605,110	(214,644)	0.0003	-	(214,644)	0.0003	-	-	-	-	-	-
Perry County Memorial Hospital	682,477	(416,905)	0.0007	(1,842)	(418,747)	0.0007	2,243,291	(1,443,359)	0.0022	253,112	(1,190,247)	0.0018
Pershing Memorial Hospital	37,550	(70,748)	0.0001	(4,127)	(74,875)	0.0001	1,148,792	(582,722)	0.0009	(43,157)	(625,879)	0.0009
Phelps Health	11,641,726	(4,360,586)	0.0070	19,304	(4,341,282)	0.0070	19,112,474	(8,227,001)	0.0124	(30,435)	(8,257,436)	0.0125
Pike County Memorial Hospital	66,137	(68,710)	0.0001	(20,065)	(88,775)	0.0001	1,269,330	(520,034)	0.0008	(164,650)	(684,684)	0.0010
Poplar Bluff Regional Medical Center	20,444,574	(5,945,016)	0.0096	-	(5,945,016)	0.0096	27,390,534	(6,344,499)	0.0096	-	(6,344,499)	0.0096
Putnam County Memorial Hospital	112,366	(133,360)	0.0002	(28,649)	(162,009)	0.0003	451,959	(217,504)	0.0003	(53,422)	(270,926)	0.0004
Ranken Jordan Pediatric Bridge Hospital	29,007,483	(2,246,075)	0.0036	-	(2,246,075)	0.0036	832,595	(119,841)	0.0002	-	(119,841)	0.0002
Ray County Memorial Hospital	324,232	(200,128)	0.0003	(757)	(200,885)	0.0003	1,652,671	(779,054)	0.0012	511,558	(267,496)	0.0004
Royal Oaks Hospital	7,380,711	(653,959)	0.0011	-	(653,959)	0.0011	-	-	-	-	-	-
Rusk Rehabilitation Hospital	4,911,014	(1,185,946)	0.0019	(64,674)	(1,250,620)	0.0020	-	-	-	-	-	-
Saint Francis Medical Center	28,570,524	(10,084,444)	0.0163	(517,541)	(10,601,985)	0.0171	26,353,891	(13,129,261)	0.0198	(901,065)	(14,030,326)	0.0212
Salem Memorial District Hospital	139,118	(187,072)	0.0003	(1,763)	(188,835)	0.0003	2,487,871	(774,509)	0.0012	(770)	(775,279)	0.0012
Samaritan Hospital	183,102	(194,351)	0.0003	(4,649)	(199,000)	0.0003	1,155,096	(619,719)	0.0009	(20,813)	(640,532)	0.0010
Scotland County Hospital	210,542	(137,573)	0.0002	(1,390)	(138,963)	0.0002	937,699	(524,502)	0.0008	123,037	(401,465)	0.0006
Select Specialty Hospital - Springfield	4,238,289	(1,266,724)	0.0020	-	(1,266,724)	0.0020	-	-	-	-	-	-
Select Specialty Hospital - St. Louis	1,491,550	(1,687,892)	0.0027	-	(1,687,892)	0.0027	-	-	-	-	-	-
Shriners Hospitals for Children	1,205,435	(345,133)	0.0006	-	(345,133)	0.0006	1,275,451	(346,040)	0.0005	-	(346,040)	0.0005
Signature Psychiatric Hospital	596,416	(1,126,514)	0.0018	379,654	(746,860)	0.0012	7,041	(220,446)	0.0003	207,820	(12,626)	0.0000

Southeast Behavioral Hospital	1,201,963	(657,685)	0.0011	-	(657,685)	0.0011	53,920	(28,984)	0.0000	28,984	-	-
South City Hospital	7,265,201	(1,166,430)	0.0019	-	(1,166,430)	0.0019	5,589,509	(1,175,895)	0.0018	-	(1,175,895)	0.0018
Southeast Health Center of Stoddard County	488,184	(214,537)	0.0003	(52,351)	(266,888)	0.0004	2,827,576	(1,182,526)	0.0018	(216,367)	(1,398,893)	0.0021
Southeast Hospital	7,155,154	(5,703,146)	0.0092	(96,682)	(5,799,828)	0.0094	20,812,826	(8,913,130)	0.0134	(302,184)	(9,215,314)	0.0139
SSM Health St. Mary's Hospital - Jefferson City	4,812,627	(3,216,251)	0.0052	-	(3,216,251)	0.0052	8,929,101	(4,478,345)	0.0068	-	(4,478,345)	0.0068
SSM Rehabilitation Hospital	8,395,833	(2,579,626)	0.0042	-	(2,579,626)	0.0042	40,397	(2,734,630)	0.0041	-	(2,734,630)	0.0041
St. Luke's Rehabilitation Hospital	945,000	(793,975)	0.0013	601,851	(192,124)	0.0003	-	(38)	0.0000	37	(1)	0.0000
Ste. Genevieve County Memorial Hospital	508,411	(223,481)	0.0004	(3,188)	(226,669)	0.0004	1,716,118	(1,261,923)	0.0019	(4,413)	(1,266,336)	0.0019
Sullivan County Memorial Hospital	32,107	(54,868)	0.0001	(7,687)	(62,555)	0.0001	475,685	(194,877)	0.0003	(30,436)	(225,313)	0.0003
Texas County Memorial Hospital	539,114	(207,296)	0.0003	(84,736)	(292,032)	0.0005	3,151,556	(825,428)	0.0012	(391,507)	(1,216,935)	0.0018
The Rehabilitation Institute of St. Louis	10,647,011	(2,537,917)	0.0041	(143,880)	(2,681,797)	0.0043	96,498	(250,689)	0.0004	(911)	(251,600)	0.0004
University of Missouri Health Care	105,360,181	(29,144,567)	0.0470	(4,168,582)	(33,313,149)	0.0538	91,853,564	(27,012,976)	0.0408	(4,899,848)	(31,912,824)	0.0481
Washington County Memorial Hospital	334,370	(137,595)	0.0002	(25,509)	(163,104)	0.0003	2,628,880	(573,555)	0.0009	(111,606)	(685,161)	0.0010
Western Missouri Medical Center	1,690,604	(897,922)	0.0014	(73,464)	(971,386)	0.0016	6,599,573	(3,315,733)	0.0050	(336,664)	(3,652,397)	0.0055
Wright Memorial Hospital	140,562	(230,119)	0.0004	(915)	(231,034)	0.0004	3,478,584	(1,424,093)	0.0021	(217)	(1,424,310)	0.0021
Western Mo. Mental Health	548,713	(820,041)	0.0013	-	(820,041)	0.0013	-	-	-		-	-
Fulton State Hospital	5,661,832	(4,623,751)	0.0075	-	(4,623,751)	0.0075	-	(3,471)	0.0000		(3,471)	0.0000
Northwest Mo. Psychiatric	1,140,639	(1,291,757)	0.0021	-	(1,291,757)	0.0021	-	(37)	0.0000		(37)	0.0000
Hawthorn Children's Psychiatric	9,306,652	(589,977)	0.0010	-	(589,977)	0.0010	-	-	-		-	-
St. Louis Psych Rehabilitation	2,064,953	(2,511,305)	0.0041	-	(2,511,305)	0.0041	-	-	-		-	-
Southeast Mo. Mental Health	1,107,395	(3,094,974)	0.0050	-	(3,094,974)	0.0050	-	(813)	0.0000		(813)	0.0000
BJC Healthcare	419,229,244	(126,466,566)	0.2041	10,022,345	(116,444,221)	0.1879	292,421,445	(120,437,898)	0.1817	3,300,164	(117,137,734)	0.1767
Prime Healthcare Services	6,597,129	(7,279,016)	0.0117	(89,524)	(7,368,540)	0.0119	5,268,708	(5,498,730)	0.0083	(5,277)	(5,504,007)	0.0083
Freeman Health System	22,033,776	(10,243,622)	0.0165	(24,785)	(10,268,407)	0.0166	32,899,549	(15,885,703)	0.0240	(31,820)	(15,917,523)	0.0240
HCA Midwest Division	75,541,724	(35,708,939)	0.0576	-	(35,708,939)	0.0576	58,233,386	(26,247,021)	0.0396	-	(26,247,021)	0.0396
Mosaic Life Care	26,446,557	(11,748,053)	0.0190	(1,253,963)	(13,002,016)	0.0210	45,573,377	(16,258,920)	0.0245	(2,374,410)	(18,633,330)	0.0281
Saint Luke's Health System	82,284,779	(41,372,960)	0.0668	2,617,344	(38,755,616)	0.0625	48,992,061	(30,235,672)	0.0456	4,124,622	(26,111,050)	0.0394
Mercy Health Southwest Missouri	17,065,733	(7,052,159)	0.0114	(154,765)	(7,206,924)	0.0116	19,962,713	(7,874,718)	0.0119	(581,771)	(8,456,489)	0.0128
Mercy Health East Communities	107,369,601	(52,831,372)	0.0853	(890,894)	(53,722,266)	0.0867	84,335,434	(62,962,006)	0.0950	2,691,775	(60,270,231)	0.0909
SSM Health Care	258,951,756	(64,307,886)	0.1038	-	(64,307,886)	0.1038	224,292,413	(64,702,408)	0.0976	-	(64,702,408)	0.0976
St. Luke's Health Corporation	5,453,262	(13,802,246)	0.0223	7,547,528	(6,254,718)	0.0101	6,151,248	(17,185,405)	0.0259	10,211,278	(6,974,127)	0.0105
Landmark Management Services	1,708,036	(734,027)	0.0012	(19,807)	(753,834)	0.0012	-	-	-	-	-	-
Truman Medical Centers	64,897,865	(9,044,157)	0.0146	(1,961,072)	(11,005,229)	0.0178	69,901,637	(13,715,416)	0.0207	(4,048,904)	(17,764,320)	0.0268
	1,957,409,910	**(619,600,928)**	**1.0000**	**0**	**(619,600,928)**	**1.0000**	**1,701,764,927**	**(662,810,144)**	**1.0000**	**(0)**	**(662,810,144)**	**1.0000**
	B1 Slope	**0.38584**					**B1 Slope**	**0.47773**				
	B2 Slope	**0.38582**					**B2 Slope**	**0.47712**				
	B1 / B2	**1.0001**					**B1 / B2**	**1.0013**				

Cell: D10
Comment: Amy Volkart:
Used MHD's calculation - they allocated by cycle not annually

Cell: D18
Comment: Amy Volkart:
Used MHD's calculation - they allocated by cycle not annually

MISSOURI HOSPITAL PROGRAM													
STATE FISCAL YEAR 2023													
B1/B2 CALCULATION													
Schedule 23-3 Annual Calculations													
5.40% FRA Rate	Inpatient							Outpatient					
		Inpatient	State's	Inpatient	Inpatient	Effective			Outpatient	State's	Outpatient	Outpatient	Effective
	Medicaid	State's	Tax	Pool	Effective	Tax		Medicaid	State's	Tax	Pool	Effective	Tax
Hospital Name	Revenue	Tax	Share	Adjustment	Tax	Share		Revenue	Tax	Share	Adjustment	Tax	Share

Bates County Memorial Hospital	341,494	(260,678)	0.0004	(52,767)	(313,445)	0.0005	2,408,219	(1,147,905)	0.0018	(229,790)	(1,377,695)	0.0022
Boone Hospital Center	9,074,914	(9,643,385)	0.0150	2,837,736	(6,805,649)	0.0106	6,467,445	(7,726,593)	0.0123	2,961,084	(4,765,509)	0.0076
Bothwell Regional Health Center	2,487,127	(1,434,140)	0.0022	(69,767)	(1,503,907)	0.0023	9,759,093	(3,936,558)	0.0063	(348,183)	(4,284,741)	0.0068
Cameron Regional Medical Center Inc.	935,512	(644,193)	0.0010	(46,787)	(690,980)	0.0011	3,079,904	(1,510,634)	0.0024	(153,859)	(1,664,493)	0.0027
Capital Region Medical Center	4,547,757	(2,613,749)	0.0041	165,920	(2,447,829)	0.0038	9,543,472	(7,509,727)	0.0120	1,212,286	(6,297,441)	0.0101
Carroll County Memorial Hospital	126,428	(170,569)	0.0003	35,648	(134,921)	0.0002	2,378,451	(1,215,080)	0.0019	(18,439)	(1,233,519)	0.0020
Cass Regional Medical Center	880,290	(572,226)	0.0009	(8,909)	(581,135)	0.0009	4,440,475	(2,659,203)	0.0042	(176,152)	(2,835,355)	0.0045
Cedar County Memorial Hospital	102,708	(96,290)	0.0002	(23,906)	(120,196)	0.0002	1,211,020	(366,505)	0.0006	(157,050)	(523,555)	0.0008
CenterPointe Hospital	1,285,261	(1,030,726)	0.0016	(15,218)	(1,045,944)	0.0016	428,452	(318,490)	0.0005	(360)	(318,850)	0.0005
CenterPointe Hospital of Columbia	4,239,931	(823,952)	0.0013	(192,994)	(1,016,946)	0.0016	65,341	(67,570)	0.0001	10,922	(56,648)	0.0001
Children's Mercy Kansas City	240,841,645	(41,266,040)	0.0643	(6,877,548)	(48,143,588)	0.0751	137,387,185	(25,897,950)	0.0413	(492,967)	(26,390,917)	0.0421
Citizens Memorial Hospital	2,380,209	(987,463)	0.0015	(124,050)	(1,111,513)	0.0017	10,058,053	(4,201,131)	0.0067	(544,248)	(4,745,379)	0.0076
Community Hospital, Fairfax	163,629	(178,486)	0.0003	(636)	(179,122)	0.0003	666,451	(636,433)	0.0010	(49,368)	(685,801)	0.0011
Cox Barton County Hospital	203,933	(157,379)	0.0002	(19,403)	(176,782)	0.0003	1,319,254	(661,323)	0.0011	(144,966)	(806,289)	0.0013
Cox Medical Center Branson	4,482,596	(3,022,184)	0.0047	(208,174)	(3,230,358)	0.0050	10,053,745	(5,849,735)	0.0093	(480,606)	(6,330,341)	0.0101
Cox Monett Hospital Inc.	1,008,252	(204,029)	0.0003	(19,029)	(223,058)	0.0003	3,455,480	(1,306,410)	0.0021	(96,018)	(1,402,428)	0.0022
CoxHealth	41,875,814	(18,357,557)	0.0286	(1,458,092)	(19,815,649)	0.0309	63,421,238	(30,804,177)	0.0492	(2,237,950)	(33,042,127)	0.0527
Ellett Memorial Hospital	82,882	(64,467)	0.0001	(23,032)	(87,499)	0.0001	487,927	(255,874)	0.0004	(115,668)	(371,542)	0.0006
Excelsior Springs Hospital	67,775	(98,211)	0.0002	(8,818)	(107,029)	0.0002	1,110,990	(747,117)	0.0012	(161,178)	(908,295)	0.0014
Fitzgibbon Hospital	1,265,910	(604,614)	0.0009	(81,895)	(686,509)	0.0011	3,497,910	(1,626,795)	0.0026	(198,840)	(1,825,635)	0.0029
Golden Valley Memorial Healthcare	1,828,706	(530,517)	0.0008	(121,664)	(652,181)	0.0010	9,338,031	(3,486,532)	0.0056	(583,388)	(4,069,920)	0.0065
Hannibal Regional Hospital	4,018,350	(2,934,737)	0.0046	(6,464)	(2,941,201)	0.0046	11,688,796	(5,277,903)	0.0084	(261,761)	(5,539,664)	0.0088
Harrison County Community Hospital	101,591	(122,446)	0.0002	(10,670)	(133,116)	0.0002	1,405,607	(764,532)	0.0012	(150,322)	(914,854)	0.0015
Heartland Behavioral Health Services	6,586,377	(647,441)	0.0010	(175,223)	(822,664)	0.0013	0	0	0.0000	0	0	0.0000
Hedrick Medical Center	1,629,409	(579,680)	0.0009	(13,285)	(592,965)	0.0009	5,372,680	(2,168,103)	0.0035	(140,056)	(2,308,159)	0.0037
Hermann Area District Hospital	135,648	(174,366)	0.0003	(10,755)	(185,121)	0.0003	603,007	(339,630)	0.0005	(49,677)	(389,307)	0.0006
Iron County Medical Center	50,467	(91,348)	0.0001	(508)	(91,856)	0.0001	1,123,955	(370,553)	0.0006	(72,229)	(442,782)	0.0007
Kindred Hospital Northland	5,643,615	(1,229,599)	0.0019	(67,691)	(1,297,290)	0.0020	0	(15,013)	0.0000	6,103	(8,910)	0.0000
Kindred Hospital St. Louis	2,161,317	(1,807,601)	0.0028	1,104,426	(703,175)	0.0011	0	(1,661)	0.0000	1,112	(549)	0.0000
Lake Regional Health System	6,154,633	(2,523,050)	0.0039	(297,422)	(2,820,472)	0.0044	10,598,128	(5,479,586)	0.0087	(790,920)	(6,270,506)	0.0100
Lakeland Behavioral Health System	5,461,086	(936,600)	0.0015	0	(936,600)	0.0015	0	0	0.0000	0	0	0.0000
Landmark Hospital of Cape Girardeau	1,762,424	(828,437)	0.0013	(1,807)	(830,244)	0.0013	0	0	0.0000	0	0	0.0000
Landmark Hospital of Joplin	1,908,611	(757,044)	0.0012	194,966	(562,078)	0.0009	0	0	0.0000	0	0	0.0000
Liberty Hospital	7,464,520	(5,300,597)	0.0083	(23,279)	(5,323,876)	0.0083	7,178,823	(6,275,804)	0.0100	952,193	(5,323,611)	0.0085
Madison Medical Center	98,037	(112,417)	0.0002	(15,353)	(127,770)	0.0002	749,132	(272,289)	0.0004	(118,930)	(391,219)	0.0006
Mercy Hospital Aurora	806,429	(160,099)	0.0002	(14,333)	(174,432)	0.0003	2,346,208	(659,030)	0.0011	(184,361)	(843,391)	0.0013
Mercy Hospital Cassville	91,849	(87,502)	0.0001	(19,882)	(107,384)	0.0002	1,903,540	(575,577)	0.0009	(231,562)	(807,139)	0.0013
Mercy Hospital Lebanon	1,558,864	(561,953)	0.0009	(48,850)	(610,803)	0.0010	9,152,052	(3,695,918)	0.0059	(353,581)	(4,049,499)	0.0065
Mercy Hospital Springfield	47,693,291	(19,895,232)	0.0310	(1,933,927)	(21,829,159)	0.0340	50,488,839	(24,992,184)	0.0399	(2,670,962)	(27,663,146)	0.0442
Mercy Rehabilitation Hospital Springfield	3,493,201	(1,440,420)	0.0022	(31,933)	(1,472,353)	0.0023	0	0	0.0000	0	0	0.0000
Mercy Rehabilitation Hospital St. Louis	2,318,417	(2,786,056)	0.0043	1,067,542	(1,718,514)	0.0027	0	(28)	0.0000	21	(7)	0.0000
Mercy St. Francis Hospital	85,947	(70,085)	0.0001	(4,760)	(74,845)	0.0001	1,862,103	(548,574)	0.0009	(140,540)	(689,114)	0.0011
Missouri Delta Medical Center	4,528,254	(1,606,605)	0.0025	0	(1,606,605)	0.0025	7,671,915	(2,432,711)	0.0039	0	(2,432,711)	0.0039
Moberly Regional Medical Center	1,313,158	(1,274,694)	0.0020	436,870	(837,824)	0.0013	5,234,094	(1,575,093)	0.0025	0	(1,575,093)	0.0025
Mosaic Medical Center - Albany	94,614	(150,029)	0.0002	(22,704)	(172,733)	0.0003	987,559	(561,095)	0.0009	(136,234)	(697,329)	0.0011
Mosaic Medical Center - Maryville	1,302,000	(527,280)	0.0008	(199,931)	(727,211)	0.0011	3,137,087	(1,819,070)	0.0029	(579,604)	(2,398,674)	0.0038
Nevada Regional Medical Center	2,485,803	(485,661)	0.0008	(248,859)	(734,520)	0.0011	2,932,359	(901,699)	0.0014	(412,399)	(1,314,098)	0.0021
North Kansas City Hospital	19,856,840	(14,407,158)	0.0225	(436,251)	(14,843,409)	0.0231	9,196,854	(11,291,154)	0.0180	(397,295)	(11,688,449)	0.0187
Northeast Regional Medical Center	3,032,591	(1,438,532)	0.0022	(9,065)	(1,447,597)	0.0023	4,200,851	(1,804,360)	0.0029	0	(1,804,360)	0.0029
Osage Beach Center for Cognitive Disorders	2,037,596	(264,628)	0.0004	0	(264,628)	0.0004	0	0	0.0000	0	0	0.0000
Ozarks Healthcare	4,699,176	(1,658,005)	0.0026	(175,069)	(1,833,074)	0.0029	12,960,078	(4,901,659)	0.0078	(608,471)	(5,510,130)	0.0088
Parkland Health Center -- Bonne Terre	3,528	(10,100)	0.0000	5,527	(4,573)	0.0000	799,811	(206,286)	0.0003	(64,916)	(271,202)	0.0004
Parkland Health Center -- Farmington	4,073,172	(1,427,050)	0.0022	(148,020)	(1,575,070)	0.0025	12,679,656	(3,943,656)	0.0063	(433,218)	(4,376,874)	0.0070
Pemiscot Memorial Health Systems	971,301	(293,462)	0.0005	(120,720)	(414,182)	0.0006	2,173,499	(532,783)	0.0009	(272,810)	(805,593)	0.0013
Perimeter Behavioral Hospital of Springfield	5,374,856	(417,854)	0.0007	0	(417,854)	0.0007	0	0	0.0000	0	0	0.0000
Perry County Memorial Hospital	649,378	(332,174)	0.0005	91,028	(241,146)	0.0004	2,369,692	(1,399,823)	0.0022	233,124	(1,166,699)	0.0019
Pershing Memorial Hospital	50,025	(81,674)	0.0001	(4,211)	(85,885)	0.0001	918,645	(564,375)	0.0009	(94,280)	(658,655)	0.0011
Phelps Health	11,330,104	(4,437,396)	0.0069	(258,030)	(4,695,426)	0.0073	16,390,138	(7,384,608)	0.0118	(611,119)	(7,995,727)	0.0128
Pike County Memorial Hospital	52,519	(63,780)	0.0001	(9,726)	(73,506)	0.0001	880,907	(525,148)	0.0008	(147,949)	(673,097)	0.0011
Poplar Bluff Regional Medical Center	21,271,369	(6,824,844)	0.0106	(69,131)	(6,893,975)	0.0108	18,060,306	(6,518,354)	0.0104	0	(6,518,354)	0.0104
Putnam County Memorial Hospital	47,852	(84,304)	0.0001	(11,415)	(95,719)	0.0001	288,263	(176,330)	0.0003	(44,181)	(220,511)	0.0004
Ranken Jordan Pediatric Bridge Hospital	31,499,796	(2,889,188)	0.0045	0	(2,889,188)	0.0045	477,258	(54,746)	0.0001	0	(54,746)	0.0001
Ray County Memorial Hospital	120,322	(185,271)	0.0003	141,687	(43,584)	0.0001	686,151	(650,574)	0.0010	13,190	(637,384)	0.0010
Royal Oaks Hospital	8,088,967	(825,558)	0.0013	0	(825,558)	0.0013	0	0	0.0000	0	0	0.0000
Rusk Rehabilitation Hospital	4,137,961	(1,394,462)	0.0022	(10,228)	(1,404,690)	0.0022	0	0	0.0000	0	0	0.0000
Saint Francis Medical Center	22,747,293	(9,895,046)	0.0154	(462,080)	(10,357,126)	0.0162	25,853,900	(11,771,888)	0.0188	(969,730)	(12,741,618)	0.0203
Salem Memorial District Hospital	305,518	(193,495)	0.0003	(6,339)	(199,834)	0.0003	1,983,996	(790,320)	0.0013	(128,728)	(919,048)	0.0015
Samaritan Hospital	95,087	(192,521)	0.0003	(1,728)	(194,249)	0.0003	1,001,485	(667,995)	0.0011	(66,867)	(734,862)	0.0012

Scotland County Hospital	139,498	(160,945)	0.0003	71,143	(89,802)	0.0001	700,875	(564,893)	0.0009	120,453	(444,440)	0.0007
Select Specialty Hospital - Springfield	5,942,167	(1,199,357)	0.0019	0	(1,199,357)	0.0019	0	0	0.0000	0	0	0.0000
Select Specialty Hospital - St. Louis	1,486,816	(2,198,948)	0.0034	0	(2,198,948)	0.0034	0	0	0.0000	0	0	0.0000
Shriners Hospitals for Children	563,198	(245,703)	0.0004	0	(245,703)	0.0004	521,002	(199,314)	0.0003	0	(199,314)	0.0003
Signature Psychiatric Hospital	602,587	(1,181,709)	0.0018	922,113	(259,596)	0.0004	65,144	(248,538)	0.0004	215,567	(32,971)	0.0001
South City Hospital	7,927,671	(1,249,479)	0.0019	0	(1,249,479)	0.0019	5,125,926	(941,176)	0.0015	0	(941,176)	0.0015
Southeast Behavioral Hospital	484,637	(161,007)	0.0003	132,015	(28,992)	0.0000	249	(7,550)	0.0000	7,111	(439)	0.0000
Southeast Health Center of Stoddard County	510,447	(207,612)	0.0003	(93,663)	(301,275)	0.0005	2,780,664	(1,162,512)	0.0019	(354,997)	(1,517,509)	0.0024
Southeast Hospital	7,264,423	(7,081,289)	0.0110	(82,454)	(7,163,743)	0.0112	19,502,491	(9,638,175)	0.0154	(260,072)	(9,898,247)	0.0158
SSM Health St. Mary's Hospital - Jefferson City	5,179,984	(2,992,634)	0.0047	0	(2,992,634)	0.0047	9,077,921	(3,835,291)	0.0061	0	(3,835,291)	0.0061
SSM Rehabilitation Hospital	6,616,766	(3,270,975)	0.0051	0	(3,270,975)	0.0051	68,311	(2,590,462)	0.0041	0	(2,590,462)	0.0041
St. Luke's Rehabilitation Hospital	967,299	(1,063,439)	0.0017	119,780	(943,659)	0.0015	0	(1,518)	0.0000	1,331	(187)	0.0000
Ste. Genevieve County Memorial Hospital	685,141	(235,088)	0.0004	(7,331)	(242,419)	0.0004	2,583,769	(1,251,108)	0.0020	(136,849)	(1,387,957)	0.0022
Sullivan County Memorial Hospital	41,488	(55,390)	0.0001	(5,886)	(61,276)	0.0001	437,265	(185,707)	0.0003	(45,997)	(231,704)	0.0004
Texas County Memorial Hospital	751,198	(273,107)	0.0004	(127,951)	(401,058)	0.0006	2,897,657	(786,445)	0.0013	(378,680)	(1,165,125)	0.0019
The Rehabilitation Institute of St. Louis	8,764,378	(2,872,165)	0.0045	(164,666)	(3,036,831)	0.0047	13,979	(17,261)	0.0000	2,905	(14,356)	0.0000
University of Missouri Health Care	102,700,661	(28,449,121)	0.0444	(6,289,668)	(34,738,789)	0.0542	76,250,784	(25,293,738)	0.0404	(2,111,566)	(27,405,304)	0.0437
Washington County Memorial Hospital	428,661	(148,467)	0.0002	(19,627)	(168,094)	0.0003	2,577,272	(643,990)	0.0010	(233,649)	(877,639)	0.0014
Western Missouri Medical Center	1,696,950	(895,280)	0.0014	(113,344)	(1,008,624)	0.0016	5,335,372	(2,993,694)	0.0048	(410,787)	(3,404,481)	0.0054
Wright Memorial Hospital	224,968	(222,317)	0.0003	(1,882)	(224,199)	0.0003	3,876,102	(1,521,156)	0.0024	(161,575)	(1,682,731)	0.0027
Center for Behavioral Medicine	177,164	(764,506)	0.0012	0	(764,506)	0.0012	0	0	0.0000	0	0	0.0000
Hawthorn Children's Psychiatric Hospital	8,916,887	(568,547)	0.0009	0	(568,547)	0.0009	0	0	0.0000	0	0	0.0000
Northwest Missouri Psychiatric Rehabilitation C	733,237	(1,244,887)	0.0019	0	(1,244,887)	0.0019	0	(44)	0.0000	0	(44)	0.0000
Fulton State Hospital	6,413,160	(4,691,422)	0.0073	0	(4,691,422)	0.0073	0	(204)	0.0000	0	(204)	0.0000
Southeast Missouri Mental Health Center	1,265,173	(3,350,993)	0.0052	0	(3,350,993)	0.0052	0	(514)	0.0000	0	(514)	0.0000
St. Louis Psychiatric Rehabilitation Center	2,248,075	(2,439,345)	0.0038	0	(2,439,345)	0.0038	0	(10)	0.0000	0	(10)	0.0000
BJC Healthcare	357,291,804	(140,632,345)	0.2193	7,043,494	(133,588,851)	0.2083	235,955,537	(114,857,492)	0.1833	4,121,463	(110,736,029)	0.1767
Prime Healthcare Services	7,275,858	(7,258,845)	0.0113	(94,880)	(7,353,725)	0.0115	5,012,915	(5,406,439)	0.0086	248,255	(5,158,184)	0.0082
Freeman Health System	15,226,443	(9,671,748)	0.0151	(78,533)	(9,750,281)	0.0152	22,366,671	(15,042,466)	0.0240	(659,544)	(15,702,010)	0.0251
HCA Midwest Division	71,482,600	(37,319,478)	0.0582	0	(37,319,478)	0.0582	50,748,599	(25,231,133)	0.0403	0	(25,231,133)	0.0403
Mosaic Life Care	28,150,208	(12,981,928)	0.0202	(738,383)	(13,720,311)	0.0214	39,035,326	(16,337,980)	0.0261	(1,879,057)	(18,217,037)	0.0291
Saint Luke's Health System	76,806,140	(41,457,445)	0.0646	1,535,312	(39,922,133)	0.0623	41,889,093	(26,819,450)	0.0428	2,063,947	(24,755,503)	0.0395
Mercy Health Southwest Missouri	12,896,571	(5,604,506)	0.0087	(379,130)	(5,983,636)	0.0093	15,348,689	(6,426,636)	0.0103	(885,181)	(7,311,817)	0.0117
Mercy Health East Communities	105,801,561	(53,296,859)	0.0831	(1,692,129)	(54,988,988)	0.0857	79,581,555	(62,276,385)	0.0994	1,219,740	(61,056,645)	0.0974
SSM Health Care	192,200,195	(64,208,612)	0.1001	0	(64,208,612)	0.1001	148,120,592	(58,871,625)	0.0940	0	(58,871,625)	0.0940
St. Luke's Health Corporation	4,122,372	(13,095,910)	0.0204	8,284,329	(4,811,581)	0.0075	4,673,709	(15,838,723)	0.0253	10,448,879	(5,389,844)	0.0086
Landmark Management Services	2,415,640	(971,101)	0.0015	(77,671)	(1,048,772)	0.0016	0	0	0.0000	0	0	0.0000
University Health (PKA Truman)	62,850,129	(10,386,204)	0.0162	0	(10,386,204)	0.0162	67,009,041	(13,733,435)	0.0219	0	(13,733,435)	0.0219
	1,676,868,091	**(641,277,049)**	**1.0000**	**(0)**	**(641,277,049)**	**1.0000**	**1,357,492,020**	**(626,566,918)**	**1.0000**	**(0)**	**(626,566,918)**	**1.0000**
	B1 Slope	**0.52356**					**B1 Slope**	**0.67578**				
	B2 Slope	**0.52353**					**B2 Slope**	**0.66825**				
	B1 / B2	**1.0001**					**B1 / B2**	**1.0113**				

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FMP IP Directed Payments

- CMS withheld approval of capitation rates back to SFY 2018 due to FMP
- CMS has concerns with current structure and is closely monitoring progress

- FMP payments account for approximately 46% of total IP MC payments, on average (based on SFY 2021 direct Medicaid add-on payments and SFY 2019 MC payments)

FMP IP Directed Payments

42 CFR §438.6(c)

A state Medicaid agency has the ability to tell its MC plans how to pay network (and possibly non-network) providers.

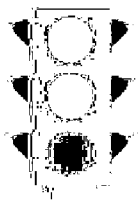
FMP IP Directed Payments

- States must complete CMS MC directed payment pre-print template and obtain approval from CMS
- Payments must be tied to actual service utilization
- Per 42 CFR §438.60, additional payments cannot be made outside the capitation rate for services included in MC

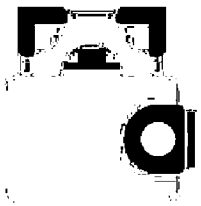
- While not published in regulation, CMS has imposed a limit on total provider reimbursement to providers at the ACR
- States must compare total payments to a benchmark like Medicare or Commercial rates and cannot exceed 150% of Medicare (this can be done by hospital grouping or by individual hospital)

FMP IP Directed Payments

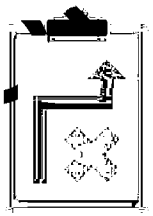
Transition the MC FMP to a Directed Payment



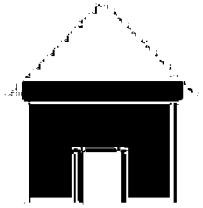
To meet CMS requirements allowing the approval of MC contracts.



To reasonably maintain stability in revenue for IP hospital services.

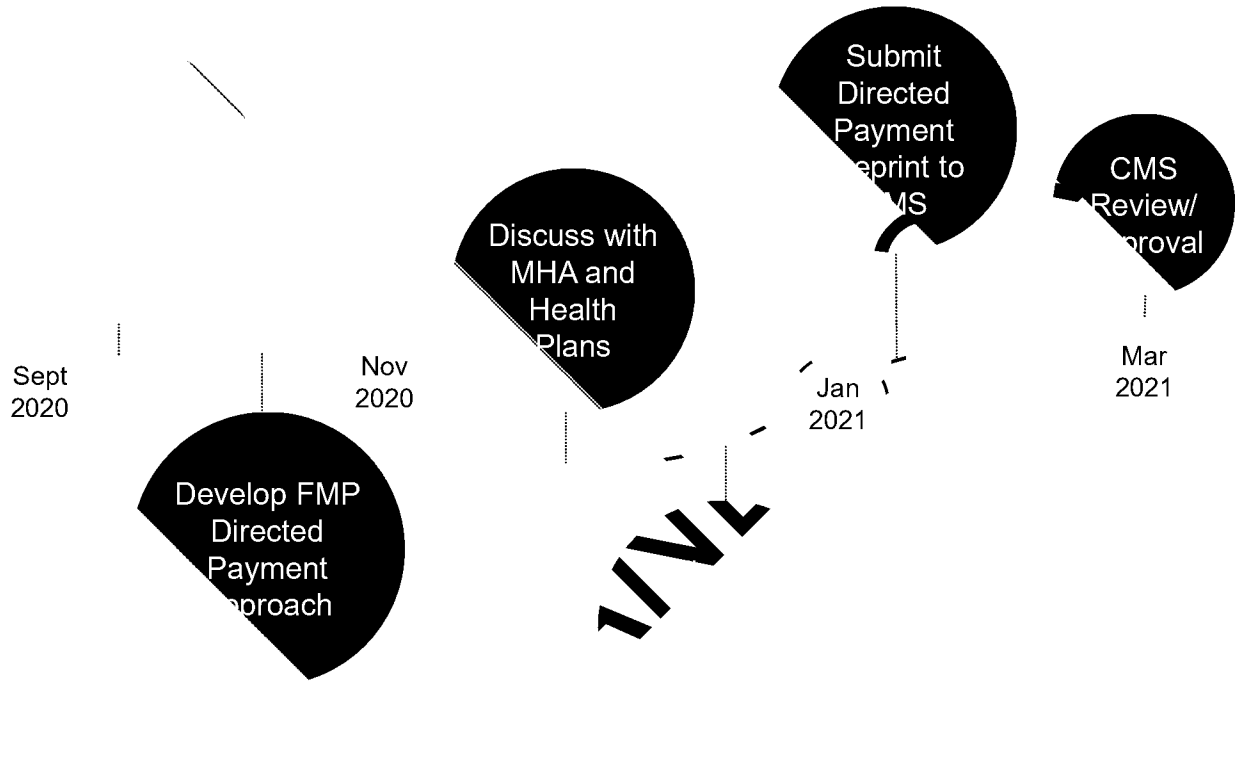


To limit administrative burden and simplify reimbursement.



To provide a foundation for future IP reimbursement strategies.

FMP IP Directed Payments



Setting the foundation for future reimbursement strategies across MC and FFS

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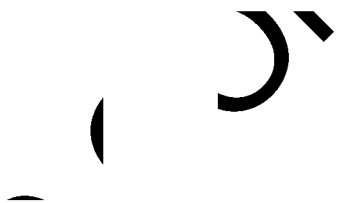
FMP IP Directed Payment Approach

MHD considered the following approaches for the FMP MC directed payment:



MHD directing the health plans to pay a uniform dollar or percentage increase to providers for IP services

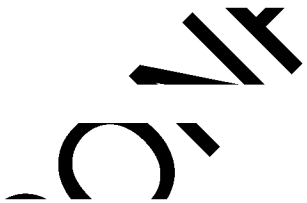
MHD directing the health plans to pay a specified fee schedule for IP hospital services to providers

FMP IP Directed Payment Approach

MHD decided to use the **Alternative Fee Schedule** approach to:

- Balance the reimbursement impact by hospital with maintaining fair, reasonable and transparent levels of payment
- Limit the shifts in IP hospital reimbursement for MC services as much as possible
- Consider IP reimbursement relative to current cost levels

FMP IP Directed Payment Approach



- Specialty Hospitals (18)
- Teaching Hospitals (23)
- 1–100 Licensed Beds (20)
- More than 100 Licensed Beds (21)

FMP IP Directed Payment Approach

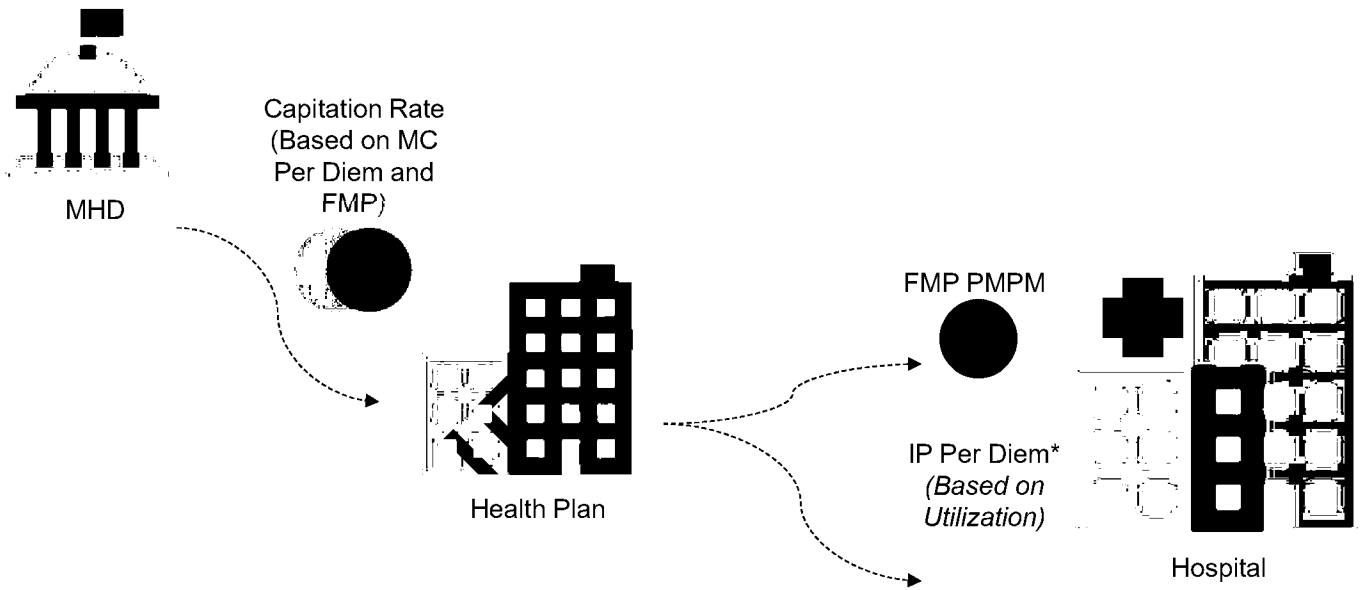
The characteristics of each hospital to identify similarities

The shifts of projected payments among providers as compared to payments under the current system

Projected payments within each provider class as compared to Medicare benchmarks

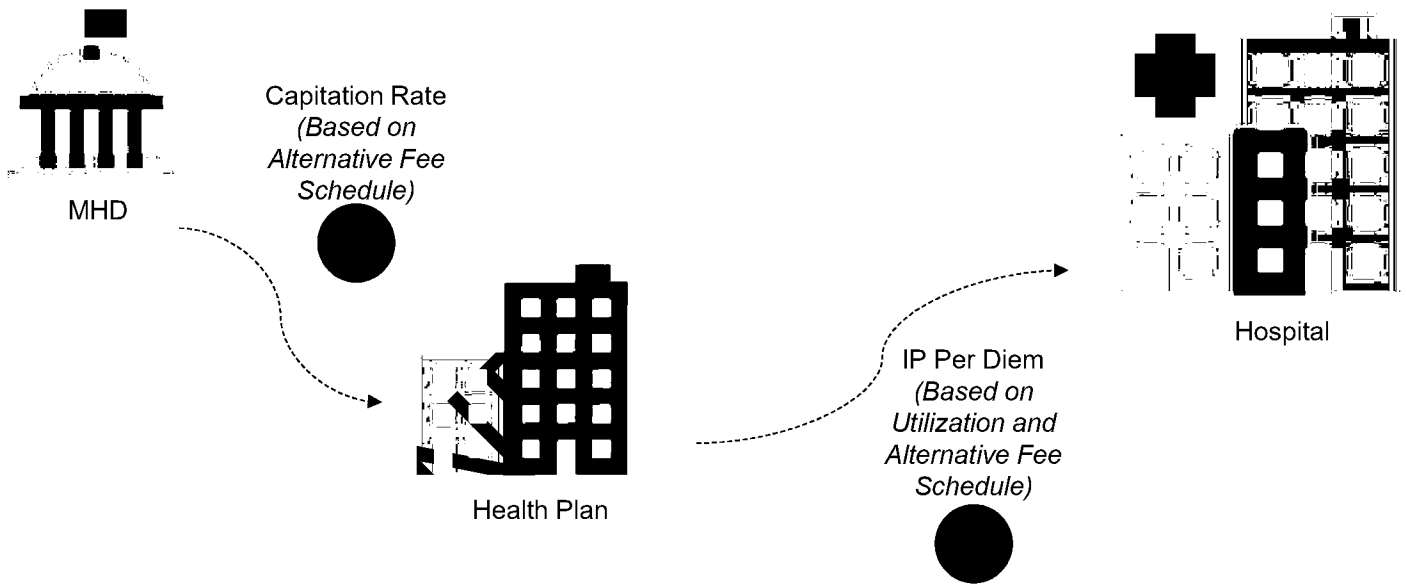
**The payments made to hospitals must either be developed with a consistent methodology across all hospitals or within each hospital provider class.*

FMP IP Directed Payment Approach

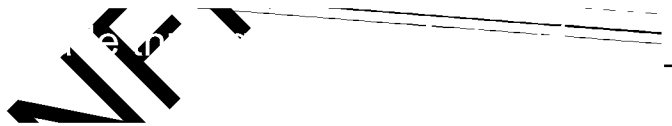


**IP per diems are negotiated between the health plans and hospitals.*

FMP IP Directed Payment Approach



FMP IP Directed Payment Approach



- $877 million in current IP reimbursement (base + FMP); $406 million from direct Medicaid add-on payments
- 34% of all current payments go to the five Children's Hospitals
- 41% of all current payments go to the 23 Teaching Hospitals

- Continue to have hospital-specific per diems
- Transitioning to a consistent payment level across multiple hospitals within each provider class requires increases to some hospitals while decreasing others

DRAFT AND CONFIDENTIAL

Alternative Fee Schedule

To maintain a fair and reasonable level of funding that meets program goals and complies with CMS requirements, MHD is:

1. Using recent Medicaid cost report data as the foundation of the per diems in the Alternative Fee Schedule (FYE 2018 trended to SFY 2022) to:
   A. Move away from separate payments for the base per diem and FMP.
   B. Address the disconnect between current MC payments and Medicaid costs.
2. Assigning each hospital to a provider class to allow for:
   A. Flexibility in varying the per diem criteria in the Alternative Fee Schedule
   B. Flexibility to apply the Medicare threshold/ceiling to each provider class in aggregate, rather than for each hospital individually.

Alternative Fee Schedule

3. Developing SFY 2022 hospital-specific per diems for in-state hospitals only.
   A. Based on current reimbursement levels as a percentage of Medicaid costs.
   B. Includes a ceiling reimbursement level within each hospital provider class.

4. Developing an out-of-state per diem that will be paid for all IP hospital services provided by out-of-state hospitals (may include separate out-of-state rates for border hospitals versus all others).

Alternative Fee Schedule

Hospital Classes		Count of Hospitals	Total SFY 2019 MC Days	Total SFY 2019 MC IP Payments in Current System [1]	SFY 2019 Estimated Medicaid Costs [2]	SFY 2019 Payments as % of Costs
Tier 1	Children's Hospitals	5	63,258	$298,650,742	$270,456,698	110%
Tier 2	CAHs (Federal and State)	34	11,612	$19,766,626	$19,885,489	99%
Tier 3	Specialty Hospitals	18	17,360	$19,034,751	$16,095,206	118%
Tier 4	Teaching Hospitals	23	144,481	$355,981,958	$262,622,074	136%
Tier 5	1–100 Licensed Beds	20	11,665	$24,441,643	$23,611,874	104%
Tier 6	More Than 100 Licensed Beds	21	60,343	$136,822,663	$116,934,129	117%

[1] MC IP Payments in Current System include the base per diem and the FMP payments.

[2] Estimated Medicaid Costs equal the hospital-specific Medicaid cost per diem from the FYE 2018 cost reports (trended to SFY 2019) times the SFY 2019 MC days, and include the FRA Medicaid MC costs.

For Illustration Purposes Only

Alternative Fee Schedule

Hospital Classes		% of Hospital Medicaid Cost Per Diem[1]	Maximum Hospital Per Diem (Ceiling)[2]
Tier 1	Children's Hospitals	118%	120% of Median Cost Per Diem
Tier 2	CAHs (Federal and State)	100%	100% of Median Cost Per Diem
Tier 3	Specialty Hospitals	104%	100% of Median Cost Per Diem
Tier 4	Teaching Hospitals	130%	130% of Median Cost Per Diem
Tier 5	1–100 Licensed Beds	109%	100% of Median Cost Per Diem
Tier 6	More Than 100 Licensed Beds	115%	110% of Median Cost Per Diem

[1] Represents the multiple applied to the hospital-specific Medicaid cost per diems (trended to SFY 2022) for determination of the preliminary payment rate in the Alternative Fee Schedule (before applying the ceiling). Percentage is based on the median ratio of current payments to costs in each class.

[2] Represents the limit or "ceiling" for each hospital class, where the payment rate for each hospital cannot exceed the established maximum for each class.

For Illustration Purposes Only

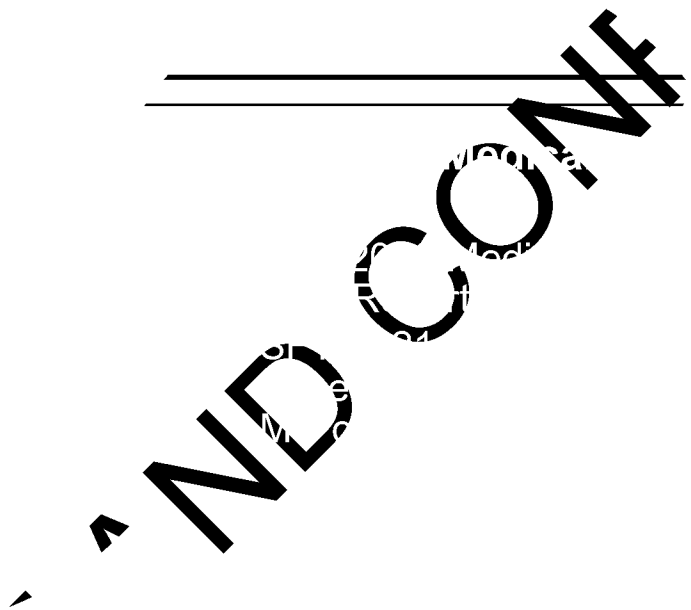
Alternative Fee Schedule

Hospital Classes		Total SFY 2019 MC IP Payments in Current System	Total Projected SFY 2022 MC IP Payments[1]	Estimated Impact	% Change
Tier 1	Children's Hospitals	$298,650,742	$286,383,393	$(12,267,349)	-4.1%
Tier 2	CAHs (Federal and State)	$19,766,626	$20,531,052	$764,426	3.9%
Tier 3	Specialty Hospitals	$19,034,751	$15,474,411	$(3,560,340)	-18.7%
Tier 4	Teaching Hospitals	$355,981,958	$342,984,580	$(12,997,378)	-3.7%
Tier 5	1–100 Licensed Beds	$24,441,643	$20,971,243	$(3,470,400)	-14.2%
Tier 6	More Than 100 Licensed Beds	$136,822,663	$123,888,332	$(12,934,331)	-9.5%

[1] Represents the SFY 2022 Alternative Fee Schedule per diem (hospital-specific Medicaid cost per diem from the FYE 2018 cost reports, trended to SFY 2022, including the FRA Medicaid MC costs) times the SFY 2019 MC days.

For Illustration Purposes Only

Alternative Fee Schedule



**Per diems in the final Alternative Fee Schedule will reflect SFY 2022 levels*

Alternative Fee Schedule

- MHD will be finalizing the hospital classes, fee schedule approach and SFY 2022 per diem rates for the Alternative Fee Schedule in the coming weeks

Other considerations for FMP reimbursement changes in the near and/or long term are:

- Value based payment approaches
- Other factors contributing to hospital cost and reimbursement differentials

Alternative Fee Schedule

This presentation covers preliminary information on inpatient hospital reimbursement in managed care and the potential impact of transitioning the current inpatient FMP reimbursement considered in rate development to a directed payment, as requested by CMS, through an alternative fee schedule. The information provided is a preliminary draft and for discussion purposes only. It is expected that methodologies and results will change from what is included in this presentation.

This presentation is prepared on behalf of MHD, and is intended to be relied upon by MHD. It should be read in its entirety and has been prepared under the direction of Angie WasDyke, who is a member of the American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is made by and between the MHA Management Services Corporation (MSC), an affiliate of the Missouri Hospital Association, Home State Health Plan (Home State), Missouri Care, Inc. (Missouri Care) and UnitedHealthcare of the Midwest, Inc. (UHC). Home State, Missouri Care and UHC are collectively referred to herein as MCOs.

WHEREAS, MHA's members consist of Missouri hospitals that participate in the Federal Reimbursement Allowance (FRA) program, through which they pay a provider tax to the state which, in turn, generates federal matching dollars under the Medicaid program; and

WHEREAS, the FRA program funds Medicaid reimbursements to hospitals by the MO HealthNet Division; and

WHEREAS, MSC currently administers a voluntary pooling arrangement by which participating hospitals pool their Medicaid reimbursements; and

WHEREAS, the pool employs a methodology for distributing pooled funds among pool participants; and

WHEREAS, that formula currently accounts for direct Medicaid add-on payments made by the MO HealthNet Division to hospitals; and

WHEREAS, the MO HealthNet Division has decided to expand the managed care program for children and low-income parents statewide, effective May 1, 2017; and

WHEREAS, the MO HealthNet Division has awarded contracts to Home State, Missouri Care and UHC to serve as the managed care organizations for its beneficiaries; and

WHEREAS, based on recent federal guidance, the MO HealthNet Division will transition the direct Medicaid add-on payments from fee-for-service to managed care for the managed care population; and

WHEREAS, the MO HealthNet Division has adjusted the capitated rates to incorporate the additional costs associated with direct Medicaid add-on payments; and

WHEREAS, the MO HealthNet Division's contracts with the MCOs note the MCOs must use the increased hospital funds for reimbursement of inpatient and outpatient hospital services; and

WHEREAS, CMS issued final guidance on January 18, 2017, which clarifies that the MO HealthNet Division cannot incorporate the direct Medicaid add-on payments into the capitation rates as a pass-through; and

WHEREAS, the parties wish to establish an agreed upon process for distributing the direct Medicaid add-on payments in a manner that complies with CMS guidance while maintaining the financial soundness of MHA's members.

NOW, THEREFORE, in consideration of the foregoing and good and valuable consideration hereinafter described, the parties agree as follows:

I. Mutual Understanding and Representations

A. The MO HealthNet Division intends to expand its managed care program for children and low-income parents to a statewide program effective May 1, 2017.
B. Under the fee-for-service program, hospital payments for treating Medicaid beneficiaries are comprised of claims payments (for both inpatient and outpatient services) and direct Medicaid add-on payments.
C. Inpatient direct payments are designed to supplement per diem payments to ensure hospitals are compensated for their inpatient cost-per-day, including increased allowable costs attributable to the FRA assessment. Outpatient direct payments are designed to recognize hospitals' increased allowable costs attributable to the FRA assessment.
D. The MO HealthNet Division publishes an inpatient and outpatient hospital rate list which represents Full Medicaid Pricing, hereinafter referred to as the "rate list". MHD periodically updates the rate list as rate changes occur.
E. Add-on payments are currently calculated as part of the total reimbursement paid to hospitals under fee-for-service to determine Full Medicaid Pricing.
F. The FRA funds 100 percent of the state share of direct Medicaid add-on payments that will be transitioned from fee-for-service to managed care. In addition, FRA funds a significant portion of claims payments.
G. Both the claims payments and the direct Medicaid add-on payments related to managed care have been incorporated into the capitated rates.
H. The MO HealthNet Division's contracts with the MCOs note the MCOs must use the increased hospital funds for reimbursement of inpatient and outpatient hospital services; however, federal regulation prohibits such contracts from specifying which hospitals must receive the funds or that the amount distributed must equal the amount incorporated into the capitated rates.
I. The MO HealthNet Division's contracts with the MCOs require the MCOs to submit a monthly questionnaire to the MO HealthNet Division containing key data elements necessary for tracking payments to hospitals.
J. The parties agree to work together in good faith to ensure stability through an orderly transition for the hospital industry and the continued success of the FRA program. The transition is keeping with the spirit of the Medicaid and CHIP Managed Care Final Rule, and will provide time and flexibility to integrate current payment arrangements into different payment structures as needed to comply with federal and state standards as those standards are clarified.
K. The parties agree that the memorandum of understanding is conditional on their understanding of information as available at that time from the State and Mercer related to the direct Medicaid add-on payments.

II. MSC Responsibilities

A. MSC staff will continue to administer a voluntary pooling arrangement to handle the payments that are transitioned to the MCOs.

B. Upon completion of this MOU, MSC staff will hold a series of webinars to educate hospitals about the agreed upon process for handling this transition and explain the flow of funds and its implications for hospitals that contract or do not contract with the MCOs.
C. MSC staff will work with hospitals to provide the MCOs with the necessary bank account information to administer payments, and MSC will facilitate the appropriate permissions from the hospitals to allow the MCOs to meet the reporting requirements of this MOU.

III. MCO Responsibilities

A. The MCOs agree to utilize a common process, outlined in Exhibit A, for calculating and remitting amounts owed to hospitals as direct Medicaid add-on payments.
B. The MCOs agree to use the principles outlined in section IV below as the basis for developing the process outlined in Exhibit A.
C. The MCOs will negotiate confidential inpatient and outpatient claims payments directly with the hospitals for the component of hospital costs deemed to not be attributable to the direct Medicaid add-on payment.

IV. Direct Medicaid Add-On Principles

A. Amount to be Distributed
   1. Each MCO will use their actual membership experience and cash payment received from the MO HealthNet Division, reflecting adjustments that may be applied by MHD to determine their total monthly direct Medicaid add-on payment to hospitals. Once the MCOs receive payment from the MHD, each MCO will subsequently process the payment and distribute funds accordingly.
   2. The total amount distributed for the direct Medicaid add-on payment will not exceed the amount of capitation, including adjustments, defined by the MO HealthNet Division as the Full Medicaid Pricing impact and paid to each MCO, except as agreed upon pursuant to Section VI.A of this MOU. The amount to be distributed will be allocated to inpatient and outpatient based on capitation information provided by the MO HealthNet Division, with Emergency Room capitation payments categorized as Outpatient.

B. MCO Payment Structure for Hospitals That Have Agreements with MCOs (Participating Hospitals)
   1. Inpatient Direct Medicaid Payment
      a. The MCO will use the inpatient direct Medicaid payment as a per diem from column E published on the rate list for determining the inpatient direct Medicaid payments.
      b. The MCO will use the projected managed care days provided by the MO HealthNet Division for determining the inpatient direct Medicaid payments.

c. For each facility on the rate list, multiply step 1.a. times 1.b. to establish the facility-specific allocation of the inpatient direct Medicaid payments to be made annually by all of the MCO payers.

2. Outpatient Direct Medicaid Payment
   a. The MCO will use the outpatient direct Medicaid payment as a percentage from column I published on the rate list for determining the outpatient direct Medicaid payments.
   b. The MCO will use the projected managed care charges provided by the MO HealthNet Division for determining the outpatient direct Medicaid payments.
   c. For each facility on the rate list, multiply step 2.a times 2.b to establish the facility-specific allocation of the outpatient direct Medicaid payment to be made annually by all of the MCO payers.

3. Timing and Flow of Inpatient and Outpatient Direct Medicaid Payments
   a. The annual inpatient and outpatient direct Medicaid payments will be divided by twelve payrolls to determine the monthly payment.
   b. Monthly payments will be processed and paid no later than the second provider check date of each month based on the Claims Processing and Payment Schedule published by the MO HealthNet Division on its website at: http://manuals.momed.com/ClaimsProcessingSchedule.html.
   c. The monthly payments will begin after the May capitation payment is received on Friday, June 5, 2017, for both the current managed care areas of the state and the expansion areas of the state.
   d. The direct Medicaid payments will be deposited into each hospital's Central Bank account unless otherwise indicated by the hospital.
   e. Two days prior to making the monthly payment, each MCO will send a report to MSC that includes the facility name, the NPI number, the bank and routing account numbers, and the total amount that will be paid to each facility.

C. MCO Payment Structure for Hospitals That Do Not Have Agreements With MCO (Non-Participating Hospitals)
   1. Inpatient Direct Medicaid Payment
      a. The MCO will use the inpatient direct Medicaid payment as a per diem from column E published on the rate list for determining the inpatient direct Medicaid payments.
      b. The MCO will use the projected managed care days provided by the MO HealthNet Division for determining the inpatient direct Medicaid reserve.
      c. The MCO will use the hospital's actual inpatient utilization for determining the inpatient direct Medicaid payments. The actual inpatient utilization used in this calculation will be limited to the projected managed care days provided by MHD.

d. For each facility on the rate list, multiply step 1.a. times 1.b. to establish the facility-specific inpatient direct Medicaid payment to be made, reflecting adjustments based on variances in utilization.

2. Outpatient Direct Medicaid Payment

a. The MCO will use the outpatient direct Medicaid payment as a percentage from column I published on the rate list for determining the outpatient direct Medicaid payments.
b. The MCO will use the projected managed care charges provided by the MO HealthNet Division for determining the outpatient direct Medicaid reserve.
c. The MCO will use the hospital's actual outpatient charges for determining the outpatient direct Medicaid payments. The actual outpatient charges used in this calculation will be limited to the projected outpatient charges provided by MHD.
d. For each facility on the rate list, multiply step 2.a times 2.b to establish the facility-specific outpatient direct Medicaid payment to be made, reflecting adjustments based on variances in utilization.

3. Timing and Flow of Inpatient and Outpatient Direct Medicaid Payments

a. Payments to Non-PAR hospitals will use actual paid claim experience versus using a prospective payment methodology. Each MCO will reserve the portion of the direct Medicaid add-on payment for Non-PAR facilities in a liability account as cash is received from the MO HealthNet Division. Payment will be drawn from this reserve as claims are paid to these Non-PAR hospitals.
b. The monthly payments for actual claims experience will begin once the May capitation payment is received on Friday, June 5, 2017, for both the current managed care areas of the state and the expansion areas of the state.
c. Monthly payments will be processed and paid no later than the second provider check date of each month based on the Claims Processing and Payment Schedule published by the MO HealthNet Division on its website at: http://manuals.momed.com/ClaimsProcessingSchedule.html.
d. The direct Medicaid payments will be deposited into each hospital's Central Bank account unless otherwise indicated by the hospital.
e. Two days prior to making the monthly payment, each MCO will send a report to MSC that includes the facility name, the NPI number, the bank and routing account numbers, and the total amount that will be paid to each facility.

D. Distribution of Unspent Funds.

1. A reconciliation of the direct Medicaid add-on payments received by MCOs versus distributed by MCOs will be completed 180 days after the state fiscal year to allow sufficient time for claims run-out. This reconciliation does not apply to NICU payments. The NICU payments reconciliation will be completed 365 days after the state fiscal year to allow sufficient time for claims run-out.

2. Any unspent funds will be distributed to hospitals no later than 210 days following the end of each state fiscal year for which the payments related. For NICU, any unspent funds will be distributed 395 days following the end of each state fiscal year for which the payments related.
3. Any unspent funds will be distributed proportionally to all hospitals based on forward-looking utilization estimates as outlined in Exhibit A.
4. Following the later of the distribution of unspent funds or the applicable reconciliation period as identified in section 1 or 2 above, there shall be no further request, reconciliation or settlement of funds related to direct Medicaid add-on payments for the associated state fiscal year.

E. Inpatient and Outpatient Claims Payments
   1. Inpatient and outpatient claims will be processed and paid based on each health plan's established payment schedule.
   2. The claims payments will be deposited into a bank account as directed by each hospital.
   3. Nonparticipating hospitals will be paid the rate published by the MO HealthNet Division.

V. Term and Termination

A. This MOU shall be effective on the date of the last signature below and shall continue until June 30, 2018, unless MSC and all MCOs agree to an alternative agreement to be effective prior to June 30, 2018.
B. This MOU will terminate effective June 30, 2018, unless MSC and all MCOs agree to extend it. At a maximum, this MOU may renew for four successive, one-year terms only in the event the MO HealthNet Division exercises its option to renew the contracts of the MCOs.
C. This MOU shall automatically terminate if there is a change in state law or federal regulation that prevents implementation of statewide managed care or that regulates the FRA payment process in a way that conflicts with this MOU.

VI. Miscellaneous

A. The parties foresee that the transition from Medicaid fee-for-service payments to Medicaid managed care will cause an interruption in payments to hospitals. The MCOs will consider in good faith, on a case-by-case basis, a short-term cash advance for those hospitals for which such interruption causes financial hardship. MHA will provide a listing of these hospitals, the amount and timing of the requested cash advance for each hospital and detailed information to support the requested cash advance for MCO review prior to May 31, 2017.

B. The parties agree that the administrative costs incurred by the MCOs to comply with the requirements of this MOU should be considered an allowable cost that should be incorporated into the actuarially sound rates paid by the state. For purposes of determining the allowable administrative costs, the percentage applied to the direct Medicaid add-on payments shall mirror the administrative percentage applied by MSC.

C. The parties agree to create an FRA Working Group that will include representatives from each MCO and from MSC. The FRA Working Group will examine the process and assumptions underlying this MOU at least quarterly and make adjustments as required to be in compliance with all laws and regulations, and address any unforeseen gaps in the process or calculations.

D. The MHA membership will continue to evaluate alternative methodologies for payment as permitted under federal regulation to transition to a more value-based and quality centered payment solution. Any alternative payment methodologies will be presented by MSC staff to the FRA Working Group. Upon approval by the parties, such a proposal shall be implemented and supplant the initial proportional distribution.

E. This MOU only may be amended by written agreement of all parties.

F. For purposes of this MOU, Central Bank is Central Bank of Jefferson City, and the ABA Routing Number shall be provided by MSC.

G. Any and all data shared between MSC and the MCOs pursuant to this MOU are deemed confidential and are not to be used for any other purpose except as set forth in this paragraph. Disclosure of such data is permissible to comply with the requirements of this MOU or federal or state law or regulation and for the purposes of an audit. MSC may disclose such data to the board of trustees of MHA, the board of directors of MSC, any committees and task forces of the boards, and any member hospitals that are participants in the voluntary FRA pool. Any additional exception to such confidentiality not contemplated by this MOU shall be permitted only if such disclosure is agreed to in writing by MSC and the MCOs. Any breach of this confidentiality that is not covered by an exception shall result in the immediate termination of this agreement.

H. This MOU is intended to comply with any and all federal and state statutes, regulations and rules, including but not limited to HIPAA, 42 U.S.C. § 1320a-7b(b) (the "Fraud and Abuse Statute"), 42 U.S.C. §1395nn and 42 U.S.C. § 1395nn (the "Stark Law"), federal and state antitrust statutes, and the safe harbors and exceptions promulgated pursuant the Fraud and Abuse Statute and the Stark Law, as amended from time to time. In the event

that any law, regulation or administrative or judicial interpretation is adopted, amended, promulgated, modified or issued which prohibits or restricts all or any party of this MOU, the Parties shall either: (i) renegotiate this MOU in the manner intended to comply with such law, regulation or decision; or (ii) terminate the MOU without penalty to either party.

Each person signing this MOU represents that he or she is duly authorized and has the legal capacity to execute and deliver this MOU.

MHA MANAGEMENT SERVICES CORPORATION

(b)(6)

Herb B. Kuhn (Mar 17, 2017)

Herb B. Kuhn
President and CEO

03/17/2017

Date

HOME STATE HEALTH PLAN

(b)(6)

Ryan Litteken:
Sr. Director Finance

3/17/2017

Date

MISSOURI CARE, INC.

(b)(6)

Lou Gianquinto (Mar 17, 2017)

Lou Gianquinto
President, Missouri Care

3/3/16/2017

Date

UNITEDHEALTHCARE OF THE MIDWEST, INC.

(b)(6)

Jamie Bruce (Mar 17, 2017)

Jamie A. Bruce
Missouri Health Plan CEO

03/17/17

Date

jcd/mk

Exhibit A

This Exhibit A sets out the actual, definitive process covered by this understanding. The MCO FRA Reconciliation Tool, or "MFRT," which is attached to this Exhibit A as Attachment 1, contains many of the data points and calculations that would be used to execute the processes in this MOU. The three MCOs agree to the following, specific steps for calculating direct Medicaid add on payments:

In simplest terms, each MCO would do the following steps each month:

1) Enter MCO Name, dates etc.
2) Enter MCO paid membership from the 820.
3) Enter or update FRA Facility Information
4) Enter any adjustments from prior periods, such as retroactive adjustments to rates or membership
5) Bring over any ending FRA reserve balances from prior periods where applicable for Non-Participating FRA Facilities
6) Enter utilization on paid claims for current period where applicable for Non-Participating FRA Facilities
7) Print for submission
    a. Reports and EFT banking forms are set to print
    b. Check work
8) Make any notes for next period

The steps above are illustrative, the information below sets out the actual, definitive process covered by this process.

Step 1 – PMPM FRA Estimate: Each MCO calculates the FRA component of its monthly capitation payments received from the MO HealthNet Division. This can be done using the information contained in the data package from the State of Missouri for each population and category of service (inpatient, emergency room and outpatient). There is a spreadsheet job aid, "MCO FRA Reconciliation Tool" (or "MFRT"), that contains appropriate spaces to enter those PMPM amounts. Each MCO will enter that information into appropriate cells into their own MFRT. The PMPM FRA estimate will be updated as MHD publishes new information and adjusts the capitated rates, including MCO-specific adjustments such as risk scores.

Step 2 – Enrollment Calculation and FRA Collected: Each MCO calculates the monthly enrollment from the MHD 820 MCO payment file information for paid membership. The MFRT has designated cells to enter the membership by population, region and current versus retrospective the MO HealthNet Division adjustments. Enter the 820 information into the MFRT. This process would be performed monthly by each MCO as each MHD 820 is received. This enrollment is then multiplied by the PMPMs in Step 1 to establish the total inpatient ("820IPFRA") and outpatient ("820OPFRA") direct Medicaid included in the rates for the period.

Step 3 – Allocation of Inpatient and Outpatient Direct Medicaid by Facility: Each MCO Determines individual facility amounts using the "Inpatient and Outpatient Hospital Rates" list published by MHD.

1) Inpatient

a) List the facilities designated by MHD to receive FRA funds (the "FRA Facilities"). List the respective FRA Facility's MHD Inpatient Direct Medicaid Payment As a Per Diem ("IPFRAPD") as published by MHD. The MFRT has appropriate spaces for both of these items. For each FRA Facility, multiply the "Inpatient Direct Medicaid Payment As a Per Diem" amount by the total projected managed care days for each hospital as provided by MHD, (the "IP Utilization Estimate" or "IPUX"). Calculate the product of IPUX and IPFRAPD for each FRA Facility ("IP Product"), and the sum of those IP Products for all FRA Facilities. The sum all IP Products equates to a forward looking, utilization based estimate of all MHD FRA funds for a relevant period. The MFRT has appropriate places for the FRA Facilities, IPFRAPDs, IPUXs and IP Products; each MCO enters it in their MFRT. These entries would only need to be updated as MHD publishes new information. The MFRT contains all of the appropriate calculations.

b) Calculate the quotient of each FRA Facility's IP Product divided by sum of all IP Facility Products. This provides the estimated inpatient FRA portion ("IP Portion") for each facility based on forward looking utilization estimates. The MFRT contains all of the appropriate calculations.

c) If there are inpatient adjustments from prior periods add them now to the 820IPFRA calculated above to get the IP FRA allocated to hospitals the current period (the "Period IPFRA"). The MFRT has a place to enter an adjustment amount.

d) Calculate the IP MCO period allocation to each facility ("IP Facility Allocation") by taking the product of Period IPFRA and IP Portion for each FRA Facility. The MFRT contains all of the appropriate calculations.

2) Outpatient (Emergency Room/Outpatient Combined)

a) List the facilities designated by MHD to receive FRA funds (the "FRA Facilities"). List the respective FRA Facility's MHD Outpatient Direct Medicaid Payment as a Percentage ("OPFRAPB") as published by MHD. The MFRT has appropriate spaces for both of these items. MHD will publish updates to that schedule periodically. For each FRA Facility, multiply the OPFRAPB by the total projected managed care outpatient billed charges for each FRA Facility hospital as provided by MHD, (the "OP Utilization Estimate" or "OPUX"). Calculate the product of OPUX and OPFRAPB for each FRA Facility ("OP Product"), and the sum of those OP Products for all FRA Facilities. The sum all OP Products equates to a forward looking, utilization based estimate of all MHD FRA funds for a relevant period. The MFRT has appropriate places for the FRA Facilities, OPFRAPBs, OPUXs and OP Products; each MCO enters it in their MFRT. These entries would only need to be

updated as MHD publishes new information. The MFRT contains all of the appropriate calculations.

b) Calculate the quotient of each FRA Facility's OP Product divided by sum of all OP Facility Products. This provides the estimated outpatient FRA portion ("OP Portion") for each facility based on forward looking utilization estimates. The MFRT contains all of the appropriate calculations.

c) If there are outpatient adjustments from prior periods add them now to the 820OPFRA calculated above to get the OP FRA allocated to hospitals from the current period (the "Period OPFRA"). The MFRT has a place to enter an adjustment amount.

d) Calculate the OP MCO period outpatient FRA allocation ("OP Facility Allocation") for each facility by taking the product of Period OPFRA and OP Portion for each FRA Facility. The MFRT contains all of the appropriate calculations.

Step 4 – Calculate Participating and Non-Participating Facility Inpatient and Outpatient Direct Medicaid Payments:

1) **For Providers that have an agreement with a given MCO to participate in this process ("Participating FRA Facilities"), that MCO perform the following steps.**

- For each Participating FRA Facility add the IP Facility Allocation and the OP Facility Allocation together to calculate the FRA Facility Period Payment. If the FRA Facility is designated as "Participating FRA Facility" in the MFRT, this will calculate automatically and carry the figure over to the electronic funding template.
- Create an electronic banking transaction ("EFT PAR FRA") to each of the FRA Par Facilities in the full amount of their respective "FRA Facility Period Payment." These prospective payments are predicated on projected statewide utilization, with actual payments specific to each MCO based on their unique mix of membership. If this methodology is consistent across all MCOs, the providers will receive approximately the same dollars as originally projected by MHD.
- Two days prior to making the "FRA Facility Period Payments" to the FRA Par Facilities, send a report to MHA Management Services Corporation that includes the facility name, the NPI number, the bank routing and account number, and the total amount that will be paid to each Participating FRA Facility.
- Pay the "FRA Facility Period Payment" via the EFT PAR FRA on the second payroll date of each month as reflected on MHD's Claims Processing Schedule to the participating hospital. The payments should be deposited into the Central Bank accounts unless otherwise indicated by the hospital. The PAR FRA Facilities will provide all necessary codes to the MCOs directly or instruct MHA to do so on their behalf.
- The MFRT contains all of the relevant fields, calculations and exhibits.

2) **For providers that do not have an agreement with a given MCO to participate in this process ("Non-Participating FRA Facility"), that MCO performs the following steps so that the payments will be made consistent with the information published by MHD.**
   - For each Non-Participating FRA Facility add the IP Facility Allocation and the OP Facility Allocation together to calculate the FRA Facility Period Reserve.
   - Reserve that appropriate amount as a payable liability by adding the FRA Facility Period Reserve to the FRA Facility Total Reserve, which is the sum of historical FRA Facility Period Reserves (that remain after having deducted historical payments as indicated in the next step). For each Non-Participating FRA Facility, record any inpatient days ("IP Days") or outpatient billed charges ("OP Charges") incurred on or after May 1, 2017, and paid on claims during the period beginning the first day of the just completed calendar month through the end of the just completed calendar month.
   - Calculate the FRA Facility Period Payment by taking a) the product of the IP Days and the IPFRAPD, plus b) the product of the OP Charges and the OPFRAPB.
   - Calculate and create the EFT Non-Par FRA by taking the smaller positive number when comparing each FRA Facility Period Payment to the FRA Facility Total Reserve.
   - To the extent there continues to be, with respect to a given Non-Participating FRA Facility, a positive balance of FRA Facility Total Reserve after prior period claims are estimated to be complete and the corresponding EFT Non-Par FRAs have been paid to that Non-Participating FRA Facility, the MCO will deduct those funds from the FRA Facility Total Reserve and distribute them by adding that amount to the next Period IP FRA or Period OP FRA, as most appropriate. The parties expect to allow a minimum of 180 days to account for adequate paid claims run-out to completion.
   - The MFRT contains the relevant fields and calculations.

AMENDMENT TO MEMORANDUM OF UNDERSTANDING

This Amendment is entered into by the MHA Management Services Corporation (MSC), an affiliate of the Missouri Hospital Association, Home State Health Plan, Missouri Care, Inc. and UnitedHealthcare of the Midwest, Inc. Home State Health Plan, Missouri Care, Inc. and UnitedHealthcare of the Midwest, Inc. each are also referred to herein as an MCO.

WHEREAS, the parties entered into the underlying Memorandum of Understanding on March 17, 2017; and

WHEREAS, after that date, the MO HealthNet Division changed the method by which outpatient direct Medicaid payments will be made; and

WHEREAS, the parties wish to amend the Memorandum of Understanding to reflect the appropriate payment methodology.

The parties therefore agree to amend the Memorandum of Understanding as follows:

- Strike Section IV.B.2 in its entirety and insert the following language:

  2. Outpatient Direct Medicaid Payment

     a. The MCO will use the Estimated Total Charges from columns D and E as provided by the MO HealthNet Division on the Outpatient Billed Charge Summary.
     b. The MCO will use the Estimated Outpatient Direct Medicaid Payment Percentage Rate from columns F and G as provided by the MO HealthNet Division on the Outpatient Billed Charge Summary.
     c. For each facility on the Outpatient Billed Charges Summary, multiply the Estimated Total Charges Paid at Percentage of Billed Charge (Column D) times the Estimated Outpatient Direct Medicaid Payment Percentage Rate – Billed Charges (Column F).
     d. For each facility on the Outpatient Billed Charges Summary, multiply the Estimated Total Charges Paid at Fee Schedule (Column E) times the Estimated Outpatient Direct Medicaid Payment Percentage Rate – Fee Schedule (Column G).
     e. For each facility on the Outpatient Billed Charges Summary, add the result of Step 2.c and 2.d to establish the facility-specific allocation of the outpatient direct Medicaid payment to be made annually by all of the MCO payers.

- Strike Section IV.C.2 in its entirety and insert the following language:

  2. Outpatient Direct Medicaid Payment

     a. The MCO will use the Estimated Total Charges from columns D and E as provided by the MO HealthNet Division on the Outpatient Billed Charge Summary for determining the outpatient direct Medicaid reserve.
     b. The MCO will use the Estimated Outpatient Direct Medicaid Payment Percentage Rate from columns F and G as provided by the MO HealthNet Division on the Outpatient Billed Charge Summary.

c. For each facility on the Outpatient Billed Charges Summary, multiply the Estimated Total Charges Paid at Percentage of Billed Charge (Column D) times the Estimated Outpatient Direct Medicaid Payment Percentage Rate – Billed Charges (Column F) for determining the outpatient direct Medicaid reserve.
d. For each facility on the Outpatient Billed Charges Summary, multiply the Estimated Total Charges Paid at Fee Schedule (Column E) times the Estimated Outpatient Direct Medicaid payment Percentage Rate – Fee Schedule (Column G) for determining the outpatient direct Medicaid reserve.
e. For each facility on the Outpatient Billed Charges Summary, add the result of Step 2.c and 2.d to establish the facility-specific allocation of the outpatient direct Medicaid reserve to be made annually by all of the MCO payers.
f. The MCOs will use the hospital's actual outpatient charges instead of the Estimated Total Charges for determining the outpatient direct Medicaid add-on payments following the calculation as outlined above. The actual outpatient charges used in this calculation will be limited to the Estimated Total Charges provided by MHD.

Each person signing this Amendment represents that he or she is duly authorized and has the legal capacity to execute and deliver this Amendment.

MHA MANAGEMENT SERVICES CORPORATION

(b)(6)
Herb B Kuhn (May 8, 2017)

Herb B. Kuhn
President and CEO

05/08/2017

Date

HOME STATE HEALTH PLAN

(b)(6)
Kimberly D. Tuck (May 1, 2017)

Kim Tuck
Plan President and CEO

05/01/2017

Date

MISSOURI CARE, INC.

(b)(6)
Lou Gianquinto (May 3, 2017)

Lou Gianquinto
President, Missouri Care

5/3/2017

Date

UNITEDHEALTHCARE OF THE MIDWEST, INC.

(b)(6)

Jamie A. Bruce
Missouri Health Plan CEO

05/05/2017

Date

jcd/mk

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2500 Security Blvd. Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 21, 2023

Dear Mr. Richardson:

The Centers for Medicare & Medicaid Services (CMS) is providing this letter to reiterate concerns regarding the State of Missouri's Federal Reimbursement Allowance (FRA) hospital tax program and to encourage the state to take immediate action to ensure its FRA tax arrangement meets federal requirements. As currently structured, the state's FRA tax program appears to include a prohibited "hold harmless" arrangement that involves hospitals pooling Medicaid payments and redistributing those Medicaid payments across its hospitals so that FRA-taxpaying hospitals are not financially harmed by the FRA tax. It appears that the redistributed Medicaid payments typically benefit hospitals that serve low percentages of Medicaid beneficiaries or no Medicaid beneficiaries at all. In some cases, this means that federal Medicaid dollars are being used to pay the FRA tax bill for hospitals that do not participate in the Medicaid program.

CMS recognizes the importance of FRA tax revenue to Missouri's Medicaid program. Since 2020, CMS has regularly offered technical assistance to the state and provided multiple opportunities to make practical modifications to its FRA tax arrangement so that the state could continue collecting its FRA tax without a reduction in federal funds. Due to apparent hold harmless arrangments, the required reduction would equal $236,629,533 federal financial participation (FFP) on the (QE) December 31, 2022 Form CMS-64 expenditure report. However, the state could ensure compliance by working with its providers and/or legislature to stop the redistribution of approximately $55 million in annual Medicaid payments, which are redistributed from hospitals that serve a high percentage of Medicaid patients to hospitals with a low percentage of (or no) Medicaid patients and to correct the redistribution for the QE December 31, 2022 quarter. CMS remains hopeful that the state will take appropriate administrative and/or legislative action to modify its FRA tax program to ensure compliance with federal requirements. If the state desires, CMS stands ready to partner with the state through rapid technical assistance to remedy the impermissible tax arrangement. Should the state not take appropriate action to ensure its compliance with federal statute and regulations, CMS intends to initiate a disallowance of federal financial participation as required by section 1903(w)(1)(A)(iii) of the Social Security Act. CMS intends to take this action no earlier than 60 days following issuance of this letter.

As currently structured, the tax appears to contain a hold harmless arrangement, which would violate section 1903(w)(1)(A)(iii) and 1903(w)(4) of the Act and implementing regulations in 42 C.F.R. § 433.68(b)(3) and (f). CMS understands the state's FRA tax program to operate as follows. Missouri imposes a tax on net patient revenues separately on inpatient and outpatient hospital services. These revenues provide the state with the source of funding for the non-federal share of Medicaid payments for hospital services and increased managed care capitation rates that support increased payments to hospitals. A voluntary FRA pool program operated by the

Missouri Hospital Association (MHA) then appears to redistribute Medicaid payments among the participating hospitals using a formula that ensures hospitals paying more in tax than they receive in Medicaid payments are not harmed by the tax. Such an arrangement appears to ensure that participating hospitals are held harmless for all or a portion of their FRA tax, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 C.F.R. § 433.68(f)(3).

In a document entitled, "Rapid Response Review- Assessment of Missouri Medicaid Program" issued by the Missouri Department of Social Services on February 11, 2019, there is a flowchart entitled "Exhibit 12: Missouri Hospital Association FRA Funding Pool." According to the flow chart, providers that receive more in Medicaid payments funded by the FRA than the provider pays in tax transfer some of the provider's FRA-funded Medicaid payments to the pool operated by the MHA. If a provider receives less in Medicaid payments funded by the FRA than it pays in tax, the provider receives a payment from the pool consisting of amounts from the pooled Medicaid payments from other providers. The goal is to "net out the FRA paid with the payments received" or, in other words, to guarantee that no taxpayer is financially harmed by the cost of the tax.

CMS is also aware of multiple documents previously publicly available on MHA's website that describe the hold harmless arrangement relating to the FRA tax program that appears to occur through pooling and redistribution. For example, the MHA described the pooling arrangement and indicated that it "…redistributes some FRA-funded payments so that participants in the FRA pooling arrangement are not financially harmed by the FRA program. By insulating pool participants against financial loss, the pooling arrangement enables industry concurrence with the state's use of provider taxes, which generates more funding than likely would be possible under alternative scenarios." [1]

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Implementing regulations at 42 C.F.R. § 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount" (emphasis added). In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments)."[2]

The word "indirect" in the regulation, highlighted in the excerpt above, 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. It is possible for a state to indirectly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that guarantees to hold

[1] https://web.mhanet.com/media-library/missouris-hospital-provider-tax-pooling-arrangement/
[2] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008)

taxpayers harmless for any portion of the costs of the tax, if some or all of the taxpayers receive those payments at issue through an intermediary (for example, a hospital association or similar provider affiliated organization) rather than directly from the state or its contracted managed care plan. As CMS further explained in preamble to the 2008 final rule, we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[3] In the preamble, CMS also gave an example of state laws providing grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes; even though no state law typically required residents to use the grant funds to pay the increased nursing home fees, these direct state payments to nursing home residents indirectly held the nursing facilities harmless for their health care-related tax costs because of the reasonable expectation that their residents would use the state payments to repay the nursing facilities for all or a portion of their tax costs.[4]

It remains true that hold harmless arrangements typically are not overtly established through state law but can be based instead on reasonable expectations that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related tax costs. In these hold harmless arrangements, including what appears to be the case with Missouri's FRA tax program, agreements exist among providers (explicit or implicit in nature) such that providers that furnish a relatively high percentage of Medicaid covered services redistribute a portion of their Medicaid payments to providers with relatively low (or no) Medicaid service percentage. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

To date, Missouri has been unable to provide assurance that there is not an arrangement to redistribute Medicaid payments to hold taxpayers harmless for the cost of the FRA tax. Instead, the state has continued to assert that the Missouri Partnership Plan (MPP) signed in 2008 by Missouri and CMS authorizes the hold harmless arrangement that appears to exist relating to the FRA program. This assertion does not take into account that CMS has obtained more information about the FRA pooling and redistribution arrangement since 2008, that the state's FRA tax program may have changed significantly since that time, and that the MPP did not authorize (and could not have authorized) the state to collect revenue for a health care-related tax program that includes a hold harmless arrangement without a reduction to the state's Medicaid expenditures as required by section 1903(w)(1)(A)(iii) of the Act.

Further, CMS has provided the state clear, repeated notice of its concerns regarding the apparent hold harmless arrangement, including in July 20, 2020, and July 15, 2022 letters to the state and additional email and verbal communication. As discussed in these letters, CMS understood that the state would ensure that the pooling arrangement would end for contract rating periods after June 30, 2021 and that all hospital payments would be financed and paid in accordance with all applicable federal requirements. However, based on various recent communications between CMS and the state, it appears the state does not intend to ensure that the FRA pooling arrangement has ended consistent with CMS's understanding articulated in the July 20, 2020 letter.

[3] 73 Federal Register 9694
[4] *Id.*

As indicated in our July 15, 2022 letter, CMS is committed to ensuring the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section 1903(w)(4) of the Act and federal regulations at 42 C.F.R. § 433.68(f)(3). In that July 15, 2022 letter and prior communication with the state including a July 20, 2020 letter, CMS reiterated concerns that CMS the state's FRA tax program appeared to contain a hold harmless arrangement, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 C.F.R. § 433.68(f)(3). The July 2022 letter also indicated that CMS intended to conduct a focused review of Missouri's FRA program related to expenditures reported to CMS on the Form CMS-64, the results of which are described in this letter.

CMS initiated this review in February 2023, obtained additional information from the state, and asked follow-up questions relating to the state's August 25, 2022 reply letter to CMS's July 2022 letter. While CMS appreciates the state's August 25, 2022 response to our July 15, 2022 letter and additional information provided on March 10, 2023 and March 21, 2023, CMS remains concerned that Missouri's FRA program does not appear to meet federal requirements. Further, the state did not provide certain requested information on provider pooling and redistributions that are integral to the state's FRA program. Section 1902(a)(6) of the Act, 45 C.F.R. § 75.364, 42 C.F.R. § 433.74 include requirements related to CMS's authority to request records and documentation related to the Medicaid program. In particular, 42 C.F.R. § 433.74(a) requires that states, "must also provide any additional information requested by the Secretary related to any . . . taxes imposed on . . . health care providers," and the "States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures." 42 C.F.R. § 433.74(d) specifies that a failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation.

CMS takes its responsibility for financial oversight of the Medicaid program seriously to ensure its long-term health and financial stability. CMS remains committed to ensuring that the non-federal share of Medicaid expenditures comply with all applicable federal requirements, including those related to health care-related taxes in section 1903(w)(4) of the Act and federal regulations at 42 C.F.R. § 433.68(f)(3). If the FRA-related hold harmless arrangements described above no longer exist or if Missouri has initiated action to end those arrangements, such as informing providers to cease the pooling and redistribution of Medicaid payments, please provide a detailed description of any actions taken by the state and/or participating hospitals to this end. In particular, if the state has taken any action or is aware of any action by providers to reverse redistribution payments that held taxpayers harmless for FRA tax amounts with respect to the QE December 31, 2022, please provide a detailed description of the same to inform whether a disallowance with respect to that quarter may not be necessary.

As noted above, should the state not take appropriate action to ensure its compliance with federal statute and regulations, CMS intends to initiate a disallowance of federal financial participation as required by section 1903(w)(1)(A)(iii) of the Act. CMS intends to take this action no earlier than 60 days following issuance of this letter.

CMS remains committed to providing additional technical assistance on this issue and is available to continue discussions with Missouri to ensure its sources of non-federal share meet all applicable federal requirements, and if possible, avoid a recovery of FFP by ensuring the state's tax meets federal requirements.

Should you require further details or have any questions regarding this matter, please contact XXXX@cms.hhs.gov.

Sincerely,

Message

From: Howe, Rory (CMS/CMCS) (b)(6) (b)(6)
Sent: 1/3/2023 8:56:41 PM
To: Boston, Beverly (CMS/CMCS) (b)(6) (b)(6) adams, lia (CMS/CMCS) (b)(6) (b)(6)
CC: Arnold, Charlie (CMS/CMCS) (b)(6) (b)(6) Maccarroll, Amber (CMS/CMCS) (b)(6) (b)(6)
Subject: FW: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements
Attachments: Healthcare Related Taxes CIB-Final (CMSDOGCmarkup) FMG.docx

Hi, Beverly and Lia. Would you mind making should make sure the attached track changes based on a few suggestions from Tim make it into the final version? Please let me know if you have any questions.

Thanks,
Rory

From: Howe, Rory (CMS/CMCS)
Sent: Tuesday, January 3, 2023 3:49 PM
To: Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>
Subject: RE: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Hi Tim,

Happy New Year. I appreciate you taking the time to review and to comment. Thanks for catching the typo and for highlighting where we could be more precise to avoid misinterpretations. We'll update the draft CIB to address the comments/edit. Thanks again.

Rory

From: Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 3:16 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Rory –

I understand the CIB was FYI-only, but I feel compelled to share with you a few things in the attached. I was only reading it to try to learn the policy, but there is a place in the CIB where a reader could easily take away the wrong message. And a typo.

Tim Engelhardt (he/him)
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
(b)(6)

From: CMS CLEARANCES <CLEARANCES@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 1:35 PM
To: Worstell, Megan (CMS/OFM) <Megan.Worstell@cms.hhs.gov>; Czajkowski, John (CMS/OFM) <John.Czajkowski@cms.hhs.gov>; Plater, Morris (CMS/OFM) <Morris.Plater@cms.hhs.gov>; Stokes-Murray (He/Him), Heinz (CMS/OFM) <KHeinz.Stokes-Murray@cms.hhs.gov>; Tierney, Janet (CMS/OFM) <Janet.Tierney@cms.hhs.gov>; Kelsey, Ashley (CMS/OFM) <Ashley.Kelsey@cms.hhs.gov>; Carmichael, Wanda (CMS/OFM) <Wanda.Carmichael@cms.hhs.gov>; Benns, Antoinette (CMS/OFM) <Antoinette.Benns@cms.hhs.gov>; Richter (she/her), Liz (CMS/CM) <elizabeth.richter@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Ahern, Robert (CMS/CM) <Robert.Ahern@cms.hhs.gov>; Mays, Beth (CMS/CM) <Beth.Mays@cms.hhs.gov>; Blackford (she/her), Carol (CMS/CM) <Carol.Blackford@cms.hhs.gov>; Pequigney, Susan (CMS/CM) <Susan.Pequigney@cms.hhs.gov>; Farran, Patti (CMS/CM) <Patti.Farran@cms.hhs.gov>; Beder, Victoria (CMS/CM) <Victoria.Beder@cms.hhs.gov>; Feaster, Simone (CMS/CM) <simone.feaster@cms.hhs.gov>; Uebersax, Julie (CMS/CM) <Julie.Uebersax@cms.hhs.gov>; 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Subject: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Please copy **Enrico Dinges** and on **ALL** responses pertaining to this item when replying to CMS Clearances.

Please see attached internal qas for review. The informational bulletin is FYI ONLY. Thank you.

Comments Due: 1:00 PM ET Thursday, January 5, 2023

All: For your review and input. Concurrent HHS/CMS review.

Title: Internal Q&As for CMCS informational bulletin on health care related taxes and hold harmless arrangements.
Agency/Office: CMCS

Subject/Description: CMS will release an informational bulletin on health care related taxes and hold harmless arrangements involving the redistribution of Medicaid payments. This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). There will be a reactive statement, listserv message, and internal questions-and-answers for this item.

COMMs Materials for Rollout: Internal Q&As

Deadline for COMMS Clearance comments: Thursday, January 5 by 1:00 PM

Requested Release date: 2/7/2023

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMCS Informational Bulletin

DATE: xx xx, xxxx

FROM: Daniel Tsai, Deputy Administrator and Director

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

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax would comply with the statutory and regulatory prohibition on hold harmless arrangements, as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations. In response to these questions, this informational bulletin reiterates our longstanding position on the existing federal requirements that pertain to health-care related taxes and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

CMS recognizes that health care-related taxes are a critically important source of funding for many states' Medicaid programs, including for payments to safety net providers. CMS supports states' adoption of health care-related taxes when they are consistent with federal requirements. CMS approves many state payment proposals annually that are supported by health care-related taxes that appear to meet federal requirements. CMS recognizes the challenges faced by states and health care providers in identifying sources of non-federal share financing and implementing payment methodologies that pay appropriately for services furnished to Medicaid beneficiaries.

The statute and regulations afford states flexibility to tailor health care-related taxes within certain parameters to meet their provider community needs and align with broader state tax policies and the state's priorities for its Medicaid program. CMS remains committed to providing states with technical assistance aiming to ensure that health care-related taxes used to finance the non-federal share of Medicaid expenditures meet the states' policy goals and comply with federal requirements. There are statutory and regulatory flexibilities afforded states in how they design health care-related tax programs. For example, CMS is authorized to waive the requirements that health care-related taxes be broad-based and/or uniform, when applicable conditions are met. CMS regularly works with states to approve such waivers in furtherance of state goals while still complying with federal requirements.

Although the applicable statutory and regulatory provisions afford states considerable flexibility in establishing health care-related taxes, 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. Occasionally, CMS encounters health care-related tax programs that appear to contain hold harmless arrangements, which are inconsistent with section 1903(w)(1)(A)(iii) and (w)(4) of the Act and 42 C.F.R. § 433.68(b)(3) and (f). Such arrangements are inconsistent with existing statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax arrangements that appear to contain a hold harmless arrangement that involves the taxpaying providers redistributing Medicaid payments after receipt to ensure that all taxpaying providers receive all or a portion of their tax costs back (typically ensuring that each taxpaying provider receives at least its total tax amount back).

In this informational bulletin, CMS is clarifying the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, we are encouraging states and providers to be as transparent as possible regarding any agreements in place or under development to ensure that all health care-related taxes meet federal requirements to avoid a statutorily required reduction in the state's Medicaid expenditures eligible for federal financial participation. CMS recommends that states that have concerns about the permissibility of a health care-related tax to raise these concerns to CMS early in the process of developing the state's tax program to avoid issues surrounding the permissibility of the non-federal share of Medicaid expenditures.

Health Care-Related Taxes and Hold Harmless Arrangements

During standard oversight activities and the review of state payment proposals, particularly managed care state directed payments (SDPs) and fee-for-service payment state plan amendments (SPAs), CMS is increasingly encountering health care-related taxes that appear to contain hold harmless arrangements involving the redistribution of Medicaid payments. In these arrangements, a state or other unit of government imposes a health-care related tax, then uses the tax revenue to support the non-federal share of Medicaid payments back to the class of providers subject to the tax. The taxpayers appear to have entered into oral or written agreements (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments to ensure that all taxpayers receive all or a portion of their tax costs back, when considering each provider's retained portion of any original Medicaid payment (either directly from the state of from the state through an MCO) and any redistribution payment received by the provider from another taxpayer or taxpayers. These redistribution payments may be made directly from one taxpaying provider to another, or the funds may be contributed first to an intermediary redistribution pool.

In these hold harmless arrangements, there appear to be agreements among providers such that providers that furnish a relatively high percentage of Medicaid-covered services redistribute a portion of their Medicaid payments to providers with relatively lower (or no) Medicaid service percentage. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the cost of a health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These taxes appear to contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 CFR 433.68(f)(3) that would lead to a reduction in medical assistance expenditures prior to the calculation of federal financial participation as required under section 1903(w)(1)(A) and (w)(1)(A)(iii) of the Act. Here is a detailed example of a hold harmless arrangement involving Medicaid payment redistribution:

- A state imposes a hospital tax based on the volume of inpatient hospital services provided. The tax is broad-based, uniform, and is imposed on 10 hospitals.
- Six of the hospitals serve a high percentage of Medicaid beneficiaries, three serve a low percentage of Medicaid beneficiaries, and one hospital does not participate in Medicaid.
- The state uses the tax revenue as the source of non-federal share of Medicaid payments, which are made back to nine of the hospitals through SDPs. The tenth hospital, which does not participate in Medicaid, does not receive any SDPs directly from state-contracted MCOs.
- All ten hospitals enter into oral or written agreements (meaning an explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments that the nine Medicaid-participating hospitals receive. Under this arrangement, the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from MCOs, then redistribute a portion of their Medicaid payments to the remaining four hospitals with lower Medicaid service percentages (including to the one hospital that does not participate in Medicaid). The redistribution amounts are calculated to guarantee that all hospitals, including those redistributing their own payments and those receiving the redistribution amounts, receive most, all, or more than all of their total tax cost back.
- The agreement among the taxpaying hospitals results in a reasonable expectation that the taxpaying hospitals, whether directly through their Medicaid payments or due to the availability of the redistributed payments received from the six high Medicaid service volume hospitals (regardless of whether the funds were first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.
- The high-percentage Medicaid hospitals are willing to participate because they still financially benefit from the tax program (even net of the redistribution payments they make to the lower Medicaid service volume hospitals), and the redistribution enables broad support for the tax program from all hospitals, ensuring constituent support for the state law authorizing tax program.
- Any increased payments the hospitals receive as a result of the distribution arrangements are federal dollars and there is no net increase paid for with state funds.

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Implementing regulations at 42 CFR 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any

portion of the tax amount" (emphasis added). In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments).".[1]

The word "indirect" in the regulation, highlighted in the excerpt above, makes clear that the state 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. The word "indirect" appears twice in the regulation. We are referring here to indirect payments because indirect guarantees are already defined in the regulation at 42 CFR § 433.68 (f)(3)(i)(a). A state can directly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that guarantees to hold taxpayers harmless for any portion of the costs of the tax even if some of the taxpayers that are held harmless receive the payment through an intermediary rather than directly from the state or its contracted MCO. As CMS further explained in preamble to the 2008 final rule, we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[2] We gave an example of state laws providing grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes; even though no state law typically required residents to use the grant funds to pay the increased nursing home fees, these direct state payments to nursing home residents indirectly held the nursing facilities harmless for their health care-related tax costs because of the reasonable expectation that their residents would use the state payments to repay the nursing facilities for all or a portion of their tax costs.[3] It remains true that hold harmless arrangements typically are not overtly established through state law but can be based instead on reasonable expectations that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related tax costs.

Accordingly, an arrangement in which hospitals receive Medicaid payments from the state (or from a state-contracted MCO), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 CFR 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 CFR 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.

Some states have cited challenges with identifying and providing details on redistribution arrangements because they may not be parties to the redistribution agreements. A lack of transparency involving health care-related taxes and Medicaid payments may prevent both CMS and states from having information necessary to ensure sources of non-federal share meet statutory requirements.

As part of the agency's normal oversight activities, CMS intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of health care-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements. Consistent with federal requirements,

[1] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[2] 73 Federal Register 9694
[3] *Id.*

CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments, and states should work with their providers to ensure necessary information is available. Where appropriate, states may wish to examine their provider participation agreements and MCO 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. States may consult section 1902(a)(6) of the Act, 45 CFR 75.364, and 42 CFR 433.74 for requirements related to CMS' authority to request records and documentation related to the Medicaid program. In particular, 42 CFR 433.74(a) requires that states, "must also provide any additional information requested by the Secretary related to any . . . taxes imposed on . . . health care providers," and the "States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures." 42 CFR 433.74(d) specifies that a failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation. CMS is available to provide technical assistance and work with states to ensure the permissibility of all of the sources of the non-federal share of Medicaid expenditures, including any health care-related taxes the state may impose.

Conclusion

CMS recognizes that health care-related taxes can be a permissible source of funding for the non-federal share of Medicaid expenditures. CMS is available to provide technical assistance to states, reviewing proposals and providing feedback to develop health care-related taxes that align with state policy goals and meet federal requirements. One key federal requirement is that a health care-related tax cannot have a hold harmless provision that guarantees to return all or a portion of the tax back to the taxpayer. Health care-related tax programs in which taxpayers enter into agreements 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.

CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS intends to work collaboratively with states by providing technical assistance as necessary to ensure the programmatic and fiscal integrity of the Medicaid program.

For questions or to request technical assistance, please contact Rory Howe at [HYPERLINK "mailto:rory.howe@cms.hhs.gov"].

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Sent: 3/17/2023 6:21:07 PM

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CC: (b)(6); Tsai, Daniel (CMS/CMCS) (b)(6); Woronoff, Arielle (CMS/OL) (b)(6); Yao, Kristiana (CMS/OA) (b)(6) (b)(6) (b)(6) Abbott, Linda B (CMS/OSORA) (b)(6) (b)(6) Briskin, Perrie (CMS/CMCS) (b)(6) (b)(6) Croston, Diane (CMS/OACT) (b)(6) (b)(6) Forrester, Shelia (HHS/OGC) [Shelia.Forrester@hhs.gov]; Harshman, Sara (CMS/CMCS) (b)(6) (b)(6) Hitchcock, Angela (CMS/OA) (b)(6) (b)(6) Hitchcock, Katherine (CMS/OEDA) (b)(6) (b)(6); Jackson, Marilyn (CMS/OSORA) (b)(6) (b)(6) Keene, Danyail (CMS/OL) (b)(6) (b)(6); Khan, Farooq (CMS/OSORA) (b)(6) (b)(6); Lee, Doris (HHS/OGC) (b)(6) (b)(6) McClenathan, Jane (CMS/CMCS) (b)(6) (b)(6) McLemore, Monica (CMS/OSORA) (b)(6) (b)(6); Miller, Ruth-Sam (CMS/OSORA) (b)(6) (b)(6) Moore, Cathy (CMS/OSORA) (b)(6) (b)(6) Parker, Don (HHS/OGC) (b)(6) (b)(6) Reynolds, Kerrian (CMS/OSORA) (b)(6) (b)(6) Richmond, Carly (CMS/OSORA) (b)(6) (b)(6) (b)(6); Smith, Mary (HHS/OGC) [Mary.Smith@HHS.GOV]; Teal, Lela (CMS/CMCS) (b)(6) (b)(6) Terry (She/Her), Tequila (CMS/CMMI) (b)(6) (b)(6) Vitolo, Sara (CMS/CMCS) (b)(6) (b)(6) (b)(6)

Subject: CMCS Issues Meeting Materials 3.20.23

Attachments: CMCS Issues Meeting Agenda and Materials 3-20-23.pdf

Leadership encourages your active participation in the discussion when topics are relevant to the work of your Office or Center.

****

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Office of Strategic Operations and Regulatory Affairs

March 17, 2023

To: Chiquita Brooks-LaSure
Administrator

Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer

Through: Kathleen Cantwell
Director

From: Monica McLemore
Program Coordinator

SUBJECT: CMCS Issues Meeting: Administrator Level
DATE: March 20, 2023
TIME: 10:00 AM – 11:00 AM
PLACE: 314G; Zoom
https://cms.zoomgov.com/j/ (b)(6) pwd=VDJhLzVpSHFjd1Q0bjB0dUhFZ1NsUT09

IRA-Related Policies: No

Participants: OA: Erin Richardson, Kyla Ellis, Hannah Katch, Will Harris, Kristiana Yao, Natalia Chalmers, Eden Tesfaye; CMCS: Dan Tsai, Anne Marie Costello, Sara Vitolo; CM: Meena Seshamani; CCIIO: Ellen Montz; CCSQ: Lee Fleisher; OGC: Janice Hoffman; Barbara Fisher; OL: Arielle Woronoff, Jennifer Boulanger, Mary Ellen Stahlman; OSORA: Kathleen Cantwell; OC: Bruce Alexander; OACT: Paul Spitalnic, Chris Truffer; EPM: Megan Curran; FCHCO: Tim Engelhardt; OMH: LaShawn McIver; CMMI: Liz Fowler; CPI: Dara Corrigan; OPOLE: Nancy O'Connor; OBRHI: Mary Greene; OEDA: Allison Oelschlaeger

Purpose: This meeting is being held to brief you and request your guidance on the items below.

Agenda:

Discussion Items:

1. **Oregon Basic Health Program (BHP) and Bridge Plan**
   - Brief and seek feedback on how to proceed with Oregon's BHP and Bridge Plan. The bridge plan would smooth transition from Medicaid-to-Marketplace Coverage at the end of the Medicaid continuous enrollment condition. (b)(5) (b)(5) In Oregon, Medicaid is available for adults who earn up to 133% of the federal poverty line and pregnant women who make up to 185% of the federal poverty line. The bridge plan would be for people making between 133% and 200% of the poverty line.
     - Briefers: Sarah deLone, Meg Barry, and Cassie Lagorio

- Page 1

2. **Missouri Deferral – Federal Reimbursement Allowance (FRA) Tax**

Brief and seek feedback on a recommended Missouri deferral related to the state's FRA tax. Specifically, the tax program appears to include a hold harmless arrangement that involves hospitals pooling, then redistributing Medicaid payments. (b)(5)

(b)(5)

(b)(5) CMS must notify the state by March 31, 2023 to meet the regulatory imposed deadline.

- Briefer: Rory Howe
- Page 6

Informational Item:

3. **CMCS Issues Follow-up Items** – None at this time.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Office of Strategic Operations and Regulatory Affairs

March 17, 2023

To: Chiquita Brooks-LaSure
Administrator

Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer

Through: Kathleen Cantwell
Director

From: Monica McLemore
Program Coordinator

SUBJECT: CMCS Issues Meeting: Administrator Level
DATE: March 20, 2023
TIME: 10:00 AM – 11:00 AM
PLACE: 314G; Zoom
https://cms.zoomgov.com/j/(b)(6)?pwd=VDJhLzVpSHFjd1Q0bjB0dUhFZ1NsUT09

IRA-Related Policies: No

Participants: OA: Erin Richardson, Kyla Ellis, Hannah Katch, Will Harris, Kristiana Yao, Natalia Chalmers, Eden Tesfaye; CMCS: Dan Tsai, Anne Marie Costello, Sara Vitolo; CM: Meena Seshamani; CCIIO: Ellen Montz; CCSQ: Lee Fleisher; OGC: Janice Hoffman; Barbara Fisher; OL: Arielle Woronoff, Jennifer Boulanger, Mary Ellen Stahlman; OSORA: Kathleen Cantwell; OC: Bruce Alexander; OACT: Paul Spitalnic, Chris Truffer; EPM: Megan Curran; FCHCO: Tim Engelhardt; OMH: LaShawn McIver; CMMI: Liz Fowler; CPI: Dara Corrigan; OPOLE: Nancy O'Connor; OBRHI: Mary Greene; OEDA: Allison Oelschlaeger

Purpose: This meeting is being held to brief you and request your guidance on the items below.

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    - Briefer: Rory Howe
    - Page 6

Informational Item:

3. **CMCS Issues Follow-up Items** – None at this time.

Discussion Items for Administrator

1. Oregon Basic Health Program (BHP) and Bridge Plan

- **Issue Summary:** CMCS will brief and seek feedback on how to proceed with Oregon's BHP and Bridge Plan. The bridge plan would smooth transition from Medicaid-to-Marketplace Coverage at the end of the Medicaid continuous enrollment condition. (b)(5) (b)(5) (b)(5) In Oregon, Medicaid is available for adults who earn up to 133% of the federal poverty line and pregnant women who make up to 185% of the federal poverty line. The bridge plan would be for people making between 133% and 200% of the poverty line.

- **Target Release Date:** CMCS and CCIIO would like to discuss the outcome with Oregon on the March 22, 2023 check-in call.

- **IRA-Related Policies:** N/A

- **CMS Cross-Component Coordination:** The Oregon Bridge Plan involves coordination between CMCS and CCIIO.

- **Background/Context:** Oregon is working to establish a bridge program for adults with income between 133%-200% of the Federal Poverty Level (FPL), in order to provide continuity of coverage during the unwinding period. The state also seeks to establish a longer-term program for adults whose income fluctuates across the current Medicaid eligibility limit of 133% FPL. The state proposed that this bridge program consist of a section 1115 demonstration, and then transition to a Basic Health Program (BHP) and a section 1332 waiver.

  Until recently, the state's draft bridge program timeline was as follows:
  - April 2023 – July 2024: Implement a temporary section 1115 demonstration to continue to provide Medicaid coverage to individuals disenrolling from Medicaid during the unwinding period.
  - July 2024-December 2024: Implement a partial BHP, covering only individuals disenrolling from Medicaid.
  - January 2025: Implement a full BHP as well as a section 1332 waiver that allows for the use of a gold benchmark for premium tax credit calculations for Marketplace enrollees.
  - January 2027: State becomes a State-Based Exchange (SBE).

(b)(5)

(b)(5)

- **Options and Pros and Cons**

Option 1: (b)(5)

(b)(5)

Pros:

(b)(5)

Cons:

(b)(5)

(b)(5)

Option 2: (b)(5)

(b)(5)

Pros:

(b)(5)

Cons:

(b)(5)

Option 3: (b)(5)

(b)(5)

Pros:

(b)(5)

Cons:

(b)(5)

(b)(5)

- **Attachments/Additional Information:** N/A

2. Missouri Deferral – Federal Reimbursement Allowance (FRA) Tax

- **Issue Summary:** CMCS will brief and seek feedback on a recommended Missouri deferral related to the state's FRA tax. Specifically, the tax program appears to include a hold harmless arrangement that involves hospitals pooling, then redistributing Medicaid payments. (b)(5)

(b)(5)

CMS must notify the state by March 31, 2023 to meet the regulatory imposed deadline.

- **Target Release Date:** March 30, 2023

- **IRA-Related Policies:** No

- **CMS Cross-Component Coordination:** N/A

- **Background/Context:** Missouri funds a portion of its Medicaid program through a hospital tax, known as the FRA. The Missouri Hospital Association (MHA), with state knowledge and potential involvement, administers a voluntary pooling arrangement to redistribute Medicaid managed care organization (MCO) payments among Missouri hospitals. As recently as October 24, 2017, the MHA described the pooling arrangement and indicated that it "*...redistributes some FRA-funded payments so that participants in the FRA pooling arrangement are not financially harmed by the FRA program. By insulating pool participants against financial loss, the pooling arrangement enables industry concurrence with the state's use of provider taxes, which generates more funding than likely would be possible under alternative scenarios.*"[1] This appears to be a hold harmless arrangement prohibited by statute and regulations. (b)(5)

(b)(5)

CMS engaged the state in an effort to correct the financing prospectively and provided ample notice to the state of its current position.

CMCS issued a letter to Missouri on July 28, 2020 documenting concerns regarding the state's managed care payment approach and the hold harmless concerns regarding the hospital tax. Prior to issuing the letter, CMCS obtained verbal commitment from the state to end the problematic non-federal share financing arrangement by June 30, 2021. Given the

[1] https://web.mhanet.com/media-library/missouris-hospital-provider-tax-pooling-arrangement/

state's commitment on the financing arrangement, CMS supported providing the state limited time to transition its problematic payment arrangement into a state-directed payment (SDP). The July 28, 2020 letter documented the state commitments and timeline on these two issues. Contrary to its commitment documented in the July 28, 2020 letter, the state recently informed CMS that it does not intend to end its pooling arrangement.

On July 15, 2022, in conjunction with the approval an additional year of SDPs funded in part through the FRA, CMS sent a companion letter reiterating CMS concerns with the tax. The companion letter described how the pooling and redistribution arrangement worked and outlined the history of the discussions between Missouri and CMS surrounding these arrangements. It also stated that CMS intended to conduct a "focused review" of the state's CMS-64 to determine if the FRA met federal requirements and to recoup federal funding, if appropriate.

As part of the review of the CMS-64 for the December 31, 2022 quarter, on February 17, 2023, CMS sent the state some questions to confirm our understanding of the Missouri FRA program and pooling arrangement. On March 10, 2023, the state responded to CMS with responses that supported our continued concerns regarding the tax; therefore, we are recommending issuing a deferral. (b)(5)

(b)(5)

The $236,629,533 deferral amount (approximately 7.6% of the state's quarterly Medicaid expenditures) represents the federal portion of the FRA tax collected by the state for the first quarter of fiscal year 2023. CMCS determined the deferral amount based on the requirement in section 1903(w)(1)(A)(iii) of the Social Security Act that states CMS must reduce a state's Medicaid expenditures by the amount of any health care-related tax collected if there is a hold harmless provision in effect. The statute does not permit only deferring a portion of an unallowable tax. Crucially, the state could preserve its entire tax collection by ending the redistributions, which CMCS believes only involve a relatively small portion of the total FRA tax collected.

Medicaid Deferral Process:

A deferral is taken when CMS questions the allowability of, or needs additional information about, an expenditure a state has claimed on its CMS-64. The purpose of the deferral is to raise questions related to a state's claim on the CMS-64 while temporarily withholding federal financial participation (FFP). It is not a final determination, but a way for CMS to identify an issue through a quarterly expenditure review, put a state on notice that there is a concern, and obtain information necessary to determine the claim's allowability. The deferral must be taken within 60 days of receipt of the CMS-64 on which the questionable expenditure was claimed.

After CMS issues a deferral, the following may occur:

- CMS determines the claim is allowable and pays the deferred funds to the state.
- CMS determines the claim is unallowable and initiates a formal disallowance.
- CMS cannot make a determination on allowability of the claim within 90 days, and returns the funds while CMS continues to review the claims. If CMS returns the deferred funds to the state, it does not preclude CMS from taking a disallowance action later.

- **Major Issues and Policy Goals:** Ensuring that states properly fund the non-federal share funding sources is critical to protecting Medicaid's sustainability through responsible stewardship of public funds. State use of impermissible non-federal share sources often artificially inflate federal Medicaid expenditures. Further, these arrangements reward providers based on their ability to fund the state share, instead of on Medicaid utilization, quality, equity, health outcomes, or other Medicaid program goals. Currently, Missouri has arrangements that are specifically designed to redirect Medicaid payments away from higher Medicaid utilized providers to providers that have low Medicaid utilization or do not participate in Medicaid. To prevent impermissible financing from proliferating nationally, we must apply consistent compliance enforcement. In February 2023, CMCS issued an informational bulletin reminding states that this type of arrangement is impermissible.

(b)(5)

(b)(5) Regulations require that CMS issue the deferral within 60 days of receipt of the CMS-64, which is March 31, 2023.

(b)(5)

- **Estimated Financial Impact of Policy:** The financial impact of this policy is significant and the impact on Missouri is approximately $236,629,533 FFP quarterly until resolved.

- **Health Equity Impacts:** Impermissible non-federal share financing arrangements that involve redistributing Medicaid payments have a negative impact on health equity, based on concerns described in "Policy Goals" section above.

- **Anticipated Stakeholder Reaction:** CMS expects Missouri will react unfavorably to the deferral and any subsequent disallowance action. Although the state could fix the FRA tax

(b)(5)

Attachment A

Timeline Missouri FRA Review/Compliance Enforcement (Quarter 1, FY 2023)			
Action	**Date**	**Detail**	**Status**
CMS Notifies State of Focused Review	7/15/22	In conjunction with SDP approvals, CMS issues a companion letter reiterating FRA concerns and notifying state of upcoming focused CMS-64 review	Completed
State Reports FRA on the Quarterly CMS-64	1/31/23	Missouri reports FRA tax collection amounts on the CMS-64 for the Quarter Ended 12/31/22	Completed
Develop Draft Questions to issue to State	2/8/23	FMG developed questions to confirm understanding of Missouri FRA program and pooling arrangement	Completed
Communication with State	2/22/23	CMCS informed the state that we will conduct a focused review of the FRA program during the QE 12/31/22 CMS-64 review and provided a list of questions	Completed
Receive State Response	3/10/23	FMG received and will begin review of state's response	Review in process
Prepare Deferral Package	3/16/23	FMG prepares deferral package, as necessary	In process
Brief OA	3/20/23	Brief OA during CMCS Issues meeting	In process
Issue Deferral	3/31/23	FMG issues deferral by 60th day, if needed	In process
Receive State Response to Deferral	7/29/23	State response due within 60 days (5/30/23) plus optional 60 days extension	
Convert Deferral to Disallowance/OGC Review	8/29/23	FMG obtains OGC concurrence to convert deferral to disallowance, if needed	
Disallowance/OCD Clearance	9/29/23	FMG recommends disallowance, brief CMCS leadership	
Disallowance/OA Clearance	10/10/23	CMCS presents disallowance to OA, if needed	
Issue Disallowance	10/27/23	CMS issues disallowance 90 days following state response to deferral, if needed, or release deferral.	

Message

From: Boston, Beverly (CMS/CMCS) (b)(6)
(b)(6)

Sent: 3/23/2023 6:39:41 PM

To: Curry, Celestine (CMS/CMCS) (b)(6)
(b)(6) Ferguson, Dorothy
(CMS/CMCS) (b)(6)
(b)(6) Endelman (he/him),
Jonathan (CMS/CMCS) (b)(6)
(b)(6) McClure, Deb
(CMS/CMCS) (b)(6)
(b)(6) Powell, Eric
(CMS/CMCS (b)(6)
(b)(6) Arnold, Charlie
(CMS/CMCS (b)(6)
(b)(6) Clark, Jennifer
(CMS/CMCS) (b)(6)
(b)(6) Cuno, Richard
(CMS/CMCS (b)(6)
(b)(6) Fan, Kristin
(CMS/CMCS) (b)(6)
(b)(6) Goldstein, Stuart
(CMS/CMCS) (b)(6)
(b)(6) ; Heitt, Melissa
(CMS/FCHCO) (b)(6)
(b)(6) Mosley, Elle (CMS/CMCS)
(b)(6)
(b)(6) ; Schoonover, Matthew
(CMS/CMCS) (b)(6) p
(b)(6) Goldstein, Stuart
(CMS/CMCS) (b)(6)
(b)(6) ; Lane, Robert
(CMS/CMCS) (b)(6)
(b)(6) ; Barraza, Leticia
(CMS/CMCS) (b)(6)
(b)(6) ; Kimble, Davida
(CMS/CMCS) (b)(6)
(b)(6)

CC: Howe, Rory (CMS/CMCS) (b)(6)
(b)(6) Silanskis, Jeremy
(CMS/CMCS) (b)(6)
(b)(6) Maccarroll, Amber
(CMS/CMCS) (b)(6)
(b)(6) ; adams, lia (CMS/CMCS)
(b)(6)
(b)(6)

Subject: DUE COB TODAY: RE: Plan to Release the Missouri Deferral

Attachments: Reactive Missouri Deferral Mar 22 1021am.docx

Hello,

Circling back with the attached (and in the SP link) Reactive statement for the MO deferral. The language is taken from the taxes CIB and other supporting documents i..e the talkers and briefing paper.

(b)(6)

MO Deferral Planned Release Steps:

(1) **Weds 3/23 by COB**: OA TPs, deferral letter, timeline & reactive statement to **Dan's book for his review**

(2) **Fri 3/24- Mon 3/27**: DFP will clear the OA TPs and deferral letter with OGC and will provide any edits.

(3) **TBD** – Connect with OL to share timeline, reactive/ discuss any outreach to members that might be needed (I'm thinking this should likely be Tuesday? – but open to other thoughts)

(4) **Weds 3/29**: Reach out to SMD (Rory/OCD) and Governor's office (OA) to schedule call for Thursday

(5) **Tues 3/29**: Rory and the OCD will contact/call the MO SMD (Todd Richardson) OCD and OA will contact the MO Governor's office to signal that the deferral is coming

(6) **Weds 3/29**: to explain the reason for the deferral and that CMS is working with the state to obtain any additional documentation to support the claims

(7) **Thurs 3/30**: Rory/Dan call w/ SMD; OA/Dan call w/ Governor

(8) **Thurs 3/30**: OCD confirms that the Night Note went forward to OC in prep for a the 3/31 Grant award deferral letter being issued to the state

(9) **Fri 3/31@ 12pm: Deferral letter is Issued to the state.**

Beverly A. Boston
Senior Advisor & Assistant to the Group Director
Financial Management Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Beverly.Boston@CMS.HHS.Gov
410-786-4186

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 12:15 PM
To: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>;

Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

I'll make updates based on these timeframes and will recirculate. Thanks

Beverly

From: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Sent: Thursday, March 23, 2023 11:27 AM
To: Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Here are my notes from conversation w OCD this morning:

- **COB today 3/23** – send OA TPs, deferral letter, timeline & reactive statement to Dan's book for his review
- **Fri 3/24 – Mon 3/27** – clear deferral letter, TPs & reactive statement w OGC (same as listed below)
- **TBD** – connect with OL to share timeline, reactive/ discuss any outreach to members that might be needed (I'm thinking this should likely be Tuesday? – but open to other thoughts)
- **Wed., 3/29** – reach out to SMD (Rory/OCD) and Governor's office (OA) to schedule call for Thursday
- **Thurs., 3/30** – Rory/Dan call w/ SMD; OA/Dan call w/ Governor
- **Fri., 3/31 -** release deferral (same as below)

Thanks, Amber

From: Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:48 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Adding Davida.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:45 AM
To: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Thank you!

Beverly

From: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:44 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark,

Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Thanks Beverly. I did get some insight re: Dan's thoughts on timing of calls this morning. I will send those around shortly.

Thanks, Amber

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:42 AM
To: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Thanks Dorothy,

I will give the OCD a heads-up on the planned strategy for the deferral and will confirm timeframes for the SMD and Gov calls. Thanks

MO Deferral Planned Release Steps:

(1) Fri 3/24- Mon 3/27: DFP will clear the OA TPs and deferral letter with OGC and will provide any edits.

(2) Tues 3/28: Rory and the OCD will contact/call the MO SMD (Todd Richardson) to signal that the deferral is coming (ETA time for the call needed)

(3) Weds 3/29: OCD and OA will contact the MO Governor's office to explain the reason for the deferral and that CMS is working with the state to obtain any additional documentation to support the claims(ETA time for the call needed)

(4) Thurs 3/30: OCD confirms that the Night Note went forward to OC in prep for a the 3/31 Grant award deferral letter being issued to the state

(5) Fri 3/31@ 12pm: Deferral letter is Issued to the state.

Beverly

From: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:38 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Beverly,

Confirming the 3/31/2023 date and what you have written below.

Thanks,
Dorothy Ferguson, 214-767-6385
Director
Division of Financial Operations West, FMG, CMCS
Centers for Medicare & Medicaid Services (CMS)

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:21 AM
To: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>

Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Hi Jonathan,

Thanks for flagging, I actually made this item #1 on the list as an action to be started asap. **Deborah**, regarding the 60th day, there was discussion at the DFO/DFP TB and there is a possible disconnect between MBES calculation and manual calculation of the 60th day. DFO-W, did confirm that 60th date is 3/31. DFO-W please feel free to chime in.

MO Deferral Planned Release Steps:

(1) Fri 3/24- Mon 3/27: DFP will clear the OA TPs and deferral letter with OGC and will provide any edits.

(2) Tues 3/28: Rory and the OCD will contact/call the MO SMD (Todd Richardson) to signal that the deferral is coming (ETA time for the call needed)

(3) Weds 3/29: OCD and OA will contact the MO Governor's office to explain the reason for the deferral and that CMS is working with the state to obtain any additional documentation to support the claims(ETA time for the call needed)

(4) Thurs 3/30: OCD confirms that the Night Note went forward to OC in prep for a the 3/31 Grant award deferral letter being issued to the state

(5) Fri 3/31@ 12pm: Deferral letter is Issued to the state.

Thanks

Beverly

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:50 AM
To: McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Beverly,

I just want to flag regarding clearing the talking points and the deferral letter with OGC, particularly Jeremy Vogel, and also the litigators, particularly Garrett Mannchen. I know that was mentioned before. I want to make sure it goes on the timeline. I would think that would need to happen before the call on 3/29.

Best,

Jonathan

Jonathan Endelman, PhD
Social Science Research Analyst
Centers for Medicare & Medicaid Services (CMS)
Center for Medicaid and CHIP Services (CMCS)
Financial Management Group (FMG)
Division of Financial Policy (DFP)
410.786.4738
jonathan.endelman@cms.hhs.gov
7500 Security Blvd.
Mail Stop, S3-14-28
Baltimore, MD 21244-1850

From: McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:27 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

All, MBES is showing the 60th day for Missouri is 3/30. Can we confirm on the 3/31 date below to release the deferral?

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:08 AM
To: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO)

<Melissa.Heitt@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: Plan to Release the Missouri Deferral

Good morning,

We are gearing up to issue a **deferral to MO in the amount of $236,629,533 on Friday March 31, 2023 at 12pm** noon related to Missouri's Federal Reimbursement Allowance (FRA) tax. Please see below anticipated steps that will need to be followed prior to issuing the deferral letter to the state. I will connect with the OCD on the ETA for items 1 and 2. Please let me know if I have missed anything in the steps below. For your awareness, the OCD Comms Team along with the Office of Communications is preparing a "**Reactive Statement**" that I will circle back with the team on, to confirm any edits. Please let me know if I have missed anything, or if you have questions.

(1) **Tues 3/28**: Rory and the OCD will contact/call the MO SMD (Todd Richardson) to signal that the deferral is coming (ETA time for the call needed)

(2) **Weds 3/29**: OCD and OA will contact the MO Governor's office to explain the reason for the deferral and that CMS is working with the state to obtain any additional documentation to support the claims(ETA time for the call needed)

(3) **Thurs 3/30**: OCD confirms that the Night Note went forward to OC in prep for a the 3/31 Grant award deferral letter being issued to the state

(4) **Fri 3/31@ 12pm: Deferral letter is Issued to the state.**

Thanks

Beverly

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Wednesday, March 22, 2023 9:36 AM
To: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>
Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: Night Note for Missouri Deferral

Good morning +Rory/Jeremy

Thanks Dorothy. I made some edits to the NN. Also, the OCD pinged me this morning on the TP Dan has requested for DPC. Not sure if anyone is work on those?

Missouri Federal Reimbursement Allowance (FRA) Tax Deferral

Tomorrow, CMCS will issue a deferral (a temporary hold on funding while CMS investigates further) related to Missouri's Federal Reimbursement Allowance (FRA) tax in the amount of $236,629,533 in federal financial participation (FFP). On December 31, 2022, CMS conducted a focused CMS-64 quarterly report review of Missouri's FRA tax, to determine compliance with statutory and regulatory requirements, specifically whether a hold harmless arrangement exists due to providers redistributing Medicaid payments. The review confirmed our previous concerns that the tax may be unallowable, and as a result, a temporary hold Is being placed on a portion of Medicaid funding while CMS continues to review information from the state to make a final determination of the allowability of the tax. Regulations require that a deferral must be taken within 60 days of receipt of the state's quarterly expenditure report, which is March 31, 2023.

Beverly A. Boston
Senior Advisor & Assistant to the Group Director
Financial Management Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Beverly.Boston@CMS.HHS.Gov
410-786-4186

From: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>
Sent: Tuesday, March 21, 2023 12:55 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: Night Note for Missouri Deferral

Beverly, here is the night note for the Missouri Deferral to be taken on March 31, 2023. If you need additional information in the night note, let me know.

Tomorrow, CMCS will issue a deferral related to Missouri's Federal Reimbursement Allowance (FRA) tax in the amount of $236,629,533 in federal financial participation as a result of a focused review of Missouri's FRA tax on the December 31, 2022, CMS-64 quarterly report, to determine compliance with statutory and regulatory requirements, specifically whether a hold harmless arrangement exists due to providers redistributing Medicaid payments. The review confirmed our previous concerns that the tax may be unallowable, and as a result, a temporary hold Is being placed on a portion of Medicaid funding while CMS continues to review information from the state to make a final determination of the allowability of the tax. Regulations require that a deferral must be taken within 60 days of receipt of the state's quarterly expenditure report, which is March 31, 2023.

Thanks,

Dorothy Ferguson ‖ Director, Division of Financial Operations West, FMG, CMCS ‖Centers for Medicare & Medicaid Services (CMS) ‖ 1301 Young Street, Suite 837 ‖ Dallas, TX 75202 ‖Dorothy.Ferguson@cms.hhs.gov ‖ 214-767-6385 (ph) ‖ 443-380-6399 (fax) ‖

REACTIVE MEDIA STATEMENT

After reviewing information from Missouri in response to longstanding concerns about federal Medicaid financing requirements, the Centers for Medicare & Medicaid Services (CMS) fulfilled its oversight obligations and commitment to financial stewardship by issuing a Medicaid deferral. This deferral addresses the federal portion of a hospital tax, known as the "FRA," which may represent a hold harmless arrangement prohibited by statute and regulations.

CMS takes its commitment to enforce existing federal statutory and regulatory requirements seriously, and stands ready to assist states in ensuring appropriate sources for the nonfederal share of financing. This work is is critical to protecting Medicaid's sustainability through responsible stewardship.

Additional Background:

- A deferral is taken when CMS questions the allowability of, or needs additional information about, an expenditure a state has claimed on its Form CMS-64. The purpose of the deferral is to raise questions related to a state's claim while temporarily withholding federal financial participation. The deferral must be taken within 60 days of receipt of a Form CMS-64 with questionable expenditures. CMS will now determine whether the claims related to the deferral are allowable. The $236,629,533 deferral amount represents the federal portion of the FRA tax collected by the state for the first quarter of 2023.
- In July 2022, CMS issued a letter to Missouri documenting concerns regarding the state's managed care payment approach and the FRA hospital tax. In July 2022, in conjunction with approving an additional year of state directed payments funded in part through the state's FRA hospital tax, CMS sent a companion letter to Missouri reiterating its concerns. As part of the agency's review of Missouri's Form CMS-64 for last quarter of 2022, CMS sent a letter in February 2023 requesting answers to questions on the FRA hospital tax. On March 10, 2023, the state responded with information that supported CMS' continued concerns.
- CMS has long maintained that using impermissible nonfederal share sources in Medicaid financing can artificially inflate federal expenditures. If states use these arrangements to pay providers based on their ability to fund the nonfederal share, it can also disconnect Medicaid payment from services, quality of care, health outcomes, and other program goals. Additionally, such redistribution arrangements involve redirecting Medicaid payments away from Medicaid providers who serve a high share of Medicaid beneficiaries to providers who do not participate in Medicaid or have relatively lower Medicaid utilization. For additional information, consult the [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf"].
- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS remains committed to working with states on existing or possible arrangements that would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

Message

From: Maccarroll, Amber (CMS/CMCS) (b)(6)
(b)(6)
Sent: 3/23/2023 6:43:01 PM
To: Howe, Rory (CMS/CMCS) (b)(6)
(b)(6)
CC: adams, lia (CMS/CMCS) (b)(6)
(b)(6)
Subject: timeline for Missouri
Attachments: Reactive Missouri Deferral Mar 22 1021am.docx

Hey Rory –

The timeline is in the email below – Lia is dropping it into a word document – let her know if you have edits

MO Deferral Planned Release Steps:

(1) Weds 3/23 by COB: OA TPs, deferral letter, timeline & reactive statement to **Dan's book for his review**

(2) Fri 3/24- Mon 3/27: DFP will clear the OA TPs and deferral letter with OGC and will provide any edits.

(3) TBD – Connect with OL to share timeline, reactive/ discuss any outreach to members that might be needed (I'm thinking this should likely be Tuesday? – but open to other thoughts)

(4) Weds 3/29: Reach out to SMD (Rory/OCD) and Governor's office (OA) to schedule call for Thursday

(5) Tues 3/29: Rory and the OCD will contact/call the MO SMD (Todd Richardson) OCD and OA will contact the MO Governor's office to signal that the deferral is coming

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(8) Thurs 3/30: OCD confirms that the Night Note went forward to OC in prep for a the 3/31 Grant award deferral letter being issued to the state

(9) Fri 3/31@ 12pm: Deferral letter is Issued to the state.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 2:40 PM
To: Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>;

Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: DUE COB TODAY: RE: Plan to Release the Missouri Deferral

Hello,

Circling back with the attached (and in the SP link) Reactive statement for the MO deferral. The language is taken from the taxes CIB and other supporting documents i..e the talkers and briefing paper.

(b)(6)

MO Deferral Planned Release Steps:

(1) **Weds 3/23 by COB**: OA TPs, deferral letter, timeline & reactive statement to **Dan's book for his review**

(2) **Fri 3/24- Mon 3/27**: DFP will clear the OA TPs and deferral letter with OGC and will provide any edits.

(3) **TBD** – Connect with OL to share timeline, reactive/ discuss any outreach to members that might be needed (I'm thinking this should likely be Tuesday? – but open to other thoughts)

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(9) **Fri 3/31@ 12pm: Deferral letter is Issued to the state.**

Beverly A. Boston
Senior Advisor & Assistant to the Group Director
Financial Management Group
Center for Medicaid and CHIP Services
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410-786-4186

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 12:15 PM
To: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

I'll make updates based on these timeframes and will recirculate. Thanks

Beverly

From: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Sent: Thursday, March 23, 2023 11:27 AM
To: Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
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Subject: RE: Plan to Release the Missouri Deferral

Here are my notes from conversation w OCD this morning:

- **COB today 3/23** – send OA TPs, deferral letter, timeline & reactive statement to Dan's book for his review
- **Fri 3/24 – Mon 3/27** – clear deferral letter, TPs & reactive statement w OGC (same as listed below)
- **TBD** – connect with OL to share timeline, reactive/ discuss any outreach to members that might be needed (I'm thinking this should likely be Tuesday? – but open to other thoughts)
- **Wed., 3/29** – reach out to SMD (Rory/OCD) and Governor's office (OA) to schedule call for Thursday
- **Thurs., 3/30** – Rory/Dan call w/ SMD; OA/Dan call w/ Governor
- **Fri., 3/31 -** release deferral (same as below)

Thanks, Amber

From: Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:48 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Kimble, Davida (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>
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Subject: RE: Plan to Release the Missouri Deferral

Adding Davida.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:45 AM
To: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS)

<Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Thank you!

Beverly

From: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:44 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

Thanks Beverly. I did get some insight re: Dan's thoughts on timing of calls this morning. I will send those around shortly.

Thanks, Amber

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:42 AM
To: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
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Subject: RE: Plan to Release the Missouri Deferral

Thanks Dorothy,

I will give the OCD a heads-up on the planned strategy for the deferral and will confirm timeframes for the SMD and Gov calls. Thanks

MO Deferral Planned Release Steps:

(1) Fri 3/24- Mon 3/27: DFP will clear the OA TPs and deferral letter with OGC and will provide any edits.

(2) Tues 3/28: Rory and the OCD will contact/call the MO SMD (Todd Richardson) to signal that the deferral is coming (ETA time for the call needed)

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Beverly

From: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>
Sent: Thursday, March 23, 2023 10:38 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
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Subject: RE: Plan to Release the Missouri Deferral

Beverly,

Confirming the 3/31/2023 date and what you have written below.

Thanks,
Dorothy Ferguson, 214-767-6385
Director
Division of Financial Operations West, FMG, CMCS

Centers for Medicare & Medicaid Services (CMS)

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:21 AM
To: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
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Subject: RE: Plan to Release the Missouri Deferral

Hi Jonathan,

Thanks for flagging, I actually made this item #1 on the list as an action to be started asap. **Deborah**, regarding the 60th day, there was discussion at the DFO/DFP TB and there is a possible disconnect between MBES calculation and manual calculation of the 60th day. DFO-W, did confirm that 60th date is 3/31. DFO-W please feel free to chime in.

MO Deferral Planned Release Steps:

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(5) Fri 3/31@ 12pm: Deferral letter is Issued to the state.

Thanks
Beverly

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:50 AM
To: McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Boston, Beverly (CMS/CMCS)

<Beverly.Boston@cms.hhs.gov>; Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
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Subject: RE: Plan to Release the Missouri Deferral

Beverly,

I just want to flag regarding clearing the talking points and the deferral letter with OGC, particularly Jeremy Vogel, and also the litigators, particularly Garrett Mannchen. I know that was mentioned before. I want to make sure it goes on the timeline. I would think that would need to happen before the call on 3/29.

Best,

Jonathan

Jonathan Endelman, PhD
Social Science Research Analyst
Centers for Medicare & Medicaid Services (CMS)
Center for Medicaid and CHIP Services (CMCS)
Financial Management Group (FMG)
Division of Financial Policy (DFP)
410.786.4738
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7500 Security Blvd.
Mail Stop, S3-14-28
Baltimore, MD 21244-1850

From: McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>
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adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Plan to Release the Missouri Deferral

All, MBES is showing the 60th day for Missouri is 3/30. Can we confirm on the 3/31 date below to release the deferral?

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, March 23, 2023 9:08 AM
To: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: Plan to Release the Missouri Deferral

Good morning,

We are gearing up to issue a **deferral to MO in the amount of $236,629,533 on Friday March 31, 2023 at 12pm** noon related to Missouri's Federal Reimbursement Allowance (FRA) tax. Please see below anticipated steps that will need to be followed prior to issuing the deferral letter to the state. I will connect with the OCD on the ETA for items 1 and 2. Please let me know if I have missed anything in the steps below. For your awareness, the OCD Comms Team along with the Office of Communications is preparing a "**Reactive Statement**" that I will circle back with the team on, to confirm any edits. Please let me know if I have missed anything, or if you have questions.

(1) Tues 3/28: Rory and the OCD will contact/call the MO SMD (Todd Richardson) to signal that the deferral is coming (ETA time for the call needed)

(2) Weds 3/29: OCD and OA will contact the MO Governor's office to explain the reason for the deferral and that CMS is working with the state to obtain any additional documentation to support the claims(ETA time for the call needed)

(3) Thurs 3/30: OCD confirms that the Night Note went forward to OC in prep for a the 3/31 Grant award deferral letter being issued to the state

(4) Fri 3/31@ 12pm: Deferral letter is Issued to the state.

Thanks
Beverly

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Wednesday, March 22, 2023 9:36 AM
To: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>
Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: Night Note for Missouri Deferral

Good morning +Rory/Jeremy

Thanks Dorothy. I made some edits to the NN. Also, the OCD pinged me this morning on the TP Dan has requested for DPC. Not sure if anyone is work on those?

Missouri Federal Reimbursement Allowance (FRA) Tax Deferral

Tomorrow, CMCS will issue a deferral (a temporary hold on funding while CMS investigates further) related to Missouri's Federal Reimbursement Allowance (FRA) tax in the amount of $236,629,533 in federal financial participation (FFP). On December 31, 2022, CMS conducted a focused CMS-64 quarterly report review of Missouri's FRA tax, to determine compliance with statutory and regulatory requirements, specifically whether a hold harmless arrangement exists due to providers redistributing Medicaid payments. The review confirmed our previous concerns that the tax may be unallowable, and as a result, a temporary hold Is being placed on a portion of Medicaid funding while CMS continues to review information from the state to make a final determination of the allowability of the tax. Regulations require that a deferral must be taken within 60 days of receipt of the state's quarterly expenditure report, which is March 31, 2023.

Beverly A. Boston
Senior Advisor & Assistant to the Group Director
Financial Management Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Beverly.Boston@CMS.HHS.Gov
410-786-4186

From: Ferguson, Dorothy (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>
Sent: Tuesday, March 21, 2023 12:55 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Powell, Eric (CMS/CMCS) <Eric.Powell@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin

(CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: Night Note for Missouri Deferral

Beverly, here is the night note for the Missouri Deferral to be taken on March 31, 2023. If you need additional information in the night note, let me know.

Tomorrow, CMCS will issue a deferral related to Missouri's Federal Reimbursement Allowance (FRA) tax in the amount of $236,629,533 in federal financial participation as a result of a focused review of Missouri's FRA tax on the December 31, 2022, CMS-64 quarterly report, to determine compliance with statutory and regulatory requirements, specifically whether a hold harmless arrangement exists due to providers redistributing Medicaid payments. The review confirmed our previous concerns that the tax may be unallowable, and as a result, a temporary hold Is being placed on a portion of Medicaid funding while CMS continues to review information from the state to make a final determination of the allowability of the tax. Regulations require that a deferral must be taken within 60 days of receipt of the state's quarterly expenditure report, which is March 31, 2023.

Thanks,
Dorothy Ferguson ‖ Director, Division of Financial Operations West, FMG, CMCS ‖Centers for Medicare & Medicaid Services (CMS) ‖ 1301 Young Street, Suite 837 ‖ Dallas, TX 75202 ‖Dorothy.Ferguson@cms.hhs.gov ‖ 214-767-6385 (ph) ‖ 443-380-6399 (fax) ‖ Please consider the environment before printing this e-mail.

REACTIVE MEDIA STATEMENT

After reviewing information from Missouri in response to longstanding concerns about federal Medicaid financing requirements, the Centers for Medicare & Medicaid Services (CMS) fulfilled its oversight obligations and commitment to financial stewardship by issuing a Medicaid deferral. This deferral addresses the federal portion of a hospital tax, known as the "FRA," which may represent a hold harmless arrangement prohibited by statute and regulations.

CMS takes its commitment to enforce existing federal statutory and regulatory requirements seriously, and stands ready to assist states in ensuring appropriate sources for the nonfederal share of financing. This work is is critical to protecting Medicaid's sustainability through responsible stewardship.

Additional Background:

- A deferral is taken when CMS questions the allowability of, or needs additional information about, an expenditure a state has claimed on its Form CMS-64. The purpose of the deferral is to raise questions related to a state's claim while temporarily withholding federal financial participation. The deferral must be taken within 60 days of receipt of a Form CMS-64 with questionable expenditures. CMS will now determine whether the claims related to the deferral are allowable. The $236,629,533 deferral amount represents the federal portion of the FRA tax collected by the state for the first quarter of 2023.
- In July 2022, CMS issued a letter to Missouri documenting concerns regarding the state's managed care payment approach and the FRA hospital tax. In July 2022, in conjunction with approving an additional year of state directed payments funded in part through the state's FRA hospital tax, CMS sent a companion letter to Missouri reiterating its concerns. As part of the agency's review of Missouri's Form CMS-64 for last quarter of 2022, CMS sent a letter in February 2023 requesting answers to questions on the FRA hospital tax. On March 10, 2023, the state responded with information that supported CMS' continued concerns.
- CMS has long maintained that using impermissible nonfederal share sources in Medicaid financing can artificially inflate federal expenditures. If states use these arrangements to pay providers based on their ability to fund the nonfederal share, it can also disconnect Medicaid payment from services, quality of care, health outcomes, and other program goals. Additionally, such redistribution arrangements involve redirecting Medicaid payments away from Medicaid providers who serve a high share of Medicaid beneficiaries to providers who do not participate in Medicaid or have relatively lower Medicaid utilization. For additional information, consult the [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf"].
- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS remains committed to working with states on existing or possible arrangements that would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

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- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS remains committed to working with states on existing or possible arrangements that would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

MO Deferral Planned Release Steps:

(1) **Thursday 3/23 by 3PM**: OA TPs, deferral letter and timeline to **Dan's book for review**

(2) **Friday 3/24 by 3PM**: Reactive Statement to **Dan's book for review**

(3) **TBD** – FMG connects with OL to share timeline, reactive/ discuss any outreach to members that might be needed (I'm thinking this should likely be Tuesday? – but open to other thoughts)

(4) **Fri 3/24- Mon 3/27**: FMG sends deferral letter with OCD's comments to OGC for review (OGC is expecting the document and is ready to review quickly)

(5) **Weds 3/29**: FMG reaches out to SMD to schedule Thursday call with Todd/Dan/Rory and OA contacts governor's office to schedule Thursday call with Dan/OA/MO Gov

(6) **Thurs 3/30**: Call with Todd/Dan/Rory and separate call with Dan/OA/MO Gov to signal that the deferral is coming

(7) **Thurs 3/30**: OCD confirms that the Night Note went forward to OC in prep for the 3/31 Grant award deferral letter being issued to the state

(8) **Fri 3/31@ 12pm: Deferral letter is Issued to the state.**

Message

From: Richardson (she/her), Erin (CMS/OA) (b)(6)
(b)(6)
Sent: 4/25/2023 2:35:40 PM
To: Kaiser, Alyssa (CMS/OL) (b)(6)
(b)(6) Bellios, Toula (CMS/OSPR) (b)(6)
(b)(6) Harris, Will (CMS/OA) (b)(6)
(b)(6) Hitchcock, Angela (CMS/OA) (b)(6)
(b)(6) Ellis (she/her), Kyla (CMS/OA) (b)(6)
(b)(6)
Subject: RE: RE: Review Required --> Cabinet Report due TODAY
Attachments: 2023 04 24 - CMS Weekly Report - vd(AK)(ER).docx

Thanks, Alyssa. Additional edits in the attached.

From: Kaiser, Alyssa (CMS/OL) <Alyssa.Kaiser@cms.hhs.gov>
Sent: Tuesday, April 25, 2023 10:02 AM
To: Bellios, Toula (CMS/OSPR) <Toula.Bellios@cms.hhs.gov>; Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Hitchcock, Angela (CMS/OA) <Angela.Hitchcock@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>
Subject: RE: Review Required --> Cabinet Report due TODAY

A few edits from me. Thanks!

From: Bellios, Toula (CMS/OSPR) <Toula.Bellios@cms.hhs.gov>
Sent: Tuesday, April 25, 2023 8:42 AM
To: Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Hitchcock, Angela (CMS/OA) <Angela.Hitchcock@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Kaiser, Alyssa (CMS/OL) <Alyssa.Kaiser@cms.hhs.gov>
Subject: FW: Review Required --> Cabinet Report due TODAY

Good morning, resending this so that it's at the top of your inboxes.
Also, CMCS has asked that we remove this bullet. I'll make this update AFTER I've received any additional edits from OA. please remove this one – launch date is still TBD.

- **Missouri Notice Letter:** On/about April 28th, CMS will release a Medicaid deferral letter to Missouri regarding longstanding concerns about federal Medicaid financing requirements, specifically FRA hospital taxes. This may represent a hold harmless arrangement, which is prohibited by statute and regulations.

Thanks, Toula

Toula Bellios
410 786 5501
7500 Security Blvd

Baltimore, MD 21244
e-mail: toula.bellios@cms.hhs.gov

From: Bellios, Toula (CMS/OSPR)
Sent: Monday, April 24, 2023 6:43 PM
To: Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Hitchcock, Angela (CMS/OA) <Angela.Hitchcock@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Kaiser, Alyssa (CMS/OL) <Alyssa.Kaiser@cms.hhs.gov>
Subject: Review Required --> Cabinet Report due TOMORROW

Hi everyone,

Attached is this week's Cabinet Report for your review. OC, OL & OSORA provided updates this week. CMCS comments are outstanding.

Thanks, Toula

Toula Bellios
410 786 5501
7500 Security Blvd
Baltimore, MD 21244
e-mail: toula.bellios@cms.hhs.gov

Weekly Report - Agency
Submitted on MM/DD/YYYY

Weekly reports should be Arial, size 14 font; additional information, if necessary, may be included in the appendix

WEEKLY REPORT

April 25, 2022

MEMORANDUM FOR THE CABINET SECRETARY

FROM: Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services, (b)(6)

SUBJECT: HHS Weekly Report | Week ending April 28, 2022

ECONOMY / LOWERING COSTS

- **Significant activity for consideration to raise to the attention of POTUS:** N/A
- **Past Week Accomplishments and Setbacks/Obstacles:** N/A
- **Requests for White House Collaboration:** N/A
- **Next Week – Upcoming Events / Tasks / Developments:** N/A

UNITY AGENDA

- **Significant activity for consideration to raise to the attention of POTUS:** N/A
- **Past Week Accomplishments and Setbacks/Obstacles:** N/A
- **Requests for White House Collaboration:** N/A
- **Next Week – Upcoming Events / Tasks / Developments:** N/A

INFRASTRUCTURE

- **Significant activity for consideration to raise to the attention of POTUS:** N/A

- **Past Week Accomplishments and Setbacks/Obstacles:** N/A

- **Requests for White House Collaboration:** N/A

- **Next Week – Upcoming Events / Tasks / Developments:** N/A

CLIMATE

- **Significant activity for consideration to raise to the attention of POTUS:** N/A

- **Past Week Accomplishments and Setbacks/Obstacles:** N/A

- **Requests for White House Collaboration:** N/A

- **Next Week – Upcoming Events / Tasks / Developments:** N/A

FOREIGN POLICY

- **Significant activity for consideration to raise to the attention of POTUS:** N/A

- **Past Week Accomplishments and Setbacks/Obstacles:** N/A

- **Requests for White House Collaboration:** N/A

- **Next Week – Upcoming Events / Tasks / Developments:** N/A

SIGNIFICANT EXECUTIVE ORDER (EO) IMPLEMENTATION & ADDITIONAL AGENCY ACTIVITY

- **Significant activity for consideration to raise to the attention of POTUS:** N/A

- **Past Week Accomplishments and Setbacks/Obstacles:**

- **Clarifying Eligibility for a Qualified Health Plan, Medicaid, CHIP and Basic Health Plan (CMS 9894-P):** On April 24th, CMS published the Clarifying Eligibility a Qualified Health Plan, Medicaid, CHIP and Basic Health Plan proposed rule. This rule will amend the definition of "lawful presence," for purposes of Medicaid and Affordable Care Act coverage and includes Deferred Action for Childhood Arrivals (DACA) recipients. The DACA program allows young people to live and work in the only country they know as home.
- **Frequently Asked Questions (FAQs): CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency (PHE):** On/about April 26th, CMS will publish FAQs addressing various issues related to the May 11, 2023, end of the COVID-19 PHE and its impact on various waivers and flexibilities implemented to address the pandemic.
- **Notice of Proposed Rule Making (NPRM): Ensuring Access to Medicaid Services (CMS 2442-P):** On April 27th, CMS will issue a notice of proposed rulemaking (NPRM), entitled "Assuring Access to Medicaid Services", that includes provisions to enhance Medicaid beneficiaries' access to health care services across fee-for-service, managed care, and home and community-based services delivery systems. The proposed regulatory improvements will affect access to care by increasing transparency and accountability, and by promoting standardized data and monitoring. The NPRM also includes opportunities for states to leverage active beneficiary engagement in their Medicaid programs.
- **Notice of Proposed Rulemaking (NPRM): Managed Care Access, Finance, and Quality (CMS-2439-P):** On April 27th, CMS will release a proposed rule that would add additional parameters under managed care delivery systems related to access to care requirements, states' use of in Lieu of Services or Settings, state directed payments, quality rating systems, and other policy and reporting changes to ensure the efficient operation of state managed care programs.
- **Organ Procurement Organization (OPO) Annual Public Performance Data:** On/about April 27th, CMS will post the Organ Procurement Organization (OPO) specific performance outcomes report to the Quality, Safety, and Oversight Reports (QCOR)

webpage. The requirement to make the measures publicly available was established in the 2020 OPO final rule (85 FR 77898). Posting this data is critical to holding OPOs accountable as a crucial step in reforming the organ donation system. The publication will provide transparency and demonstrate how OPOs compare to each other. Although these standards are not yet enforceable, publication of this information will allow OPOs to compare their organization's performance to other OPOs.

- **The Transplant Eco-System: The Role of Data in CMS Oversight of the Organ Procurement Organizations Blog:** On/about April 27th, CMS will release a blog outlining its strategy with respect to Organ Procurement Organization data. CMS recently released the Organ Transplantation Affinity Group (OTAG), draft recommendations which are geared toward effectively using data-driven approaches to improve organ donation, procurement, and transplantation system for patients, donors, and their families and caregivers as well as providers. In concert, the Health Resources Services Administration (HRSA) released their Organ Procurement and Transplantation Network Modernization Initiative. CMS aims to share information to improve the public trust of increasing transplantation of organs and implementing it in an equitable manner.
- **Consumer Fact Sheet on Over-the-Counter (OTC) Testing for COVID-19 After the End of the Public Health Emergency (PHE):** On/about April 28th, CMS will release a consumer fact sheet that addresses insurance coverage of COVID-19 over-the-counter tests after the end of the PHE.
- **Quality Safety Oversight (QSO) Memo: Guidance for the End of the COVID-19 Public Health Emergency (PHE) and Termination of 1135 Emergency Waivers:** On/about April 28th, CMS will post and release guidance for the end of the COVID-19 public health emergency (PHE) and termination of 1135 emergency waivers. This Quality, Safety & Oversight memorandum will guide key stakeholders on returning to a more normal delivery of quality health care for beneficiaries, provide additional guidance for regulations released during the PHE as Interim Final Rules with Comment, and give details such as dates and CMS expectations of compliance following the end of the PHE.

- **Public Release of Acute Hospital Care at Home Data Set:** On/about April 28th, CMS will make available, upon request, data from the Acute Hospital Care at Home (AHCAH) data set. The data includes 14 months of information in two finders' files for the period from November 2020-December 2021. One file contains patient-specific data, as well as claims aggregation and eligibility data of Medicare Fee-for-Service and non-managed Medicaid beneficiaries who have been provided acute care by hospitals across the country under the AHCAH initiative. The second file includes hospital-specific information related to the number admissions to the home setting, the number of patient escalations of care from the home to the hospital, and the number of unexpected patient mortalities. File release is pending publication in JAMA of a companion article under development.

- **Requests for White House Collaboration**: N/A

- **Next Week – Upcoming Events / Tasks / Developments:**
  - **2023 CMS Quality Conference:** May 1st through May 3rd, CMS will host the 2023 CMS Quality Conference. This conference convenes leaders across the health care spectrum to explore how patients, advocates, providers, researchers, and champions in health care quality improvement can develop and spread solutions to address America's most pervasive health system challenges.
  - **Organ Transplantation Affinity Group (OTAG) Public Launch:** On/about May 3rd, CMS and the Health Resources and Services Administration will announce the formation of their first collaborative Organ Transplantation Affinity Group. The launch will introduce five goals for organ transplantation system improvement.
  - **CMS/American Hospital Association (AHA) Stakeholder Call on Public Health Emergency (PHE):** On May 4th, CMS and the American Hospital Association will host a stakeholder call on the public health emergency (PHE) ending on May 11. Information will be shared and questions answered about Medicare waivers and flexibilities after the ending of the COVID-19 PHE.
  - **CMS Roundup:** On May 5th, CMS will release a Roundup highlighting agency initiatives and activities in a condensed, plain-language, reader-friendly narrative format with embedded links to

information on the CMS website for reference. The Roundup is distributed twice a month to media and stakeholders.

APPENDIX

- **Major announcements for potential POTUS involvement in the next 60 days (Cabinet agencies only):** N/A

- **Week ahead messaging:**
  - **CMS: Deferred Action for Childhood Arrivals (DACA)**
    - CMS proposed to expand health care for DACA recipients through the Affordable Care Act marketplaces, Medicaid, and the Children's Health Insurance Program.
    - Young people who come to this country—in many cases, the only country they have ever known as home—work hard to build their lives here, and they should be able to keep themselves and their families healthy.
    - The Biden-Harris Administration is committed to ensuring affordable, quality health care for all, and to providing DACA recipients the opportunities and support they need to succeed.
    - These changes support the goals of the Affordable Care Act (ACA) by increasing access to health coverage and improving the health and well-being of many DACA recipients who currently are without coverage.
    - If the rule is finalized as proposed, it could lead to 129,000 previously uninsured DACA recipients receiving health care coverage. Over the last decade, DACA has provided peace of mind and work authorization to more than 800,000 Dreamers.
    - The proposed rule, if finalized, would remove the current exclusion that treats DACA recipients differently from other individuals with deferred action who would otherwise be eligible for coverage under select CMS programs.
    - The proposed rule would amend the definition of "lawfully present" to include DACA recipients for the purposes of Medicaid and CHIP.
    - In effect, this would extend Medicaid and CHIP coverage to children and pregnant women in states that have elected the "CHIPRA 214" option for children and/or pregnant individuals, the Basic Health Program, and Affordable Care Act

Marketplace coverage. DACA recipients would need to meet all other eligibility requirements to qualify for coverage.
    - Additionally, DACA recipients would be eligible for financial assistance through the Marketplace such as advance payments of the premium tax credit and cost-sharing reductions if they meet all other eligibility requirements.
- **CMS: Public Health Emergency (PHE) Unwinding and Medicaid Redeterminations**
    - Based on current COVID-19 trends, the Department of Health and Human Services is planning for the federal Public Health Emergency (PHE) for COVID-19 to expire on May 11, 2023.
    - Thanks to the Administration's whole-of-government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from an emergency phase.
    - There are changes unrelated to the end of the PHE as to Medicaid redeterminations, as required by the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328), enacted on December 29, 2022. As required by law, the Medicaid continuous enrollment condition will end on March 31, 2023, and the temporary FMAP increase will be gradually reduced and phased down beginning April 1, 2023 (and will end on December 31, 2023). States may begin the process of initiating Medicaid eligibility redeterminations as early as February 1, 2023. Beginning April 1, 2023, states will be able to terminate Medicaid enrollment for individuals no longer eligible.
    - CMS is collaborating closely with state agencies, other federal agencies, and stakeholders to plan and prepare for the end of the continuous enrollment condition through regular workgroups, all-state calls, and individualized technical assistance. CMS has also provided states extensive guidance and resources over the past several months to help them make the transition back to normal operations. These resources are available and frequently updated on CMS' Medicaid unwinding/redeterminations webpage.
    - In light of the changes enacted in the CAA, 2023, on January 5, 2023, CMS released an informational bulletin that is the first in a series of guidance updates for states on the changes to FFCRA section 6008 and other amendments related to the

unwinding period. On January 29, 2023, CMS released a state health official (SHO) letter outlining new requirements in the CAA, 2023, that impact state activities for Medicaid and CHIP regarding the continuous enrollment condition. CMS also released information on a temporary Exceptional Circumstances Marketplace Special Enrollment Period (SEP) for consumers losing Medicaid/CHIP coverage due to unwinding of the continuous enrollment condition.

- From March 31, 2023, through July 31, 2024, Health Insurance Marketplaces® using the federal platform will be providing additional flexibility for eligible consumers to enroll in Marketplace coverage during and immediately following the end of the Medicaid continuous enrollment condition unwinding period. CMS is available to provide states with technical assistance as they begin to implement these changes and prepare for the end of the continuous enrollment condition.

- **Travel:** N/A

  Past Travel (Previous Week):

  Future Travel (Upcoming 3+ Weeks):
  - CMS: On May 1st, CMS' Jonathan Blum (Principal Deputy Administrator and Chief Operating Officer) will be traveling to Alaska. The visit will i3nclude time with the National Tribal Health Conference and stakeholder meetings.

- **Speeches:**
  - CMS: On April 24th, Jonathan Blum (Principal Deputy Administrator and Chief Operating Officer) participated in the American Hospital Association (AHA) Annual Membership Meeting. The meeting brings together members from across the country to provide industry updates, education, and an opportunity for networking.
  - CMS: On April 24th, Dr. Liz Fowler (Deputy Administrator and Director, Center for Medicare and Medicaid Innovation) met with Representative Doris (Sacramento, CA) Dr. Fowler will give Representative Matsui an overview of CMMI.

- CMS: On April 25th, Dr. Natalia Chalmers (Chief Dental Officer) participated in the Dental Trade Alliance Conference. The conference aims to educate Dental Trade Alliance members on federal policy and regulations in the interest of oral healthcare and how to advocate nationally. Dr. Chalmers will speak about the priorities of CMS and oral health initiatives across CMS.
- CMS: On April 25th, Dr. Meena Seshamani (Deputy Administrator and Director, Center for Medicare) participated in a fireside chat with the Association of Community Health Plans (ACHP) CEO Ceci Connolly on Medicare, including Medicare Advantage, the Inflation Reduction Act, the end of the COVID-19 public health emergency, and what these mean for ACHP member plans.
- CMS: On April 25th, Dr. Meena Seshamani (Deputy Administrator and Director, Center for Medicare) gave a pre-recorded fireside chat about Medicare Advantage for the Virtual Medicare Advantage Summit. Dr. Seshamani's session will air between April 25-28th.
- CMS: On April 27th, Jonathan Blum (Principal Deputy Administrator and Chief Operating Officer) will join the United States of Care on their 5-year anniversary as they convene an influential collective of trailblazers at the intersection of health care, policy and advocacy, and private sector innovation for a critical conversation to drive change for an equitable health care system.
- CMS: On April 27th, Dr. Lee Fleisher (Chief Medical Officer and Director, Center for Clinical Standards & Quality (CCSQ)) will participate in the Survey Executive Training Institute (SETI) 2023. Dr. Fleisher will speak at the annual meeting of all state agency directors in Baltimore and cover CCSQ's plans and priorities.
- CMS: On April 27th, Dr. Lee Fleisher (Chief Medical Officer and Director, Center for Clinical Standards & Quality (CCSQ)) will participate in Johns Hopkins Population Health Forum on the Care of Medicare Beneficiaries with Diabetes. Dr. Fleisher will be the keynote speaker.
- CMS: On April 27th, Dr. Dora Hughes (Chief Medical Officer, Center for Medicare and Medicaid Innovation (CMMI)) will participate in the Humanity Talent Network's (HTN) Virtual Summit: Advancing Equity Through Value-Based Care. The summit is a forum for senior healthcare and life sciences leaders

to engage in meaningful discourse around value-based care. It focuses on best practices in forming effective partnerships with other care givers or accountable care organizations (ACOs) to share data and enhance patient outcomes, leveraging patient data in order to align incentives with quality of care, and discusses effective rollouts of value-based care delivery plans and how to market your strategic differentiation vs fee-for-service plans. Dr. Hughes will be a keynote speaker.

- CMS: On April 27th, Dr. Liz Fowler (Deputy Administrator and Director, Center for Medicare and Medicaid Innovation (CMMI)) will participate in the National Academy of Medicine's (NAM) Action Collaborative on Decarbonizing the U.S. Health Sector Public Meeting. NAM was founded in 1970 as the Institute of Medicine (IOM), the National Academy of Medicine (NAM) is one of three academies that make up the National Academies of Sciences, Engineering, and Medicine (the National Academies) in the United States. Operating under the 1863 Congressional charter of the National Academy of Sciences, the National Academies are private, nonprofit institutions that work outside of government to provide objective advice on science, technology, and health.
- CMS: On April 28th, Dr. Lee Fleisher (Chief Medical Officer and Director, Center for Clinical Standards & Quality (CCSQ)) will participate in the Medical Device Manufacturers Association (MDMA) 2023 Annual Meeting. Dr. Fleisher will give a keynote on CMS updates and priorities.
- CMS: On May 1st, CMS Administrator Chiquita Brooks-LaSure will provide pre-recorded remarks for the 2023 CMS Quality Conference. This year's conference theme is "Building Resilient Communities - Having an Equitable Foundation for Equitable Health Care."
- CMS: On May 1st, Dr. Natalia Chalmers (Chief Dental Officer) will give the keynote address at the 2023 National Medicaid, Medicare, and Children's Health Insurance Program (CHIP) Oral Health Symposium on accelerating oral health equity for Medicaid, Medicare, and CHIP beneficiaries.
- CMS: On May 3rd, Dr. Liz Fowler (Deputy Administrator and Director, Center for Medicare and Medicaid Innovation (CMMI)) will participate in the Blue Venture Fund Annual Meeting. This

meeting is a gathering of healthcare industry professionals, investors, and startups to discuss trends and innovations in healthcare.

- CMS: On May 4th, Dr. Lee Fleisher (Chief Medical Officer and Director, Center for Clinical Standards & Quality (CCSQ)) and Dr. Michelle Schreiber (Director, Quality Measurement and Value-Based Incentives Group, CCSQ) will participate in the American College of Physicians (ACP) Performance Measurement Committee (PMC) Meeting. Dr. Fleisher and Dr. Schreiber will discuss the CMS Universal Foundation Initiative.
- CMS: On May 4th, Dr. Meena Seshamani (Deputy Administrator and Director, Center for Medicare) will participate in the National Association of Accountable Care Organizations (NAACOS) Spring Conference 2023. Dr. Seshamani will speak during the opening plenary session.
- CMS: On May 5th, Dr. Lee Fleisher (Chief Medical Officer and Director, Center for Clinical Standards & Quality), Dr. Meena Seshamani (Deputy Administrator and Director, Center for Medicare) and Dr. Liz Fowler (Deputy Administrator and Director, Center for Medicare & Medicaid Innovation) will participate in a moderated town hall-style program to discuss how the Institute for Healthcare Alliance network could better help CMS to lead change.
- CMS: On May 5th, Dr. Liz Fowler (Deputy Administrator and Director, Center for Medicare and Medicaid Innovation (CMMI)) will participate in the National Association of Accountable Care Organizations (NAACOS) Spring Conference 2023. Dr. Fowler will speak during a plenary session.
- CMS: On May 5th, Dr. Meena Seshamani (Deputy Administrator and Director, Center for Medicare) will speak at the University of Pennsylvania's Drug Pricing After the Inflation Reduction Act Conference. Dr. Seshamani will discuss CMS' progress in implementing the Medicare drug provisions in the Inflation Reduction Act.

- **Media:**
  - **CMS: Medicaid Redeterminations Second Virtual Regional Pen-and-Pad:** On/about May 1st, CMS will host a virtual pen-and-pad with reporters from select states (Connecticut, Colorado,

Kansas, Nebraska, Pennsylvania, Kentucky, Indiana, Utah, Ohio, Oklahoma, and Tennessee) to discuss Medicaid eligibility redeterminations as the continuous enrollment condition ends. This supports CMS' ongoing efforts to engage in national and regional media education about Medicaid and Children's Health Insurance Program redeterminations.

- **Principal level meetings or calls with Governors, Mayors, or other elected officials of note:** N/A

- **Noteworthy public engagement:**
  - **CMS: Quarterly National Stakeholder Call with CMS Administrator:** On April 25th, CMS Administrator Chiquita Brooks-LaSure, and her leadership team will provide an update on CMS' recent accomplishments and how the cross-cutting initiatives are advancing CMS' Strategic Plan. CMS serves the public as a trusted partner and steward dedicated to promoting health equity, expanding coverage, and improving health outcomes as we engage the communities we serve throughout the policymaking and implementation process.
  - **CMS: National Stakeholder Call on Public Health Emergency (PHE):** On April 25th, CMS will host a national stakeholder call on the public health emergency (PHE) ending on May 11. Information will be shared and questions answered about Medicare waivers and flexibilities after the ending of the COVID-19 PHE.
    - **Conversation with CMS Office of Minority Health (OMH) Leadership on Health Equity Engagements and Initiatives:** On April 27th, CMS will host a Conversation with CMS Office of Minority Health (OMH) Leadership on Health Equity. This event is an invitation-only virtual session. Dr. LaShawn McIver (Director, Office of Minority Health) and her leadership team will review prior feedback from stakeholders and provide updates on the CMS Health Equity Conference.
  -
  -

- **Principal level meetings or calls with Members of Congress:**

- CMS: On April 24th, Deputy Administrator and Director of the Innovation Center, Liz Fowler, met with Rep. Doris Matsui (D-CA), a delegation of Sacramento-area healthcare workers and stakeholders, who are visiting DC as part of their yearly Capitol-to-Capitol advocacy program, hosted by the Sacramento Metro Chamber.
- CMS: On April 24th, CMS Principal Deputy Administrator, Jonathan Blum met with Rep. Sanford Bishop (D-GA) to discuss the involuntary termination action taken against Pioneer Health of Central Georgia.
- CMS: On April 28th, Administrator Chiquita Brooks-LaSure will have a phone call with Sen. Tom Carper (D-DE) to discuss implementation of the drug price negotiation program in the Inflation Reduction Act (IRA).
-

- **Noteworthy inquiries from Congressional committees or Members of Congress; scheduled testimony by Secretary or Deputy Secretary:** N/A

- **Noteworthy rulemaking in the Federal Register:** N/A
  - Displayed: April 19, 2023: Notice of Benefit and Payment Parameters for 2024 Final Rule
  - CMS [target dates pending timely resolution of HHS & OMB comments]:
    - April 24, 2023: QHP Eligibility, Advance Payments of Premium Tax Credit, Cost-Sharing Reductions, BHP, Medicaid, and CHIP Proposed Rule
    - April 27, 2023: Access to Medicaid Services Proposed Rule
    - April 27, 2023: Medicaid Managed Care Proposed Rule
    - May 9, 2023: Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program Proposed Rule
    - May 22, 2023: Transitional Coverage for Emerging Technologies [TCET] Notice with Comment
    - May 26, 2023: Oversight of Accrediting Organizations and Preventing AO Conflict of Interest Proposed Rule
    - May 26, 2023: Hospital Medicare DSH Part C Days Final Rule

- **Funding Announcements:** N/A
- **Grant Notices (NOFA/NOFOs):** N/A

Message

From: Katch (she/her), Hannah (CMS/OA) (b)(6) (b)(6)

Sent: 3/20/2023 2:56:30 PM

To: OToole, Meghan (CMS/OA) (b)(6) (b)(6) Harris, Will (CMS/OA) (b)(6) (b)(6) Ellis (she/her), Kyla (CMS/OA) (b)(6) (b)(6); Richardson (she/her), Erin (CMS/OA) (b)(6) (b)(6) Yao, Kristiana (CMS/OA) (b)(6) (b)(6) Tesfaye, Eden (CMS/OA) (b)(6) (b)(6) Kaiser, Alyssa (CMS/OL) (b)(6) (b)(6)

Subject: OA Issues notes - week of 3/20

Attachments: CMCS Issues Meeting Agenda and Materials 3-20-23.pdf

CMCS Issues – 3.20.23

- **BHP – OR Issue**
  - Goal – enroll people in BHP-like program as an off-ramp to unwinding
    - Challenge – no clear path to BHP
  - CMCS/CCIIO recommendations
    - Bridge for people 133-200% FPL losing coverage during unwinding
    - Coverage through 1115 – in place April 2023 – July 2024
    - 1332 to establish a BHP lookalike – using passthrough funding for individuals over 200% FPL – starting in January 2026
    - 3 options included in the paper (attached)

(b)(5)

  - **Hub update (non-decisional)**
    - Reminder – the CSI service only available to states currently using it due to funding issues
    - MA, MT, RI – new ask to come in – because Equifax increased rates on their state contracts – additional states may come in with the same ask (in addition to HI and MD)
    - Current year funding unlikely to cover these states' use of the Hub for CSI pings

- **MO disallowance**
  - State SDPs includes a "hold harmless" arrangement
  - In 2020 – CMS sent a letter to MO with a 2021 date to transition their payments to allowable financing sources
  - In 2022, MO told CMS they no longer intend to honor the arrangement
  - Next step – review of provider tax structure – outlined in July 2022 letter from CMS to MO
  - Review final this week; $236M deferral for impermissible provider tax arrangement – amount calculated based on statutory requirements (per quarter)
    - Regulatory deadline – March 31
    - CMCS will call Medicaid director prior to the communication
  - **ACBL concurrence – she would like to call the Governor prior to the 3/31 letter (with Dan)**
    - Need OC and OL reactives

- Context:
  - MO has a hospital tax that is used to finance the non-federal share of certain Medicaid payments. Some or all of the tax-paying hospitals have entered into private arrangements under which they pool and redistribute those payments to ensure all hospitals recoup all or almost all of their tax amounts. Based on our interpretation of the statute, those arrangements violate the statutory prohibition against hold-harmless arrangements.
  - Over the past several years, CMS has been on the record indicating the impermissibility of this tax (see more detail below). However, details about the hold harmless arrangement were newly revealed to CMS over the past several years.
  - Last month, CMS released guidance affirming that hold harmless arrangements of this type violate the statutory prohibition on hold harmless.
  - Missouri and other states contend that our interpretation is inconsistent with the Medicaid statute and regulations, and Missouri specifically contends that CMS has known about and approved of its health care-related tax and related Medicaid payment redistribution arrangement for many years.
- CMS/HHS must decide how to move forward on enforcement action

(b)(5)

- After additional consultation with OGC, we are proposing:

(b)(5)

- The alternative we considered was i

(b)(5)

(b)(5)

(b)(5)

Additional background

CMS' concerns with the MO hold-harmless arrangement (b)(5)

(b)(5)

- Context:
  - MO has a hospital tax with a voluntary hold harmless arrangement between hospitals, which we believe violates the statutory requirement that provider taxes apply to facilities uniformly.
  - Over the past several years, CMS has been on the record indicating the impermissibility of this tax (see more detail below). However, details about the hold harmless arrangement were newly revealed to CMS over the past several years.
  - Last month, CMS released guidance affirming that hold harmless arrangements of this type violate the statutory prohibition on hold harmless.
- CMS/HHS must decide how to move forward on enforcement action

(b)(5)

- After additional consultation with OGC, we are proposing:

(b)(5)

- The alternative we considered was i (b)(5)

(b)(5)

Additional background

CMS' concerns with the MO hold-harmless arrangement (b)(5)

(b)(5)

Message

From: Katch (she/her), Hannah (CMS/OA) (b)(6)
(b)(6)
Sent: 2/14/2023 9:18:58 PM
To: Richardson (she/her), Erin (CMS/OA) (b)(6)
(b)(6) Wagner, Rachel (CMS/OC) (b)(6)
(b)(6) Aldana, Karen (CMS/OC) (b)(6)
(b)(6) Alexander, Bruce (CMS/OC) (b)(6)
(b)(6) Blum, Jonathan (CMS/OA) (b)(6)
(b)(6) Boulanger, Jennifer (CMS/OL) (b)(6)
(b)(6) Ellis (she/her), Kyla (CMS/OA) (b)(6)
(b)(6) Franklin, Julie (CMS/OC)
(b)(6)
(b)(6) Harris, Will (CMS/OA)
(b)(6)
(b)(6) Howden, Catherine (CMS/OC) (b)(6)
(b)(6) OToole, Meghan (CMS/OA) (b)(6)
(b)(6) Schinderle, Elizabeth (CMS/OC) (b)(6)
(b)(6) Toomey, Mary (CMS/OC)
(b)(6)
(b)(6) Woronoff, Arielle (CMS/OL) (b)(6)
(b)(6) Yao, Kristiana (CMS/OA)
(b)(6)
(b)(6)
CC: Dinges, Enrico (CMS/OC) (b)(6)
(b)(6) Trucil, Daniel (CMS/OC)
(b)(5)
(b)(6) Mauser, Gayle (CMS/OL)
(b)(6)
(b)(6)
Subject: RE: RE: For OA Review: Reactive statement-CIB on Health Care Related Taxes and Hold Harmless Arrangements
Attachments: Reactive CIB Health care related taxes and hold harmless Feb 13 4.30pm - hk.docx

Edits attached, and adding Gayle here too since I think the Hill will care about this one. I tried to simplify/beef up the language a bit – see what you think. Thanks!

From: Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>
Sent: Tuesday, February 14, 2023 4:14 PM
To: Wagner, Rachel (CMS/OC) <Rachel.Wagner@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Alexander, Bruce (CMS/OC) <Bruce.Alexander@cms.hhs.gov>; Blum, Jonathan (CMS/OA) <Jonathan.Blum@cms.hhs.gov>; Boulanger, Jennifer (CMS/OL) <Jennifer.Boulanger@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Franklin, Julie (CMS/OC) <Julie.Franklin@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Howden, Catherine (CMS/OC) <Catherine.Howden@cms.hhs.gov>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Schinderle, Elizabeth (CMS/OC) <elizabeth.schinderle@cms.hhs.gov>; Toomey, Mary (CMS/OC)

<Mimi.Toomey@cms.hhs.gov>; Woronoff, Arielle (CMS/OL) <Arielle.Woronoff@cms.hhs.gov>; Yao, Kristiana (CMS/OA) <Kristiana.Yao1@cms.hhs.gov>
Cc: Dinges, Enrico (CMS/OC) <Eric.Dinges@cms.hhs.gov>; Trucil, Daniel (CMS/OC) <Daniel.Trucil@cms.hhs.gov>
Subject: RE: For OA Review: Reactive statement-CIB on Health Care Related Taxes and Hold Harmless Arrangements

Nothing from me. Defer to Hannah on this one.

From: Wagner, Rachel (CMS/OC) <Rachel.Wagner@cms.hhs.gov>
Sent: Tuesday, February 14, 2023 3:41 PM
To: Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Alexander, Bruce (CMS/OC) <Bruce.Alexander@cms.hhs.gov>; Blum, Jonathan (CMS/OA) <Jonathan.Blum@cms.hhs.gov>; Boulanger, Jennifer (CMS/OL) <Jennifer.Boulanger@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Franklin, Julie (CMS/OC) <Julie.Franklin@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Howden, Catherine (CMS/OC) <Catherine.Howden@cms.hhs.gov>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Schinderle, Elizabeth (CMS/OC) <elizabeth.schinderle@cms.hhs.gov>; Toomey, Mary (CMS/OC) <Mimi.Toomey@cms.hhs.gov>; Woronoff, Arielle (CMS/OL) <Arielle.Woronoff@cms.hhs.gov>; Yao, Kristiana (CMS/OA) <Kristiana.Yao1@cms.hhs.gov>
Cc: Dinges, Enrico (CMS/OC) <Eric.Dinges@cms.hhs.gov>; Trucil, Daniel (CMS/OC) <Daniel.Trucil@cms.hhs.gov>
Subject: RE: For OA Review: Reactive statement-CIB on Health Care Related Taxes and Hold Harmless Arrangements

Hi all,

Pinging on this.

Could you please let us know if there are any edits?

Thank you,

Kindly,

Rachel A. Wagner, MS

Deputy Director
Media Relations Group (MRG) | Office of Communications (OC)
Centers for Medicare & Medicaid Services (CMS)
☎: (b)(6) (mobile)
rachel.wagner@cms.hhs.gov

Confidential and deliberative, pre-decisional communication

From: Wagner, Rachel (CMS/OC)
Sent: Monday, February 13, 2023 4:43 PM
To: Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Alexander, Bruce (CMS/OC) <Bruce.Alexander@cms.hhs.gov>; Blum, Jonathan (CMS/OA) <Jonathan.Blum@cms.hhs.gov>; Boulanger, Jennifer (CMS/OL) <Jennifer.Boulanger@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Franklin, Julie (CMS/OC) <Julie.Franklin@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Howden, Catherine (CMS/OC) <Catherine.Howden@cms.hhs.gov>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Schinderle, Elizabeth (CMS/OC) <elizabeth.schinderle@cms.hhs.gov>; Toomey, Mary (CMS/OC) <Mimi.Toomey@cms.hhs.gov>; Woronoff, Arielle (CMS/OL) <Arielle.Woronoff@cms.hhs.gov>; Yao, Kristiana (CMS/OA) <Kristiana.Yao1@cms.hhs.gov>

Cc: enrico.dinges@cms.hhs.gov; Trucil, Daniel (CMS/OC) <Daniel.Trucil@cms.hhs.gov>
Subject: For OA Review: Reactive statement-CIB on Health Care Related Taxes and Hold Harmless Arrangements

Hello OA colleagues,

Please find enclosed the Reactive Statement for the CIB on Health Care Related Taxes and Hold Harmless Arrangements. We are tracking this for Friday, 2/17.

Could you please provide any comments/edits by tomorrow at 11 AM?

Thank you,

Kindly,

Rachel A. Wagner, MS

Deputy Director
Media Relations Group (MRG) | Office of Communications (OC)
Centers for Medicare & Medicaid Services (CMS)
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Confidential and deliberative, pre-decisional communication

REACTIVE MEDIA STATEMENT

To promote greater transparency, program integrity, and opportunity for states to improve the operation of their Medicaid programs, the Centers for Medicare & Medicaid Services (CMS) released a Medicaid informational bulletin that clarifies federal requirements regarding health care-related taxes and closes an important loophole in Medicaid financing arrangements.

If states use of impermissible nonfederal share sources, it can artificially inflate federal Medicaid expenditures. If states use these arrangements to pay providers based on their ability to fund the nonfederal share, it can disconnect Medicaid payment from services, quality of care, health outcomes, and other program goals. This guidance closes a loophole that otherwise would permit states to redirect Medicaid payments away from Medicaid providers who serve a high share of Medicaid beneficiaries to providers who do not participate in Medicaid or have relatively lower Medicaid utilization.

The informational bulletin will clarify existing federal statutory and regulatory requirements and assist states in ensuring appropriate sources for the nonfederal share of financing, which is critical to protecting Medicaid's sustainability through responsible stewardship.

Additional Background:

- CMS has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs).

- This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed SDPs. Many of these questions have focused on whether health care related tax arrangements, involving the redistribution of Medicaid payments among providers subject to the tax, comply with the statutory and regulatory prohibition on hold harmless arrangements, as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations.

- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS remains committed to working with states on existing or possible arrangements that would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

Message

From: Wagner, Rachel (CMS/OC) (b)(6)
(b)(6)

Sent: 2/16/2023 6:39:31 PM

To: Aldana, Karen (CMS/OC) (b)(6)
(b)(6) Alexander, Bruce (CMS/OC) (b)(6)
(b)(6) Ciccone, Caroline (HHS/ASPA) (b)(6)
(b)(6) Franklin, Julie (CMS/OC)
(b)(6)
(b)(6) Howden, Catherine (CMS/OC) (b)(6)
(b)(6) Levin, Michael (HHS/ASPA) (b)(6)
(b)(6) Richardson (she/her), Erin (CMS/OA) (b)(6)
(b)(6) Schinderle, Elizabeth (CMS/OC) (b)(6)
(b)(6) Smalley, Elizabeth (HHS/ASPA) (b)(6)
(b)(6) Toomey, Mary (CMS/OC)
(b)(6)
(b)(6)

CC: Trucil, Daniel (CMS/OC (b)(6)
(b)(6) Hennessy, Amy (CMS/OC) (b)(6)
(b)(6) Dinges, Enrico (CMS/OC) (b)(6)
(b)(6)

Subject: For ASPA- Reactive statement-CIB on Health Care Related Taxes and Hold Harmless Arrangements

Attachments: CIB_Healthcare Related Taxes_DRAFT_02.15.2023.docx; Reactive CIB Health care related taxes and hold harmless Feb 16 1221pm.docx; CMS - Health Care Taxes CIB and FL Financial Management Review

Good afternoon, ASPA colleagues,

Enclosed is the latest Reactive Statement, reflecting all the changes requested from OA, CMCS, etc. We are also attaching the CIB for reference and last night's email on this topic where an earlier version was shared forward for awareness.

We are presently tracking this for tomorrow, Friday, Feb. 17 at 3 PM EST.

Please let us know if you have any questions.

Thank you,

Kindly,

Rachel A. Wagner, MS

Deputy Director
Media Relations Group (MRG) | Office of Communications (OC)
Centers for Medicare & Medicaid Services (CMS)
☎ (b)(5) (mobile)

rachel.wagner@cms.hhs.gov

Confidential and deliberative, pre-decisional communication

REACTIVE MEDIA STATEMENT

To promote greater transparency, program integrity, and opportunity for states to improve the operation of their Medicaid programs, the Centers for Medicare & Medicaid Services (CMS) released a Medicaid informational bulletin that reiterates its longstanding position on existing federal requirements regarding health care-related taxes and addresses a need for understanding Medicaid financing arrangements.

If states use impermissible nonfederal share sources, it can artificially inflate federal Medicaid expenditures. If states use these arrangements to pay providers based on their ability to fund the nonfederal share, it can disconnect Medicaid payment from services, quality of care, health outcomes, and other program goals. Additionally, the redistribution arrangements that are the subject of the informational bulletin involve redirecting Medicaid payments away from Medicaid providers who serve a high share of Medicaid beneficiaries to providers who do not participate in Medicaid or have relatively lower Medicaid utilization.

The informational bulletin reminds states of existing federal statutory and regulatory requirements and assists states in ensuring appropriate sources for the nonfederal share of financing, which is critical to protecting Medicaid's sustainability through responsible stewardship.

Additional Background:

- CMS has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs).
- This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed SDPs. Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax comply with the statutory and regulatory prohibition on hold harmless arrangements, as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act and implementing regulations.
- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS remains committed to working with states on existing or possible arrangements that would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

Message

From: Briskin, Perrie (CMS/CMCS) [(b)(6)]

Sent: 2/15/2023 11:49:28 PM

To: Pryor, Rachel (HHS/OS/IOS) [rachel.pryor@hhs.gov]

CC: Ciccone, Caroline (HHS/ASPA) [caroline.ciccone@hhs.gov]; Arguello, Andres (OS/IOS) [andres.arguello@hhs.gov]; Alexander, Bruce (CMS/OC) [bruce.alexander@cms.hhs.gov]; Wagner, Rachel (CMS/OC) [rachel.wagner@cms.hhs.gov]; Aldana, Karen (CMS/OC) [karen.aldana@cms.hhs.gov]; Trucil, Daniel (CMS/OC) [daniel.trucil@cms.hhs.gov]; Hennessy, Amy (CMS/OC) [amy.hennessy@cms.hhs.gov]; Katch (she/her), Hannah (CMS/OA) [hannah.katch@cms.hhs.gov]; Janu, Shanna (CMS/CMCS) [shanna.janu@cms.hhs.gov]; Dorsey, Jennifer (CMS/CMCS) [jennifer.dorsey@cms.hhs.gov]; Boston, Beverly (CMS/CMCS) [beverly.boston@cms.hhs.gov]; Kirchgraber, Kate (CMS/OL) [kate.kirchgraber@cms.hhs.gov]; Mauser, Gayle (CMS/OL) [gayle.mauser@cms.hhs.gov]; Hebert, Krista (CMS/CMCS) [krista.hebert@cms.hhs.gov]; Tsai, Daniel (CMS/CMCS) [daniel.tsai@cms.hhs.gov]; Costello, Anne Marie (CMS/CMCS) [annemarie.costello@cms.hhs.gov]; Vitolo, Sara (CMS/FCHCO) [sara.vitolo@cms.hhs.gov]; Howe, Rory (CMS/CMCS) [rory.howe@cms.hhs.gov]

Subject: CMS - Health Care Taxes CIB and FL Financial Management Review

Attachments: CIB_Healthcare Related Taxes_DRAFT_02.15.2023.docx; CIB_Healthcare Related Taxes Reactive_DRAFT_02.15.2023.docx; FL Companion Letter, 9-29-22.pdf; EC-FM-2023-FL-01-D Engagement Letter DRAFT.docx

Hi Rachel,

As we have discussed, CMS has three upcoming actions regarding healthcare related taxes.

1. **CMS Informational Bulletin (CIB) on healthcare related taxes** – release this Friday, February 17, 3pm
    a. Attached: CIB draft, CIB reactive statement draft.
    b. This will be posted to Medicaid.gov. CMS will send a listserv notice, no press release or social.
2. **Florida Financial Management Review (FMR) Notification related to the state's healthcare related taxes** – next Wednesday, February 22
    a. Attached: Letter draft, September 2022 letter to the state where CMS initially notified them that this FMR was coming.
    b. CMS will issue to the state of Florida a notification in the form of a letter to the state of an FMR of Florida's managed care state directed payments (SDPs) funded by the state's health-related tax (the same taxes highlighted by the CIB).
    c. CMS has until the end of this calendar year to issue a final FMR report.
    d. The letter is not public and will not be posted by CMS.
    e. The state was made aware of this forthcoming action last September (see 9-29-22 PDF attached) and is expecting CMS's letter. CMS staff will also alert Florida in advance this Friday of the letter to be sent to them next Wednesday.
    f. Reactive (Draft): "As a matter of policy, CMS does not speculate on active reviews."
3. **Missouri Question-Set Related in Advance of CMS-64 review, related to the state's healthcare related taxes** – next Wednesday, February 22
    a. Question-set to the state in advance of the focused CMS-64 review regarding any pooling/redistribution of funds issues. The focused CMS-64 review can result in a deferral if we find issues.
    b. The question set is not public and will not be posted by CMS.
    c. CMS staff will also alert Missouri in advance this Friday of the question-set to be sent to them next Wednesday.

I am cc'ing here ASPA and OC leadership to get everyone on the same thread. Everything is still in draft form, but we plan to only make minor tweaks at this point. See more information below on the Florida FMR and our rollout timeline.

Please let us know if you have any questions.

Thank you!

Best,
Perrie

More on the Florida FMR

On Wednesday, February 22, the Florida Deputy Secretary for Medicaid, Tom Wallace, will receive a letter notifying the state of the engagement by CMS of a Financial Management Review (FMR) of Florida's managed care state directed payments (SDPs) funded by its health-related tax. The state was previously made aware of this coming FMR in a companion letter issued as part of the SDP approval in September 2022 (attached). The FMR will review the state's operation of and supervision over its Local Provider Participation Fund (LPPF) health care-related tax program as a source of Florida's non-federal share. CMCS is aware that other states have similar hospital tax arrangements. The states appear to have pre-arranged agreements to redirect Medicaid payments away from Medicaid providers serving a high percentage of Medicaid beneficiaries to hospitals that either do not participate in Medicaid or serve a low percentage of beneficiaries. This payment redirection appears to violate federal requirements. Florida's LPPF tax structure and media reports indicate that the Florida LPPF arrangement may be similar to the other state arrangements. To date, Florida's Agency for Health Care Administration (AHCA) has been unable (or unwilling) to provide assurance that there is not an arrangement to redistribute Medicaid state directed payments.

Rollout Timeline

(1) ROLL-OUT – The CIB will be released on Friday by 3pm

- Friday 2/17 **– Prior to Taxes CIB being released, FMG will contact Florida Medicaid Director regarding engaging on a FMR** of Florida's managed care state directed payments (SDPs) funded by their health related tax. We did make the state aware in a companion letter issued as part of SDP approval in September 2022.
- Friday 2/17 – **Prior to Taxes CIB being released, FMG will contact the Missouri Medicaid regarding a focused CMS-64** review of the state's inpatient/outpatient Federal Reimbursement Allowance (FRA) hospital tax and will review expenditures for quarter ended 12/31/2022 .
- Friday 2/17 - **CIB RELEASED @3pm**

(2) State Follow-Up Actions Post Issuance of the Taxes CIB (Week of 2/20):

- On Weds 2/22 CMS will issue the FL FMR engagement letter to the state
- On Weds 2/22 CMS will issue a question-set to the state in advance of the focused CMS-64 review regarding any pooling/redistribution of funds issues.

Perrie Briskin
Policy Advisor, Office of the Center Director
Center for Medicaid and CHIP Services (CMCS)
Cell (b)(6)

REACTIVE MEDIA STATEMENT

To promote greater transparency, program integrity, and opportunity for states to improve the operation of their Medicaid programs, the Centers for Medicare & Medicaid Services (CMS) released a Medicaid informational bulletin that clarifies federal requirements regarding health care-related taxes and addresses an important need for understanding Medicaid financing arrangements.

If states use of impermissible nonfederal share sources, it can artificially inflate federal Medicaid expenditures. If states use these arrangements to pay providers based on their ability to fund the nonfederal share, it can disconnect Medicaid payment from services, quality of care, health outcomes, and other program goals. This guidance clarifies that states are not permitted to redirect Medicaid payments away from Medicaid providers who serve a high share of Medicaid beneficiaries to providers who do not participate in Medicaid or have relatively lower Medicaid utilization.

The informational bulletin will clarify existing federal statutory and regulatory requirements and assist states in ensuring appropriate sources for the nonfederal share of financing, which is critical to protecting Medicaid's sustainability through responsible stewardship.

Additional Background:

- CMS has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs).

- This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed SDPs. Many of these questions have focused on whether health care related tax arrangements, involving the redistribution of Medicaid payments among providers subject to the tax, comply with the statutory and regulatory prohibition on hold harmless arrangements, as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations.

- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS remains committed to working with states on existing or possible arrangements that

would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

September 29, 2022

Tom Wallace,
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Dear Director Wallace:

The Centers for Medicare & Medicaid Services (CMS) is providing this letter as a companion to the approval of Florida's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts (FL_Fee.IPH.OPH4_Renewal _20211001-20220930). CMS understands the important role of sustainable financing and support for safety net providers, including through use of Medicaid state directed payment and permissible health care-related taxes. However, CMS is concerned that the state's use of revenues derived from its Local Provider Participation Program (LPPF) tax program as a source of Florida's non-federal share for payments under this preprint may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act (the Act) and implementing regulations in 42 CFR 433.68(f)(3).

As we understand the LPPF arrangement, twenty-one cities or counties impose health care-related taxes on gross or net inpatient and/or outpatient hospital service revenue at a rate of less than six percent. These revenues provide the state with the source of funding for the non-federal share of payments for hospital services that support increased payments to hospitals. Recently, CMS has become aware that other states have similar hospital tax arrangements in connection with which there appear to be pre-arranged agreements to redirect Medicaid payments away from Medicaid providers serving a high percentage of Medicaid beneficiaries to hospitals that do not participate in Medicaid or that serve a low percentage of Medicaid beneficiaries. Florida's LPPF tax structure and media reports indicate that the Florida LPPF arrangement may be similar to other states' arrangements that appear to violate federal requirements. To date, Florida's Agency for Health Care Administration (AHCA) has been unable to provide assurance that there is not an arrangement to redistribute Medicaid state directed payments.

These pre-arranged agreements identified in other states appear to occur with varying levels of state knowledge or direction. Such arrangements appear designed to ensure that participating hospitals are held harmless for all or a portion of their hospital tax costs, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 CFR 433.68(f)(3).

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, Section 1903(w)(4)(C) states that "the State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Implementing regulations at 42 CFR 433.68(f)(3) state that a

hold harmless arrangement exists where a state imposing a healthcare-related tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax," 73 Federal Register 9694-9695 (Feb. 22, 2008) (confirming proposed rule preamble statement in 72 Federal Register 13730 (Mar. 23, 2007)).

CMS stated that the addition of the word "indirectly" in the regulation indicates that the state itself need not be involved in the actual redistribution of Medicaid funds for the purpose of making taxpayers whole in order for the arrangement to qualify as a hold harmless. CMS further explained in the same preamble that we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless," 73 Federal Register 9694. Therefore, hold harmless arrangements are not always overtly established through state law but can be based instead only on reasonable expectations of certain actions among entities participating in the hold harmless arrangement.

As a result, an arrangement in which hospitals receive Medicaid payments from the state, then redistribute those payments with an aim of holding taxed providers harmless for all or any portion of their cost of the tax would constitute a hold harmless under section 1903(w)(4) of the Act and 42 CFR 433.68(f). Section 1903(w)(1)(A)(iii) of the Act and 42 CFR 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements.

CMS requested information from Florida to ensure that its hospitals do not have pre-arranged agreements to redirect or redistribute Medicaid state directed payments as part of a hold harmless arrangement. In a September 21, 2022 letter, AHCA offered an assurance that it "is unaware of any arrangement between the State or another unit of government and a taxpaying entity involving a payment, offset, or waiver imposing any offset falling within the ambit of § 433.68(f)." This limited assurance differed from previous communication on assurances provided by the state on August 10, 2022. While CMS appreciates that AHCA asserts it is unaware of such an arrangement, this assurance does not address whether hospitals participate in a hold harmless arrangement without state knowledge using Medicaid state directed payments, which include federal Medicaid matching funds.

CMS recognizes that the statute clearly permits certain health care-related taxes and supports states' adoption of these non-federal financing strategies where consistent with federal legal requirements. CMS approves hundreds of state payment proposals annually that are funded by health care-related taxes that appear to meet statutory requirements. All health care-related taxes must be imposed in a manner consistent with applicable federal statutes and regulations and cannot include direct or indirect hold harmless arrangements.

CMS takes its responsibility for financial oversight of the Medicaid program seriously to ensure its long-term health and financial stability. CMS remains committed to ensuring that the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section 1903(w)(4) of the Act and federal regulations at 42 CFR 433.68(f)(3). At this time, CMS intends to conduct a focused review of the state's LPPF program during Federal Fiscal Year 2023. Should CMS determine that the LPPF tax program involves a hold harmless arrangement, we intend to initiate formal action to reduce the state's medical assistance expenditures before calculating federal financial participation (FFP), as required by section 1903(w)(1)(A)(iii) of the Act. Please note that CMS may seek to recover FFP based on the results of this review, another CMS review, or a review

by another oversight entity (such as the Department of Health and Human Services Office of Inspector General or the Single State Auditor).

CMS recognizes the invaluable role that safety net hospitals play as a critical part of our nation's healthcare infrastructure and as an indispensable asset for ensuring that the most vulnerable in our society receive quality, affordable health care in a timely manner. CMS is available to continue discussions with Florida to ensure its sources of non-federal share meet all applicable federal requirements. CMS is also ready to provide additional technical assistance, including on utilizing health care-related taxes, exploring options for the use of statutorily-permitted tax waivers of broad based and/or uniformity requirements, and ensuring that financing mechanisms are compliant with federal requirements.

Sincerely,

Rory C. Howe -S

Digitally signed by Rory C. Howe -S
Date: 2022.09.29 12:49:21 -04'00'

Rory Howe
Director
Financial Management Group
Center for Medicaid and CHIP Services

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

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

Financial Management Group
Division of Financial Operations East

January XX, 2023

Thomas J. Wallace
Deputy Secretary of Medicaid
Agency of Health Care Admin
2727 Mahan Drive
Tallahassee, FL 32308

Re: Notification of Financial Management Review - Use of Local Provider Participation Funds as a Source of the non-Federal share in the State Directed Payment Program Under Medicaid Managed Care (FY 2022), Control Number EC-FM-2023-FL-01-D

Dear Mr. Wallace:

The purpose of this letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) will perform a Financial Management Review (FMR) which will take place over the next several months. The review will focus on Florida's Medicaid Managed Care State Directed Payments (SDP) for federal fiscal year 2022 approved on September 29, 2022 (FL_Fee.IPH.OPH4_Renewal_20211001-20220930) and the state's use of revenues derived from its Local Provider Participation Program (LPPF) tax program as a source of Florida's non-federal share. In conjunction with the approval of this SDP, CMS issued a companion letter to the state identifying concerns that the LPPF tax program may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act (the Act) and implementing regulations in 42 CFR 433.68(f)(3). The companion letter also informed Florida that CMS intended to conduct the FMR described in this letter during Federal Fiscal Year 2023.

As we understand the LPPF arrangement, twenty-one cities or counties impose health care-related taxes on gross or net inpatient and/or outpatient hospital service revenue at a rate of less than six percent. These revenues provide the state with the source of funding for the non-federal share of payments for hospital services that support increased payments to hospitals. Recently, CMS has become aware that other states have similar hospital tax arrangements in connection with which there appear to be pre-arranged agreements to redirect Medicaid payments away from Medicaid providers serving a high percentage of Medicaid beneficiaries to hospitals that do not participate in Medicaid or that serve a low percentage of Medicaid beneficiaries. Florida's LPPF tax structure and media reports indicate that the Florida LPPF arrangement may be similar to other states' arrangements that appear to violate federal requirements. To date, Florida's

Agency for Health Care Administration (AHCA) has been unable to provide assurance that there is not an arrangement to redistribute Medicaid state directed payments.

The FMR's primary objectives will be to (1) examine whether the state's source of non-federal share including the LPPF tax program complies with Federal statute and regulations and (2) determine if the SDPs are properly calculated and made in accordance with the approved managed care preprints and implemented in alignment with regulatory requirements. At this time, we expect this review will be performed remotely, however, if there is a need for any on-site work related to this review, we will advise you and coordinate any on-site activity.

We will review SDPs for the fiscal quarters beginning October 1, 2021 and ending September 30, 2022. Attached to this letter is a preliminary information request list. This list is not all-inclusive, and we may request additional information necessary as the review progresses. Please provide the requested materials and responses by MMMM DD, YYYY. We request all information be provided to us in electronic format via email or through the use of a secure network, BOX. CMS will grant state staff providing requested documentation access to BOX. CMS has obtained contractor support to assist us with this review. The contractor is the National Opinion Research Center (NORC). The NORC team will be involved with all aspects of this review.

We plan to conduct an entrance meeting and start our review work during the week of MMMM DD, 2023. Please respond to this letter with your availability during this period and provide a liaison to coordinate with us on this review. We will contact your staff to coordinate meetings, obtain information, and to hold any discussions relating to this review as it progresses. At the completion of the review, we will schedule an exit conference and provide the state the chance to respond to any potential findings or observations prior to development of a draft report. We will consider the state's input in preparation of the draft report. We anticipate the issuance of the draft report to the state by the end of calendar year 2023. The state will then have 30 days to formally respond to the draft report. Afterwards a final report will be issued that will incorporate the state's response to any findings, observations, and recommendations including CMS comments to the state's response.

If you have any questions or concerns about our review, please contact Ricardo Holligan, Branch Chief, at 212-616-2424, email [HYPERLINK

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2023%20FMG%20Joint%20Clearance/Ricardo.Holligan@cms.hhs.gov"], or Sidney Staton 850-878-3486, email Sidney.Staton@cms.hhs.gov. Please refer to control number EC-FM-2023-FL-01-D in all correspondence. Additionally, please include our contractor, NORC, at [HYPERLINK "mailto:MedicaidFMR@norc.org"] in all email correspondence relating to this review. We appreciate your assistance in this review.

Sincerely,

Robert Lane
Director, Division of Financial Operations East

Message

From: McLemore, Monica (CMS/OSORA) [redacted]

Sent: 1/12/2023 3:30:16 PM

To: Alexander, Bruce (CMS/OC) [redacted]; Boulanger, Jennifer (CMS/OL) [redacted]; Cantwell, Kathleen (CMS/OSORA) [redacted]; Chalmers, Natalia (CMS/OA) [redacted]; CMS OA Book [redacted]; Corrigan, Dara (CMS/CPI) [redacted]; Costello, Anne Marie (CMS/CMCS) [redacted]; Ellis (she/her), Kyla (CMS/OA) [redacted]; Engelhardt, Tim (CMS/FCHCO) [redacted]; Fisher, Barbara (HHS/OGC) [redacted]; Fleisher, Lee (CMS/CCSQ) [redacted]; Fowler (she/her), Liz (CMS/CMMI) [redacted]; Greene, Mary (CMS/OBRHI) [redacted]; Harris, Will (CMS/OA) [redacted]; Hoffman, Janice (HHS/OGC) [redacted]; Katch (she/her), Hannah (CMS/OA) [redacted]; Lynk, Beth (CMS/OC) [florence.lynk@cms.hhs.gov]; Montz, Ellen (CMS/CCIIO) [redacted]; Oconnor, Nancy (CMS/OPOLE) [redacted]; Oelschlaeger, Allison (CMS/OEDA) [redacted]; Richardson (she/her), Erin (CMS/OA) [redacted]; Seshamani, Meena (CMS/OA) [redacted]; Shaw, Alita (CMS/OL) [redacted]; Spitalnic, Paul (CMS/OACT) [redacted]; Stahlman, Mary Ellen (CMS/OL) [redacted]; Truffer, Christopher (CMS/OACT) [redacted]; Tsai, Daniel (CMS/CMCS) [redacted]; Woronoff, Arielle (CMS/OL) [redacted]

CC: [redacted]; Yao, Kristiana (CMS/OA) [redacted] Abbott, Linda B (CMS/OSORA) [redacted]; Briskin, Perrie (CMS/CMCS) [redacted]; Croston, Diane (CMS/OACT) [redacted] Edmondson-Parrott, Michele (CMS/OSORA [redacted]; Forrester, Shelia (HHS/OGC) [Shelia.Forrester@hhs.gov]; Harshman, Sara (CMS/CMCS) [redacted] Hitchcock, Angela (CMS/OA) [redacted]; Hitchcock, Katherine (CMS/OEDA) [redacted] Jackson, Marilyn (CMS/OSORA) [redacted]; Keene, Danyail (CMS/OL) [redacted]; Khan, Farooq (CMS/OSORA) [redacted]; Lee, Doris (HHS/OGC) [redacted] McClenathan, Jane (CMS/CMCS) [redacted]; McLemore, Monica (CMS/OSORA) [redacted]; Miller, Ruth-Sam (CMS/OSORA) [redacted]; Moore, Cathy (CMS/OSORA) [redacted]; Parker, Don (HHS/OGC) [redacted]; Reynolds, Kerrian (CMS/OSORA) [redacted]; Richmond, Carly (CMS/OSORA) [redacted]; Smith, Mary (HHS/OGC) [Mary.Smith@HHS.GOV]; Teal, Lela (CMS/CMCS) [redacted] Terry (She/Her), Tequila (CMS/CMMI) [redacted] Vitolo, Sara (CMS/FCHCO) [redacted]

Subject: CMCS Issues Meeting Materials 1.13.22

Attachments: CMCS Materials Issues Meeting 1.13.23.pdf

Leadership encourages your active participation in the discussion when topics are relevant to the work of your Office or Center.

****

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Office of Strategic Operations and Regulatory Affairs

January 12, 2023

To: Chiquita Brooks-LaSure
Administrator

Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer

Through: Kathleen Cantwell
Director

From: Monica McLemore
Program Coordinator

SUBJECT: CMCS Issues Meeting: Administrator Level
DATE: January 13, 2023
TIME: 1:00 PM – 2:00 PM
PLACE: 314G; Zoom
https://cms.zoomgov.com/[(b)(6)]?pwd=d2xZeGVERUtzWFlmY0xyYzl1QmNsdz09

IRA-Related Policies: No

Participants: OA: Erin Richardson, Kyla Ellis, Hannah Katch, Will Harris, Kristiana Yao, Natalia Chalmers; CMCS: Dan Tsai, Anne Marie Costello, Sara Vitolo; CM: Meena Seshamani; CCIIO: Ellen Montz; CCSQ: Lee Fleisher; OGC: Janice Hoffman; Barbara Fisher; OL: Arielle Woronoff, Jennifer Boulanger, Mary Ellen Stahlman; OSORA: Kathleen Cantwell; OC: Bruce Alexander; OACT: Paul Spitalnic, Chris Truffer; EPM: Megan Curran; FCHCO: Tim Engelhardt; OMH: LaShawn McIver; CMMI: Liz Fowler; CPI: Dara Corrigan; OPOLE: Nancy O'Connor; OBRHI: Mary Greene; OEDA: Allison Oelschlaeger

Purpose: This meeting is being held to brief you and request your guidance on the items below.

Agenda:

Decision Item:

1. **Section 1115 Justice-Involved Amendment to California Advancing & Innovating Medi-Cal**

Seeks concurrence on approval of an amendment to the section 1115 demonstration "California Advancing and Innovating Medi-Cal (CalAIM)," which would be the first approval to provide limited Medicaid coverage to certain incarcerated individuals for up to 90 days immediately prior to the beneficiary's expected date of release, in accordance with section 1115(a) of the Social Security Act. With this amendment, CMS is also approving federal matching funds for Designated State Health Programs that California will use, going forward, to partially support the Providing Access and Transforming Health program that was approved as part of CalAIM on December 29, 2021. In addition, California's budget neutrality methodology will be updated for

consistency with current CMS policy regarding coverage of services to address Health-Related Social Needs for the state's previously approved recuperative care and short-term post-hospitalization services.

- Decision deadline: January 13, 2023
- Briefer: Mehreen Rashid
- Page 1
- IRA-Related Policies: No

Informational Items:

2. **CMCS Information Bulletin (CIB) on Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments**
   Overview of an upcoming CIB to states reiterating certain federal statutory and regulatory requirements that pertain to health care-related taxes. Recently, CMS has discovered a few states with health care-related tax programs that appear to involve impermissible agreements among providers to redistribute their Medicaid payments to hold all taxpayers harmless for the cost of the tax. The CIB reminds states that such arrangements are prohibited by the statute and regulations, and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.
   - Action: No action needed; informational only
   - Briefer: Rory Howe
   - Page 7
   - IRA-Related Policies: No

3. **CMCS Issues Follow-up Items** – None at this time.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Office of Strategic Operations and Regulatory Affairs

January 12, 2023

To: Chiquita Brooks-LaSure
Administrator

Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer

Through: Kathleen Cantwell
Director

From: Monica McLemore
Program Coordinator

SUBJECT: CMCS Issues Meeting: Administrator Level
DATE: January 13, 2023
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IRA-Related Policies: No

Participants: OA: Erin Richardson, Kyla Ellis, Hannah Katch, Will Harris, Kristiana Yao, Natalia Chalmers; CMCS: Dan Tsai, Anne Marie Costello, Sara Vitolo; CM: Meena Seshamani; CCIIO: Ellen Montz; CCSQ: Lee Fleisher; OGC: Janice Hoffman; Barbara Fisher; OL: Arielle Woronoff, Jennifer Boulanger, Mary Ellen Stahlman; OSORA: Kathleen Cantwell; OC: Bruce Alexander; OACT: Paul Spitalnic, Chris Truffer; EPM: Megan Curran; FCHCO: Tim Engelhardt; OMH: LaShawn McIver; CMMI: Liz Fowler; CPI: Dara Corrigan; OPOLE: Nancy O'Connor; OBRHI: Mary Greene; OEDA: Allison Oelschlaeger

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federal matching funds for Designated State Health Programs that California will use, going forward, to partially support the Providing Access and Transforming Health program that was approved as part of CalAIM on December 29, 2021. In addition, California's budget neutrality methodology will be updated for consistency with current CMS policy regarding coverage of services to address Health-Related Social Needs for the state's previously approved recuperative care and short-term post-hospitalization services.

- Decision deadline: January 13, 2023
- Briefer: Mehreen Rashid
- Page 1
- IRA-Related Policies: No

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   - Action: No action needed; informational only
   - Briefer: Rory Howe
   - Page 7
   - IRA-Related Policies: No

3. **CMCS Issues Follow-up Items** – None at this time.

Decision Item for Administrator

1. **Section 1115 Justice-Involved Amendment to California Advancing & Innovating Medi-Cal**

   - **OA Decision Needed By:** January 13, 2023
   - **Target Release Date:** January 20, 2023
   - **IRA-Related Policies:** No
   - **CMS Cross-Component Coordination:** N/A
   - **Issue Summary:** Seeks concurrence on approval of an amendment to the section 1115 demonstration "California Advancing and Innovating Medi-Cal (CalAIM)," which would be the first approval to provide limited Medicaid coverage to certain incarcerated individuals for up to 90 days immediately prior to the beneficiary's expected date of release, in accordance with section 1115(a) of the Social Security Act. With this amendment, CMS is also approving federal matching funds for Designated State Health Programs (DSHP) that California will use, going forward, to partially support the Providing Access and Transforming Health program that was approved as part of CalAIM on December 29, 2021. In addition, California's budget neutrality methodology will be updated for consistency with current CMS policy regarding coverage of services to address Health-Related Social Needs (HRSN) for the state's previously approved recuperative care and short-term post-hospitalization services.
   - **Policy Goals:** Approval of this demonstration amendment will meet the Administration's section 1115 policy priorities to enhance/expand coverage; improve access; promote health equity; improve quality; and reduce health disparities. This demonstration will align with forthcoming CMS guidance in a State Medicaid Director Letter that will describe a demonstration opportunity to support community reentry and improvement in care transitions for individuals who are incarcerated and soon-to-be released (referred to as the "Reentry Demonstration Opportunity"), as directed by section 5032(b) of the SUPPORT Act.
   - **Background/Context:** The CalAIM demonstration was approved on December 29, 2021, as an extension of the state's previous Medi-Cal 2020 demonstration, to help address many of the complex challenges facing California's most vulnerable residents, including individuals who are homeless and those with limited behavioral health care access, children with complex medical conditions, and the growing justice-involved population with significant clinical needs. Under the CalAIM demonstration, CMS approved the PATH program to provide transitional funding to enable the state to support continuity of services, as well as efforts to maintain and support the provider and community-based organization (CBO) capacity. The approved PATH expenditures include support for planning and development activities for the pre-release eligibility education, application support, and enrollment assistance activities under the reentry

demonstration initiative under this amendment. The approved demonstration also includes expenditure authority for short-term post-hospitalization housing and recuperative care services delivered by managed care plans, and continued expenditure authority to allow federal financial participation (FFP) for expenditures for Medi-Cal services provided to beneficiaries who are short-term residents of Institutions for Mental Diseases (IMDs) receiving Drug Medi-Cal Organized Delivery System (DMC-ODS) program services for SUD treatment.

In the December 2021 approval letter, CMS indicated that discussions were continuing with the state on its pending request related to services and supports for justice-involved adults and youth. Additionally, in the December 2021 approval letter, CMS committed to continuing to review the state's proposal for DSHP.

- **Option(s)/Recommendation(s):** (b)(5)

(b)(5)

CMS is requiring, as a condition of approval of this demonstration amendment, that California make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the facilities in which the demonstration is

functioning. Without outreach and support to assist all interested individuals to apply for Medicaid coverage or renewal, it is generally not possible to assess who "may be eligible" for Medicaid and limit outreach and enrollment support to a subset of inmates. Upon an individual entering a correctional facility, California will suspend, not terminate, Medicaid eligibility. If an individual is not enrolled in Medicaid when entering a correctional facility, California will ensure that the individual receives assistance with completing and submitting a Medicaid application, unless the individual voluntarily refuses such assistance.

Under the reentry demonstration initiative, California expects to achieve the following goals:

- **Increase coverage, continuity of coverage, and appropriate service uptake** through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
- **Improve access to services** prior to release and improve transitions and continuity of care into the community upon release;
- **Improve coordination and communication** between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;
- **Increase additional investments in health care and related services**, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release;
- **Improve connections between carceral settings and community services** upon release to address physical health, behavioral health, and health-related social needs;
- **Provide intervention** for certain behavioral health conditions with stabilizing medications like injectable long-acting anti-psychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, overdose, and deaths from overdose and suicide in the near-term post-release; and
- **Reduce post-release acute care utilizations such as emergency department (ED) visits and inpatient hospitalizations and all-cause deaths** among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care post-release.

California will be required to submit for CMS approval a Reentry Initiative Implementation Plan and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing state funding for carceral health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

Designated State Health Programs (DSHP)

In December 2017, CMS issued SMDL #17-005, titled "Phase-out of Expenditure Authority for Designated State Health Programs in Section 1115 Demonstrations," in

which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP. CMS has rescinded this previous guidance, effective December 23, 2022, and is implementing an updated approach to DSHP as discussed below and as reflected in other recent section 1115 demonstration approvals. CMS has decided to approve section 1115 demonstrations that provide federal funding for DSHPs, with defined criteria. These approvals will limit both the size and scope of DSHP, and apply additional parameters and guardrails. Federal expenditure authority for DSHP will be provided only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services.

As stated in our December 2021 approval letter, CMS pledged to continue reviewing the state's DSHP request and has now completed that review. With this amendment, CMS is approving authority for federal funds for DSHP to support prospective expenditures for certain portions of the PATH program that were approved in the December 2021 approval of CalAIM. CMS will generally not approve DSHP requests for expenditures associated with initiatives that are already approved. As with other recent DSHP approvals, the state can seek federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose.

- As a condition of approval for expenditure authority for DSHP, the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care by closing the gap between Medicaid and Medicare rates by at least 2 percentage points, should the state's average Medicaid to Medicare provider rate ratio be below 80 percent in any of these categories. For California, at this time, Medicaid fee-for-service provider base payment rates for primary care and obstetrics care, along with Medicaid managed care payment rates for obstetrics care, are below 80 percent of Medicare rates and must be increased. In addition, California will further increase the fee-for-service and managed care provider rates for obstetrics care up to 10 percentage points, equivalent to $22 million (total computable) per year for a commitment of 3 years.

- **Estimated Financial Impact of Policy:** Under section 1115(a) demonstration authority, states can establish demonstrations to test innovative approaches that are likely to advance the objectives of Medicaid. CMS has long required that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been without the demonstration. CMS has determined that this demonstration is projected to be budget neutral to the federal government.

  With this amendment, CMS is modifying certain aspects of the budget neutrality approach described in a 2018 budget neutrality SMD Letter, in an attempt to better support state innovation, while maintaining its commitment to fiscal integrity. These changes are consistent with recent budget neutrality policy changes approved in Arizona,

Arkansas, Massachusetts, and Oregon. CMS is making several changes that are intended to give states greater access to funding, including "savings" from prior approval periods, while still maintaining fiscal integrity. CMS is now treating two HRSN expenditures – recuperative care (medical respite) and short-term post-hospitalization services, previously referred to as community supports – as "hypothetical" for purposes of California's budget neutrality calculation. CMS is applying a special budget neutrality spending cap to HRSN services expenditures newly considered hypothetical and an additional sub-cap to HRSN infrastructure expenditures. Lastly, CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations in which expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration.

Taken together, CMS considers this a more rational, transparent and standardized approach to the treatment of expenditures that can be addressed during the course of a demonstration, with the effects of strengthening fiscal accountability, and lowering financial vulnerability for the state.

Monitoring and Evaluation: Consistent with CMS requirements for section 1115 demonstrations, the state is required to conduct systematic monitoring and robust independent evaluation of the demonstration, including the policies and initiatives approved through this amendment, per applicable CMS guidance and technical assistance. For evaluation of the reentry initiative, for example, in alignment with the stated goals described above, the state must assess the initiative's impacts on beneficiary outcomes such as coverage and enrollment, preventive and routine physical and behavioral health care utilization, avoidable emergency department visits and inpatient hospitalizations, all-cause deaths, as well as decompensation, overdose, and overdose and suicide deaths in the period soon after release. To the best extent feasible, the state will be expected to collect necessary data to support demographically stratified analyses to provide a fuller understanding of existing disparities in access and quality and any potential improvements resulting from the demonstration policies.

- **Health Equity Impacts:** This amendment will assist in ensuring continuity of health coverage and care for justice-involved populations, which is expected to support California significantly in reducing its health disparities. This group of low-income adults and youth is composed disproportionately of people of color who have considerable health care needs but who are often without care and needed medications upon release due to gaps in enrollment processes and limitations on the services Medicaid is eligible to pay for during incarceration. Individuals leaving incarceration are particularly at risk for poor health outcomes— justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of violence, overdose, and suicide than are

people who have never been incarcerated.[1] This demonstration will support individuals preparing for reentry after incarceration by connecting them to needed medical care and care coordination, and providing needed prescription medication for the first 30 days post-release, thereby promoting access to Medicaid coverage in the post-release period.

- **Anticipated Stakeholder Reaction:** CMCS anticipates stakeholder support for approval of this amendment. The state and advocates in support of the policy notes the importance of in-reach services for justice-involved populations to ease reentry and reduce barriers to Medicaid services, as well as the need for 90 days of coverage of pre-release services to effectively coordinate care. Advocates also highlight that coverage of pre-release services would promote continuity of care and timely access of care for justice-involved populations, help address social needs through care coordination with community-based supports, and have the potential to enhance health outcomes and reduce recidivism.

- **Anticipated Congressional Reaction/ Topics of Significant Interest to Congress:** We expect there will be significant congressional interest in this approval as it represents a first-of-its-kind section 1115 reentry demonstration initiative, focused on certain justice-involved individuals. The related guidance required under Section 5032 of the SUPPORT Act has also generated a lot of Congressional and advocate interest. This guidance has not yet been issued and will likely not be issued at the time of this demonstration amendment approval. Members of Congress recently inquired about when this guidance will be issued, and when CMS will respond to other states' pending section 1115 demonstration requests that seek to authorize Medicaid coverage of pre-release services; approval of California's demonstration is likely to generate renewed interest and questions about whether those states' proposals will be approved.

- **OGC Analysis:** OGC has provided significant feedback and input on this demonstration amendment, which CMCS has generally accepted. As such, OGC has not flagged major issues with this demonstration amendment.

- **Related External Rollout, Including Messaging:** TBD

- **Attachments/Additional Information:** N/A

[1] For example, see: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration#:~:text=Studies%20have%20shown%20that%20when,%2C%20hepatitis%20C%2C%20and%20HIV; https://www.ncdhhs.gov/news/press-releases/2022/03/21/north-carolina-reports-40-increase-overdose-deaths-2020-compared-2019-ncdhhs-continues-fight-against; https://www.publichealth.columbia.edu/public-health-now/news/incarceration-strongly-linked-premature-death-us.

Informational Item for Administrator

2. CMCS Information Bulletin on Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

- **Issue Summary:** Overview of an upcoming CMCS Information (CIB) to states reiterating certain federal statutory and regulatory requirements that pertain to health-care related taxes. Recently, CMS has discovered a few states with health care-related tax programs that appear to involve impermissible agreements among providers to redistribute their Medicaid payments to hold all taxpayers harmless for the cost of the tax. The CIB reminds states that such arrangements are prohibited by the statute and regulations and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

- **Target Release Date:** January 23, 2023

- **IRA-Related Policies:** No

- **CMS Cross-Component Coordination:** N/A

- **Background/Context:** Over the past few years, it appears that health care-related tax programs with problematic hold harmless arrangements are starting to proliferate nationally. Several states have been imposing taxes on health care providers to finance the non-federal share of Medicaid expenditures, known as health care-related taxes, that contain impermissible arrangements whereby providers are guaranteed to receive a portion of their tax cost back. These arrangements occur when certain high-Medicaid volume providers redistribute a portion of their Medicaid payments to low-Medicaid volume providers to hold the latter harmless for the cost of the tax and ensure that they are not harmed financially. This arrangement often occurs to garner political support from low-Medicaid volume providers to impose the tax as part of the state legislative process. CMS has been encountering this issue more recently as part of reviewing the sources of non-federal share financing for Medicaid managed care state-directed payments (SDPs).

  Some of these states claim that because the state is not directly involved in running these redistribution arrangements, it is not the responsibility of the state or CMS to ensure that they are not in place. Essentially, states argue that the redistribution arrangements are private business arrangements involving third parties that cannot be regulated. (b)(5)

  (b)(5)

  The CIB aims to ensure that states clearly understand the existing requirements so that they can develop approvable methodologies and make modifications as necessary to

come into compliance with federal requirements.

- **Major Issues and Policy Goals:** CMCS intends to release the CIB to clarify the impermissibility of these redistribution arrangements, as it relates to health care-related taxes. This CIB reiterates existing statutory and regulatory requirements and does not establish new policy. The recent discovery of the possible proliferation of these types of arrangements in several states such as Texas, Florida, Missouri, North Carolina, and Nevada have shown that this clarification is warranted to stem the proliferation of these arrangements.

  The CIB supports the strategic pillar of protecting our programs' sustainability for future generations by serving as a responsible steward of public funds. Ensuring permissible non-federal share sources is critical to this goal. State use of impermissible non-federal share sources often artificially inflate federal Medicaid expenditures. Further, impermissible non-federal share arrangements typically reward providers based on their ability to fund the state share, and disconnect the Medicaid payment from Medicaid services, quality of care, health outcomes, or other Medicaid program goals. Of critical concern, it appears that the redistribution arrangements discussed in this CIB are specifically designed to redirect Medicaid payments away from Medicaid providers that serve a high percentage of Medicaid individuals to providers that do not participate in Medicaid or have relatively lower Medicaid utilization.

- **Estimated Federal Impact of Policy:** Problematic tax programs involving redistribution arrangements are more favorable to providers with relatively low Medicaid utilization. We anticipate that most affected states will adjust existing tax programs or alter future tax programs to ensure compliance, which can be accomplished by ensuring that providers do not redistribute their Medicaid payments. If states are unable or unwilling to restructure their tax programs to ensure compliance, they may have to find alternative sources of non-federal share, such as state appropriations. Ultimately, modifications to end hold harmless arrangements would financially benefit providers with relatively high Medicaid utilization and have a negative financial impact on providers with relatively low Medicaid utilization.

- **Health Equity Impacts:** Although we do not anticipate this will have a significant impact on health equity, we believe the CIB may ultimately advance health equity. Impermissible non-federal share financing arrangements can have a negative impact on beneficiaries. These particular arrangements result in managed care state-directed payments (after the payment redistributions) that reward providers based on their ability to fund the state share, instead of on Medicaid utilization, quality, equity, health outcomes, or other Medicaid program goals. Additionally, the payment redistributions are specifically designed to redirect Medicaid payments away from providers with relatively high Medicaid utilization to or providers with relatively low or no Medicaid utilization.

- **Anticipated Stakeholder Reaction:** We anticipate that some states will react negatively to the CIB, specifically those states that have taxes with these types of arrangements in

place. We are currently aware of five states that have or may have these types of arrangements in place. We will work with the affected states to come into compliance with these requirements. In addition to states that have taxes with these arrangements in place, we also anticipate that provider industry trade groups, such as hospital associations, will react negatively to this CIB as they appear to be involved in running some of these arrangements.

However, we also believe that high-Medicaid volume hospitals may react positively to the CIB, because they may no longer need to redirect a portion of their Medicaid payments to other providers. Of note, these providers may not be willing to publicize their support given the positions may conflict with association, other provider, and state interests. In addition, we believe that other governmental oversight bodies, such as the Health and Human Services/Office of Inspector General (OIG) and the Government Accountability Office will react positively to the CIB, since it will display CMS's commitment for acting as a responsible steward for federal tax dollars.

- **Anticipated Congressional Reaction/ Topics of Significant Interest to Congress:** (b)(5) anticipate that the CIB may not be received well by some members of Congress from states that have taxes with redistribution arrangements in place. For example, during our review of several managed care SDPs in Texas, which we believe may have been funded using taxes that contain this type of arrangement, CMS received outreach from members of the Texas delegation during this time, many of whom urged CMS to approve the SDPs.

  Additionally, some members of Congress and authorizing committee staff have long expressed concerns about Medicaid financing arrangements. While these members may view CMS' issuance of this guidance as a positive step forward, it also may spur questions about what states have financing arrangements that may be considered impermissible, and what CMS is doing to address those arrangements.

- **Attachments/Additional Information:** In messaging to states, we feel that it is important to stress that health-care related taxes are still a permissible means of financing the non-federal share of Medicaid expenditures, when they are collected in accordance with federal requirements. Also, we work with many states on a regular basis that have permissible health care-related taxes in place that are compliant with federal statute and regulation. CMS does not want to stop states from collecting permissible health care-related taxes to fund their Medicaid programs. In addition, we wish to stress that this does not represent new guidance or new interpretations. Rather, this is simply a restatement of our existing interpretation of existing federal statute and regulation that we are issuing, because we have encountered several issues with it. Finally, we would like to stress that CMS is ready and willing to provide technical assistance to states as needed to avoid these types of issues. We recommend that states engage with CMS early and often to ensure compliance of health care-related taxes with federal requirements.

Message

From: Bellios, Toula (CMS/OSPR) (b)(6) (b)(6)
Sent: 4/25/2023 12:41:39 PM
To: Richardson (she/her), Erin (CMS/OA) (b)(6) (b)(6) Harris, Will (CMS/OA) (b)(6) (b)(6) ; Hitchcock, Angela (CMS/OA) (b)(6) (b)(6) Ellis (she/her), Kyla (CMS/OA) (b)(6) (b)(6) Kaiser, Alyssa (CMS/OL) (b)(6) (b)(6)
Subject: FW: FW: Review Required --> Cabinet Report due TODAY
Attachments: 2023 04 24 - CMS Weekly Report - vd.docx

Flag: Follow up

Good morning, resending this so that it's at the top of your inboxes.
Also, CMCS has asked that we remove this bullet. I'll make this update AFTER I've received any additional edits from OA. please remove this one – launch date is still TBD.

- **Missouri Notice Letter:** On/about April 28th, CMS will release a Medicaid deferral letter to Missouri regarding longstanding concerns about federal Medicaid financing requirements, specifically FRA hospital taxes. This may represent a hold harmless arrangement, which is prohibited by statute and regulations.

Thanks, Toula

Toula Bellios
410 786 5501
7500 Security Blvd
Baltimore, MD 21244
e-mail: toula.bellios@cms.hhs.gov

From: Bellios, Toula (CMS/OSPR)
Sent: Monday, April 24, 2023 6:43 PM
To: Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Hitchcock, Angela (CMS/OA) <Angela.Hitchcock@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Kaiser, Alyssa (CMS/OL) <Alyssa.Kaiser@cms.hhs.gov>
Subject: Review Required --> Cabinet Report due TOMORROW

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e-mail: toula.bellios@cms.hhs.gov

Message

From: Kaiser, Alyssa (CMS/OL) (b)(6) (b)(6)
Sent: 4/25/2023 2:01:31 PM
To: Bellios, Toula (CMS/OSPR) (b)(6) (b)(6) Richardson (she/her), Erin (CMS/OA) (b)(6) (b)(6) Harris, Will (CMS/OA) (b)(6) (b)(6) Hitchcock, Angela (CMS/OA) (b)(6) (b)(6) Ellis (she/her), Kyla (CMS/OA) (b)(6) (b)(6)
Subject: RE: RE: Review Required --> Cabinet Report due TODAY
Attachments: 2023 04 24 - CMS Weekly Report - vd(AK).docx

Flag: Follow up

A few edits from me. Thanks!

From: Bellios, Toula (CMS/OSPR) <Toula.Bellios@cms.hhs.gov>
Sent: Tuesday, April 25, 2023 8:42 AM
To: Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Hitchcock, Angela (CMS/OA) <Angela.Hitchcock@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Kaiser, Alyssa (CMS/OL) <Alyssa.Kaiser@cms.hhs.gov>
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(CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Kaiser, Alyssa (CMS/OL) <Alyssa.Kaiser@cms.hhs.gov>
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e-mail: toula.bellios@cms.hhs.gov

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Plaintiffs*, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA, *Defendants*.	Civ. Action No. _____

ORIGINAL COMPLAINT

1. Every day, Texas's Medicaid program ensures access to high-quality medical care for nearly 5 million Texans. For decades, the program has been a bedrock part of the State's social safety net, and its enduring vitality depends on the joint collaborative efforts of the State and the federal government.

2. Unfortunately, for the second time in three years, the Centers for Medicare and Medicaid Services (CMS), which administers Medicaid at the federal level, has wielded its oversight role as a cudgel to force Texas to adopt its policy

preferences. In the process, it has shaken the structural foundation of Medicaid's operations in Texas.

3. This case implicates how Medicaid gets funded, which is always an important issue and recently has become a contentious one. As a general matter, Medicaid is jointly paid for by the federal and state governments. Texas finances a large share of its contributions to Medicaid through the collection of healthcare provider taxes. Such taxes are expressly permissible under the Social Security Act, but the Act imposes several notable conditions on those taxes. The most relevant to this suit is that States may not hold taxpaying providers harmless for the cost of such taxes. *See* 42 U.S.C. § 1396b(w); *see also* 42 C.F.R. § 433.68. If CMS concludes that such a hold harmless provision exists, the financial consequences for the State are severe: the amount of the State's requested reimbursement from the federal government must be "reduced by the sum of any revenues received by the State" through a "broad-based health care related tax" that operates as "a hold harmless provision." *Id.* § 1396b(w)(1)(A)(iii).

4. The Act provides three separate definitions of a hold harmless provision. *Id.* § 1396b(w)(4)(A)-(C). Only one is relevant to this case: a hold harmless provision exists if "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." *Id.* § 1396b(w)(4)(C)(i).

5. This definition is straightforward: when *the State or other government unit* provides a payment, offset, or waiver that (directly or indirectly) guarantees to

hold a taxpayer harmless, that arrangement constitutes a prohibited hold harmless provision. Rather than apply that plain text, CMS has adopted the view that an agreement between two *private* providers to protect against financial loss constitutes "a hold harmless arrangement involving Medicaid payment redistribution" if there is a "reasonable expectation" that the taxpaying provider will receive a portion of its provider tax costs returned as part of a private agreement. Ex. A at 3-4. And CMS has done so not through notice-and-comment rulemaking but by issuing an informational bulletin purporting to give immediate force and effect to this extra-textual reading of the Social Security Act. The bulletin follows years of failed rulemakings and unsuccessful threats to compel Texas's compliance with the agency's preferred interpretation of the Act. And, perhaps most disturbingly, this expanded definition applies not just prospectively but also retroactively to payments that were made years ago, requiring Texas to monitor private-party arrangements on pain of the loss of billions of dollars in federal funding.

6. The bulletin is unlawful under the Administrative Procedure Act (APA) and should be set aside. It is inconsistent with the plain language of the Social Security Act and CMS's own regulations. It was not issued with an opportunity for notice and comment. And it is arbitrary and capricious because it contradicts CMS's prior position—that private arrangements do *not* fall within the ambit of a prohibited hold harmless provision—without even attempting to explain why that position was incorrect. In the interim, the bulletin is already causing the State irreparable harm.

CMS and the other federal defendants should not be permitted to enforce or rely on the bulletin pending a final resolution of its legality.

PARTIES

7. Plaintiff Texas is a sovereign State. *See* Tex. Const. art. I, § 1. Texas brings this suit on its own behalf and on behalf of its citizens *parens patriae* to ensure that federal officials comply with the statutory and regulatory limits on their power when making decisions that will affect millions of Texans. Texas has the authority and responsibility to protect the health, safety, and welfare of its citizens.

8. Plaintiff Texas Health and Human Services Commission (HHSC) is an executive branch agency organized under the laws of Texas. It is the state agency designated under 42 C.F.R. § 431.10 to administer Texas's Medicaid program. For ease of reference, HHSC will be referred to collectively with the State as "Texas."

9. Defendant CMS is a federal agency organized under the laws of the United States. It is responsible for federally administering Medicaid. Although HHSC has been informed that certain actions relating to this suit are being coordinated out of CMS's office in Baltimore, CMS maintains a regional office located in Texas for administering its operations in Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

10. Defendant United States Department of Health and Human Services (HHS) is a cabinet-level federal executive branch agency organized under the laws of the United States. It is responsible for administering federal healthcare policy and is the cabinet-level Department of which CMS is a part.

11. Defendant Xavier Becerra is the Secretary of HHS. He is sued in his official capacity.

12. Defendant Chiquita Brooks-LaSure is the Administrator for CMS. She is sued in her official capacity.

13. Defendant United States of America is the federal sovereign.

JURISDICTION AND VENUE

14. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331 because this suit concerns the legality of actions taken by federal agencies and federal officers in their official capacities.

15. The Court is authorized to award the requested declaratory and injunctive relief under 5 U.S.C. §§ 702 and 706, 28 U.S.C. § 1361, 28 U.S.C. §§ 2201-2202, Federal Rules of Civil Procedure 57 and 65, and by the Court's general legal and equitable powers.

16. Venue lies in this district pursuant to 28 U.S.C. § 1391(e)(1)(B) because the United States, two of its agencies, and two of its officers in their official capacities are defendants. Plaintiff Texas resides in this judicial district, and a substantial part of the events or omissions giving rise to Texas's claims occurred in this district. Texas previously sued these same defendants in this Court to prevent CMS from arbitrarily revoking its approval of Texas's request to extend and amend the State's managed-care system, *see Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154219, at *1 (E.D. Tex. Aug. 20, 2021), and the defendants did not challenge venue in that case. Moreover, the first federal audit, initiated by the HHS Office of the Inspector General

to ensure that a Texas jurisdiction is in compliance with the bulletin, is of Smith County. That action began roughly contemporaneously with CMS approving Texas's state directed payment programs (SDPs) to avoid sanctions in the last suit. The audit has occurred and will continue to occur in this judicial district and division.

BACKGROUND

I. Overview of Medicaid and Hold Harmless Provisions

A. Medicaid's cooperative federalism framework

17. Medicaid is designed as a cooperative federal-state program that has provided medically necessary healthcare to low-income families and individuals with disabilities since 1965. *See* 42 U.S.C. § 1396 *et seq.*; *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). At the federal level, Medicaid is administered by the Secretary of Health and Human Services, who in turn exercises his authority through CMS. *Ahlborn*, 547 U.S. at 275. At the state level, participating States are required to designate a single agency to administer their Medicaid programs. *See* 42 U.S.C. § 1396a(a)(5). HHSC fills that role for the State of Texas.

18. A State that chooses to participate in the Medicaid program—as all States, including Texas have—must submit a state Medicaid plan to CMS for federal approval. 42 U.S.C. § 1396a. After CMS approves the state plan, "the state administers Medicaid with little to no federal oversight," *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2022 WL 741065, at *2 (E.D. Tex. Mar. 11, 2022), and the participating State is entitled to receive reimbursement from the federal government for the federal share of specified covered services. 42 U.S.C. § 1396b; 42 C.F.R. § 430.30(a)(1).

19. The federal share of a participating State's Medicaid expenditures is primarily based on the federal medical assistance percentage (FMAP). *See* 42 U.S.C. § 1396d(b), 42 U.S.C. § 1396b(a). In Texas, that percentage is presently approximately 60%. The compensation to which a State is entitled can also include supplemental Medicaid payments such as payments for incentive arrangements, pass-through payments, and directed payment programs. 42 C.F.R. § 438.6. "Although the federal contribution to a State's Medicaid program is referred to as a 'reimbursement,' the stream of revenue is actually a series of huge quarterly advance payments that are based on the State's estimate . . . of future expenditures." *Bowen v. Massachusetts*, 487 U.S. 879, 883-84 (1988) (citing 42 U.S.C. § 1396b(d)).

B. The Social Security Act's prohibition on hold harmless provisions

20. To receive reimbursements from the federal government, States must provide assurances that they have adequate methods to pay the state share of Medicaid. *See* 42 U.S.C. § 1396b; 42 C.F.R. § 430.30.

21. Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments in 1991, which addresses CMS's authority to restrict or reduce federal matching funds for Medicaid. Pub. L. No. 102-234, § 2, 105 Stat. 1793 (1991) (adding subsection 1903(w), codified at 42 U.S.C. § 1396b(w), to the Social Security Act).

22. The 1991 amendments require a reduction in the amount of patient-care costs for which the States may seek reimbursement—and which are used to calculate

the federal financial participation payment—when the State obtains revenues from certain sources. *See* 42 U.S.C. § 1396b(w)(1)(A).

23. Relevant here, the amendments require the amount of the State's requested reimbursement to be "reduced by the sum of any revenues received by the State" through a "broad-based health-care-related tax" that operates as "a hold harmless provision." *Id.* § 1396b(w)(1)(A)(iii). The amendments include three definitions of a "hold harmless provision." The first is when the State or local government entity "provides (directly or indirectly) for a payment . . . to taxpayers" that is "positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan." *Id.* § 1396b(w)(4)(A). The second is when "[a]ll or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid." *Id.* § 1396b(w)(4)(B). And the third, and the subject of the February 17 bulletin, is when the State or local government entity "provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." *Id.* § 1396b(w)(4)(C)(i).

C. CMS's regulations implementing the 1991 amendments

24. In 1993, HHS promulgated a rule to implement these amendments. *See* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156 (Aug. 13, 1993) (codified at 42 C.F.R. §§ 433, 447).

25. The regulations incorporate the Social Security Act's definition of a hold harmless provision into subsection (f) of 42 C.F.R. § 433.68 by "set[ting] out the three

ways of finding a 'hold harmless provision' for a state tax program." *Brooks-LaSure*, 2022 WL 741065, at *5 (setting out this history).

26. The regulation also "added detail on the third hold harmless definition" by adopting a two-part test—later formally adopted by Congress—for determining when the government entity's levy of an excessive amount of taxes on a healthcare provider rises to the level of a hold harmless "guarantee." *Id.* at *5-6; *see also* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals 57 Fed. Reg. 55,129-30 (Nov. 24, 1992) (interim final rule).

27. Under that test, "[i]f the tax on the providers' revenue was at or below 6% (selected as the national average sales tax), the tax would be assumed permissible," but if "the tax was above 6%," "a numerical test would deem a hold harmless situation to exist when Medicaid rates are used to repay (within a 12-month period) at least 75 percent of providers for at least 75 percent of their total tax cost." *Brooks-LaSure*, 2022 WL 741065, at *5 (citing 57 Fed. Reg. at 55,142-55,143).

28. Twelve years elapsed until a new development, spurred by CMS's own internal adjudicative body, prompted CMS to again take regulatory action. In 2005, after years of litigation, HHS's Departmental Appeals Board rejected CMS's effort to retroactively disallow years of federal funding to five States based on an overbroad interpretation of what constitutes a hold harmless provision. Specifically, without basis in statute, CMS had determined that certain state programs providing grants to nursing homes or tax credits to patients constituted impermissible hold harmless

provisions under CMS's regulations. *See Brooks-LaSure*, 2022 WL 741065, at *6-7 (citing *In re: Hawaii Dep't of Human Servs.*, Docket No. A-01-40, 2005 WL 1540188 (Dep't Appeals Bd., Appellate Div. June 24, 2005)).

29. The Board held, however, that the programs at issue did not meet either the first or third definitions of a hold harmless provision. *Id.* As to the third definition, the Board explained that no language in the States' grant or credit programs offered an explicit or direct assurance of any payment to a taxpayer-provider, and it rejected CMS's argument that the third definition was merely a "broad catch-all provision." *Id.* at *6. Ultimately, the Board found that for a state taxing authority to guarantee a payment, offset, or waiver the Board expected to see a "legally enforceable promise" in "these States' laws." *Id.* at *7.

30. Following the Board's ruling, CMS's enforcement arm sought to alleviate the purported "confusion" that the ruling caused and "clarify" the tests for finding an impermissible hold harmless arrangement. *See, e.g.*, Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9,685, 9,686, 9,690 (Feb. 22, 2008) (final rule). CMS amended the regulatory definition of the third hold harmless provision to "cover[] the situation where a government provides for a certain financial measure 'such that' the measure guarantees" the taxpayer will be held harmless. *Brooks-LaSure*, 2022 WL 741065, at *8. This was a departure from the statutory definition in which Congress defined a hold harmless provision to include "certain financial measure[s] 'that guarantees' indemnification." *Id.* at *7. This change "deliberate[ly]"

"remove[d] the statute's tight grammatical link between *the government*, as the actor providing for something, and *a guarantee*, as the thing provided for." *Id.*

31. As a result of the agency's "loosen[ing]" of the required link between the state taxing authority and the guarantee itself, CMS has contended that the third definition "focus[es] on the 'reasonable expectation' [of the taxpayer] about the 'result' of a state payment, as opposed to what the state provided when making a payment." *Id.* (citing 73 Fed. Reg. 9,694-95).

D. CMS's failed 2019 amendment efforts

32. In 2019, CMS tried to stretch the definition of a hold harmless provision in section 1396b(w)(4)(C)(i) even farther to cover private, non-governmental arrangements. *See* Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,742 (Nov. 18, 2019).

33. CMS's proposed rule conflicted with the agency's prior representations to providers across the country. In early 2019, Kristin Fan, then Director of CMS's Financial Management Group, told counsel for concerned providers that though CMS is "aware that there may be arrangements" between providers that CMS may "not particularly like," CMS "do[es] not have statutory authority to address" those arrangements. Fan also agreed that States should not be expected "to seek information about these agreements or providers to disclose these agreements to the state/local government in connection with CMS' questions." This exchange was widely circulated across the country.

34. In the proposed rule, issued only nine months later, CMS took a different approach entirely. The proposal said that the agency had "become aware of

impermissible arrangements that exist where a state or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-federal share of Medicaid payments back to the taxpayers." 84 Fed. Reg. at 63,734. Critically, CMS clarified that it considered such arrangements to violate the law even if "a private entity makes the redistribution" to another private entity. *Id.* at 63,735. It reasoned that a purely private arrangement still "constitutes an indirect payment from the [S]tate or unit of government to the entity being taxed that holds it harmless for the cost of the tax." *Id.* That is because "[t]he taxpayers have a reasonable expectation to be held harmless for all or a portion of their tax amount." *Id.* at 63,734.

35. As a result, CMS proposed to amend 42 C.F.R. § 433.68(f)(3) to specify that CMS would consider the "net effect" of a particular arrangement—*i.e.*, whether the "net effect" is a "reasonable expectation" by the taxpayer that it will recoup all or a portion of its tax payment through Medicaid payments—to determine whether a hold harmless arrangement exists. *Id.* at 63,735.

36. CMS received more than 10,000 comments on the proposal, many of which faulted CMS for "lack[ing] statutory authority" and "creating regulatory provisions that were ambiguous or unclear and subject to excessive Agency discretion." This ultimately led CMS to "withdraw the proposed provisions." Medicaid Program; Medicaid Fiscal Accountability Regulation, 86 Fed. Reg. 5,105, 5,105 (Jan. 19, 2021).

37. One such commenter was Daniel Tsai—the author of the February 17 bulletin and CMS's current Deputy Administrator and Director for the Center for

Medicaid and CHIP Services—who was then serving as the Medicaid Director for the State of Massachusetts. Tsai explained that the proposed rule—including its "'net effect[]' test"—"introduce[d] new state obligations" and "significant administrative and operational burdens" that "represent[ed] an unprecedented federal overreach," "exceed[ed] CMS' statutory authority," contain[ed] "provisions [that] are highly susceptible to arbitrary and capricious application," "[was] not supported by the underlying statute," and "includ[ed] reporting on business dealings of private entities that are not available to the state." HHSC submitted a similar comment letter along those lines, as did many others.

II. Overview of Texas Medicaid[1] and the State's Funding Mechanisms

38. To allow flexibility from the default requirements of the Social Security Act, CMS may issue a waiver that exempts a State from those otherwise mandatory requirements. One common waiver is authorized by section 1115 of the Act, codified at 42 U.S.C. § 1315. Such a waiver allows a State to implement an "experimental, pilot, or demonstration project" that diverges from federal requirements so long as

[1] A more fulsome background of the Texas Medicaid system, including its section 1115 waiver, is available in Texas's First Amended Complaint from its earlier-filed lawsuit, which is expressly incorporated herein by reference. *See Texas v. Brooks-LaSure*, No. 6:21-cv-00191 (E.D. Tex. Aug. 31, 2021), ECF No. 54. To avoid burdening the Court, this complaint discusses only those aspects of Texas Medicaid necessary for resolving the parties' current dispute, which was first litigated in the context of Texas's motion to enforce the Court's preliminary injunction. *See id.*, Mot. to Enforce J., (Nov. 2, 2021), ECF No. 75; *id.*, Reply in Supp. of Mot. to Enforce J., (Nov. 22, 2021), ECF No. 84.

the project "is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a).

39. In 2011, Texas applied for and received a section 1115 waiver for a demonstration project called the Texas Healthcare Transformation and Quality Improvement Program. The waiver allowed Texas to transition its Medicaid program from a fee-for-service model to a managed-care model. Through that updated model, Texas contracts with health-insurance companies to deliver healthcare services through Medicaid. The State pays a monthly capitation payment to a managed care organization for each Medicaid recipient, which reduces the overall state and federal government Medicaid expenditures by encouraging recipients to take advantage of preventative care.

40. The Texas Legislature authorized another important change to Medicaid in 2013. In addition to furthering the transition to a managed-care model, as was discussed in the prior lawsuit, Texas law was amended to allow designated hospital districts, counties, and municipalities to "administer a healthcare provider participation program to provide additional compensation to certain hospitals located in the hospital district, county, or municipality by collecting mandatory payments from each of those hospitals to be used to provide the nonfederal share of a Medicaid supplemental payment program[.]" Tex. Health & Safety Code § 300.0001; *see* Act of May 24, 2013, 83d Leg., R.S., ch. 1369, 2013 Tex. Gen. Laws 3630 (codified at Tex. Health & Safety Code ch. 288); Tex. Health & Safety Code ch. 288–300A.

41. These mandatory payments are deposited into a Local Provider Participation Fund (LPPF), which is a dedicated-purpose account that local governments may use for certain statutorily authorized purposes, including intergovernmental transfers to HHSC to support specified Medicaid programs. HHSC uses these statutorily permitted local funds as the non-federal share of Medicaid funds that are then matched with federal funds.

42. The LPPFs are managed by local government entities and are subject to a host of relevant restrictions. If the government entity authorizes a healthcare provider participation program, it must require an annual mandatory payment to be assessed based upon the net patient revenue of each institutional healthcare provider located in the applicable local unit of government.[2] Tex. Health & Safety Code § 300.0151. Money deposited into the local provider participation fund is authorized for limited purposes, including the intergovernmental transfers from the local government to the State to provide the state share of Medicaid payments for statutorily specified Medicaid programs. *See* Tex. Health & Safety Code § 300.0103(b)(1). The levies imposed by the local unit of government must be broad-based and uniform, as required under federal law. *See id.* § 300.0151(b). All local governments authorized to collect mandatory payments in LPPFs are prohibited from assessing mandatory payments that exceed six percent of net patient revenue. *Id.*

[2] The Texas statutes which authorize hospital districts to collect and deposit mandatory payments into LPPFs explicitly state that such mandatory payments are not taxes for the purposes of Article IX of Texas Constitution. However, these payments are considered healthcare-related taxes for purposes of federal law. *See, e.g.*, 42 U.S.C. § 1396b(w)(3)(A); 42 C.F.R. § 433.55.

§ 300.0151(c). And consistent with the Social Security Act, Texas law specifically prohibits these programs from holding harmless any institutional healthcare provider. *Id.* § 300.0151(b).

43. CMS encouraged Texas to implement these funds, which have grown more important to the State over time. Collectively, the funds comprised about 17.7% of Texas's state share of Medicaid funding in the last fiscal year. HHSC expects this trend: when the funding mechanism was first piloted, it required express permission from the Legislature on a jurisdiction-by-jurisdiction basis. *E.g.*, 2013 Tex. Gen. Laws 3630. With the encouragement of CMS, the Texas Legislature has since made the authorization more general. Tex. Health & Safety Code §§ 300.0001, .0003.

44. As the statewide administrator of Texas Medicaid, HHSC ensures that the authority that administers each LPPF does not provide for any payment, offset, or waiver that directly or indirectly guarantees to hold the taxpaying providers harmless for any portion of their tax costs. But HHSC does not have statutorily conferred taxing or regulatory authority over the local government entities that manage those funds, nor does HHSC have authority to examine or consider any contractual arrangements that might exist between private businesses whose taxes contribute to those funds.

45. The taxes that flow into those funds are unrelated to the methodology for calculating the Medicaid reimbursements that HHSC disburses to healthcare providers. The State does not make any such reimbursements based on the amount that a provider is taxed by a local government. Instead, Medicaid payments to

providers are based exclusively on programmatic methodologies that consider, among other factors, what an estimated Medicare or average commercial payer would have paid for those same services.

46. CMS has approved SDPs that use LPPF to fund as the non-federal share. Those programs include:

- The Comprehensive Hospital Increase Reimbursement Program (CHIRP), which began on September 1, 2021, (but not approved by CMS until March 25, 2022) and replaced a prior directed payment program no longer in effect. CHIRP provides increased Medicaid payments to hospitals for inpatient and outpatient services to eligible recipients. On August 1, 2022, CMS renewed approval for CHIRP for the program period covering September 1, 2022, to August 31, 2023.

- The Quality Incentive Payment Program (QIPP), which is a performance-based payment program designed to incentivize eligible nursing facilities to improve the quality and innovation of their services. CMS has approved this program for six straight years (but delayed approval for the program period that began on September 1, 2021, until November 15, 2021). On August 1, 2022, CMS approved QIPP for the program period covering September 1, 2022, to August 31, 2023.

- The Texas Incentives for Physicians and Professional Services (TIPPS) program, which began on September 1, 2021 (but not approved by CMS until March 25, 2022), provides increased Medicaid payments to certain physician groups providing healthcare services to eligible Medicaid recipients. On August 1, 2022, CMS renewed approval for TIPPS for the program period covering September 1, 2022, to August 31, 2023.

- The Rural Access to Primary and Preventive Services (RAPPS) program, which began on September 1, 2021 (but not approved by CMS until March 25, 2022), is designed to incentivize rural health clinics that provide primary and preventive care services to eligible Medicaid recipients in rural areas of Texas. On August 1, 2022, CMS renewed approval for RAPPS for the program period covering September 1, 2022, to August 31, 2023.

- The Directed Payment Program for Behavioral Health Services (DPP BHS), which began on September 1, 2021 (but not approved by CMS until November 15, 2021), is designed to promote and improve access to

> behavioral health services, coordination of care, and successful care transitions for eligible Medicaid recipients. On August 1, 2022, CMS renewed approval for DPP BHS for the program period covering September 1, 2022, to August 31, 2023.

47. The directed payment programs are complex, and Texas must have its directed-payment-program proposals, called "preprints," approved annually by August to process the payments the following September. Texas typically submits the preprints to CMS for approval in March. In total, CMS has approved pre-prints that contemplate the use of LPPFs at least nine times since the funds were first introduced in 28 local jurisdictions. CMS has also issued federal financial participation for the Delivery System Reform Incentive Payment (DSRIP) program and the Uncompensated Care (UC) program, which have used LPPF funds at least four times per year since 2016.

III. CMS's Initial Encouragement of LPPFs and Sudden About-Face

48. CMS has been involved in the development of LPPFs in Texas from the outset of their existence. It was at CMS's encouragement that the Texas Legislature began authorizing LPPFs for certain jurisdictions. Later, in 2018 and 2019, CMS and Texas had lengthy discussions about the structure of LPPFs. At the time, Texas and CMS were working to resolve a disallowance that had been issued by CMS related to funds transferred from government entities in Dallas and Tarrant Counties. (Texas challenged the disallowance, and litigation is ongoing.) CMS reviewed the structure of the proposed LPPFs in Dallas and Tarrant Counties and allowed Texas to substitute funds derived from the LPPFs operated by the hospital districts in those counties for the disallowed funds.

49. Texas has long understood that its LPPFs do not run afoul of the Social Security Act's hold harmless prohibition and structured its regulatory regime accordingly. That understanding was gained in part based on CMS's assurances. In early 2019, HHSC first became aware of the possibility that business agreements might exist between private entities. HHSC officials promptly contacted CMS for guidance. CMS assured HHSC that, so long as neither the State nor a unit of local government was providing a guarantee, there was no prohibition on private business arrangements. This assurance was consistent with the email discussed above from Kristin Fan that was circulated to providers across the country around that same time.

50. Texas continued to rely upon that assurance in setting up its team that monitors local funds used as the non-federal share in the Medicaid program, including funds that are transferred to HHSC from a LPPF. Unfortunately, since the withdrawal of the 2019 proposed rule, CMS has reneged on its word and twice unsuccessfully sought to force HHSC to police private agreements.

51. During negotiations over the extension of the State's demonstration project (which was set to expire in September 2022), CMS attempted to insert special terms and conditions imposing many of the same requirements from the withdrawn proposed rule. Because those terms would have been inconsistent with the Social Security Act, Texas refused to agree to the requested terms and conditions.

52. On January 15, 2021, CMS informed Texas that its extension application was approved for a ten-year period ending on September 30, 2030. Just

three months later, on April 16, 2021, CMS reversed course and rescinded that approval. Texas challenged CMS's decision, and this Court issued a preliminary injunction obligating "defendants to treat Texas's demonstration project (Waiver Number 11-W-00278/6) as currently remaining in effect as it existed on April 15, 2021." *Brooks-LaSure*, 2021 WL 5154219, at *15.

53. As a result of that preliminary injunction, defendants were prohibited from implementing the rescission letter. The Court's orders made clear that CMS was required to treat the demonstration project as remaining in effect and to cooperate with Texas in negotiating various terms, including negotiating the approval of Texas's SDPs. *Brooks-LaSure*, 2022 WL 741065, at *10; *see also, e.g.*, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154086, at *1-2 (E.D. Tex. Aug. 12, 2021).

54. Despite the Court's instructions, CMS attempted to impose the rejected LPPF-related terms by holding approval of five SDPs hostage until Texas would agree to CMS's terms to police private arrangements. That effort failed, too, but only after Texas returned to this Court to compel CMS to promptly issue a final decision on those SDPs. *Brooks-LaSure*, 2022 WL 741065, at *10. Even then, CMS would not withdraw its demand until this Court threatened to impose sanctions. *See id.*; Notice of Compliance with Order, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, (E.D. Tex. Mar. 25, 2022), ECF No. 100 (confirming that CMS approved the SDPs).

55. Ultimately, under threat of sanction by this Court, CMS approved the state directed payment programs, which was the only remaining issue in the prior lawsuit, and the case was dismissed.

IV. OIG Audits and the February 17 Bulletin

56. On November 29, 2021, the HHS Office of the Inspector General (OIG) announced an audit workplan of "States' Use of Local Provider Participation Funds as the State Share of Medicaid Payments." The choice of wording was unusual: OIG did not announce a review of provider taxes categorically, or even provider taxes operated by units of local government. Instead, OIG specifically identified a review of "Local Provider Participation Funds," which is the term that Texas (and a limited number of other States) uses in state statutes authorizing this method of finance for units of local government.

57. On March 25, 2022, at approximately the same time that CMS finally agreed to the state directed payment programs contemplated by the 2021 waiver extension, OIG notified Texas that the State was selected for OIG's audit of LPPFs and held an entrance conference with Texas on April 14, 2022. After collecting information from Texas about the operation of LPPFs in this State, OIG selected Smith County, the home county for this Court, for a detailed review. OIG officials contacted Smith County and asked for information regarding private business agreements to which Smith County is not a party. The officials informed Texas that the audit would take approximately 12 months to complete, and that OIG would issue its report, including any findings, in the summer of 2023.

58. On February 17, 2023, the Deputy Administrator and Director of the Center for Medicaid and CHIP Services at CMS issued a bulletin announcing a retroactive change in CMS's definition of a hold harmless arrangement. *See* Ex. A. Without the notice and comment that CMS acknowledged was necessary when it

issued the 2019 proposed rule change, the bulletin pronounced that an agreement between private providers to redistribute Medicaid payments constitutes "a hold harmless arrangement involving Medicaid payment redistribution" if there is a "reasonable expectation" that the taxpaying providers will receive a portion of their provider tax costs returned as part of a private agreement. *Id.* at 3.

59. CMS described how, in its view, "taxpayers appear to have entered into oral or written agreements" to redirect or redistribute their Medicaid payments "to ensure that all taxpayers receive all or a portion of their tax back." *Id.* at 3. Notwithstanding the acknowledged absence of state participation in such agreements, CMS concluded they were impermissible because "[t]he redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax." *Id.*

60. Without pointing to any statutory authority, the bulletin further stated CMS "intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of healthcare-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements." Ex. A at 5. Henceforth, States are expected "to make available *all requested documentation* regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments" as part of CMS's "oversight activities and review of state payment proposals[.]" *Id.* (emphasis added).

61. CMS threatened to "take enforcement action as necessary" if an audit uncovers "impermissible financing practices." *Id.* And without regard to whether the requested documentation exists, CMS ominously warned that a State's failure to supply requested documentation regarding redistribution arrangements "may result in a deferral or disallowance of federal financial participation." *Id.*

62. After the bulletin was issued, OIG moved up the expected timeframe for completion of its report on Smith County to May 2023. On March 1, 2023, OIG sent a letter to HHSC indicating its intent to conduct new audits of local provider participation funds in Amarillo, Tarrant, and Webb counties. The "objective" of the second audit "is to determine whether the State agency adhered to the hold-harmless provisions in Federal regulations."

63. On March 9, 2023, OIG notified Texas that it had changed the original audit objective of the Smith County LPPF audit (referenced in paragraph 57) from the broad examination of whether LPPF funds were permissible and in accordance with state and federal law to the much narrower objective utilized in the new audit of the three additional local government entities.

V. Immediate and Long-Term Effects of the Bulletin on Texas

64. This bulletin, if allowed to be implemented, will have an immediate impact on not just HHSC's ability to provide vitally needed healthcare services to Texans but also on Texas's sovereign interest in enforcing its laws.

65. Relying on the text of both the Social Security Act and CMS's existing regulations, the Texas Legislature has never deemed it necessary to create a

regulatory body with authority to examine contractual agreements that might exist between two private businesses. Nor has the Legislature ever seen fit to provide HHSC with such authority. As a result, to comply with the bulletin, HHSC will have to arrogate power to itself that it lacks under state law.

66. Beyond that injury to its sovereignty, Texas faces significant monetary costs to comply with the bulletin: it would be required to establish and operate a regulatory entity with sufficient resources to examine the contractual arrangements and financial management of every private hospital that exists in a jurisdiction with a LPPF. Ex. A at 5 (States are expected "to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments."). That is the only way Texas could accurately determine what private contractual relationships exist and whether those contracts are related to their provider tax payments. Texas would then need to take decisive action to halt private contractual agreements that fall within the scope of the bulletin's definition of a hold harmless arrangement. Ex. A at 5 (States must "take steps to curtail these practices if they exist.").

67. HHSC estimates that to achieve compliance, it will need to expend tens of millions of dollars and hire many new staff. There are 304 privately-owned hospitals located in jurisdictions that currently have a LPPF, 27% of which are not-for-profit organizations. Texas hospitals are extremely complex organizations, which have innumerable private contracts with various types of entities that Texas would

be required to examine to determine whether each contract constituted hold harmless arrangements under the bulletin's vague definitions.

68. Because current law only requires HHSC to monitor agreements involving local government entities, HHSC currently employs only about a dozen compliance staff aimed at ensuring no impermissible hold harmless provisions exist. HHSC would need to hire hundreds of additional staff to "curtail" any actions that might be inconsistent with the bulletin: those staff would include professionals like auditors, financial examiners, financial analysts, and attorneys who could competently interpret the thousands (potentially millions) of contracts or other business arrangements at each hospital and the billions of dollars of revenues and expenditures that are associated with the running of those hospitals.

69. HHSC would also need to investigate private associations or individual citizens who may have financial or other contractual relationships with any Medicaid provider that is assessed a mandatory payment as part of a LPPF. And at that juncture, HHSC would risk transgressing the First Amendment, which protects the free-association rights of individuals and nonprofit organizations—including nonprofit hospital associations.

70. The last several years have been challenging for Texas Medicaid: the pandemic, combined with CMS's past conduct that precipitated Texas's earlier lawsuit, have put providers and patients on edge. CMS's latest salvo threatens to undermine the work that HHSC has done to restore confidence in the Texas Medicaid Program and is destabilizing to the safety net that Texans enrolled in the Medicaid

program rely on to provide them life-saving care. LPPFs fund nearly a fifth of Texas's state share of Medicaid expenditures. Moreover, LPPFs are typically operated by hospital districts and other local government entities—meaning that CMS's current effort to shut off Medicaid funding is aimed at the very local government entities that are charged with creating an aspect of the entire social-safety net that serves emergent or acute medical needs. In Texas, most hospital associations are non-profits and, to comply with the bulletin, HHSC would be compelled to examine them to evaluate any financial relationship they might have with hospitals located in jurisdictions that operate LPPFs. Texas hospitals cannot afford, and the Texans they serve cannot afford, the type of uncertainty in future funding that has resulted from the bulletin.

CLAIMS

Count I

The February 17 Bulletin Exceeds CMS's Statutory Authority and is Not in Accordance with Law (5 U.S.C. § 706)

71. Plaintiffs incorporate by reference all preceding paragraphs.

72. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

73. The February 17 bulletin defines a hold harmless arrangement to reach agreements solely between private healthcare providers. Defendants lack statutory and regulatory authority to issue a definition of a hold harmless arrangement that

contradicts the plain language of the Social Security Act and CMS's own agency rules. *See* 42 U.S.C. § 1396b(w)(4); *see also* 42 C.F.R. § 433.68(f)(3).

74. The Social Security Act's definition of a prohibited hold harmless provision does not encompass private agreements exclusively between private providers. Instead, the Act requires that a) *the State or other unit of government* imposing the tax provide the payment, offset, or waiver, and b) the payment, offset, or waiver guarantees to hold taxpayers harmless for any portion of the tax. 42 U.S.C. § 1396b(w)(4)(C)(i). The redistribution agreements between private providers that CMS described in the February 17 bulletin are not hold harmless arrangements because they do not involve "[t]he State or other unit of government imposing the tax" acting to hold taxpayers harmless. *Id.* § 1396b(w)(4)(C)(i).

75. The bulletin also elevates a legally unenforceable "expectation" to the level of a guarantee, which is contrary to the plain meaning of the term "expectation." There is no indication that Congress intended for "guarantee" to have any definition other than its plain meaning.

76. Defendants did not act in accordance with the law and exceeded their statutory and regulatory authority when promulgating and relying upon the February 17 bulletin. Accordingly, the bulletin should be set aside.

Count II

The February 17 Bulletin Did Not Comport with the Requirements of Notice-and-Comment Rulemaking (5 U.S.C. § 553)

77. Plaintiffs incorporate by reference all preceding paragraphs.

78. The February 17 bulletin is a substantive or legislative rule that required notice-and-comment rulemaking under the APA. *See* 5 U.S.C. § 553. The bulletin is not exempt from the APA's notice-and-comment requirements as the bulletin is not an interpretive rule, general statement of policy, or the rule of agency organization, procedure, or practice. *See id.* § 553(b)(A).

79. "Agencies have never been able to avoid notice and comment simply by mislabeling their substantive pronouncements." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019). "On the contrary, courts have long looked to the *contents* of the agency's action, not the agency's self-serving *label*, when deciding whether statutory notice and comment demands apply." *Id.*

80. CMS acknowledged that defining hold harmless arrangements to include agreements to which neither the State nor local government entities were a party is a substantive rule requiring notice-and-comment rulemaking when it initiated such a process in 2019. That conclusion was proven correct by the thousands of comments submitted to CMS discussing not only its lack of statutory authority but also the real-world obligations that the proposed rule would impose on both private parties and the States.

81. Moreover, the bulletin easily meets the definition of a legislative rule requiring notice and comment. Specifically, courts "evaluate two criteria to distinguish policy statements from substantive rules: whether the rule (1) impose[s] any rights and obligation and (2) genuinely leaves the agency and its decision-makers

free to exercise discretion." *Texas v. United States*, 809 F.3d 134, 171 (5th Cir. 2015) ("*DAPA*") (quotation marks omitted).

82. Here, the bulletin imposes rights and obligations and does not leave CMS and its decisionmakers free to exercise discretion regarding the scope of the Social Security Act's hold harmless prohibition: because of the bulletin, "an arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under" the Social Security Act. Ex. A at 5.

83. CMS is *required* to "reduce a state's medical assistance expenditures by the amount of healthcare-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation." *Id.* The bulletin is therefore substantive because it imposes more than "derivative, incidental, or mechanical burdens" and it "change[s] the substantive standards by which" CMS determines how to enforce the Social Security Act and its implementing regulations. *DAPA*, 809 F.3d at 176; *Texas v. EEOC*, 933 F.3d 433, 443-46 (5th Cir. 2019).

84. The February 17 bulletin is invalid because CMS failed to use the proper notice-and-comment procedures required by the APA. *See* 5 U.S.C. §§ 553, 706.

Count III

The February 17 Bulletin Is Arbitrary and Capricious (5 U.S.C. § 706)

85. Plaintiffs incorporate by reference all preceding paragraphs.

86. Federal administrative agencies are required to engage in reasoned decision-making. "Not only must an agency's decreed result be within the scope of its lawful authority, but the process by which it reaches that result must be logical and rational." *Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 374 (1998). And when an agency reverses "prior policy," it must provide a "detailed justification" for doing so. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009) (plurality op.).

87. The February 17 bulletin is arbitrary and capricious because it fails to acknowledge CMS's change in position. In 2019, CMS acknowledged the absence of statutory or regulatory authority to police, or require States to police, private provider agreements under the Social Security Act. The bulletin reaches the exact opposite conclusion, with no explanation (or even acknowledgement) of that change in position. The bulletin therefore cannot survive arbitrary-and-capricious review.

88. "[A]gencies must typically provide a 'detailed explanation' for contradicting a prior policy, particularly when the prior policy has engendered serious reliance interests." *BST Holdings, L.L.C. v. OSHA*, 17 F.4th 604, 614 (5th Cir. 2021) (quoting *Fox*, 556 U.S. at 515); *see DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020) (applying this principle even when there were serious questions as to the legality of the rule to be rescinded). The February 17 bulletin fails to discuss the reliance interests of States like Texas that have never needed to police redistribution agreements between private providers, and which now lack the structural and financial systems necessary to comply with CMS's edict.

89. The bulletin also fails to discuss Medicaid recipients' need for access to care that is funded by LPPFs. CMS well knows that Texas relies on $3 billion from LPPFs as part of the non-federal share of Medicaid payments. Withholding federal matching funds for this large amount of funding based on the State's inability to immediately comply with the bulletin, as CMS has threatened, Ex. A at 5-6, would devastate Texas's Medicaid finances, significantly destabilize the State's Medicaid provider network, and jeopardize the availability of options for quality healthcare for all Texans, including Medicaid recipients.

90. Moreover, agency action may be set aside as arbitrary and capricious if the agency fails to "comply with its own regulations." *See Environmental, LLC v. FCC*, 661 F.3d 80, 85 (D.C. Cir. 2011). The bulletin is inconsistent with CMS's implementing regulations, that specify that a hold harmless provision exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount." *See* 42 C.F.R. § 433.68(f)(3). CMS's bulletin therefore conflicts not just with the text of the Social Security Act but with the agency's own regulations, and should be set aside on this basis, too.

91. Based on these and other flaws, the bulletin should be set aside as arbitrary and capricious.

Count IV

Alternatively, the 2008 Rule Is Not in Accordance with Law (5 U.S.C. § 706)

92. Plaintiffs incorporate by reference all preceding paragraphs.

93. CMS has taken the position that the February 17 bulletin was supported by the preamble to the 2008 rule. This is legally incorrect as a rule's preamble cannot impose obligations that are inconsistent with the rule's text. *See Entergy Servs., Inc. v. FERC*, 375 F.3d 1204, 1209 (D.C. Cir. 2004). It also misreads the preamble.

94. If the Court disagrees, however, then the 2008 rule is contrary to CMS's statutory authority and should be set aside for the reasons discussed above.

95. Although any claim challenging the process by which the 2008 rule was adopted is time-barred, 28 U.S.C. § 2401(a); *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991); *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985), Texas may still challenge the legality of the rule if it has been applied to Texas within the last six years, *Dunn-McCampbell Royalty Int., Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997).

96. CMS has applied or attempted to apply its (incorrect) interpretation of the 2008 Rule multiple times since 2021: when CMS demanded the interpretation be applied as a condition of the extension of Texas's section 1115 waiver in 2021, when CMS refused to approve Texas's directed payment programs until Texas agreed to the interpretation in 2022, and now when CMS demands documents based on the interpretation of the rule in 2023.

DEMAND FOR JUDGMENT

Plaintiffs request that the Court:

a. Declare unlawful and set aside the February 17 bulletin;

b. Issue preliminary and permanent injunctive relief enjoining defendants from enforcing or implementing the February 17 bulletin against Texas;

c. Compel defendants to conduct any Medicaid audit and oversight activities against Texas in accordance with the Social Security Act and its implementing regulations and without reliance on the February 17 bulletin;

d. Award Texas the costs of this action and reasonable attorney's fees; and

e. Award such other and further relief as the Court deems equitable and just.

Dated: April 5, 2023.

Respectfully submitted.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Plaintiffs*, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA, *Defendants*.	Civ. Action No. _____

Original Complaint

Exhibit A

Centers for Medicare and Medicaid Services Bulletin Feb. 17, 2023

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

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

CMCS Informational Bulletin

DATE: February 17, 2023

FROM: Daniel Tsai, Deputy Administrator and Director

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

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs) under 42 C.F.R. § 438.6(c). Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax would comply with the statutory and regulatory prohibition on "hold harmless" arrangements—that is, arrangements in which the "State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax"—as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations. In response to these questions, this informational bulletin reiterates our longstanding position on the existing federal requirements that pertain to health-care related taxes and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

CMS recognizes that health care-related taxes are a critical source of funding for many states' Medicaid programs, including for payments to safety net providers. CMS supports states' adoption of health care-related taxes when they are consistent with federal requirements. CMS approves many state payment proposals annually that are supported by health care-related taxes that appear to meet federal requirements. CMS recognizes the challenges faced by states and health care providers in identifying sources of non-federal share financing and implementing Medicaid payment methodologies that assure payments are consistent with federal requirements.

Medicaid statute and regulations afford states flexibility to tailor health care-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 remains committed to providing states with technical assistance aiming to ensure that health care-related taxes used to finance the non-federal share of Medicaid expenditures meet the states' policy goals and comply with federal requirements. For example, CMS is authorized to waive the requirements that health care-related

taxes be broad-based and/or uniform, when applicable conditions are met. [1] CMS regularly works with states to approve such waivers in furtherance of state goals while complying with federal requirements.

Although the applicable statutory and regulatory provisions afford states considerable flexibility in establishing health care-related taxes, 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. Occasionally, CMS encounters health care-related tax programs that appear to contain hold harmless arrangements, which contravene section 1903(w)(1)(A)(iii) and (w)(4) of the Act and 42 C.F.R. § 433.68(b)(3) and (f). Such arrangements are inconsistent with statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax programs that appear to contain a hold harmless arrangement that involves the taxpaying providers redistributing Medicaid payments after receipt to ensure that all taxpaying providers receive all or a portion of their tax costs back (typically ensuring that each taxpaying provider receives at least its total tax amount back).

In this informational bulletin, CMS is reiterating the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, states and providers should be transparent regarding any explicit or implicit agreements in place or under development to ensure that all health care-related taxes meet federal requirements to avoid a statutorily required reduction in the state's Medicaid expenditures otherwise eligible for federal financial participation. CMS recommends that states that have questions or concerns about the permissibility of a health care-related tax raise these concerns to CMS early in the process of developing the state's tax program to avoid issues surrounding the permissibility of the non-federal share of Medicaid expenditures. CMS also intends to work with states that may have existing questionable arrangements to ensure compliance with federal statutory and regulatory requirements.

Health Care-Related Taxes and Hold Harmless Arrangements

During standard oversight activities and the review of state payment proposals, particularly managed care SDPs and fee-for-service payment state plan amendments (SPAs), CMS is increasingly encountering health care-related tax programs that appear to contain hold harmless arrangements involving the redistribution of Medicaid payments. In these arrangements, a state or other unit of government imposes a health-care related tax, then uses the tax revenue to support the non-federal share of Medicaid payments back to the class of providers subject to the

[1] For non-broad based and/or non-uniform health care related taxes, these conditions are: that the tax be imposed on a permissible class or class, that the tax be generally redistributive, that the tax be not directly correlated with Medicaid payments, and that the tax lack a hold harmless arrangement. See section 1903 (w)(3)(E)(ii) for the requirement that the tax demonstrate that it is 'generally redistributive" and "not directly correlated with Medicaid payments." For the statistical test demonstrating that the tax is "generally redistributive" see 42 CFR § 433.68 (e)(1) for waivers of the broad based requirement only and 42 C.F.R. § 433.68 (e)(2) for waivers of the uniformity requirement whether or not the tax is broad-based. See section 1903 (w)(4) and implementing regulations at 42 C.F.R. § 433.68 (f) for the hold harmless requirements. See section 1903 (w)(7) and 42 C.F.R. § 433.56 for a list of permissible classes upon which states may impose health care-related taxes.

tax. The taxpayers appear to have entered into oral or written agreements (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments to ensure that all taxpayers receive all or a portion of their tax back, when considering each provider's retained portion of any original Medicaid payment (either directly from the state or from the state through a managed care plan[2]) and any redistribution payment received by the provider from another taxpayer or taxpayers. These redistribution payments may be made directly from one taxpaying provider to another, or the funds may be contributed first to an intermediary redistribution pool.

In these hold harmless arrangements, there appear to be agreements among providers (explicit or implicit in nature) such that providers that furnish a relatively high percentage of Medicaid-covered services redistribute a portion of their Medicaid payments to providers with relatively low (or no) Medicaid service percentage. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These tax programs appear to contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3) that require a reduction in medical assistance expenditures prior to the calculation of federal financial participation as required under section 1903(w)(1)(A) and (w)(1)(A)(iii) of the Act. Here is a detailed example of a hold harmless arrangement involving Medicaid payment redistribution:

- A state imposes a hospital tax based on the volume of inpatient hospital services provided. The tax is broad-based, uniform, and is imposed on 10 hospitals.
- Six of the hospitals serve a high percentage of Medicaid beneficiaries, three serve a low percentage of Medicaid beneficiaries, and one hospital does not participate in Medicaid.
- The state uses the tax revenue as the source of non-federal share of Medicaid payments, which are made back to nine of the hospitals through SDPs. The tenth hospital, which does not participate in Medicaid, does not receive any SDPs directly from state-contracted managed care plans.
- Nine hospitals enter into oral or written agreements (meaning an explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments that the eight of the nine Medicaid-participating hospitals receive. Under this arrangement, five of the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from the managed care plans, then redistribute a portion of their Medicaid payments to the remaining four hospitals with lower Medicaid service percentages (including to the one hospital that does not participate in Medicaid). The redistribution amounts are calculated to guarantee that the nine participating hospitals, including those redistributing their own payments and those receiving the redistribution amounts, receive most, all, or more than all of their total tax cost back.
- The agreement among the taxpaying hospitals results in a reasonable expectation that the taxpaying hospitals, whether directly through their Medicaid payments or due to the

[2] The term managed care plan is used here and throughout this guidance to include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) as defined in 42 C.F.R. § 438.2.

availability of the redistributed payments received from five of the six high Medicaid service volume hospitals (regardless of whether the funds were first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.

- The high-percentage Medicaid hospitals are willing to participate because they still financially benefit from the tax program (even net of the redistribution payments they make to the lower Medicaid service volume hospitals), and the redistribution enables broad support for the tax program from all hospitals, ensuring constituent support for the state law authorizing the tax program.

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Implementing regulations at 42 C.F.R. § 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount" (emphasis added). In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments)."[3]

The word "indirect" in the regulation, highlighted in the excerpt above, 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. It is possible for a state to indirectly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that guarantees to hold taxpayers harmless for any portion of the costs of the tax, if some or all of the taxpayers receive those payments at issue through an intermediary (for example, a hospital association or similar provider affiliated organization) rather than directly from the state or its contracted managed care plan. As CMS further explained in preamble to the 2008 final rule, we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[4] In the preamble, we also gave an example of state laws providing grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes; even though no state law typically required residents to use the grant funds to pay the increased nursing home fees, these direct state payments to nursing home residents indirectly held the nursing facilities harmless for their health care-related tax costs because of the reasonable expectation that their residents would use the state payments to repay the nursing facilities for all or a portion of their tax costs.[5] It remains true that hold harmless arrangements typically are not overtly established through state law but can be based instead on reasonable expectations that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related tax costs.

[3] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[4] 73 Federal Register 9694
[5] *Id.*

Accordingly, an arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 C.F.R. § 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.

Some states have cited challenges with identifying and providing details on redistribution arrangements because they may not be parties to the redistribution agreements. A lack of transparency involving health care-related taxes and Medicaid payments may prevent both CMS and states from having information necessary to ensure sources of non-federal share meet statutory requirements. States have an obligation to ensure that the sources of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, states should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist.

As part of the agency's normal oversight activities and review of state payment proposals, CMS intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of health care-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements. As part of their obligation to ensure state sources of non-federal share meet federal requirements, we expect states to have detailed information available regarding their health care-related taxes. Consistent with federal requirements, CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments. States should work with their providers to ensure necessary information is available. Where appropriate, 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. States may consult section 1902(a)(6) of the Act, 45 C.F.R. § 75.364, 42 C.F.R. § 433.74, and 42 C.F.R. part 438 for any requirements related to CMS' authority to request records and documentation related to the Medicaid program. In particular, 42 C.F.R. § 433.74(a) requires that states, "must also provide any additional information requested by the Secretary related to any . . . taxes imposed on . . . health care providers," and the "States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures." 42 C.F.R. § 433.74(d) specifies that a failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation. If CMS or an outside oversight agency, such as the state auditing agency or the HHS Office of Inspector General discovers the existence of impermissible financing practices related to health care-related taxes CMS will take enforcement action as necessary. CMS is available to provide technical assistance and work with states to ensure the permissibility of all of the sources of the non-federal share of Medicaid expenditures, including any health care-related taxes the state may impose.

Conclusion

CMS recognizes that health care-related taxes can be a permissible source of funding for the non-federal share of Medicaid expenditures. CMS is available to provide technical assistance to states, including by reviewing proposals or existing arrangements and providing feedback to develop or modify health care-related taxes to align with state policy goals and federal requirements. One key federal requirement is that a health care-related tax cannot have a hold harmless provision that guarantees to return all or a portion of the tax back to the taxpayer. 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.

CMS will continue to approve permissible health care-related tax programs that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS intends to work collaboratively with states by providing technical assistance as necessary to ensure the programmatic and fiscal integrity of the Medicaid program. For questions or to request technical assistance, please contact Rory Howe at rory.howe@cms.hhs.gov.

Message

From: CMS CLEARANCES (b)(6) (b)(6)

Sent: 1/3/2023 6:34:37 PM

To: Worstell, Megan (CMS/OFM) (b)(6) (b)(6) Czajkowski, John (CMS/OFM) (b)(6) (b)(6); Plater, Morris (CMS/OFM) (b)(6) (b)(6); Stokes-Murray (He/Him), Heinz (CMS/OFM) (b)(6) (b)(6); Tierney, Janet (CMS/OFM) (b)(6) (b)(6); Kelsey, Ashley (CMS/OFM) (b)(6) (b)(6) Carmichael, Wanda (CMS/OFM) (b)(6) (b)(6); Benns, Antoinette (CMS/OFM) (b)(6) (b)(6); Richter (she/her), Liz (CMS/CM) (b)(6) (b)(6) Rice, Cheri (CMS/CM) (b)(6) (b)(6) Ahern, Robert (CMS/CM) (b)(6) (b)(6); Mays, Beth (CMS/CM) (b)(6) (b)(6); Blackford (she/her), Carol (CMS/CM) (b)(6) (b)(6); Pequigney, Susan (CMS/CM) (b)(6) (b)(6); Farran, Patti (CMS/CM) (b)(6) (b)(6) Beder, Victoria (CMS/CM) (b)(6) (b)(6); Feaster, Simone (CMS/CM) (b)(6) (b)(6); Uebersax, Julie (CMS/CM) (b)(6) (b)(6); Held, William (CMS/CM) (b)(6) (b)(6); OToole, Meghan (CMS/OA) (b)(6) (b)(6); Labonte, Christiane (CMS/CM) (b)(6); Martin, Kristi (CMS/CM) (b)(6) Turco, Molly (CMS/CM); Jacobs, Douglas (CMS/CM) (b)(6); Hunter, Leah (CMS/CM) (b)(6) CMS CPI Clearance Box; Hart, Bradley (CMS/CPI)

(b)(6); Lindstrom, Jennifer (CMS/CPI) (b)(6); Mills, George (CMS/CPI) (b)(6); Brentzel, Ingrid (CMS/CPI) (b)(6); Graham, John (CMS/CPI) (b)(6); Wilson-Coe, Tomiko (CMS/CPI) (b)(6); Allen, Nakia (CMS/CPI) (b)(6); Ahmad, Namirah (CMS/CPI) (b)(6); Barkai, Melissa (CMS/CPI) (b)(6); Coates, Nikita (CMS/CPI) (b)(6); Mitchell, Dashe (CMS/CPI) (b)(6); Tott, Karen (CMS/CPI) (b)(6); Stevenson, Bryant (CMS/CPI (b)(6) (b)(6) DB]; Oelschlaeger, Allison (CMS/OEDA) (b)(6) up (b)(6) Shatto, Andrew (CMS/OEDA) (b)(6) (b)(6); Hitchcock, Katherine (CMS/OEDA) (b)(6) (b)(6); Harper, Bernice (CMS/OEDA (b)(6) (b)(6); CMS Front Office - CCIIO Clearances (b)(6) (b)(6); Wu (he/him), Jeff (CMS/CCIIO) (b)(6) (b)(6) Wilson, Lisa (CMS/CCIIO) (b)(6) (b)(6); Oconnor, Nancy (CMS/OPOLE) (b)(6) (b)(6); Rosta (she/her), Sara (CMS/CCIIO (b)(6) up (b)(6); Arapi, Leslie (CMS/OPOLE) (b)(6) (b)(6); Frimpong, Janny (CMS/CCIIO) (b)(6) (b)(6); Brooks, Kiahana (CMS/CCIIO) (b)(6) (b)(6); Cantwell, Kathleen (CMS/OSORA) (b)(6) (b)(6) Garcia, Vanessa (CMS/OSORA) (b)(6) (b)(6); Jackson, Marilyn (CMS/OSORA) (b)(6) (b)(6); Barnett Sherrill (She/Her), Alexis (CMS/OSORA) (b)(6) (b)(6) er]; Taylor, Isabel (CMS/OSORA) [(b)(6)

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Howden, Catherine (CMS/OC) (b)(6)
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Wagner, Rachel (CMS/OC) (b)(6)
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Thorn, Raymond (CMS/OC) (b)(6)
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(b)(6); Waskiewicz, Beth (CMS/OAGM) (b)(6); Tatum, Kimberly (CMS/OAGM (b)(6) (b)(6); Calabro, Alice (CMS/OAGM) (b)(6) Kelly, Ryan (CMS/OAGM) (b)(6) Hazelwood, Antoinette (CMS/OAGM) (b)(6) (b)(6); Schmitz, Stefanie (CMS/OAGM) (b)(6) (b)(6); Lanasa, Michele (CMS/OAGM) (b)(6) (b)(6); Eberhart, Christina (CMS/OAGM) (b)(6) (b)(6) Dionne.Brown@cms.hhs.gov; Rippey (she/her), Catherine (CMS/OHI) (b)(6) (b)(6) Hamilton, Andrea (CMS/OHI) (b)(6) (b)(6) Brauer (he/him), Randy (CMS/OHI) (b)(6) (b)(6); Slade, James (CMS/OHI) (b)(6) (b)(6); Hernandez (she/her), Laura (CMS/OHI) (b)(6) (b)(6); Teal, Lela (CMS/CMCS) (b)(6) (b)(6); Harris, Monica (CMS/CMCS) (b)(6) (b)(6); Harshman, Sara (CMS/CMCS (b)(6) (b)(6); Stegmaier, Jason (CMS/CMCS) (b)(6) (b)(6); Whelan, Ellen-Marie (CMS/CMCS) (b)(6) (b)(6); Miller, Courtney (CMS/CMCS (b)(6) (b)(6); Janu, Shanna (CMS/CMCS) (b)(6) (b)(6) Dorsey, Jennifer (CMS/CMCS) (b)(6) (b)(6) Fowler (she/her), Liz (CMS/CMMI) (b)(6) (b)(6) Tabe-Bedward, Arrah (CMS/CMMI (b)(6) (b)(6) Rushton, Andrew (CMS/CMMI (b)(6) (b)(6); Dziak, Kathleen (CMS/CMMI (b)(6) (b)(6); Cardin, Megan (CMS/CMMI (b)(6) (b)(6) OToole, Meghan (CMS/OA (b)(6) (b)(6); Wells, Carrie (CMS/CMMI) (b)(6) (b)(6); Barberi, Jade (CMS/CMMI) (b)(6)

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(b)(6) McGinley, Katelynn (CMS/CMMI) (b)(6)
(b)(6) Greene, Mary (CMS/OBRHI) (b)(6)
(b)(6) McClain, Rena (CMS/OBRHI) (b)(6)
(b)(6) Jackson, Michelle (CMS/CPI) (b)(6)
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(b)(6) St. Louis, Aileah (CMS/OC) (b)(6)
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(b)(6); Ellis (she/her), Kyla (CMS/OA) (b)(6)
(b)(6) Harris, Will (CMS/OA)
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(b)(6) Richardson (she/her), Erin (CMS/OA) (b)(6)
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(b)(6) Smalley, Elizabeth (HHS/ASPA (b)(6)
(b)(6); Levin, Michael (HHS/ASPA) (b)(6)
(b)(6); HHSPress@hhs.gov; releases@hhs.gov

CC: CMS CLEARANCES (b)(6)
(b)(6); Dinges, Enrico (CMS/OC)
(b)(6)
s]

Subject: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Attachments: Internal QAs CIB Health Care Related Taxes Hold Harmless Dec 27 4pm.docx; Healthcare Related Taxes CIB-Final (CMSDOGCmarkup) Responded rev FMG .docx

Please copy **Enrico Dinges** and on **ALL** responses pertaining to this item when replying to CMS Clearances.

Please see attached internal qas for review. The informational bulletin is FYI ONLY. Thank you.

Comments Due: 1:00 PM ET Thursday, January 5, 2023

All: For your review and input. Concurrent HHS/CMS review.

Title: Internal Q&As for CMCS informational bulletin on health care related taxes and hold harmless arrangements.
Agency/Office: CMCS

Subject/Description: CMS will release an informational bulletin on health care related taxes and hold harmless arrangements involving the redistribution of Medicaid payments. This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). There will be a reactive statement, listserv message, and internal questions-and-answers for this item.

COMMs Materials for Rollout: Internal Q&As

Deadline for COMMS Clearance comments: Thursday, January 5 by 1:00 PM

Requested Release date: 2/7/2023

Internal Questions and Answers
CIB on HealthCare Taxes and Hold Harmless Arrangements
EXPECTED RELEASE: February 7, 2023

Q: What is CMS announcing today?

CMCS is issuing an informational bulletin (CIB) to states reiterating certain federal requirements that pertain to health-care related taxes. Recently, CMS has discovered a few states with health care-related tax programs that appear to involve agreements among providers to redistribute their Medicaid payments to hold taxpayers harmless for the cost of the tax. The CIB reminds states that such arrangements are prohibited by the statute and regulations and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

Q: How do the problematic tax programs work?

In the arrangements, a state or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-federal share of state directed Medicaid payments back to the provider taxpayers. The taxpayers appear to enter a pre-arranged agreement to redistribute the Medicaid payments to ensure that all taxpayers, when accounting for both the original Medicaid payment (from the state through an MCO) and any redistribution payment from another taxpayer or taxpayers, receive all or any portion of their tax amount back.

Q: Why is this CIB important?

In the past few years, it appears that health care-related tax programs with problematic hold harmless arrangements are starting to proliferate nationally. CMS is aware of a few states with such problematic arrangements in place and a few additional states that intend to propose similar tax programs soon. These particular tax programs are typically emerging in connection with very large-dollar state directed payment proposals under Medicaid managed care. The CIB aims to ensure that states clearly understand the existing requirements so that they can develop approvable methodologies and make modifications as necessary to come into compliance with federal requirements.

Ensuring permissible non-federal share sources is critical to protecting Medicaid's sustainability through responsible stewardship of public funds. State use of impermissible non-federal share sources often artificially inflate federal Medicaid expenditures. Further, these arrangements reward providers based on their ability to fund the state share, and disconnect the Medicaid payment from Medicaid services, quality of care, health outcomes, or other Medicaid program goals. Of critical concern, it appears that the redistribution arrangements in this particular type of tax program are specifically designed to redirect Medicaid payments away from Medicaid providers that serve a high percentage of Medicaid individuals to providers that do not participate in Medicaid or have relatively lower Medicaid utilization.

Q: Does CMS support states' adoption of health care-related taxes?
Yes, when the tax meets statutory and regulatory requirements. CMS approves hundreds of state payment proposals per year that are funded by health care-related taxes that appear permissible.

Q: How will this impact/benefit Medicaid beneficiaries? How will this impact Medicaid providers?
The CIB is merely reiterating existing statutory and regulatory requirements and does not establish new policy. However, impermissible non-federal share financing arrangements can have a negative impact on beneficiaries. These particular arrangements result in managed care state-directed payments (after the payment redistributions) that reward providers based on their ability to fund the state share, instead of on Medicaid utilization, quality, equity, health outcomes, or other Medicaid program goals. Additionally, the payment redistributions are specifically designed to redirect Medicaid payments away from Medicaid providers to non-participating Medicaid providers.

Compared to permissible health care-related taxes, these problematic tax programs are more favorable to providers with relatively low Medicaid utilization. It is possible that some states may adjust existing tax programs or alter future tax programs to ensure compliance. Ultimately, we expect that such changes are beneficial to providers with relatively high Medicaid utilization and unfavorable to providers with relatively low Medicaid utilization.

Q. Is today's action being taken in response to any particular state's arrangements relating to generating the non-federal share of Medicaid funding?
No, this action is not being taken in response to any particular state's Medicaid financing arrangements. However, as described above CMS is aware of at least three states with existing arrangements that appear problematic (Texas, Florida, and Missouri). Additionally, CMS is concerned that North Carolina and Nevada may be planning to implement similar arrangements. Recently, CMCS worked with the Louisiana and its hospitals to avoid implementing a problematic tax program and ensuring compliance.

Message

From: Boston, Beverly (CMS/CMCS) (b)(6) (b)(6)
Sent: 1/12/2023 9:31:36 PM
To: Maccarroll, Amber (CMS/CMCS) (b)(6) (b)(6)
CC: Howe, Rory (CMS/CMCS) (b)(6) (b)(6); Silanskis, Jeremy (CMS/CMCS) (b)(6) (b)(6)
Subject: RE: RE: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements
Attachments: Healthcare Related Taxes CIB-Final (CMSDOGCmarkup) FMG.docx

I'm fine if you want to add them (attached)😁. I'm working on huge GAO CAPs report request on supplemental payments that will go to the Divs for update. Thank you!

HC Related Taxes CIB

Q/As Taxes CIB

Reactive Statement - Tax CIB

Beverly

From: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Sent: Thursday, January 12, 2023 4:25 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Good catch Beverly. Sorry I missed those. Yes, they need to be added in. Do you have time or do you want me to add them?

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, January 12, 2023 4:23 PM
To: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Amber. I do not see Tim Engelhardt's edits that he requested. Do they need to be added?

Beverly

From: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Sent: Thursday, January 12, 2023 4:00 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>

Subject: RE: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Hi Beverly –

I reviewed and provided a few minor (mainly formatting) edits. These are good to go by me, but I think Rory will likely want to review also before they go back.

Thanks, Amber

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, January 12, 2023 2:44 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Good afternoon,

The FMG Front Office is up next to clear the CIB and underlying docs prior to moving them back to the OCD. Please make any additional edits. I will accept the changes and will provide OCD with both clean and redlined versions. I'll be online late if needed.

HC Related Taxes CIB

Q/As Taxes CIB

Reactive Statement - Tax CIB

Thanks
Beverly

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, January 12, 2023 2:41 PM
To: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: RE: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Great. Thanks Jonathan, Kristin and team. I will clear the updates with the FMG Front Office and will move the items forward. So far, what I am hearing is that the CIB will not go through another round of CMS clearance, but will be moved forward to IOS/OMB/DPC.

Thank you!
Beverly

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Thursday, January 12, 2023 2:33 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: RE: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Beverly,

I believe Kristin and I have responded to all the comments and made of the edits that we feel are appropriate, including for the reactive statement. I don't think there is anything left for us to do. Please let us know if we can be of any further assistance. I will be glad to make any other changes anyone else suggests. Thank you.

Best,

Jonathan

Jonathan Endelman
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7500 Security Blvd.
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Baltimore, MD 21244-1850

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, January 12, 2023 2:26 PM
To: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: DUE COB TODAY: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Good afternoon team – **I am checking in on the status of the updated CIB. I understand from Rory that we are fine to reject the re-framing references proposed by OL. As the CIB is on a timeline for release by 1/23, can all edits/comments be wrapped up on the CIB/Q/As and Reactive Statement by COB today?**

Hello, **I am adding a SP link (below) for the reactive statement with OL comments/edits (attached) to be to aligned with the updated CIB and Q/As. Will these changes impact the OA briefing paper? We normally wait until we have clearance comments before going to OA, but I understand we are on a somewhat tight timeline.**

OC reconciled the comments. I did move the reconciled version of the CIB and Q/As to SharePoint (below). Please see attached with separate line edits/comments for full disclosure from OL and OGC. Please make edits in the reconciled version.

HC Related Taxes CIB

Q/As Taxes CIB

Reactive Statement - Tax CIB

Beverly

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Monday, January 9, 2023 4:31 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks, Beverly. I think some of the line edits are visible in the CIB, but many by OL are not visible. Is there a version with the line edits visible?

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, January 9, 2023 3:34 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Hello,

Please see attached with OL and OGC comments. Can you take a look and let me know **when you'll be able to turn around clean versions**? As a reminder, next step is R2 CMS and the OCD will concurrently send it directly to Rachel in IOS, Sara Sills in OMB (Rory I did mention to Perrie that we shared and advanced copy with OMB), and Jessica Schubel in DPC to review.

Thanks

Beverly

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Friday, January 6, 2023 4:29 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Looks good. I will circle back if there are any questions. Thank you all.

Beverly

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Friday, January 6, 2023 4:08 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

My edits are in and this is good to go. Thanks, all!

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Friday, January 6, 2023 2:47 PM
To: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Kristin,

Based on your comments would the below edits work? Please others review Kristin's comments in the attached and make edits here ➔ reactive that was drafted by OC **by COB today**.

(b)(5)

Thanks
Beverly

From: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Friday, January 6, 2023 2:19 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

I made some suggestions.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Friday, January 6, 2023 1:33 PM
To: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Kristin,

Status update: OCD confirmed we are still aiming for 1/23. OCD is awaiting OGC comments (if any) on the CIB. Once the CIB clears Comms, the OCD will send it directly to Rachel in IOS, Sara Sills in OMB (Rory I did mention to Perrie that we shared and advanced copy with OMB), and Jessica Schubel in DPC to review.

In addition due COB today - Here is the reactive that was drafted by OC for the CIB. **Please let me know if you have edits to the reactive statement developed by OC.**

Thanks
Beverly

From: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Wednesday, January 4, 2023 9:45 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Beverly. I defer to others but don't think the edits are helpful for the CIB. It was carefully crafted language. I would not recommend accepting these changes.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Wednesday, January 4, 2023 8:46 AM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: CIB Health Care Related Taxes and Hold Harmless Arrangements

Good morning and HNY!

Looping others. All Comms clearance comments on the CIB are due from commenters on 1/5. Please hold the attached FCHCO comments until all other comments on the CIB are received**. I will need clean and redlined comments once all comments are received**.

In addition due 12pm tomorrow 1/5 - Here is the reactive that was drafted by OC for the CIB. Please let me know if you have edits to the reactive statement developed by OC.

Thank you

Beverly

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 3:57 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Cc: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Hi, Beverly and Lia. Would you mind making should make sure the attached track changes based on a few suggestions from Tim make it into the final version? Please let me know if you have any questions.

Thanks,
Rory

From: Howe, Rory (CMS/CMCS)
Sent: Tuesday, January 3, 2023 3:49 PM
To: Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>
Subject: RE: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Hi Tim,

Happy New Year. I appreciate you taking the time to review and to comment. Thanks for catching the typo and for highlighting where we could be more precise to avoid misinterpretations. We'll update the draft CIB to address the comments/edit. Thanks again.

Rory

From: Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 3:16 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Rory –

I understand the CIB was FYI-only, but I feel compelled to share with you a few things in the attached. I was only reading it to try to learn the policy, but there is a place in the CIB where a reader could easily take away the wrong message. And a typo.

Tim Engelhardt (he/him)
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
202.690.6277

From: CMS CLEARANCES <CLEARANCES@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 1:35 PM
To: Worstell, Megan (CMS/OFM) <Megan.Worstell@cms.hhs.gov>; Czajkowski, John (CMS/OFM) <John.Czajkowski@cms.hhs.gov>; Plater, Morris (CMS/OFM) <Morris.Plater@cms.hhs.gov>; Stokes-Murray (He/Him), Heinz (CMS/OFM) <KHeinz.Stokes-Murray@cms.hhs.gov>; Tierney, Janet (CMS/OFM) <Janet.Tierney@cms.hhs.gov>; Kelsey, Ashley (CMS/OFM) <Ashley.Kelsey@cms.hhs.gov>; Carmichael, Wanda (CMS/OFM) <Wanda.Carmichael@cms.hhs.gov>; Benns, Antoinette (CMS/OFM) <Antoinette.Benns@cms.hhs.gov>; Richter (she/her), Liz (CMS/CM) <elizabeth.richter@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Ahern, Robert (CMS/CM) <Robert.Ahern@cms.hhs.gov>; Mays, Beth (CMS/CM) <Beth.Mays@cms.hhs.gov>; Blackford (she/her), Carol (CMS/CM) <Carol.Blackford@cms.hhs.gov>; Pequigney, Susan (CMS/CM) <Susan.Pequigney@cms.hhs.gov>; Farran, Patti (CMS/CM) <Patti.Farran@cms.hhs.gov>; Beder, Victoria (CMS/CM) <Victoria.Beder@cms.hhs.gov>; Feaster, Simone (CMS/CM) <simone.feaster@cms.hhs.gov>; Uebersax, Julie (CMS/CM) <Julie.Uebersax@cms.hhs.gov>; Held, William (CMS/CM) <William.Held@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Labonte, Christiane (CMS/CM) <Christiane.Labonte@cms.hhs.gov>; Martin, Kristi (CMS/CM) <Kristina.Martin@cms.hhs.gov>; Turco, Molly (CMS/CM) <Molly.Turco@cms.hhs.gov>; Jacobs, Douglas (CMS/CM) <Douglas.Jacobs@cms.hhs.gov>; Hunter, Leah (CMS/CM) <Leah.Hunter@cms.hhs.gov>; CMS CPI Clearance Box <CPI_Clearance_Box@cms.hhs.gov>; Hart, Bradley (CMS/CPI); Lindstrom, Jennifer (CMS/CPI) <Jennifer.Lindstrom@cms.hhs.gov>; Mills, George (CMS/CPI) <george.mills@cms.hhs.gov>; Brentzel, Ingrid (CMS/CPI) <Ingrid.Brentzel@cms.hhs.gov>; Graham, John (CMS/CPI) <John.Graham@cms.hhs.gov>; Wilson-Coe, Tomiko (CMS/CPI) <Tomiko.Wilson-Coe@cms.hhs.gov>; Allen, Nakia (CMS/CPI) <nakia.allen-mcghee@cms.hhs.gov>; Ahmad, Namirah (CMS/CPI) <Namirah.Ahmad@cms.hhs.gov>; Barkai, Melissa (CMS/CPI) <Melissa.Barkai@cms.hhs.gov>; Coates, Nikita (CMS/CPI) <Nikita.Coates@cms.hhs.gov>; Mitchell, Dashe (CMS/CPI) <Dashe.Mitchell@cms.hhs.gov>; Tott, Karen (CMS/CPI) <Karen.Tott@cms.hhs.gov>; Stevenson, Bryant (CMS/CPI) <bryant.stevenson@cms.hhs.gov>; Oelschlaeger, Allison (CMS/OEDA) <Allison.Oelschlaeger@cms.hhs.gov>; Shatto, Andrew (CMS/OEDA) <Andrew.Shatto@cms.hhs.gov>; Hitchcock, Katherine (CMS/OEDA) <Katherine.Hitchcock@cms.hhs.gov>; Harper, Bernice (CMS/OEDA) <Bernice.Harper@cms.hhs.gov>; CMS Front Office - CCIIO Clearances <FrontOffice-CCIIOClearances@cms.hhs.gov>; Wu (he/him), Jeff (CMS/CCIIO) <Jeff.Wu@cms.hhs.gov>; Wilson, Lisa (CMS/CCIIO) <lisa.wilson@cms.hhs.gov>; Oconnor, Nancy (CMS/OPOLE) <Nancy.OConnor@cms.hhs.gov>; Rosta (she/her), Sara (CMS/CCIIO) <Sara.Rosta@cms.hhs.gov>; Arapi, Leslie (CMS/OPOLE) <Leslie.Arapi@cms.hhs.gov>; Frimpong, Janny (CMS/CCIIO) <Janny.Frimpong@cms.hhs.gov>; Brooks, Kiahana (CMS/CCIIO) <Kiahana.Brooks@cms.hhs.gov>; Cantwell, Kathleen (CMS/OSORA) <Kathleen.Cantwell@cms.hhs.gov>; Garcia, Vanessa (CMS/OSORA) <Vanessa.Garcia@cms.hhs.gov>; Jackson, Marilyn (CMS/OSORA) <Marilyn.Jackson@cms.hhs.gov>; Barnett Sherrill

(She/Her), Alexis (CMS/OSORA) <Alexis.Sherrill@cms.hhs.gov>; Taylor, Isabel (CMS/OSORA) <Isabel.Taylor@cms.hhs.gov>; Palmer, Erin (CMS/OSORA) <erin.palmer@cms.hhs.gov>; Unruh, Patti (CMS/OSORA) <Patti.Unruh@cms.hhs.gov>; Khan, Farooq (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Lafferty, Tiffany (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>; Parham, William (CMS/OSORA) <WILLIAM.PARHAM@cms.hhs.gov>; Jones, Martique (CMS/OSORA) <Martique.Jones@cms.hhs.gov>; Phan, Thomas (CMS/OSORA) <Thomas.Phan@cms.hhs.gov>; Edmondson-Parrott, Michele (CMS/OSORA) <michele.edmondsonparrott@cms.hhs.gov>; Miller, Ruth-Sam (CMS/OSORA) <Ruth.Miller@cms.hhs.gov>; Lilley, Edward (CMS/OSORA) <Edward.Lilley@cms.hhs.gov>; McLemore, Monica (CMS/OSORA) <Monica.McLemore@cms.hhs.gov>; Witherspoon, Tia (CMS/OSORA) <Tia.Witherspoon@cms.hhs.gov>; CMS OIT Correspondence <OITCorrespondence@cms.hhs.gov>; Howden, Catherine (CMS/OC) <Catherine.Howden@cms.hhs.gov>; Tross, Jason (CMS/OC) <Jason.Tross@cms.hhs.gov>; Wagner, Rachel (CMS/OC) <Rachel.Wagner@cms.hhs.gov>; Fortin-Garcia, Carolina (CMS/OC) <Carolina.Fortin-Garcia@cms.hhs.gov>; Boykin, Jibril (CMS/OC) <Jibril.Boykin@cms.hhs.gov>; Dinges, Enrico (CMS/OC) <Eric.Dinges@cms.hhs.gov>; Joy-Bush, Keya (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Martin, Patrice (CMS/OC) <Patrice.Martin@cms.hhs.gov>; Mengel, Jonathan (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Myers, Gregory (CMS/OC) <Gregory.Myers@cms.hhs.gov>; Smith, Aaron (CMS/OC) <Aaron.Smith@cms.hhs.gov>; Sokol, Lisa (CMS/OC) <Lisa.Sokol@cms.hhs.gov>; Thorn, Raymond (CMS/OC) <Raymond.Thorn@cms.hhs.gov>; Washington, April (CMS/OC) <April.Washington@cms.hhs.gov>; Trucil, Daniel (CMS/OC) <Daniel.Trucil@cms.hhs.gov>; Ryan, Lorraine (CMS/OC) <lorraine.ryan@cms.hhs.gov>; Schinderle, Elizabeth (CMS/OC) <elizabeth.schinderle@cms.hhs.gov>; Mahoney, Christine (CMS/OC) <Christine.Mahoney@cms.hhs.gov>; Brager, Mark (CMS/OC) <Mark.Brager@cms.hhs.gov>; Clemens, Kristen (CMS/OC) <Kristen.Clemens@cms.hhs.gov>; Reeves, Alison (CMS/OC) <Alison.Reeves@cms.hhs.gov>; Walker, Chantel (CMS/OC) <Chantel.Walker@cms.hhs.gov>; Chambers, Gwendolyn (CMS/OC) <Gwendolyn.Chambers@cms.hhs.gov>; Gross, Jessica (CMS/OC) <Jessica.Gross@cms.hhs.gov>; Alexander, Bruce (CMS/OC) <Bruce.Alexander@cms.hhs.gov>; Wallace, Mary (CMS/OC) <Mary.Wallace@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Bradley, Tasha (CMS/OC) <Tasha.Bradley1@cms.hhs.gov>; Toomey, Mary (CMS/OC) <Mimi.Toomey@cms.hhs.gov>; Perkins, Valerie (CMS/OC) <Valerie.Perkins@cms.hhs.gov>; Williams, Tamika (CMS/OC) <Tamika.Williams@cms.hhs.gov>; Patrick, Michele (CMS/OC) <Michele.Patrick@cms.hhs.gov>; Mazzone, Maria (CMS/OC) <Maria.Mazzone@cms.hhs.gov>; Pressley, Erin (CMS/OC) <Erin.Pressley@cms.hhs.gov>; Miner, Amy (CMS/OC) <Amy.Miner@cms.hhs.gov>; Harmatuk, Frances (CMS/OC) <Frances.Harmatuk@cms.hhs.gov>; Reilly, Megan (CMS/OC) <Megan.Reilly@cms.hhs.gov>; Gordon, Erin (CMS/OC) <Erin.Gordon@cms.hhs.gov>; Franklin, Julie (CMS/OC) <Julie.Franklin@cms.hhs.gov>; Winer, Rachel (CMS/OC) <Rachel.Winer@cms.hhs.gov>; Dinicolo, Kelly (CMS/OC) <Kelly.Dinicolo@cms.hhs.gov>; Shaham, Lauren (CMS/OC) <Lauren.Shaham1@cms.hhs.gov>; Walen, Alyssa (CMS/OC) <Alyssa.Walen@cms.hhs.gov>; Jenkins, Courtney (CMS/OC) <Courtney.Jenkins@cms.hhs.gov>; Broccolino, Michele (CMS/OC) <Michele.Broccolino@cms.hhs.gov>; Booth, Jon (CMS/OC) <Jon.Booth@cms.hhs.gov>; Hennessy, Amy (CMS/OC) <Amy.Hennessy@cms.hhs.gov>; Costello, Stefanie (CMS/OC) <Stefanie.Costello@cms.hhs.gov>; McIver, LaShawn (CMS/OMH) <LaShawn.McIver@cms.hhs.gov>; Finch, Wanda (CMS/OMH) <Wanda.Finch@cms.hhs.gov>; Gentry, Pamela (CMS/OMH) <Pamela.Gentry@cms.hhs.gov>; Peddicord-Austin, Ashley (CMS/OMH) <Ashley.Peddicord-Austin@cms.hhs.gov>; Young, Brian (CMS/OMH) <Brian.Young@cms.hhs.gov>; Fleisher, Lee (CMS/CCSQ) <Lee.Fleisher@cms.hhs.gov>; Ling, Shari (CMS/CCSQ) <Shari.Ling@cms.hhs.gov>; Schreiber, Michelle (CMS/CCSQ) <Michelle.Schreiber@cms.hhs.gov>; Iwugo, Jeneen (CMS/CCSQ) <jeneen.iwugo@cms.hhs.gov>; Spence, Ashley (CMS/CCSQ) <Ashley.Spence@cms.hhs.gov>; Jenkins, Courtney (CMS/OC) <Courtney.Jenkins@cms.hhs.gov>; 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Subject: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Please copy **Enrico Dinges** and on **ALL** responses pertaining to this item when replying to CMS Clearances.

Please see attached internal qas for review. The informational bulletin is FYI ONLY. Thank you.

Comments Due: 1:00 PM ET Thursday, January 5, 2023

All: For your review and input. Concurrent HHS/CMS review.

Title: Internal Q&As for CMCS informational bulletin on health care related taxes and hold harmless arrangements.
Agency/Office: CMCS

Subject/Description: CMS will release an informational bulletin on health care related taxes and hold harmless arrangements involving the redistribution of Medicaid payments. This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). There will be a reactive statement, listserv message, and internal questions-and-answers for this item.

COMMs Materials for Rollout: Internal Q&As

Deadline for COMMS Clearance comments: Thursday, January 5 by 1:00 PM

Requested Release date: 2/7/2023