

Disapproval
South Carolina State Plan Amendment 16-0012-A, 17-0006-A, and 18-0011-A
Internal Questions and Answers

Question 1: What do South Carolina state plan amendment (SPA) 16-0012-A, 17-0006-A, and 18-0011-A propose to do?

These SPAs propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology.

Question 2: What are the effective dates of the SPAs and the projected federal budget impact?

SC-16-0012-A: Effective date is October 1, 2016. The state projected a federal budget impact for FFY 2017 of \$6,100,000.

SC-17-0006-A: Effective date is April 1, 2017. The state projected federal budget impacts for FFY 2017 of \$(141,531) and for FFY 2018 of \$(283,062).

SC-18-0011-A: Effective date is April 1, 2018. The state projected federal budget impacts for FFY 2018 of \$(1,532,791) and for FFY 2019 of \$(3,065,582).

Question 3: Why is CMS disapproving the SPAs?

Supplemental payments under these SPAs would be made to eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland Hospital. The payments proposed under these SPAs would be funded by transfers from the state's "Setoff Debt Collection Program", which garnishes state individual income tax refunds to satisfy outstanding liabilities owed to governmental entities for previously rendered medical services performed at the governmental providers. CMS reviewed the proposed state plan language, answers to the funding questions, and other documents related to these SPAs. The funding of the non-federal share of the proposed payments does not originate from a permissible source. Absent a permissible source of the non-federal share of payments, CMS cannot approve the proposed SPAs.

Specifically, South Carolina did not establish that the proposed payments to be made under these SPAs are consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

Question 4: When did CMS communicate this concern to the state?

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that this funding arrangement is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the

disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019 CMS communicated with the South Carolina Medicaid Director that CMS will issue a disapproval for the aforementioned SPAs unless the state provides new information regarding the source of the non-federal share for the proposed supplemental payments.

Question 5: What solutions has CMS explored with the state?

CMS discussed with the state the unallowable funding arrangement of the non-federal share of payments associated with these SPAs. CMS recommended finding an alternative funding arrangement that is allowable under statute and regulations. CMS also recommended the state withdraw SPAs 16-0012-A, 17-0006-A, and 18-0011-A in order to avoid future disapprovals.

Enforcement of the Provider Reassignment Regulation

Issue: On May 6th, the Department published the provider reassignment regulation (CMS 2413-F). This rule eliminates a state's ability to reassign reimbursement to third parties. Effective July 5, 2019, any state that previously reassigned portions of a provider's reimbursement to third parties must discontinue this practice. In order to ensure compliance with this regulation, CMS is proposing the following enforcement plan which includes several short-term and long-range measures:

Short-term Measures:

In order to ensure compliance with the provider reassignment regulation, FMG proposes drafting a CIB to communicate the following to states and/or providers:

- States are prohibited from reassigning provider reimbursement to third parties.
- If a state has been reassigning provider reimbursement to third parties, it must discontinue this practice by July 5, 2019.
- CMS will create a process to allow states to provide assurances that it is making payments to providers in accordance with 42 CFR 447.10.
- CMS may perform program oversight actions (audits/programs reviews) to verify that states have discontinued any practices that violate 42 CFR 447.10.
- Any state that is found to be out of compliance with the requirements of 42 CFR 447.10 may be at risk of disallowance of FFP associated with the applicable payment. For instance, if a state has continued to reassign reimbursement to third parties with regard to personal care service payments, once the extent of the issue is quantified via audit or program review, an applicable portion of the state's claim of FFP for personal care services could be at risk.
- CMS will create a Provider Reassignment Regulation mailbox to allow questions from states.

As will be mentioned in the CIB, states will be required to provide an assurance of compliance with 42 CFR 447.10. In addition to the initial assurance of compliance, CMS will also require states to periodically reaffirm continued compliance with the provider reassignment rule through the State plan process.

Long-range Measures:

CMS recognizes that any enforcement plan must also involve verification of compliance. As such, a certain level of auditing or program review should take place to verify whether a state has truly discontinued any impermissible reassignments. As FMG does not have the resources to perform the level of review required to determine whether a state is complying with the provider reassignment regulation, the Centers for Program Integrity (CPI) is better equipped to perform this oversight measure. While CPI may randomly select states as far as provider reassignment audits, FMG can also inform the selection of states by utilizing the State plan process. With regard to any State plan amendment to implement or amend reimbursement rates for practitioner services, FMG can ask a standard question to confirm that states have and continue to comply with this regulation. If a state fails to respond to this question or indicates that it has not discontinued impermissible reassignments, FMG can recommend the state to CPI for further review.

Enforcement of the Provider Reassignment Regulation

If, after an audit, a state is found to be non-compliant with the requirements in 42 CFR 447.10, FMG could then use the audit findings to disallow claims of FFP or attempt to fix the issue of non-compliance prospectively.

Other Considerations:

1) Use of TMSIS to verify compliance with the provider reassignment regulation

As TMSIS is a claims-based system, FMG does not believe it can be used to solely verify a provider received 100% of the reimbursement he/she was entitled to. While the claim in TMSIS or the state's MMIS may contain the dollar amounts to be paid to the provider, the process by which reassignment takes place may occur outside of these claims-based systems and the process, itself, may vary vastly from state to state. As such, the best option to confirm compliance of the provider reassignment regulation would be an audit/program review.

2) State Plan Assurances

FMG has observed that some State plans have assurances that payment is made in accordance with the requirements of 42 CFR 447.10. For instance, below is the language that is on page 68 of Attachment 4.21 of Arizona's State plan:

“Prohibition against Reassignment of Provider Claims
Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.”

While we can put forth an initiative to have states either reaffirm or memorialize these assurances in their State plans, this initiative would have to be followed by some level of verification via audit or a program review in order to be completely effective.

Enforcement of the Provider Reassignment Regulation

Enforcement Plan

- **Phase I-** Communication:
 - FMG proposes to draft a CIB to communicate the following to states and/or providers with regard to the Provider Reassignment Regulation:
 - States are prohibited from reassigning provider reimbursement to third parties.
 - If a state has been reassigning provider reimbursement to third parties, it must discontinue this practice by July 5, 2019.
 - CMS will create a process to allow states to provide assurances that it is making payments to providers in accordance with 42 CFR 447.10
 - CMS may perform program oversight actions (audits/programs reviews) to verify that states have discontinued any practices that violate 42 CFR 447.10.
 - Any state that is found to be out of compliance with the requirements of 42 CFR 447.10 may be at risk of disallowance of FFP associated with the applicable payment. For instance, if a state has continued to reassign reimbursement to third parties with regard to personal care service payments, once the extent of the issue is quantified via audit or program review, an applicable portion of the state's claim of FFP for personal care services could be at risk.
 - CMS will create a Provider Reassignment Regulation mailbox to allow questions from states.
- **Phase II-** Confirmation:
 - **Assurances:** As will be mentioned in the CIB, states will be required to provide an assurance of compliance with 42 CFR 447.10.
 - Through the State plan process, CMS will also require states to periodically reaffirm continued compliance with the Provider Reassignment Rule.
- **Phase III-** Verification:
 - **On-going Audits/Program Reviews:** FMG believes CPI has the resources to perform this level of program oversight.
- **Phase IV-** Measures if/when states are found to be non-compliant:
 - Deferrals/Disallowance of claims for personal cares services and/or other applicable practitioner services.

California Medicaid Financing Issues

Issue 1:

California has numerous longstanding unresolved financial issues that have resulted in overdrawn balances in various fiscal years' Medicaid Payment Management System (PMS) subaccounts.

Background:

Over the past few years, the state has actively worked with CMS on numerous financial issues that has resulted in resolving approximately \$900 million of overdrawn balances in various Medicaid PMS subaccounts. In January of 2018, the state's negative Medicaid PMS balances totaled more than \$1.1 billion. As of March 2019, the state's negative Medicaid balances total approximately \$187.9 million.

These overdraws are a result of the state drawing Medicaid funding in excess of its reported and allowable expenditures. CMS has determined that the vast majority of the negative balance amounts are the result of the state's inappropriate draw practices, longstanding unresolved deferrals, delayed CMS-64 certifications, and delayed certified public expenditure reconciliations.

The state has been drawing federal funds for deferred Medicaid expenditures without returning the money back to their PMS subaccounts. In addition, the state has a long standing practice of not resolving these deferred funds. The state refers to these as "placeholder" deferrals and there is currently approximately \$3.3 billion in outstanding placeholder deferrals.

California has a historical practice that goes back prior to 2003 of requesting that CMS not take action on its outstanding deferrals. These placeholder deferrals are mostly for claims based on estimates submitted to allow the state to preserve its ability to claim beyond the 2 year filing limit. We estimate that at one point there were about 15 years of deferrals outstanding. Throughout most of this process the state had not actively tried to resolve these deferrals. They routinely cited resource issues and difficulty obtaining documentation from counties and providers.

The state has also been delayed in certifying its expenditures due to current issues with providing supporting documentation for Medicaid expansion expenditures claimed at 100% FMAP. Since 2014, this issue has been cited as part of CMS' annual CFO audit.

In addition, the state has outstanding Certified Public Expenditure (CPE) reconciliations authorized through two separate 1115 waivers for which they have not performed either an interim and/or a final reconciliation. The state's last final reconciliation was completed for SFY 05/06. These delays also impact other aspects of California's claiming system.

Current Status:

California Medicaid Financing Issues

CMS has raised the issue of the PMS negative balance and the deferral resolution with the state on numerous occasions over the past seven years. In November 2015, CMS approved an STC to the state's 1115 waiver to ensure that the state would work to bring its PMS account into balance. The STC required that the state work collaboratively with CMS to identify, document, and prioritize outstanding issues, and create a timeline for resolution by June 30, 2017. In addition, the STCs require that the state immediately return federal funds to the applicable PMS subaccount when a deferral is issued.

There are numerous financial issues remaining that need to be addressed related to the fiscal deficiencies in the state's Medicaid Program.

To comply with the STCs, the state provide CMS with 2 proposed timelines to resolve longstanding deferrals. The first is related to deferrals for CA SPA 06-016 approved August 2, 2012 with an effective date of October 14, 2006 and covers costs through September 2014. The SPA, which has not been implemented, has an estimated \$517,646,800 FFP in outstanding deferrals. Under the state's proposed timeline, they propose to begin making payment in February of 2018 and payments would continue through June of 2020.

The second timeline is related to deferrals for CA county inmate services. The period for service was retroactively approved back to October 2010 and continues through March 31, 2017. These deferrals represent an estimated \$120,629,619 in FFP. Under the state's proposed timeline, they propose to begin making payment in August of 2018 and payments would continue through December of 2019.

Based on a March 2019 meeting with the state, they were waiting for a CMS approval below taking the above actions. CMS informed the state that they should be working to resolve all financial issue and do not need CMS' approval.

Because the state has a historical practice of significantly over estimating their claims, we question the accuracy of the state's reported estimated amounts for these deferrals.

Recommendations:

We recommends that:

- 1) CMS reiterate to California that CMS has no authority to allow deferrals (placeholder claims) to remain unresolved for extended periods of time and that CMS will resolve all deferrals in accordance with the regulations. (The practice of allowing questionable (estimated) claims as placeholders is inconsistent with the general claiming requirements, as well as contradictory to the certification language that states must sign when filing a quarterly expenditure report.) In addition, enforce the requirement for the state to immediately return federal funds to the applicable PMS subaccount when a deferral is issued.
- 2) CMS provide the state revised timelines for resolution of the long outstanding deferrals as follows:

California Medicaid Financing Issues

- a. For all deferrals prior to the first quarter of 2015, CMS should notify the state that they need to provide the required supporting documentation within 120 days or CMS will disallow these deferrals. (These are deferrals that should be resolved through the STC 161 process that include deferrals for cost from 2012 and earlier.)
- b. For all deferrals from the first quarter of 2015 and later, CMS should notify the state that we will enforce the deferral timeframes outlined in the regulations and the state should provide the documentation within 120 days or they would be at risk of CMS issuing disallowances to the state.
- c. For all other deferrals, CMS should notify the state that in accordance with the statute and regulations it has no authority to allow the claims unless the state can provide support that the claims meet the timely claims filing requirements or one of its exceptions.

***Note:** The state has resolved a large portion of its backlogged deferrals since the since the approval of the 1115 waiver.*

- 3) CMS work with the state to facilitate the completion of the outstanding CMS-64 reviews, including the focused Medicaid expansion reviews. The state should also provide assurances that it will timely certify the CMS-64 each quarter and if the required documentation is not available, the state will remove the questionable expenditures and certify. If the state does not remove the questionable expenditures, CMS will continue to issue deferrals to the state until such time as the reviews are completed.
- 4) CMS accept the state's proposed timeline for completion of the CPE reconciliations. The state provided CMS a chart that indicates specific FYs by which it would finalize the cost settlements. They propose to finalize all the 1115 waiver CPE payments for FY2006 through FY2015 by FY2018/2019 and finalize all the state plan supplemental payment CPE methodologies for FY2002 through FY2014 by FY2022/2023. CMS should be clear that if the state does not finalized the cost settlements by the proposed timeframes, the cost settlements/final reconciliations will be time barred.

California Medicaid Financing Issues

Issue 2:

California does not submit Medicaid managed care contracts and capitation rates to CMS timely for review and approval.

Background:

Medicaid managed care is the predominant delivery system for the vast majority of Medicaid beneficiaries in California. As of March 2016, over 10.5 million Medicaid beneficiaries (68 percent) received comprehensive care through Medicaid managed care.¹

All states are required to submit Medicaid managed care contracts and rate certifications to CMS for review and approval, with MCO contracts requiring prior CMS approval, in accordance with 42 CFR §438.3(a), 438.7(a) and 438.806(b). California is consistently late in submitting Medicaid managed care contracts and rate certifications to CMS for review and approval. For example, on November 30, 2016, the State submitted its State Fiscal Year (SFY) 2016 (July 1, 2015 through June 30, 2016) rates for most of its managed care programs (i.e. five months after the rating period ended). Additionally, on December 30, 2016, the State submitted its SFY 2017 rates for most of its managed care programs (i.e. six months after the rating period began). Many states submit contracts and rates prospectively, but states often submit rate certifications after the start of the rating period (mean - 65 days late; median -17 days late). California is currently the most delayed of any state with contract and rate submissions.

The State is also delayed in responding to the CMS Office of the Actuary's (OACT) questions on active rate reviews. While the State has made progress, many question sets have been with the State for over 5 months. The lack of timely submission and response to OACT's questions limits CMS's ability to conduct efficient and timely rate reviews. See the attached appendix for further details on the status of active rate reviews and outstanding rate submissions.

California's current practice for rate submissions also poses difficulties for OACT's budget projections. Typically, the State submits base capitation rates to CMS often after the rating period has ended and then later submits rate adjustments, very close to the 2-year timely filing deadline, to include pass-through payments funded by intergovernmental transfers (IGTs) and other assessments after the amount is known. These adjustments are sizeable, with OACT estimating pass-through payments for calendar year 2014 of approximately \$790 million for the New Adult population alone.²

Current Status:

CMS has raised our concerns regarding the late submissions to the State on several occasions. The State had indicated that they plan to move to prospective submission of contracts and rates

¹ Data is reported by the state: <http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx> June 2016

² This OACT estimate is based on the mid-point of the capitation rate ranges included within the rate certifications.

California Medicaid Financing Issues

beginning with SFY 2018; however the State failed to accomplish this. Rate certifications for SFY 2018 remain outstanding as well as many rate certifications for SFYs 2016 and 2017 (a total of 22 rate certifications for base rates). In September 2017, CMS requested that the State provide an estimated timeframe for each outstanding rate certification (base certifications and rate amendments). The State failed to meet its initial estimated timeframe for many of these rate certifications. For example, of the 11 base certifications and 5 rate amendments the State committed to submit to CMS between September and November 2017, CMS has only received 1 base certification and 5 rate amendments, leaving 10 base certifications outstanding. On December 19, 2017, the State provided a revised estimated timeline for all outstanding rate certifications. Originally, the State proposed to have all outstanding rate submissions to CMS by January 2018; the State's revised timeline now extends until May 2018. See the attached appendix for further details.

Recommendation:

CMS recommends that we require the State to submit a corrective action plan (CAP) with dates that the State will submit all of its contract and rate submissions through SFY 2018/CY s2018 for strict oversight. If the State does not meet the timelines in its CAP, CMS should consider financial consequences for the State. CMCS is currently working with the Office of General Counsel to identify options for reasonable financial consequences that could be imposed upon the State.

California Medicaid Financing Issues

Appendix for Issue Two: Status of California's Medicaid Managed Care Rate Submissions³

Active Rate Submissions Currently with the State: (as of 12/26/2017)

#	Name of Program	Rating Period	Date of Last CMS Submission to State	Notes
1	Geographic Managed Care (GMC) Classic	July 2015 - June 2016 (SFY 2016) Rate Amendment	06/23/2017	
2	GMC Rural Expansion	SFY 2016 Rate Amendment	06/23/2017	
3	Two Plan	SFY 2016 Rate Amendment	06/23/2017	
4	Coordinated Care Initiative (CCI) – Non Duals	SFY2016 Rate Amendment	06/27/2017	
5	County Organized Health System (COHS) Classic	SFY 2016 Rate Amendment	06/27/2017	
6	COHS Rural Expansion	SFY 2016 Rate Amendment	06/27/2017	
7	Medicaid Expansion	SFY 2016 Rate Amendment	06/29/2017	
8	Dental LA County	SFY 2016 Base Rates	08/01/2017	State responded to Round 1 questions on 06/28/2017.
9	Dental Sacramento County	SFY 2016 Base Rates	08/01/2017	State responded to Round 1 questions on 06/28/2017.
10	CCI - Duals	CY 2015 Base Rates	09/27/2017	State responded to Round 1 questions on 07/18/2017.
11	Two Plan	July 2016 - June 2017 (SFY 2017) Rate Amendment	09/22/2017	
12	GMC Rural Expansion	SFY 2017 Rate Amendment	09/22/2017	
13	GMC Classic	SFY 2017 Rate Amendment	09/22/2017	
14	COHS (Classic and Rural Expansion)	SFY 2017 Rate Amendment	09/22/2017	
15	Medicaid Expansion	SFY 2017 Rate Amendment	11/28/2017	
16	CCI – Non Duals	SFY 2017 Base Rates	11/29/2017	

³ California's State Fiscal Year (SFY) is July 1 to June 30 (i.e. SFY 2017 would be July 1, 2016 to June 30, 2017).

California Medicaid Financing Issues

Active Rate Submissions Currently with CMS: (as of 12/26/2017)

#	Name of Program	Rate Period	Date of Last State Submission to CMS	Notes
1	HIF Amendment	CY 2015 Rate Amendment		Pending completion of base rate review. No further technical questions at this time.
2	Medicaid Expansion	SFY 2016 Base Rates	07/18/2017	No further technical questions at this time, however pending review of COHS Classic and Two Plan certifications.
3	GMC Classic	SFY 2017 Base Rates	10/12/2017	Round 2 responses under review by OACT.
4	GMC Rural Expansion	SFY 2017 Base Rates	10/12/2017	Round 2 responses under review by OACT.
5	COHS Classic	SFY 2016 Base Rates	11/06/2017	Round 3 responses under review by OACT.
6	Two Plan	SFY 2016 Base Rates	11/06/2017	Round 3 responses under review by OACT.
7	Expansion	SFY 2017 Base Rates	11/06/2017	Round 2 responses under review by OACT.
8	COHS Classic	SFY 2017 Base Rates	11/06/2017	Round 2 responses under review by OACT.
9	Two Plan	SFY 2017 Base Rates	11/06/2017	Round 2 responses under review by OACT.

California Medicaid Financing Issues

Outstanding Rate Submissions: *(as of 12/26/2017)*

This list includes (1) rate certifications for development of initial rate ranges (i.e. base rates); and (2) any anticipated rate amendments. California routinely submits rate amendments for its comprehensive programs to account for pass-through payments and other programmatic changes.

#	Program	Rating Period	Original Expected Submission Date (Provided 09/14/2017)	Revised Expected Submission Date (Provided 12/19/2017)
1	AIDS Healthcare Foundation	01/01/2016-06/30/2016	September 2017	December 2017/January 2018
2	AIDS Healthcare Foundation	SFY 2017	September 2017	December 2017/January 2018
3	AIDS Healthcare Foundation	SFY 2018	January 2018	January 2018/February 2018
4	California Children's Services (CCS) – San Mateo	SFY 2018 (Package 1)	January 2018	End January 2018
5	CCS – San Mateo	SFY 2018 (Package 2)	N/A	May 2018
6	COHS (Classic and Rural Expansion)	01/01/2017-06/30/2017 (Rate Amendment)	January 2018	May 2018
7	COHS (Classic and Rural Expansion)	SFY 2018 (Package 1)	January 2018	End January 2018
8	COHS (Classic and Rural Expansion)	SFY 2018 (Package 2)	N/A	May 2018
9	CCI Duals	CY 2016	October/November 2017	December 2017/January 2018
10	CCI – Duals	CY 2017	January 2018	February 2018
11	CCI – Non Dual	SFY 2018 (Package 1)	January 2018	End January 2018
12	CCI – Non Dual	SFY 2018 (Package 2)	N/A	May 2018
13	Delta Dental	SFY 2017	October/November 2017	December 2017
14	Delta Dental	SFY 2018	October/November 2017	December 2017
15	Family Mosaic	SFY 2016	September/October 2017	TBD
16	Family Mosaic	SFY 2017	September/October 2017	TBD
17	Family Mosaic	SFY 2018	September/October 2017	TBD
18	GMC Classic	01/01/2017-06/30/2017 (Rate Amendment)	January 2018	May 2018
19	GMC Classic	SFY 2018 (Package 1)	January 2018	End January 2018

California Medicaid Financing Issues

#	Program	Rating Period	Original Expected Submission Date (Provided 09/14/2017)	Revised Expected Submission Date (Provided 12/19/2017)
20	GMC Classic	SFY 2018 (Package 2)	N/A	May 2018
21	GMC Rural Expansion	01/01/2017-06/30/2017 (Rate Amendment)	January 2018	May 2018
22	GMC Rural Expansion	SFY 2018 (Package 1)	January 2018	End January 2018
23	GMC Rural Expansion	SFY 2018 (Package 2)	N/A	May 2018
24	LA County Dental	SFY 2017	October/November 2017	December 2017
25	LA County Dental	SFY 2018	January 2018	January 2018/February 2018
26	Medicaid Expansion Population	01/01/2017-06/30/2017 (Rate Amendment)	January 2018	May 2018
27	Medicaid Expansion Population	SFY 2018 (Package 1)	January 2018	End January 2018
28	Medicaid Expansion Population	SFY 2018 (Package 2)	N/A	May 2018
29	Sacramento Dental	SFY 2017	October/November 2017	December 2017
30	Sacramento Dental	SFY 2018	January 2018	January 2018/February 2018
31	Two Plan	01/01/2017-06/30/2017 (Rate Amendment)	January 2018	May 2018
32	Two Plan	SFY 2018 (Package 1)	January 2018	End January 2018
33	Two Plan	SFY 2018 (Package 2)	N/A	May 2018

California Medicaid Financing Issues

Certifications Received Since September 2017

#	Program	Rating Period	Expected State Submission Date
1	CCI – Non Dual	SFY 2017	September 2017 – Received 09/22/2017
2	GMC Classic	7/1/16-12/31/16 Rate Amendment	September 2017 – Received 09/22/2017
3	GMC Rural Expansion	7/1/16-12/31/16 Rate Amendment	September 2017 – Received 09/22/2017
4	Two Plan	7/1/16-12/31/16 Rate Amendment	September 2017 – Received 09/22/2017
5	COHS (Classic and Rural Expansion)	7/1/16-12/31/16 Rate Amendment	September 2017 – Received 09/22/2017
6	Medicaid Expansion Population	7/1/16-12/31/16 Rate Amendment	September 2017 – Received 09/22/2017

	A	B	C	D	E
1	California Disallowances and Deferral Tracker By Year				
2					
3					
4			Year	Total Disallowances/Deferrals	Amount
5	Disallowances		2019	2	\$ 87,716,894
6			2015-2018	0	\$ -
7					
8	Deferrals		2018	8	\$ 76,631,679
9			2017	29	\$ 211,668,964
10			2016	89	\$ 2,529,678,495
11			2015	68	\$ 870,243,490

Financial Management Group Clearance Items

May 15, 2019

Time: 1pm – 1:30pm

Location: **Conference Room A**

Conference Dial-in Number: 1-877-267-1577

Meeting ID: b6

Standing Items:

Access NPRM, *J. Silanskis*, no paper

Medicaid Fiscal Accountability Regulation (MFAR), *DRSF/DFO*, no paper

DSH Allotment Reduction Rule, *R. Howe*, no paper

Discussion Items:

1. **Topic:** South Carolina SPA Disapprovals, *DRSF*, **paper**

Action Needed By: May 15, 2019

Decision Requested: Yes, FMG would like OCD to concur with moving forward with the disapprovals.

Summary: South Carolina's proposed SPAs 16-0012-A, 17-0006-A, and 18-0011-A would add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. The payments proposed under these SPAs would be funded by transfers from the state's "Setoff Debt Collection Program", which garnishes state individual income tax refunds to satisfy outstanding liabilities owed to governmental entities for previously rendered medical services performed at the governmental providers. The funding of the non-federal share of the proposed payments originates from medical revenue rather than a permissible source (state or local tax revenue). Absent a permissible source of the non-federal share of payments, CMS cannot approve the proposed SPAs.

2. **Topic:** Enforcement of the Provider Payment Reassignment Rule, *C. Thompson*, **paper**

Action Needed By: N/A

Decision Requested: N/A

Summary: FMG would like to present a four phase approach to the implementation and enforcement of the provider reassignment regulation.

3. **Topic:** State-only Findings check-in, *K. Fan*, **no paper**
Action Needed By: N/A
Decision Requested: Yes, FMG would like direction from OCD with regards to moving forward with the disallowances.
Summary: FMG would like to revisit the topic of State-only findings with OCD and where we stand with next steps.

4. **Topic:** CA Financing Issues (Deferrals, Disallowances & Negative Balances), *DFO*, **paper**
Action Needed By: N/A
Decision Requested: N/A
Summary: OCD previously requested a paper on California's previous deferrals and disallowances. FMG is providing OCD with a list of those for fiscal years 2015-2019, along with a paper summarizing California Medicaid financing issues.

SC CAN BE SENT TODAY: MO PENDING 7/11: Signed Letters for SC and MO

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>
Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Tue, 09 Jul 2019 14:57:03 +0000
Attachments: Jennifer Tidball_ Signed.doc (177.66 kB); SC Disapproval Letter Final_ Signed.docx (121.99 kB); RE: Night Note (119.81 kB)

Good morning,

See attached from Rosa, SC has been cleared for release. **PLEASE TYPE TODAY'S DATE ON THE SC LETTER** prior to sending it to the ROG for release. DRSF please circle back with me once the state has been notified so I can close the loop with the OCD.

Missouri is going to Night Notes on 7/10 for a 7/11 release.

Thank you!

Beverly

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, July 8, 2019 10:40 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>
Subject: DO NOT YET SEND: Signed Letters for SC and MO

Good morning,

See attached, Calder now has an electronic signature. We are still awaiting the greenlight in order send both SC Disapproval and MO Reconsideration to the pertinent states.

Please DO NOT instruct the ROG to send these until we have been given the official okay from the OCD.

I will get back to DRSF first, as the OCD is aware of tomorrow due date for SC, DFO by the end of the week.

Thank you

Beverly

From: Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Sent: Monday, July 8, 2019 10:05 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Subject: Signed Letters for SC and MO

Please remember NOT to send the letters until OCD have given the official approval that it is okay to send. We know that SC must be sent by tomorrow and that MO out the door on Friday.

Thank you,

Lela Teal
Center for Medicaid and CHIP Services | O: 410.786.1064 | iPhone: 443-934-4049 | lela.teal@cms.hhs.gov

"This e-mail is intended for the sole use of the intended recipient and may contain privileged, sensitive, or protected health information. If you are not the intended recipient, be advised that the unauthorized use, disclosure, copying, distribution, or action taken in reliance on the contents of this communication is prohibited. If you have received this e-mail in error, please notify the sender via telephone or return e-mail and immediately delete this e-mail."

Ms. Jennifer Tidball, Acting Director
Department of Social Services
PO Box 1527
Jefferson City, MO

RE: Reconsideration of Disallowance Control Number: MO/2019/001/MAP

Dear Ms. Tidball:

I have reviewed your May 8, 2019, request for reconsideration of CMS' March 12, 2019, decision to disallow \$4,824,901 federal financial participation (FFP) for unallowable outpatient prescription drugs.

In your request for reconsideration, you raised several arguments, none of which present adequate cause for CMS to alter its analysis in this case. After careful consideration, CMS determined that the state did not provide any additional or new information for CMS to consider. For these reasons, as well as those stated in the March 12, 2019, disallowance letter, the \$4,824,901 FFP disallowance is affirmed.

We request that the state make a decreasing adjustment in the amount of \$4,824,901 FFP on Line 10A of your Form CMS-64 for the next quarter.

The state also requested that CMS provide: copies of all of the CMS quarterly drug tapes relevant to the claims that are the subject of this disallowance; a list of all of the drugs questioned and whether each drug had a rebate agreement with HHS for the time period at issue; and, a list of the outpatient drug claims that CMS maintains are "unsupported", and a description of the documentation required to support those claims.

In accordance with 42 CFR 92.42 it is the state's responsibility to maintain documentation for a period of three years or if an audit has been started before the expiration of the three years, the records must be maintained until the completion of the action and resolution of all issues which arise from it, whichever is later. Additionally, the OIG provided Missouri with the list of drug expenditures that were questioned in the audit.

Appeals to the HHS Departmental Appeals Board (DAB)

A notice of appeal to the DAB must be submitted within 60 calendar days following the state's receipt of an unfavorable determination for the Secretary's reconsideration. Refer to 45 C.F.R. Part 16 for procedures of the DAB. The notice of appeal must be submitted by mail, commercial delivery, facsimile/fax (for appeals 10 pages or less), or electronically via the DAB's electronic filing system (DAB E-File). For the DAB filing procedures, see <http://www.hhs.gov/dab/divisions/appellate/guidelines/procedures.html>. Depending on the particular transmission mode, the appeal is recognized to have been submitted on the date that it

Page 2 – Jennifer Tidball, Acting Director

was postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully transmitted via DAB E-File. Regardless of the mode utilized to transmit the original copy, a duplicate hard copy must be simultaneously forwarded to my attention at the address at the top of this letter. Once submitted, the DAB will directly notify the state of further procedures. Information regarding specific modes follows.

Mail or commercial delivery must be addressed as follows:

U.S. Department of Health and Human Services
Departmental Appeals Board, MS 6127, Appellate Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington D.C. 20201

Facsimile/fax delivery (permitted only if the notice of appeal is 10 pages or less) must use the DAB Appellate Division's fax number: (202) 565-0238.

Use of DAB E-File (<https://dab/efile.hhs.gov/>) requires that you or a member of your staff become a registered user by clicking "Register" at the bottom of the homepage and entering the information requested on the "Register New Account" form and then clicking the "Register Account" button. Once registered, sign on to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions are available on the homepage.

Should you require further details regarding this matter, please contact James G. Scott, Director Division of Medicaid Field Operations North, at (816) 426-5925.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized flourish at the end.

Calder Lynch
Acting 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



Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid state plan amendments (SPAs) 16-0012-A, 17-0006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs.

In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds

that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed non-federal share funding source is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019, CMS communicated with the South Carolina Medicaid Director that CMS would issue a disapproval for the aforementioned SPAs unless the state provided new information regarding the source of the non-federal share for the proposed supplemental payments. The state requested time to provide additional information to support the proposals, which CMS granted. The information that the state subsequently provided did not describe an alternative funding source that would allow us to approve the proposed SPAs.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations in 42 C.F.R. § 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations in 42 C.F.R. § 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized, flowing script.

Calder Lynch
Acting Deputy Administrator and Director

RE: RE: Night Note

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>
Cc: "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>
Date: Tue, 09 Jul 2019 14:36:52 +0000

Great, we'll date stamp the letter and will inform the ROG that the disapproval package can be sent to the state. I'll circle back when the state has been notified.

Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:35 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Yes on SC.

MO—lets wait until it is officially on the NN.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:27 AM
To: Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

We have to release SC today, or else the SPA will be deemed approved. Can I inform staff and ROG to send it?

Beverly

From: Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:26 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

I got Calder approval on SC and MO on July 3rd

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

It will be on the NN on July 10th to be issued on July 11th.

Lela normally handles the signing of the letter, etc. So not sure if she's been able to get that in front of him yet...

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:22 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Great, thank you. Please let me know if Calder is okay with us sending the letter as soon as NN clears? Thurs is the latest, but folks here and in the ROG would greatly appreciate if we can close this out as soon as practicable.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:20 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Ok, that works. I sent it up yesterday as well.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6)

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:19 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

We would like to get it out by Thurs 7/11. We want to avoid any Friday mishaps with folks not being in the office etc...

Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 7:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Welcome.

When are we sending MO?

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:19 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Thanks!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:10 PM
To: Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: FW: Night Note

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Mack, Rosa (CMS/CMCS)
Sent: Monday, July 8, 2019 4:02 PM
To: Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Cc: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Williams, Tamika M.

(CMS/OC) <Tamika.Williams@cms.hhs.gov>

Subject: Re: Night Note

Letter/email to the state.

Also, the 90th day is tomorrow. So we have to send it tomorrow.

Sent from my iPhone

On Jul 8, 2019, at 3:58 PM, Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov> wrote:

Hey Rosa,

Can you clarify how Disapproval of South Carolina Medicaid State Plan Amendment will be notified? Is it a letter to the state?

Disapproval of South Carolina Medicaid State Plan Amendment	CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21, 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.	Disapproval to South Carolina's Medicaid state plan amendments

From: Mack, Rosa (CMS/CMCS)

Sent: Monday, July 8, 2019 2:26 PM

To: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>

Subject: RE: Night Note

FYI there's no rollout for these—they do not get posted, etc. The regions just send the state the letter. That's it.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>
Sent: Monday, July 8, 2019 2:24 PM
To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>
Subject: RE: Night Note

Plus OC leadership – we have a handful of rollouts slated for the 11th so flagging

Brittney Manchester
Senior Advisor
Integrated Communications Management Staff
Office of Communications
Centers for Medicare & Medicaid Services
brittney.manchester1@cms.hhs.gov
202-205-8028 (office)
b6 (cell)

From: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>
Sent: Monday, July 8, 2019 2:22 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Subject: RE: Night Note

Adding Keya.

We can add this to the NN on the 10th (To go out the 11th). This won't make the NN today.

Jason Stegmaier

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 1:25 PM
To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>
Subject: Night Note

Hi Jason,

We have a two items that we need to get added to the next possible (earliest) night note. Let me know if you need anything. Thanks!

Disapproval of South Carolina Medicaid State Plan Amendment

Tomorrow CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21 , 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.

Missouri Disallowance Reconsideration

Tomorrow CMS will notify the state of Missouri of a Medicaid disallowance in the amount \$4,824,901 for unallowable outpatient prescription drugs were no longer eligible for reimbursement or were inadequately documented in accordance with federal requirements. After careful consideration, CMS determined that the state did not provide any additional or new information for CMS to consider. For these reasons, as well as those stated in the March 12, 2019 disallowance letter, CMS is affirming the \$4,824,901 disallowance. The letter outlines the states options regarding an appeal. The state is aware of the disallowance reconsideration, and there will be no planned media covering this item.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

Materials for FMG's Wednesday 1pm EST Meeting with the CMCS OCD

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Nelson, Barbara A. (CMS/CMCS)" <barbara.nelson@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Dunn, Victoria (CMS/CMCS)" <victoria.dunn@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>, "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>, "Traylor, Christopher (CMS/CMCS)" <christopher.traylor@cms.hhs.gov>, "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>
Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Keller, Betty S. (CMS/CMCS)" <betty.keller@cms.hhs.gov>, "Cooley, Mark S. (CMS/CMCS)" <mark.cooley@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Hall, Melissa R. (CMS/CMCS)" <melissa.hall@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Cieslicki, Mary E. (CMS/CMCS)" <mary.cieslicki@cms.hhs.gov>, "Weaver, Robert K. (CMS/CMCS)" <robert.weaver@cms.hhs.gov>, "Badaracco, Andrew (CMS/CMCS)" <andrew.badaracco@cms.hhs.gov>, "Mikow, Asher S. (CMS/CMCS)" <asher.mikow@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "Kimble, Davida R. (CMS/CMCHO)" <davida.kimble@cms.hhs.gov>, "Glaze, Jackie L. (CMS/CMCHO)" <jackie.glaze@cms.hhs.gov>, "Ruiz, Susan F. (CMS/CMCS)" <susan.ruiz@cms.hhs.gov>, "Holzbaur, Charlene M. (CMS/CMCHO)" <charlene.holzbaur@cms.hhs.gov>, "Dubois, Anna M. 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Date: Tue, 25 Jun 2019 19:15:41 +0000

Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB); Draft RAI Response for CMS 19-0003 DME Cures Act.docx (20 kB); Draft RAI Response TN 19-0006 SUD.DOCX (19.14 kB); DME - 2018 State Submission Tracking.xlsx (25.46 kB); DME SMDL_OCD Summary_06.25.19.docx (15.12 kB); MD Q2 2019 DSH+IP_Brief_6-25-19SG.DOCX (25.37 kB); Access strategy CIB final.docx (40.77 kB); FMG CLEARANCE Agenda 06-26-2019.docx (34.9 kB)

CMCS CENTER DIRECTOR CLEARANCE WITH THE FINANCIAL MANAGEMENT GROUP (FMG)

June 26, 2019

Conference Room A, 1pm – 2pm EST

Conference Dial in Number: **877-267-1577**

Meeting ID

b6

Please see attached an agenda and materials for Wednesday's **1pm – 2pm** EST clearance meeting with the Office of the Center Director. **For those participating by phone, please be sure to dial into the call at the start of the meeting and plan to stay until completion.** This will help with any disruption while discussions are still ongoing.

Agenda:

<<...>>

Standing Items:

ACCESS NPRM, J. Silanskis, paper

<<...>>

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, no paper

DSH Allotment Reduction Rule, R. Howe, no paper

Discussion Items:

1. South Carolina SPA Disapproval, DRSF, no paper

2. Maryland Deferral, DFO, paper

<<...>>

3. Program Integrity Strategy Update for PRR, K. Fan, no paper

4. **New Hampshire SPA, RAI Responses, *DRSF*, paper**

<<...>> <<...>>

5. **Durable Medical Equipment FFP Limit Update, *DRSF*, paper**

<<...>> <<...>>

	A	B	C	D
1	State's Meeting the DME Compliance Requirements through DME Demonstration			
2	State	Date Received	Compliant Via Demonstration	Variance (Under)/Over (Total Computable)
3	CONNECTICUT	3/19/2019	Demonstration	\$ (1,518,096.79)
4	MASSACHUSETTS	3/26/2019	Demonstration	\$ (5,709,413.27)
5	NEW HAMPSHIRE	2/20/2019	Demonstration	\$ (83,589.30)
6	RHODE ISLAND	3/6/2019	Demonstration	\$ 15,722.28
7	NEW JERSEY	4/22/2019	Demonstration	\$ (293,435.66)
8	NEW YORK	5/15/2019	Demonstration	\$ (3,532,120.32)
9	DELAWARE	5/16/2019	Demonstration	\$ (960,068.00)
10	PENNSYLVANIA	3/27/2019	Demonstration	\$ 278,111.48
11	GEORGIA	4/1/2019	Demonstration	\$ (4,898,082.62)
12	KENTUCKY	4/17/2019	Demonstration	\$ (46,473.68)
13	MISSISSIPPI	3/27/2019	Demonstration	\$ (382,627.17)
14	NORTH CAROLINA	3/29/2019	Demonstration	\$ 2,704,681.91
15	SOUTH CAROLINA	4/1/2019	Demonstration	\$ 484,499.15
16	INDIANA	5/13/2019	Demonstration	\$ 2,596,211.03
17	MICHIGAN	3/27/2019	Demonstration	\$ (372,104.20)
18	OHIO	3/22/2019	Demonstration	\$ (357,524.04)
19	WISCONSIN	3/19/2019	Demonstration	\$ 2,398,448.74
20	LOUISIANA	5/7/2019	Demonstration	\$ 26,756.73
21	OKLAHOMA	3/28/2019	Demonstration	\$ 87,949.39
22	TEXAS	3/25/2019	Demonstration	\$ (27,162.18)
23	KANSAS	3/6/2019	Demonstration	\$ 9,135.09
24	MISSOURI	3/26/2019	Demonstration	\$ 1,071,138.10
25	SOUTH DAKOTA	4/15/2019	Demonstration	\$ 648,566.41
26	UTAH	2/28/2019	Demonstration	\$ (923,814.56)
27	WYOMING	2/27/2019	Demonstration	\$ 661,999.44
28	ARIZONA	5/22/2019	Demonstration	\$ (10,655,195.62)
29	CALIFORNIA	3/29/2019	Demonstration	\$ (11,651,677.28)
30	NEVADA	5/27/2019	Demonstration	\$ (2,557,244.87)
31	ALASKA	6/6/2019	Demonstration	\$ 519,636.38
32	IDAHO	4/1/2019	Demonstration	\$ (1,351,296.09)
33	Total Computable Overpayment:			\$ 11,502,856.12
34				
35	State's Meeting the DME Compliance Requirements through the SPA Process			
36	State	Date Received	Compliance Via State Plan or Demonstration	
37	VERMONT		Managed Care	
38	PUERTO RICO		Managed Care	
39	VIRGIN ISLANDS		1915j	
40	DISTRICT OF COLUMBIA	4/25/2019	SPA	
41	VIRGINIA		SPA	
42	WEST VIRGINIA	4/25/2019	SPA	
43	ALABAMA		SPA	
44	TENNESSEE	4/18/2019	Managed Care	
45	NEBRASKA		SPA	
46	COLORADO		SPA	
47	MONTANA		SPA	
48	NORTH DAKOTA		SPA	
49	AMERICAN SAMOA		1915j	
50	FED STATE MICRONESIA		1915j	
51	GUAM		1915j	
52	MARIANA ISLANDS		1915j	
53	WASHINGTON		SPA	
54				
55	States that Have Not Met the DME Compliance Requirements			
56				
57	State*	Status		
58	MAINE			
59	MARYLAND			
60	FLORIDA	<i>Plans to Submit by 6/30</i>		
61	ILLINOIS			
62	MINNESOTA			
63	ARKANSAS	<i>Plans to Submit by 7/1</i>		
64	NEW MEXICO	<i>Has Approved SPA - Needs Work</i>		
65	IOWA			
66	HAWAII			
67	OREGON			
68	<i>*All Non-Compliant States have been contacted</i>			

A	B	C	D	E	F	G	H	I	J	K	L	M
State	RO	Abbv	Date Received	State Plan or Demonstration	State or CMS Demonstration	Variance (Under)/Over (Total Computable)	If SPA, list SPA #	Sent Assurances?	Received Assurances?	Completed & Finalized?	Received From (Email)	Notes
CONNECTICUT	1	CT	3/19/2019	Demonstration	CMS	\$ (1,518,096.79)	CT 18-0019	Yes	Yes	Yes	Nicole.Godburn@ct.gov	
MASSACHUSETTS	1	MA	3/26/2019	Demonstration	CMS	\$ (5,709,413.27)	MA 18-009	Yes	Yes	Yes	Nathan.Bosdet2@state.ma.us	
MAINE	1	ME										
NEW HAMPSHIRE	1	NH	2/20/2019	Demonstration	CMS	\$ (83,589.30)		Yes	Yes	Yes	Sheri.Lacasse@dhs.nh.gov	
RHODE ISLAND	1	RI	3/6/2019	Demonstration	CMS	\$ 15,722.28		Yes	No		Michelle.Amado@cchhs.ri.gov	
VERMONT	1	VT		Managed Care								
NEW JERSEY	2	NJ	4/22/2019	Demonstration	CMS	\$ (293,435.66)		Yes	Yes	Yes	Gregory.H.Lovell@dhs.state.nj.us	
NEW YORK	2	NY	5/15/2019	Demonstration	CMS	\$ (3,532,120.32)		Yes	No		Thomas Heckert	
PUERTO RICO	2	PR		Managed Care								
VIRGIN ISLANDS	2	VI		1915]								
DISTRICT OF COLUMBIA	3	DC	4/25/2019	SPA								Uses 100% of Competitive Bid Rates & DMEPOS State said they paid Medicare, rates were far less.
DELAWARE	3	DE	5/16/2019	Demonstration	CMS	\$ (960,068.00)		Yes	Yes	Yes		
MARYLAND	3	MD										
PENNSYLVANIA	3	PA	3/27/2019	Demonstration	State	\$ 278,111.48		Yes	Yes	Yes	Lantes@pa.gov	
VIRGINIA	3	VA		SPA			VA 14-016					
WEST VIRGINIA	3	WV	4/25/2019	SPA								80% of existing Medicare Rate
ALABAMA	4	AL		SPA			AL 18-0001, 100% Medicare					
FLORIDA	4	FL										
GEORGIA	4	GA	4/1/2019	Demonstration	CMS	\$ (4,898,082.62)		Yes	No		peter.dalba@dch.ga.gov	
KENTUCKY	4	KY	4/17/2019	Demonstration	State	\$ (46,473.68)					Jacob.Wilson@ky.gov	
MISSISSIPPI	4	MS	3/27/2019	Demonstration	State	\$ (382,627.17)		Yes	Yes	Yes	Michael.Daschbach@medicaid.mys.gov	State Developed - Converted some "UE" to "NU" or "RR"
NORTH CAROLINA	4	NC	3/29/2019	Demonstration	CMS	\$ 2,704,681.91		Yes	Yes	Yes	Betty.J.Stanton@dhs.nc.gov	
SOUTH CAROLINA	4	SC	4/1/2019	Demonstration	State	\$ 484,499.15		Yes	No		Brian.Amicke@scdhs.gov	
TENNESSEE	4	TN	4/18/2019	Managed Care								Provided an assurance that DME is 100% managed care
ILLINOIS	5	IL										
INDIANA	5	IN	5/13/2019	Demonstration	CMS	\$ 2,596,211.03		No	No		Gabrielle.Koenig@fssa.IN.gov	
MICHIGAN	5	MI	3/27/2019	Demonstration	CMS	\$ (372,104.20)		Yes	Yes	Yes	Blacke@michigan.gov	
MINNESOTA	5	MN										
OHIO	5	OH	3/22/2019	Demonstration	State	\$ (357,524.04)		Yes	Yes	Yes	Mark.Rogers@medicaid.ohio.gov	
WISCONSIN	5	WI	3/19/2019	Demonstration	State	\$ 2,398,448.74		Yes	Yes	Yes	Matthew.DeLaBruere@dhs.wisconsin.gov	
ARKANSAS	6	AR										
LOUISIANA	6	LA	5/7/2019	Demonstration	State	\$ 26,756.73		Yes	Yes	Yes	Marjorie.Jenkins@LA.GOV	
NEW MEXICO	6	NM										
OKLAHOMA	6	OK	3/28/2019	Demonstration	CMS	\$ 87,949.39						Not enough information in data file - followed up w/ State
TEXAS	6	TX	3/25/2019	Demonstration	CMS	\$ (27,162.18)		Yes	Yes	Yes	Bereengere.dutra@bhsc.state.tx.us	
IOWA	7	IA										
KANSAS	7	KS	3/6/2019	Demonstration	CMS	\$ 9,135.09	KS 18-0004	Yes	Yes	Yes	William.Stelzer@kansas.gov	
MISSOURI	7	MO	3/26/2019	Demonstration	CMS	\$ 1,071,138.10		Yes	Yes	Yes	Glenda.A.Kremer@dss.mo.gov	Provided Area-Data, and June 2018 Rural Data
NEBRASKA	7	NE		SPA			NE 18-0005					
COLORADO	8	CO		SPA			CO 17-0044					
MONTANA	8	MT		SPA			MT 18-0033					
NORTH DAKOTA	8	ND		SPA			Yes					
SOUTH DAKOTA	8	SD	4/15/2019	Demonstration	CMS	\$ 648,566.41	SD 19-0001	Yes	No		Matthew.Ballard@state.sd.us	State will follow Medicare for items subject to limit
UTAH	8	UT	2/28/2019	Demonstration	State	\$ (925,814.56)		Yes	No		kcirless@utah.gov	Call on 4/24 to discuss demonstration
WYOMING	8	WY	2/27/2019	Demonstration	CMS	\$ 661,999.44	(set all rates to 100% Medicare, except oxygen)	Yes	Yes	Yes	amy.guimond@wyo.gov	
AMERICAN SAMOA	9	AS		1915]								
ARIZONA	9	AZ	5/22/2019	Demonstration	CMS		pending					
CALIFORNIA	9	CA	3/29/2019	Demonstration	CMS	\$ (11,651,677.28)	Yes- Pending access study- 10% decrease- CA-19-0005	Yes	Yes			
FED STATE MICRONESIA	9	FM		1915]								
GUAM	9	GU		1915]								
HAWAII	9	HI										
MARIANA ISLANDS	9	MP		1915]								
NEVADA	9	NV	5/27/2019	Demonstration	CMS	\$ (2,557,244.87)	No	Yes	Yes	Yes		
ALASKA	10	AK	6/6/2019	Demonstration	CMS	\$ 519,636.38	AK 18-0002	Yes	No			
IDAHO	10	ID	4/1/2019	Demonstration	State	\$ (1,351,296.09)	ID 18-0004	Yes	Yes	Yes	Angela.Toomey@dhw.idaho.gov	
OREGON	10	OR										
WASHINGTON	10	WA		SPA			WA 18-0011					
Totals					Total Impact	\$ (23,161,873.91)						
SPA	9				Total Over	\$ 11,502,856.12						
Demonstration	30				Total Under	\$ (34,664,730.04)						
Managed Care	3											
1915]	5											
No Response	10											

DME FFP Limit Summary

Effective January 1, 2018, the statute requires a limit to available FFP for state Medicaid fee-for-service expenditures for DME, per Section 1903(i)(27) of the Act.

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1861(n) and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of title XVIII, including, as applicable, under a competitive acquisition program under section 1847 in an area of the State.

The limit is calculated in the aggregate to the amount that Medicare would [have](#) paid for the same items through the Medicare DMEPOS fee schedule, or, as applicable, the Medicare competitive bidding program. The statute specifically applies to items of durable medical equipment that are covered by both Medicare and Medicaid, and does not limit Medicaid's ability to provide DME that is not covered by Medicare. It does not include prosthetics, orthotics, or supplies. The statute also does not mandate that states pay Medicare rates for all Medicaid DME.

States have one of two methods of demonstrating compliance with the statutory provisions:

1. *Calculation of an FFP Limit Demonstration* – For states the FFP Limit, states will be required to calculate the FFP limit in the aggregate by comparing the existing state Medicaid payment rate for each qualifying item of DME to the most current and relevant Medicare fee schedule payment rate for the same item of DME multiplied by the Medicaid volume and applying the relevant fee schedule in the same area of the state. The aggregate payments in Medicaid for all medical equipment and appliances must be less than or equal to the aggregate payments for the same items of DME in Medicare. The demonstrations are due to CMS by the end of March for the prior calendar year.
2. *Compliance through the Submission of a State Plan Amendment* – States may choose to submit a state plan amendment to demonstrate compliance with the regulatory provisions by setting their payment rates at the amount that Medicare would pay for DME in the state. A state that sets its Medicaid rates for medical equipment and appliances at an amount that is less than or equal to the Medicare DME payment rates would be considered to have met the requirements of this rule because such a methodology would prevent the state from exceeding the statutory limit.

Maryland DSH Timely Filing - Deferral Brief

Amount of FFP: \$20,132,172 FFP

Time Period: FY 2015

How CMS Identified the Issue: Q2 2019 CMS-64 Review

Basis for Deferral: Maryland claimed \$20,132,172 Federal Financial Participation (FFP) as a prior period increasing adjustment. However, the state has not provided the necessary documentation to support this adjustment. In accordance 42 C.F.R 430.40 we are requesting that the state submits additional documentation to support the claim.

Last Communication with State: 6/20/19 – CMS discussed these prior period adjustments (PPAs) with the state and with their contractor. The Regional Office requested supporting documentation to justify the state’s adjustments, but the state has not yet provided the necessary support.

THREE THINGS YOU NEED TO KNOW:

1. In order to properly redistribute DSH funds, a state must submit a redistribution methodology to be approved by CMS. MD has an approved methodology, but it does not allow the state to reclassify DSH claims to inpatient claims
2. Based on findings from the State of Maryland’s FY 2015 Final DSH report, hospitals had received a net amount of \$20,132,172 FFP over their hospital-specific DSH limits. Maryland returned the amount in full as a Line 10B prior period decreasing adjustment, but also made a corresponding/matching increasing prior period adjustment (Line 8 adjustment) of \$20,132,172 FFP for inpatient claims.
3. The Health Services Cost Review Commission (HSCRC) sets an “all payer rate” for hospitals under a Medicare waiver. If these DSH payments would have been collected by the state, the facilities would have been paid below their HSCRC rate. MD is attempting to reclassify these expenditures as IP claims to maintain the rates set by the HSCRC Medicare waiver. The Regional Office requested support for these adjustments, but the state has yet to provide any documentation.

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

BACKGROUND:

The Regional Office has performed its review of the State of Maryland's CMS-64 expenditures for the quarter ending March 31, 2019. Maryland claimed \$20,132,172 FFP as a prior period increasing adjustment for previously claimed DSH expenditures. MD has attempted to reallocate the funds from DSH to inpatient payments. Based on findings from Maryland's FY2015 Final DSH report, hospitals had received a net amount of \$20,132,172 FFP over their hospital-specific DSH limits. Maryland returned the amount in full as a decreasing PPA, but also made a corresponding/matching increasing PPA of \$20,132,172 FFP for inpatient claims.

The intended adjustment out of compliance with the state's CMS-approved DSH redistribution methodology. The attempted reclassification of these DSH claims to inpatient claims also creates secondary issues with the HSCRC program. The HSCRC sets an "all payer rate" for hospitals, regardless of whether the facilities are private, public, etc. Because these facilities were paid over their hospital-specific limit and the funds had to be returned, if the funds were collected by the state, the facilities would have been paid below their HSCRC rate.

KEY STAKEHOLDER CONSIDERATIONS:

Currently we are not aware of any stakeholder considerations.

ANTICIPATED LEGISLATIVE REACTION

Currently we are not aware of any concerns raised by legislators.

COST/COVERAGE IMPACT

The anticipated budget impact is \$20,132,172 FFP

ATTACHMENTS

N/A

RECOMMENDATION:

The East Division of the Regional Operations Group (ROG) requests concurrence to issue a disallowance to Maryland in the amount of \$20,132,172 FFP.

Agree with Recommendation: Yes _____ No _____

Calder Lynch – CMCS Acting Center Director _____

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



CMCS Informational Bulletin

DATE:

FROM: Calder Lynch
Acting Deputy Administrator and Director

SUBJECT: Comprehensive Strategy for Monitoring Access in Medicaid

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that we are initiating a strategy to measure and monitor beneficiary access to care across Medicaid. We are committed to develop a new data-driven strategy to understand access to care in the Medicaid program across fee-for-service and managed care delivery systems, as well as in home and community-based services (HCBS) waiver programs. This new strategy will focus on a more uniform and comprehensive methodology for analyzing Medicaid access data for all states and will be led by CMS working in partnership with states.

Background:

Section 1902(a)(30)(A) of the Act requires states to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” In the November 2, 2015 **Federal Register** (80 FR 67576) we published the “Methods for Assuring Access to Covered Medicaid Services” final rule with comment period that outlined a data-driven process for states to document their compliance with section 1902(a)(30)(A) of the Act. Among other requirements, the 2015 final rule with comment period required states to develop and submit to CMS an access monitoring review plan (AMRP) for certain Medicaid services that is updated at least every three years. Additionally, the rule required that when states submit a State plan amendment (SPA) to reduce or restructure provider payment rates, they must consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed reduction or restructuring of Medicaid payment rates on beneficiary access to care.

Numerous states expressed concern regarding the administrative burden associated with the November 2015 regulatory requirements, especially those states with high rates of beneficiary enrollment in managed care. States have also questioned whether the AMRP process is the most effective or accurate reflection of access to care in a state’s Medicaid program. In

attempt to address some of the states' concerns regarding unnecessary administrative burden, in the March 23, 2018 **Federal Register** (83 FR 12696), we published a proposed rule that would have exempted states from requirements to analyze certain data or monitor access when the vast majority of their covered beneficiaries receive services through managed care plans and would have provided similar flexibility to all states when they make nominal rate reductions to fee-for-service payment rates. Based on the responses we received during the public comment period, we have decided not to finalize the proposed exemptions and instead are setting out a new approach to understanding access and ensuring statutory compliance while eliminating unnecessary burden on states.

Please note that CMS' intent is to improve access to care and will continue to ask states how they are meeting the statutory requirements, and address access to care concerns expressed by beneficiaries and other stakeholders.

While CMS believes the AMRPs can be useful to guide states overall process to monitor beneficiary access, because they are generally limited to access in fee-for-service delivery systems and focused on targeted payment rate changes rather than the availability of care or population health outcomes, we have decided a more comprehensive approach is warranted. Concurrently with this Informational Bulletin, we are publishing a Notice of Proposed Rulemaking (NPRM) in the **Federal Register** that proposes to rescind the requirements of the 2015 final rule with comment period while we develop a more comprehensive approach to monitoring access across delivery systems. Through the NPRM, we are seeking comments and feedback from our stakeholders regarding both the rescission of the current regulatory requirements and our approach moving forward.

It is important to note, that until such point that the NPRM is finalized, the current regulatory requirements are still applicable. And, although the NPRM would remove the regulatory process requirements for states to develop and update an AMRP and to submit certain access analysis when proposing to reduce or restructure provider payment rates, states still are obligated by the statute **to ensure Medicaid payment rates are sufficient to enlist enough providers to assure that beneficiary access to covered care and services is at least consistent with that of the general population in the same geographic area, particularly when reducing or restructuring Medicaid payment rates through SPAs.** If the regulatory amendments in this proposed rule are finalized, we would utilize existing CMS authority concurrently with the publication of the final rule through a letter to State Medicaid Directors to provide information on data and analysis that states may submit with SPAs to support compliance with section 1902(a)(30)(A) of the Act. Such data might include: rate comparisons; ratios of participating providers to total providers in the geographic area; ratios of participating providers to beneficiaries in the geographic area; available transportation in the geographic area; direct comparisons of access for Medicaid beneficiaries to that of the general population in the geographic area; and provider, beneficiary, and other stakeholder complaints and recommendations for resolution of such complaints.

Developing a New Access Strategy:

We want to work collaboratively with states and other stakeholders to develop a streamlined, comprehensive approach to monitoring access across Medicaid delivery systems by identifying uniform access indicators that may be measured through available data. To accomplish this, we

will convene workgroups and technical expert panels that include key state and federal stakeholders in the upcoming months. The workgroup will focus on identifying: 1) how the current requirements could be improved; 2) the most effective approach to ensuring beneficiary access to care; 3) how can CMS best ensure states comply with the statutory access requirements; and 4) the best way to align access monitoring across fee-for-service and managed care delivery systems. The workgroups will also identify data that could be available to conduct access reviews at the federal level and the types of analyses that would be beneficial.

Next Steps:

In the coming weeks, CMS will be working with the National Association of Medicaid Directors (NAMd) to identify states that would be interested in partnering with us on this important initiative by participating in technical expert panels and ongoing working groups. Our focus will be to identify measures and benchmarks and data that may be used as common access indicators across fee-for-service, managed care and home and community based waivers. Throughout the process, we will be soliciting feedback and input on the strategy and will work collaboratively with our state partners and other stakeholders to determine a comprehensive access measurement approach.

/s/

Financial Management Group Clearance Items

June 26, 2019

Time: 1pm – 2pm

Location: **Conference Room A**

Conference Dial-in Number: 1-877-267-1577

Meeting ID: b6

Standing Items:

Access NPRM, *J. Silanskis*, no paper

Medicaid Fiscal Accountability Regulation (MFAR), *DRSF/DFO*, no paper

DSH Allotment Reduction Rule, *R. Howe*, no paper

Discussion Items:

1. **Topic:** South Carolina SPA Disapprovals Update, *DRSF*, no paper

Action Needed By: N/A

Decision Requested: N/A

Summary: South Carolina's proposed SPAs 16-0012-A, 17-0006-A, and 18-0011-A. The payments proposed under these SPAs would be funded by transfers from the state's "Setoff Debt Collection Program", which garnishes state individual income tax refunds to satisfy outstanding liabilities owed to governmental entities for previously rendered medical services performed at the governmental providers. The funding of the non-federal share of the proposed payments originates from medical revenue rather than a permissible source (state or local tax revenue). Absent a permissible source of the non-federal share of payments, CMS cannot approve the proposed SPAs.

2. **Topic:** Maryland Deferral, *DFO*, paper

Action Needed By: June 26, 2019

Decision Requested: FMG would like OCD to concur with moving forward with the deferral.

Summary: Maryland claimed \$20,132,172 Federal Financial Participation (FFP) as a prior period increasing adjustment. However, the state has not provided the necessary documentation to support this adjustment. In order to properly redistribute DSH funds, a state must have an approved redistribution methodology in their state plan. MD has an approved methodology, but it does not allow the state to reclassify DSH claims to inpatient claims. On June 20, 2019, CMS discussed these prior period adjustments (PPAs) with the state and with their contractor. The Regional Office requested supporting documentation to justify the state's adjustments, but the state has not yet provided the necessary support.

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3. **Topic:** Program Integrity Strategy Update for PPR, *K. Fan*, **no paper**
Action Needed By: N/A
Decision Requested: N/A
Summary: FMG would like to discuss the current status for the PPR Program Integrity Strategy.

4. **Topic:** New Hampshire SPA, RAI Responses, *DRSF*, **paper**
Action Needed By: N/A
Decision Requested: N/A
Summary: FMG would like to discuss with OCD the state's draft RAI responses to SPAs 19-0003 and 19-0006, related to donations.

5. **Topic:** Durable Medical Equipment FFP Limit Update, *DRSF*, **paper**
Action Needed By: N/A
Decision Requested: N/A
Summary: FMG wants to discuss the statutorily limited FFP for DME expenditures, effective January 1, 2018, which allows states to choose from two methods of demonstrating compliance with the provision and the state submission tracking chart.

RE: RE: Missouri Reconsideration Night Note

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>
Cc: "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Date: Thu, 11 Jul 2019 19:30:45 +0000
Attachments: MO - Reconsideration of Disallowance - MO/2019/001/MAP (350.21 kB)

It's out the door. Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Thursday, July 11, 2019 2:00 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>
Subject: RE: Missouri Reconsideration Night Note

Yes. Please let us know when you send the letter. Thanks!

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, July 11, 2019 1:59 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Subject: Missouri Reconsideration Night Note

Hello,

Checking whether we are still on target to release the MO reconsideration letter today? Has it cleared night notes.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

It will be on the NN on July 10th to be issued on July 11th.

Lela normally handles the signing of the letter, etc. So not sure if she's been able to get that in front of him yet...

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:22 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Great, thank you. Please let me know if Calder is okay with us sending the letter as soon as NN clears? Thurs is the latest, but folks here and in the ROG would greatly appreciate if we can close this out as soon as practicable.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:20 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Ok, that works. I sent it up yesterday as well.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6 6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:19 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

We would like to get it out by Thurs 7/11. We want to avoid any Friday mishaps with folks not being in the office etc...

Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 7:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Welcome.

When are we sending MO?

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6 b6)

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:19 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Thanks!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:10 PM
To: Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: FW: Night Note

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6)

From: Mack, Rosa (CMS/CMCS)
Sent: Monday, July 8, 2019 4:02 PM
To: Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Cc: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>
Subject: Re: Night Note

Letter/email to the state.

Also, the 90th day is tomorrow. So we have to send it tomorrow.

Sent from my iPhone

On Jul 8, 2019, at 3:58 PM, Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov> wrote:

Hey Rosa,

Can you clarify how Disapproval of South Carolina Medicaid State Plan Amendment will be notified? Is it a letter to the state?

Disapproval of South Carolina Medicaid State Plan Amendment	CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21, 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.	Disapproval to South Carolina's Medicaid state plan amendments

From: Mack, Rosa (CMS/CMCS)

Sent: Monday, July 8, 2019 2:26 PM

To: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>

Subject: RE: Night Note

FYI there's no rollout for these—they do not get posted, etc. The regions just send the state the letter. That's it.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6)

From: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>
Sent: Monday, July 8, 2019 2:24 PM
To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>
Subject: RE: Night Note

Plus OC leadership – we have a handful of rollouts slated for the 11th so flagging

Brittney Manchester

Senior Advisor
Integrated Communications Management Staff
Office of Communications
Centers for Medicare & Medicaid Services
brittney.manchester1@cms.hhs.gov
202-205-8028 (office)
b6 ll)

From: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>
Sent: Monday, July 8, 2019 2:22 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Subject: RE: Night Note

Adding Keya.

We can add this to the NN on the 10th (To go out the 11th). This won't make the NN today.

Jason Stegmaier

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 1:25 PM
To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>
Subject: Night Note

Hi Jason,

We have a two items that we need to get added to the next possible (earliest) night note. Let me know if you need anything. Thanks!

Disapproval of South Carolina Medicaid State Plan Amendment

Tomorrow CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections

rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21 , 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.

Missouri Disallowance Reconsideration

Tomorrow CMS will notify the state of Missouri of a Medicaid disallowance in the amount \$4,824,901 for unallowable outpatient prescription drugs were no longer eligible for reimbursement or were inadequately documented in accordance with federal requirements. After careful consideration, CMS determined that the state did not provide any additional or new information for CMS to consider. For these reasons, as well as those stated in the March 12, 2019 disallowance letter, CMS is affirming the \$4,824,901 disallowance. The letter outlines the states options regarding an appeal. The state is aware of the disallowance reconsideration, and there will be no planned media covering this item.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell b6

MO - Reconsideration of Disallowance - MO/2019/001/MAP

From: CMS ROkcmMCH <rokcmch@cms.hhs.gov>
To: jennifer.tidball@dss.mo.gov
Cc: todd.richardson@dss.mo.gov, helen.jaco@dss.mo.gov, marissa.crump@dss.mo.gov, brenda.s.becker@dss.mo.gov, "Scott, James G. (CMS/CMCHO)" <james.scott1@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Burns, James P. (CMS/CMCHO)" <james.burns@cms.hhs.gov>, "Mizell, Dee A. (CMS/CMCHO)" <dee.mizell@cms.hhs.gov>, "Barraza, Leticia (CMS/CMCHO)" <leticia.barraza@cms.hhs.gov>
Date: Thu, 11 Jul 2019 19:19:45 +0000
Attachments: CMS Letter_ Signed7-11-19.doc (174.08 kB)

Good day,

Forwarding Advanced Copy. Original to be delivered via Certified Mail Return Receipt.

CMS has reviewed your May 8, 2019, request for reconsideration of CMS' March 12, 2019, decision to disallow \$4,824,901 federal financial participation (FFP) for unallowable outpatient prescription drugs. Please see attached.

Stefanie Miles
Office Support Assistant
Centers for Medicare & Medicaid Services
Kansas City Regional Operations Group
Division of Medicaid Field Operations - North
Kansas City, MO
Phone: (816) 426-6749





July 11, 2019

Ms. Jennifer Tidball, Acting Director
Department of Social Services
PO Box 1527
Jefferson City, MO 65102-1527

RE: Reconsideration of Disallowance Control Number: MO/2019/001/MAP

Dear Ms. Tidball:

I have reviewed your May 8, 2019, request for reconsideration of CMS' March 12, 2019, decision to disallow \$4,824,901 federal financial participation (FFP) for unallowable outpatient prescription drugs.

In your request for reconsideration, you raised several arguments, none of which present adequate cause for CMS to alter its analysis in this case. After careful consideration, CMS determined that the state did not provide any additional or new information for CMS to consider. For these reasons, as well as those stated in the March 12, 2019, disallowance letter, the \$4,824,901 FFP disallowance is affirmed.

We request that the state make a decreasing adjustment in the amount of \$4,824,901 FFP on Line 10A of your Form CMS-64 for the next quarter.

The state also requested that CMS provide: copies of all of the CMS quarterly drug tapes relevant to the claims that are the subject of this disallowance; a list of all of the drugs questioned and whether each drug had a rebate agreement with HHS for the time period at issue; and, a list of the outpatient drug claims that CMS maintains are "unsupported", and a description of the documentation required to support those claims.

In accordance with 42 CFR 92.42 it is the state's responsibility to maintain documentation for a period of three years or if an audit has been started before the expiration of the three years, the records must be maintained until the completion of the action and resolution of all issues which arise from it, whichever is later. Additionally, the OIG provided Missouri with the list of drug expenditures that were questioned in the audit.

Appeals to the HHS Departmental Appeals Board (DAB)

A notice of appeal to the DAB must be submitted within 60 calendar days following the state's receipt of an unfavorable determination for the Secretary's reconsideration. Refer to 45 C.F.R. Part 16 for procedures of the DAB. The notice of appeal must be submitted by mail, commercial delivery, facsimile/fax (for appeals 10 pages or less), or electronically via the DAB's electronic filing system (DAB E-File). For the DAB filing procedures, see <http://www.hhs.gov/dab/divisions/appellate/guidelines/procedures.html>. Depending on the particular transmission mode, the appeal is recognized to have been submitted on the date that it

Page 2 – Jennifer Tidball, Acting Director

was postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully transmitted via DAB E-File. Regardless of the mode utilized to transmit the original copy, a duplicate hard copy must be simultaneously forwarded to my attention at the address at the top of this letter. Once submitted, the DAB will directly notify the state of further procedures. Information regarding specific modes follows.

Mail or commercial delivery must be addressed as follows:

U.S. Department of Health and Human Services
Departmental Appeals Board, MS 6127, Appellate Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington D.C. 20201

Facsimile/fax delivery (permitted only if the notice of appeal is 10 pages or less) must use the DAB Appellate Division's fax number: (202) 565-0238.

Use of DAB E-File (<https://dab/efile.hhs.gov/>) requires that you or a member of your staff become a registered user by clicking "Register" at the bottom of the homepage and entering the information requested on the "Register New Account" form and then clicking the "Register Account" button. Once registered, sign on to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions are available on the homepage.

Should you require further details regarding this matter, please contact James G. Scott, Director Division of Medicaid Field Operations North, at (816) 426-5925.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized flourish extending to the right.

Calder Lynch
Acting Deputy Administrator and Director

Materials for FMG's Thursday 12:30pm EST Meeting with the CMCS OCD

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>

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Date: Wed, 25 Sep 2019 19:47:32 +0000

Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB); DSH Allotment Reductions FY 2020.xlsx (37.45 kB); FMG Cover Page DSHRule.docx (13.85 kB); FMG Cover Page AR FMR FU.docx (14.07 kB); FMG Cover Page WI CALL.docx (14.15 kB); Oregon CHIP Contingency Fund Issue Paper 9-25-19.docx (23.92 kB); FMG Cover Page OR CHIP CF.docx (14.12 kB); FMG Cover Page PRR CIB.DOCX (13.95 kB); Federal Register Notice SC SPAs.docx (35.45 kB); Joshua D Baker SC SMD Letter.docx (27.12 kB); Letter to Administrator SC SPAs.docx (32.72 kB); SC Disapproval Letter Final Signed.pdf (150.55 kB); Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF (7.67 MB); FMG Cover Page SC ReconsDis.docx (14.14 kB); FMG CLEARANCE Agenda 09-26-2019.docx (36.85 kB)

CMCS CENTER DIRECTOR CLEARANCE WITH THE FINANCIAL MANAGEMENT GROUP (FMG)

September 26, 2019

Conference Room A, 12:30pm – 1pm EST

Conference Dial in Number: 877-267-1577

Meeting ID b6

Please see attached an agenda and materials for Thursday's **12:30pm – 1pm EST** clearance meeting with the Office of the Center Director. **For those participating by phone, please be sure to dial into the call at the start of the meeting and plan to stay until completion.** This will help with any disruption while discussions are still ongoing.

Agenda:

<<...>>

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

<<...>> <<...>>

Discussion Items:

- 1. Arkansas FMR Follow-up, J. Gavens, verbal only**

- <<...>>
2. **Wisconsin Rehabilitation Cost Reporting Issue, *DRSF*, verbal only**
<<...>>
3. **Oregon CHIP Contingency Fund, *DFO*, paper**
<<...>> <<...>>
4. **Provider Payment Reassignment Rule/CIB, *C. Thompson*, verbal only**
<<...>>
5. **South Carolina SPA Disapproval Reconsideration Package, *OSG/DRSF*, paper**
<<...>> <<...>> <<...>> <<...>> <<...>> <<...>>

	A	B	C	D	E	F	G	H	I	J	K	L
1	FY 2020 Medicaid DSH Allotment Reductions - State-by-State Summary											
2												
3							Uninsured Percentage Factor (UPF)		High Volume of Medicaid Inpatients Factor (HMF)		High Level of Uncompensated Care Factor (HUF)	
	State	Low DSH State	Unreduced FY 2020 DSH Allotment	Total FY 2020 DSH Allotment Reduction	FY 2020 Reduced Allotment	Total Allotment Reduction Percentage	UPF Reduction Amount	UPF Reduction Percentage	HMF Reduction Amount	HMF Reduction Percentage	HUF Reduction Amount	HUF Reduction Percentage
4												
5	Alabama	N	\$ 359,660,329	\$ 121,357,183	\$ 238,303,146	33.74%	\$ 40,977,879	11.39%	\$ 39,579,494	11.00%	\$ 40,799,809.81	11.34%
6	Alaska	Y	\$ 23,824,945	\$ 2,362,104	\$ 21,462,841	9.91%	\$ 536,192	2.25%	\$ 1,171,458	4.92%	\$ 654,454.56	2.75%
7	Arizona	N	\$ 118,424,743	\$ 19,098,864	\$ 99,325,879	16.13%	\$ 12,716,762	10.74%	\$ 4,575,405	3.86%	\$ 1,806,696.19	1.53%
8	Arkansas	Y	\$ 50,455,120	\$ 1,788,941	\$ 48,666,179	3.55%	\$ 1,744,449	3.46%	\$ 42,300	0.08%	\$ 2,191.56	0.00%
9	California	N	\$ 1,282,203,690	\$ 388,664,709	\$ 893,538,981	30.31%	\$ 202,062,235	15.76%	\$ 91,335,848	7.12%	\$ 95,266,626.93	7.43%
10	Colorado	N	\$ 108,190,505	\$ 29,269,958	\$ 78,920,547	27.05%	\$ 16,391,992	15.15%	\$ 11,944,984	11.04%	\$ 932,981.87	0.86%
11	Connecticut	N	\$ 233,925,417	\$ 66,506,706	\$ 167,418,711	28.43%	\$ 50,270,515	21.49%	\$ 11,163,914	4.77%	\$ 5,072,276.11	2.17%
12	Delaware	Y	\$ 10,588,863	\$ 1,565,483	\$ 9,023,380	14.78%	\$ 531,536	5.02%	\$ 419,028	3.96%	\$ 614,918.55	5.81%
13	Dist. Of Col.	N	\$ 71,639,659	\$ 30,915,021	\$ 40,724,638	43.15%	\$ 25,838,641	36.07%	\$ 2,296,351	3.21%	\$ 2,780,028.60	3.88%
14	Florida	N	\$ 233,925,417	\$ 72,494,638	\$ 161,430,779	30.99%	\$ 20,519,879	8.77%	\$ 18,029,958	7.71%	\$ 33,944,801.20	14.51%
15	Georgia	N	\$ 314,337,279	\$ 83,814,365	\$ 230,522,914	26.66%	\$ 26,242,397	8.35%	\$ 24,717,328	7.86%	\$ 32,854,639.70	10.45%
16	Hawaii	Y	\$ 11,398,943	\$ 1,268,499	\$ 10,130,444	11.13%	\$ 795,310	6.98%	\$ 157,517	1.38%	\$ 315,671.80	2.77%
17	Idaho	Y	\$ 19,225,747	\$ 2,708,577	\$ 16,517,170	14.09%	\$ 492,198	2.56%	\$ 738,353	3.84%	\$ 1,477,844.42	7.69%
18	Illinois	N	\$ 251,469,823	\$ 81,797,781	\$ 169,672,042	32.53%	\$ 41,179,343	16.38%	\$ 40,362,023	16.05%	\$ 256,415.15	0.10%
19	Indiana	N	\$ 250,007,791	\$ 75,237,256	\$ 174,770,535	30.09%	\$ 34,466,063	13.79%	\$ 13,711,034	5.48%	\$ 27,060,158.45	10.82%
20	Iowa	Y	\$ 46,061,247	\$ 3,046,223	\$ 43,015,024	6.61%	\$ 2,774,115	6.02%	\$ -	0.00%	\$ 272,107.36	0.59%
21	Kansas	N	\$ 48,247,117	\$ 15,261,970	\$ 32,985,147	31.63%	\$ 6,271,466	13.00%	\$ 5,713,188	11.84%	\$ 3,277,315.87	6.79%
22	Kentucky	N	\$ 169,595,928	\$ 75,049,831	\$ 94,546,097	44.25%	\$ 34,257,993	20.20%	\$ 17,505,827	10.32%	\$ 23,286,010.84	13.73%
23	Louisiana	N	\$ 801,970,270	\$ 251,879,601	\$ 550,090,669	31.41%	\$ 114,628,379	14.29%	\$ 59,536,527	7.42%	\$ 77,714,694.85	9.69%
24	Maine	N	\$ 122,810,842	\$ 24,515,723	\$ 98,295,119	19.96%	\$ 17,446,258	14.21%	\$ 4,109,724	3.35%	\$ 2,959,740.82	2.41%
25	Maryland	N	\$ 89,184,067	\$ 23,488,951	\$ 65,695,116	26.34%	\$ 16,938,193	18.99%	\$ 5,863,246	6.57%	\$ 687,511.83	0.77%
26	Massachusetts	N	\$ 356,736,260	\$ 168,666,225	\$ 188,070,035	47.28%	\$ 147,045,846	41.22%	\$ 10,810,190	3.03%	\$ 10,810,189.70	3.03%
27	Michigan	N	\$ 309,951,178	\$ 118,939,504	\$ 191,011,674	38.37%	\$ 65,360,908	21.09%	\$ 26,911,932	8.68%	\$ 26,666,664.14	8.60%
28	Minnesota	Y	\$ 87,358,131	\$ 7,685,323	\$ 79,672,808	8.80%	\$ 5,647,411	6.46%	\$ 240,504	0.28%	\$ 1,797,407.46	2.06%
29	Mississippi	N	\$ 178,368,129	\$ 55,476,554	\$ 122,891,575	31.10%	\$ 16,762,749	9.40%	\$ 9,827,938	5.51%	\$ 28,885,867.16	16.19%
30	Missouri	N	\$ 554,110,831	\$ 169,362,603	\$ 384,748,228	30.56%	\$ 67,085,493	12.11%	\$ 54,314,067	9.80%	\$ 47,963,043.30	8.66%
31	Montana	Y	\$ 13,276,175	\$ 2,025,521	\$ 11,250,654	15.26%	\$ 459,668	3.46%	\$ 765,559	5.77%	\$ 800,294.13	6.03%
32	Nebraska	Y	\$ 33,098,366	\$ 2,878,087	\$ 30,220,279	8.70%	\$ 1,135,133	3.43%	\$ 1,555,460	4.70%	\$ 187,494.33	0.57%
33	Nevada	N	\$ 54,095,252	\$ 6,400,938	\$ 47,694,314	11.83%	\$ 5,500,114	10.17%	\$ 397,600	0.73%	\$ 503,224.50	0.93%
34	New Hampshire	N	\$ 187,255,567	\$ 49,800,833	\$ 137,454,734	26.60%	\$ 37,129,818	19.83%	\$ 7,032,648	3.76%	\$ 5,638,366.72	3.01%
35	New Jersey	N	\$ 752,947,436	\$ 236,126,730	\$ 516,820,706	31.36%	\$ 115,367,914	15.32%	\$ 68,653,392	9.12%	\$ 52,105,423.72	6.92%
36	New Mexico	Y	\$ 23,824,945	\$ 2,010,879	\$ 21,814,066	8.44%	\$ 711,671	2.99%	\$ 1,296,585	5.44%	\$ 2,622.76	0.01%
37	New York	N	\$ 1,878,713,503	\$ 637,846,635	\$ 1,240,866,868	33.95%	\$ 397,019,185	21.13%	\$ 154,335,939	8.21%	\$ 86,491,511.27	4.60%
38	North Carolina	N	\$ 345,039,989	\$ 105,035,717	\$ 240,004,272	30.44%	\$ 36,678,978	10.63%	\$ 26,781,574	7.76%	\$ 41,575,164.05	12.05%
39	North Dakota	Y	\$ 11,172,256	\$ 604,925	\$ 10,567,331	5.41%	\$ 438,289	3.92%	\$ 49,230	0.44%	\$ 117,406.01	1.05%
40	Ohio	N	\$ 475,161,005	\$ 201,229,447	\$ 273,931,558	42.35%	\$ 83,859,727	17.65%	\$ 45,199,547	9.51%	\$ 72,170,173.54	15.19%
41	Oklahoma	Y	\$ 42,355,454	\$ 4,834,299	\$ 37,521,155	11.41%	\$ 848,558	2.00%	\$ 1,515,261	3.58%	\$ 2,470,479.42	5.83%
42	Oregon	Y	\$ 52,944,322	\$ 5,239,093	\$ 47,705,229	9.90%	\$ 2,133,026	4.03%	\$ 1,911,721	3.61%	\$ 1,194,365.55	2.26%
43	Pennsylvania	N	\$ 656,453,200	\$ 256,270,341	\$ 400,182,859	39.04%	\$ 134,863,490	20.54%	\$ 68,438,363	10.43%	\$ 52,968,487.57	8.07%
44	Rhode Island	N	\$ 76,025,760	\$ 39,578,505	\$ 36,447,255	52.06%	\$ 21,243,589	27.94%	\$ 12,791,009	16.82%	\$ 5,543,907.06	7.29%
45	South Carolina	N	\$ 383,052,870	\$ 145,147,353	\$ 237,905,517	37.89%	\$ 41,707,118	10.89%	\$ 39,819,781	10.40%	\$ 63,620,454.73	16.61%
46	South Dakota	Y	\$ 12,918,118	\$ 495,896	\$ 12,422,222	3.84%	\$ 375,087	2.90%	\$ 58,255	0.45%	\$ 62,554.07	0.48%
47	Tennessee*	N	\$ 53,100,000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
48	Texas	N	\$ 1,118,455,900	\$ 247,181,860	\$ 871,274,040	22.10%	\$ 71,976,985	6.44%	\$ 77,503,070	6.93%	\$ 97,701,804.52	8.74%
49	Utah	Y	\$ 22,945,726	\$ 3,915,167	\$ 19,030,559	17.06%	\$ 692,946	3.02%	\$ 1,303,666	5.68%	\$ 1,918,554.69	8.36%
50	Vermont	N	\$ 26,316,611	\$ 14,747,025	\$ 11,569,586	56.04%	\$ 7,444,210	28.29%	\$ 3,446,096	13.09%	\$ 3,856,718.35	14.66%
51	Virginia	N	\$ 102,468,191	\$ 31,818,964	\$ 70,649,227	31.05%	\$ 13,255,856	12.94%	\$ 1,529,263	1.49%	\$ 17,033,844.61	16.62%
52	Washington	N	\$ 216,381,011	\$ 84,830,962	\$ 131,550,049	39.20%	\$ 38,386,009	17.74%	\$ 24,798,068	11.46%	\$ 21,646,885.40	10.00%
53	West Virginia	N	\$ 78,949,828	\$ 22,009,913	\$ 56,939,915	27.88%	\$ 14,015,346	17.75%	\$ 4,420,339	5.60%	\$ 3,574,227.58	4.53%
54	Wisconsin	Y	\$ 110,568,148	\$ 7,708,703	\$ 102,859,445	6.97%	\$ 5,765,902	5.21%	\$ 1,296,501	1.17%	\$ 646,299.81	0.58%
55	Wyoming	Y	\$ 264,722	\$ 39,617	\$ 225,105	14.97%	\$ 7,196	2.72%	\$ 22,753	8.60%	\$ 9,667.41	3.65%
56												
57	National Total/Average		\$ 12,831,456,626	\$ 4,000,000,000	\$ 8,778,356,626	25.05%	\$ 2,000,000,000	12.52%	\$ 1,000,000,000	6.28%	\$ 1,000,000,000.00	6.25%
58												
59	Key	* Under section 1923(f)(6)(A)(vi) of the Act, notwithstanding any other provision of subsection 1923(f), or any other provision of law, the DSH allotment for Tennessee is established at \$53.1 million per year for FY 2015 through FY 2025. Therefore, Tennessee's DSH allotment is not subject to reduction under section 1923(f)(7) of the Act.										
60	Low-DSH States											
61	Expansion States											

Financial Management Group Clearance Item Cover Page

Date: September 26, 2019

Time: 12:30pm – 1pm

Topic: DSH Allotment Reduction Rule

Paper: YES, attachment

Summary: FMG has attached the FY 2020 DSH Reductions for OCD review.

Requested: Yes, FMG wants OCD approval to issue the reduction amounts.

Financial Management Group Clearance Item Cover Page

Date: September 26, 2019

Time: 12:30pm – 1pm

Topic: Arkansas FMR Follow-up

Paper: NO

Summary: FMG originally brought the AR FMR to Clearance on 9/11. DE reviewed this FMR and is in agreement with the findings. OCD raised the concern that all 83 private home health providers reviewed were not in compliance with the Surety Bond requirement. When reviewers were out there, the State said they were unaware of the Surety Bond requirement and they rely on their fiscal advisor to be on top of things like this. OCD is interested in knowing whether there are other states out there that are “unaware” of this requirement. OCD was fine with proceeding with issuing the FMR and requested additional information on whether other states are aware of the Surety Bond requirement, for a future Clearance meeting.

Decision Requested: No

Financial Management Group Clearance Item Cover Page

Date: September 26, 2019

Time: 12:30pm – 1pm

Topic: Wisconsin Rehabilitation Cost Reporting Issue

Paper: NO

Summary: This item was originally discussed during the 9/11 Clearance meeting. The State made interim payments and claimed FFP on the CPE generated. They have no claims data to support their numbers and want to use FY 2017 costs as a proxy for the FY 2010-2014 expenditures. We repeatedly advised the state, starting in 2009, that they cannot do this. We did approve their SPA in 2009 without the cost report because the State said it was not finished yet and that they would submit it once it was completed. OCD agreed with moving forward with the disallowance as long as we can confirm that we told the state they needed to provide us the cost report as soon as it was completed. FMG has information to provide supporting the State was informed.

Decision Requested: NO

Contingency Fund Briefing Paper

Issue

Oregon appears to qualify for a CHIP contingency fund payment approximating \$113 million despite a CHIP program need of approximately \$4 million. FMG has been working with OGC to explore potential policy options to avoid making a payment to Oregon so far in excess of its CHIP program need.

Background on CHIP Shortfall Funding

The Social Security Act provides two sources of potential funding if a state's CHIP allotment for a fiscal year is not sufficient to cover its expenditures (i.e. a shortfall): 1) child enrollment contingency fund payments and 2) redistribution payments. The statute articulates very specific formulas for determining which states qualify and the payment amount for each payment. Although both payments consider a state's shortfall status in determining which states qualify, contingency fund payment amounts are not based on a state's shortfall while redistribution payments are. Also, the statute requires us to consider whether a state qualifies for a contingency fund payment first, then consider redistribution payments.

Contingency Fund Payments – Section 2104(n) of the Social Security Act

Qualification

- The statute requires that “the Secretary shall pay...” prior to September 30th of the relevant fiscal year a contingency fund payment to states that have a CHIP shortfall and have CHIP related enrollment in excess of a statutorily determined enrollment target.

Payment Amount

- Subject to the availability of funds, the statute specifies the payment amount is equal to the amount that a state's average monthly CHIP enrollment for a fiscal year exceeds the target enrollment for such fiscal year multiplied by the federal share of the state's projected per capita CHIP expenditures for the fiscal year.
- Payment amounts are determined without regard to any redistribution payment a state receives for the fiscal year.
- This payment amount may be more or less than the actual state shortfall.
- There are no restrictions in statute on the use of contingency fund payments and OGC has opined that states may expend contingency funds on non-health care related items.

Redistribution Payments - Section 2104(f) of the Social Security Act

Qualification

- The statute requires the redistribution of unspent allotments from previous fiscal years to states' projecting a CHIP funding shortfall for a fiscal year.

Payment Amount

- Subject to the availability of funds, the payment amount is equal to the state's shortfall for the federal fiscal year. The statute requires contingency fund payments a state receives to be considered in qualifying for and calculating redistribution payments.

Retrospective Adjustment – 2105(e) of the Social Security Act

Section 2105(e) permits the Secretary to make advance CHIP payments to states on the basis of estimates, then make retroactively adjust payments to account for any over or underpayments. We've interpreted this provision to authorize our standard advance grant award process (which we use for Medicaid, too). The process allows CMS to use state budget estimates submitted prior to each quarter (on the Form CMS-37 or CMS-21B) as the basis for issuing grants to states in advance of actual expenditure amount being available. This affords states sufficient cash flow for CHIP financial obligations (paying providers, incurring state admin costs, etc.) until actual expenditures are available.

Once actual expenditures are reported through the CMS-64 or CMS-21, we reconcile estimates against actual expenditures and we adjust state funding to account for any over- or underestimates.

This provision applies to contingency fund payments. Accordingly, we have historically made advance contingency fund payments based on estimates, then retrospectively adjusted the payment amount based on actual data.

OGC Input/Options on Oregon

As requested by OCD at the 9/18/19 FMG Clearance meeting, FMG asked OGC if there is any flexibility in statute to A) limit OR's contingency fund payment to its shortfall amount or B) not make a contingency fund payments to Oregon.

A - Limited Payment Feedback

OGC preliminarily opined that one possible read of the retrospective adjustment provision at 2105(e) would permit CMS to make an interim contingency fund payment to the state based on the statutory formula, then retrospectively adjust the interim payment to align with the state's actual CHIP shortfall. Under this read, CMS would make an interim contingency fund payment by 9/30/19 using the statutory formula (approximately \$113 million), then recover the amount that the interim payment would exceed the shortfall (recovering approximately \$109 million).

OGC noted that there would likely be significant litigation risk associated with this approach should the state choose to challenge us, which seems very likely. This approach could be viewed as inconsistent with the statute's very specific payment formula for calculating contingency fund payment amounts, inconsistent with our historical interpretation of the retrospective adjustment provision, and inconsistent with historical interpretation of the contingency fund payment formula.

B - No Payment Feedback

Policy OGC cited a lack of expertise in this area and referred CMCS to OGC's General Law Division if CMCS remains interested in evaluating risk associated with CMS not making a payment to Oregon. FMG is seriously concerned that not making a payment or delaying payment could violate the CHIP statute, existing CMS regulations, the Cash Management Improvement Act, or the Anti-Deficiency Act.

Recommendation

To ensure consistency across states and avoid significant litigation risk, FMG recommends:

- 1) making the full FY 2019 contingency fund payment to Oregon as specified in statute, and
- 2) continuing recommending to Congress to remove/modify the contingency fund provisions to prevent excessive payments.

Information on Previous Contingency Fund Payments:

- FY 2011: \$29,517,883 – Iowa (Shortfall: -\$2,571,074)
- FY 2015: \$52,585,365 – Michigan (Shortfall: -\$114,035,551)
- FY 2016: \$226,722,992 – Tennessee (Shortfall: -\$24,885,402)
- Potential FY 2019: \$113,260,984 - Oregon (Shortfall: -\$4,209,184)

Financial Management Group Clearance Item Cover Page

Date: September 26, 2019

Time: 12:30pm – 1pm

Topic: Oregon CHIP Contingency Fund

Paper: YES, 1 attachment

Summary: Oregon qualifies for a CHIP contingency fund payment approximating \$113 million despite a CHIP program need of approximately \$4 million. FMG briefly raised this item at the end of the 9/18 Clearance meeting and wants to provide OCD with more information on the contingency fund payment/provision, and input from OGC. FMG has specifically discussed with GC if there is flexibility in the statute to limit OR's contingency fund payment to its shortfall amount or not make a contingency fund payments to Oregon.

Decision Requested: YES, FMG seeks concurrence from OCD to make the full contingency fund payment and continue recommending to Congress the removal/modification of the contingency fund provisions to prevent excessive payments.

Financial Management Group Clearance Item Cover Page

Date: September 26, 2019

Time: 12:30pm – 1pm

Topic: Provider Payment Reassignment Rule CIB, meeting follow-up

Paper: YES, 1 attachment

Summary: FMG met with Nasuad to discuss the newly released PRR CIB, and CMS' plans going forward, with regard to states' compliance to the Rule. At the end of the meeting, Nasuad asked if FMG can follow-up with an email summarizing the meeting discussion.

Decision Requested: YES, FMG wants OCDs concurrence to provide Nasuad a follow-up email.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval
South Carolina Medicaid State Plan Amendment (SPA)
16-0012-A, 17-006-A, and 18-0011-A

AGENCY: Centers for Medicare & Medicaid Services (CMS)

HHS ACTION: Notice of Hearing: Reconsideration of Disapproval

SUMMARY: This notice announces an administrative hearing to be held on November 20, 2019, at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909 to reconsider CMS' decision to disapprove South Carolina's Medicaid SPA 16-0012-A, 17-006-A, and 18-0011-A.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by **[insert date 15 days after publication in the Federal Register]**.

FOR FURTHER INFORMATION CONTACT:

Benjamin R. Cohen, Presiding Officer
CMS
2520 Lord Baltimore Drive
Suite L
Baltimore, Maryland 21244
Telephone: (410) 786-3169

SUPPLEMENTARY INFORMATION:

This notice announces an administrative hearing to reconsider CMS' decision to disapprove South Carolina's Medicaid state plan amendment (SPA) 16-0012-A, 17-006-A, and 18-0011-A, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the “Setoff Debt Collection Program,” rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.
- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as

the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

Section 1116 of the Act and federal regulations at 42 CFR Part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish in the Federal Register a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the state Medicaid agency of additional issues that will be considered at the hearing, we will also publish that notice in the Federal Register.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to South Carolina announcing an administrative hearing to reconsider the disapproval of its SPAs reads as follows:

Joshua D. Baker

Director

South Carolina Department of Health and Human Services

Post Office Box 8206

Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to the September 6, 2019 request for reconsideration of the decision to disapprove South Carolina's State Plan amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A. South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019. I am scheduling a hearing on the request for reconsideration to be held on November 20, 2019 at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786-3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide

names of the individuals who will represent the State at the hearing. If the hearing date is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the “Setoff Debt Collection Program”, rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

In the event that CMS and the State come to agreement on resolution of the issues which formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Seema Verma

Administrator

cc: Benjamin R. Cohen

Section 1116 of the Social Security Act (42 U.S.C. section 1316; 42 CFR section 430.18) (Catalog of Federal Domestic Assistance program No. 13.714. Medicaid Assistance Program.)

Dated:

Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services

Joshua D. Baker
Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to the September 6, 2019 request for reconsideration of the decision to disapprove South Carolina's State Plan amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A. South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019. I am scheduling a hearing on the request for reconsideration to be held on November 20, 2019 at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786-3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing. If the hearing date is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the "Setoff Debt Collection Program", rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

In the event that CMS and the State come to agreement on resolution of the issues which formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Seema Verma
Administrator

cc: Benjamin R. Cohen

DATE:

TO: Seema Verma
Administrator

FROM: Karen M. Shields,
Deputy Center Director, Center for Medicaid and CHIP Services

SUBJECT: Reconsideration of South Carolina's Medicaid state plan amendments (SPAs)
16-0012-A, 17-006-A, and 18-0011-A

ACTION REQUIRED BY: October 4, 2019

PURPOSE:

The attached letter to the State of South Carolina and *Federal Register* notice announce an administrative hearing on November 20, 2019, to reconsider the disapproval decision for the South Carolina Medicaid SPAs 16-0012-A, 17-006-A, and 18-0011-A.

The South Carolina Medicaid SPAs 16-0012-A, 17-006-A, and 18-0011-A, submitted on December 21, 2016, June 28, 2017, and June 29, 2018, requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology.

The Center for Medicaid and CHIP Services (CMCS) was unable to approve this SPA as submitted because it is inconsistent with the requirements of sections 1902(a)(2), 1903(a) and 1905(b) of the Social Security Act (the Act).

On September 6, 2019, a request for reconsideration was submitted on the behalf of the state of South Carolina, challenging CMS' disapproval of these SPAs. The state of South Carolina does not agree with the disapprovals and asserts that SPAs 16-0012-A, 17-006-A, and 18-0011-A conform to the requirements for approval, as none of the cited sections, or any other section of Title XIX or CMS's implementing regulations, limit Intergovernmental Transfers (IGTs) to "state or local tax revenue."

In the event that CMS and the state come to agreement on resolution of the issues which formed the basis for disapprovals, these SPAs may be moved to approval and a hearing would not be needed.

If a hearing does occur, the issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of

adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

During the course of the SPA review, CMS worked with the state to resolve the outstanding issues. CMS issued a Request for Additional Information (RAI) to South Carolina on March 20, 2017, September 08, 2017, and September 13, 2018 and the state responded on April 10, 2019 and May 09, 2019. The state's response to the RAI set forth the state's reasons in support of the state's belief that the SPAs are consistent with the requirements of Sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Act. The state, however, could not resolve the outstanding issue that the source of the intergovernmental transfers made by the Greenville Health Authority are from the Setoff Debt Collection Program and not from state or local tax revenues, as required by 1903(w)(6)(A) of the Act for a proper intergovernmental transfer.

PROCEDURES FOR RECONSIDERATION:

Section 1116 of the Act, and 42 CFR Part 430, Subparts B and D, govern reconsideration of Medicaid SPAs. Federal regulations at 42 CFR 430.18 and 430.70 require the Administrator to notify a state of the time and place of the hearing within 30 days after receipt of the state's request for a reconsideration. The federal regulations at 42 CFR 430.72(b) provide for the hearing to be held in the city of the servicing CMS regional office or in any place chosen by the presiding officer with regard for the convenience and necessity of the parties. The hearing must be scheduled no less than 30 days, nor more than 60 days, after the date on which the notice of the hearing is furnished to the state (42 CFR 430.72(a)). In this case, the state's request was received on September 6, 2019, and therefore the required notification is being sent by October 4, 2019, and informs the state that the hearing has been scheduled for November 20, 2019. The scheduled date may be changed by written agreement between CMS and the state.

You must also designate, in writing, a presiding officer and notify the parties of the selection (42 CFR 430.66). The regulations state that the presiding officer may be the Administrator or the Administrator's designee. There are no requirements governing the qualifications of the presiding officer prescribed in the regulations.

The presiding officer is responsible for conducting the hearing, in accordance with the procedures in 42 CFR, part 430, subpart D, and certifying to the Administrator the entire

record, including recommended findings and proposed decision. The Administrator must then serve a copy of the recommended findings and proposed decision upon all parties to the hearing. The parties then have 20 days to file exceptions to the recommended findings and proposed decision. The Administrator is required to issue a final decision within 60 days of the date the recommended decision was served (42 CFR 430.102(b)(3)).

We are recommending Mr. Benjamin R. Cohen as the presiding officer in this case. Mr. Cohen is an attorney and has considerable experience in the conduct of hearings for CMS. Attached is a proposed letter designating Mr. Cohen as the presiding officer and stating the hearing is to be held on November 20, 2019. The letter advises the state to contact the presiding officer if the arrangements present any problems.

You are also required to publish in the *Federal Register* a copy of the notice to the state agency that informs the agency of the time and place of the hearing, the issues to be considered, and the identity of the presiding officer (42 CFR 430.70).

If you subsequently notify the agency of additional issues which will be considered at the hearing, that notice should also be published in the *Federal Register*.

In accordance with 42 CFR 430.76(b)(2), any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice in the *Federal Register*. Also, any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins, pursuant to 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

CONSEQUENCES OF DISAPPROVAL:

If South Carolina's request for reconsideration is not granted, we would violate section 1116 of the Act, which requires us to provide a reconsideration hearing.

If we do not publish a notice of the hearing, we would violate a regulatory requirement to provide an opportunity for interested individuals and groups to participate in the hearing (42 CFR 430.70 and 430.76). Therefore, by not publishing a notice in the *Federal Register*, we might nullify any decision by the presiding officer.

URGENCY:

The Federal regulations at 42 CFR 430.18 and 430.70 require you to notify the state of the hearing within 30 days of receipt of the state's request for reconsideration. Since South Carolina's request was received on September 6, 2019, the 30th day would be October 6, 2019, but since October 6 is a Sunday, the notification must be October 4, 2019.

We are required to schedule the hearing no less than 30 days nor more than 60 days after the date on which the notice of the hearing is furnished to the state.

Attachments:

- Letter to the State
- *Federal Register* Notice
- July 9, 2019, Disapproval Letter to the State

cc: Jeremy Vogel, OGC



July 9, 2019

Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid state plan amendments (SPAs) 16-0012-A, 17-0006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs.

In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed non-federal share funding source is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019, CMS communicated with the South Carolina Medicaid Director that CMS would issue a disapproval for the aforementioned SPAs unless the state provided new information regarding the source of the non-federal share for the proposed supplemental payments. The state requested time to provide additional information to support the proposals, which CMS granted. The information that the state subsequently provided did not describe an alternative funding source that would allow us to approve the proposed SPAs.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations in 42 C.F.R. § 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations in 42 C.F.R. § 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized, flowing script.

Calder Lynch
Acting Deputy Administrator and Director



Brown & Peisch PLLC
1233 20th Street NW
Suite 505
Washington, DC 20036

Via Certified Mail

September 5, 2019

Maritza Bodon
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mail Stop S2-62-12
Baltimore, MD 21244-1850

**RE: Request for Reconsideration South Carolina SPAs 16-0012-A, 17-006-A,
and 18-0011-A**

Dear Ms. Bodon:

On behalf of the South Carolina Department of Health and Human Services, we are requesting reconsideration of the attached notice of disapproval of State Plan Amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A, pursuant to 42 C.F.R. § 430.18. The notice of disapproval was sent to the Department from Calder Lynch by letter dated July 9, 2019. (Attachment A.)

The SPAs propose to continue supplemental payments to physicians associated with Greenville Memorial Hospital and Palmetto Health Richland.

The letter asserts that the basis of disapproval is that the “state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903, 1903(w)(6)(A), and 1905(b) of the Social Security Act” because the payments proposed under the SPAs are funded through intergovernmental transfers (IGTs) from the Greenville Health Authority that are not derived from “state or local tax revenue as required by the statute.”

The Department requests that the Administrator reconsider the issue of whether the SPAs conform to the requirements for approval, as none of the cited sections, or any other section of Title XIX or CMS’s implementing regulations, limit IGTs to “state or local tax revenue.” Specifically:

1. Section 1902(a)(2) provides “for financial participation by the State equal to not less than 40 per centum of the non-Federal share of expenditures” and for carrying out the



plan on a basis “which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.”

This ground for disapproval should be reconsidered. The State provides financial participation well in excess of 40 percent of the non-Federal share and there is no claim that there is a lack of adequate funds from local sources that will result in lowering the amount, duration, scope, or quality of care and services. To the contrary, the funds from the Greenville Health Authority will help to sustain the quality of care of the teaching physicians associated with Greenville Memorial Hospital and Palmetto Health Richland. Therefore, Section 1902(a)(2) is not a reasonable or appropriate basis for disapproval.

2. Section 1903 provides for federal financial participation (FFP) in expenditures under the State Plan according to the federal medical assistance percentage (FMAP) formula set forth in Section 1905(b).

This ground for disapproval should be reconsidered. The physician services for which the supplemental payments are to be made under the SPAs are state plan services for which the State will claim FFP at the FMAP rate. There is no contention that the expenditures are not covered by the state plan as required by Section 1903(a)(1) or that the State intends to claim a match rate other than the one set forth in Section 1905(b). Therefore, Section 1903 and Section 1905(b) are not reasonable or appropriate bases for disapproval.

3. Section 1903(w)(6) provides that “the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider . . . unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.”

This ground for disapproval should be reconsidered. There is no contention that the transferred funds are derived from impermissible donations or taxes. Rather, CMS appears to be interpreting the clause that “the Secretary may not restrict States’ use of funds . . . derived from State or local taxes” as imposing a “requirement” that States can only accept IGTs that use funds derived from these sources.

Such a reading of the statute is not consistent with CMS regulations at 42 C.F.R. §433.51(b), which permits transfers of “public funds” from “public agencies,” and does not limit transfers to funds derived from State or local taxes. More importantly, limiting IGTs to funds derived from state and local taxes is not consistent with the statute that enacted Section 1903(w), the “Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,” Pub. L. 102-234. (Attachment B.) The stated purposes of the statute was to prevent impermissible taxes and donations but “to maintain the treatment of intergovernmental transfers” as a source of funding of the non-Federal share. At the time, the regulatory language regarding IGTs was the same as it is currently (although appearing in a different section).



In accordance with that purpose, Section 5 of Pub. L. 102-234 gave the Secretary the authority to issue “interim final” regulations implementing its provisions but specified that:

[t]he Secretary may not issue any interim final regulation that changes the treatment . . . of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds . . . that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

Further, the Secretary was directed to “consult with the States before issuing any regulations under this Act.” Id. § 5(c).

When CMS (then known as the Health Care Financing Administration, or HCFA) did publish interim final regulations a few months later, it complied with this congressional mandate and did not change the treatment of intergovernmental transfers, and it informed the States that:

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax. Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

See Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55043, 55119 (Nov. 24, 1992) (Attachment C).

Similarly, in 2007, when CMS did finalize a rule governing the non-Federal share (which was later withdrawn), it informed States that transfers from units of government were permissible “from a variety of sources (including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds);” that “patient care revenues from other third party payers and other revenues similar to those listed above . . . would also be acceptable sources of financing the non-Federal share of Medicaid payments” as long as they were not derived from impermissible sources; and that “governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues.” *See* Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748, 29766 (May 29, 2007) (Attachment D). The stated basis of the disallowance contradicts all of these prior statements from CMS.



Maritza Bodon
September 5, 2019
Page 4

Given the 1991 congressional mandate that the Secretary may only change the treatment of intergovernmental transfers by final regulation issued under the Administrative Procedure Act, after consultation with the States, and that CMS has twice subsequently told the States that sources other than state and local taxes are permissible sources of such transfers, Section 1903(w)(6) is not a reasonable or appropriate basis for disapproval.

The Department appreciates the reconsideration of the disapproval on the basis of the arguments set forth above.

Respectfully,

Caroline Brown /RES

Caroline M. Brown
Philip J. Peisch

Enclosures

Cc: Shantrina Roberts
Bryon Roberts

Attachment A

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



July 9, 2019

Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid state plan amendments (SPAs) 16-0012-A, 17-0006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs.

In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed non-federal share funding source is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019, CMS communicated with the South Carolina Medicaid Director that CMS would issue a disapproval for the aforementioned SPAs unless the state provided new information regarding the source of the non-federal share for the proposed supplemental payments. The state requested time to provide additional information to support the proposals, which CMS granted. The information that the state subsequently provided did not describe an alternative funding source that would allow us to approve the proposed SPAs.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations in 42 C.F.R. § 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations in 42 C.F.R. § 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized, flowing script.

Calder Lynch
Acting Deputy Administrator and Director

Attachment B

Public Law 102-234
102d Congress

An Act

To delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source.

Dec. 12, 1991
 [H.R. 3595]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991".

Medicaid
 Voluntary
 Contribution
 and
 Provider-
 Specific Tax
 Amendments of
 1991.
 42 USC 1305
 note.

SEC. 2. PROHIBITION ON USE OF VOLUNTARY CONTRIBUTIONS, AND LIMITATION ON THE USE OF PROVIDER-SPECIFIC TAXES TO OBTAIN FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection.

"(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

"(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

"(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

"(II) donations described in paragraph (2)(C);

"(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

"(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

"(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

"(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as deter-

mined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

"(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

"(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

"(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

"(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(iii) In this subparagraph and subparagraph (E), the term 'impermissible tax' means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

"(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

"(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

Effective dates.

"(F) In this paragraph in the case of a State—

"(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

"(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

"(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in

1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

"(2)(A) In this subsection (except as provided in paragraph (6)), the term 'provider-related donation' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

"(i) a health care provider (as defined in paragraph (7)(B)),

"(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

"(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

"(B) For purposes of paragraph (1)(A)(i)(I), the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

"(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

"(3)(A) In this subsection (except as provided in paragraph (6)), the term 'health care related tax' means a tax (as defined in paragraph (7)(F)) that—

"(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

"(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

"(B) In this subsection, the term 'broad-based health care related tax' means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

"(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

"(ii) is imposed uniformly (in accordance with subparagraph (C)).

"(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

"(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

"(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

"(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

"(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

"(ii) Subject to subparagraphs (I) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

"(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

"(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

"(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

"(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

"(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

"(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

"(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph. Regulations.

"(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

"(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment 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.

"(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

"(C) 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.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

"(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

"(B)(i) In subparagraph (A), the term 'State base percentage' means, with respect to a State, an amount (expressed as a percentage) equal to—

"(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

"(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

"(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

"(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

"(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

"(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

"(7) For purposes of this subsection:

"(A) Each of the following shall be considered a separate class of health care items and services:

"(i) Inpatient hospital services.

"(ii) Outpatient hospital services.

"(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

"(iv) Services of intermediate care facilities for the mentally retarded.

"(v) Physicians' services.

"(vi) Home health care services.

"(vii) Outpatient prescription drugs.

"(viii) Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).

"(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

"(B) The term 'health care provider' means an individual or person that receives payments for the provision of health care items or services.

"(C) An entity is considered to be 'related' to a health care provider if the entity—

"(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

"(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

"(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

"(iv) has a similar, close relationship (as defined in regulations) to the provider.

"(D) The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(E) The 'State fiscal year' means, with respect to a specified year, a State fiscal year ending in that specified year.

"(F) The term 'tax' includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty

imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

"(G) The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State."

(b) CONFORMING AMENDMENTS.—(1) Section 1902(t) of such Act (42 U.S.C. 1396a(t)) is amended—

(A) by striking "Except as provided in section 1903(i), nothing" and inserting "Nothing", and

(B) by striking "taxes (whether or not of general applicability)" and inserting "taxes of general applicability".

(2) Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by striking paragraph (10) inserted by section 4701(b)(2)(B) of the Omnibus Budget Reconciliation Act of 1990.

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date. 42 USC 1396a note.

(2) Except as specifically provided in section 1903(w) of the Social Security Act and notwithstanding any other provision of such Act, the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure. 42 USC 1396b note.

(3) The interim final rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56132), relating to the State share of financial participation under the medicaid program, is hereby nullified and is of no effect. No part of such rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 3. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) REPEAL OF PROHIBITION OF UPPER PAYMENT LIMIT FOR DISPROPORTIONATE SHARE HOSPITALS.—Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)) is amended by striking "to limit" the first place it appears and all that follows through "special needs or".

(b) LIMITATION ON AGGREGATE PAYMENT ADJUSTMENTS.—

(1) IN GENERAL.—Section 1923 of such Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

"(1) IN GENERAL.—

"(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

"(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

"(I) the payment adjustments are made—

"(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

"(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

"(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

"(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

"(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the year (as specified in paragraph (2)).

"(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

"(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

"(i) the national DSH payment limit for the fiscal year, and

"(ii) the State DSH allotment for each State for the year.

"(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

"(i) The hospital's medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

"(ii) The hospital's low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

"(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is

equal to at least 1 percent of the total number of such days for all hospitals in the State.

"(iv) The hospital meets such alternative requirements as the Secretary may establish by regulation, taking into account the special circumstances of children's hospitals, hospitals located in rural areas, and sole community hospitals.

"(E) CONDITION FOR OPTION.—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a state exercising such option.

"(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

"(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

"(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

"(B) EXCEPTIONS.—

"(i) LIMIT TO 12 PERCENT OR BASE ALLOTMENT.—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State based allotment.

"(ii) EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

"(3) STATE SUPPLEMENTAL AMOUNTS.—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

"(A) DETERMINATION OF REDISTRIBUTION POOL.—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

"(i) the total of the State base allotments for high DSH States;

"(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

"(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal year; and

"(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

"(B) DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.—The supplemental amount for a State for a fiscal year is equal to the lesser of—

"(i) the product of the amount determined under subparagraph (A) and the ratio of—

"(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

"(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

"(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

"(4) DEFINITIONS.—In this subsection:

"(A) HIGH DSH STATE.—The term 'high DSH State' means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

"(B) STATE.—The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(C) STATE BASE ALLOTMENT.—The term 'State base allotment' means, with respect to a State, the greater of—

"(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

"(ii) \$1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

"(D) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the lesser of—

"(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

"(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

"(E) STATE GROWTH FACTOR.—The term 'State growth factor' means, for a State for a fiscal year, the percentage by which the expenditures described in section 1908(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year."

(2) CONFORMING AMENDMENTS.—(A) Such section 1923 is further amended—

(i) in subsection (a)(2)(B), by striking "subsection (c)," and inserting "subsections (c) and (f)"; and

(ii) in subsection (c), by striking "In order" and inserting "Subject to subsection (f), in order".

(B) Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "and section 1923(f)" after "of this section".

(c) **LIMITS ON AUTHORITY TO RESTRICT DSH DESIGNATIONS.**— 42 USC 1396r-4.
Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4)."

(d) **STUDY OF DSH PAYMENT ADJUSTMENTS.**—

42 USC 1396r-4
note.

(1) **IN GENERAL.**—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) **ITEMS INCLUDED IN STUDY.**—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) **REPORT.**—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section shall take effect January 1, 1992.

42 USC 1396a
note.

(2) The proposed rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56141), relating to the standards for defining disproportionate share hospitals under the medicaid program, shall be withdrawn and can-

celed. No part of such proposed rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 4. REPORTING REQUIREMENT.

(a) **IN GENERAL.**—Section 1903(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following:

“(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

“(i) provider-related donations made to the State or units of local government during such fiscal year, and

“(ii) health care related taxes collected by the State or such units during such fiscal year.

“(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.”

42 USC 1396b
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to fiscal years ending after the date of the enactment of this Act.

42 USC 1396b
note.

SEC. 5. INTERIM FINAL REGULATIONS.

(a) **IN GENERAL.**—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) **REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.**—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that

are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) **CONSULTATION WITH STATES.**—The Secretary shall consult with the States before issuing any regulations under this Act.

Approved December 12, 1991.

LEGISLATIVE HISTORY—H.R. 3595:

HOUSE REPORTS: Nos. 102-810 (Comm. on Energy and Commerce) and 102-409 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 137 (1991):

Nov. 19, considered and passed House.

Nov. 26, considered and passed Senate, amended. House agreed to conference report.

Nov. 27, Senate agreed to conference report.

Attachment C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 433 and 447

[MB-062-IFC]

RIN 0938-AF42

Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule establishes in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The rule also adds provisions that establish limits on the aggregate amount of payments a State may make to disproportionate share hospitals for which FFP is available.

This interim final rule implements provisions of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991.

DATES: *Effective date:* These interim final rules are effective December 24, 1992. However, the statutory requirements at sections 2(c)(1) and 3(e)(1) of Public Law 102-234 have an effective date of January 1, 1992, and are effective on that date regardless of the effective date of this interim final rule.

COMMENT DATE: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 25, 1993.

ADDRESSES: Mail comments to the following address:

Health Care Financing Administration,
Department of Health and Human
Services, Attention: MB-062-IFC P.O.
Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey
Building, 200 Independence Avenue,
SW, Washington, DC 20201, or
Room 132, East High Rise Building, 6325
Security Boulevard, Baltimore,
Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code MB-062-IFC. Written comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-690-7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Paperwork Burden" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Laura Oliven, Office of Management and Budget, New Executive Office Building (Room 3002), Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT:

Theresa Pratt (Donations and Taxes)
(410) 966-9535

Betty Kern (Disproportionate Share
Payments) (410) 966-4580

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. Medicaid programs are administered by the States in accordance with Federal regulations. State Medicaid agencies conduct their programs according to a Medicaid State plan approved by the Health Care Financing Administration (HCFA). To carry out the mandates of the Medicaid program, the State agency pays providers for medical care and services provided to eligible Medicaid recipients. Providers that wish to participate in the Medicaid program must agree to comply with certain requirements specified in a provider agreement.

While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. The Federal government pays its share of medical assistance expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The State pays its share of medical assistance

expenditures in accordance with section 1902(a)(2) of the Act.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers and revenues generated by certain health care-related taxes. This law also amended section 1923 of the Act to establish limits on the amount of FFP for expenditures made to hospitals that serve a disproportionate number of Medicaid recipients and other low-income individuals. These hospitals are referred to as disproportionate share hospitals.

This interim final rule interprets and implements the provisions of Public Law 102-234. The two issues that are affected by this law (provider-related donations and health care-related taxes, and disproportionate share hospital payments) are addressed separately in this preamble.

II. Provider-Related Donations and Health Care-Related Taxes

Section 1902(a)(2) of the Act requires States to share in the cost of medical assistance expenditures, and permits both State and local governments to participate in the financing of the non-Federal portion of expenditures under the Medicaid program. This section specifies the minimum percentage of the State's share of the non-Federal costs, and requires that the State share be sufficient to assure that the lack of adequate funds from local government sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State. Section 1903 of the Act requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

Public Law 102-234 amended section 1903 of the Act by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in FFP will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstaffed eligibility worker donation requirements, as specified in

the law. The law also specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. Such taxes are broad-based taxes which apply in a uniform manner to all health care providers in a class, and which do not hold providers harmless for their tax costs. However, the law permits States which have received, by specific date prior to the enactment of this law, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

Public Law 102-234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax.

Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The provisions of Public Law 102-234 apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section

1115 of the Act. The exemption is currently limited to Arizona. The provisions apply to donations to State or local governments from providers and related entities and to revenues generated by health care-related taxes, regardless of whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government, and regardless of whether the State uses these funds as the State share of medical assistance expenditures for FFP purposes. However, the provisions do not apply to the treatment of donations from entities not related to providers or the receipt of revenues generated by generally applicable taxes or other non-health care-related taxes.

A discussion of the specific provisions of Public Law 102-234 relating to treatment of provider-related donations and health care-related tax revenues and the implementing regulatory provisions follows.

General Rule

Section 1903(w)(1) of the Act provides that, effective January 1, 1992, before calculating the amount of FFP, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are as follows:

Donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers);

Impermissible health care-related taxes; and Until October 1, 1995, permissible health care-related taxes that exceed a specified limit.

It is important to note that the new statutory requirements apply to all impermissible provider-related donations and health care-related tax revenues received by State or local governments, without consideration of the use of the funds. If a State levies a tax on hospitals that is impermissible under section 1903(w) of the Act, and deposits the revenues in an account designated for some purpose other than Medicaid funding, the statute requires that the funds be offset from Medicaid expenditures even though the State is not using the revenues as its share of Medicaid expenditures for FFP purposes. For this purpose, the statute treats the State, and units of local government within the State, as a single entity. The fact that the funds were not received directly by the Medicaid agency does not alter the statute's

requirements that the funds be reduced from the State's claimed expenditures.

Section 1903(w)(2)(A) of the Act defines "provider-related donations" as any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses. Section 1903(w)(2)(B) defines "bona fide provider-related donations" as provider-related donations that have no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established to the satisfaction of the Secretary. The statute also gives the Secretary the authority to specify, by regulation, types of provider-related donations that will be considered to be bona fide provider-related donations.

Section 1903(w)(3)(A) of the Act defines "health care-related taxes" as those taxes that are related to: (1) Health care items or services; (2) the provision of such items or services; (3) the authority to provide health care items or services; or (4) the payment for such items or services.

In accordance with section 1903(w) of the Act, we are defining the term "permissible health care-related taxes" to mean those health care-related taxes which are broad-based taxes, uniformly applied to a class of health care items, services or providers (as specified in section 1903(w)(7)(A) of the Act), and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which HCFA has granted a waiver. Health care-related taxes that do not meet these requirements are "impermissible health care-related taxes."

As specified in section 1903(w)(1)(C)(i) of the Act, these provisions apply to revenues received by a State on or after January 1, 1992 (except for certain donations and taxes permitted under a transition period, which are subject to a limit). Revenues received by States prior to January 1, 1992 are not subject to these statutory provisions. In addition, since these provisions restrict the receipt of taxes and donations, they do not apply to expenditures that are made on or after January 1, 1992, that are funded by these pre-January 1, 1992 revenues.

We are revising subpart B in 42 CFR part 433 to incorporate the statutory provisions of section 1903(w) of the Act

Attachment D



Federal Register

**Tuesday,
May 29, 2007**

Part V

**Department of
Health and Human
Services**

Centers for Medicare & Medicaid Services

**42 CFR Parts 433, 447, and 457
Medicaid Program; Cost Limit for
Providers Operated by Units of
Government and Provisions To Ensure
the Integrity of Federal-State Financial
Partnership; Final Rule**

1903(w)(6)(A) of the Act, is taxing authority or the ability to directly access tax funding. Even though sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Act are not directly binding for all statutory purposes, we sought a definition that would be consistent with readings of both statutory provisions.

69C. Comment: One commenter quoted prior CMS statements from regulations published in 2001 and 2002, wherein CMS did not take regulatory action with respect to intergovernmental transfers, suggesting that CMS is now not only contradicting itself but also imposing restrictions on IGTs that Congress never intended.

69R. Response: The provisions of this regulation continue to protect the use of IGTs; the regulation merely sets out in clear terms the circumstances in which the provisions of section 1903(w)(6)(A) of the Act provides that an IGT from a governmentally-operated health care provider would not trigger review as a provider tax or donation. This regulation supersedes prior CMS statements on the issue and would provide important clarity in an area that has been the subject of much confusion. Furthermore, we disagree with the commenters' contention concerning congressional intent. In section 1903(w)(6)(A) of the Act, the Medicaid statute clearly protects only IGTs or certified public expenditures that are "derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred or certified by units of government within a state." To the extent that the provisions of this regulation impose restrictions on IGTs, such restrictions are consistent with this statutory provision and serve to clarify and give meaning to the statutory language.

70C. Comment: Many commenters stated that the provisions of the regulation require sources of all IGTs must be state or local taxes and that such a restriction on IGT funding is inconsistent with the Medicaid statute. These commenters noted that governments derive their funding from a variety of sources, not just tax proceeds, and such funds are no less governmental due to their source. Some of the non-tax sources of governmental revenue that were cited include patient care revenues from other third party payers, penalties, fees, grants, earned interest, library fines, restaurant inspection fees, vending machine sales, traffic fines, unreserved general fund balances, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds, and gifts. These commenters suggested that

CMS should allow all public funding, regardless of source, to be used as the non-Federal share of Medicaid expenditures. A number of commenters cited Section 1902(a)(2) of the Act, which permits up to 60 percent of the non-Federal share to come from "local sources," without further restriction. This citation was given to counter a perceived CMS position that the provisions of the regulation require that the sources of all IGTs must be state or local taxes. Several other commenters suggested that CMS should allow all public funding, regardless of source, to be used as the non-Federal share of Medicaid expenditures, and that CMS has no statutory authority to limit the sources of transferred funds to tax revenue only.

70R. Response: Provisions regarding non-federal share financing were established in recognition of the Federal Medicaid statute at section 1903(w), which places severe statutory restriction on States' receipt of funds from health care providers to fund Medicaid payments. (see Public Law 102-234, section 2, *Prohibition on Use of Voluntary Contributions*, and Limitation on the Use of Provider-Specific Taxes to Obtain Financial Participation under Medicaid."). Under Public Law 102-234, the Congress included an exception to a general prohibition on the receipt of voluntary contributions from health care providers by allowing units of government, including governmentally-operated health care providers, to participate in financing of the non-Federal share via intergovernmental transfers and certified public expenditures. Specifically, section 1903(w)(6)(A) of the Social Security Act states:

Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

This statutory language allows funding derived from State or local taxes to be used for purposes of financing the non-Federal share of Medicaid payments. CMS recognizes that units of government that are not health care providers may collect revenue from a variety of sources (including fees, grants, earned interest, fines, sale or

lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds) that are ultimately deposited into the government's general fund, which is used to finance the government's operations. We find such general fund revenues to be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the general fund does not derive any of its revenue from impermissible sources (such as, "recycled" Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations).

Governmentally-operated health care providers may maintain accounts separate from the general fund to finance the operations of the governmentally-operated health care provider. The governmentally-operated health care provider's account may include patient care revenues from other third party payers and other revenues similar to those listed above. Such revenues would also be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the governmentally-operated health care provider's operating account does not derive any of its revenue from impermissible sources (such as, "recycled" Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations).

As previously explained, governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues. A governmentally-operated health care provider is always able to access tax revenue, a characteristic of which reflects a health care provider's governmental status, and helps to define eligibility to participate in IGTs.

71C. Comment: A number of commenters asked CMS to clarify that intragovernmental transfers (transfers within a unit of government, such as a transfer from the State's mental health agency to the State Medicaid Agency) are not considered "intergovernmental transfers" for purposes of § 433.51.

71R. Response: Neither the Medicaid statute nor Federal regulation uses the term "intragovernmental transfer." For purposes of the Medicaid statute, a transfer of funding between any governmental entity within a State to the State Medicaid Agency is considered an intergovernmental transfer, irrespective of whether or not those entities are operated by the same unit of government (e.g., a State Department of Mental Health

Financial Management Group Clearance Item Cover Page

Date: September 26, 2019

Time: 12:30pm – 1pm

Topic: South Carolina SPA Disapproval Reconsideration Package, OSG Request

Paper: YES, 5 attachments

Summary: OSG has requested this item (Disapproved SPAs 16-0012-A, 17-0006-A and 18-0011-A, amendment proposal adding new eligible physicians associated with Greenville Memorial Hosp. and Palmetto Health Richland to the current physician teaching supplemental payment methodology) be added to the FMG 9/26 Clearance agenda due to the expedited timeframe. The Administrator must sign this package and CMS must reply by October 4th.

Decision Requested: No

Financial Management Group Clearance Items

September 26, 2019

Time: 12:30pm – 1pm

Location: **Conference Room A**

Conference Dial-in Number: 1-877-267-1577

Meeting ID

b6

Standing Items:

Access NPRM, *J. Silanskis*, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), *DRSF/DFO*, verbal only

DSH Allotment Reduction Rule/FY 2020 DSH Reductions, *K.Fan/DFO*, paper

Discussion Items:

1. **Topic:** Arkansas FMR Follow-up, *J. Gavens*, verbal only

Action Needed By: N/A

Decision Requested: N/A

Summary: FMG originally brought the AR FMR to Clearance on 9/11. DE reviewed this FMR and is in agreement with the findings. OCD raised the concern that all 83 private home health providers reviewed were not in compliance with the Surety Bond requirement. When reviewers were out there, the State said they were unaware of the Surety Bond requirement and they rely on their fiscal advisor to be on top of things like this. OCD is interested in knowing whether there are other states out there that are “unaware” of this requirement. OCD was fine with proceeding with issuing the FMR and requested additional information on whether other states are aware of the Surety Bond requirement, for a future Clearance meeting.

2. **Topic:** Wisconsin Rehabilitation Cost Reporting Issue, *DRSF*, verbal only

Action Needed By: N/A

Decision Requested: N/A

Summary: This item was originally discussed during the 9/11 Clearance meeting. The State made interim payments and claimed FFP on the CPE generated. They have no claims data to support their numbers and want to use FY 2017 costs as a proxy for the FY 2010-2014 expenditures. We repeatedly advised the state, starting in 2009, that they cannot do this. We did approve their SPA in 2009 without the cost report because the State said it was not finished yet and that they would submit it once it was completed. OCD agreed with moving forward with the disallowance as long as we can confirm that we told the state they needed to provide us the cost report as soon as it was completed. FMG has information to provide supporting the State was informed.

3. **Topic:** Oregon CHIP Contingency Fund, *DFO*, **paper**
Action Needed By: September, 30. 2019
Decision Requested: FMG seeks concurrence from OCD to make the full contingency fund payment and continue recommending to Congress the removal/modification of the contingency fund provisions to prevent excessive payments.
Summary: Oregon qualifies for a CHIP contingency fund payment approximating \$113 million despite a CHIP program need of approximately \$4 million. FMG briefly raised this item at the end of the 9/18 Clearance meeting and wants to provide OCD with more information on the contingency fund payment/provision, and input from OGC. FMG has specifically discussed with GC if there is flexibility in the statute to limit OR's contingency fund payment to its shortfall amount or not make a contingency fund payments to Oregon.
4. **Topic:** Provider Payment Reassignment Rule/CIB, *C. Thompson*, **verbal only**
Action Needed By: N/A
Decision Requested: FMG wants OCDs concurrence to provide Nasuad a follow-up email.
Summary: FMG met with Nasuad to discuss the newly released PRR CIB, and CMS' plans going forward, with regard to states' compliance to the Rule. At the end of the meeting, Nasuad asked if FMG can follow-up with an email summarizing the meeting discussion.
5. **Topic:** South Carolina SPA Disapproval Reconsideration Package, *OSG/DRSF*, **paper**
Action Needed By: N/A
Decision Requested: N/A
Summary: OSG has requested this item (Disapproved SPAs 16-0012-A, 17-0006-A and 18-0011-A, amendment proposal adding new eligible physicians associated with Greenville Memorial Hosp. and Palmetto Health Richland to the current physician teaching supplemental payment methodology) be added to the FMG 9/26 Clearance agenda due to the expedited timeframe. The Administrator must sign this package and CMS must reply by October 4th.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval
South Carolina Medicaid State Plan Amendments
(SPAs) 16-0012-A, 17-006-A, and 18-0011-A

AGENCY: Centers for Medicare & Medicaid Services (CMS)

HHS ACTION: Notice of Hearing: Reconsideration of Disapproval

SUMMARY: This notice announces an administrative hearing to be held on November 20, 2019, at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909 to reconsider CMS' decision to disapprove South Carolina's Medicaid SPAs 16-0012-A, 17-006-A, and 18-0011-A.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by **[insert date 15 days after publication in the Federal Register]**.

FOR FURTHER INFORMATION CONTACT:

Benjamin R. Cohen, Presiding Officer
CMS
2520 Lord Baltimore Drive
Suite L
Baltimore, Maryland 21244
Telephone: (410) 786-3169

SUPPLEMENTARY INFORMATION:

This notice announces an administrative hearing to reconsider CMS' decision to disapprove South Carolina's Medicaid state plan amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, respectively, and disapproved on July

9, 2019. These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use amounts transferred from the Greenville Health Authority to the State Medicaid Agency for use as the non-federal share of the proposed payments. The source of the transfers would be from the “Setoff Debt Collection Program,” which garnishes state individual income tax refunds to satisfy medical debt liabilities for services furnished by certain providers, rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from previously uncollected patient revenue.

Commented [OGC1]:

b5

b5

Commented [OGC2]: Legal. CMS, confirm.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act, which provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.
- Sections 1903(a) and 1905(b) of the Act, which provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.

- Section 1903(w)(6)(A) of the Act, which allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under section 1903 of the Act.

Section 1116 of the Act and federal regulations at 42 CFR Part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish in the Federal Register a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the state Medicaid agency of additional issues that will be considered at the hearing, we will also publish that notice in the Federal Register.

Any interested individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled or moved, the presiding officer will notify all participants.

The notice to South Carolina announcing an administrative hearing to reconsider the disapproval of its SPAs reads as follows:

Commented [OGC3]: Legal. Please ensure this is updated to reflect the revised letter to the state.

Joshua D. Baker

Director

South Carolina Department of Health and Human Services

Post Office Box 8206

Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to the September 6, 2019 request for reconsideration of the decision to disapprove South Carolina's State Plan amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A. South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019. I am scheduling a hearing on the request for reconsideration to be held on November 20, 2019 at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786-3169. In order to facilitate any

communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing. If the hearing date is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the “Setoff Debt Collection Program”, rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

In the event that CMS and the State come to agreement on resolution of the issues which formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Seema Verma

Administrator

cc: Benjamin R. Cohen

Section 1116 of the Social Security Act (42 U.S.C. section 1316; 42 CFR section 430.18) (Catalog of Federal Domestic Assistance program No. 13.714. Medicaid Assistance Program.)

Dated:

Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services



Brown & Peisch PLLC
1233 20th Street NW
Suite 505
Washington, DC 20036

Via Certified Mail

September 5, 2019

Maritza Bodon
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mail Stop S2-62-12
Baltimore, MD 21244-1850

**RE: Request for Reconsideration South Carolina SPAs 16-0012-A, 17-006-A,
and 18-0011-A**

Dear Ms. Bodon:

On behalf of the South Carolina Department of Health and Human Services, we are requesting reconsideration of the attached notice of disapproval of State Plan Amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A, pursuant to 42 C.F.R. § 430.18. The notice of disapproval was sent to the Department from Calder Lynch by letter dated July 9, 2019. (Attachment A.)

The SPAs propose to continue supplemental payments to physicians associated with Greenville Memorial Hospital and Palmetto Health Richland.

The letter asserts that the basis of disapproval is that the “state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903, 1903(w)(6)(A), and 1905(b) of the Social Security Act” because the payments proposed under the SPAs are funded through intergovernmental transfers (IGTs) from the Greenville Health Authority that are not derived from “state or local tax revenue as required by the statute.”

The Department requests that the Administrator reconsider the issue of whether the SPAs conform to the requirements for approval, as none of the cited sections, or any other section of Title XIX or CMS’s implementing regulations, limit IGTs to “state or local tax revenue.” Specifically:

1. Section 1902(a)(2) provides “for financial participation by the State equal to not less than 40 per centum of the non-Federal share of expenditures” and for carrying out the



plan on a basis “which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.”

This ground for disapproval should be reconsidered. The State provides financial participation well in excess of 40 percent of the non-Federal share and there is no claim that there is a lack of adequate funds from local sources that will result in lowering the amount, duration, scope, or quality of care and services. To the contrary, the funds from the Greenville Health Authority will help to sustain the quality of care of the teaching physicians associated with Greenville Memorial Hospital and Palmetto Health Richland. Therefore, Section 1902(a)(2) is not a reasonable or appropriate basis for disapproval.

2. Section 1903 provides for federal financial participation (FFP) in expenditures under the State Plan according to the federal medical assistance percentage (FMAP) formula set forth in Section 1905(b).

This ground for disapproval should be reconsidered. The physician services for which the supplemental payments are to be made under the SPAs are state plan services for which the State will claim FFP at the FMAP rate. There is no contention that the expenditures are not covered by the state plan as required by Section 1903(a)(1) or that the State intends to claim a match rate other than the one set forth in Section 1905(b). Therefore, Section 1903 and Section 1905(b) are not reasonable or appropriate bases for disapproval.

3. Section 1903(w)(6) provides that “the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider . . . unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.”

This ground for disapproval should be reconsidered. There is no contention that the transferred funds are derived from impermissible donations or taxes. Rather, CMS appears to be interpreting the clause that “the Secretary may not restrict States’ use of funds . . . derived from State or local taxes” as imposing a “requirement” that States can only accept IGTs that use funds derived from these sources.

Such a reading of the statute is not consistent with CMS regulations at 42 C.F.R. §433.51(b), which permits transfers of “public funds” from “public agencies,” and does not limit transfers to funds derived from State or local taxes. More importantly, limiting IGTs to funds derived from state and local taxes is not consistent with the statute that enacted Section 1903(w), the “Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,” Pub. L. 102-234. (Attachment B.) The stated purposes of the statute was to prevent impermissible taxes and donations but “to maintain the treatment of intergovernmental transfers” as a source of funding of the non-Federal share. At the time, the regulatory language regarding IGTs was the same as it is currently (although appearing in a different section).



In accordance with that purpose, Section 5 of Pub. L. 102-234 gave the Secretary the authority to issue “interim final” regulations implementing its provisions but specified that:

[t]he Secretary may not issue any interim final regulation that changes the treatment . . . of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds . . . that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

Further, the Secretary was directed to “consult with the States before issuing any regulations under this Act.” Id. § 5(c).

When CMS (then known as the Health Care Financing Administration, or HCFA) did publish interim final regulations a few months later, it complied with this congressional mandate and did not change the treatment of intergovernmental transfers, and it informed the States that:

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax. Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

See Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55043, 55119 (Nov. 24, 1992) (Attachment C).

Similarly, in 2007, when CMS did finalize a rule governing the non-Federal share (which was later withdrawn), it informed States that transfers from units of government were permissible “from a variety of sources (including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds);” that “patient care revenues from other third party payers and other revenues similar to those listed above . . . would also be acceptable sources of financing the non-Federal share of Medicaid payments” as long as they were not derived from impermissible sources; and that “governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues.” *See* Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748, 29766 (May 29, 2007) (Attachment D). The stated basis of the disallowance contradicts all of these prior statements from CMS.



Maritza Bodon
September 5, 2019
Page 4

Given the 1991 congressional mandate that the Secretary may only change the treatment of intergovernmental transfers by final regulation issued under the Administrative Procedure Act, after consultation with the States, and that CMS has twice subsequently told the States that sources other than state and local taxes are permissible sources of such transfers, Section 1903(w)(6) is not a reasonable or appropriate basis for disapproval.

The Department appreciates the reconsideration of the disapproval on the basis of the arguments set forth above.

Respectfully,

Caroline Brown /RES

Caroline M. Brown
Philip J. Peisch

Enclosures

Cc: Shantrina Roberts
Bryon Roberts

Attachment A

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



July 9, 2019

Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid state plan amendments (SPAs) 16-0012-A, 17-0006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs.

In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed non-federal share funding source is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019, CMS communicated with the South Carolina Medicaid Director that CMS would issue a disapproval for the aforementioned SPAs unless the state provided new information regarding the source of the non-federal share for the proposed supplemental payments. The state requested time to provide additional information to support the proposals, which CMS granted. The information that the state subsequently provided did not describe an alternative funding source that would allow us to approve the proposed SPAs.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations in 42 C.F.R. § 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations in 42 C.F.R. § 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized, flowing script.

Calder Lynch
Acting Deputy Administrator and Director

Attachment B

Public Law 102-234
102d Congress

An Act

To delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source.

Dec. 12, 1991
 [H.R. 3595]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991".

Medicaid
 Voluntary
 Contribution
 and
 Provider-
 Specific Tax
 Amendments of
 1991.
 42 USC 1305
 note.

SEC. 2. PROHIBITION ON USE OF VOLUNTARY CONTRIBUTIONS, AND LIMITATION ON THE USE OF PROVIDER-SPECIFIC TAXES TO OBTAIN FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection.

"(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

"(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

"(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

"(II) donations described in paragraph (2)(C);

"(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

"(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

"(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

"(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as deter-

mined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

"(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

"(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

"(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

"(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(iii) In this subparagraph and subparagraph (E), the term 'impermissible tax' means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

"(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

"(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

Effective dates.

"(F) In this paragraph in the case of a State—

"(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

"(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

"(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in

1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

"(2)(A) In this subsection (except as provided in paragraph (6)), the term 'provider-related donation' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

"(i) a health care provider (as defined in paragraph (7)(B)),

"(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

"(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

"(B) For purposes of paragraph (1)(A)(i)(I), the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

"(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

"(3)(A) In this subsection (except as provided in paragraph (6)), the term 'health care related tax' means a tax (as defined in paragraph (7)(F)) that—

"(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

"(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

"(B) In this subsection, the term 'broad-based health care related tax' means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

"(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

"(ii) is imposed uniformly (in accordance with subparagraph (C)).

"(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

"(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

"(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

"(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

"(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

"(ii) Subject to subparagraphs (I) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

"(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

"(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

"(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

"(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

"(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

"(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

"(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph. Regulations.

"(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

"(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment 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.

"(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

"(C) 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.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

"(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

"(B)(i) In subparagraph (A), the term 'State base percentage' means, with respect to a State, an amount (expressed as a percentage) equal to—

"(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

"(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

"(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

"(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

"(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

"(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

"(7) For purposes of this subsection:

"(A) Each of the following shall be considered a separate class of health care items and services:

"(i) Inpatient hospital services.

"(ii) Outpatient hospital services.

"(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

"(iv) Services of intermediate care facilities for the mentally retarded.

"(v) Physicians' services.

"(vi) Home health care services.

"(vii) Outpatient prescription drugs.

"(viii) Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).

"(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

"(B) The term 'health care provider' means an individual or person that receives payments for the provision of health care items or services.

"(C) An entity is considered to be 'related' to a health care provider if the entity—

"(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

"(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

"(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

"(iv) has a similar, close relationship (as defined in regulations) to the provider.

"(D) The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(E) The 'State fiscal year' means, with respect to a specified year, a State fiscal year ending in that specified year.

"(F) The term 'tax' includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty

imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

"(G) The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State."

(b) CONFORMING AMENDMENTS.—(1) Section 1902(t) of such Act (42 U.S.C. 1396a(t)) is amended—

(A) by striking "Except as provided in section 1903(i), nothing" and inserting "Nothing", and

(B) by striking "taxes (whether or not of general applicability)" and inserting "taxes of general applicability".

(2) Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by striking paragraph (10) inserted by section 4701(b)(2)(B) of the Omnibus Budget Reconciliation Act of 1990.

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date. 42 USC 1396a note.

(2) Except as specifically provided in section 1903(w) of the Social Security Act and notwithstanding any other provision of such Act, the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure. 42 USC 1396b note.

(3) The interim final rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56132), relating to the State share of financial participation under the medicaid program, is hereby nullified and is of no effect. No part of such rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 3. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) REPEAL OF PROHIBITION OF UPPER PAYMENT LIMIT FOR DISPROPORTIONATE SHARE HOSPITALS.—Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)) is amended by striking "to limit" the first place it appears and all that follows through "special needs or".

(b) LIMITATION ON AGGREGATE PAYMENT ADJUSTMENTS.—

(1) IN GENERAL.—Section 1923 of such Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

"(1) IN GENERAL.—

"(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

"(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

"(I) the payment adjustments are made—

"(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

"(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

"(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

"(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

"(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the year (as specified in paragraph (2)).

"(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

"(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

"(i) the national DSH payment limit for the fiscal year, and

"(ii) the State DSH allotment for each State for the year.

"(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

"(i) The hospital's medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

"(ii) The hospital's low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

"(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is

equal to at least 1 percent of the total number of such days for all hospitals in the State.

"(iv) The hospital meets such alternative requirements as the Secretary may establish by regulation, taking into account the special circumstances of children's hospitals, hospitals located in rural areas, and sole community hospitals.

"(E) CONDITION FOR OPTION.—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a state exercising such option.

"(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

"(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

"(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

"(B) EXCEPTIONS.—

"(i) LIMIT TO 12 PERCENT OR BASE ALLOTMENT.—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State based allotment.

"(ii) EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

"(3) STATE SUPPLEMENTAL AMOUNTS.—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

"(A) DETERMINATION OF REDISTRIBUTION POOL.—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

"(i) the total of the State base allotments for high DSH States;

"(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

"(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal year; and

"(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

"(B) DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.—The supplemental amount for a State for a fiscal year is equal to the lesser of—

"(i) the product of the amount determined under subparagraph (A) and the ratio of—

"(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

"(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

"(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

"(4) DEFINITIONS.—In this subsection:

"(A) HIGH DSH STATE.—The term 'high DSH State' means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

"(B) STATE.—The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(C) STATE BASE ALLOTMENT.—The term 'State base allotment' means, with respect to a State, the greater of—

"(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

"(ii) \$1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

"(D) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the lesser of—

"(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

"(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

"(E) STATE GROWTH FACTOR.—The term 'State growth factor' means, for a State for a fiscal year, the percentage by which the expenditures described in section 1908(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year."

(2) CONFORMING AMENDMENTS.—(A) Such section 1923 is further amended—

(i) in subsection (a)(2)(B), by striking "subsection (c)," and inserting "subsections (c) and (f)"; and

(ii) in subsection (c), by striking "In order" and inserting "Subject to subsection (f), in order".

(B) Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "and section 1923(f)" after "of this section".

(c) **LIMITS ON AUTHORITY TO RESTRICT DSH DESIGNATIONS.**— 42 USC 1396r-4.
Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4)."

(d) **STUDY OF DSH PAYMENT ADJUSTMENTS.**—

42 USC 1396r-4
note.

(1) **IN GENERAL.**—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) **ITEMS INCLUDED IN STUDY.**—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) **REPORT.**—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section shall take effect January 1, 1992.

42 USC 1396a
note.

(2) The proposed rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56141), relating to the standards for defining disproportionate share hospitals under the medicaid program, shall be withdrawn and can-

celed. No part of such proposed rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 4. REPORTING REQUIREMENT.

(a) **IN GENERAL.**—Section 1903(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following:

“(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

“(i) provider-related donations made to the State or units of local government during such fiscal year, and

“(ii) health care related taxes collected by the State or such units during such fiscal year.

“(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.”

42 USC 1396b
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to fiscal years ending after the date of the enactment of this Act.

42 USC 1396b
note.

SEC. 5. INTERIM FINAL REGULATIONS.

(a) **IN GENERAL.**—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) **REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.**—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that

are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) **CONSULTATION WITH STATES.**—The Secretary shall consult with the States before issuing any regulations under this Act.

Approved December 12, 1991.

LEGISLATIVE HISTORY—H.R. 3595:

HOUSE REPORTS: Nos. 102-810 (Comm. on Energy and Commerce) and 102-409 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 137 (1991):

Nov. 19, considered and passed House.

Nov. 26, considered and passed Senate, amended. House agreed to conference report.

Nov. 27, Senate agreed to conference report.

Attachment C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 433 and 447

[MB-062-IFC]

RIN 0938-AF42

Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule establishes in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The rule also adds provisions that establish limits on the aggregate amount of payments a State may make to disproportionate share hospitals for which FFP is available.

This interim final rule implements provisions of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991.

DATES: *Effective date:* These interim final rules are effective December 24, 1992. However, the statutory requirements at sections 2(c)(1) and 3(e)(1) of Public Law 102-234 have an effective date of January 1, 1992, and are effective on that date regardless of the effective date of this interim final rule.

COMMENT DATE: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 25, 1993.

ADDRESSES: Mail comments to the following address:

Health Care Financing Administration,
Department of Health and Human
Services, Attention: MB-062-IFC P.O.
Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey
Building, 200 Independence Avenue,
SW, Washington, DC 20201, or
Room 132, East High Rise Building, 6325
Security Boulevard, Baltimore,
Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code MB-062-IFC. Written comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-690-7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Paperwork Burden" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Laura Oliven, Office of Management and Budget, New Executive Office Building (Room 3002), Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT:

Theresa Pratt (Donations and Taxes)
(410) 966-9535

Betty Kern (Disproportionate Share
Payments) (410) 966-4580

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. Medicaid programs are administered by the States in accordance with Federal regulations. State Medicaid agencies conduct their programs according to a Medicaid State plan approved by the Health Care Financing Administration (HCFA). To carry out the mandates of the Medicaid program, the State agency pays providers for medical care and services provided to eligible Medicaid recipients. Providers that wish to participate in the Medicaid program must agree to comply with certain requirements specified in a provider agreement.

While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. The Federal government pays its share of medical assistance expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The State pays its share of medical assistance

expenditures in accordance with section 1902(a)(2) of the Act.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers and revenues generated by certain health care-related taxes. This law also amended section 1923 of the Act to establish limits on the amount of FFP for expenditures made to hospitals that serve a disproportionate number of Medicaid recipients and other low-income individuals. These hospitals are referred to as disproportionate share hospitals.

This interim final rule interprets and implements the provisions of Public Law 102-234. The two issues that are affected by this law (provider-related donations and health care-related taxes, and disproportionate share hospital payments) are addressed separately in this preamble.

II. Provider-Related Donations and Health Care-Related Taxes

Section 1902(a)(2) of the Act requires States to share in the cost of medical assistance expenditures, and permits both State and local governments to participate in the financing of the non-Federal portion of expenditures under the Medicaid program. This section specifies the minimum percentage of the State's share of the non-Federal costs, and requires that the State share be sufficient to assure that the lack of adequate funds from local government sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State. Section 1903 of the Act requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

Public Law 102-234 amended section 1903 of the Act by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in FFP will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstafioned eligibility worker donation requirements, as specified in

the law. The law also specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. Such taxes are broad-based taxes which apply in a uniform manner to all health care providers in a class, and which do not hold providers harmless for their tax costs. However, the law permits States which have received, by specific date prior to the enactment of this law, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

Public Law 102-234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax.

Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The provisions of Public Law 102-234 apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section

1115 of the Act. The exemption is currently limited to Arizona. The provisions apply to donations to State or local governments from providers and related entities and to revenues generated by health care-related taxes, regardless of whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government, and regardless of whether the State uses these funds as the State share of medical assistance expenditures for FFP purposes. However, the provisions do not apply to the treatment of donations from entities not related to providers or the receipt of revenues generated by generally applicable taxes or other non-health care-related taxes.

A discussion of the specific provisions of Public Law 102-234 relating to treatment of provider-related donations and health care-related tax revenues and the implementing regulatory provisions follows.

General Rule

Section 1903(w)(1) of the Act provides that, effective January 1, 1992, before calculating the amount of FFP, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are as follows:

Donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers);

Impermissible health care-related taxes; and Until October 1, 1995, permissible health care-related taxes that exceed a specified limit.

It is important to note that the new statutory requirements apply to all impermissible provider-related donations and health care-related tax revenues received by State or local governments, without consideration of the use of the funds. If a State levies a tax on hospitals that is impermissible under section 1903(w) of the Act, and deposits the revenues in an account designated for some purpose other than Medicaid funding, the statute requires that the funds be offset from Medicaid expenditures even though the State is not using the revenues as its share of Medicaid expenditures for FFP purposes. For this purpose, the statute treats the State, and units of local government within the State, as a single entity. The fact that the funds were not received directly by the Medicaid agency does not alter the statute's

requirements that the funds be reduced from the State's claimed expenditures.

Section 1903(w)(2)(A) of the Act defines "provider-related donations" as any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses. Section 1903(w)(2)(B) defines "bona fide provider-related donations" as provider-related donations that have no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established to the satisfaction of the Secretary. The statute also gives the Secretary the authority to specify, by regulation, types of provider-related donations that will be considered to be bona fide provider-related donations.

Section 1903(w)(3)(A) of the Act defines "health care-related taxes" as those taxes that are related to: (1) Health care items or services; (2) the provision of such items or services; (3) the authority to provide health care items or services; or (4) the payment for such items or services.

In accordance with section 1903(w) of the Act, we are defining the term "permissible health care-related taxes" to mean those health care-related taxes which are broad-based taxes, uniformly applied to a class of health care items, services or providers (as specified in section 1903(w)(7)(A) of the Act), and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which HCFA has granted a waiver. Health care-related taxes that do not meet these requirements are "impermissible health care-related taxes."

As specified in section 1903(w)(1)(C)(i) of the Act, these provisions apply to revenues received by a State on or after January 1, 1992 (except for certain donations and taxes permitted under a transition period, which are subject to a limit). Revenues received by States prior to January 1, 1992 are not subject to these statutory provisions. In addition, since these provisions restrict the receipt of taxes and donations, they do not apply to expenditures that are made on or after January 1, 1992, that are funded by these pre-January 1, 1992 revenues.

We are revising subpart B in 42 CFR part 433 to incorporate the statutory provisions of section 1903(w) of the Act

Attachment D



Federal Register

Tuesday,
May 29, 2007

Part V

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 447, and 457
Medicaid Program; Cost Limit for
Providers Operated by Units of
Government and Provisions To Ensure
the Integrity of Federal-State Financial
Partnership; Final Rule

1903(w)(6)(A) of the Act, is taxing authority or the ability to directly access tax funding. Even though sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Act are not directly binding for all statutory purposes, we sought a definition that would be consistent with readings of both statutory provisions.

69C. Comment: One commenter quoted prior CMS statements from regulations published in 2001 and 2002, wherein CMS did not take regulatory action with respect to intergovernmental transfers, suggesting that CMS is now not only contradicting itself but also imposing restrictions on IGTs that Congress never intended.

69R. Response: The provisions of this regulation continue to protect the use of IGTs; the regulation merely sets out in clear terms the circumstances in which the provisions of section 1903(w)(6)(A) of the Act provides that an IGT from a governmentally-operated health care provider would not trigger review as a provider tax or donation. This regulation supersedes prior CMS statements on the issue and would provide important clarity in an area that has been the subject of much confusion. Furthermore, we disagree with the commenters' contention concerning congressional intent. In section 1903(w)(6)(A) of the Act, the Medicaid statute clearly protects only IGTs or certified public expenditures that are "derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred or certified by units of government within a state." To the extent that the provisions of this regulation impose restrictions on IGTs, such restrictions are consistent with this statutory provision and serve to clarify and give meaning to the statutory language.

70C. Comment: Many commenters stated that the provisions of the regulation require sources of all IGTs must be state or local taxes and that such a restriction on IGT funding is inconsistent with the Medicaid statute. These commenters noted that governments derive their funding from a variety of sources, not just tax proceeds, and such funds are no less governmental due to their source. Some of the non-tax sources of governmental revenue that were cited include patient care revenues from other third party payers, penalties, fees, grants, earned interest, library fines, restaurant inspection fees, vending machine sales, traffic fines, unreserved general fund balances, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds, and gifts. These commenters suggested that

CMS should allow all public funding, regardless of source, to be used as the non-Federal share of Medicaid expenditures. A number of commenters cited Section 1902(a)(2) of the Act, which permits up to 60 percent of the non-Federal share to come from "local sources," without further restriction. This citation was given to counter a perceived CMS position that the provisions of the regulation require that the sources of all IGTs must be state or local taxes. Several other commenters suggested that CMS should allow all public funding, regardless of source, to be used as the non-Federal share of Medicaid expenditures, and that CMS has no statutory authority to limit the sources of transferred funds to tax revenue only.

70R. Response: Provisions regarding non-federal share financing were established in recognition of the Federal Medicaid statute at section 1903(w), which places severe statutory restriction on States' receipt of funds from health care providers to fund Medicaid payments. (see Public Law 102-234, section 2, *Prohibition on Use of Voluntary Contributions*, and *Limitation on the Use of Provider-Specific Taxes to Obtain Financial Participation under Medicaid*). Under Public Law 102-234, the Congress included an exception to a general prohibition on the receipt of voluntary contributions from health care providers by allowing units of government, including governmentally-operated health care providers, to participate in financing of the non-Federal share via intergovernmental transfers and certified public expenditures. Specifically, section 1903(w)(6)(A) of the Social Security Act states:

Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

This statutory language allows funding derived from State or local taxes to be used for purposes of financing the non-Federal share of Medicaid payments. CMS recognizes that units of government that are not health care providers may collect revenue from a variety of sources (including fees, grants, earned interest, fines, sale or

lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds) that are ultimately deposited into the government's general fund, which is used to finance the government's operations. We find such general fund revenues to be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the general fund does not derive any of its revenue from impermissible sources (such as, "recycled" Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations).

Governmentally-operated health care providers may maintain accounts separate from the general fund to finance the operations of the governmentally-operated health care provider. The governmentally-operated health care provider's account may include patient care revenues from other third party payers and other revenues similar to those listed above. Such revenues would also be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the governmentally-operated health care provider's operating account does not derive any of its revenue from impermissible sources (such as, "recycled" Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations).

As previously explained, governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues. A governmentally-operated health care provider is always able to access tax revenue, a characteristic of which reflects a health care provider's governmental status, and helps to define eligibility to participate in IGTs.

71C. Comment: A number of commenters asked CMS to clarify that intragovernmental transfers (transfers within a unit of government, such as a transfer from the State's mental health agency to the State Medicaid Agency) are not considered "intergovernmental transfers" for purposes of § 433.51.

71R. Response: Neither the Medicaid statute nor Federal regulation uses the term "intragovernmental transfer." For purposes of the Medicaid statute, a transfer of funding between any governmental entity within a State to the State Medicaid Agency is considered an intergovernmental transfer, irrespective of whether or not those entities are operated by the same unit of government (e.g., a State Department of Mental Health

RE: RE: Notes for folks

From: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>
To: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Date: Tue, 01 Oct 2019 16:46:20 +0000
Attachments: MFAR NPRM HHS paper.docx (24.45 kB); Medicaid Fiscal Accountability Regulation (CMS 2393-P).pptx (77.3 kB)

I'm attaching the brief that we used for HHS and a PP that describes each proposed provision. The team is working to update the comms documents to highlight bad financing arrangements. Re: the transition periods, the 5 year transition/renewal applies to states updating SPA methodologies for supplemental payments to add in the proposed comprehensive methodology requirements and there is a new 3 year approval period for tax waivers. There is no transition to the extent we find problematic financing so I think we could address those issues quickly through FMRs and disallowances.

From: Freeze, Janet G. (CMS/CMCS)
Sent: Monday, September 30, 2019 5:36 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: Re: Notes for folks

From today's CMCS OA Issues De-Brief:

SC Reconsideration Hearing letters – good to go

MFAR – wants more examples included in the comms documents of schemes that MFAR will curtail. One example cited by ASV: Indiana nursing homes (ASV is, of course, familiar with that one). Add other examples/scenarios – will not use state names however

MFAR – for the proposed rule ASV wants to go with a THREE YEAR compliance transition timeline instead of the FIVE. Will discuss this with OMB once we have their passback

MFAR ACTION ITEM: – ASV wants options on how existing “egregious” arrangements could be terminated more quickly (i.e., fast than even the 3 years).

MFAR ACTION ITEM: – ASV needs a refresh on all the issues; send Calder current versions of all relevant briefing papers.

Janet Freeze, J.D. | Deputy Director | Financial Management Group | Center for Medicaid and CHIP Services | Centers for Medicare & Medicaid Services | 410-786-5917 | janet.freeze@cms.hhs.gov

Medicaid Fiscal Accountability Rule (MFAR) Proposed Rule (CMS-2393-P)

HHS Reviewers Briefing Paper

Overview:

The President's FFY 2019 Medicaid administrative budget proposals included improving data collection for Medicaid supplemental payments and reducing gimmicks that may be used to inappropriately fund state Medicaid programs. To address these issues, CMS has drafted a proposed rule that proposes to improve accountability, transparency and clarity through: additional state reporting, stronger financial definitions, and clearer federal guidance.

Background:

This proposed rule will respond to criticisms from oversight agencies about our ability to oversee and understand Medicaid supplemental payments, disproportionate share hospital payments and the associated non-federal share. Specifically, it will increase our capacity to evaluate payments at a provider-specific level for both state plan services and demonstration programs, improve efforts to provide technical assistance to states, aid in developing future policies to increase transparency and accountability, and support the agency's program oversight goals. The proposed rule would also address several areas of program vulnerability associated with states' use of intergovernmental transfers and certified public expenditures and with health-care related taxes and donation policies.

In the past, CMS has taken several actions to improve the accountability and increase transparency of Medicaid payments. In the early 2000s, CMS strengthened UPL regulations to limit payments by designated provider classes to what would have been paid under Medicare for similar services. To improve data availability, in 2010 CMS required states to separately report supplemental payment amounts for services subject to a UPL. Also, CMS issued State Medicaid Director Letters in 2013 and 2014, respectively, to mandate annual submission of UPL demonstrations and clarify that providers may not inappropriately participate in the funding their own Medicaid payments.

Although CMS has made these significant efforts to address program vulnerabilities through guidance and program reviews, additional regulatory backing will ensure we have improved tools to oversee the Medicaid program and states have better guidance to comply with the statute. Further, the policies described in the proposed rule will address several long-standing recommendations from the GAO and more recent recommendations from MACPAC.

Overview of the NPRM Changes:

Improved Reporting on Supplemental Payments

- Require states to report provider-specific payment information on payments received through state plan services and demonstration programs and identify the specific authority (SPA/demonstration).
- Require states to report the source of the non-federal share for such payments.
- Provide guidance on comprehensive supplemental payment methodologies, including: the purpose of the payment, the intended and measurable outcomes/results, which providers receive the payments, the payment calculation and the timeframe for payment distribution.
- Allow CMS and states to evaluate the effects of the payments by sunseting existing and new supplemental payment methodologies after 5 years and requiring states to request approval to continue the payments beyond 5 years.

- Mandate the use of OMB approved templates and CMS guidelines on acceptable upper payment limit calculations.

Clarified Medicaid Financing Definitions

- Develop regulatory definitions for Medicaid “base” and “supplemental” payments.
- Clarify the definitions and processes associated with the non-federal share financing arrangements.
- Clarify the upper payment limit ownership categories to close loopholes and be more consistent with the statute.

Reduce “State Gimmicks”

State Reliance on Providers to Fund the Non-federal Share

- Re-affirm the statutory requirement that intergovernmental transfers (IGTs) must be derived from state or local tax revenues and clarify regulations that refer to IGTs as “public funds.”
- Restrict facilities that change ownership from receiving additional Medicaid payments solely on the basis of the ownership transfer.
- Require states to cost settle when using a certified public expenditure and send the full amount of federal financial participation claimed for services to the provider.
- Clarify in regulation that the provider must receive and retain 100% of the payment. This clarification will prevent states and local units of government from recycling Medicaid payments to be reused as the source of state financing for additional payments.
- Restrict states/local governments from charging providers an administrative fee based on a percentage of Medicaid payments a provider receives.

Health Care-Related Taxes and Donations

- Incorporate into regulation existing State Health Official (SHO) Letter 14-004 and recent DAB decisions prohibiting financial arrangements (often under the guise of public/private partnerships) designed to mask impermissible donations.
- Clarify the existing requirements that prohibit states from structuring health care-related taxes that unduly burden the Medicaid program (e.g., higher tax rates on Medicaid services than non-Medicaid services), including by closing an inadvertent regulatory loophole.
- Incorporate into regulation existing SHO letter 14-001 prohibiting states from circumventing health care-related tax requirements by masking health care-related taxes.
- Update permissible tax classes to include health insurers as a permissible class.
- Strengthen oversight and monitoring of approved tax waivers.

Medicaid Disproportionate Share Hospital (DSH) Payments

- Strengthen transparency and oversight of annual Medicaid DSH audits by requiring a quantification of individual audit findings by hospital and clarifying reporting requirements.
- Clarify the overpayment discovery and redistribution procedures associated with DSH payments to ensure timely and proper DSH claims.
- Modernizes DSH allotment publication process.

Medicaid Fiscal Accountability Regulation (CMS 2393-P)

MFAR

Target Publication Date: November 2019

MFAR – Goals

- Increase the agency's capacity to evaluate payments at a provider-specific level.
- Improve efforts to provide technical assistance to states.
- Increase transparency and accountability through better data reporting and improved oversight.
- Further the agency's program integrity goals by addressing loopholes and financing schemes.

MFAR – Overview of the NPRM

- Require states submit provider-level information and other data needed to ensure Medicaid payments are consistent with the statute.
- Clarify Medicaid financing definitions to better align with the statute.
- Re-affirm statutory requirements that describe health care-related taxes and donations and the source of the non-federal share for Medicaid expenditures.
- Strengthen transparency and oversight of DSH payments by clarifying reporting requirements and requiring quantification of individual audit findings by hospital.

Proposed Provision - Disallowance of claims for FFP (§ 430.42)

- Proposal - allow states and CMS to communicate the disallowance reconsideration process through electronic mail or another electronic system specified by the Secretary.
- Current Requirements – communications must be through certified mail.

Proposed Provision: State share of financial participation (§ 433.51)

- Proposal - clarify the sources of intergovernmental transfers must come from state or local tax revenue.
- Current Requirements – regulations currently deviate from the statute and allow for “public funds.”
- Proposal – describe protocols states may use to identify Medicaid expenditures associated with certified public expenditures.
- Current Requirements – no specific requirements in regulation. CMS has relied on Medicare and 2 CFR 200. Proposal is consistent with this policy.
- Proposal – Funds provided as IGTs that are contingent upon receiving, or replaced by, unallowable sources will be non-bona fide donations.
- Current Requirements – This is consistent with our interpretation of the current requirements but we are providing clearer regulatory language.

Proposed Provision: General definitions (§ 433.52)

- Proposal – clarifies the following terms for purposes of Medicaid financing through provider taxes and donations – Medicaid activity, non-Medicaid activity, parameters for a tax, provider-related donations, provider-related, taxpayer group.
- Current Requirements - most of the proposed terms are not in the existing regulations and serve to clarify weaknesses within the rules that could promote financing schemes or help states to better understand the requirements.

Proposed Provision: Bona fide donations (§ 433.54)

- Proposal: clarifies the standard used to determine whether the state (or other unit of government) that receives a donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees the return of any portion of the donation to the provider (or other party or parties responsible for the donation).
- Current Requirements: under current policy we examine the totality of the circumstances that determine the net effect of an arrangement between the state (or other unit of government) and the provider, provider class, or provider-related entity responsible for the donation.

Proposed Provision: Health care-related taxes defined (§ 433.55)

- Proposal: Clarifies that differential treatment occurs when a tax program treats some individuals or entities that are providing or paying for health care items or services differently than 1) individuals or entities that are providers or payers of any health care items or services that are not subject to the tax or 2) other individuals or entities that are subject to the tax.
- Current Requirements: Codifies existing policy.
- Proposal: Clarifies that we examine the parameters of the tax as defined by the state or other unit of government, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject (and not subject) to the tax and at which rate, in determining whether the tax program involves differential treatment as provided in 1903(w)(3)(A)(ii).
- Current Requirements: Codifies existing policy.
- Proposal: Clarifies when CMS would consider the treatment of individuals or entities providing or paying for health care items or services to be different from the treatment provided to other individuals or entities.
- Current Requirements: Codifies existing policy.

Proposed Provision: Classes of health care services and providers defined (§ 433.56)

- Proposal: Adds health insurers to the class of services and providers on which a state may impose a tax.
- Current Requirements: Currently health insurers are not explicitly included as a permissible class of providers. We are aware that some states are imposing taxes on health insurers.

Proposed Provision: Permissible health care-related taxes (§ 433.68(e) and (f))

- Proposal: A tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid. States will need to begin on the effective date of any final rule for tax waivers that have not yet been approved before the effective date of any final rule. For existing tax waivers, they will need to comply using the 3 year renewal period discussed in 433.55.
- Current Requirements: Current P1/P2 tests do not sufficiently address this issue.
- Proposal: States that there is a hold harmless provision if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold the taxpayer harmless for any portion of the costs of the tax. Thwarts efforts by states to skirt hold harmless provisions by paying supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a health care-related tax.
- Current Requirements: Echoes the statute and current policy.

Proposed Provision: Waiver provisions applicable to health care-related taxes (§ 433.72)

- Proposal: Limits CMS approved waivers of the requirements for health care-related taxes to a 3 year term.
- Current Requirements: Currently there is no timeframe whereby CMS may re-review the tax waivers and determine whether a state remains in compliance with part 433, subpart B.
- Proposal: Requires a state to ensure a CMS approved the waiver continues to meet the waiver conditions for approval at all times during which the waiver is in effect; and (2) request a new waiver if the state or other unit of government imposing the tax modifies the tax program in specified ways. If the tax is modified in a non-uniform manner the state would be required to request a new waiver.
- Current Requirements: These requirements are new.

Proposed Provision: When discovery of overpayment occurs and its significance (§ 433.316)

- Proposal: Specifies the date of discovery of overpayments as it relates to the annual DSH independent certified audit. We will consider the overpayment as discovered on the earliest of the date that the state submits the DSH independent certified audit report or: the date on which any Medicaid agency official or other state official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; the date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; and the date on which any state official or fiscal agent of the state initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.
- Current Requirements: Current regulations provide for determining the date of discovery of an overpayment, which is necessary to determine the statutory 1-year period, in three distinct cases: when the overpayment results from a situation other than fraud; when the overpayment results from fraud; and when the overpayment is identified through a federal review.

Proposed Provision: State plan requirements (§ 447.201)

- Proposal: Specifies that the state plan may not provide for variation in FFS payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan.
- Current Requirements: Codifies long-standing CMS policy.

Proposed Provision: Payments funded by certified public expenditures made to providers that are units of government (§ 447.206)

- Proposal: Specifies standards for states to document Medicaid expenditures that units of government may certify through a CPE for a claim for FFP. When CPEs are used, limits reimbursement to the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, to Medicare cost principles specified in 42 CFR part 413. Define general rules for CPE cost protocols.
- Current Requirements: Codifies long-standing CMS policies.
- Proposal: Certifying entity of the CPE to receive and retain the full FFP associated with the Medicaid payment, consistent with the cost identification protocols in the Medicaid state plan.
- Current Requirements: States may choose to settle with certifying providers or keep the FFP associated with the reimbursement.

Proposed Provision: Retention of Payments (§ 447.207)

- Proposal: Requires that payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved state plan (or the approved provisions of a waiver or demonstration, if applicable).
- Current Requirements: Codifies existing CMS policy.

Proposed Provision: State plan requirements (§ 447.252)

- Proposal: implements new approval requirements for inpatient state plans and any SPAs proposing to make supplemental payments to providers, which:
 - Limits approval for any Medicaid supplemental payments to a period of not more than 5 years.
 - Request states to: explain how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, the criteria to determine which providers are eligible to receive the supplemental payment, a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including specified content, the duration of the supplemental payment authority (not to exceed 5 years), a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries, and for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.
 - Require the states to provide all of the following: (i) the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment; (ii) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment; (iii) the timing of the supplemental payment to each eligible provider; (iv) an assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.271; and (v) if not already submitted, an UPL demonstration as required by § 447.272 and described in proposed § 447.288.
- Current Requirements: Regulations require a comprehensive state plan methodology but do not define specific requirements. Currently there are no time limits on supplemental payments.

Proposed Provisions: Inpatient services: Application of upper payment limits (§ 447.272)

- Proposal: replaces the current ownership groups used to establish the UPL with “state government providers,” “non-state government providers,” and “private providers.”
- Current Requirements: defined as: state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities.
- Proposal: clarifies that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of chapter 42 of the CFR; or allowed costs established in accordance with Medicaid cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413.
- Current Requirements: defined as a reasonable estimate of the amount that would be paid under Medicaid payment principles.

Proposed Provisions: Basis and purpose (§ 447.284)

- Proposal: requires states to submit quarterly and annual reports which detail the total provider payments, including base and supplemental payments, authorized under the state plan and demonstration authority.
- Current Requirements: We receive aggregate expenditures information through the MBES and projected payments through UPL submissions.
- Proposal: requires states submit an additional annual report disclosing the amount of provider contributions provided to the state to support the non-federal share of the Medicaid payments along with the total payments received by the contributing providers.
- Current Requirements: We receive aggregate expenditures information through the MBES and projected payments through UPL submissions.

Proposed Provisions: Definitions (§ 447.286)

- Proposal: defines the following terms: base payment, non-state government provider, private provider, state government provider, and supplemental payment.
- Current Requirements: These terms are not currently defined in regulations. The new definitions will align with proposed data reporting requirements and help reduce Medicaid financing schemes.

Proposed Provisions: Reporting requirements for upper payment limit demonstrations and supplemental payments (§ 447.288)

- Proposal: defines documentation requirements for UPL demonstrations, including standards for methodologies required through demonstration submissions, and for states that make supplemental payments.
- Current Requirements: CMS has previously issued OMB approved templates for UPL data submissions but has not described standards as they apply to certain UPL methodologies.
- Proposal: no longer requires states to submit UPL demonstrations for psychiatric residential treatment facilities (PRTFs) and clinics.
- Current Requirements: States are required to submit customary charge limit demonstrations for PRTFs and Medicaid equivalent demonstrations for clinics.

Proposed Provisions: Failure to report required information (§ 447.290)

- Proposal: specifies an appropriate avenue of enforcement (deferral) in the event that a state does not comply with the proposed data reporting requirements in § 447.288.
- Current Requirements: While we could defer if a state has not submitted a UPL demonstration or otherwise met the regulatory requirements, we are codifying in regulations.

Proposed Provisions: Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992 (§ 447.297)

- Proposal: the Secretary will post preliminary and final national expenditure targets and state DSH allotments in the MBES and at Medicaid.gov (or similar successor system or website). Removes the date in which final national target and allotments are published by from April 1st to as soon as practicable.
- Current Requirements: CMS must publish the DSH allotments in the federal register by April 1st.

Proposed Provisions: Reporting requirements (§ 447.299)

- Proposal: New data element would require auditors to quantify the financial impact of any finding which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.
- Current Requirements: This requirements is new.

Proposed Provisions: State plan requirements (§ 447.302)

- Proposal: implements new approval requirements for outpatient hospital state plans and any SPAs proposing to make supplemental payments to providers, which:
 - Limits approval for any Medicaid supplemental payments to a period of not more than 5 years.
 - Request states to: explain how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, the criteria to determine which providers are eligible to receive the supplemental payment, a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including specified content, the duration of the supplemental payment authority (not to exceed 5 years), a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries, and for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.
 - Require the states to provide all of the following: (i) the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment; (ii) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment; (iii) the timing of the supplemental payment to each eligible provider; (iv) an assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.321; and (v) if not already submitted, an UPL demonstration as required by § 447.321 and described in proposed § 447.288.
- Current Requirements: Regulations require a comprehensive state plan methodology but do not define specific requirements. Currently there are no time limits on supplemental payments.

Proposed Provisions: Outpatient hospital services: Application of upper payment limits (§ 447.321)

- Proposal: change the title of this section to “Outpatient Hospital Services: Application of upper payment limits” in order to remove clinic services from the UPL requirements in § 447.321.
- Current Requirements: Clinics are held to a reasonable Medicaid estimate.
- Proposal: replaces the current ownership groups used to establish the UPL with “state government providers,” “non-state government providers,” and “private providers.”
- Current Requirements: defined as: state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities.
- Proposal: clarifies that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of chapter 42 of the CFR; or allowed costs established in accordance with Medicaid cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413.
- Current Requirements: defined as a reasonable estimate of the amount that would be paid under Medicaid payment principles.

Proposed Provisions: Medicaid practitioner supplemental payments (§ 447.406)

- Proposal: limits Medicaid practitioner supplemental payments to 50% of fee-for-service base payments to the eligible provider for practitioner services, or 75% of such payments for services provided within HRSA-designated geographic Health Provider Shortage Areas (HPSAs) or Medicare-defined rural areas
- Current Requirements: CMS policy allows states to make payments up to the average commercial payment rates of the top 5 commercial payers.

Proposed Provisions: Definitions (§ 455.301)

- Proposal: defines the independent certified audit in order to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital.
- Current Requirements: This applies a new requirement.

Proposed Provisions: Process and calculation of state allotments for fiscal year after FY 2008 (§ 457.609)

- Proposal: remove from § 457.609 the reference to our discretionary option to publish in the **Federal Register** the national CHIP allotment amounts as determined on an annual basis for the fiscal years specified in statute. Instead, we are proposing to post CHIP allotments in the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) and at Medicaid.gov (or similar successor systems or websites) annually.
- Current Requirements: We have not published this information since 2013.

FW: FW: Notes for folks

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Thu, 03 Oct 2019 16:06:26 +0000
Attachments: MFAR NPRM HHS paper.docx (24.45 kB); Medicaid Fiscal Accountability Regulation (CMS 2393-P).pptx (77.3 kB)

Hello,

John Giles reached out to find out if we were working on putting together 10 examples? (not sure if she requested 10?) of bad financing in states as requested by Administrator?

Beverly

From: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Sent: Tuesday, October 1, 2019 12:46 PM
To: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: RE: Notes for folks

I'm attaching the brief that we used for HHS and a PP that describes each proposed provision. The team is working to update the comms documents to highlight bad financing arrangements. Re: the transition periods, the 5 year transition/renewal applies to states updating SPA methodologies for supplemental payments to add in the proposed comprehensive methodology requirements and there is a new 3 year approval period for tax waivers. There is no transition to the extent we find problematic financing so I think we could address those issues quickly through FMRs and disallowances.

From: Freeze, Janet G. (CMS/CMCS)
Sent: Monday, September 30, 2019 5:36 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: Re: Notes for folks

From today's CMCS OA Issues De-Brief:

SC Reconsideration Hearing letters – good to go

MFAR – wants more examples included in the comms documents of schemes that MFAR will curtail. One example cited by ASV: Indiana nursing homes (ASV is, of course, familiar with that one). Add other examples/scenarios – will not use state names however

MFAR – for the proposed rule ASV wants to go with a THREE YEAR compliance transition timeline instead of the FIVE. Will discuss this with OMB once we have their passback

MFAR ACTION ITEM: – ASV wants options on how existing “egregious” arrangements could be terminated more quickly (i.e., fast than even the 3 years).

MFAR ACTION ITEM: – ASV needs a refresh on all the issues; send Calder current versions of all relevant briefing papers.

Medicaid Fiscal Accountability Rule (MFAR) Proposed Rule (CMS-2393-P)

HHS Reviewers Briefing Paper

Overview:

The President's FFY 2019 Medicaid administrative budget proposals included improving data collection for Medicaid supplemental payments and reducing gimmicks that may be used to inappropriately fund state Medicaid programs. To address these issues, CMS has drafted a proposed rule that proposes to improve accountability, transparency and clarity through: additional state reporting, stronger financial definitions, and clearer federal guidance.

Background:

This proposed rule will respond to criticisms from oversight agencies about our ability to oversee and understand Medicaid supplemental payments, disproportionate share hospital payments and the associated non-federal share. Specifically, it will increase our capacity to evaluate payments at a provider-specific level for both state plan services and demonstration programs, improve efforts to provide technical assistance to states, aid in developing future policies to increase transparency and accountability, and support the agency's program oversight goals. The proposed rule would also address several areas of program vulnerability associated with states' use of intergovernmental transfers and certified public expenditures and with health-care related taxes and donation policies.

In the past, CMS has taken several actions to improve the accountability and increase transparency of Medicaid payments. In the early 2000s, CMS strengthened UPL regulations to limit payments by designated provider classes to what would have been paid under Medicare for similar services. To improve data availability, in 2010 CMS required states to separately report supplemental payment amounts for services subject to a UPL. Also, CMS issued State Medicaid Director Letters in 2013 and 2014, respectively, to mandate annual submission of UPL demonstrations and clarify that providers may not inappropriately participate in the funding their own Medicaid payments.

Although CMS has made these significant efforts to address program vulnerabilities through guidance and program reviews, additional regulatory backing will ensure we have improved tools to oversee the Medicaid program and states have better guidance to comply with the statute. Further, the policies described in the proposed rule will address several long-standing recommendations from the GAO and more recent recommendations from MACPAC.

Overview of the NPRM Changes:

Improved Reporting on Supplemental Payments

- Require states to report provider-specific payment information on payments received through state plan services and demonstration programs and identify the specific authority (SPA/demonstration).
- Require states to report the source of the non-federal share for such payments.
- Provide guidance on comprehensive supplemental payment methodologies, including: the purpose of the payment, the intended and measurable outcomes/results, which providers receive the payments, the payment calculation and the timeframe for payment distribution.
- Allow CMS and states to evaluate the effects of the payments by sunseting existing and new supplemental payment methodologies after 5 years and requiring states to request approval to continue the payments beyond 5 years.

- Mandate the use of OMB approved templates and CMS guidelines on acceptable upper payment limit calculations.

Clarified Medicaid Financing Definitions

- Develop regulatory definitions for Medicaid “base” and “supplemental” payments.
- Clarify the definitions and processes associated with the non-federal share financing arrangements.
- Clarify the upper payment limit ownership categories to close loopholes and be more consistent with the statute.

Reduce “State Gimmicks”

State Reliance on Providers to Fund the Non-federal Share

- Re-affirm the statutory requirement that intergovernmental transfers (IGTs) must be derived from state or local tax revenues and clarify regulations that refer to IGTs as “public funds.”
- Restrict facilities that change ownership from receiving additional Medicaid payments solely on the basis of the ownership transfer.
- Require states to cost settle when using a certified public expenditure and send the full amount of federal financial participation claimed for services to the provider.
- Clarify in regulation that the provider must receive and retain 100% of the payment. This clarification will prevent states and local units of government from recycling Medicaid payments to be reused as the source of state financing for additional payments.
- Restrict states/local governments from charging providers an administrative fee based on a percentage of Medicaid payments a provider receives.

Health Care-Related Taxes and Donations

- Incorporate into regulation existing State Health Official (SHO) Letter 14-004 and recent DAB decisions prohibiting financial arrangements (often under the guise of public/private partnerships) designed to mask impermissible donations.
- Clarify the existing requirements that prohibit states from structuring health care-related taxes that unduly burden the Medicaid program (e.g., higher tax rates on Medicaid services than non-Medicaid services), including by closing an inadvertent regulatory loophole.
- Incorporate into regulation existing SHO letter 14-001 prohibiting states from circumventing health care-related tax requirements by masking health care-related taxes.
- Update permissible tax classes to include health insurers as a permissible class.
- Strengthen oversight and monitoring of approved tax waivers.

Medicaid Disproportionate Share Hospital (DSH) Payments

- Strengthen transparency and oversight of annual Medicaid DSH audits by requiring a quantification of individual audit findings by hospital and clarifying reporting requirements.
- Clarify the overpayment discovery and redistribution procedures associated with DSH payments to ensure timely and proper DSH claims.
- Modernizes DSH allotment publication process.

Medicaid Fiscal Accountability Regulation (CMS 2393-P)

MFAR

Target Publication Date: November 2019

MFAR – Goals

- Increase the agency's capacity to evaluate payments at a provider-specific level.
- Improve efforts to provide technical assistance to states.
- Increase transparency and accountability through better data reporting and improved oversight.
- Further the agency's program integrity goals by addressing loopholes and financing schemes.

MFAR – Overview of the NPRM

- Require states submit provider-level information and other data needed to ensure Medicaid payments are consistent with the statute.
- Clarify Medicaid financing definitions to better align with the statute.
- Re-affirm statutory requirements that describe health care-related taxes and donations and the source of the non-federal share for Medicaid expenditures.
- Strengthen transparency and oversight of DSH payments by clarifying reporting requirements and requiring quantification of individual audit findings by hospital.

Proposed Provision - Disallowance of claims for FFP (§ 430.42)

- Proposal - allow states and CMS to communicate the disallowance reconsideration process through electronic mail or another electronic system specified by the Secretary.
- Current Requirements – communications must be through certified mail.

Proposed Provision: State share of financial participation (§ 433.51)

- Proposal - clarify the sources of intergovernmental transfers must come from state or local tax revenue.
- Current Requirements – regulations currently deviate from the statute and allow for “public funds.”
- Proposal – describe protocols states may use to identify Medicaid expenditures associated with certified public expenditures.
- Current Requirements – no specific requirements in regulation. CMS has relied on Medicare and 2 CFR 200. Proposal is consistent with this policy.
- Proposal – Funds provided as IGTs that are contingent upon receiving, or replaced by, unallowable sources will be non-bona fide donations.
- Current Requirements – This is consistent with our interpretation of the current requirements but we are providing clearer regulatory language.

Proposed Provision: General definitions (§ 433.52)

- Proposal – clarifies the following terms for purposes of Medicaid financing through provider taxes and donations – Medicaid activity, non-Medicaid activity, parameters for a tax, provider-related donations, provider-related, taxpayer group.
- Current Requirements - most of the proposed terms are not in the existing regulations and serve to clarify weaknesses within the rules that could promote financing schemes or help states to better understand the requirements.

Proposed Provision: Bona fide donations (§ 433.54)

- Proposal: clarifies the standard used to determine whether the state (or other unit of government) that receives a donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees the return of any portion of the donation to the provider (or other party or parties responsible for the donation).
- Current Requirements: under current policy we examine the totality of the circumstances that determine the net effect of an arrangement between the state (or other unit of government) and the provider, provider class, or provider-related entity responsible for the donation.

Proposed Provision: Health care-related taxes defined (§ 433.55)

- Proposal: Clarifies that differential treatment occurs when a tax program treats some individuals or entities that are providing or paying for health care items or services differently than 1) individuals or entities that are providers or payers of any health care items or services that are not subject to the tax or 2) other individuals or entities that are subject to the tax.
- Current Requirements: Codifies existing policy.
- Proposal: Clarifies that we examine the parameters of the tax as defined by the state or other unit of government, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject (and not subject) to the tax and at which rate, in determining whether the tax program involves differential treatment as provided in 1903(w)(3)(A)(ii).
- Current Requirements: Codifies existing policy.
- Proposal: Clarifies when CMS would consider the treatment of individuals or entities providing or paying for health care items or services to be different from the treatment provided to other individuals or entities.
- Current Requirements: Codifies existing policy.

Proposed Provision: Classes of health care services and providers defined (§ 433.56)

- Proposal: Adds health insurers to the class of services and providers on which a state may impose a tax.
- Current Requirements: Currently health insurers are not explicitly included as a permissible class of providers. We are aware that some states are imposing taxes on health insurers.

Proposed Provision: Permissible health care-related taxes (§ 433.68(e) and (f))

- Proposal: A tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid. States will need to begin on the effective date of any final rule for tax waivers that have not yet been approved before the effective date of any final rule. For existing tax waivers, they will need to comply using the 3 year renewal period discussed in 433.55.
- Current Requirements: Current P1/P2 tests do not sufficiently address this issue.
- Proposal: States that there is a hold harmless provision if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold the taxpayer harmless for any portion of the costs of the tax. Thwarts efforts by states to skirt hold harmless provisions by paying supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a health care-related tax.
- Current Requirements: Echoes the statute and current policy.

Proposed Provision: Waiver provisions applicable to health care-related taxes (§ 433.72)

- Proposal: Limits CMS approved waivers of the requirements for health care-related taxes to a 3 year term.
- Current Requirements: Currently there is no timeframe whereby CMS may re-review the tax waivers and determine whether a state remains in compliance with part 433, subpart B.
- Proposal: Requires a state to ensure a CMS approved the waiver continues to meet the waiver conditions for approval at all times during which the waiver is in effect; and (2) request a new waiver if the state or other unit of government imposing the tax modifies the tax program in specified ways. If the tax is modified in a non-uniform manner the state would be required to request a new waiver.
- Current Requirements: These requirements are new.

Proposed Provision: When discovery of overpayment occurs and its significance (§ 433.316)

- Proposal: Specifies the date of discovery of overpayments as it relates to the annual DSH independent certified audit. We will consider the overpayment as discovered on the earliest of the date that the state submits the DSH independent certified audit report or: the date on which any Medicaid agency official or other state official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; the date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; and the date on which any state official or fiscal agent of the state initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.
- Current Requirements: Current regulations provide for determining the date of discovery of an overpayment, which is necessary to determine the statutory 1-year period, in three distinct cases: when the overpayment results from a situation other than fraud; when the overpayment results from fraud; and when the overpayment is identified through a federal review.

Proposed Provision: State plan requirements (§ 447.201)

- Proposal: Specifies that the state plan may not provide for variation in FFS payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan.
- Current Requirements: Codifies long-standing CMS policy.

Proposed Provision: Payments funded by certified public expenditures made to providers that are units of government (§ 447.206)

- Proposal: Specifies standards for states to document Medicaid expenditures that units of government may certify through a CPE for a claim for FFP. When CPEs are used, limits reimbursement to the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, to Medicare cost principles specified in 42 CFR part 413. Define general rules for CPE cost protocols.
- Current Requirements: Codifies long-standing CMS policies.
- Proposal: Certifying entity of the CPE to receive and retain the full FFP associated with the Medicaid payment, consistent with the cost identification protocols in the Medicaid state plan.
- Current Requirements: States may choose to settle with certifying providers or keep the FFP associated with the reimbursement.

Proposed Provision: Retention of Payments (§ 447.207)

- Proposal: Requires that payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved state plan (or the approved provisions of a waiver or demonstration, if applicable).
- Current Requirements: Codifies existing CMS policy.

Proposed Provision: State plan requirements (§ 447.252)

- Proposal: implements new approval requirements for inpatient state plans and any SPAs proposing to make supplemental payments to providers, which:
 - Limits approval for any Medicaid supplemental payments to a period of not more than 5 years.
 - Request states to: explain how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, the criteria to determine which providers are eligible to receive the supplemental payment, a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including specified content, the duration of the supplemental payment authority (not to exceed 5 years), a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries, and for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.
 - Require the states to provide all of the following: (i) the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment; (ii) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment; (iii) the timing of the supplemental payment to each eligible provider; (iv) an assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.271; and (v) if not already submitted, an UPL demonstration as required by § 447.272 and described in proposed § 447.288.
- Current Requirements: Regulations require a comprehensive state plan methodology but do not define specific requirements. Currently there are no time limits on supplemental payments.

Proposed Provisions: Inpatient services: Application of upper payment limits (§ 447.272)

- Proposal: replaces the current ownership groups used to establish the UPL with “state government providers,” “non-state government providers,” and “private providers.”
- Current Requirements: defined as: state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities.
- Proposal: clarifies that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of chapter 42 of the CFR; or allowed costs established in accordance with Medicaid cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413.
- Current Requirements: defined as a reasonable estimate of the amount that would be paid under Medicaid payment principles.

Proposed Provisions: Basis and purpose (§ 447.284)

- Proposal: requires states to submit quarterly and annual reports which detail the total provider payments, including base and supplemental payments, authorized under the state plan and demonstration authority.
- Current Requirements: We receive aggregate expenditures information through the MBES and projected payments through UPL submissions.
- Proposal: requires states submit an additional annual report disclosing the amount of provider contributions provided to the state to support the non-federal share of the Medicaid payments along with the total payments received by the contributing providers.
- Current Requirements: We receive aggregate expenditures information through the MBES and projected payments through UPL submissions.

Proposed Provisions: Definitions (§ 447.286)

- Proposal: defines the following terms: base payment, non-state government provider, private provider, state government provider, and supplemental payment.
- Current Requirements: These terms are not currently defined in regulations. The new definitions will align with proposed data reporting requirements and help reduce Medicaid financing schemes.

Proposed Provisions: Reporting requirements for upper payment limit demonstrations and supplemental payments (§ 447.288)

- Proposal: defines documentation requirements for UPL demonstrations, including standards for methodologies required through demonstration submissions, and for states that make supplemental payments.
- Current Requirements: CMS has previously issued OMB approved templates for UPL data submissions but has not described standards as they apply to certain UPL methodologies.
- Proposal: no longer requires states to submit UPL demonstrations for psychiatric residential treatment facilities (PRTFs) and clinics.
- Current Requirements: States are required to submit customary charge limit demonstrations for PRTFs and Medicaid equivalent demonstrations for clinics.

Proposed Provisions: Failure to report required information (§ 447.290)

- Proposal: specifies an appropriate avenue of enforcement (deferral) in the event that a state does not comply with the proposed data reporting requirements in § 447.288.
- Current Requirements: While we could defer if a state has not submitted a UPL demonstration or otherwise met the regulatory requirements, we are codifying in regulations.

Proposed Provisions: Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992 (§ 447.297)

- Proposal: the Secretary will post preliminary and final national expenditure targets and state DSH allotments in the MBES and at Medicaid.gov (or similar successor system or website). Removes the date in which final national target and allotments are published by from April 1st to as soon as practicable.
- Current Requirements: CMS must publish the DSH allotments in the federal register by April 1st.

Proposed Provisions: Reporting requirements (§ 447.299)

- Proposal: New data element would require auditors to quantify the financial impact of any finding which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.
- Current Requirements: This requirements is new.

Proposed Provisions: State plan requirements (§ 447.302)

- Proposal: implements new approval requirements for outpatient hospital state plans and any SPAs proposing to make supplemental payments to providers, which:
 - Limits approval for any Medicaid supplemental payments to a period of not more than 5 years.
 - Request states to: explain how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, the criteria to determine which providers are eligible to receive the supplemental payment, a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including specified content, the duration of the supplemental payment authority (not to exceed 5 years), a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries, and for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.
 - Require the states to provide all of the following: (i) the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment; (ii) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment; (iii) the timing of the supplemental payment to each eligible provider; (iv) an assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.321; and (v) if not already submitted, an UPL demonstration as required by § 447.321 and described in proposed § 447.288.
- Current Requirements: Regulations require a comprehensive state plan methodology but do not define specific requirements. Currently there are no time limits on supplemental payments.

Proposed Provisions: Outpatient hospital services: Application of upper payment limits (§ 447.321)

- Proposal: change the title of this section to “Outpatient Hospital Services: Application of upper payment limits” in order to remove clinic services from the UPL requirements in § 447.321.
- Current Requirements: Clinics are held to a reasonable Medicaid estimate.
- Proposal: replaces the current ownership groups used to establish the UPL with “state government providers,” “non-state government providers,” and “private providers.”
- Current Requirements: defined as: state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities.
- Proposal: clarifies that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of chapter 42 of the CFR; or allowed costs established in accordance with Medicaid cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413.
- Current Requirements: defined as a reasonable estimate of the amount that would be paid under Medicaid payment principles.

Proposed Provisions: Medicaid practitioner supplemental payments (§ 447.406)

- Proposal: limits Medicaid practitioner supplemental payments to 50% of fee-for-service base payments to the eligible provider for practitioner services, or 75% of such payments for services provided within HRSA-designated geographic Health Provider Shortage Areas (HPSAs) or Medicare-defined rural areas
- Current Requirements: CMS policy allows states to make payments up to the average commercial payment rates of the top 5 commercial payers.

Proposed Provisions: Definitions (§ 455.301)

- Proposal: defines the independent certified audit in order to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital.
- Current Requirements: This applies a new requirement.

Proposed Provisions: Process and calculation of state allotments for fiscal year after FY 2008 (§ 457.609)

- Proposal: remove from § 457.609 the reference to our discretionary option to publish in the **Federal Register** the national CHIP allotment amounts as determined on an annual basis for the fiscal years specified in statute. Instead, we are proposing to post CHIP allotments in the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) and at Medicaid.gov (or similar successor systems or websites) annually.
- Current Requirements: We have not published this information since 2013.

RE: RE: DSH Agenda and Chart 12.9.19

From: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>
Cc: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Mon, 09 Dec 2019 14:54:51 +0000
Attachments: RE: Team Meeting Agenda (144.38 kB); RE: Mary Boosalis SWIFT response (174.08 kB); FW: NJ SPA Pages Requested (192 kB); Fwd: Medicaid DSH Third Party Payments - 2017 Rule (185.34 kB); Revised Medicaid DSH webpage v3.docx (18.84 kB); FW: Medicaid DSH Payment and Third Party Payments (156.67 kB); FW: NIRT Team Meeting (275.97 kB); FMG DSH Overpayments & Redistrib. Qs. 20191114 (CMSDOGCResponses).docx (15.68 kB); 12.09.2019 DSH Issues Tracking.xlsx (27.93 kB)

Agenda:

1. **Good Cause Waivers**
 - a. North Carolina
<<...>>
 - b. New Jersey
<<...>> <<...>>
 - c. Process
2. **OGC Response to Questions**
<<...>>
3. **DSH SWIFT**
<<...>>
4. **DSH Litigation and implications OGC – CHAT (district court) additional briefing on effective date and website changes**
<<...>> <<...>>
5. **Consultant Question on TPP**
<<...>>

Tracking Chart:

<<...>>

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, December 2, 2019 10:57 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Agenda and Chart 12.2.19

Tracking Chart

<< Message: FW: NIRT Team Meeting >>

Agenda:

1. Reductions – updates by Rory
 2. OGC Response to Questions
 - California TCF DSH Question
 - Colorado Overpayment and Redistribution

<< Message: RE: Medicaid DSH Third Party Payments - 2017 Rule >>
 3. MO-IMD DSH Opinion
 - Meeting scheduled for 12/2 1-2pm

<< Message: RE: Medicaid DSH Third Party Payments - 2017 Rule >>
 4. SWIFT – Boosalis – response requested by 12/3
 5. << Message: RE: NEW SWIFT CONTROL: Boosalis_103020194026 >>
2017 TPP Rule – effective date
 6. << Message: Missouri IMD DSH Appeal Brief >>
Medicaid DSH webpage edits from OGC
 7. << Message: FW: DSH Overpayments & Redistributions >>
North Carolina GCW
- << File: 12.02.2019 DSH Issues Tracking.xlsx >>

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, November 18, 2019 10:04 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Agenda and Chart 11.18.2019

Tracking Chart

<< File: 11.18.2019 DSH Issues Tracking.xlsx >>

Agenda:

1. Reductions – updates by Rory?
2. Missouri IMD DSH Opinion

- Tim Weidler emailed DSH Team giving us the heads up that he is going to setup a time with RO in future to discuss how 1923(h) of the Act prohibits MO from amending FY 1995, 2014, 2015 alone or in conjunction with 1132(a) of the Act. Jason Oller OGC is would like a brief overview of how 1923(h) works in practice.
- Rory would like to learn more about the briefings OGC presented and overall what happened
- 3. **DSH Allotment Excess Expenditures FY 18 and FY 19**
- Rich sent email to region branch managers – closed item on tracking list
- 4. **2017 Rule Updates**
- Lindsay emailed with updates on the 2017 rule. Wants confirmation on effective date for rule.

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, November 4, 2019 9:24 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Chart 11.04.2019

Tracking Chart:

<< Message: RE: DSH Redistribution Payments >>

Agenda:

DSH Issues	
1) Discussion: Colorado Overpayments and GCW Request	<< Message: FW: MO - IMD DSH Opinion 9 26 19 >> << Message: FW: Medicaid DSH Payment and Third Party Payments >>
2) Update: Wendy scheduled meeting with coverage for Wednesday, Nov 6th	
3) Update: Rich reach out to Brian/Mark on California TCF DSH	
4) Discussion: Arkansas Adjustment – GCW	<< Message: RE: The Max Group Letter / Are Hospital Based FQHC Licensed as Hospital Outpatient Departments >>
5) Discussion: South Carolina DSH Allotment	<< Message: RE: DSH Good Cause response letter >>
6) Update: Rich will get language back to Joyce on Alabama overpayment and reach out to region branch managers.	
7) Discussion: GCW Inquiry by Gary Knight	<< Message: FW: FFY 2015 DSH Allotment Question >>
8) Discussion/Update: Max Group Letter/ New York	<< Message: RE: Letter regarding the current DSH litigation >>
9) Discussion: Consultant on TPP Ruling	<< Message: RE: DSH Redistribution Payments >>
DSH Litigation	
1) MO-IMD DSH Opinion 9/26/2019	<< Message: RE: DSH Redistribution Payments >>
2) Discussion: Questions we want to discuss with OGC post-DC Ruling	

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, October 28, 2019 1:17 PM

To: Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: FW: DSH Chart 10.23.19

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Wednesday, October 23, 2019 8:34 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Chart 10.23.19

Hi DSH Team,

Here is the link with DSH Issues Tracking (also attached in email):

b5

Please let me know if you have something to add or feel free to add it directly on SharePoint.

Attachments:

1. Virginia State Plan Language "FW: DSH Questions"
2. California TCF DSH Question: "RE: Timely Filing Policy questions for DSH – California"
3. Colorado overpayments and redistribution/GCW request: "RE: DSH Redistribution Payments"
4. Arkansas: "RE: Letter regarding the current DSH litigation"
5. South Carolina Allotment Question: "FW: FFY 2015 DSH Allotment Question"
6. Alabama Overpayment: "FW: FY2019 DSH"

Best,
Lia

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Tuesday, October 8, 2019 8:03 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Chart 10.08.19 - revised

Hi – attaching updated DSH Issues tracking chart along with relevant emails.

Thanks,
Lia

From: Adams, Lia (CMS/CMCS)

Sent: Monday, October 7, 2019 6:46 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <lia.adams@cms.hhs.gov>

Subject: DSH Chart 10.07.19

Good morning DSH Team,

I compiled pending or need to be discussed in the attached DSH Issues Tracking Chart. Please let me know your *thoughts on the chart* (how can it be improved for usability?) and any *items you would like to add*.

Thanks,
Lia << File: 11.04.2019 DSH Issues Tracking.xlsx >>

FW: FW: NJ SPA Pages Requested

From: "Holzbaur, Charlene M. (CMS/CMCS)" <charlene.holzbaur@cms.hhs.gov>
To: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
Cc: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Lee, Tai (CMS/CMCS)" <tai.lee@cms.hhs.gov>
Date: Thu, 05 Dec 2019 19:46:37 +0000
Attachments: SMAHS-CO-8819120514340.pdf (90.39 kB)

Pages of SPA for the 2 hospitals FAQ 33/34 attached, I-264 University, I-270 Bergen Regional Medical Center

NJ will let me know either later today or tomorrow am timeframe for 2013 addendum. They do not believe will have 2016 audit to us in time for Sept Qtr claim. They said they prefer a deferral for both or only 2016 if don't meet our timeline but did eventually say it/they could be pulled from sept qtr.

From: Jacqueline.Cantlin@dhs.state.nj.us [mailto:Jacqueline.Cantlin@dhs.state.nj.us]
Sent: Thursday, December 5, 2019 2:39 PM
To: Holzbaur, Charlene M. (CMS/CMCS) <Charlene.Holzbaur@cms.hhs.gov>
Subject: NJ SPA Pages Requested

This E-mail, including any attachments, may be intended solely for the personal and confidential use of the sender and recipient(s) named above. This message may include advisory, consultative and/or deliberative material and, as such, would be privileged and confidential and not a public document. Any Information in this e-mail identifying a client of the Department of Human Services or the Department of Children and Families is confidential. If you have received this e-mail in error, you must not review, transmit, convert to hard copy, copy, use or disseminate this e-mail or any attachments to it and you must delete this message. You are requested to notify the sender by return e-mail.

5. **Payments for the University of Medicine and Dentistry**

a) The Commissioner of Human Services shall designate as a DSH and make a DSH payment to teaching hospitals whose medical programs are established by the Department of Education and whose board of trustees include the Commissioner of Health and Senior Services or his or her successor.

b) Payments shall be calculated in the following manner:

i) The DSH payments for UMDNJ shall equal the total operating cost of the hospital, less any third party amounts, including all other Medicaid payments, (other than DSH payments) and payments from non-governmental sources for services provided by the hospital to individuals who are either eligible for medical assistance or uninsured. The following formula illustrates the payment adjustment to be made to eligible hospitals:

$$\text{Payment} = \text{Total Operating Cost} - [(\text{Medicaid Payments excluding DSH}) + (\text{Third Party Payments and Non-State Sourced Payments})]$$

c) Effective with the State Fiscal Year that begins on or after September 30, 2002, and ends on the last day of the succeeding State Fiscal Year, DSH payments for UMDNJ shall equal 175 percent of the total operating cost of the hospital, less any third party amounts, including all other Medicaid payments and payments from non-governmental sources, for services provided by the hospital to individuals who are either eligible for medical assistance or uninsured. Payments shall be calculated in the following manner:

$$\text{Payment} = 1.75 \times \{ \text{Total Operating Cost} - [\text{Medicaid Payments excluding DSH} + (\text{Third Party Payments and Non-State Sourced Payments})] \}$$

04-08-MA (NJ)

TN: 04-08-MA (NJ)
Supersedes: 03-08-MA (NJ)

Approval Date APR 19 2005
Effective Date AUG 11 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Adjustment

11. DSH payments for governmental acute care hospitals shall equal the total operating cost of the facility, less any third party amounts, including all other Medicaid payments, as well as payments from non-governmental sources for services provided by the hospital during the facility's fiscal year.

98-13-MA(NJ)

TN 98-13 Approval Date JUN 06 2001
Supersedes TN New Effective Date MAY 01 1998

FW: FW: Medicaid DSH Payment and Third Party Payments

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Thu, 05 Dec 2019 16:54:52 +0000

Wendy L. Harrison, LSW

Technical Advisor to the Group Director
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
Financial Management Group
Division of Reimbursement and State Financing
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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7 410-786-8533
✉ Wendy.Harrison@cms.hhs.gov

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From: John McCarthy [mailto:jmccarthy@oconco.com]
Sent: Thursday, December 5, 2019 11:51 AM
To: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Subject: RE: Medicaid DSH Payment and Third Party Payments
Importance: High

Wendy,

Following up on my email, regarding what year's third parties payments, i.e. Medicare and private insurers are included in calculations of Disproportionate Share Hospital (DSH) payment.

Thank you,

John

John G. McCarthy

Vice President
O'Conco Healthcare Consultants
732.292.0840

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From: John McCarthy
Sent: Wednesday, November 20, 2019 9:32 AM

To: 'wendy.harrison@cms.hhs.gov' <wendy.harrison@cms.hhs.gov>
Subject: FW: Medicaid DSH Payment and Third Party Payments

Wendy,

I am hoping you can clarify what year's third parties payments, i.e. Medicare and private insurers are included in calculations of Disproportionate Share Hospital (DSH) payment caps. Based on the court ruling below I cannot determine the effective periods.

On August 13, 2019, the D.C. Circuit Court of Appeals (the D.C. Circuit) issued an opinion in *Children's Hospital Association of Texas v. Azar* (No.18-5135), allowing the Department of Health and Human Services (HHS) to include payments from third parties, including Medicare and private insurers, in calculations of Disproportionate Share Hospital (DSH) payment caps. The D.C. Circuit had previously ruled against HHS' implementation of its 2017 rule, which included third-party payments in the calculation of the hospital-specific caps on allowable DSH payments.

I am trying to determine what years the ruling applies. Will the 2016 DSH limits, as well as next year's DSH limits, exclude Medicare and private insurance payments? Going forward, the inclusion of Medicare and private insurance payments in calculating DSH limits will be subject to the outcome of ongoing federal litigation.

Thank you,

John

John G. McCarthy

Vice President

O'Conco Healthcare Consultants

2323 Highway 34, Manasquan, NJ 08736

732.292.0840 | jmccarthy@oconco.com

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FW: FW: NIRT Team Meeting

From: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Cc: "Endelman, Jonathan (CMS/CMCS)" <jonathan.endelman@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
Date: Tue, 26 Nov 2019 16:28:28 +0000
Attachments: NC GCW Responses - 2014 - 2015.doc (134.14 kB)

Forwarding the NC's GCW draft approval letter to the team for review. Anna is going back to the state to verify that it will be able to get the claims in on the QE 12/31/19 CMS-64.

From: Dubois, Anna M. (CMS/CMCS) <Anna.Dubois@cms.hhs.gov>
Sent: Tuesday, November 26, 2019 9:00 AM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Subject: RE: NIRT Team Meeting

Hi Rich, <<...>>

Attached is the NC GCW for both 2014 and 2015 combined. Not sure who should be signing, but I included Davida's acting role.

From: Cuno, Richard A. (CMS/CMCS)
Sent: Friday, November 22, 2019 10:34 AM
To: Dubois, Anna M. (CMS/CMCS) <Anna.Dubois@cms.hhs.gov>
Subject: RE: NIRT Team Meeting

We should probably do one letter for ease of approval purposes...one signature and out the door!

From: Dubois, Anna M. (CMS/CMCS) <Anna.Dubois@cms.hhs.gov>
Sent: Wednesday, November 20, 2019 8:28 AM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Subject: RE: NIRT Team Meeting

Hi Rich, << File: NC 2015 GCW Response.doc >> << File: NC 2014 GCW Response.doc >>

Below, I was asking if I could combine the GCWs into one letter. I have that prepared if that is preferred. Attached are two letters: one for 2014 and one for 2015

From: Dubois, Anna M. (CMS/CMCS)
Sent: Tuesday, November 19, 2019 3:05 PM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Subject: RE: NIRT Team Meeting

Hi Rich,

NC submitted two GCWs – one for SPRY 2014 and one for SPRY 2015. Can I combine the two GCWs for NC into one response letter, or should I prepare a letter for each year?

Thanks,

Anna

From: Cuno, Richard A. (CMS/CMCS)
Sent: Tuesday, November 19, 2019 12:07 PM
Subject: RE: NIRT Team Meeting

Here's a copy of the DSH GCW template.

<< File: DSH GCW Letter Template 2.0 WH edits.docx >>

-----Original Appointment-----

From: Weidler, Timothy A. (CMS/CMCS) <Timothy.Weidler@cms.hhs.gov>
Sent: Tuesday, July 30, 2019 9:50 AM
When: Tuesday, November 19, 2019 10:00 AM-11:00 AM (UTC-06:00) Central Time (US & Canada).
Where: CO: S3-06-21

<< File: NIRT SPA Submissions, April 2018 through Present.xlsx >> << File:
final_upl_submission_report_20191104.xlsx >> << File: Agenda for NIRT Team Mtg 110519.docx >>

Placeholder appointment for NIRT Team Meetings.
DO NOT DELETE OR CHANGE ANY OF THE TEXT BELOW THIS LINE

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303-8909



Atlanta Regional Operations Group

November 29, 2019

Dave Richard, Director
Division of Medical Assistance
NC Department of Health & Human Services
1985 Umstead Drive (Physical Address)
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: Disproportionate Share Hospital Good Cause Waiver Request

Dear Mr. Richard:

On June 24, 2019, the North Carolina Department of Health and Human Services, Division of Health Benefits requested good cause waivers of the two-year timely filing limit at 45 C.F.R. § 95, subpart A. The waivers were requested for certain Medicaid disproportionate share hospital (DSH) claims for the period covering state plan rate years (SPRY) 2014 and 2015 as a result of the Centers for Medicare & Medicaid Services' (CMS) decision to withdraw FAQs 33 & 34 from the Medicaid DSH guidance issued in January 2010.

On April 30, 2019, CMS issued guidance related to the withdrawal of FAQs 33 & 34 indicating that CMS would accept revised DSH audits that cover hospital services furnished before June 2, 2017. States generally must file claims for federal funding within two years after the quarter in which the state made the relevant expenditures. 42 U.S.C. § 1320b-2(a); 45 C.F.R. § 95.7. However, CMS indicated its intention to grant good cause waivers to the two year timely filing rule if states avail themselves to the opportunity to resubmit audits from SPRYs 2011 through 2015, which result in additional allowable claims for federal funding.

CMS has reviewed the state's request for a good cause waiver and has determined that the lateness of the state filing was due to circumstances beyond the state's control. Therefore, CMS is approving your request for a good cause waiver.

States are expected to comply with 42 C.F.R. § 433.312(a) and that any overpayments identified in the audits will either be redistributed to other DSH-eligible hospitals in accordance with the applicable state plan, see 73 Fed. Reg. 77904 (Dec. 19, 2008), or that the federal portion will be refunded to CMS in accordance with the regulation.

Medicaid claims for federal financial participation for expenditures related to this waiver should be included on the Form CMS-64 for the quarter ending December 31, 2019.

Mr. Richard
Page 2 of 2

Should the state have any questions or need additional information, please contact Anna Dubois at 850-878-0916.

Sincerely,

Davida R. Kimble
Acting Deputy Director
Division of Medicaid Field Operations South

We are asking OGC to opine on a few questions we have that are related to DSH overpayments and redistributions of DSH overpayments.

Redistribution of Overpayments:

In the 2008 DSH final rule we indicated that the independent certified audit will result in discovery of DSH overpayments and will trigger requirements to refund the federal share of those overpayments pursuant to existing requirements at 42 CFR Part 433, Subpart F. The rule did not specify the date of discovery nor did it specify the mechanics and timing of DSH overpayment redistributions, other than indicating that they must be done in accordance with the approved state plan. Given this, our current regulations related to both the date of discovery of DSH overpayments and the time period that states have to make redistributions are ambiguous.

Colorado has indicated that while it collects all DSH overpayments from providers and returns them to CMS within the one year period from discovery, the state does its redistributions in the quarter following the end of the one year period. The state has also indicated that it needs an additional quarter following the collection of overpayments in order to make the redistributions. We believe this sounds reasonable especially given that we are proposing in MFAR to give states *two years* from the date of discovery to redistribute DSH overpayments.

Accordingly, to date we have not required states to submit waiver requests because of this ambiguity and to also avoid unnecessary burden for normal program operations which we believe are consistent with the DSH audit regulations. Additionally we have not placed much scrutiny on when other states have been doing their redistributions, so we don't want to single out Colorado and prohibit the state from operating on this timeframe. However, we have addressed this issue through SWIFT responses to members of Congress, although we are unsure who drafted them. I've attached the SWIFTs to this email. In the third paragraph we indicate that the state may make its redistributions after the statutorily required deadline to return overpayments one year after the date of discovery to CMS. We go on to indicate that the state may do so provided it "does so in accordance with its approved Medicaid state plan and applicable federal requirements, including the *2-year time limit* [emphasis added] for filing claims," adding to the ambiguity related to when states may make redistributions of DSH overpayments.

Q: While MFAR will clarify these issues, do we have the flexibility to allow Colorado and other states to make the redistributions following the one-year period without issuing a GCW?

b5

Delayed Redistribution and Return of Overpayments Because of Litigation

We believe many states, given the uncertainty with the DSH litigation, have delayed returning and redistributing DSH overpayments. Earlier this year we informed states that we intend to grant good cause waivers to the two year timely filing rule if states resubmit audits for SPRYs 2011 through 2015.

Q: Do we have the same flexibility to approve GCWs for states that merely delayed making returns and redistributions of DSH overpayments due to the uncertainty related to the ongoing litigation, but are not submitting revised audits to CMS?

b5

Q: If so, do we have any discretion to not require states to pay interest on late overpayment returns, as specified in 42 CFR 433.320(a)(4)?

b5

California's 175% UCC

The Balanced Budget Act of 1997 established a hospital-specific DSH limit of 175 percent of California's public hospitals' UCC. To make these payments, the state utilizes both CPE funded payments to pay costs up to 100 percent of UCC, while making IGT funded DSH payments to pay the remainder of UCC up to the 175 percent limit. Both the CPE and IGT payments are paid to providers on the same timeline – this includes the quarterly interim payments and final reconciliation payments.

Given the relationship between the CPE and IGT funded payments, we believe the IGT payment is dependent upon the CPE funded payment and therefore should be viewed as an adjustment to the CPE rather than a separate payment. As such, we believe we should tie the IGT claiming to that of the corresponding CPE claim. Moreover, since the final settlement of costs associated with the CPE will occur outside of the two year time period, the final IGT payment paying providers up to 175 percent of UCC will also occur beyond the two year time period. As a result of the dependency upon a CPE reconciliation before final IGT funded payments can be made, we believe the final IGT payment should meet the exception to the time limit at 45 CFR 95.19(a) as an adjustment to prior year costs. Not only is this final IGT funded payment dependent upon settled CPE cost, but it is also based on an interim payment methodology and also may be subject to further adjustments based on the DSH audit.

Q: Do you agree that these payments qualify to meet this exception to the two year timely filing rule?

b5

b5

RE: RE: Today's 1pm Managers Meeting and Thursday's Clearance Meeting

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>
Date: Tue, 24 Sep 2019 15:41:14 +0000
Attachments: FW: clearance next week for SC reconsideration request (8.12 MB)

Hi Wendy,

Per the OCD, we'll need to add the SC SPA disapproval reconsideration package to our clearance meeting.

Thanks

Beverly

From: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Sent: Tuesday, September 24, 2019 11:34 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; McCullough, Francis T. (CMS/CMCS) <Francis.McCullough@cms.hhs.gov>
Subject: Today's 1pm Managers Meeting and Thursday's Clearance Meeting

Hello All!!

Here is what I currently have for today's Managers Meeting and **THURSDAY's** Clearance Meeting. Please provide me any edits and additional items by 12:30pm today!!

Thanks!!

FMG's Managers' Meeting – 09/24/19 – 1pm

DISCUSSION:

- Senior Staff Updates
-

CLEARANCE MEETING – 09/26 @ 4:30pm:

Standing Items:

- ACCESS NPRM – no paper
- MFAR (OCD suggested changing compliance timeline to 3 years, through OMB comments) – no paper
- DSH Allotment Reduction Rule (Bring our answers to EOP questions back to Clearance when we have them completed.)– paper

Signature or Discussion Items (Paper/Presenter):

1. Maine PNMI Follow-up from 9/4 Clearance (OCD request – combined briefing memo and updated letter), *DRSF*, paper
2. Arkansas FMR Follow-up from 9/11 Clearance (OCD additional information request), *DFO/J. Gavens*, no paper
3. VII Group Reporting Issues/CIB proposal follow-up from 9/18 Clearance (OCD wants to know what options we have regarding the supp payment approach only being by claims and wants FMG to check into our ability to require that.), *A. MacCarroll*, paper

4. Wisconsin Cost Reporting Issue (OCD requested additional information to confirm that we told the state it needed to submit a cost report in order to claim for the CRS services), *DRSF*, no paper (?)
5. (Possible item) Briefing memo on “Ensuring Appropriate Cost Allocation – Oversight of Undocumented Immigrants”, K. Fan, paper

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
Baltimore, MD 21244

☎ Desk: 410-786-2075 Cell: b6 7: 410-786-8533

✉ Wendy.Harrison@cms.hhs.gov

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FW: FW: clearance next week for SC reconsideration request

From: "Bodon, Maritza (CMS/CMCS)" <maritza.bodon@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Cc: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>
Date: Mon, 23 Sep 2019 18:00:54 +0000
Attachments: Federal Register Notice SC SPAs.docx (35.45 kB); Joshua D Baker SC SMD Letter.docx (27.12 kB); Letter to Administrator SC SPAs.docx (32.72 kB); SC Disapproval Letter Final_Signed.pdf (150.55 kB); Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.pdf (7.67 MB)

Hi Beverly,

There is a reconsideration package for three FMG SPAs that need OCD's clearance. We thought it would be best to flag this for them via email before the regularly scheduled FMG clearance on Thursday and before the items are placed in CMS clearance. Would you be so kind as to send to OCD via email? Please let me know if you need additional information.

We are working on an extremely expedited timeframe. The Administrator must sign this package and CMS must reply by October 4th.

Also, feel free to copy me and let me know if OCD clears so that I can submit to CMS Clearance.

From: Bodon, Maritza (CMS/CMCS)
Sent: Monday, September 23, 2019 1:09 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Cc: Yablochnikov, Daniil (CMS/CMCS) <Daniil.Yablochnikov@cms.hhs.gov>
Subject: RE: clearance next week for SC reconsideration request

Okay. I'll work with Beverly and Lela to get this moving. Thanks

From: Silanskis, Jeremy D. (CMS/CMCS)
Sent: Monday, September 23, 2019 1:07 PM
To: Bodon, Maritza (CMS/CMCS) <Maritza.Bodon@cms.hhs.gov>
Cc: Yablochnikov, Daniil (CMS/CMCS) <Daniil.Yablochnikov@cms.hhs.gov>
Subject: Re: clearance next week for SC reconsideration request

Given the timing that may be our only option.

Sent from my iPhone

On Sep 23, 2019, at 12:31 PM, Bodon, Maritza (CMS/CMCS) <Maritza.Bodon@cms.hhs.gov> wrote:

Good afternoon Jeremy,

OSG's clearance for tomorrow has been cancelled. ☹️ What are your thoughts on sharing the package with OCD via email as a heads up? I know OCD likes to see things prior to submitting items to CMS clearance but Thursday is very late. Let me know what you prefer.

Maritza

From: Bodon, Maritza (CMS/CMCS)
Sent: Thursday, September 19, 2019 3:52 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: clearance next week for SC reconsideration request

Great! I'll keep you posted.

From: Silanskis, Jeremy D. (CMS/CMCS)
Sent: Thursday, September 19, 2019 3:30 PM
To: Bodon, Maritza (CMS/CMCS) <Maritza.Bodon@cms.hhs.gov>
Subject: RE: clearance next week for SC reconsideration request

Thanks. That would work for me!

From: Bodon, Maritza (CMS/CMCS)
Sent: Thursday, September 19, 2019 3:28 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: clearance next week for SC reconsideration request

Hi Jeremy,

Just wanted to give you a heads up that OSG's clearance is next Tuesday at 4:00, and as you are aware it is subject to change. I'm trying to get us some time on the agenda. Angela is out of the office this week so I can't confirm until Monday or early Tuesday if this is even possible.

Thanks!

Maritza Bodon | Division of Operations & Executive Support | Operations Services Group | CENTERS FOR MEDICARE & MEDICAID SERVICES | desk 410.786.6879 | email: Maritza.Bodon@cms.hhs.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval
South Carolina Medicaid State Plan Amendment (SPA)
16-0012-A, 17-006-A, and 18-0011-A

AGENCY: Centers for Medicare & Medicaid Services (CMS)

HHS ACTION: Notice of Hearing: Reconsideration of Disapproval

SUMMARY: This notice announces an administrative hearing to be held on November 20, 2019, at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909 to reconsider CMS' decision to disapprove South Carolina's Medicaid SPA 16-0012-A, 17-006-A, and 18-0011-A.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by **[insert date 15 days after publication in the Federal Register]**.

FOR FURTHER INFORMATION CONTACT:

Benjamin R. Cohen, Presiding Officer
CMS
2520 Lord Baltimore Drive
Suite L
Baltimore, Maryland 21244
Telephone: (410) 786-3169

SUPPLEMENTARY INFORMATION:

This notice announces an administrative hearing to reconsider CMS' decision to disapprove South Carolina's Medicaid state plan amendment (SPA) 16-0012-A, 17-006-A, and 18-0011-A, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the “Setoff Debt Collection Program,” rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.
- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as

the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

Section 1116 of the Act and federal regulations at 42 CFR Part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish in the Federal Register a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the state Medicaid agency of additional issues that will be considered at the hearing, we will also publish that notice in the Federal Register.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to South Carolina announcing an administrative hearing to reconsider the disapproval of its SPAs reads as follows:

Joshua D. Baker

Director

South Carolina Department of Health and Human Services

Post Office Box 8206

Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to the September 6, 2019 request for reconsideration of the decision to disapprove South Carolina's State Plan amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A. South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019. I am scheduling a hearing on the request for reconsideration to be held on November 20, 2019 at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786-3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide

names of the individuals who will represent the State at the hearing. If the hearing date is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the “Setoff Debt Collection Program”, rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

In the event that CMS and the State come to agreement on resolution of the issues which formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Seema Verma

Administrator

cc: Benjamin R. Cohen

Section 1116 of the Social Security Act (42 U.S.C. section 1316; 42 CFR section 430.18) (Catalog of Federal Domestic Assistance program No. 13.714. Medicaid Assistance Program.)

Dated:

Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services

Joshua D. Baker
Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to the September 6, 2019 request for reconsideration of the decision to disapprove South Carolina's State Plan amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A. South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 and disapproved on July 9, 2019. I am scheduling a hearing on the request for reconsideration to be held on November 20, 2019 at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786-3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing. If the hearing date is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. Specifically, SPAs 16-0012-A, 17-006-A, and 18-0011-A proposed to use intergovernmental transfers from the Greenville Health Authority to the State Medicaid Agency as the non-federal share of the proposed payments. The source of the transfers would be from the "Setoff Debt Collection Program", rather than state or local tax revenue and required by Section 1903(w)(6)(A) of the Social Security Act. The revenue collected from the Setoff Debt Collection Program is derived from uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

In the event that CMS and the State come to agreement on resolution of the issues which formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Seema Verma
Administrator

cc: Benjamin R. Cohen

DATE:

TO: Seema Verma
Administrator

FROM: Karen M. Shields,
Deputy Center Director, Center for Medicaid and CHIP Services

SUBJECT: Reconsideration of South Carolina's Medicaid state plan amendments (SPAs)
16-0012-A, 17-006-A, and 18-0011-A

ACTION REQUIRED BY: October 4, 2019

PURPOSE:

The attached letter to the State of South Carolina and *Federal Register* notice announce an administrative hearing on November 20, 2019, to reconsider the disapproval decision for the South Carolina Medicaid SPAs 16-0012-A, 17-006-A, and 18-0011-A.

The South Carolina Medicaid SPAs 16-0012-A, 17-006-A, and 18-0011-A, submitted on December 21, 2016, June 28, 2017, and June 29, 2018, requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology.

The Center for Medicaid and CHIP Services (CMCS) was unable to approve this SPA as submitted because it is inconsistent with the requirements of sections 1902(a)(2), 1903(a) and 1905(b) of the Social Security Act (the Act).

On September 6, 2019, a request for reconsideration was submitted on the behalf of the state of South Carolina, challenging CMS' disapproval of these SPAs. The state of South Carolina does not agree with the disapprovals and asserts that SPAs 16-0012-A, 17-006-A, and 18-0011-A conform to the requirements for approval, as none of the cited sections, or any other section of Title XIX or CMS's implementing regulations, limit Intergovernmental Transfers (IGTs) to "state or local tax revenue."

In the event that CMS and the state come to agreement on resolution of the issues which formed the basis for disapprovals, these SPAs may be moved to approval and a hearing would not be needed.

If a hearing does occur, the issues to be considered at the hearing are whether South Carolina SPAs 16-0012-A, 17-006-A, and 18-0011-A are inconsistent with the requirements of:

- Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of

adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
- Section 1903(w)(6)(A) of the Act allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

During the course of the SPA review, CMS worked with the state to resolve the outstanding issues. CMS issued a Request for Additional Information (RAI) to South Carolina on March 20, 2017, September 08, 2017, and September 13, 2018 and the state responded on April 10, 2019 and May 09, 2019. The state's response to the RAI set forth the state's reasons in support of the state's belief that the SPAs are consistent with the requirements of Sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Act. The state, however, could not resolve the outstanding issue that the source of the intergovernmental transfers made by the Greenville Health Authority are from the Setoff Debt Collection Program and not from state or local tax revenues, as required by 1903(w)(6)(A) of the Act for a proper intergovernmental transfer.

PROCEDURES FOR RECONSIDERATION:

Section 1116 of the Act, and 42 CFR Part 430, Subparts B and D, govern reconsideration of Medicaid SPAs. Federal regulations at 42 CFR 430.18 and 430.70 require the Administrator to notify a state of the time and place of the hearing within 30 days after receipt of the state's request for a reconsideration. The federal regulations at 42 CFR 430.72(b) provide for the hearing to be held in the city of the servicing CMS regional office or in any place chosen by the presiding officer with regard for the convenience and necessity of the parties. The hearing must be scheduled no less than 30 days, nor more than 60 days, after the date on which the notice of the hearing is furnished to the state (42 CFR 430.72(a)). In this case, the state's request was received on September 6, 2019, and therefore the required notification is being sent by October 4, 2019, and informs the state that the hearing has been scheduled for November 20, 2019. The scheduled date may be changed by written agreement between CMS and the state.

You must also designate, in writing, a presiding officer and notify the parties of the selection (42 CFR 430.66). The regulations state that the presiding officer may be the Administrator or the Administrator's designee. There are no requirements governing the qualifications of the presiding officer prescribed in the regulations.

The presiding officer is responsible for conducting the hearing, in accordance with the procedures in 42 CFR, part 430, subpart D, and certifying to the Administrator the entire

record, including recommended findings and proposed decision. The Administrator must then serve a copy of the recommended findings and proposed decision upon all parties to the hearing. The parties then have 20 days to file exceptions to the recommended findings and proposed decision. The Administrator is required to issue a final decision within 60 days of the date the recommended decision was served (42 CFR 430.102(b)(3)).

We are recommending Mr. Benjamin R. Cohen as the presiding officer in this case. Mr. Cohen is an attorney and has considerable experience in the conduct of hearings for CMS. Attached is a proposed letter designating Mr. Cohen as the presiding officer and stating the hearing is to be held on November 20, 2019. The letter advises the state to contact the presiding officer if the arrangements present any problems.

You are also required to publish in the *Federal Register* a copy of the notice to the state agency that informs the agency of the time and place of the hearing, the issues to be considered, and the identity of the presiding officer (42 CFR 430.70).

If you subsequently notify the agency of additional issues which will be considered at the hearing, that notice should also be published in the *Federal Register*.

In accordance with 42 CFR 430.76(b)(2), any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice in the *Federal Register*. Also, any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins, pursuant to 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

CONSEQUENCES OF DISAPPROVAL:

If South Carolina's request for reconsideration is not granted, we would violate section 1116 of the Act, which requires us to provide a reconsideration hearing.

If we do not publish a notice of the hearing, we would violate a regulatory requirement to provide an opportunity for interested individuals and groups to participate in the hearing (42 CFR 430.70 and 430.76). Therefore, by not publishing a notice in the *Federal Register*, we might nullify any decision by the presiding officer.

URGENCY:

The Federal regulations at 42 CFR 430.18 and 430.70 require you to notify the state of the hearing within 30 days of receipt of the state's request for reconsideration. Since South Carolina's request was received on September 6, 2019, the 30th day would be October 6, 2019, but since October 6 is a Sunday, the notification must be October 4, 2019.

We are required to schedule the hearing no less than 30 days nor more than 60 days after the date on which the notice of the hearing is furnished to the state.

Attachments:

- Letter to the State
- *Federal Register* Notice
- July 9, 2019, Disapproval Letter to the State

cc: Jeremy Vogel, OGC



July 9, 2019

Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid state plan amendments (SPAs) 16-0012-A, 17-0006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs.

In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed non-federal share funding source is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019, CMS communicated with the South Carolina Medicaid Director that CMS would issue a disapproval for the aforementioned SPAs unless the state provided new information regarding the source of the non-federal share for the proposed supplemental payments. The state requested time to provide additional information to support the proposals, which CMS granted. The information that the state subsequently provided did not describe an alternative funding source that would allow us to approve the proposed SPAs.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations in 42 C.F.R. § 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations in 42 C.F.R. § 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized, cursive script.

Calder Lynch
Acting Deputy Administrator and Director



Brown & Peisch PLLC
1233 20th Street NW
Suite 505
Washington, DC 20036

Via Certified Mail

September 5, 2019

Maritza Bodon
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mail Stop S2-62-12
Baltimore, MD 21244-1850

**RE: Request for Reconsideration South Carolina SPAs 16-0012-A, 17-006-A,
and 18-0011-A**

Dear Ms. Bodon:

On behalf of the South Carolina Department of Health and Human Services, we are requesting reconsideration of the attached notice of disapproval of State Plan Amendments (SPAs) 16-0012-A, 17-006-A, and 18-0011-A, pursuant to 42 C.F.R. § 430.18. The notice of disapproval was sent to the Department from Calder Lynch by letter dated July 9, 2019. (Attachment A.)

The SPAs propose to continue supplemental payments to physicians associated with Greenville Memorial Hospital and Palmetto Health Richland.

The letter asserts that the basis of disapproval is that the “state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903, 1903(w)(6)(A), and 1905(b) of the Social Security Act” because the payments proposed under the SPAs are funded through intergovernmental transfers (IGTs) from the Greenville Health Authority that are not derived from “state or local tax revenue as required by the statute.”

The Department requests that the Administrator reconsider the issue of whether the SPAs conform to the requirements for approval, as none of the cited sections, or any other section of Title XIX or CMS’s implementing regulations, limit IGTs to “state or local tax revenue.” Specifically:

1. Section 1902(a)(2) provides “for financial participation by the State equal to not less than 40 per centum of the non-Federal share of expenditures” and for carrying out the



plan on a basis “which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.”

This ground for disapproval should be reconsidered. The State provides financial participation well in excess of 40 percent of the non-Federal share and there is no claim that there is a lack of adequate funds from local sources that will result in lowering the amount, duration, scope, or quality of care and services. To the contrary, the funds from the Greenville Health Authority will help to sustain the quality of care of the teaching physicians associated with Greenville Memorial Hospital and Palmetto Health Richland. Therefore, Section 1902(a)(2) is not a reasonable or appropriate basis for disapproval.

2. Section 1903 provides for federal financial participation (FFP) in expenditures under the State Plan according to the federal medical assistance percentage (FMAP) formula set forth in Section 1905(b).

This ground for disapproval should be reconsidered. The physician services for which the supplemental payments are to be made under the SPAs are state plan services for which the State will claim FFP at the FMAP rate. There is no contention that the expenditures are not covered by the state plan as required by Section 1903(a)(1) or that the State intends to claim a match rate other than the one set forth in Section 1905(b). Therefore, Section 1903 and Section 1905(b) are not reasonable or appropriate bases for disapproval.

3. Section 1903(w)(6) provides that “the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider . . . unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.”

This ground for disapproval should be reconsidered. There is no contention that the transferred funds are derived from impermissible donations or taxes. Rather, CMS appears to be interpreting the clause that “the Secretary may not restrict States’ use of funds . . . derived from State or local taxes” as imposing a “requirement” that States can only accept IGTs that use funds derived from these sources.

Such a reading of the statute is not consistent with CMS regulations at 42 C.F.R. §433.51(b), which permits transfers of “public funds” from “public agencies,” and does not limit transfers to funds derived from State or local taxes. More importantly, limiting IGTs to funds derived from state and local taxes is not consistent with the statute that enacted Section 1903(w), the “Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,” Pub. L. 102-234. (Attachment B.) The stated purposes of the statute was to prevent impermissible taxes and donations but “to maintain the treatment of intergovernmental transfers” as a source of funding of the non-Federal share. At the time, the regulatory language regarding IGTs was the same as it is currently (although appearing in a different section).



In accordance with that purpose, Section 5 of Pub. L. 102-234 gave the Secretary the authority to issue “interim final” regulations implementing its provisions but specified that:

[t]he Secretary may not issue any interim final regulation that changes the treatment . . . of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds . . . that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

Further, the Secretary was directed to “consult with the States before issuing any regulations under this Act.” Id. § 5(c).

When CMS (then known as the Health Care Financing Administration, or HCFA) did publish interim final regulations a few months later, it complied with this congressional mandate and did not change the treatment of intergovernmental transfers, and it informed the States that:

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax. Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

See Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55043, 55119 (Nov. 24, 1992) (Attachment C).

Similarly, in 2007, when CMS did finalize a rule governing the non-Federal share (which was later withdrawn), it informed States that transfers from units of government were permissible “from a variety of sources (including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds);” that “patient care revenues from other third party payers and other revenues similar to those listed above . . . would also be acceptable sources of financing the non-Federal share of Medicaid payments” as long as they were not derived from impermissible sources; and that “governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues.” *See* Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748, 29766 (May 29, 2007) (Attachment D). The stated basis of the disallowance contradicts all of these prior statements from CMS.



Maritza Bodon
September 5, 2019
Page 4

Given the 1991 congressional mandate that the Secretary may only change the treatment of intergovernmental transfers by final regulation issued under the Administrative Procedure Act, after consultation with the States, and that CMS has twice subsequently told the States that sources other than state and local taxes are permissible sources of such transfers, Section 1903(w)(6) is not a reasonable or appropriate basis for disapproval.

The Department appreciates the reconsideration of the disapproval on the basis of the arguments set forth above.

Respectfully,

Caroline Brown /RES

Caroline M. Brown
Philip J. Peisch

Enclosures

Cc: Shantrina Roberts
Bryon Roberts

Attachment A

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



July 9, 2019

Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid state plan amendments (SPAs) 16-0012-A, 17-0006-A, and 18-0011-A, which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT. Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs.

In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed non-federal share funding source is not permissible. In subsequent e-mails and discussions, CMS indicated that if the funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPAs because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A. On January 30, 2019, CMS communicated with the South Carolina Medicaid Director that CMS would issue a disapproval for the aforementioned SPAs unless the state provided new information regarding the source of the non-federal share for the proposed supplemental payments. The state requested time to provide additional information to support the proposals, which CMS granted. The information that the state subsequently provided did not describe an alternative funding source that would allow us to approve the proposed SPAs.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations in 42 C.F.R. § 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations in 42 C.F.R. § 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

A handwritten signature in black ink, appearing to read "Calder Lynch", with a stylized, flowing script.

Calder Lynch
Acting Deputy Administrator and Director

Attachment B

Public Law 102-234
102d Congress

An Act

To delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source.

Dec. 12, 1991
 [H.R. 3595]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991".

Medicaid
 Voluntary
 Contribution
 and
 Provider-
 Specific Tax
 Amendments of
 1991.
 42 USC 1305
 note.

SEC. 2. PROHIBITION ON USE OF VOLUNTARY CONTRIBUTIONS, AND LIMITATION ON THE USE OF PROVIDER-SPECIFIC TAXES TO OBTAIN FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection.

"(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

"(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

"(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

"(II) donations described in paragraph (2)(C);

"(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

"(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

"(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

"(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as deter-

mined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

"(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

"(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

"(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

"(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(iii) In this subparagraph and subparagraph (E), the term 'impermissible tax' means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

"(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

"(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

Effective dates.

"(F) In this paragraph in the case of a State—

"(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

"(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

"(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in

1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

"(2)(A) In this subsection (except as provided in paragraph (6)), the term 'provider-related donation' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

"(i) a health care provider (as defined in paragraph (7)(B)),

"(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

"(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

"(B) For purposes of paragraph (1)(A)(i)(I), the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

"(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

"(3)(A) In this subsection (except as provided in paragraph (6)), the term 'health care related tax' means a tax (as defined in paragraph (7)(F)) that—

"(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

"(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

"(B) In this subsection, the term 'broad-based health care related tax' means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

"(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

"(ii) is imposed uniformly (in accordance with subparagraph (C)).

"(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

"(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

"(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

"(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

"(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

"(ii) Subject to subparagraphs (I) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

"(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

"(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

"(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

"(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

"(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

"(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

"(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph. Regulations.

"(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

"(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment 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.

"(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

"(C) 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.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

"(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

"(B)(i) In subparagraph (A), the term 'State base percentage' means, with respect to a State, an amount (expressed as a percentage) equal to—

"(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

"(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

"(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

"(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

"(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

"(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

"(7) For purposes of this subsection:

"(A) Each of the following shall be considered a separate class of health care items and services:

"(i) Inpatient hospital services.

"(ii) Outpatient hospital services.

"(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

"(iv) Services of intermediate care facilities for the mentally retarded.

"(v) Physicians' services.

"(vi) Home health care services.

"(vii) Outpatient prescription drugs.

"(viii) Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).

"(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

"(B) The term 'health care provider' means an individual or person that receives payments for the provision of health care items or services.

"(C) An entity is considered to be 'related' to a health care provider if the entity—

"(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

"(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

"(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

"(iv) has a similar, close relationship (as defined in regulations) to the provider.

"(D) The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(E) The 'State fiscal year' means, with respect to a specified year, a State fiscal year ending in that specified year.

"(F) The term 'tax' includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty

imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

"(G) The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State."

(b) CONFORMING AMENDMENTS.—(1) Section 1902(t) of such Act (42 U.S.C. 1396a(t)) is amended—

(A) by striking "Except as provided in section 1903(i), nothing" and inserting "Nothing", and

(B) by striking "taxes (whether or not of general applicability)" and inserting "taxes of general applicability".

(2) Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by striking paragraph (10) inserted by section 4701(b)(2)(B) of the Omnibus Budget Reconciliation Act of 1990.

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date. 42 USC 1396a note.

(2) Except as specifically provided in section 1903(w) of the Social Security Act and notwithstanding any other provision of such Act, the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure. 42 USC 1396b note.

(3) The interim final rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56132), relating to the State share of financial participation under the medicaid program, is hereby nullified and is of no effect. No part of such rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 3. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) REPEAL OF PROHIBITION OF UPPER PAYMENT LIMIT FOR DISPROPORTIONATE SHARE HOSPITALS.—Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)) is amended by striking "to limit" the first place it appears and all that follows through "special needs or".

(b) LIMITATION ON AGGREGATE PAYMENT ADJUSTMENTS.—

(1) IN GENERAL.—Section 1923 of such Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

"(1) IN GENERAL.—

"(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

"(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

"(I) the payment adjustments are made—

"(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

"(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

"(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

"(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

"(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the year (as specified in paragraph (2)).

"(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

"(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

"(i) the national DSH payment limit for the fiscal year, and

"(ii) the State DSH allotment for each State for the year.

"(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

"(i) The hospital's medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

"(ii) The hospital's low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

"(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is

equal to at least 1 percent of the total number of such days for all hospitals in the State.

"(iv) The hospital meets such alternative requirements as the Secretary may establish by regulation, taking into account the special circumstances of children's hospitals, hospitals located in rural areas, and sole community hospitals.

"(E) CONDITION FOR OPTION.—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a state exercising such option.

"(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

"(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

"(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

"(B) EXCEPTIONS.—

"(i) LIMIT TO 12 PERCENT OR BASE ALLOTMENT.—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State based allotment.

"(ii) EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

"(3) STATE SUPPLEMENTAL AMOUNTS.—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

"(A) DETERMINATION OF REDISTRIBUTION POOL.—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

"(i) the total of the State base allotments for high DSH States;

"(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

"(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal year; and

"(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

"(B) DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.—The supplemental amount for a State for a fiscal year is equal to the lesser of—

"(i) the product of the amount determined under subparagraph (A) and the ratio of—

"(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

"(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

"(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

"(4) DEFINITIONS.—In this subsection:

"(A) HIGH DSH STATE.—The term 'high DSH State' means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

"(B) STATE.—The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(C) STATE BASE ALLOTMENT.—The term 'State base allotment' means, with respect to a State, the greater of—

"(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

"(ii) \$1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

"(D) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the lesser of—

"(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

"(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

"(E) STATE GROWTH FACTOR.—The term 'State growth factor' means, for a State for a fiscal year, the percentage by which the expenditures described in section 1908(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year."

(2) CONFORMING AMENDMENTS.—(A) Such section 1923 is further amended—

(i) in subsection (a)(2)(B), by striking "subsection (c)," and inserting "subsections (c) and (f)"; and

(ii) in subsection (c), by striking "In order" and inserting "Subject to subsection (f), in order".

(B) Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "and section 1923(f)" after "of this section".

(c) **LIMITS ON AUTHORITY TO RESTRICT DSH DESIGNATIONS.**— 42 USC 1396r-4.
Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4)."

(d) **STUDY OF DSH PAYMENT ADJUSTMENTS.**—

42 USC 1396r-4
note.

(1) **IN GENERAL.**—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) **ITEMS INCLUDED IN STUDY.**—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) **REPORT.**—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section shall take effect January 1, 1992.

42 USC 1396a
note.

(2) The proposed rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56141), relating to the standards for defining disproportionate share hospitals under the medicaid program, shall be withdrawn and can-

celed. No part of such proposed rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 4. REPORTING REQUIREMENT.

(a) **IN GENERAL.**—Section 1903(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following:

“(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

“(i) provider-related donations made to the State or units of local government during such fiscal year, and

“(ii) health care related taxes collected by the State or such units during such fiscal year.

“(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.”

42 USC 1396b
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to fiscal years ending after the date of the enactment of this Act.

42 USC 1396b
note.

SEC. 5. INTERIM FINAL REGULATIONS.

(a) **IN GENERAL.**—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) **REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.**—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that

are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) **CONSULTATION WITH STATES.**—The Secretary shall consult with the States before issuing any regulations under this Act.

Approved December 12, 1991.

LEGISLATIVE HISTORY—H.R. 3595:

HOUSE REPORTS: Nos. 102-810 (Comm. on Energy and Commerce) and 102-409 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 137 (1991):

Nov. 19, considered and passed House.

Nov. 26, considered and passed Senate, amended. House agreed to conference report.

Nov. 27, Senate agreed to conference report.

Attachment C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 433 and 447

[MB-062-IFC]

RIN 0938-AF42

Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule establishes in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The rule also adds provisions that establish limits on the aggregate amount of payments a State may make to disproportionate share hospitals for which FFP is available.

This interim final rule implements provisions of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991.

DATES: *Effective date:* These interim final rules are effective December 24, 1992. However, the statutory requirements at sections 2(c)(1) and 3(e)(1) of Public Law 102-234 have an effective date of January 1, 1992, and are effective on that date regardless of the effective date of this interim final rule.

COMMENT DATE: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 25, 1993.

ADDRESSES: Mail comments to the following address:

Health Care Financing Administration,
Department of Health and Human
Services, Attention: MB-062-IFC P.O.
Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey
Building, 200 Independence Avenue,
SW, Washington, DC 20201, or
Room 132, East High Rise Building, 6325
Security Boulevard, Baltimore,
Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code MB-062-IFC. Written comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-690-7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Paperwork Burden" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Laura Oliven, Office of Management and Budget, New Executive Office Building (Room 3002), Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT:

Theresa Pratt (Donations and Taxes)
(410) 966-9535

Betty Kern (Disproportionate Share
Payments) (410) 966-4580

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. Medicaid programs are administered by the States in accordance with Federal regulations. State Medicaid agencies conduct their programs according to a Medicaid State plan approved by the Health Care Financing Administration (HCFA). To carry out the mandates of the Medicaid program, the State agency pays providers for medical care and services provided to eligible Medicaid recipients. Providers that wish to participate in the Medicaid program must agree to comply with certain requirements specified in a provider agreement.

While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. The Federal government pays its share of medical assistance expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The State pays its share of medical assistance

expenditures in accordance with section 1902(a)(2) of the Act.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers and revenues generated by certain health care-related taxes. This law also amended section 1923 of the Act to establish limits on the amount of FFP for expenditures made to hospitals that serve a disproportionate number of Medicaid recipients and other low-income individuals. These hospitals are referred to as disproportionate share hospitals.

This interim final rule interprets and implements the provisions of Public Law 102-234. The two issues that are affected by this law (provider-related donations and health care-related taxes, and disproportionate share hospital payments) are addressed separately in this preamble.

II. Provider-Related Donations and Health Care-Related Taxes

Section 1902(a)(2) of the Act requires States to share in the cost of medical assistance expenditures, and permits both State and local governments to participate in the financing of the non-Federal portion of expenditures under the Medicaid program. This section specifies the minimum percentage of the State's share of the non-Federal costs, and requires that the State share be sufficient to assure that the lack of adequate funds from local government sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State. Section 1903 of the Act requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

Public Law 102-234 amended section 1903 of the Act by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in FFP will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstafioned eligibility worker donation requirements, as specified in

the law. The law also specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. Such taxes are broad-based taxes which apply in a uniform manner to all health care providers in a class, and which do not hold providers harmless for their tax costs. However, the law permits States which have received, by specific date prior to the enactment of this law, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

Public Law 102-234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax.

Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The provisions of Public Law 102-234 apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section

1115 of the Act. The exemption is currently limited to Arizona. The provisions apply to donations to State or local governments from providers and related entities and to revenues generated by health care-related taxes, regardless of whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government, and regardless of whether the State uses these funds as the State share of medical assistance expenditures for FFP purposes. However, the provisions do not apply to the treatment of donations from entities not related to providers or the receipt of revenues generated by generally applicable taxes or other non-health care-related taxes.

A discussion of the specific provisions of Public Law 102-234 relating to treatment of provider-related donations and health care-related tax revenues and the implementing regulatory provisions follows.

General Rule

Section 1903(w)(1) of the Act provides that, effective January 1, 1992, before calculating the amount of FFP, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are as follows:

Donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers);

Impermissible health care-related taxes; and Until October 1, 1995, permissible health care-related taxes that exceed a specified limit.

It is important to note that the new statutory requirements apply to all impermissible provider-related donations and health care-related tax revenues received by State or local governments, without consideration of the use of the funds. If a State levies a tax on hospitals that is impermissible under section 1903(w) of the Act, and deposits the revenues in an account designated for some purpose other than Medicaid funding, the statute requires that the funds be offset from Medicaid expenditures even though the State is not using the revenues as its share of Medicaid expenditures for FFP purposes. For this purpose, the statute treats the State, and units of local government within the State, as a single entity. The fact that the funds were not received directly by the Medicaid agency does not alter the statute's

requirements that the funds be reduced from the State's claimed expenditures.

Section 1903(w)(2)(A) of the Act defines "provider-related donations" as any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses. Section 1903(w)(2)(B) defines "bona fide provider-related donations" as provider-related donations that have no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established to the satisfaction of the Secretary. The statute also gives the Secretary the authority to specify, by regulation, types of provider-related donations that will be considered to be bona fide provider-related donations.

Section 1903(w)(3)(A) of the Act defines "health care-related taxes" as those taxes that are related to: (1) Health care items or services; (2) the provision of such items or services; (3) the authority to provide health care items or services; or (4) the payment for such items or services.

In accordance with section 1903(w) of the Act, we are defining the term "permissible health care-related taxes" to mean those health care-related taxes which are broad-based taxes, uniformly applied to a class of health care items, services or providers (as specified in section 1903(w)(7)(A) of the Act), and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which HCFA has granted a waiver. Health care-related taxes that do not meet these requirements are "impermissible health care-related taxes."

As specified in section 1903(w)(1)(C)(i) of the Act, these provisions apply to revenues received by a State on or after January 1, 1992 (except for certain donations and taxes permitted under a transition period, which are subject to a limit). Revenues received by States prior to January 1, 1992 are not subject to these statutory provisions. In addition, since these provisions restrict the receipt of taxes and donations, they do not apply to expenditures that are made on or after January 1, 1992, that are funded by these pre-January 1, 1992 revenues.

We are revising subpart B in 42 CFR part 433 to incorporate the statutory provisions of section 1903(w) of the Act

Attachment D



Federal Register

Tuesday,
May 29, 2007

Part V

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 447, and 457
Medicaid Program; Cost Limit for
Providers Operated by Units of
Government and Provisions To Ensure
the Integrity of Federal-State Financial
Partnership; Final Rule

1903(w)(6)(A) of the Act, is taxing authority or the ability to directly access tax funding. Even though sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Act are not directly binding for all statutory purposes, we sought a definition that would be consistent with readings of both statutory provisions.

69C. Comment: One commenter quoted prior CMS statements from regulations published in 2001 and 2002, wherein CMS did not take regulatory action with respect to intergovernmental transfers, suggesting that CMS is now not only contradicting itself but also imposing restrictions on IGTs that Congress never intended.

69R. Response: The provisions of this regulation continue to protect the use of IGTs; the regulation merely sets out in clear terms the circumstances in which the provisions of section 1903(w)(6)(A) of the Act provides that an IGT from a governmentally-operated health care provider would not trigger review as a provider tax or donation. This regulation supersedes prior CMS statements on the issue and would provide important clarity in an area that has been the subject of much confusion. Furthermore, we disagree with the commenters' contention concerning congressional intent. In section 1903(w)(6)(A) of the Act, the Medicaid statute clearly protects only IGTs or certified public expenditures that are "derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred or certified by units of government within a state." To the extent that the provisions of this regulation impose restrictions on IGTs, such restrictions are consistent with this statutory provision and serve to clarify and give meaning to the statutory language.

70C. Comment: Many commenters stated that the provisions of the regulation require sources of all IGTs must be state or local taxes and that such a restriction on IGT funding is inconsistent with the Medicaid statute. These commenters noted that governments derive their funding from a variety of sources, not just tax proceeds, and such funds are no less governmental due to their source. Some of the non-tax sources of governmental revenue that were cited include patient care revenues from other third party payers, penalties, fees, grants, earned interest, library fines, restaurant inspection fees, vending machine sales, traffic fines, unreserved general fund balances, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds, and gifts. These commenters suggested that

CMS should allow all public funding, regardless of source, to be used as the non-Federal share of Medicaid expenditures. A number of commenters cited Section 1902(a)(2) of the Act, which permits up to 60 percent of the non-Federal share to come from "local sources," without further restriction. This citation was given to counter a perceived CMS position that the provisions of the regulation require that the sources of all IGTs must be state or local taxes. Several other commenters suggested that CMS should allow all public funding, regardless of source, to be used as the non-Federal share of Medicaid expenditures, and that CMS has no statutory authority to limit the sources of transferred funds to tax revenue only.

70R. Response: Provisions regarding non-federal share financing were established in recognition of the Federal Medicaid statute at section 1903(w), which places severe statutory restriction on States' receipt of funds from health care providers to fund Medicaid payments. (see Public Law 102-234, section 2, *Prohibition on Use of Voluntary Contributions*, and *Limitation on the Use of Provider-Specific Taxes to Obtain Financial Participation under Medicaid*). Under Public Law 102-234, the Congress included an exception to a general prohibition on the receipt of voluntary contributions from health care providers by allowing units of government, including governmentally-operated health care providers, to participate in financing of the non-Federal share via intergovernmental transfers and certified public expenditures. Specifically, section 1903(w)(6)(A) of the Social Security Act states:

Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

This statutory language allows funding derived from State or local taxes to be used for purposes of financing the non-Federal share of Medicaid payments. CMS recognizes that units of government that are not health care providers may collect revenue from a variety of sources (including fees, grants, earned interest, fines, sale or

lease of public resources, legal settlements and judgments, revenue from bond issuances, tobacco settlement funds) that are ultimately deposited into the government's general fund, which is used to finance the government's operations. We find such general fund revenues to be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the general fund does not derive any of its revenue from impermissible sources (such as, "recycled" Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations).

Governmentally-operated health care providers may maintain accounts separate from the general fund to finance the operations of the governmentally-operated health care provider. The governmentally-operated health care provider's account may include patient care revenues from other third party payers and other revenues similar to those listed above. Such revenues would also be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the governmentally-operated health care provider's operating account does not derive any of its revenue from impermissible sources (such as, "recycled" Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations).

As previously explained, governmentally-operated health care providers are not required to demonstrate that funds transferred are, in fact, tax revenues. A governmentally-operated health care provider is always able to access tax revenue, a characteristic of which reflects a health care provider's governmental status, and helps to define eligibility to participate in IGTs.

71C. Comment: A number of commenters asked CMS to clarify that intragovernmental transfers (transfers within a unit of government, such as a transfer from the State's mental health agency to the State Medicaid Agency) are not considered "intergovernmental transfers" for purposes of § 433.51.

71R. Response: Neither the Medicaid statute nor Federal regulation uses the term "intragovernmental transfer." For purposes of the Medicaid statute, a transfer of funding between any governmental entity within a State to the State Medicaid Agency is considered an intergovernmental transfer, irrespective of whether or not those entities are operated by the same unit of government (e.g., a State Department of Mental Health

RE: RE: FFY 2019-20 DSH allotments

From: "Sampson, Tamara L. (CMS/CMCS)" <tamara.sampson@cms.hhs.gov>
To: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Weaver, Robert K. (CMS/CMCS)" <robert.weaver@cms.hhs.gov>
Cc: "McMillion, Todd (CMS/CMCS)" <todd.mcmillion@cms.hhs.gov>, "Storey, Christine B. (CMS/CMCS)" <christine.storey@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Wed, 22 Jan 2020 20:24:05 +0000

Thank you

From: Cuno, Richard A. (CMS/CMCS)
Sent: Wednesday, January 22, 2020 2:06 PM
To: Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: FFY 2019-20 DSH allotments

Tammy,

We're actively working on responding to Colorado, but will have to loop back with OGC before we can get back to the state. We're hoping to get this resolved soon.

Rich

From: Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>
Sent: Wednesday, January 22, 2020 3:02 PM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>
Subject: FW: FFY 2019-20 DSH allotments
Importance: High

Good Afternoon Rich,

Can the DSH team provide any technical assistance to Colorado?

Does the DSH team have a standard response we can send to states regarding DSH allotments?

DRR is open to having an internal call with the DSH team to discuss Colorado's issue.

Thanks,
Tammy

From: Hunt, Trinia J. (CMS/CMCS)
Sent: Wednesday, January 22, 2020 1:54 PM
To: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>
Cc: Ferguson, Dorothy A. (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>
Subject: FW: FFY 2019-20 DSH allotments

Hi Todd,

Could you please assist Colorado with their inquiry below and attached regarding DSH? We've attempted several times to get headquarters to respond but have not had much success. I will be informing Nancy Dolson with Colorado that I have referred her request for information onto the DRR for response.

Thanks,

Trinia Hunt
Medicaid Financial Management Branch Manager
Division of Financial Operations West, FMG
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
(303) 844-7066

From: Dolson - HCPF, Nancy <nancy.dolson@state.co.us>

Sent: Tuesday, January 21, 2020 11:32 AM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Cc: greg.tanner@state.co.us; jerrod.cotosman@state.co.us; Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: Re: FFY 2019-20 DSH allotments

Thanks for the update, Trinia. Any news yet?

Nancy Dolson
Special Financing Division Director
Finance Office



P 303-866-3698 | F 303-866-4411 | State Relay: 711
1570 Grant Street, Denver, CO 80203
Nancy.Dolson@state.co.us | Colorado.gov/hcpf



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On Wed, Jan 8, 2020 at 6:19 PM Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov> wrote:

Hi Nancy,

We have not received feedback or guidance from our headquarters but we will continue to follow-up with them.

Trinia Hunt
Medicaid Financial Management Branch Manager
Division of Financial Operations West, FMG
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
(303) 844-7066

From: Dolson, Nancy <nancy.dolson@state.co.us>

Sent: Monday, January 6, 2020 3:26 PM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; Dolson, Nancy <nancy.dolson@state.co.us>; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Hi Trinia,

Happy New Year! Now that we're past the holidays, I wanted to check to see if CMS has feedback or guidance on Colorado's questions, below.

thanks

Nancy Dolson
Special Financing Division Director
Colorado Department of Health Care Policy and Financing
P 303.866.3698 | State Relay: 711
Nancy.Dolson@state.co.us

This email message and any included attachments, from the Colorado Department of Health Care Policy and Financing, are confidential and intended solely for the use of the individual or entity to which it is addressed. The information contained herein may include protected health information or otherwise privileged information. Unauthorized review, forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you received this message in error, please notify the sender by replying to this message and delete the email without disclosure. Thank you.

From: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Sent: Wednesday, December 18, 2019 6:18 PM

To: Dolson, Nancy <nancy.dolson@state.co.us>; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Curtis Volesky <Curtis.Volesky@cms.hhs.gov>; Christine Storey <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Thanks Nancy. We will work with our headquarters to facilitate providing you a response.

From: Dolson, Nancy <nancy.dolson@state.co.us>

Sent: Wednesday, December 18, 2019 5:58 PM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; nancy.dolson@state.co.us; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Hi Trinia,

Thank you for reaching out. The Department and our DSH hospitals would very much appreciate any additional information you can provide. Our understanding of the current situation is that the reduction to FFY 2019-20 DSH allotments remain, but the implementation of that reduction is delayed until 5/23/2020 through the budget agreement reached between Congress and the President this week.

I have several questions :

1. Is our understanding of the current budget action correct?
2. Can Colorado continue to make DSH payments based on the unreduced amount until 5/23 or other federal action occurs?
3. If the reduction goes into effect on 5/23, does the state have 12 months to attempt to recover any DSH overexpenditures for FFY 2019-20 from hospitals?
4. If the reduction is reversed through future action, the state assumes we have 2 year timely filing to claim any unspent FFY 2019-20 DSH allotment. Can you confirm?
5. The Department will submit a SPA this month to make changes to DSH payment methodologies effective FFY 2019-20. Our public and tribal notices and SPA reflect the current law with the expected reduced DSH allotment. If additional action is taken to reverse the reduction this year, does the state need to submit a new SPA including new public and tribal notification?

Any other information or guidance would be most welcome. Thanks again for asking.

Nancy

Nancy Dolson

Special Financing Division Director

Colorado Department of Health Care Policy and Financing

P 303.866.3698 | State Relay: 711

Nancy.Dolson@state.co.us

This email message and any included attachments, from the Colorado Department of Health Care Policy and Financing, are confidential and intended solely for the use of the individual or entity to which it is addressed. The information contained herein may include protected health information or otherwise privileged information. Unauthorized review, forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you received this message in error, please notify the sender by replying to this message and delete the email without disclosure. Thank you.

From: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Sent: Wednesday, December 18, 2019 5:48 PM

To: nancy.dolson@state.co.us; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Curtis Volesky <Curtis.Volesky@cms.hhs.gov>; Christine Storey <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Subject: FFY 2019-20 DSH allotments

Hi Nancy et al,

Since next week's call with HCPF and CMS is canceled please let us know what it is you're seeking clarification on regarding your 2019-2020 DSH allotment.

Thanks,

Trinia

FW: FW: Federal Register -- DSH Allotments

From: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
To: "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Cc: "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>
Date: Fri, 07 Feb 2020 13:27:54 +0000

FYI

From: Brewer, Annette M. (CMS/OSORA) <Annette.Brewer@cms.hhs.gov>
Sent: Friday, February 7, 2020 8:26 AM
To: Lafferty, Tiffany R. (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Isaac, Elliott (CMS/OSORA) <Elliott.Isaac@cms.hhs.gov>; Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>
Subject: RE: Federal Register -- DSH Allotments

Good morning,

This notice will be assigned to Elliott Isaac. Please contact Elliott, Gaysha (our TA), or me if you have any questions.

Thanks,

Annette M. Brewer 

Director, Division of Regulations Development-C
' 410-786-6580 / 443-934-2006 | **ADS on Mondays**

From: Lafferty, Tiffany R. (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>
Sent: Wednesday, February 5, 2020 3:57 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>; Brewer, Annette M. (CMS/OSORA) <Annette.Brewer@cms.hhs.gov>
Cc: Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Subject: RE: Federal Register -- DSH Allotments

Thank you all. This will be CMS-2436-N. Just going off of the actual schedule for last year's notice, it took a little over 3 months to clear and publish from the date we received it in OSORA, so I targeted 5/29 for publication for this one, but if it moves through clearance quickly, we could publish sooner. Annette will confirm the regs analyst that will be working with you on the notice.

Please let us know if you have any questions!
Tiffany

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Wednesday, February 5, 2020 2:04 PM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Lafferty, Tiffany R. (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>; Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>; Brewer, Annette M. (CMS/OSORA) <Annette.Brewer@cms.hhs.gov>
Cc: Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Subject: RE: Federal Register -- DSH Allotments

We just briefed the OCD that we're working on the Notice, so fine to move forward.

Beverly

From: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Sent: Wednesday, February 5, 2020 1:53 PM
To: Lafferty, Tiffany R. (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>; Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>; Brewer, Annette M. (CMS/OSORA) <Annette.Brewer@cms.hhs.gov>
Cc: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS)

<STUART.GOLDSTEIN@cms.hhs.gov>

Subject: RE: Federal Register -- DSH Allotments

We should be able to have it to you by the end of next week.

From: Lafferty, Tiffany R. (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>

Sent: Thursday, January 30, 2020 4:45 PM

To: Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS)

<Richard.Cuno@cms.hhs.gov>; Brewer, Annette M. (CMS/OSORA) <Annette.Brewer@cms.hhs.gov>

Cc: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS)

<STUART.GOLDSTEIN@cms.hhs.gov>

Subject: RE: Federal Register -- DSH Allotments

Thanks Gaysha. Rich, Please let me know when you think you'll have the draft notice ready to send to us.

Tiffany

From: Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>

Sent: Thursday, January 30, 2020 3:15 PM

To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Brewer, Annette M. (CMS/OSORA)

<Annette.Brewer@cms.hhs.gov>; Lafferty, Tiffany R. (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>

Cc: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS)

<STUART.GOLDSTEIN@cms.hhs.gov>

Subject: RE: Federal Register -- DSH Allotments

Looping in Tiffany.

From: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Sent: Thursday, January 30, 2020 3:13 PM

To: Brewer, Annette M. (CMS/OSORA) <Annette.Brewer@cms.hhs.gov>; Brooks, Gaysha M. (CMS/OSORA) <Gaysha.Brooks@cms.hhs.gov>

Cc: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS)

<STUART.GOLDSTEIN@cms.hhs.gov>

Subject: Federal Register -- DSH Allotments

Annette and Gaysha,

We're currently drafting the notice for publishing the final FY 2018 and preliminary FY 2020 DSH allotments and IMD limits, so I wanted to contact you about obtaining a notice number and setting things in motion to publish.

Thanks,

Rich

RE: RE: FFY 2019-20 DSH allotments

From: "Sampson, Tamara L. (CMS/CMCS)" <tamara.sampson@cms.hhs.gov>
To: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Weaver, Robert K. (CMS/CMCS)" <robert.weaver@cms.hhs.gov>
Cc: "McMillion, Todd (CMS/CMCS)" <todd.mcmillion@cms.hhs.gov>, "Storey, Christine B. (CMS/CMCS)" <christine.storey@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Wed, 22 Jan 2020 20:24:05 +0000

Thank you

From: Cuno, Richard A. (CMS/CMCS)
Sent: Wednesday, January 22, 2020 2:06 PM
To: Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: FFY 2019-20 DSH allotments

Tammy,

We're actively working on responding to Colorado, but will have to loop back with OGC before we can get back to the state. We're hoping to get this resolved soon.

Rich

From: Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>
Sent: Wednesday, January 22, 2020 3:02 PM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>
Subject: FW: FFY 2019-20 DSH allotments
Importance: High

Good Afternoon Rich,

Can the DSH team provide any technical assistance to Colorado?

Does the DSH team have a standard response we can send to states regarding DSH allotments?

DRR is open to having an internal call with the DSH team to discuss Colorado's issue.

Thanks,
Tammy

From: Hunt, Trinia J. (CMS/CMCS)
Sent: Wednesday, January 22, 2020 1:54 PM
To: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>
Cc: Ferguson, Dorothy A. (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>
Subject: FW: FFY 2019-20 DSH allotments

Hi Todd,

Could you please assist Colorado with their inquiry below and attached regarding DSH? We've attempted several times to get headquarters to respond but have not had much success. I will be informing Nancy Dolson with Colorado that I have referred her request for information onto the DRR for response.

Thanks,

Trinia Hunt
Medicaid Financial Management Branch Manager
Division of Financial Operations West, FMG
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
(303) 844-7066

From: Dolson - HCPF, Nancy <nancy.dolson@state.co.us>

Sent: Tuesday, January 21, 2020 11:32 AM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Cc: greg.tanner@state.co.us; jerrod.cotosman@state.co.us; Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: Re: FFY 2019-20 DSH allotments

Thanks for the update, Trinia. Any news yet?

Nancy Dolson
Special Financing Division Director
Finance Office



P 303-866-3698 | F 303-866-4411 | State Relay: 711
1570 Grant Street, Denver, CO 80203
Nancy.Dolson@state.co.us | Colorado.gov/hcpf



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On Wed, Jan 8, 2020 at 6:19 PM Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov> wrote:

Hi Nancy,

We have not received feedback or guidance from our headquarters but we will continue to follow-up with them.

Trinia Hunt
Medicaid Financial Management Branch Manager
Division of Financial Operations West, FMG
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
(303) 844-7066

From: Dolson, Nancy <nancy.dolson@state.co.us>

Sent: Monday, January 6, 2020 3:26 PM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; Dolson, Nancy <nancy.dolson@state.co.us>; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Hi Trinia,

Happy New Year! Now that we're past the holidays, I wanted to check to see if CMS has feedback or guidance on Colorado's questions, below.

thanks

Nancy Dolson
Special Financing Division Director
Colorado Department of Health Care Policy and Financing
P 303.866.3698 | State Relay: 711
Nancy.Dolson@state.co.us

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From: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Sent: Wednesday, December 18, 2019 6:18 PM

To: Dolson, Nancy <nancy.dolson@state.co.us>; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Curtis Volesky <Curtis.Volesky@cms.hhs.gov>; Christine Storey <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Thanks Nancy. We will work with our headquarters to facilitate providing you a response.

From: Dolson, Nancy <nancy.dolson@state.co.us>

Sent: Wednesday, December 18, 2019 5:58 PM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; nancy.dolson@state.co.us; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Hi Trinia,

Thank you for reaching out. The Department and our DSH hospitals would very much appreciate any additional information you can provide. Our understanding of the current situation is that the reduction to FFY 2019-20 DSH allotments remain, but the implementation of that reduction is delayed until 5/23/2020 through the budget agreement reached between Congress and the President this week.

I have several questions :

1. Is our understanding of the current budget action correct?
2. Can Colorado continue to make DSH payments based on the unreduced amount until 5/23 or other federal action occurs?
3. If the reduction goes into effect on 5/23, does the state have 12 months to attempt to recover any DSH overexpenditures for FFY 2019-20 from hospitals?
4. If the reduction is reversed through future action, the state assumes we have 2 year timely filing to claim any unspent FFY 2019-20 DSH allotment. Can you confirm?
5. The Department will submit a SPA this month to make changes to DSH payment methodologies effective FFY 2019-20. Our public and tribal notices and SPA reflect the current law with the expected reduced DSH allotment. If additional action is taken to reverse the reduction this year, does the state need to submit a new SPA including new public and tribal notification?

Any other information or guidance would be most welcome. Thanks again for asking.

Nancy

Nancy Dolson

Special Financing Division Director

Colorado Department of Health Care Policy and Financing

P 303.866.3698 | State Relay: 711

Nancy.Dolson@state.co.us

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From: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Sent: Wednesday, December 18, 2019 5:48 PM

To: nancy.dolson@state.co.us; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Curtis Volesky <Curtis.Volesky@cms.hhs.gov>; Christine Storey <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Subject: FFY 2019-20 DSH allotments

Hi Nancy et al,

Since next week's call with HCPF and CMS is canceled please let us know what it is you're seeking clarification on regarding your 2019-2020 DSH allotment.

Thanks,

Trinia

Federal Register Notice -- DSH Allotments

From: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
To: "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Cc: "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
Date: Fri, 24 Jan 2020 16:47:51 +0000
Attachments: FR Notice DSH Allot 2018 2020 clean version.docx (47.2 kB); FR Notice DSH Allot 2018 2020 track changes.docx (132.04 kB); DSH Allot 2018 2020 Addendum.xlsx (52.91 kB)

Charles and Lia,

Here's a draft of the FR notice for publication of the final FY 2018 and preliminary FY 2020 DSH allotments and IMD limits. I've included both a clean and a track changes version of the notice. In the past we've had OSORA insert the tables, so I've included them as a separate attachment.

If you have a chance to look it over, please let me know if you have any comments.

Thanks,

Rich

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS--N]

RIN 0938-ZB50

**Medicaid Program; Final FY 2018 and Preliminary FY 2020 Disproportionate Share
Hospital Allotments, and Final FY 2018 and Preliminary FY 2020 Institutions for Mental
Diseases Disproportionate Share Hospital Limits**

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2018 and the preliminary federal share DSH allotments for FY 2020. This notice also announces the final FY 2018 and the preliminary FY 2020 limitations on aggregate DSH payments that states may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of states' FY DSH allotments.

DATE: This notice is effective [insert date 30 days after the date of publication in the **Federal Register**]. The final allotments and limitations set forth in this notice are applicable for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT:

Stuart Goldstein, (410) 786-0694 and Richard Cuno, (410) 786-1111.

SUPPLEMENTARY INFORMATION:

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I. Background

A. Fiscal Year DSH Allotments

A state's federal fiscal year (FY) disproportionate share hospital (DSH) allotment represents the aggregate limit on the federal share amount of the state's DSH payments to DSH hospitals in the state for the FY. The amount of such allotment is determined in accordance with the provisions of section 1923(f)(3) of the Social Security Act (the Act), with some state-specific exceptions as specified in section 1923(f) of the Act. Under such provisions, in general a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the previous FY.

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively, the Affordable Care Act), amended Medicaid DSH provisions, adding section 1923(f)(7) of the Act. Section 1923(f)(7) would have required reductions to states' FY DSH allotments from FY 2014 through FY 2020, the calculation of which was described in the Disproportionate Share Hospital Payment Reduction final rule published in the September 18, 2013 **Federal Register** (78 FR 57293). Subsequent legislation, most recently by the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94, enacted December 20, 2019), delayed the start of these reductions, beginning with the FY 2020 DSH allotment reductions, until May 22, 2020. A proposed rule delineating a revised methodology for the calculation of DSH allotment reductions previously scheduled to begin in FY 2018 was published in the July 28, 2017 **Federal Register** (82 FR 35155).

Because there are no reductions to DSH allotments for FY 2018 and are not currently in

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effect for FY 2020 under section 1923(f)(7) of the Act, as amended, this notice contains only the state-specific final FY 2018 DSH allotments and preliminary FY 2020 DSH allotments, as calculated under the statute without application of the reductions that would have been imposed under the Affordable Care Act provisions beginning with FY 2014. This notice also provides information on the calculation of such FY DSH allotments, the calculation of the states' institutions for mental diseases (IMDs) DSH limits, and the amounts of states' final FY 2018 IMD DSH limits and preliminary FY 2020 IMD DSH limits.

B. Determination of Fiscal Year DSH Allotments

Generally, in accordance with the methodology specified under section 1923(f)(3) of the Act, a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the CPI-U for the previous FY. Also in accordance with section 1923(f)(3) of the Act, a state's DSH allotment for a FY is subject to the limitation that an increase to a state's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the state's DSH allotment for the previous FY or 12 percent of the state's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Furthermore, under section 1923(h) of the Act, federal financial participation (FFP) for DSH payments to IMDs and other mental health facilities is limited to state-specific aggregate amounts. Under this provision, the aggregate limit for DSH payments to IMDs and other mental health facilities is the lesser of a state's FY 1995 total computable (state and federal share) IMD and other mental health facility DSH expenditures applicable to the state's FY 1995 DSH allotment (as reported on the Form CMS-64 as of January 1, 1997), or the amount equal to the

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product of the state's current year total computable DSH allotment and the applicable percentage specified in section 1923(h) of the Act.

In general, we determine states' DSH allotments for a FY and the IMD DSH limits for the same FY using the most recent available estimates of or actual medical assistance expenditures, including DSH expenditures in their Medicaid programs and the most recent available change in the CPI-U used for the FY in accordance with the methodology prescribed in the statute. The indicated estimated or actual expenditures are obtained from states for each relevant FY from the most recent available quarterly Medicaid budget reports (Form CMS-37) or quarterly Medicaid expenditure reports (Form CMS-64), respectively, submitted by the states. For example, as part of the initial determination of a state's FY DSH allotment (referred to as the preliminary DSH allotments) that is determined before the beginning of the FY for which the DSH allotments and IMD DSH limits are being determined, we use estimated expenditures for the FY obtained from the August submission of the CMS-37 submitted by states prior to the beginning of the FY; such estimated expenditures are subject to update and revision during the FY before such actual expenditure data become available. We also use the most recent available estimated CPI-U percentage change that is available before the beginning of the FY for determining the states' preliminary FY DSH allotments; such estimated CPI-U percentage change is subject to update and revision during the FY before the actual CPI-U percentage change becomes available. In determining the final DSH allotments and IMD DSH limits for a FY we use the actual expenditures for the FY and actual CPI-U percentage change for the previous FY.

II. Provisions of the Notice

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A. Calculation of the Final FY 2018 Federal Share State DSH Allotments, and the Preliminary FY 2020 Federal Share State DSH Allotments

1. Final FY 2018 Federal Share State DSH Allotments

Addendum 1 to this notice provides the states' final FY 2018 DSH allotments determined in accordance with section 1923(f)(3) of the Act. As described in the background section, in general, the DSH allotment for a FY is calculated by increasing the FY DSH allotment for the preceding FY by the CPI-U increase for the previous fiscal year. For purposes of calculating the states' final FY 2018 DSH allotments, the preceding final fiscal year DSH allotments (for FY 2017) were published in the February 11, 2019 **Federal Register** (84 FR3169). For purposes of calculating the states' final FY 2018 DSH allotments we are using the actual Medicaid expenditures for FY 2018. Finally, for purposes of calculating the states' final FY 2018 DSH allotments, the applicable historical percentage change in the CPI-U for the previous FY (FY 2017) was 2.1 percent; we note that this is lower than the estimated 2.4 percentage change in the CPI-U for FY 2017 that was available and used in the calculation of the preliminary FY 2018 DSH allotments which were published in the July 6, 2018 **Federal Register** (83 FR 31536).

2. Calculation of the Preliminary FY 2020 Federal Share State DSH Allotments

Addendum 2 to this notice provides the preliminary FY 2020 DSH allotments determined in accordance with section 1923(f)(3) of the Act. The preliminary FY 2020 DSH allotments contained in this notice were determined based on the most recent available estimates from states of their FY 2020 total computable Medicaid expenditures. Also, the preliminary FY 2020 allotments contained in this notice were determined by increasing the preliminary FY 2019 DSH allotments. The estimated percentage increase in the CPI-U for FY 2019 was 1.9 percent (CMS

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originally published the preliminary FY 2019 DSH allotments in the February 11, 2019 **Federal Register** (84 FR 3169)).

We will publish states' final FY 2020 DSH allotments in a future notice based on the states' four quarterly Medicaid expenditure reports (Form CMS-64) for FY 2020 available following the end of FY 2020 utilizing the actual change in the CPI-U for FY 2019.

B. Calculation of the Final FY 2018 and Preliminary FY 2020 IMD DSH Limits

Section 1923(h) of the Act specifies the methodology to be used to establish the limits on the amount of DSH payments that a state can make to IMDs and other mental health facilities. FFP is not available for DSH payments to IMDs or other mental health facilities that exceed the IMD DSH limits. In this notice, we are publishing the final FY 2018 and the preliminary FY 2020 IMD DSH limits determined in accordance with the provisions discussed above.

Addendums 3 and 4 to this notice detail each state's final FY 2018 and preliminary FY 2020 IMD DSH limit, respectively, determined in accordance with section 1923(h) of the Act.

III. Collection of Information Requirements

As it relates to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), this notice does not impose any new or revised collection of information requirements or burden. While discussed in section I.B. and in Addendums 3 and 4 of this notice, the requirements and burden associated with Form CMS-37 and Form CMS-64 are unaffected by this notice. Both forms are approved by the Office of Management and Budget (OMB) under control number 0938-1265. Since this notice will not impose any new or revised requirements/burden, we are not making any changes under that control number.

IV. Regulatory Impact Analysis

We have examined the impact of this notice as required by Executive Order 12866 on

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Regulatory Planning and Review (September 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4; enacted on March 22, 1995) (UMRA '95), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This notice reaches the \$100 million economic threshold and thus is considered a major rule under the Congressional Review Act.

The final FY 2018 DSH allotments being published in this notice are \$36 million less than the preliminary FY 2018 DSH allotments published in the July 6, 2018 **Federal Register** (83 FR31536). This is due to the actual percentage change in the CPI-U for FY 2017 used in the calculation of the final FY 2018 allotments (2.1 percent) being less than the estimated percentage change in the CPI-U for FY 2017 used in the calculation of the preliminary FY 2018 allotments (2.4 percent). The final FY 2018 IMD DSH limits being published in this notice are \$2.4 million less than the preliminary FY 2018 IMD DSH limits published in the July 6, 2018 **Federal Register** (83 FR 31536). Since the final FY 2018 DSH allotments were less than the preliminary FY 2018 DSH allotments, the associated FY 2018 IMD DSH limits also decreased.

The preliminary FY 2020 DSH allotments being published in this notice have been

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increased by approximately \$201 million more than the preliminary FY 2019 DSH allotments published in the February 11, 2019 **Federal Register** (84 FR3169). The increase in the DSH allotments is due to the application of the statutory formula for calculating DSH allotments under which the prior fiscal year allotments are increased by the percentage increase in the CPI-U for the prior fiscal year. The preliminary FY 2020 IMD DSH limits being published in this notice are approximately \$20 million more than the preliminary FY 2019 IMD DSH limits published in the February 11, 2019 **Federal Register** (84 FR 3169). The increases in the IMD DSH limits are because the DSH allotment for a FY is a factor in the determination of the IMD DSH limit for the FY. Since the preliminary FY 2020 DSH allotments are greater than the preliminary FY 2019 DSH allotments, the associated preliminary FY 2020 IMD DSH limits for some states also increased.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any one year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have significant economic impact on a substantial number of small entities. Specifically, any impact on providers is due to the effect of the various controlling statutes; providers are not impacted as a result of the independent regulatory action in publishing this notice. The purpose of the notice is to announce the latest DSH allotments and IMD DSH limits, as required by the statute.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis

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if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area for Medicaid payment regulations and has fewer than 100 beds. We are not preparing analysis for section 1102(b) of the Act because the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

The Medicaid statute specifies the methodology for determining the amounts of states' DSH allotments and IMD DSH limits; and as described previously, the application of the methodology specified in statute results in the decreases or increases in states' DSH allotments and IMD DSH limits for the applicable FYs. The statute applicable to these allotments and limits does not apply to the determination of the amounts of DSH payments made to specific DSH hospitals; rather, these allotments and limits represent an overall limit on the total of such DSH payments. For this reason, we do not believe that this notice will have a significant economic impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately \$150 million. This notice will have no consequential effect on spending by state, local, or tribal governments, in the aggregate, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has

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Federalism implications. Since this notice does not impose any costs on state or local governments or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017. It has been determined that this notice is a transfer rule and is not a regulatory action for the purposes of Executive Order 13771.

A. Alternatives Considered

The methodologies for determining the states’ fiscal year DSH allotments and IMD DSH limits, as reflected in this notice, were established in accordance with the methodologies and formula for determining states’ allotments and limits as specified in statute. This notice does not put forward any further discretionary administrative policies for determining such allotments and limits, or otherwise.

B. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 1, we have prepared an accounting statement showing the classification of the estimated expenditures associated with the provisions of this notice. Table 1 provides our best estimate of the change (decrease) in the federal share of states’ Medicaid DSH payments resulting from the application of the provisions of the Medicaid statute relating to the calculation of states’ FY DSH allotments and the increase in the FY DSH allotments from FY 2019 to FY 2020.

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TABLE 1: Accounting Statement: Classification of Estimated Expenditures, from the FY 2019 to FY 2020 (in Millions)

Category	TRANSFERS
Annualized Monetized Transfers	\$201
From Whom To Whom?	Federal Government to States

C. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

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Dated: _____.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: _____.

Alex M Azar II,

Secretary,

Department of Health and Human Services.

Key to ADDENDUM 1: Final DSH Allotments for FY 2018.

The Final FY 2018 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Final FY 2018 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.	
Column	Description
Column A	State.
Column B	FY 2018 FMAPs. This column contains the States' FY 2018 Federal Medical Assistance Percentages.
Column C	Prior FY (2017) DSH Allotments This column contains the States' prior FY 2017 DSH Allotments.
Column D	Prior FY (2017) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 102.1 percent. This column contains the amount in Column C increased by 1 plus the percentage increase in the CPI-U for the prior FY (102.1 percent).
Column E	FY 2018 TC MAP Exp. Including DSH. This column contains the amount of the States' FY 2018 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2018 TC DSH Expenditures. This column contains the amount of the States' FY 2018 total computable DSH expenditures.
Column G	FY 2018 TC MAP Exp. Net of DSH. This column contains the amount of the States' FY 2018 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2017 Allotment or 12 percent Limit. This column contains the greater of the State's prior FY (FY 2017) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2018 DSH Allotment. This column contains the States' final FY 2018 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 1: FINAL DSH ALLOTMENTS FOR FISCAL YEAR: 2018

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Key to ADDENDUM 2: Preliminary DSH Allotments for FY 2020.

The Preliminary FY 2020 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Preliminary FY 2020 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.

Column	Description
Column A	State.
Column B	FY 2020 FMAPs. This column contains the States' FY 2020 Federal Medical Assistance Percentages.
Column C	Prior FY (2019) DSH Allotments This column contains the States' prior preliminary FY 2019 DSH Allotments.
Column D	Prior FY (2019) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 101.9percent. This column contains the amount in Column C increased by 1 plus the estimated percentage increase in the CPI-U for the prior FY (101.9 percent).
Column E	FY 2020 TC MAP Exp. Including DSH. This column contains the amount of the States' projected FY 2020 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2020 TC DSH Expenditures. This column contains the amount of the States' projected FY 2020 total computable DSH expenditures.
Column G	FY 2020 TC MAP Exp. Net of DSH. This column contains the amount of the States' projected FY 2020 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2019 Allotment or 12 percent Limit. This column contains the greater of the State's preliminary prior FY (FY 2019) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2020 DSH Allotment. This column contains the States' preliminary FY 2020 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 2: PRELIMINARY DSH ALLOTMENTS FOR FISCAL YEAR: 2019

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Key to ADDENDUM 3: Final IMD DSH Limits for FY 2018

The final FY 2018 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2018 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.

Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2018 Federal Share DSH Allotment. This column contains the states' FY 2018 DSH allotments from Addendum 1, Column J.
Column G	FY 2018 FMAP.
Column H	FY 2018 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2018 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2018 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2018 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2018 TC IMD DSH Limit. Lesser of Col. I or C This column contains the total computable FY 2018 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2018 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2018 Federal Share IMD DSH limit determined by converting the total computable FY 2018 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2018 FMAP in Column G.

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ADDENDUM 3: FINAL IMD DSH LIMIT FOR FY: 2018

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Key to ADDENDUM 4: Preliminary IMD DSH Limits for FY 2020

The preliminary FY 2020 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2020 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.	
Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2020 Federal Share DSH Allotment. This column contains the states' preliminary FY 2020 DSH allotments from Addendum 1, Column J.
Column G	FY 2020 FMAP.
Column H	FY 2020 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2020 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2020 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2020 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2020 TC IMD DSH Limit. Lesser of Col. I or C. This column contains the total computable FY 2020 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2020 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2020 Federal Share IMD DSH limit determined by converting the total computable FY 2020 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2020 FMAP in Column G.

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ADDENDUM 4: PRELIMINARY IMD DSH LIMIT FOR FISCAL YEAR: 2020

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS--N]

RIN 0938-ZB50

**Medicaid Program; Final FY 2018 and Preliminary FY 2020 Disproportionate Share
Hospital Allotments, and Final FY 2018 and Preliminary FY 2020 Institutions for Mental
Diseases Disproportionate Share Hospital Limits**

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2018 and the preliminary federal share DSH allotments for FY 2020. This notice also announces the final FY 2018 and the preliminary FY 2020 limitations on aggregate DSH payments that states may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of states' FY DSH allotments.

DATE: This notice is effective **[insert date 30 days after the date of publication in the Federal Register]**. The final allotments and limitations set forth in this notice are applicable for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT:

Stuart Goldstein, (410) 786-0694 and Richard Cuno, (410) 786-1111.

SUPPLEMENTARY INFORMATION:

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I. Background

A. Fiscal Year DSH Allotments

A state's federal fiscal year (FY) disproportionate share hospital (DSH) allotment represents the aggregate limit on the federal share amount of the state's DSH payments to DSH hospitals in the state for the FY. The amount of such allotment is determined in accordance with the provisions of section 1923(f)(3) of the Social Security Act (the Act), with some state-specific exceptions as specified in section 1923(f) of the Act. Under such provisions, in general a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the previous FY.

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively, the Affordable Care Act), amended Medicaid DSH provisions, adding section 1923(f)(7) of the Act. Section 1923(f)(7) would have required reductions to states' FY DSH allotments from FY 2014 through FY 2020, the calculation of which was described in the Disproportionate Share Hospital Payment Reduction final rule published in the September 18, 2013 **Federal Register** (78 FR 57293). Subsequent legislation, most recently by the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94, enacted December 20, 2019), delayed the start of these reductions, beginning with the FY 2020 DSH allotment reductions, until May 22, 2020. A proposed rule delineating a revised methodology for the calculation of DSH allotment reductions previously scheduled to begin in FY 2018 was published in the July 28, 2017 **Federal Register** (82 FR 35155).

Because there are no reductions to DSH allotments for FY 2018 and are not currently in

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effect for FY 2020 under section 1923(f)(7) of the Act, as amended, this notice contains only the state-specific final FY 2018 DSH allotments and preliminary FY 2020 DSH allotments, as calculated under the statute without application of the reductions that would have been imposed under the Affordable Care Act provisions beginning with FY 2014. This notice also provides information on the calculation of such FY DSH allotments, the calculation of the states' institutions for mental diseases (IMDs) DSH limits, and the amounts of states' final FY 2018 IMD DSH limits and preliminary FY 2020 IMD DSH limits.

B. Determination of Fiscal Year DSH Allotments

Generally, in accordance with the methodology specified under section 1923(f)(3) of the Act, a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the CPI-U for the previous FY. Also in accordance with section 1923(f)(3) of the Act, a state's DSH allotment for a FY is subject to the limitation that an increase to a state's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the state's DSH allotment for the previous FY or 12 percent of the state's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Furthermore, under section 1923(h) of the Act, federal financial participation (FFP) for DSH payments to IMDs and other mental health facilities is limited to state-specific aggregate amounts. Under this provision, the aggregate limit for DSH payments to IMDs and other mental health facilities is the lesser of a state's FY 1995 total computable (state and federal share) IMD and other mental health facility DSH expenditures applicable to the state's FY 1995 DSH allotment (as reported on the Form CMS-64 as of January 1, 1997), or the amount equal to the

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product of the state's current year total computable DSH allotment and the applicable percentage specified in section 1923(h) of the Act.

In general, we determine states' DSH allotments for a FY and the IMD DSH limits for the same FY using the most recent available estimates of or actual medical assistance expenditures, including DSH expenditures in their Medicaid programs and the most recent available change in the CPI-U used for the FY in accordance with the methodology prescribed in the statute. The indicated estimated or actual expenditures are obtained from states for each relevant FY from the most recent available quarterly Medicaid budget reports (Form CMS-37) or quarterly Medicaid expenditure reports (Form CMS-64), respectively, submitted by the states. For example, as part of the initial determination of a state's FY DSH allotment (referred to as the preliminary DSH allotments) that is determined before the beginning of the FY for which the DSH allotments and IMD DSH limits are being determined, we use estimated expenditures for the FY obtained from the August submission of the CMS-37 submitted by states prior to the beginning of the FY; such estimated expenditures are subject to update and revision during the FY before such actual expenditure data become available. We also use the most recent available estimated CPI-U percentage change that is available before the beginning of the FY for determining the states' preliminary FY DSH allotments; such estimated CPI-U percentage change is subject to update and revision during the FY before the actual CPI-U percentage change becomes available. In determining the final DSH allotments and IMD DSH limits for a FY we use the actual expenditures for the FY and actual CPI-U percentage change for the previous FY.

II. Provisions of the Notice

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A. Calculation of the Final FY 2018 Federal Share State DSH Allotments, and the Preliminary FY 2020 Federal Share State DSH Allotments

1. Final FY 2018 Federal Share State DSH Allotments

Addendum 1 to this notice provides the states' final FY 2018 DSH allotments determined in accordance with section 1923(f)(3) of the Act. As described in the background section, in general, the DSH allotment for a FY is calculated by increasing the FY DSH allotment for the preceding FY by the CPI-U increase for the previous fiscal year. For purposes of calculating the states' final FY 2018 DSH allotments, the preceding final fiscal year DSH allotments (for FY 2017) were published in the February 11, 2019 **Federal Register** (84 FR3169). For purposes of calculating the states' final FY 2018 DSH allotments we are using the actual Medicaid expenditures for FY 2018. Finally, for purposes of calculating the states' final FY 2018 DSH allotments, the applicable historical percentage change in the CPI-U for the previous FY (FY 2017) was 2.1 percent; we note that this is lower than the estimated 2.4 percentage change in the CPI-U for FY 2017 that was available and used in the calculation of the preliminary FY 2018 DSH allotments which were published in the July 6, 2018 **Federal Register** (83 FR 31536).

2. Calculation of the Preliminary FY 2020 Federal Share State DSH Allotments

Addendum 2 to this notice provides the preliminary FY 2020 DSH allotments determined in accordance with section 1923(f)(3) of the Act. The preliminary FY 2020 DSH allotments contained in this notice were determined based on the most recent available estimates from states of their FY 2020 total computable Medicaid expenditures. Also, the preliminary FY 2020 allotments contained in this notice were determined by increasing the preliminary FY 2019 DSH allotments. The estimated percentage increase in the CPI-U for FY 2019 was 1.9 percent (CMS

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originally published the preliminary FY 2019 DSH allotments in the February 11, 2019 **Federal Register** (84 FR 3169)).

We will publish states' final FY 2020 DSH allotments in a future notice based on the states' four quarterly Medicaid expenditure reports (Form CMS-64) for FY 2020 available following the end of FY 2020 utilizing the actual change in the CPI-U for FY 2019.

B. Calculation of the Final FY 2018 and Preliminary FY 2020 IMD DSH Limits

Section 1923(h) of the Act specifies the methodology to be used to establish the limits on the amount of DSH payments that a state can make to IMDs and other mental health facilities. FFP is not available for DSH payments to IMDs or other mental health facilities that exceed the IMD DSH limits. In this notice, we are publishing the final FY 2018 and the preliminary FY 2020 IMD DSH limits determined in accordance with the provisions discussed above.

Addendums 3 and 4 to this notice detail each state's final FY 2018 and preliminary FY 2020 IMD DSH limit, respectively, determined in accordance with section 1923(h) of the Act.

III. Collection of Information Requirements

As it relates to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), this notice does not impose any new or revised collection of information requirements or burden. While discussed in section I.B. and in Addendums 3 and 4 of this notice, the requirements and burden associated with Form CMS-37 and Form CMS-64 are unaffected by this notice. Both forms are approved by the Office of Management and Budget (OMB) under control number 0938-1265. Since this notice will not impose any new or revised requirements/burden, we are not making any changes under that control number.

IV. Regulatory Impact Analysis

We have examined the impact of this notice as required by Executive Order 12866 on

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Regulatory Planning and Review (September 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4; enacted on March 22, 1995) (UMRA '95), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This notice reaches the \$100 million economic threshold and thus is considered a major rule under the Congressional Review Act.

The final FY 2018 DSH allotments being published in this notice are \$36 million less than the preliminary FY 2018 DSH allotments published in the July 6, 2018 **Federal Register** (83 FR31536). This is due to the actual percentage change in the CPI-U for FY 2017 used in the calculation of the final FY 2018 allotments (2.1 percent) being less than the estimated percentage change in the CPI-U for FY 2017 used in the calculation of the preliminary FY 2018 allotments (2.4 percent). The final FY 2018 IMD DSH limits being published in this notice are \$2.4 million less than the preliminary FY 2018 IMD DSH limits published in the July 6, 2018 **Federal Register** (83 FR 31536). Since the final FY 2018 DSH allotments were less than the preliminary FY 2018 DSH allotments, the associated FY 2018 IMD DSH limits also decreased.

The preliminary FY 2020 DSH allotments being published in this notice have been

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increased by approximately \$201 million more than the preliminary FY 2019 DSH allotments published in the February 11, 2019 **Federal Register** (84 FR3169). The increase in the DSH allotments is due to the application of the statutory formula for calculating DSH allotments under which the prior fiscal year allotments are increased by the percentage increase in the CPI-U for the prior fiscal year. The preliminary FY 2020 IMD DSH limits being published in this notice are approximately \$20 million more than the preliminary FY 2019 IMD DSH limits published in the February 11, 2019 **Federal Register** (84 FR 3169). The increases in the IMD DSH limits are because the DSH allotment for a FY is a factor in the determination of the IMD DSH limit for the FY. Since the preliminary FY 2020 DSH allotments are greater than the preliminary FY 2019 DSH allotments, the associated preliminary FY 2020 IMD DSH limits for some states also increased.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any one year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have significant economic impact on a substantial number of small entities. Specifically, any impact on providers is due to the effect of the various controlling statutes; providers are not impacted as a result of the independent regulatory action in publishing this notice. The purpose of the notice is to announce the latest DSH allotments and IMD DSH limits, as required by the statute.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis

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if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area for Medicaid payment regulations and has fewer than 100 beds. We are not preparing analysis for section 1102(b) of the Act because the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

The Medicaid statute specifies the methodology for determining the amounts of states' DSH allotments and IMD DSH limits; and as described previously, the application of the methodology specified in statute results in the decreases or increases in states' DSH allotments and IMD DSH limits for the applicable FYs. The statute applicable to these allotments and limits does not apply to the determination of the amounts of DSH payments made to specific DSH hospitals; rather, these allotments and limits represent an overall limit on the total of such DSH payments. For this reason, we do not believe that this notice will have a significant economic impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately \$150 million. This notice will have no consequential effect on spending by state, local, or tribal governments, in the aggregate, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has

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Federalism implications. Since this notice does not impose any costs on state or local governments or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017. It has been determined that this notice is a transfer rule and is not a regulatory action for the purposes of Executive Order 13771.

A. Alternatives Considered

The methodologies for determining the states’ fiscal year DSH allotments and IMD DSH limits, as reflected in this notice, were established in accordance with the methodologies and formula for determining states’ allotments and limits as specified in statute. This notice does not put forward any further discretionary administrative policies for determining such allotments and limits, or otherwise.

B. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 1, we have prepared an accounting statement showing the classification of the estimated expenditures associated with the provisions of this notice. Table 1 provides our best estimate of the change (decrease) in the federal share of states’ Medicaid DSH payments resulting from the application of the provisions of the Medicaid statute relating to the calculation of states’ FY DSH allotments and the increase in the FY DSH allotments from FY 2019 to FY 2020.

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TABLE 1: Accounting Statement: Classification of Estimated Expenditures, from the FY 2019 to FY 2020 (in Millions)

Category	TRANSFERS
Annualized Monetized Transfers	\$201
From Whom To Whom?	Federal Government to States

C. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

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Dated: _____.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: _____.

Alex M Azar II,

Secretary,

Department of Health and Human Services.

Key to ADDENDUM 1: Final DSH Allotments for FY 2018.

The Final FY 2018 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Final FY 2018 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.	
Column	Description
Column A	State.
Column B	FY 2018 FMAPs. This column contains the States' FY 2018 Federal Medical Assistance Percentages.
Column C	Prior FY (2017) DSH Allotments This column contains the States' prior FY 2017 DSH Allotments.
Column D	Prior FY (2017) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 102.1 percent. This column contains the amount in Column C increased by 1 plus the percentage increase in the CPI-U for the prior FY (102.1 percent).
Column E	FY 2018 TC MAP Exp. Including DSH. This column contains the amount of the States' FY 2018 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2018 TC DSH Expenditures. This column contains the amount of the States' FY 2018 total computable DSH expenditures.
Column G	FY 2018 TC MAP Exp. Net of DSH. This column contains the amount of the States' FY 2018 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2017 Allotment or 12 percent Limit. This column contains the greater of the State's prior FY (FY 2017) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2018 DSH Allotment. This column contains the States' final FY 2018 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 1: FINAL DSH ALLOTMENTS FOR FISCAL YEAR: 2018

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Key to ADDENDUM 2: Preliminary DSH Allotments for FY 2020.

The Preliminary FY 2020 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Preliminary FY 2020 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.	
Column	Description
Column A	State.
Column B	FY 2020 FMAPs. This column contains the States' FY 2020 Federal Medical Assistance Percentages.
Column C	Prior FY (2019) DSH Allotments This column contains the States' prior preliminary FY 2019 DSH Allotments.
Column D	Prior FY (2019) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 101.9percent. This column contains the amount in Column C increased by 1 plus the estimated percentage increase in the CPI-U for the prior FY (101.9 percent).
Column E	FY 2020 TC MAP Exp. Including DSH. This column contains the amount of the States' projected FY 2020 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2020 TC DSH Expenditures. This column contains the amount of the States' projected FY 2020 total computable DSH expenditures.
Column G	FY 2020 TC MAP Exp. Net of DSH. This column contains the amount of the States' projected FY 2020 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2019 Allotment or 12 percent Limit. This column contains the greater of the State's preliminary prior FY (FY 2019) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2020 DSH Allotment. This column contains the States' preliminary FY 2020 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 2: PRELIMINARY DSH ALLOTMENTS FOR FISCAL YEAR: 2019

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Key to ADDENDUM 3: Final IMD DSH Limits for FY 2018

The final FY 2018 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2018 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.

Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2018 Federal Share DSH Allotment. This column contains the states' FY 2018 DSH allotments from Addendum 1, Column J.
Column G	FY 2018 FMAP.
Column H	FY 2018 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2018 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2018 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2018 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2018 TC IMD DSH Limit. Lesser of Col. I or C This column contains the total computable FY 2018 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2018 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2018 Federal Share IMD DSH limit determined by converting the total computable FY 2018 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2018 FMAP in Column G.

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ADDENDUM 3: FINAL IMD DSH LIMIT FOR FY: 2018

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Key to ADDENDUM 4: Preliminary IMD DSH Limits for FY 2020

The preliminary FY 2020 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2020 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.	
Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2020 Federal Share DSH Allotment. This column contains the states' preliminary FY 2020 DSH allotments from Addendum 1, Column J.
Column G	FY 2020 FMAP.
Column H	FY 2020 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2020 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2020 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2020 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2020 TC IMD DSH Limit. Lesser of Col. I or C. This column contains the total computable FY 2020 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2020 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2020 Federal Share IMD DSH limit determined by converting the total computable FY 2020 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2020 FMAP in Column G.

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ADDENDUM 4: PRELIMINARY IMD DSH LIMIT FOR FISCAL YEAR: 2020

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	A	B	C	D	E	F	G	H	I	J	K	L
1									FINAL IMD DSH LIMIT FOR FY:			2018
2	A	B	C	D	E	F	G	H	I	J	K	L
3		Inpatient Hospital	IMD And	Total Inpatient & IMD &	Applicable	FY 2018	FY 2018	FY 2018	Applicable Percentage	FY 2018	FY 2018	MMA
4		Services FY 95 DSH	Mental Health	Mental Health FY 95 DSH	Percent	Allotment	FMAPs	Allotments	Applied to FY 2018	TC IMD Limit	IMD Limit	LOW DSH
5	STATE	Total Computable	Services FY 95 DSH	Total Computable				in TC	Allotments in TC	(Lesser Of	In FS	STATUS
6			Total Computable	Col B + C	Col C/D	In FS		Col F/G	Col E x Col H	Col I or Col C)	Col G x J	
7	ALABAMA	\$413,006,229	\$4,451,770	\$417,457,999	1.07%	\$344,614,197	71.44%	\$482,382,695	\$5,144,127	\$4,451,770	\$3,180,344	N/A
8	ARIZONA	\$93,916,100	\$28,474,900	\$122,391,000	23.27%	\$113,470,529	69.89%	\$162,355,886	\$37,772,938	\$28,474,900	\$19,901,108	N/A
9	CALIFORNIA	\$2,189,879,543	\$1,555,919	\$2,191,435,462	0.07%	\$1,228,563,619	50.00%	\$2,457,127,238	\$1,744,560	\$1,555,919	\$777,960	N/A
10	COLORADO	\$173,900,441	\$594,776	\$174,495,217	0.34%	\$103,664,433	50.00%	\$207,328,866	\$706,691	\$594,776	\$297,388	N/A
11	CONNECTICUT	\$303,359,275	\$105,573,725	\$408,933,000	25.82%	\$224,139,315	50.00%	\$448,278,630	\$115,731,537	\$105,573,725	\$52,786,863	N/A
12	DISTRICT OF COLUMBIA	\$39,532,234	\$6,545,136	\$46,077,370	14.20%	\$68,642,665	70.00%	\$98,060,950	\$13,929,229	\$6,545,136	\$4,581,595	N/A
13	FLORIDA	\$184,468,014	\$149,714,986	\$334,183,000	33.00%	\$224,139,315	61.79%	\$362,743,672	\$119,705,412	\$119,705,412	\$73,965,974	N/A
14	GEORGIA	\$407,343,557	\$0	\$407,343,557	0.00%	\$301,187,205	68.50%	\$439,689,350	\$0	\$0	\$0	N/A
15	ILLINOIS	\$315,868,508	\$89,408,276	\$405,276,784	22.06%	\$240,949,764	50.74%	\$474,871,431	\$104,761,579	\$89,408,276	\$45,365,759	N/A
16	INDIANA	\$79,960,783	\$153,566,302	\$233,527,085	33.00%	\$239,548,895	65.59%	\$365,221,673	\$120,523,152	\$120,523,152	\$79,061,135	N/A
17	KANSAS	\$11,587,208	\$76,663,508	\$88,250,716	33.00%	\$46,228,733	54.74%	\$84,451,467	\$27,868,984	\$27,868,984	\$15,255,482	N/A
18	KENTUCKY	\$158,804,908	\$37,443,073	\$196,247,981	19.08%	\$162,501,004	71.17%	\$228,327,953	\$43,563,761	\$37,443,073	\$26,648,235	N/A
19	LOUISIANA	\$1,078,512,169	\$132,917,149	\$1,211,429,318	10.97%	\$768,420,420	63.69%	\$1,206,500,895	\$132,376,406	\$132,376,406	\$84,310,533	N/A
20	MAINE	\$99,957,958	\$60,958,342	\$160,916,300	33.00%	\$117,673,139	64.34%	\$182,892,662	\$60,354,579	\$60,354,579	\$38,832,136	N/A
21	MARYLAND	\$22,226,467	\$120,873,531	\$143,099,998	33.00%	\$85,453,115	50.00%	\$170,906,230	\$56,399,056	\$56,399,056	\$28,199,528	N/A
22	MASSACHUSETTS	\$469,653,946	\$105,635,054	\$575,289,000	18.36%	\$341,812,455	50.00%	\$683,624,910	\$125,527,786	\$105,635,054	\$52,817,527	N/A
23	MICHIGAN	\$133,258,800	\$304,765,552	\$438,024,352	33.00%	\$296,984,593	64.78%	\$458,451,054	\$151,288,848	\$151,288,848	\$98,004,916	N/A
24	MISSISSIPPI	\$182,608,033	\$0	\$182,608,033	0.00%	\$170,906,227	75.65%	\$225,917,022	\$0	\$0	\$0	N/A
25	MISSOURI	\$521,946,524	\$207,234,618	\$729,181,142	28.42%	\$530,930,002	64.61%	\$821,745,863	\$233,541,681	\$207,234,618	\$133,894,287	N/A
26	NEVADA	\$73,560,000	\$0	\$73,560,000	0.00%	\$51,832,216	65.75%	\$78,832,268	\$0	\$0	\$0	N/A
27	NEW HAMPSHIRE	\$92,675,916	\$94,753,948	\$187,429,864	33.00%	\$179,421,865	50.00%	\$358,843,730	\$118,418,431	\$94,753,948	\$47,376,974	N/A
28	NEW JERSEY	\$736,742,539	\$357,370,461	\$1,094,113,000	32.66%	\$721,448,421	50.00%	\$1,442,896,842	\$471,293,833	\$357,370,461	\$178,685,231	N/A
29	NEW YORK	\$2,418,869,368	\$605,000,000	\$3,023,869,368	20.01%	\$1,800,118,873	50.00%	\$3,600,237,746	\$720,316,777	\$605,000,000	\$302,500,000	N/A
30	NORTH CAROLINA	\$193,201,966	\$236,072,627	\$429,274,593	33.00%	\$330,605,489	67.61%	\$488,989,039	\$161,366,383	\$161,366,383	\$109,099,811	N/A
31	OHIO	\$535,731,956	\$93,432,758	\$629,164,714	14.85%	\$455,282,985	62.78%	\$725,203,863	\$107,694,846	\$93,432,758	\$58,657,085	N/A
32	PENNSYLVANIA	\$388,207,319	\$579,199,682	\$967,407,001	33.00%	\$628,990,952	51.82%	\$1,213,799,599	\$400,553,868	\$400,553,868	\$207,567,014	N/A
33	RHODE ISLAND	\$108,503,167	\$2,397,833	\$110,901,000	2.16%	\$72,845,277	51.45%	\$141,584,601	\$3,061,255	\$2,397,833	\$1,233,685	N/A
34	SOUTH CAROLINA	\$366,681,364	\$72,076,341	\$438,757,705	16.43%	\$367,028,128	71.58%	\$512,752,344	\$84,231,712	\$72,076,341	\$51,592,245	N/A
35	TENNESSEE	\$0	\$0	\$0	0.00%	\$53,100,000	65.82%	\$80,674,567	\$0	\$0	\$0	N/A
36	TEXAS	\$1,220,515,401	\$292,513,592	\$1,513,028,993	19.33%	\$1,071,666,101	56.88%	\$1,884,082,456	\$364,249,284	\$292,513,592	\$166,381,731	N/A
37	VERMONT	\$19,979,252	\$9,071,297	\$29,050,549	31.23%	\$25,215,675	53.47%	\$47,158,547	\$14,725,683	\$9,071,297	\$4,850,423	N/A
38	VIRGINIA	\$129,313,480	\$7,770,268	\$137,083,748	5.67%	\$98,181,508	50.00%	\$196,363,016	\$11,130,373	\$7,770,268	\$3,885,134	N/A
39	WASHINGTON	\$171,725,815	\$163,836,435	\$335,562,250	33.00%	\$207,328,867	50.00%	\$414,657,734	\$136,837,052	\$163,837,052	\$68,418,526	N/A
40	WEST VIRGINIA	\$66,962,606	\$18,887,045	\$85,849,651	22.00%	\$75,647,019	73.24%	\$103,286,481	\$22,723,172	\$18,887,045	\$13,832,872	N/A
41	TOTAL	\$13,402,460,846	\$4,118,758,904	\$17,521,219,750		\$11,748,543,001		\$20,850,241,279	\$3,967,542,995	\$3,507,464,529	\$1,971,951,501	
42												
43	LOW DSH STATES											
44	ALASKA	\$2,506,827	\$17,611,765	\$20,118,592	33.00%	\$22,828,245	50.00%	\$45,656,490	\$15,066,642	\$15,066,642	\$7,533,321	LOW DSH
45	ARKANSAS	\$2,422,649	\$819,351	\$3,242,000	25.27%	\$48,344,366	70.87%	\$68,215,558	\$17,240,125	\$819,351	\$580,674	LOW DSH
46	DELAWARE	\$0	\$7,069,000	\$7,069,000	33.00%	\$10,145,886	56.43%	\$17,979,596	\$5,933,267	\$5,933,267	\$3,348,142	LOW DSH
47	HAWAII	\$0	\$0	\$0	0.00%	\$10,922,076	54.78%	\$19,938,072	\$0	\$0	\$0	LOW DSH
48	IDAHO	\$2,081,429	\$0	\$2,081,429	0.00%	\$18,421,452	71.17%	\$25,883,732	\$0	\$0	\$0	LOW DSH
49	IOWA	\$12,011,250	\$0	\$12,011,250	0.00%	\$44,134,308	58.48%	\$75,469,063	\$0	\$0	\$0	LOW DSH
50	MINNESOTA	\$24,240,000	\$5,257,214	\$29,497,214	17.82%	\$83,703,566	50.00%	\$167,407,132	\$29,836,551	\$5,257,214	\$2,628,607	LOW DSH
51	MONTANA	\$237,048	\$0	\$237,048	0.00%	\$12,720,775	65.38%	\$19,456,676	\$0	\$0	\$0	LOW DSH
52	NEBRASKA	\$6,449,102	\$1,811,337	\$8,260,439	21.93%	\$31,713,720	52.55%	\$60,349,610	\$13,233,374	\$1,811,337	\$951,858	LOW DSH
53	NEW MEXICO	\$6,490,015	\$254,786	\$6,744,801	3.78%	\$22,828,245	72.16%	\$31,635,595	\$1,195,040	\$254,786	\$183,854	LOW DSH
54	NORTH DAKOTA	\$214,523	\$988,478	\$1,203,001	33.00%	\$10,704,873	50.00%	\$21,409,746	\$7,065,216	\$988,478	\$494,239	LOW DSH
55	OKLAHOMA	\$20,019,969	\$3,273,248	\$23,293,217	14.05%	\$40,583,544	58.57%	\$69,290,668	\$9,736,978	\$3,273,248	\$1,917,141	LOW DSH
56	OREGON	\$11,437,908	\$19,975,092	\$31,413,000	33.00%	\$50,729,435	63.62%	\$79,738,188	\$26,313,602	\$19,975,092	\$12,708,154	LOW DSH
57	SOUTH DAKOTA	\$321,120	\$751,299	\$1,072,419	33.00%	\$12,377,698	55.34%	\$22,366,639	\$7,380,991	\$751,299	\$415,769	LOW DSH
58	UTAH	\$3,621,116	\$934,586	\$4,555,702	20.51%	\$21,985,808	70.26%	\$31,292,069	\$6,419,456	\$934,586	\$656,640	LOW DSH
59	WISCONSIN	\$6,609,524	\$4,492,011	\$11,101,535	33.00%	\$105,942,609	58.77%	\$180,266,478	\$59,487,938	\$4,492,011	\$2,639,955	LOW DSH
60	WYOMING	\$0	\$0	\$0	0.00%	\$253,647	50.00%	\$507,294	\$0	\$0	\$0	LOW DSH
61	TOTAL LOW DSH STATES	\$98,662,480	\$63,238,167	\$161,900,647		\$548,340,253		\$936,862,605	\$198,909,179	\$59,557,310	\$34,058,354	
62												
63	TOTAL	\$13,501,123,326	\$4,181,997,071	\$17,683,120,397		\$12,296,883,254		\$21,787,103,884	\$4,166,452,175	\$3,567,021,839	\$2,006,009,855	
64	FOOTNOTES											
65	* Tennessee's DSH allotment for FY 2018, determined under section 1923(f)(6)(A) of the Act, is \$53,100,000.											

	A	B	C	D	E	F	G	H	I	J	K	L	
1								PRELIMINARY IMD DSH LIMIT FOR FISCAL YEAR:				2020	
2	A	B	C	D	E	F	G	H	I	J	K	L	
3		Inpatient Hospital	IMD And	Total Inpatient & IMD &	Applicable	FY 2020	FY 2020	FY 2020	Applicable Percentage	FY 2020	FY 2020	MMA	
4		Services FY 95 DSH	Mental Health	Mental Health FY 95 DSH	Percent	Allotment	FMAPs	Allotments	Applied to FY 2020	TC IMD Limit	IMD Limit	LOW DSH	
5	STATE	Total Computable	Services FY 95 DSH	Total Computable				in TC	Allotments in TC	(Lesser Of	In FS	STATUS	
6			Total Computable	Col B + C	Col C/D	In FS		Col F/G	Col E x Col H	Col I or Col C)	Col G x J		
7	ALABAMA	\$413,006,229	\$4,451,770	\$417,457,999	1.07%	\$359,589,752	71.97%	\$499,638,394	\$5,328,141	\$4,451,770	\$3,203,939	N/A	
8	ARIZONA	\$93,916,100	\$28,474,900	\$122,391,000	23.27%	\$118,401,505	70.02%	\$169,096,694	\$39,341,222	\$28,474,900	\$19,938,125	N/A	
9	CALIFORNIA	\$2,189,879,543	\$1,555,919	\$2,191,435,462	0.07%	\$1,281,952,080	50.00%	\$2,563,904,160	\$1,820,372	\$1,555,919	\$777,960	N/A	
10	COLORADO	\$173,900,441	\$594,776	\$174,495,217	0.34%	\$108,169,274	50.00%	\$216,338,548	\$737,401	\$594,776	\$297,388	N/A	
11	CONNECTICUT	\$303,359,275	\$105,573,725	\$408,933,000	25.82%	\$233,879,514	50.00%	\$467,759,028	\$120,760,768	\$105,573,725	\$52,786,863	N/A	
12	DISTRICT OF COLUMBIA	\$39,532,234	\$6,545,136	\$46,077,370	14.20%	\$71,625,601	70.00%	\$102,322,287	\$14,534,538	\$6,545,136	\$4,581,595	N/A	
13	FLORIDA	\$184,468,014	\$149,714,986	\$334,183,000	33.00%	\$233,879,514	61.47%	\$380,477,491	\$125,557,572	\$125,557,572	\$77,180,240	N/A	
14	GEORGIA	\$407,343,557	\$0	\$407,343,557	0.00%	\$314,275,596	67.30%	\$466,977,111	\$0	\$0	\$0	N/A	
15	ILLINOIS	\$315,868,508	\$89,408,276	\$405,276,784	22.06%	\$251,420,477	50.14%	\$501,436,931	\$110,622,205	\$89,408,276	\$44,829,310	N/A	
16	INDIANA	\$79,960,783	\$153,566,302	\$233,527,085	33.00%	\$249,958,731	65.84%	\$379,645,703	\$125,283,082	\$125,283,082	\$82,486,381	N/A	
17	KANSAS	\$11,587,208	\$76,663,508	\$88,250,716	33.00%	\$48,237,649	59.16%	\$81,537,608	\$26,907,411	\$26,907,411	\$15,918,424	N/A	
18	KENTUCKY	\$158,804,908	\$37,443,073	\$196,247,981	19.08%	\$169,562,648	71.82%	\$236,093,913	\$45,045,465	\$37,443,073	\$26,891,615	N/A	
19	LOUISIANA	\$1,078,512,169	\$132,917,149	\$1,211,429,318	10.97%	\$801,812,898	66.86%	\$1,199,241,547	\$131,579,916	\$131,579,916	\$87,974,332	N/A	
20	MAINE	\$99,957,958	\$60,958,342	\$160,916,300	33.00%	\$122,786,743	63.80%	\$192,455,710	\$63,510,384	\$60,958,342	\$38,891,422	N/A	
21	MARYLAND	\$22,226,467	\$120,873,531	\$143,099,998	33.00%	\$89,166,566	50.00%	\$178,333,132	\$58,849,934	\$58,849,934	\$29,424,967	N/A	
22	MASSACHUSETTS	\$469,653,946	\$105,635,054	\$575,289,000	18.36%	\$356,666,257	50.00%	\$713,332,514	\$130,982,721	\$105,635,054	\$52,817,527	N/A	
23	MICHIGAN	\$133,258,800	\$304,765,552	\$438,024,352	33.00%	\$309,890,355	64.06%	\$483,750,164	\$159,637,554	\$159,637,554	\$102,263,817	N/A	
24	MISSISSIPPI	\$182,608,033	\$0	\$182,608,033	0.00%	\$178,333,128	76.98%	\$231,661,637	\$0	\$0	\$0	N/A	
25	MISSOURI	\$521,946,524	\$207,234,618	\$729,181,142	28.42%	\$554,002,096	65.65%	\$843,872,195	\$239,830,026	\$207,234,618	\$136,049,527	N/A	
26	NEVADA	\$73,560,000	\$0	\$73,560,000	0.00%	\$54,084,637	63.93%	\$84,599,776	\$0	\$0	\$0	N/A	
27	NEW HAMPSHIRE	\$92,675,916	\$94,753,948	\$187,429,864	33.00%	\$187,218,822	50.00%	\$374,437,644	\$123,564,423	\$94,753,948	\$47,376,974	N/A	
28	NEW JERSEY	\$736,742,539	\$357,370,461	\$1,094,113,000	32.66%	\$752,799,683	50.00%	\$1,505,599,366	\$491,774,378	\$357,370,461	\$178,685,231	N/A	
29	NEW YORK	\$2,418,869,368	\$605,000,000	\$3,023,869,368	20.01%	\$1,878,344,839	50.00%	\$3,756,689,678	\$751,618,863	\$605,000,000	\$302,500,000	N/A	
30	NORTH CAROLINA	\$193,201,966	\$236,072,627	\$429,274,593	33.00%	\$344,972,281	67.03%	\$514,653,560	\$169,835,675	\$169,835,675	\$113,840,853	N/A	
31	OHIO	\$535,731,956	\$93,432,758	\$629,164,714	14.85%	\$475,067,763	63.02%	\$753,836,501	\$111,946,875	\$93,432,758	\$58,881,324	N/A	
32	PENNSYLVANIA	\$388,207,319	\$579,199,862	\$967,407,001	33.00%	\$656,324,383	52.25%	\$1,256,123,221	\$414,520,663	\$414,520,663	\$216,587,046	N/A	
33	RHODE ISLAND	\$108,503,167	\$2,397,833	\$110,901,000	2.16%	\$76,010,842	52.95%	\$143,552,110	\$2,397,833	\$2,397,833	\$1,269,653	N/A	
34	SOUTH CAROLINA	\$366,681,364	\$72,076,341	\$438,757,705	16.43%	\$382,977,702	70.70%	\$541,694,062	\$88,986,075	\$72,076,341	\$50,957,973	N/A	
35	TENNESSEE*	\$0	\$0	\$0	0.00%	\$53,100,000	65.21%	\$81,429,229	\$0	\$0	\$0	N/A	
36	TEXAS	\$1,220,515,401	\$292,513,592	\$1,513,028,993	19.33%	\$1,118,236,423	60.89%	\$1,836,486,160	\$355,047,501	\$292,513,592	\$178,111,526	N/A	
37	VERMONT	\$19,979,252	\$9,071,297	\$29,050,549	31.23%	\$26,311,447	53.86%	\$48,851,554	\$15,254,340	\$9,071,297	\$4,885,801	N/A	
38	VIRGINIA	\$129,313,480	\$7,770,268	\$137,083,748	5.67%	\$102,448,083	50.00%	\$204,896,166	\$11,614,055	\$7,770,268	\$3,885,134	N/A	
39	WASHINGTON	\$171,725,815	\$163,836,435	\$335,562,250	33.00%	\$216,338,550	50.00%	\$432,677,100	\$142,783,443	\$142,783,443	\$71,391,722	N/A	
40	WEST VIRGINIA	\$66,962,606	\$18,887,045	\$85,849,651	22.00%	\$78,934,335	74.94%	\$105,330,044	\$23,172,759	\$18,887,045	\$14,153,952	N/A	
41	TOTAL	\$13,402,460,846	\$4,118,758,904	\$17,521,219,750		\$12,256,780,174		\$21,548,730,937	\$4,103,551,554	\$3,556,104,381	\$2,018,840,621		
42													
43	LOW DSH STATES												
44	ALASKA	\$2,506,827	\$17,611,765	\$20,118,592	33.00%	\$23,820,269	50.00%	\$47,640,538	\$15,721,378	\$15,721,378	\$7,860,689	LOW DSH	
45	ARKANSAS	\$2,422,649	\$819,351	\$3,242,000	25.27%	\$50,445,219	71.42%	\$70,631,782	\$17,850,778	\$819,351	\$585,180	LOW DSH	
46	DELAWARE	\$0	\$7,069,000	\$7,069,000	33.00%	\$10,586,785	57.86%	\$18,297,243	\$6,038,090	\$6,038,090	\$3,493,639	LOW DSH	
47	HAWAII	\$0	\$0	\$0	0.00%	\$11,396,706	53.47%	\$21,314,206	\$0	\$0	\$0	LOW DSH	
48	IDAHO	\$2,081,429	\$0	\$2,081,429	0.00%	\$19,221,975	70.34%	\$27,327,232	\$0	\$0	\$0	LOW DSH	
49	IOWA	\$12,011,250	\$0	\$12,011,250	0.00%	\$46,052,208	61.20%	\$75,248,706	\$0	\$0	\$0	LOW DSH	
50	MINNESOTA	\$24,240,000	\$5,257,214	\$29,497,214	17.82%	\$87,340,989	50.00%	\$174,681,978	\$31,133,128	\$5,257,214	\$2,628,607	LOW DSH	
51	MONTANA	\$237,048	\$0	\$237,048	0.00%	\$13,273,569	64.78%	\$20,490,227	\$0	\$0	\$0	LOW DSH	
52	NEBRASKA	\$6,449,102	\$1,811,337	\$8,260,439	21.93%	\$33,091,871	54.72%	\$60,474,910	\$13,260,850	\$1,811,337	\$991,164	LOW DSH	
53	NEW MEXICO	\$6,490,015	\$254,786	\$6,744,801	3.78%	\$23,820,269	72.71%	\$32,760,651	\$1,237,539	\$254,786	\$185,255	LOW DSH	
54	NORTH DAKOTA	\$214,523	\$988,478	\$1,203,001	33.00%	\$11,170,064	50.05%	\$22,317,810	\$7,364,877	\$988,478	\$494,733	LOW DSH	
55	OKLAHOMA	\$20,019,969	\$3,273,248	\$23,293,217	14.05%	\$42,347,142	66.02%	\$64,142,899	\$9,013,595	\$3,273,248	\$2,160,998	LOW DSH	
56	OREGON	\$11,437,908	\$19,975,092	\$31,413,000	33.00%	\$52,933,933	61.23%	\$86,450,977	\$28,528,822	\$19,975,092	\$12,230,749	LOW DSH	
57	SOUTH DAKOTA	\$321,120	\$751,299	\$1,072,419	33.00%	\$12,915,583	57.62%	\$22,415,104	\$7,396,984	\$751,299	\$432,898	LOW DSH	
58	UTAH	\$3,621,116	\$934,586	\$4,555,702	20.51%	\$22,941,223	68.19%	\$33,643,090	\$6,901,760	\$934,586	\$637,294	LOW DSH	
59	WISCONSIN	\$6,609,524	\$4,492,011	\$11,101,535	33.00%	\$110,546,451	59.36%	\$186,230,544	\$61,456,080	\$4,492,011	\$2,666,458	LOW DSH	
60	WYOMING	\$0	\$0	\$0	0.00%	\$264,670	50.00%	\$529,340	\$0	\$0	\$0	LOW DSH	
61	TOTAL LOW DSH STATES	\$98,662,480	\$63,238,167	\$161,900,647		\$572,168,926		\$964,597,238	\$205,903,881	\$60,316,870	\$34,367,664		
62													
63	TOTAL	\$13,501,123,326	\$4,181,997,071	\$17,683,120,397		\$12,828,949,100		\$22,513,328,175	\$4,309,455,435	\$3,616,421,251	\$2,053,208,285		
64	FOOTNOTES												
65	* Tennessee's DSH allotment for FY 2020, determined under section 1923(f)(6)(A) of the Act, is \$53,100,000.												

RE: RE: Missouri DSH Audit Review 2016

From: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
To: "Wong, Mark I. (CMS/CMCS)" <mark.wong@cms.hhs.gov>
Cc: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Wed, 29 Jan 2020 14:13:44 +0000

Mark,

I'll discuss this at our next DSH meeting (if not sooner) to see how this should be handled. We will also probably need to loop in Todd to see how he would like to approach things moving forward.

Rich

From: Wong, Mark I. (CMS/CMCS) <Mark.Wong@cms.hhs.gov>
Sent: Monday, January 27, 2020 3:01 PM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Subject: Missouri DSH Audit Review 2016

Hey Rich –

I took over review of Missouri's 2016 DSH audit submission with Tim's retirement and our reorg. I did my completeness and content reviews and have drafted up some questions, but I am not sure whether I should send them out to the state. I see from Tim's documentation that he did not send Missouri review questions or acknowledgement letter for 2015 (and maybe even prior to that), and I am not sure if it's because Missouri is one of the litigation states or it was for other reasons. I was going to consult with Wendy, but I see that she is now on a detail til April.

Any idea or advice on how to proceed with my review questions for 2016? Do you have any history or background?

Thanks!
Mark

FW: FW: Clearance requested by the DSH team - acknowledgement letter for SFY 2016 DSH audits

From: "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
To: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>
Date: Fri, 10 Jan 2020 16:38:51 +0000
Attachments: Draft SFY 2016 DSH Acknowledgement ltr-tlas.docx (64.4 kB); Final DSH Audit and Reporting Acknowledgement Letter Template - SPRY 201....docx (95.29 kB); Final Incomplete DSH Acknowledgement Letter Template.doc (125.44 kB)

FYI

From: Sampson, Tamara L. (CMS/CMCS)
Sent: Friday, January 10, 2020 11:35 AM
To: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: Clearance requested by the DSH team - acknowledgement letter for SFY 2016 DSH audits

Good Morning,

I am helping out Todd.

- Attached is the draft SFY 2016 DSH acknowledgement letter. It is a shorten template that was used last year. Please review and send me your comments.
- Does this letter need to be cleared by OGC, especially with the past litigations?
- Does the DSH team want the new DRR analysts to utilize this new shorten template or the 'old' acknowledgement letters? It included information about the overpayments.
- What is our position is as it relates to overpayments?
- What template should the new DRR analysts use for overpayments?
- What is the deadline for transferring the SFY 2016 DSH audit to the NIRT drive?
- What is the deadline for completing the completeness reviews?
- What is the deadline for completing the content reviews

Attached are two examples letters utilized from SFY 2012 to use as a reference. They are the incomplete and acknowledgement letters that staff used for the SFY 2012 DSH audits.

If we need a call, then please send me an email. I will be happy to arrange a brief call.

We appreciate your assistance in this matter.

Tammy

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



March xx, 2016

Ms. Julie Hamos, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear Ms. Hamos:

The purpose of this letter is to acknowledge receipt of your September 21, 2011 submission of Illinois' state plan rate year (SPRY) 2012 Disproportionate Share Hospital (DSH) audit and report. After an initial screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have been included in your submission. This acknowledgement, however, does not constitute notice of a completed review or approval of the content of the state's submission. CMS received the following in your submission package:

- SPRY 2012 Illinois Department of HealthCare And Family Services Independent Audit of DSH Verifications
- SPRY 2012 Myers and Stauffer Statement of Independence

As you know, CMS promulgated CMS-2198-F on December 19, 2008, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. Statute requires that states submit an annual report and an independent certified audit in order to receive Federal Financial Participation (FFP). Additionally, CMS promulgated CMS-2315-F on December 3, 2014, which applies to audits beginning with SPRY 2011. The rule modifies the definition of uninsured for purposes of Medicaid DSH from an individual-specific basis to a service-specific basis.

To facilitate the audit and reporting process, CMS issued to states the following guidance relating to the final rule (these materials are available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>):

- General DSH Audit and Reporting Protocol
- DSH Report Format
- Operational Guidance Letter dated July 27, 2009
- Additional Information on the DSH Reporting and Audit Requirements

- Additional Information on the DSH Reporting and Audit Requirements – Part 2

CMS has initiated a preliminary review of the state's current submission. This review will be conducted based only on the submitted materials listed above. CMS recognizes that the state may have included in its initial submission only materials that it determined relevant, and encourages the state to submit any additional material or supporting documentation that was not originally included with the initial submission.

Please note that to the extent that audit findings demonstrate the DSH payments exceed the documented hospital-specific limits, these payments will be treated as overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, trigger the return of the federal share to the federal government. Any portion of overpayments not returned to CMS within one year of discovery are subject to disallowance per 42 CFR 430.42 and imputed interest per 42 CFR 433.320(a)(4). However, if the excess DSH payments are redistributed by the state to other qualifying hospitals as an integral part of the audit process, and in accordance with a federally approved Medicaid state plan provision, the federal share is not required to be returned.

The federal portion of overpayments not subject to redistribution must be returned in accordance with 42 CFR Part 433 Subpart F. The correct accounting for any redistributed DSH payments requires two separate entries on the CMS-64 Quarterly Expenditure Report, an increasing adjustment on line 7 for DSH payments actually redistributed and a decreasing adjustment on line 10B to report the federal portion of any identified overpayments redistributed in accordance with the approved state plan. Both the increasing and decreasing prior period adjustments should specify the year in which the original DSH payments were distributed, which would be fiscal year 2012 in the case of the audits for SPRY 2012. Finally, the state must specify if the redistribution was reflected on the SPRY data elements spreadsheet submitted as part of the annual audit report submission. If the data element report submitted with the audit report did not reflect the redistribution, states should resubmit the data elements spreadsheet to CMS to reflect final DSH payment amounts made to hospitals after redistribution. The revised data elements spreadsheet should be submitted concurrent with the submission of the CMS-64 Report that reflects the redistribution.

We will facilitate further dialogue with your agency and look forward to continued efforts and commitment on behalf of both our agencies in ensuring that the DSH audits and reports comport with section 1923(j) of the Social Security Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance.

CMS remains committed to engaging in open dialogue with the state to discuss this preliminary review and provide technical guidance, as necessary, in an effort to ensure that any adverse financial impact on the Illinois Medicaid program and its hospitals is averted. Thank you in advance for your willingness to continue working with us. Should the state have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Todd McMillion at (608) 441-5344.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

March xx, 2016

Robert Hofmann, Secretary
Agency of Human Services
State of Vermont
103 South Main Street
Waterbury, VT 05676-1201

Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear Mr. Hofmann:

This letter is in response to your December 31, 2015 submission of Vermont's state plan rate year (SPRY) 2012 Disproportionate Share Hospital (DSH) audit and report. We appreciate the expeditious manner in which you have submitted your materials. After a cursory screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have not been included in your submission.

As you know, CMS promulgated CMS-2198-F on December 19, 2008, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring State reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. Statute requires that States submit an annual report and an independent certified audit in order to receive Federal Financial Participation (FFP). Additionally, CMS promulgated CMS-2315-F on December 3, 2014, which applies to audits beginning with SPRY 2011. The rule modified the definition of uninsured for purposes of Medicaid DSH from an individual-specific basis to a service-specific basis.

To facilitate the audit and reporting process, CMS issued to states the following guidance relating to the final rule (these materials are available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>):

- General DSH Audit and Reporting Protocol
- DSH Report Format
- Operational Guidance Letter dated July 27, 2009
- Additional Information on the DSH Reporting and Audit Requirements
- Additional Information on the DSH Reporting and Audit Requirements – Part 2

In the spirit of this cooperative relationship, CMS has conducted a cursory screening of the state's initial December 31, 2015 submission and acknowledges receipt of the following:

- Independent Accountant's Report from Clifton Gunderson, LLP for SPRY 2012;

- Findings related to the Six Verifications of the Disproportionate Share Hospital Payments Final Rule for the Medicaid SPRY 2012; and
- Disproportionate Share Hospital Data Reporting Form for SPRY 2012.

Upon review of the state's current submission, CMS has determined that the submission does not comport with section 1923(j) of the Social Security Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance. This acknowledgement of receipt and cursory screening, however, does not constitute notice of a completed review or approval of the content of the State's submission. The specific area(s) of concern is/are as follows:

- The State did not report the specific data elements required by statute and regulations.

The final DSH rule provides detailed identification of the 17 data elements necessary to comply with such reporting and auditing requirements expressly contained in statute. The final rule and subsequent guidance provides States with uniform instructions that contain a detailed identification of the necessary data elements to be reported. These data elements should be submitted in an excel spreadsheet format. The DSH Report Format template is available on the CMS website.

The cursory screening was conducted based only on the submitted materials listed above. CMS recognizes that the state may have included in its initial submission only materials that it determined relevant. CMS encourages the state to submit any additional material or supporting documentation that was not originally included with the initial submission.

In order to receive FFP for DSH expenditures, Vermont must submit an annual report and an independent certified audit to CMS for SPRY 2012 that meets federal statutory, regulatory, and policy requirements. Once CMS has determined that the minimum elements required by the DSH rule have been submitted, CMS will complete its preliminary review of the state's submission. Upon completion of its preliminary review, CMS will conduct an in-depth review of audits and reports. CMS may have additional questions that will be addressed to states at that time, including requests for additional documentation to support the audits and reports and the use of the General DSH Audit and Reporting Protocol.

Please note that to the extent that audit findings demonstrate the DSH payments exceed the documented hospital-specific limits, these payments will be treated as overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, trigger the return of the federal share to the federal government. Any portion of overpayments not returned to CMS within one year of discovery are subject to disallowance per 42 CFR 430.42 and imputed interest per 42 CFR 433.320(a)(4). However, if the excess DSH payments are redistributed by the state to other qualifying hospitals as an integral part of the audit process, and in accordance with a federally approved Medicaid state plan provision, the federal share is not required to be returned.

The federal portion of overpayments not subject to redistribution must be returned in accordance with 42 CFR Part 433 Subpart F. The correct accounting for any redistributed DSH payments requires two separate entries on the CMS-64 Quarterly Expenditure Report, an increasing adjustment on line 7 for DSH payments actually redistributed and a decreasing adjustment on line 10B to report the federal portion of any identified overpayments redistributed in accordance with the approved state plan. Both the increasing and decreasing prior period adjustments should specify the year in which the original DSH payments were distributed, which would be fiscal year 2012 in the case of the audits for SPRY 2012. Finally, the state must specify if the redistribution was reflected on the SPRY 2012 data elements spreadsheet submitted as part of the annual audit report submission. If the data element

report submitted with the audit report did not reflect the redistribution, states should resubmit the data elements spreadsheet to CMS to reflect final DSH payment amounts made to hospitals after redistribution. The revised data elements spreadsheet should be submitted concurrent with the submission of the CMS-64 Report that reflects the redistribution.

CMS remains committed to engaging in open dialogue with the state to discuss this preliminary review and provide technical guidance, as necessary, in an effort to ensure that any adverse financial impact on the Vermont Medicaid program and its hospitals is averted. Consistent with this effort, CMS would like to coordinate a conference call with the State to further discuss the above guidance and provide any other assistance necessary. In the interim, we welcome any additional information that you or your staff wish to offer. Should the state have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Novena James-Hailey at (617) 565-1291.

Thank you in advance for your willingness to continue working with us.

Sincerely,

Richard R. McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

DSH TPP Rule Audit question from DRR meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>
Cc: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>
Date: Tue, 14 Jan 2020 19:19:49 +0000

Hi All,

When I presented an update today on the DSH litigation and website updates I was asked a question about the 2017 audits and told the division that I would take it back to the DSH team.

How are states supposed to document they accurately followed the TPP Rule in their audits... should they split out column 20 on the elements spreadsheet? Should they have the auditors speak to it in the narrative of the report? Are we even going to provide a recommendation or simply let the states handle it as they see fit?

Lia, could we add this to the DSH chart along with the other questions Tammy Sampson sent to us?

Thanks,

Wendy L. Harrison, LSW

Technical Advisor to the Group Director, ADS – M, Th & F/Office – Tu & W

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services

Center for Medicaid and CHIP Services

Financial Management Group

Division of Reimbursement and State Financing

7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28

Woodlawn, MD 21244

☎ 410-786-2075 Cell: b6

7 410-786-8533

✉ Wendy.Harrison@cms.hhs.gov

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RE: RE: DSH Agenda and Chart 12.9.19 * Update*

From: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>
Cc: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Mon, 09 Dec 2019 15:20:40 +0000
Attachments: FW: WV Medicaid SPRY 2016 DSH Audit (501.76 kB); FW: NIRT Team Meeting (245.25 kB)

North Carolina Revised GCW

<<...>>

WV SPRY 2016 Audit

<<...>>

From: Adams, Lia (CMS/CMCS)
Sent: Monday, December 9, 2019 9:55 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Cc: Adams, Lia (CMS/CMCS) <lia.adams@cms.hhs.gov>
Subject: RE: DSH Agenda and Chart 12.9.19

Agenda:

1. **Good Cause Waivers**
 - a. **North Carolina**
<< Message: RE: Team Meeting Agenda >>
 - b. **New Jersey**
<< Message: RE: Mary Boosalis SWIFT response >> << Message: FW: NJ SPA Pages Requested >>
 - c. **Process**
2. **OGC Response to Questions**
<< Message: Fwd: Medicaid DSH Third Party Payments - 2017 Rule >>
3. **DSH SWIFT**
<< File: Revised Medicaid DSH webpage v3.docx >>
4. **DSH Litigation and implications OGC – CHAT (district court) additional briefing on effective date and website changes**
<< Message: FW: Medicaid DSH Payment and Third Party Payments >> << Message: FW: NIRT Team Meeting >>
5. **Consultant Question on TPP**
<< File: FMG DSH Overpayments & Redistrib. Qs. 20191114 (CMSDOGCResponses).docx >>

Tracking Chart:

<< File: 12.09.2019 DSH Issues Tracking.xlsx >>

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Sent: Monday, December 2, 2019 10:57 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: DSH Agenda and Chart 12.2.19

Tracking Chart

<< Message: FW: NIRT Team Meeting >>

Agenda:

1. **Reductions – updates by Rory**
2. **OGC Response to Questions**
 - **California TCF DSH Question**
 - **Colorado Overpayment and Redistribution**
<< Message: RE: Medicaid DSH Third Party Payments - 2017 Rule >>
3. **MO-IMD DSH Opinion**
 - **Meeting scheduled for 12/2 1-2pm**
<< Message: RE: Medicaid DSH Third Party Payments - 2017 Rule >>
4. **SWIFT – Boosalis – response requested by 12/3**
<< Message: RE: NEW SWIFT CONTROL: Boosalis_103020194026 >>
5. **2017 TPP Rule – effective date**
<< Message: Missouri IMD DSH Appeal Brief >>
6. **Medicaid DSH webpage edits from OGC**
<< Message: FW: DSH Overpayments & Redistributions >>
7. **North Carolina GCW**
<< File: 12.02.2019 DSH Issues Tracking.xlsx >>

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, November 18, 2019 10:04 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Agenda and Chart 11.18.2019

Tracking Chart

<< File: 11.18.2019 DSH Issues Tracking.xlsx >>

Agenda:

1. **Reductions – updates by Rory?**
2. **Missouri IMD DSH Opinion**
 - Tim Weidler emailed DSH Team giving us the heads up that he is going to setup a time with RO in future to discuss how 1923(h) of the Act prohibits MO from amending FY 1995, 2014, 2015 alone or in conjunction with 1132(a) of the Act. Jason Oller OGC is would like a brief overview of how 1923(h) works in practice.
 - Rory would like to learn more about the briefings OGC presented and overall what happened
3. **DSH Allotment Excess Expenditures FY 18 and FY 19**
 - Rich sent email to region branch managers – closed item on tracking list
4. **2017 Rule Updates**
 - Lindsay emailed with updates on the 2017 rule. Wants confirmation on effective date for rule.

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, November 4, 2019 9:24 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: RE: DSH Chart 11.04.2019

Tracking Chart:

<< Message: RE: DSH Redistribution Payments >>

Agenda:

DSH Issues		
1)	Discussion: Colorado Overpayments and GCW Request	<< Message: FW: MO - IMD DSH Opinion 9 26 19 >> << Message: FW: Medicaid DSH Payment and Third Party Payments >>
2)	Update: Wendy scheduled meeting with coverage for Wednesday, Nov 6th	
3)	Update: Rich reach out to Brian/Mark on California TCF DSH	
4)	Discussion: Arkansas Adjustment – GCW	<< Message: RE: The Max Group Letter / Are Hospital Based FQHC Licensed as Hospital Outpatient Departments >>
5)	Discussion: South Carolina DSH Allotment	<< Message: RE: DSH Good Cause response letter >>
6)	Update: Rich will get language back to Joyce on Alabama overpayment and reach out to region branch managers.	
7)	Discussion: GCW Inquiry by Gary Knight	<< Message: FW: FFY 2015 DSH Allotment Question >>
8)	Discussion/Update: Max Group Letter/ New York	<< Message: RE: Letter regarding the current DSH litigation >>
9)	Discussion: Consultant on TPP Ruling	<< Message: RE: DSH Redistribution Payments >>
DSH Litigation		
1)	MO-IMD DSH Opinion 9/26/2019	<< Message: RE: DSH Redistribution Payments >>
2)	Discussion: Questions we want to discuss with OGC post-DC Ruling	

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Monday, October 28, 2019 1:17 PM

To: Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Subject: FW: DSH Chart 10.23.19

From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>

Sent: Wednesday, October 23, 2019 8:34 AM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold,

Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: DSH Chart 10.23.19

Hi DSH Team,

Here is the link with DSH Issues Tracking (also attached in email):
<https://share.cms.gov/center/CMCS/FMG/DFO/Shared%20Documents/DSH%20Team/DSH%20Tracking/10.23.2019%20DSH%20Issue%20Tracking.xlsx>

Please let me know if you have something to add or feel free to add it directly on SharePoint.

Attachments:

1. Virginia State Plan Language "FW: DSH Questions"
2. California TCF DSH Question: "RE: Timely Filing Policy questions for DSH – California"
3. Colorado overpayments and redistribution/GCW request: "RE: DSH Redistribution Payments"
4. Arkansas: "RE: Letter regarding the current DSH litigation"
5. South Carolina Allotment Question: "FW: FFY 2015 DSH Allotment Question"
6. Alabama Overpayment: "FW: FY2019 DSH"

Best,

Lia
From: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Sent: Tuesday, October 8, 2019 8:03 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: DSH Chart 10.08.19 - revised

Hi – attaching updated DSH Issues tracking chart along with relevant emails.

Thanks,
Lia

From: Adams, Lia (CMS/CMCS)
Sent: Monday, October 7, 2019 6:46 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Cc: Adams, Lia (CMS/CMCS) <lia.adams@cms.hhs.gov>
Subject: DSH Chart 10.07.19

Good morning DSH Team,

I compiled pending or need to be discussed in the attached DSH Issues Tracking Chart. Please let me know your *thoughts on the chart* (how can it be improved for usability?) and any *items you would like to add*.

Thanks,
Lia << File: 11.04.2019 DSH Issues Tracking.xlsx >>

FW: FW: WV Medicaid SPRY 2016 DSH Audit

From: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
To: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Mon, 09 Dec 2019 15:09:57 +0000
Attachments: Report - ARR Schedule for DHHR SFY16.xls (76.29 kB); 2016 110964 West Virginia Dept of Health and Human Resources - Compliance Report SFY16 Final_5487075_1 (003).pdf (327.92 kB)

We just received our first SPRY 2016 audit. Figured we could at least mention that at the meeting.

From: Knight, Gary L. (CMS/CMCS) <Gary.Knight@cms.hhs.gov>
Sent: Monday, December 9, 2019 7:41 AM
To: Bush, Jeffrey L <Jeffrey.L.Bush@wv.gov>
Cc: Snow, Jeanne L <Jeanne.L.Snow@wv.gov>; 'Atkins, Tony E' <Tony.E.Atkins@wv.gov>; Manning, Becky A <Becky.A.Manning@wv.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; McCullough, Francis T. (CMS/CMCS) <Francis.McCullough@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>; Weidler, Timothy A. (CMS/CMCS) <Timothy.Weidler@cms.hhs.gov>
Subject: FW: WV Medicaid SPRY 2016 DSH Audit

Good morning Jeff.

Acknowledging receipt of WV's SPRY 2016 annual DSH audit and sharing with CMCS FMG leadership and staff in Division of Financial Policy.

Thank you,
Gary

From: Bush, Jeffrey L [<mailto:Jeffrey.L.Bush@wv.gov>]
Sent: Friday, December 6, 2019 10:56 AM
To: Knight, Gary L. (CMS/CMCS) <Gary.Knight@cms.hhs.gov>
Cc: Snow, Jeanne L <Jeanne.L.Snow@wv.gov>; Atkins, Tony E <Tony.E.Atkins@wv.gov>; Manning, Becky A <Becky.A.Manning@wv.gov>
Subject: WV Medicaid SPRY 2016 DSH Audit

Hello Gary,

Please find attached the WV Medicaid SPRY 2016 DSH audit report. This also includes the Excel spreadsheet with intact formulas.

Please let us know if you have questions.

Thanks

Jeff Bush

Jeffrey L. Bush, CPA
Office Director
WV Dept. of Health & Human Resources
Office of Accountability and Management Reporting
One Davis Square, Suite 304
Charleston, WV 25301
304-558-2587

	A	B	C	D	E	F	G	H
1	State of West Virginia							
2	Schedule of Annual Reporting Requirements							
3	For the Year Ended June 30, 2016							
4	A	B	C	D	E	F	G	H
5	Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State- Defined DSH Eligibility Statistic	Regular IP/OP Medicaid FFS Rate Payments *	IP/OP Medicaid MCO Payments *	Supplemental/ Enhanced IP/OP Medicaid Payments
6	BECKLEY APPALACHIAN REGIONAL HOSPITAL	4,955,333	62.32%	25.28%	Note 1, 2, 3, 4	11,915,547	8,148,371	6,062,424
7	BLUEFIELD REGIONAL MEDICAL CENTER	8,266,196	43.61%	16.49%	Note 3, 4	5,185,379	7,533,306	5,358,176
8	BOONE MEMORIAL HOSPITAL	260,822	42.84%	28.72%	Note 2, 4, 5	2,850,943	3,682,326	-
9	BRAXTON COUNTY MEMORIAL HOSPITAL	362,049	39.08%	27.64%	Note 2, 4, 5	2,268,546	1,612,173	-
10	BROADHUS HOSPITAL	1,218,840	33.15%	23.64%	Note 2, 5	1,333,378	1,044,428	-
11	CABELL-HUNTINGTON HOSPITAL	35,663,002	52.50%	12.90%	Note 1, 3, 4	29,633,713	27,703,349	17,121,134
12	CAMDEN-CLARK MEMORIAL HOSPITAL	26,563,318	42.11%	12.61%	Note 3, 4	13,680,081	12,499,528	7,566,354
13	CHARLESTON AREA MEDICAL CENTER	85,264,743	38.50%	10.42%	Note 3, 4	53,129,746	29,433,584	33,324,116
14	CITY HOSPITAL (BERKLEY)	15,244,319	43.74%	15.05%	Note 3, 4	11,172,344	13,636,492	6,199,422
15	DAVIS MEMORIAL HOSPITAL	5,776,028	48.30%	9.82%	Note 4	4,227,853	4,390,741	4,365,470
16	FAIRMONT GENERAL HOSPITAL	6,817,780	39.87%	18.65%	Note 3, 4	9,408,850	2,751,985	3,561,400
17	GRAFTON CITY HOSPITAL	769,173	37.89%	21.06%	Note 5	1,179,091	1,103,098	-
18	GRANT MEMORIAL HOSPITAL	1,261,582	35.26%	19.88%	Note 2, 4, 5	2,133,263	4,244,422	-
19	GREENBRIER VALLEY MEDICAL CENTER	(93,429)	46.64%	12.09%	Note 3, 4	4,139,279	5,079,771	5,010,138
20	HAMPSHIRE MEMORIAL HOSPITAL	2,257,870	39.08%	24.44%	Note 2, 5	2,304,790	2,264,800	-
21	JACKSON GENERAL HOSPITAL	588,693	35.54%	22.86%	Note 2, 5	2,394,711	1,719,188	-
22	JEFFERSON MEMORIAL HOSPITAL CAH	1,663,006	46.59%	23.61%	Note 4, 5	4,817,393	6,473,596	-
23	LOGAN REGIONAL MEDICAL CENTER	552,857	45.95%	16.41%	Note 2, 3, 4	7,090,103	8,201,145	7,479,174
24	MINNIE HAMILTON HEALTH CARE CENTER	1,195,011	25.82%	18.20%	Note 5	1,423,182	533,653	-
25	MONONGALIA GENERAL HOSPITAL	8,879,581	17.12%	4.67%	Note 3, 4	5,460,859	5,537,718	2,523,400
26	MONTGOMERY GENERAL HOSPITAL CAH	254,746	33.63%	13.31%	Note 2, 4, 5	1,773,112	674,596	-
27	MORGAN COUNTY WAR MEMORIAL HOSPITAL	629,173	22.17%	16.45%	Note 5	1,414,165	1,756,814	-
28	OHIO VALLEY GENERAL HOSPITAL	5,389,129	46.50%	13.91%	Note 1, 3, 4	6,785,315	8,001,654	3,132,836
29	PLATEAU MEDICAL CENTER	312,147	36.79%	24.54%	Note 4, 5	4,903,023	2,940,922	-
30	PLEASANT VALLEY HOSPITAL	6,388,064	19.18%	3.46%	Note 4	1,628,092	-	1,762,683
31	POCAHONTAS MEMORIAL HOSPITAL	343,207	30.10%	20.25%	Note 5	1,159,509	526,896	-
32	POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	896,627	27.14%	23.25%	Note 4, 5	2,273,785	1,968,734	-
33	PRESTON MEMORIAL HOSPITAL	2,062,918	26.54%	22.83%	Note 4, 5	3,485,567	4,014,963	-
34	PRINCETON COMMUNITY HOSPITAL	6,681,645	55.09%	16.46%	Note 3, 4	9,782,094	10,180,471	3,789,351
35	RALEIGH GENERAL HOSPITAL	8,386,016	48.96%	13.13%	Note 3, 4	9,461,736	10,731,144	6,331,463
36	REYNOLDS MEMORIAL HOSPITAL	3,247,223	35.62%	10.62%	Note 4	1,758,492	1,843,318	707,208
37	ROANE GENERAL HOSPITAL	521,195	39.17%	20.91%	Note 2, 4, 5	2,466,846	2,475,931	-
38	SISTERSVILLE GENERAL HOSPITAL	306,395	6.13%	16.32%	Note 5	878,396	724,756	-
39	ST. FRANCIS HOSPITAL (Charleston Hospital, Inc.)	7,681,945	45.78%	5.98%	Note 4	2,972,924	1,878,996	1,785,500
40	ST. JOSEPH'S HOSPITAL/BUCKHANNO	644,941	53.17%	25.16%	Note 1, 4, 5	3,764,538	5,642,463	-
41	ST. MARY'S MEDICAL CENTER, INC.	48,368,883	32.94%	8.73%	Note 3, 4	15,959,619	15,061,031	10,092,819
42	STONEWALL JACKSON MEMORIAL HOSPITAL	4,093,590	35.74%	12.57%	Note 4	1,661,510	3,506,691	1,958,606
43	SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	328,709	56.51%	23.70%	Note 2, 5	1,920,684	1,412,763	-
44	SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	2,012,801	45.44%	11.77%	Note 2, 4	3,325,751	2,108,171	2,263,571
45	THOMAS MEMORIAL HOSPITAL	14,039,440	38.16%	11.22%	Note 3, 4	8,408,644	8,987,897	4,393,848
46	UNITED HOSPITAL CENTER, INC.	24,497,539	35.00%	7.21%	Note 3, 4	9,515,078	7,126,277	7,955,693
47	WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	695,802	31.90%	28.16%	Note 2, 4, 5	2,106,606	1,719,073	-
48	WEIRTON MEDICAL CENTER, INC.	9,157,621	42.28%	11.81%	Note 2, 3, 4	4,094,247	11,898,574	2,271,980
49	WELCH COMMUNITY HOSPITAL	6,050,971	41.59%	13.08%	Note 1, 4, 5	847,834	563,630	357,015
50	WEST VIRGINIA UNIVERSITY HOSPITALS	56,923,987	47.28%	15.48%	Note 1, 3, 4	55,833,595	60,135,099	35,441,551
51	WHEELING HOSPITAL, INC.	10,442,859	27.30%	7.10%	Note 3, 4	6,201,819	11,704,757	4,590,241
52								
53	Institute for Mental Disease							
54	HIGHLAND HOSPITAL**	-	42.71%	35.34%	Note 1, 2, 3, 4	6,179,635	674,776	-
55	MILDRED MITCHELL-BATEMAN HOSPITAL	17,458,248	19.45%	28.84%	Note 2, 5	410,979	16,498	-
56	RIVER PARK HOSPITAL**	(239,258)	17.93%	8.33%	Note 1, 3, 4	1,881,616	-	-
57	WILLIAM R. SHARPE JR. HOSPITAL	24,343,093	10.90%	25.20%	Note 2, 4, 5	448,786	45,828	-
58	Totals	469,386,430				349,053,048	325,916,397	185,405,573
59	* Amounts exclude third-party payor payments based on United States Court of Appeals for the District of Columbia August 13, 2019 decision							
60								
61	** Reported based on hospital fiscal year							
62								
63	Based on initial eligibility calculations:							
64	Note 1: Medicaid inpatient utilization rate one standard deviation above the mean							
65	Note 2: Low income utilization rate exceeds 25%							
66	Note 3: Excess of 3,000 Medicaid inpatient days of service during cost report year							
67	Note 4: Sum of Medicaid inpatient days to total inpatient days and Medicare SSI days to total Medicare days is => 8%							
68	Note 5: Hospital is acute care or psychiatric hospital owned by State and operated by DHHR or a critical access hospital							
69								
70								

	A	P	Q	R	S	T	U
1	State of West Virginia						
2	Schedule of Annual Reporting Requirements						
3	For the Year Ended June 30, 2016						
	A	P	Q	R	S	T	U
5	Hospital Name	Total Eligible Uncompensated Care Costs	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
6	BECKLEY APPALACHIAN REGIONAL HOSPITAL	17,105,693	1,025,820	-	0001092000; 0001092001; 0001092002	510062	88,541,771
7	BLUEFIELD REGIONAL MEDICAL CENTER	10,813,667	261,488	-	3810018667	510071	67,308,268
8	BOONE MEMORIAL HOSPITAL	1,630,620	260,824	-	0102256000	511313	21,668,290
9	BRAXTON COUNTY MEMORIAL HOSPITAL	1,692,786	362,048	-	0100178000; 0100178001	511308	14,686,223
10	BROADDUS HOSPITAL	1,639,190	1,218,840	-	0002167000	511300	13,618,436
11	CABELL-HUNTINGTON HOSPITAL	75,061,728	13,135,182	-	0001144000	510055	426,248,002
12	CAMDEN-CLARK MEMORIAL HOSPITAL	44,829,848	608,893	-	0001155000; 3810011242	510058	517,469,239
13	CHARLESTON AREA MEDICAL CENTER	138,621,125	2,545,236	-	0001342000; 0001342001; 3810001759	510022	852,729,566
14	CITY HOSPITAL (BERKLEY)	25,497,896	444,236	-	0001292000; 3810014474	510008	483,825,449
15	DAVIS MEMORIAL HOSPITAL	12,010,320	451,874	-	0001394000	510030	67,094,287
16	FAIRMONT GENERAL HOSPITAL	12,652,882	239,481	-	3910006361; 3910006603	510047	63,372,330
17	GRAFTON CITY HOSPITAL	1,554,710	769,172	-	3330106000	511307	15,385,630
18	GRANT MEMORIAL HOSPITAL	1,846,406	1,261,584	-	3810016182	511316	29,352,077
19	GREENBRIER VALLEY MEDICAL CENTER	7,826,772	-	-	0106041000	510002	54,677,298
20	HAMPSHIRE MEMORIAL HOSPITAL	1,579,771	564,468	-	3810011725	511311	21,471,054
21	JACKSON GENERAL HOSPITAL	3,041,462	588,692	-	3810023822	511320	20,804,770
22	JEFFERSON MEMORIAL HOSPITAL CAH	4,335,976	1,663,008	-	3810004211	511319	37,942,452
23	LOGAN REGIONAL MEDICAL CENTER	10,772,537	260,336	-	0102154000	510048	66,851,881
24	MINNIE HAMILTON HEALTH CARE CENTER	1,602,233	1,195,012	-	0002176000	511303	17,421,379
25	MONONGALIA GENERAL HOSPITAL	19,463,238	521,237	-	0001360000	510024	194,891,984
26	MONTGOMERY GENERAL HOSPITAL CAH	2,530,802	254,748	-	3810001695	511318	15,909,234
27	MORGAN COUNTY WAR MEMORIAL HOSPITAL	452,835	629,172	-	0106063000	511309	15,897,973
28	OHIO VALLEY GENERAL HOSPITAL	16,322,645	363,392	-	0001419000; 0001419001; 0001419002	510039	92,543,190
29	PLATEAU MEDICAL CENTER	1,696,702	312,148	-	3810000030	511317	25,818,383
30	PLEASANT VALLEY HOSPITAL	2,879,766	169,237	-	0001300000	510012	47,108,019
31	POCAHONTAS MEMORIAL HOSPITAL	2,151,998	343,208	-	3810000534	511314	11,606,439
32	POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	2,284,206	896,628	-	3810000637	511315	19,198,603
33	PRESTON MEMORIAL HOSPITAL	3,755,662	2,062,920	-	0104806000	511312	28,812,667
34	PRINCETON COMMUNITY HOSPITAL	20,098,222	355,832	-	0001111000; 0001111001; 0001111002	510046	111,528,135
35	RALEIGH GENERAL HOSPITAL	26,725,193	408,507	-	0001207000	510070	120,950,369
36	REYNOLDS MEMORIAL HOSPITAL	2,740,170	142,748	-	0001309000	510013	27,580,063
37	ROANE GENERAL HOSPITAL	1,695,463	521,196	-	0123058000	511306	23,647,429
38	SISTERSVILLE GENERAL HOSPITAL	914,984	306,396	-	0002178000	511304	10,579,480
39	ST. FRANCIS HOSPITAL (Charleston Hospital, Inc.)	11,586,669	248,705	-	0001040000	510031	78,852,922
40	ST. JOSEPH'S HOSPITAL/BUCKHANNON	3,574,411	644,940	-	3810027440	511321	31,246,411
41	ST. MARY'S MEDICAL CENTER, INC.	56,130,668	902,100	-	0001287000; 0001287001; 0001287002	510007	341,750,957
42	STONEWALL JACKSON MEMORIAL HOSPITAL	5,564,251	221,082	-	0001417000	510038	37,323,772
43	SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	1,455,640	328,708	-	106132000	511310	11,695,245
44	SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	6,090,194	313,520	-	0001243000	510082	46,161,596
45	THOMAS MEMORIAL HOSPITAL	26,692,149	462,103	-	0001391000; 0001391001; 0001391002	510029	157,742,163
46	UNITED HOSPITAL CENTER, INC.	35,961,834	687,711	-	0001276000	510006	230,910,509
47	WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	2,390,587	695,804	-	0002158000; 0002158004; 0002158003	511301	15,545,416
48	WEIRTON MEDICAL CENTER, INC.	25,397,374	289,805	-	0001352000	510023	114,869,161
49	WELCH COMMUNITY HOSPITAL	6,035,309	5,968,533	-	0001848000	510086	25,515,910
50	WEST VIRGINIA UNIVERSITY HOSPITALS	102,996,348	8,414,452	2,710,899	0001258000; 0222014004; 0222014006	510001	686,653,181
51	WHEELING HOSPITAL, INC.	20,103,951	647,521	-	0001131000	510050	232,150,413
52							
53	Institute for Mental Disease						
54	HIGHLAND HOSPITAL**	716,743	-	-	0001254000; 0001254001; 0001881000; 0001881001	514001	17,763,336
55	MILDRED MITCHELL-BATEMAN HOSPITAL	25,255,297	7,925,524	-	3810001577; 3810003416; 3810002191	514009	32,859,299
56	RIVER PARK HOSPITAL**	824,274	-	-	0001885000; 0001885001	514008	24,622,269
57	WILLIAM R. SHARPE JR. HOSPITAL	24,665,755	10,961,520	-	0001885001	514010	40,197,596
58	Totals	833,268,962	72,855,591	2,710,899			5,752,400,525
59							
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61							
62							
63							
64		Uncompensated care costs (UCC) are based on guidance published by CMS in the 73 Fed. Reg. 77904 (12/19/08) and the 79 Fed. Reg. 71679 (12/3/14). The calculated UCC represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage. The UCC was calculated using Medicare cost reporting methods, Medicaid paid claims, and hospital-provided data for eligible claims. UCC were then reduced by the total payments received for the services provided, including any applicable supplemental Medicaid payments and Section 1011 payments.					
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	A	V	W	X	Y
1	State of West Virginia				
2	Schedule of Annual Reporting Requirements				
3	For the Year Ended June 30, 2016				
4	A				
5	Hospital Name				
6	BECKLEY APPALACHIAN REGIONAL HOSPITAL				
7	BLUEFIELD REGIONAL MEDICAL CENTER				
8	BOONE MEMORIAL HOSPITAL				
9	BRAXTON COUNTY MEMORIAL HOSPITAL				
10	BROADDUS HOSPITAL				
11	CABELL-HUNTINGTON HOSPITAL				
12	CAMDEN-CLARK MEMORIAL HOSPITAL				
13	CHARLESTON AREA MEDICAL CENTER				
14	CITY HOSPITAL (BERKLEY)				
15	DAVIS MEMORIAL HOSPITAL				
16	FAIRMONT GENERAL HOSPITAL				
17	GRAFTON CITY HOSPITAL				
18	GRANT MEMORIAL HOSPITAL				
19	GREENBRIER VALLEY MEDICAL CENTER				
20	HAMPSHIRE MEMORIAL HOSPITAL				
21	JACKSON GENERAL HOSPITAL				
22	JEFFERSON MEMORIAL HOSPITAL CAH				
23	LOGAN REGIONAL MEDICAL CENTER				
24	MINNIE HAMILTON HEALTH CARE CENTER				
25	MONONGALIA GENERAL HOSPITAL				
26	MONTGOMERY GENERAL HOSPITAL CAH				
27	MORGAN COUNTY WAR MEMORIAL HOSPITAL				
28	OHIO VALLEY GENERAL HOSPITAL				
29	PLATEAU MEDICAL CENTER				
30	PLEASANT VALLEY HOSPITAL				
31	POCAHONTAS MEMORIAL HOSPITAL				
32	POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA				
33	PRESTON MEMORIAL HOSPITAL				
34	PRINCETON COMMUNITY HOSPITAL				
35	RALEIGH GENERAL HOSPITAL				
36	REYNOLDS MEMORIAL HOSPITAL				
37	ROANE GENERAL HOSPITAL				
38	SISTERSVILLE GENERAL HOSPITAL				
39	ST. FRANCIS HOSPITAL (Charleston Hospital, Inc)				
40	ST. JOSEPH'S HOSPITAL/BUCKHANNON				
41	ST. MARY'S MEDICAL CENTER, INC.				
42	STONEWALL JACKSON MEMORIAL HOSPITAL				
43	SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL				
44	SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)				
45	THOMAS MEMORIAL HOSPITAL				
46	UNITED HOSPITAL CENTER, INC.				
47	WEBSTER COUNTY MEMORIAL HOSPITAL, INC.				
48	WEIRTON MEDICAL CENTER, INC.				
49	WELCH COMMUNITY HOSPITAL				
50	WEST VIRGINIA UNIVERSITY HOSPITALS				
51	WHEELING HOSPITAL, INC.				
52					
53	Institute for Mental Disease				
54	HIGHLAND HOSPITAL**				
55	MILDRED MITCHELL-BATEMAN HOSPITAL				
56	RIVER PARK HOSPITAL**				
57	WILLIAM R. SHARPE JR. HOSPITAL				
58	Totals	11,404,692,615			
59		137	Col C, D, E and Noes col from the other spreadsheet		
60		41536342943	Col S		
61		25,543,212	Col T		
62		52,966,578,907			
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	A	B	C	D	E	F
1	State of West Virginia					
2	DSH Verification Table					
3	For the Year Ended June 30, 2016					
4		Verification 2				Informational only
5	Hospital Name	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs (UCC) for Medicaid State Plan Rate Year	DSH Payment Under (Over) Total UCC		Total Uncompensated Care Costs (UCC) including TPL Payments
6	BECKLEY APPALACHIAN REGIONAL HOSPITAL	1,025,820	17,105,693	16,079,873		1,958,116
7	BLUEFIELD REGIONAL MEDICAL CENTER	261,488	10,813,667	10,552,179		3,126,824
8	BOONE MEMORIAL HOSPITAL	260,824	1,630,620	1,369,796		(127,989)
9	BRAXTON COUNTY MEMORIAL HOSPITAL	362,048	1,692,786	1,330,738		347,012
10	BROADBUSH HOSPITAL	1,218,840	1,639,190	420,350		872,516
11	CABELL-HUNTINGTON HOSPITAL	13,135,182	75,061,728	61,926,546		29,387,870
12	CAMDEN-CLARK MEMORIAL HOSPITAL	608,893	44,829,848	44,220,955		22,723,433
13	CHARLESTON AREA MEDICAL CENTER	2,545,236	138,621,125	136,075,889		63,450,707
14	CITY HOSPITAL (BERKLEY)	444,236	25,497,896	25,053,660		11,016,559
15	DAVIS MEMORIAL HOSPITAL	451,874	12,010,320	11,558,446		4,639,652
16	FAIRMONT GENERAL HOSPITAL	239,481	12,652,882	12,413,401		7,528,526
17	GRAFTON CITY HOSPITAL	769,172	1,554,710	785,538		219,769
18	GRANT MEMORIAL HOSPITAL	1,261,584	1,846,406	584,822		65,332
19	GREENBRIER VALLEY MEDICAL CENTER	-	7,826,772	7,826,772		384,153
20	HAMPSHIRE MEMORIAL HOSPITAL	564,468	1,579,771	1,015,303		(13,582)
21	JACKSON GENERAL HOSPITAL	588,692	3,041,462	2,452,770		1,592,881
22	JEFFERSON MEMORIAL HOSPITAL CAH	1,663,008	4,335,976	2,672,968		1,326,176
23	LOGAN REGIONAL MEDICAL CENTER	260,336	10,772,537	10,512,201		(460,068)
24	MINNIE HAMILTON HEALTH CARE CENTER	1,195,012	1,602,233	407,221		1,111,640
25	MONONGALIA GENERAL HOSPITAL	521,237	19,463,238	18,942,001		14,045,495
26	MONTGOMERY GENERAL HOSPITAL CAH	254,748	2,530,802	2,276,054		1,443,524
27	MORGAN COUNTY WAR MEMORIAL HOSPITAL	629,172	452,835	(176,337)		(706,065)
28	OHIO VALLEY GENERAL HOSPITAL	363,392	16,322,645	15,959,253		9,926,706
29	PLATEAU MEDICAL CENTER	312,148	1,696,702	1,384,554		(788,737)
30	PLEASANT VALLEY HOSPITAL	169,237	2,879,766	2,710,529		307,201
31	POCAHONTAS MEMORIAL HOSPITAL	343,208	2,151,998	1,808,790		711,621
32	POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	896,628	2,284,206	1,387,578		892,816
33	PRESTON MEMORIAL HOSPITAL	2,062,920	3,755,662	1,692,742		1,814,972
34	PRINCETON COMMUNITY HOSPITAL	355,832	20,098,222	19,742,390		8,666,633
35	RALEIGH GENERAL HOSPITAL	408,507	26,725,193	26,316,686		8,421,361
36	REYNOLDS MEMORIAL HOSPITAL	142,748	2,740,170	2,597,422		701,952
37	ROANE GENERAL HOSPITAL	521,196	1,695,463	1,174,267		334,579
38	SISTERSVILLE GENERAL HOSPITAL	306,396	914,984	608,588		635,763
39	ST. FRANCIS HOSPITAL (Charleston Hospital, Inc)	248,705	11,586,669	11,337,964		6,041,408
40	ST. JOSEPH'S HOSPITAL/BUCKHANNON	644,940	3,574,411	2,929,471		667,805
41	ST. MARY'S MEDICAL CENTER, INC.	902,100	56,130,668	55,228,568		29,997,363
42	STONEWALL JACKSON MEMORIAL HOSPITAL	221,082	5,564,251	5,343,169		2,577,908
43	SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	328,708	1,455,640	1,126,932		(195,189)
44	SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	313,520	6,090,194	5,776,674		2,122,958
45	THOMAS MEMORIAL HOSPITAL	462,103	26,692,149	26,230,046		12,965,093
46	UNITED HOSPITAL CENTER, INC.	687,711	35,961,834	35,274,123		10,793,180
47	WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	695,804	2,390,587	1,694,783		696,949
48	WEIRTON MEDICAL CENTER, INC.	289,805	25,397,374	25,107,569		17,434,175
49	WELCH COMMUNITY HOSPITAL	5,968,533	6,035,309	66,776		4,653,067
50	WEST VIRGINIA UNIVERSITY HOSPITALS	11,125,351	102,996,348	91,870,997		23,130,996
51	WHEELING HOSPITAL, INC.	647,521	20,103,951	19,456,430		5,633,008
52						
53	Institute for Mental Disease					
54	HIGHLAND HOSPITAL**	-	716,743	716,743		(1,130,897)
55	MILDRED MITCHELL-BATEMAN HOSPITAL	7,925,524	25,255,297	17,329,773		24,035,859
56	RIVER PARK HOSPITAL**	-	824,274	824,274		(655,055)
57	WILLIAM R. SHARPE JR. HOSPITAL	10,961,520	24,665,755	13,704,235		23,924,276
58	Totals	75,566,490	833,268,962	757,702,472		358,250,252
59						
60	** Reported based on hospital fiscal year					

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STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

REPORT ON DISPROPORTIONATE SHARE HOSPITAL PAYMENT PROGRAM

For the Year Ended June 30, 2016

With Independent Accountant's Report

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INDEPENDENT ACCOUNTANT'S REPORT

West Virginia Department of Health and Human Resources

Report on Compliance

We have examined the State of West Virginia's compliance with the Medicaid Disproportionate Share Hospital (DSH) program requirements under 42 CFR 455.304(d) for the year ended June 30, 2016. The State of West Virginia is responsible for compliance with the specified requirements. Our responsibility is to express an opinion on the State of West Virginia's compliance with the specified requirements based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the State of West Virginia complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the State of West Virginia complied with the specified requirements. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

Our examination does not provide a legal determination on the State of West Virginia's compliance with federal Medicaid DSH requirements.

We have examined the compliance of the State of West Virginia with the following six verification requirements under 42 CFR 455.304(d) for the year ended June 30, 2016:

1. *Verification 1:* Each hospital that the State of West Virginia determined qualifies for a DSH payment in the State was allowed to retain that payment so that payment is available to offset its uncompensated care costs for furnishing inpatient and outpatient hospital services during the Medicaid State plan year to Medicaid eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

Results: In compliance.

2. *Verification 2:* DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost, as defined by Federal Register/Vol. 73, No. 245, December 19, 2008 and Vol. 79, No. 232, December 3, 2014, in that same audited Medicaid State plan rate year.

Results: Not in compliance. See attached DSH Verification Table and Finding No. 1 in the accompanying Schedule of Findings.

3. *Verification 3:* Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third-party coverage for such services, as described in Section 1923(g)(1)(A) of the Social Security Act (the Act), are eligible for inclusion in the calculation of the DSH payment limit, as described in the Act.

Results: In compliance.

4. *Verification 4:* For purposes of the hospital-specific limit calculation, all Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient and outpatient hospital services to individuals with no source of third-party coverage for such services.

Results: In compliance.

5. *Verification 5:* Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section have been separately documented and retained by the State.

Results: In compliance, with exception of one hospital, Stonewall Jackson Memorial Hospital, which was unable to provide revenue by revenue code in order to properly match charge data with the associated cost per day or ratio of cost to charge.

6. *Verification 6:* The information specified in *Verification 5* above includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient and outpatient hospital costs for furnishing such services to Medicaid eligible individuals and individuals with no source of third-party coverage for such services received.

Results: In compliance. The documentation obtained related to calculation of the hospital-specific DSH limits and includes a description of the methodology used. For DSH payment purposes, the State of West Virginia defines each hospital's payment limit in accordance with its State plan. For examination purposes, the State of West Virginia defines the hospitals' payment limit in accordance with 42 CFR 455.304.

In our opinion, except for the effect of the noncompliance described in *Verifications 2 and 5*, the State of West Virginia complied, in all material respects, with the aforementioned DSH program requirements for the year ended June 30, 2016.

Report on Internal Control over Compliance

In accordance with *Government Auditing Standards*, we are required to report material weaknesses or significant deficiencies in internal control over compliance with the compliance requirements referred to above, identifying those considered to be material weaknesses, violations of provisions of contracts or grant agreements, and abuse that could have a material effect on the State of West Virginia's compliance with federal Medicaid DSH program requirements and any fraud and illegal acts that are more than inconsequential that come to our attention during our examination. We are also required to obtain the views of management on those matters. Management of the West Virginia Department of Health and Human Resources (DHHR) is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. We performed our examination to express our opinion on the State of West Virginia's compliance with the requirements described above and not for the purpose of expressing an opinion on the effectiveness of the State of West Virginia's internal control over compliance; accordingly, we express no such opinion.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct noncompliance with the specified requirements described above on a timely basis. A material weakness in internal control over compliance is a deficiency or combination of deficiencies in internal control over compliance such that there is a reasonable possibility that material noncompliance with the specified requirements described above will not be prevented or detected and corrected on a timely basis. A significant deficiency in internal control over compliance is a deficiency or a combination of deficiencies in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies, and, therefore, material weaknesses or significant deficiencies may exist that were not identified. We did identify certain deficiencies in internal control over compliance, described in the accompanying Schedule of Findings as Findings No. 1 and 2, that we consider to be material weaknesses.

Management Responses

DHHR's responses to the noncompliance and internal control over compliance findings identified in our examination are described in the accompanying Schedule of Findings. DHHR's responses were not subjected to the procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Supplemental Information

Our examination was conducted for the purpose of forming an opinion on the State of West Virginia's compliance with the specified requirements described above. The Schedule of Annual Reporting Requirements (the Schedule) provided in accordance with 42 CFR 447.299 is presented for purposes of additional analysis and is not a required part of our report. Management has informed us that it has prepared the Schedule based on the United States Court of Appeals for the District of Columbia Circuit decision on August 13, 2019 to uphold the Centers for Medicare & Medicaid Services (CMS) Final Rule, published in the Federal Register Vol. 82, No. 62, for the treatment of third-party payor payments in calculating uncompensated care costs, effective beginning June 2, 2017. Until the CMS Final Rule becomes effective, payments made by Medicare and other third party payments have been excluded in computing the cost of uncompensated care in the Schedule. Such information is the responsibility of management and the hospitals listed in the Schedule. Such information has not been subjected to the procedures applied in the examination of compliance, and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control over compliance and the results of that testing, and not to provide an opinion on the effectiveness of the State of West Virginia's internal control over compliance. This report is an integral part of an examination performed in accordance with *Government Auditing Standards* in considering the State of West Virginia's internal control over compliance. Accordingly, this communication is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
September 26, 2019

**State of West Virginia
Department of Health and Human Resources
Disproportionate Share Hospital Payment Program
Schedule of Findings**

Year Ended June 30, 2016

Material Noncompliance and Material Weaknesses

Finding No. 1:

Criteria

In accordance with Section 1923 of the Social Security Act, Disproportionate Share Hospital (DSH) payments cannot exceed the hospital-specific DSH limit imposed by Federal requirements and the State plan.

Condition and Context

DSH payments to one of the forty-seven hospitals that received DSH payments for 2016 exceeded the hospital-specific DSH payment limits.

Cause

The estimated DSH limits are based on data from two years prior to the year of the payments as actual data is not available until after the close of the DSH year, and the methodology used in estimating the DSH limits at that time varied from the requirements of the DSH rule and, due to timing, does not reflect corrections to the methodology implemented by the Department of Health and Human Resources (DHHR) in more recent estimates.

Effect or Potential Effect

This resulted in monies being paid to the hospitals that are required to be refunded to the Federal government or, as applicable, redistributed among the hospitals.

Recommendation

We recommend DHHR continue to monitor and modify its methodology for computation of the DSH limits to conform to the requirements of the DSH rule.

West Virginia's Response and Proposed Corrective Action

The State concurs with the recommendation and will continue to evaluate the methodology for estimating DSH limits on an ongoing basis and make any necessary revisions to ensure that the estimated limits are more in line with actual data and the requirements of the DSH rule.

**State of West Virginia
Department of Health and Human Resources
Disproportionate Share Hospital Payment Program
Schedule of Findings (Continued)**

Year Ended June 30, 2016

Finding No. 2:

Criteria

The federal Medicaid DSH regulations and General DSH Audit and Reporting Protocol require separately documenting and retaining a record of all elements of uncompensated care costs.

Condition and Context

Certain data elements could not be produced or the information provided was improper and required correction. The following listing summarizes the issues encountered in the initial computation of uncompensated care cost limits of the forty-seven hospitals that received DSH payments in 2016.

Finding identified as material noncompliance (see *Verification 5*):

1. One hospital was unable to break down its charge information by revenue code properly.

Findings not identified as material noncompliance:

2. Twenty-five hospitals improperly included charges not eligible for uncompensated care. These charges included primarily patients with insurance, professional charges, charges for rural health clinic, SNF or swing beds, ambulance services, non-covered services, non-Title XIX programs, and claim dates outside of the eligible period.
3. Four hospitals provided improper breakdowns of net patient service revenue, which are used in determining eligibility for DSH.
4. Three hospitals were unable to provide reliable in-state Medicaid crossover charges and/or payments. The data provided by the state was used in lieu of the hospitals' data.
5. Twelve hospitals reported duplicate charges.
6. Two hospitals could not provide uninsured cash collection data based on payment dates.
7. One hospital provided limited information related to propriety of inclusion of claim types.
8. Four hospitals did not report inpatient days, or inpatient days were estimated.
9. Three hospitals provided revenue code mapping inconsistent with their cost report filings.
10. Four hospitals did not report all payments received for Medicaid claims.
11. One hospital was not able to provide required claim data elements (dates, revenue codes, patient days).

**State of West Virginia
Department of Health and Human Resources
Disproportionate Share Hospital Payment Program
Schedule of Findings (Concluded)**

Year Ended June 30, 2016

12. Consistent with the prior year finding, certain Medicaid outpatient charges paid under bundled payment arrangements by the State of West Virginia are reported as denied charges. The charges pertain to medical supplies, drugs, and anesthesia provided as part of a bundled service and are captured as denied charges as there is no additional payment associated with these specific charges. Although there is no additional payment, the charges should be reported as allowed charges and included with traditional paid claims.

Cause

Due to system limitations or changes, the hospitals and State of West Virginia were unable to report the necessary information in an effective manner.

Effect or Potential Effect

While the effects of these findings have been resolved in the calculation of uncompensated care costs, inconsistent data interpretation and incomplete data could result in the improper reporting of uncompensated care costs, in a manner inconsistent with the federal Medicaid DSH guidelines. These matters could result in the incorrect calculation of the DSH payments to which the hospitals are entitled.

Recommendation

We recommend DHHR continue to emphasize to the hospitals the types of claims eligible for inclusion as uncompensated care and the importance of properly developing methodologies to gather and maintain the required information in order to ensure compliance by the State of West Virginia and the hospitals with the DSH program requirements. Additionally, we recommend DHHR capture and code bundled charges as allowable charges, based on the billed amounts, and report zero payment associated with these charges.

West Virginia's Response and Proposed Corrective Action

The State concurs with the recommendation. DHHR will continue to reinforce instructions already given to DSH hospitals on the types of documentation they must develop and maintain in order to properly calculate the hospital-specific DSH limits and on claims eligible as uncompensated care. DHHR will also continue to strengthen periodic monitoring procedures to ensure that the DSH hospitals are maintaining complete and accurate data and records to support the calculation of these limits.

State of West Virginia
DSH Verification Table
For the Year Ended June 30, 2016

Hospital Name	Verification 2			Informational only
	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs (UCC) for Medicaid State Plan Rate Year	DSH Payment Under (Over) Total UCC	Total Uncompensated Care Costs (UCC) including TPL Payments
BECKLEY APPALACHIAN REGIONAL HOSPITAL	1,025,820	17,105,693	16,079,873	1,958,116
BLUEFIELD REGIONAL MEDICAL CENTER	261,488	10,813,667	10,552,179	3,126,824
BOONE MEMORIAL HOSPITAL	260,824	1,630,620	1,369,796	(127,989)
BRAXTON COUNTY MEMORIAL HOSPITAL	362,048	1,692,786	1,330,738	347,012
BROADDUS HOSPITAL	1,218,840	1,639,190	420,350	872,516
CABELL-HUNTINGTON HOSPITAL	13,135,182	75,061,728	61,926,546	29,387,870
CAMDEN-CLARK MEMORIAL HOSPITAL	608,893	44,829,848	44,220,955	22,723,433
CHARLESTON AREA MEDICAL CENTER	2,545,236	138,621,125	136,075,889	63,450,707
CITY HOSPITAL (BERKLEY)	444,236	25,497,896	25,053,660	11,016,559
DAVIS MEMORIAL HOSPITAL	451,874	12,010,320	11,558,446	4,639,652
FAIRMONT GENERAL HOSPITAL	239,481	12,652,882	12,413,401	7,528,526
GRAFTON CITY HOSPITAL	769,172	1,554,710	785,538	219,769
GRANT MEMORIAL HOSPITAL	1,261,584	1,846,406	584,822	65,332
GREENBRIER VALLEY MEDICAL CENTER	-	7,826,772	7,826,772	384,153
HAMPSHIRE MEMORIAL HOSPITAL	564,468	1,579,771	1,015,303	(13,582)
JACKSON GENERAL HOSPITAL	588,692	3,041,462	2,452,770	1,592,881
JEFFERSON MEMORIAL HOSPITAL CAH	1,663,008	4,335,976	2,672,968	1,326,176
LOGAN REGIONAL MEDICAL CENTER	260,336	10,772,537	10,512,201	(460,068)
MINNIE HAMILTON HEALTH CARE CENTER	1,195,012	1,602,233	407,221	1,111,640
MONONGALIA GENERAL HOSPITAL	521,237	19,463,238	18,942,001	14,045,495
MONTGOMERY GENERAL HOSPITAL CAH	254,748	2,530,802	2,276,054	1,443,524
MORGAN COUNTY WAR MEMORIAL HOSPITAL	629,172	452,835	(176,337)	(706,065)
OHIO VALLEY GENERAL HOSPITAL	363,392	16,322,645	15,959,253	9,926,706
PLATEAU MEDICAL CENTER	312,148	1,696,702	1,384,554	(788,737)
PLEASANT VALLEY HOSPITAL	169,237	2,879,766	2,710,529	307,201
POCAHONTAS MEMORIAL HOSPITAL	343,208	2,151,998	1,808,790	711,621
POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	896,628	2,284,206	1,387,578	892,816
PRESTON MEMORIAL HOSPITAL	2,062,920	3,755,662	1,692,742	1,814,972
PRINCETON COMMUNITY HOSPITAL	355,832	20,098,222	19,742,390	8,666,633
RALEIGH GENERAL HOSPITAL	408,507	26,725,193	26,316,686	8,421,361
REYNOLDS MEMORIAL HOSPITAL	142,748	2,740,170	2,597,422	701,952
ROANE GENERAL HOSPITAL	521,196	1,695,463	1,174,267	334,579
SISTERSVILLE GENERAL HOSPITAL	306,396	914,984	608,588	635,763
ST. FRANCIS HOSPITAL (Charleston Hospital. Inc)	248,705	11,586,669	11,337,964	6,041,408
ST. JOSEPH'S HOSPITAL/BUCKHANNON	644,940	3,574,411	2,929,471	667,805
ST. MARY'S MEDICAL CENTER, INC.	902,100	56,130,668	55,228,568	29,997,363
STONEWALL JACKSON MEMORIAL HOSPITAL	221,082	5,564,251	5,343,169	2,577,908
SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	328,708	1,455,640	1,126,932	(195,189)
SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	313,520	6,090,194	5,776,674	2,122,958
THOMAS MEMORIAL HOSPITAL	462,103	26,692,149	26,230,046	12,965,093
UNITED HOSPITAL CENTER, INC.	687,711	35,961,834	35,274,123	10,793,180
WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	695,804	2,390,587	1,694,783	696,949
WEIRTON MEDICAL CENTER, INC.	289,805	25,397,374	25,107,569	17,434,175
WELCH COMMUNITY HOSPITAL	5,968,533	6,035,309	66,776	4,653,067
WEST VIRGINIA UNIVERSITY HOSPITALS	11,125,351	102,996,348	91,870,997	23,130,996
WHEELING HOSPITAL, INC.	647,521	20,103,951	19,456,430	5,633,008
Institute for Mental Disease				
HIGHLAND HOSPITAL**	-	716,743	716,743	(1,130,897)
MILDRED MITCHELL-BATEMAN HOSPITAL	7,925,524	25,255,297	17,329,773	24,035,859
RIVER PARK HOSPITAL**	-	824,274	824,274	(655,055)
WILLIAM R. SHARPE JR. HOSPITAL	10,961,520	24,665,755	13,704,235	23,924,276
Totals	75,566,490	833,268,962	757,702,472	358,250,252

** Reported based on hospital fiscal year

**State of West Virginia
Schedule of Annual Reporting Requirements
For the Year Ended June 30, 2016**

A	B	C	D	E	F	G	H
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State- Defined DSH Eligibility Statistic	Regular IP/OP Medicaid FFS Rate Payments *	IP/OP Medicaid MCO Payments *	Supplemental/ Enhanced IP/OP Medicaid Payments
BECKLEY APPALACHIAN REGIONAL HOSPITAL	4,955,333	62.32%	25.28%	Note 1, 2, 3, 4	11,915,547	8,148,371	6,062,424
BLUEFIELD REGIONAL MEDICAL CENTER	8,266,196	43.61%	16.49%	Note 3, 4	5,185,379	7,533,306	5,358,176
BOONE MEMORIAL HOSPITAL	260,822	42.84%	28.72%	Note 2, 4, 5	2,850,943	3,682,326	-
BRAXTON COUNTY MEMORIAL HOSPITAL	362,049	39.08%	27.64%	Note 2, 4, 5	2,268,546	1,612,173	-
BROADDUS HOSPITAL	1,218,840	33.15%	23.64%	Note 2, 5	1,333,378	1,044,428	-
CABELL-HUNTINGTON HOSPITAL	35,663,002	52.50%	12.90%	Note 1, 3, 4	29,633,713	27,703,349	17,121,134
CAMDEN-CLARK MEMORIAL HOSPITAL	26,563,318	42.11%	12.61%	Note 3, 4	13,680,081	12,499,528	7,566,354
CHARLESTON AREA MEDICAL CENTER	85,264,743	38.50%	10.42%	Note 3, 4	53,129,746	29,433,584	33,324,116
CITY HOSPITAL (BERKLEY)	15,244,319	43.74%	15.05%	Note 3, 4	11,172,344	13,636,492	6,199,422
DAVIS MEMORIAL HOSPITAL	5,776,028	48.30%	9.82%	Note 4	4,227,853	4,390,741	4,365,470
FAIRMONT GENERAL HOSPITAL	6,817,780	39.87%	18.65%	Note 3, 4	9,408,850	2,751,985	3,561,400
GRAFTON CITY HOSPITAL	769,173	37.89%	21.06%	Note 5	1,179,091	1,103,098	-
GRANT MEMORIAL HOSPITAL	1,261,582	35.26%	19.88%	Note 2, 4, 5	2,133,263	4,244,422	-
GREENBRIER VALLEY MEDICAL CENTER (93,429)	46.64%	12.09%	Note 3, 4	4,139,279	5,079,771	5,010,138	-
HAMPSHIRE MEMORIAL HOSPITAL	2,257,870	39.08%	24.44%	Note 2, 5	2,304,790	2,264,800	-
JACKSON GENERAL HOSPITAL	588,693	35.54%	22.86%	Note 2, 5	2,394,711	1,719,188	-
JEFFERSON MEMORIAL HOSPITAL CAH	1,663,006	46.59%	23.61%	Note 4, 5	4,817,393	6,473,596	-
LOGAN REGIONAL MEDICAL CENTER	552,857	45.95%	16.41%	Note 2, 3, 4	7,090,103	8,201,145	7,479,174
MINNIE HAMILTON HEALTH CARE CENTER	1,195,011	25.82%	18.20%	Note 5	1,423,182	533,653	-
MONONGALIA GENERAL HOSPITAL	8,879,581	17.12%	4.67%	Note 3, 4	5,460,859	5,537,718	2,523,400
MONTGOMERY GENERAL HOSPITAL CAH	254,746	33.63%	13.31%	Note 2, 4, 5	1,773,112	674,596	-
MORGAN COUNTY WAR MEMORIAL HOSPITAL	629,173	22.17%	16.45%	Note 5	1,414,165	1,756,814	-
OHIO VALLEY GENERAL HOSPITAL	5,389,129	46.50%	13.91%	Note 1, 3, 4	6,785,315	8,001,654	3,132,836
PLATEAU MEDICAL CENTER	312,147	36.79%	24.54%	Note 4, 5	4,903,023	2,940,922	-
PLEASANT VALLEY HOSPITAL	6,388,064	19.18%	3.46%	Note 4	1,628,092	-	1,762,683
POCAHONTAS MEMORIAL HOSPITAL	343,207	30.10%	20.25%	Note 5	1,159,509	526,896	-
POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	896,627	27.14%	23.25%	Note 4, 5	2,273,785	1,968,734	-
PRESTON MEMORIAL HOSPITAL	2,062,918	26.54%	22.83%	Note 4, 5	3,485,567	4,014,963	-
PRINCETON COMMUNITY HOSPITAL	6,681,645	55.09%	16.46%	Note 3, 4	9,782,094	10,180,471	3,789,351
RALEIGH GENERAL HOSPITAL	8,386,016	48.96%	13.13%	Note 3, 4	9,461,736	10,731,144	6,331,463
REYNOLDS MEMORIAL HOSPITAL	3,247,223	35.62%	10.62%	Note 4	1,758,492	1,843,318	707,208
ROANE GENERAL HOSPITAL	521,195	39.17%	20.91%	Note 2, 4, 5	2,466,846	2,475,931	-
SISTERSVILLE GENERAL HOSPITAL	306,395	6.13%	16.32%	Note 5	878,396	724,756	-
ST. FRANCIS HOSPITAL (Charleston Hospital, Inc)	7,681,945	45.78%	5.98%	Note 4	2,972,924	1,878,996	1,785,500
ST. JOSEPH'S HOSPITAL/BUCKHANNON	644,941	53.17%	25.16%	Note 1, 4, 5	3,764,538	5,642,463	-
ST. MARY'S MEDICAL CENTER, INC.	48,368,883	32.94%	8.73%	Note 3, 4	15,959,619	15,061,031	10,092,819
STONEWALL JACKSON MEMORIAL HOSPITAL	4,093,590	35.74%	12.57%	Note 4	1,661,510	3,506,691	1,958,606
SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	328,709	56.51%	23.70%	Note 2, 5	1,920,684	1,412,763	-
SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	2,012,801	45.44%	11.77%	Note 2, 4	3,325,751	2,108,171	2,263,571
THOMAS MEMORIAL HOSPITAL	14,039,440	38.16%	11.22%	Note 3, 4	8,408,644	8,987,897	4,393,848
UNITED HOSPITAL CENTER, INC.	24,497,539	35.00%	7.21%	Note 3, 4	9,515,078	7,126,277	7,955,693
WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	695,802	31.90%	28.16%	Note 2, 4, 5	2,106,606	1,719,073	-
WEIRTON MEDICAL CENTER, INC.	9,157,621	42.28%	11.81%	Note 2, 3, 4	4,094,247	11,898,574	2,271,980
WELCH COMMUNITY HOSPITAL	6,050,971	41.59%	13.08%	Note 1, 4, 5	847,834	563,630	357,015
WEST VIRGINIA UNIVERSITY HOSPITALS	56,923,987	47.28%	15.48%	Note 1, 3, 4	55,833,595	60,135,099	35,441,551
WHEELING HOSPITAL, INC.	10,442,859	27.30%	7.10%	Note 3, 4	6,201,819	11,704,757	4,590,241
Institute for Mental Disease							
HIGHLAND HOSPITAL**	-	42.71%	35.34%	Note 1, 2, 3, 4	6,179,635	674,776	-
MILDRED MITCHELL-BATEMAN HOSPITAL	17,458,248	19.45%	28.84%	Note 2, 5	410,979	16,498	-
RIVER PARK HOSPITAL**	(239,258)	17.93%	8.33%	Note 1, 3, 4	1,881,616	-	-
WILLIAM R. SHARPE JR. HOSPITAL	24,343,093	10.90%	25.20%	Note 2, 4, 5	448,786	45,828	-
Totals	469,386,430				349,053,048	325,916,397	185,405,573

* Amounts exclude third-party payor payments based on United States Court of Appeals for the District of Columbia August 13, 2019 decision

** Reported based on hospital fiscal year

Based on initial eligibility calculations

Note 1: Medicaid inpatient utilization rate one standard deviation above the mean

Note 2: Low income utilization rate exceeds 25%

Note 3: Excess of 3,000 Medicaid inpatient days of service during cost report year

Note 4: Sum of Medicaid inpatient days to total inpatient days and Medicare SSI days to total Medicare days is => 8%

Note 5: Hospital is acute care or psychiatric hospital owned by State and operated by DHHR or a critical access hospital

State of West Virginia
Schedule of Annual Reporting Requirements
For the Year Ended June 30, 2016

A	I	J	K	L	M	N	O
Hospital Name	Total Medicaid IP/OP Payments *	Total Cost of Care- Medicaid IP/OP Services	Total Medicaid Uncompensated Care Cost	Total IP/OP Indigent Care/ Self- Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Cost
BECKLEY APPALACHIAN REGIONAL HOSPITAL	26,126,342	42,638,627	16,512,285	109,841	-	703,250	593,408
BLUEFIELD REGIONAL MEDICAL CENTER	18,076,861	27,886,977	9,810,116	151,110	-	1,154,661	1,003,551
BOONE MEMORIAL HOSPITAL	6,533,269	7,897,506	1,364,237	80,852	-	347,234	266,382
BRAXTON COUNTY MEMORIAL HOSPITAL	3,880,719	5,296,601	1,415,882	22,778	-	299,682	276,904
BROADDUS HOSPITAL	2,377,806	3,739,935	1,362,129	25,703	-	302,764	277,061
CABELL-HUNTINGTON HOSPITAL	74,458,196	147,839,606	73,381,410	621,702	-	2,302,020	1,680,318
CAMDEN-CLARK MEMORIAL HOSPITAL	33,745,963	77,451,763	43,705,800	604,585	-	1,728,633	1,124,048
CHARLESTON AREA MEDICAL CENTER	115,887,446	249,198,562	133,311,116	1,552,835	-	6,862,844	5,310,009
CITY HOSPITAL (BERKLEY)	31,008,258	54,442,710	23,434,452	542,794	-	2,606,238	2,063,444
DAVIS MEMORIAL HOSPITAL	12,984,064	24,231,623	11,247,559	339,140	-	1,101,901	762,761
FAIRMONT GENERAL HOSPITAL	15,722,235	28,188,161	12,465,926	241,201	-	428,157	186,956
GRAFTON CITY HOSPITAL	2,282,189	3,676,423	1,394,234	81,799	-	242,276	160,477
GRANT MEMORIAL HOSPITAL	6,377,685	8,096,111	1,718,426	51,832	-	179,811	127,979
GREENBRIER VALLEY MEDICAL CENTER	14,229,188	21,803,341	7,574,153	270,673	-	523,292	252,619
HAMPSHIRE MEMORIAL HOSPITAL	4,569,590	5,829,360	1,259,770	22,958	-	342,959	320,001
JACKSON GENERAL HOSPITAL	4,113,899	6,756,605	2,642,706	86,721	-	485,477	398,756
JEFFERSON MEMORIAL HOSPITAL CAH	11,290,989	14,728,214	3,437,225	443,752	-	1,342,503	898,751
LOGAN REGIONAL MEDICAL CENTER	22,770,422	33,281,486	10,511,064	113,020	-	374,493	261,473
MINNIE HAMILTON HEALTH CARE CENTER	1,956,835	3,203,616	1,246,781	46,105	-	401,557	355,452
MONONGALIA GENERAL HOSPITAL	13,521,977	32,363,233	18,841,256	827,713	-	1,449,695	621,982
MONTGOMERY GENERAL HOSPITAL CAH	2,447,708	4,645,833	2,198,125	35,261	-	367,938	332,677
MORGAN COUNTY WAR MEMORIAL HOSPITAL	3,170,979	3,350,851	179,872	24,677	-	297,640	272,963
OHIO VALLEY GENERAL HOSPITAL	17,919,805	32,726,267	14,806,462	290,899	-	1,807,082	1,516,183
PLATEAU MEDICAL CENTER	7,843,945	9,382,602	1,538,657	178,905	-	336,950	158,045
PLEASANT VALLEY HOSPITAL	3,390,775	6,139,504	2,748,729	90,831	-	221,868	131,037
POCAHONTAS MEMORIAL HOSPITAL	1,686,405	3,547,343	1,860,938	34,040	-	325,100	291,060
POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	4,242,519	6,196,930	1,954,411	59,495	-	389,290	329,795
PRESTON MEMORIAL HOSPITAL	7,500,530	10,901,270	3,400,740	546,759	-	901,681	354,922
PRINCETON COMMUNITY HOSPITAL	23,751,916	42,649,990	18,898,074	305,269	-	1,505,418	1,200,149
RALEIGH GENERAL HOSPITAL	26,524,343	52,694,340	26,169,997	579,555	-	1,134,751	555,196
REYNOLDS MEMORIAL HOSPITAL	4,309,018	6,803,313	2,494,295	124,539	-	370,414	245,875
ROANE GENERAL HOSPITAL	4,942,777	6,193,190	1,250,413	44,995	-	490,045	445,050
SISTERSVILLE GENERAL HOSPITAL	1,603,152	2,184,619	581,467	63,670	-	397,187	333,517
ST. FRANCIS HOSPITAL (Charleston Hospital, Inc)	6,637,420	17,860,787	11,223,367	275,692	-	638,994	363,302
ST. JOSEPH'S HOSPITAL/BUCKHANNON	9,407,001	12,720,628	3,313,627	248,567	-	509,351	260,784
ST. MARY'S MEDICAL CENTER, INC.	41,113,469	94,420,769	53,307,300	819,757	-	3,643,125	2,823,368
STONEWALL JACKSON MEMORIAL HOSPITAL	7,126,807	12,210,007	5,083,200	79,650	-	560,701	481,051
SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	3,333,447	4,732,646	1,399,199	40,968	-	97,410	56,442
SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	7,697,493	13,634,066	5,936,573	347,759	-	501,380	153,621
THOMAS MEMORIAL HOSPITAL	21,790,389	47,350,855	25,560,466	296,656	-	1,428,339	1,131,683
UNITED HOSPITAL CENTER, INC.	24,597,048	59,076,394	34,479,346	715,821	-	2,198,309	1,482,488
WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	3,825,679	6,051,693	2,226,014	25,377	-	189,950	164,573
WEIRTON MEDICAL CENTER, INC.	18,264,801	42,620,472	24,355,671	142,174	-	1,183,876	1,041,702
WELCH COMMUNITY HOSPITAL	1,768,479	7,222,472	5,453,993	6,038	-	587,354	581,316
WEST VIRGINIA UNIVERSITY HOSPITALS	151,410,245	248,079,997	96,669,752	1,323,999	-	7,650,595	6,326,596
WHEELING HOSPITAL, INC.	22,496,817	40,736,854	18,240,037	168,805	-	2,032,719	1,863,914
Institute for Mental Disease							
HIGHLAND HOSPITAL**	6,854,411	7,636,487	782,076	85,362	-	20,029	(65,333)
MILDRED MITCHELL-BATEMAN HOSPITAL	427,477	6,388,441	5,960,964	2,279	-	19,296,612	19,294,333
RIVER PARK HOSPITAL**	1,881,616	2,690,019	808,403	7,000	-	22,871	15,871
WILLIAM R. SHARPE JR. HOSPITAL	494,614	4,364,047	3,869,433	1,702	-	20,798,024	20,796,322
Totals	860,375,018	1,613,763,147	753,388,129	13,203,615	-	93,084,447	79,880,833

**State of West Virginia
Schedule of Annual Reporting Requirements
For the Year Ended June 30, 2016**

A	P	Q	R	S	T	U
Hospital Name	Total Eligible Uncompensated Care Costs	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
				0001092000; 0001092001; 0001092002		
BECKLEY APPALACHIAN REGIONAL HOSPITAL	17,105,693	1,025,820	-	3810018667	510062	88,541,771
BLUEFIELD REGIONAL MEDICAL CENTER	10,813,667	261,488	-	0102256000	510071	67,308,268
BOONE MEMORIAL HOSPITAL	1,630,620	260,824	-	0100178000;	511313	21,668,290
				0100178001;		
BRAXTON COUNTY MEMORIAL HOSPITAL	1,692,786	362,048	-	0100178001	511308	14,686,223
BROADDUS HOSPITAL	1,639,190	1,218,840	-	0002167000	511300	13,618,436
CABELL-HUNTINGTON HOSPITAL	75,061,728	13,135,182	-	0001144000	510055	426,248,002
				0001155000;		
CAMDEN-CLARK MEMORIAL HOSPITAL	44,829,848	608,893	-	3810011242	510058	517,469,239
				0001342000;		
				0001342001;		
CHARLESTON AREA MEDICAL CENTER	138,621,125	2,545,236	-	3810001759	510022	852,729,566
				0001292000;		
CITY HOSPITAL (BERKLEY)	25,497,896	444,236	-	3810014474	510008	483,825,449
DAVIS MEMORIAL HOSPITAL	12,010,320	451,874	-	0001394000	510030	67,094,287
				3910006361;		
FAIRMONT GENERAL HOSPITAL	12,652,882	239,481	-	3910006603	510047	63,372,330
GRAFTON CITY HOSPITAL	1,554,710	769,172	-	3330106000	511307	15,385,630
GRANT MEMORIAL HOSPITAL	1,846,406	1,261,584	-	3810016182	511316	29,352,077
GREENBRIER VALLEY MEDICAL CENTER	7,826,772	-	-	0106041000	510002	54,677,298
HAMPSHIRE MEMORIAL HOSPITAL	1,579,771	564,468	-	3810011725	511311	21,471,054
JACKSON GENERAL HOSPITAL	3,041,462	588,692	-	3810023822	511320	20,804,770
JEFFERSON MEMORIAL HOSPITAL CAH	4,335,976	1,663,008	-	3810004211	511319	37,942,452
LOGAN REGIONAL MEDICAL CENTER	10,772,537	260,336	-	0102154000	510048	66,851,881
MINNIE HAMILTON HEALTH CARE CENTER	1,602,233	1,195,012	-	0002176000	511303	17,421,379
MONONGALIA GENERAL HOSPITAL	19,463,238	521,237	-	0001360000	510024	194,891,984
MONTGOMERY GENERAL HOSPITAL CAH	2,530,802	254,748	-	3810001695	511318	15,909,234
MORGAN COUNTY WAR MEMORIAL HOSPITAL	452,835	629,172	-	0106063000	511309	15,897,973
				0001419000;		
				0001419001;		
OHIO VALLEY GENERAL HOSPITAL	16,322,645	363,392	-	0001419002	510039	92,543,190
PLATEAU MEDICAL CENTER	1,696,702	312,148	-	3810000030	511317	25,818,383
PLEASANT VALLEY HOSPITAL	2,879,766	169,237	-	0001300000	510012	47,108,019
POCAHONTAS MEMORIAL HOSPITAL	2,151,998	343,208	-	3810000534	511314	11,606,439
POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	2,284,206	896,628	-	3810000637	511315	19,198,603
PRESTON MEMORIAL HOSPITAL	3,755,662	2,062,920	-	0104806000	511312	28,812,667
				0001111000;		
				0001111001;		
PRINCETON COMMUNITY HOSPITAL	20,098,222	355,832	-	0001111002	510046	111,528,135
RALEIGH GENERAL HOSPITAL	26,725,193	408,507	-	0001207000	510070	120,950,369
REYNOLDS MEMORIAL HOSPITAL	2,740,170	142,748	-	0001309000	510013	27,580,063
ROANE GENERAL HOSPITAL	1,695,463	521,196	-	0123058000	511306	23,647,429
SISTERSVILLE GENERAL HOSPITAL	914,984	306,396	-	0002178000	511304	10,579,480
ST. FRANCIS HOSPITAL (Charleston Hospital, Inc)	11,586,669	248,705	-	0001040000	510031	78,852,922
ST. JOSEPH'S HOSPITAL/BUCKHANNON	3,574,411	644,940	-	3810027440	511321	31,246,411
				0001287000;		
				0001287001;		
ST. MARY'S MEDICAL CENTER, INC.	56,130,668	902,100	-	0001287002	510007	341,750,957
STONEWALL JACKSON MEMORIAL HOSPITAL	5,564,251	221,082	-	0001417000	510038	37,323,772
SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	1,455,640	328,708	-	106132000	511310	11,695,245
SUMMERSVILLE MEMORIAL HOSPITAL (SRMC)	6,090,194	313,520	-	0001243000	510082	46,161,596
				0001391000;		
				0001391001;		
THOMAS MEMORIAL HOSPITAL	26,692,149	462,103	-	0001391002	510029	157,742,163
UNITED HOSPITAL CENTER, INC.	35,961,834	687,711	-	0001276000	510006	230,910,509
				0002158000;		
				0002158004;		
WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	2,390,587	695,804	-	0002158003	511301	15,545,416
WEIRTON MEDICAL CENTER, INC.	25,397,374	289,805	-	0001352000	510023	114,869,161
WELCH COMMUNITY HOSPITAL	6,035,309	5,968,533	-	0001848000	510086	25,515,910
				0001258000;		
				0222014004;		
WEST VIRGINIA UNIVERSITY HOSPITALS	102,996,348	8,414,452	2,710,899	0222014006	510001	686,653,181
WHEELING HOSPITAL, INC.	20,103,951	647,521	-	0001131000	510050	232,150,413
Institute for Mental Disease						
				0001254000;		
HIGHLAND HOSPITAL**	716,743	-	-	0001254001	514001	17,763,336
				0001881000;		
MILDRED MITCHELL-BATEMAN HOSPITAL	25,255,297	7,925,524	-	0001881001	514009	32,859,299
				3810001577;		
				3810003416;		
RIVER PARK HOSPITAL**	824,274	-	-	3810002191	514008	24,622,269
				0001885000;		
WILLIAM R. SHARPE JR. HOSPITAL	24,665,755	10,961,520	-	0001885001	514010	40,197,596
Totals	833,268,962	72,855,591	2,710,899			5,752,400,525

Uncompensated care costs (UCC) are based on guidance published by CMS in the 73 Fed. Reg. 77904 (12/19/08) and the 79 Fed. Reg. 71679 (12/3/14). The calculated UCC represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage. The UCC was calculated using Medicare cost reporting methods, Medicaid paid claims, and hospital-provided data for eligible claims. UCC were then reduced by the total payments received for the services provided, including any applicable supplemental Medicaid payments and Section 1011 payments.

INDEPENDENCE DECLARATION

Berry Dunn McNeil and Parker, LLC declares it is independent of the State of West Virginia Department of Health and Human Resources and its DSH hospitals, under standards established by the American Institute of Certified Public Accountants, for the year ended June 30, 2016.

Very truly yours,

Berry Dunn McNeil & Parker, LLC

Portland, Maine
September 26, 2019

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303-8909



Atlanta Regional Operations Group

December 13, 2019

Dave Richard, Director
Division of Medical Assistance
NC Department of Health & Human Services
1985 Umstead Drive (Physical Address)
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: Disproportionate Share Hospital Good Cause Waiver Request

Dear Mr. Richard:

On June 24, 2019, the North Carolina Department of Health and Human Services, Division of Health Benefits requested good cause waivers of the two-year timely filing limit at 45 C.F.R. § 95, subpart A. The waivers were requested for certain Medicaid disproportionate share hospital (DSH) claims for the period covering state plan rate years (SPRY) 2014 and 2015 as a result of the Centers for Medicare & Medicaid Services' (CMS) decision to withdraw FAQs 33 & 34 from the Medicaid DSH guidance issued in January 2010.

On April 30, 2019, CMS issued guidance related to the withdrawal of FAQs 33 & 34 indicating that CMS would accept revised DSH audits that cover hospital services furnished before June 2, 2017. States generally must file claims for federal funding within two years after the quarter in which the state made the relevant expenditures. 42 U.S.C. § 1320b-2(a); 45 C.F.R. § 95.7. However, CMS indicated its intention to grant good cause waivers to the two year timely filing rule if states avail themselves to the opportunity to resubmit audits from SPRYs 2011 through 2015, which result in additional allowable claims for federal funding.

CMS has reviewed the state's request for a good cause waiver and has determined that the lateness of the state filing was due to circumstances beyond the state's control. Therefore, CMS is approving your request for a good cause waiver.

States are expected to comply with 42 C.F.R. § 433.312(a) and that any overpayments identified in the audits will either be redistributed to other DSH-eligible hospitals in accordance with the applicable state plan, see 73 Fed. Reg. 77904 (Dec. 19, 2008), or that the federal portion will be refunded to CMS in accordance with the regulation.

Medicaid claims for federal financial participation for expenditures related to this waiver should be included on the Form CMS-64 for the quarter ending March 31, 2020.

Mr. Richard
Page 2 of 2

Should the state have any questions or need additional information, please contact Anna Dubois at 850-878-0916.

Sincerely,

Davida R. Kimble
Acting Deputy Director
Division of Medicaid Field Operations South

DSH TPP Rule Audit question from DRR meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>
Cc: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>
Date: Tue, 14 Jan 2020 19:19:49 +0000

Hi All,

When I presented an update today on the DSH litigation and website updates I was asked a question about the 2017 audits and told the division that I would take it back to the DSH team.

How are states supposed to document they accurately followed the TPP Rule in their audits... should they split out column 20 on the elements spreadsheet? Should they have the auditors speak to it in the narrative of the report? Are we even going to provide a recommendation or simply let the states handle it as they see fit?

Lia, could we add this to the DSH chart along with the other questions Tammy Sampson sent to us?

Thanks,

Wendy L. Harrison, LSW

Technical Advisor to the Group Director, ADS – M, Th & F/Office – Tu & W

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services

Center for Medicaid and CHIP Services

Financial Management Group

Division of Reimbursement and State Financing

7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28

Woodlawn, MD 21244

☎ 410-786-2075 Cell: b6

7 410-786-8533

✉ Wendy.Harrison@cms.hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

FW: FW: Clearance requested by the DSH team - acknowledgement letter for SFY 2016 DSH audits

From: "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
To: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>
Date: Fri, 10 Jan 2020 16:38:51 +0000
Attachments: Draft SFY 2016 DSH Acknowledgement ltr-tlas.docx (64.4 kB); Final DSH Audit and Reporting Acknowledgement Letter Template - SPRY 201....docx (95.29 kB); Final Incomplete DSH Acknowledgement Letter Template.doc (125.44 kB)

FYI

From: Sampson, Tamara L. (CMS/CMCS)
Sent: Friday, January 10, 2020 11:35 AM
To: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: Clearance requested by the DSH team - acknowledgement letter for SFY 2016 DSH audits

Good Morning,

I am helping out Todd.

- Attached is the draft SFY 2016 DSH acknowledgement letter. It is a shorten template that was used last year. Please review and send me your comments.
- Does this letter need to be cleared by OGC, especially with the past litigations?
- Does the DSH team want the new DRR analysts to utilize this new shorten template or the 'old' acknowledgement letters? It included information about the overpayments.
- What is our position is as it relates to overpayments?
- What template should the new DRR analysts use for overpayments?
- What is the deadline for transferring the SFY 2016 DSH audit to the NIRT drive?
- What is the deadline for completing the completeness reviews?
- What is the deadline for completing the content reviews

Attached are two examples letters utilized from SFY 2012 to use as a reference. They are the incomplete and acknowledgement letters that staff used for the SFY 2012 DSH audits.

If we need a call, then please send me an email. I will be happy to arrange a brief call.

We appreciate your assistance in this matter.

Tammy

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group/ Division of Reimbursement Review

Name
State Medicaid/CHIP Director
Address
City, State Zip Code

Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear **Name**:

The purpose of this letter is to acknowledge receipt of your **DATE** submission of **STATE** state plan rate year (SPRY) 2016 Disproportionate Share Hospital (DSH) audit and report. After an initial screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have been included in your submission. This acknowledgement, however, does not constitute notice of a completed review or approval of the content of the state's submission. CMS received the following in your submission package:

- SPRY 2016 **STATE** Report on DSH Verifications with Independent Accountants Report
- SPRY 2016 **STATE** 21 data element report in Microsoft Excel

Thank you in advance for your willingness to continue working with us. If you have any questions, please call **DRR Analyst** name at **(XXX) XXX-XXXX** or by email at **DRR Analyst email**.

Sincerely,

Todd McMillion
Acting Director

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



March xx, 2016

Ms. Julie Hamos, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear Ms. Hamos:

The purpose of this letter is to acknowledge receipt of your September 21, 2011 submission of Illinois' state plan rate year (SPRY) 2012 Disproportionate Share Hospital (DSH) audit and report. After an initial screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have been included in your submission. This acknowledgement, however, does not constitute notice of a completed review or approval of the content of the state's submission. CMS received the following in your submission package:

- SPRY 2012 Illinois Department of HealthCare And Family Services Independent Audit of DSH Verifications
- SPRY 2012 Myers and Stauffer Statement of Independence

As you know, CMS promulgated CMS-2198-F on December 19, 2008, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. Statute requires that states submit an annual report and an independent certified audit in order to receive Federal Financial Participation (FFP). Additionally, CMS promulgated CMS-2315-F on December 3, 2014, which applies to audits beginning with SPRY 2011. The rule modifies the definition of uninsured for purposes of Medicaid DSH from an individual-specific basis to a service-specific basis.

To facilitate the audit and reporting process, CMS issued to states the following guidance relating to the final rule (these materials are available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>):

- General DSH Audit and Reporting Protocol
- DSH Report Format
- Operational Guidance Letter dated July 27, 2009
- Additional Information on the DSH Reporting and Audit Requirements

- Additional Information on the DSH Reporting and Audit Requirements – Part 2

CMS has initiated a preliminary review of the state's current submission. This review will be conducted based only on the submitted materials listed above. CMS recognizes that the state may have included in its initial submission only materials that it determined relevant, and encourages the state to submit any additional material or supporting documentation that was not originally included with the initial submission.

Please note that to the extent that audit findings demonstrate the DSH payments exceed the documented hospital-specific limits, these payments will be treated as overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, trigger the return of the federal share to the federal government. Any portion of overpayments not returned to CMS within one year of discovery are subject to disallowance per 42 CFR 430.42 and imputed interest per 42 CFR 433.320(a)(4). However, if the excess DSH payments are redistributed by the state to other qualifying hospitals as an integral part of the audit process, and in accordance with a federally approved Medicaid state plan provision, the federal share is not required to be returned.

The federal portion of overpayments not subject to redistribution must be returned in accordance with 42 CFR Part 433 Subpart F. The correct accounting for any redistributed DSH payments requires two separate entries on the CMS-64 Quarterly Expenditure Report, an increasing adjustment on line 7 for DSH payments actually redistributed and a decreasing adjustment on line 10B to report the federal portion of any identified overpayments redistributed in accordance with the approved state plan. Both the increasing and decreasing prior period adjustments should specify the year in which the original DSH payments were distributed, which would be fiscal year 2012 in the case of the audits for SPRY 2012. Finally, the state must specify if the redistribution was reflected on the SPRY data elements spreadsheet submitted as part of the annual audit report submission. If the data element report submitted with the audit report did not reflect the redistribution, states should resubmit the data elements spreadsheet to CMS to reflect final DSH payment amounts made to hospitals after redistribution. The revised data elements spreadsheet should be submitted concurrent with the submission of the CMS-64 Report that reflects the redistribution.

We will facilitate further dialogue with your agency and look forward to continued efforts and commitment on behalf of both our agencies in ensuring that the DSH audits and reports comport with section 1923(j) of the Social Security Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance.

CMS remains committed to engaging in open dialogue with the state to discuss this preliminary review and provide technical guidance, as necessary, in an effort to ensure that any adverse financial impact on the Illinois Medicaid program and its hospitals is averted. Thank you in advance for your willingness to continue working with us. Should the state have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Todd McMillion at (608) 441-5344.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

March xx, 2016

Robert Hofmann, Secretary
Agency of Human Services
State of Vermont
103 South Main Street
Waterbury, VT 05676-1201

Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear Mr. Hofmann:

This letter is in response to your December 31, 2015 submission of Vermont's state plan rate year (SPRY) 2012 Disproportionate Share Hospital (DSH) audit and report. We appreciate the expeditious manner in which you have submitted your materials. After a cursory screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have not been included in your submission.

As you know, CMS promulgated CMS-2198-F on December 19, 2008, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring State reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. Statute requires that States submit an annual report and an independent certified audit in order to receive Federal Financial Participation (FFP). Additionally, CMS promulgated CMS-2315-F on December 3, 2014, which applies to audits beginning with SPRY 2011. The rule modified the definition of uninsured for purposes of Medicaid DSH from an individual-specific basis to a service-specific basis.

To facilitate the audit and reporting process, CMS issued to states the following guidance relating to the final rule (these materials are available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>):

- General DSH Audit and Reporting Protocol
- DSH Report Format
- Operational Guidance Letter dated July 27, 2009
- Additional Information on the DSH Reporting and Audit Requirements
- Additional Information on the DSH Reporting and Audit Requirements – Part 2

In the spirit of this cooperative relationship, CMS has conducted a cursory screening of the state's initial December 31, 2015 submission and acknowledges receipt of the following:

- Independent Accountant's Report from Clifton Gunderson, LLP for SPRY 2012;

- Findings related to the Six Verifications of the Disproportionate Share Hospital Payments Final Rule for the Medicaid SPRY 2012; and
- Disproportionate Share Hospital Data Reporting Form for SPRY 2012.

Upon review of the state's current submission, CMS has determined that the submission does not comport with section 1923(j) of the Social Security Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance. This acknowledgement of receipt and cursory screening, however, does not constitute notice of a completed review or approval of the content of the State's submission. The specific area(s) of concern is/are as follows:

- The State did not report the specific data elements required by statute and regulations.

The final DSH rule provides detailed identification of the 17 data elements necessary to comply with such reporting and auditing requirements expressly contained in statute. The final rule and subsequent guidance provides States with uniform instructions that contain a detailed identification of the necessary data elements to be reported. These data elements should be submitted in an excel spreadsheet format. The DSH Report Format template is available on the CMS website.

The cursory screening was conducted based only on the submitted materials listed above. CMS recognizes that the state may have included in its initial submission only materials that it determined relevant. CMS encourages the state to submit any additional material or supporting documentation that was not originally included with the initial submission.

In order to receive FFP for DSH expenditures, Vermont must submit an annual report and an independent certified audit to CMS for SPRY 2012 that meets federal statutory, regulatory, and policy requirements. Once CMS has determined that the minimum elements required by the DSH rule have been submitted, CMS will complete its preliminary review of the state's submission. Upon completion of its preliminary review, CMS will conduct an in-depth review of audits and reports. CMS may have additional questions that will be addressed to states at that time, including requests for additional documentation to support the audits and reports and the use of the General DSH Audit and Reporting Protocol.

Please note that to the extent that audit findings demonstrate the DSH payments exceed the documented hospital-specific limits, these payments will be treated as overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, trigger the return of the federal share to the federal government. Any portion of overpayments not returned to CMS within one year of discovery are subject to disallowance per 42 CFR 430.42 and imputed interest per 42 CFR 433.320(a)(4). However, if the excess DSH payments are redistributed by the state to other qualifying hospitals as an integral part of the audit process, and in accordance with a federally approved Medicaid state plan provision, the federal share is not required to be returned.

The federal portion of overpayments not subject to redistribution must be returned in accordance with 42 CFR Part 433 Subpart F. The correct accounting for any redistributed DSH payments requires two separate entries on the CMS-64 Quarterly Expenditure Report, an increasing adjustment on line 7 for DSH payments actually redistributed and a decreasing adjustment on line 10B to report the federal portion of any identified overpayments redistributed in accordance with the approved state plan. Both the increasing and decreasing prior period adjustments should specify the year in which the original DSH payments were distributed, which would be fiscal year 2012 in the case of the audits for SPRY 2012. Finally, the state must specify if the redistribution was reflected on the SPRY 2012 data elements spreadsheet submitted as part of the annual audit report submission. If the data element

report submitted with the audit report did not reflect the redistribution, states should resubmit the data elements spreadsheet to CMS to reflect final DSH payment amounts made to hospitals after redistribution. The revised data elements spreadsheet should be submitted concurrent with the submission of the CMS-64 Report that reflects the redistribution.

CMS remains committed to engaging in open dialogue with the state to discuss this preliminary review and provide technical guidance, as necessary, in an effort to ensure that any adverse financial impact on the Vermont Medicaid program and its hospitals is averted. Consistent with this effort, CMS would like to coordinate a conference call with the State to further discuss the above guidance and provide any other assistance necessary. In the interim, we welcome any additional information that you or your staff wish to offer. Should the state have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Novena James-Hailey at (617) 565-1291.

Thank you in advance for your willingness to continue working with us.

Sincerely,

Richard R. McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

RE: RE: FFY 2019-20 DSH allotments

From: "Sampson, Tamara L. (CMS/CMCS)" <tamara.sampson@cms.hhs.gov>
To: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Weaver, Robert K. (CMS/CMCS)" <robert.weaver@cms.hhs.gov>
Cc: "McMillion, Todd (CMS/CMCS)" <todd.mcmillion@cms.hhs.gov>, "Storey, Christine B. (CMS/CMCS)" <christine.storey@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Date: Wed, 22 Jan 2020 20:24:05 +0000

Thank you

From: Cuno, Richard A. (CMS/CMCS)
Sent: Wednesday, January 22, 2020 2:06 PM
To: Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: FFY 2019-20 DSH allotments

Tammy,

We're actively working on responding to Colorado, but will have to loop back with OGC before we can get back to the state. We're hoping to get this resolved soon.

Rich

From: Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>
Sent: Wednesday, January 22, 2020 3:02 PM
To: Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>
Cc: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>
Subject: FW: FFY 2019-20 DSH allotments
Importance: High

Good Afternoon Rich,

Can the DSH team provide any technical assistance to Colorado?

Does the DSH team have a standard response we can send to states regarding DSH allotments?

DRR is open to having an internal call with the DSH team to discuss Colorado's issue.

Thanks,
Tammy

From: Hunt, Trinia J. (CMS/CMCS)
Sent: Wednesday, January 22, 2020 1:54 PM
To: McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Sampson, Tamara L. (CMS/CMCS) <Tamara.Sampson@cms.hhs.gov>
Cc: Ferguson, Dorothy A. (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>
Subject: FW: FFY 2019-20 DSH allotments

Hi Todd,

Could you please assist Colorado with their inquiry below and attached regarding DSH? We've attempted several times to get headquarters to respond but have not had much success. I will be informing Nancy Dolson with Colorado that I have referred her request for information onto the DRR for response.

Thanks,

Trinia Hunt
Medicaid Financial Management Branch Manager
Division of Financial Operations West, FMG
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
(303) 844-7066

From: Dolson - HCPF, Nancy <nancy.dolson@state.co.us>

Sent: Tuesday, January 21, 2020 11:32 AM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Cc: greg.tanner@state.co.us; jerrod.cotosman@state.co.us; Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: Re: FFY 2019-20 DSH allotments

Thanks for the update, Trinia. Any news yet?

Nancy Dolson
Special Financing Division Director
Finance Office



P 303-866-3698 | F 303-866-4411 | State Relay: 711
1570 Grant Street, Denver, CO 80203
Nancy.Dolson@state.co.us | Colorado.gov/hcpf



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On Wed, Jan 8, 2020 at 6:19 PM Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov> wrote:

Hi Nancy,

We have not received feedback or guidance from our headquarters but we will continue to follow-up with them.

Trinia Hunt
Medicaid Financial Management Branch Manager
Division of Financial Operations West, FMG
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
(303) 844-7066

From: Dolson, Nancy <nancy.dolson@state.co.us>

Sent: Monday, January 6, 2020 3:26 PM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; Dolson, Nancy <nancy.dolson@state.co.us>; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Hi Trinia,

Happy New Year! Now that we're past the holidays, I wanted to check to see if CMS has feedback or guidance on Colorado's questions, below.

thanks

Nancy Dolson
Special Financing Division Director
Colorado Department of Health Care Policy and Financing
P 303.866.3698 | State Relay: 711
Nancy.Dolson@state.co.us

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From: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Sent: Wednesday, December 18, 2019 6:18 PM

To: Dolson, Nancy <nancy.dolson@state.co.us>; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Curtis Volesky <Curtis.Volesky@cms.hhs.gov>; Christine Storey <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Thanks Nancy. We will work with our headquarters to facilitate providing you a response.

From: Dolson, Nancy <nancy.dolson@state.co.us>

Sent: Wednesday, December 18, 2019 5:58 PM

To: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; nancy.dolson@state.co.us; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Volesky, Curtis (CMS/CMCS) <Curtis.Volesky@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Bartholomew, John J. <john.bartholomew@hcpf.state.co.us>

Subject: RE: FFY 2019-20 DSH allotments

Hi Trinia,

Thank you for reaching out. The Department and our DSH hospitals would very much appreciate any additional information you can provide. Our understanding of the current situation is that the reduction to FFY 2019-20 DSH allotments remain, but the implementation of that reduction is delayed until 5/23/2020 through the budget agreement reached between Congress and the President this week.

I have several questions :

1. Is our understanding of the current budget action correct?
2. Can Colorado continue to make DSH payments based on the unreduced amount until 5/23 or other federal action occurs?
3. If the reduction goes into effect on 5/23, does the state have 12 months to attempt to recover any DSH overexpenditures for FFY 2019-20 from hospitals?
4. If the reduction is reversed through future action, the state assumes we have 2 year timely filing to claim any unspent FFY 2019-20 DSH allotment. Can you confirm?
5. The Department will submit a SPA this month to make changes to DSH payment methodologies effective FFY 2019-20. Our public and tribal notices and SPA reflect the current law with the expected reduced DSH allotment. If additional action is taken to reverse the reduction this year, does the state need to submit a new SPA including new public and tribal notification?

Any other information or guidance would be most welcome. Thanks again for asking.

Nancy

Nancy Dolson

Special Financing Division Director

Colorado Department of Health Care Policy and Financing

P 303.866.3698 | State Relay: 711

Nancy.Dolson@state.co.us

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From: Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>

Sent: Wednesday, December 18, 2019 5:48 PM

To: nancy.dolson@state.co.us; greg.tanner@state.co.us; jerrod.cotosman@state.co.us

Cc: Curtis Volesky <Curtis.Volesky@cms.hhs.gov>; Christine Storey <Christine.Storey@cms.hhs.gov>; Maitri, Jay (CMS/CMCS) <Jay.Maitri@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Subject: FFY 2019-20 DSH allotments

Hi Nancy et al,

Since next week's call with HCPF and CMS is canceled please let us know what it is you're seeking clarification on regarding your 2019-2020 DSH allotment.

Thanks,

Trinia

Federal Register Notice -- DSH Allotments

From: "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
To: "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>
Cc: "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>
Date: Fri, 24 Jan 2020 16:47:51 +0000
Attachments: FR Notice DSH Allot 2018 2020 clean version.docx (47.2 kB); FR Notice DSH Allot 2018 2020 track changes.docx (132.04 kB); DSH Allot 2018 2020 Addendum.xlsx (52.91 kB)

Charles and Lia,

Here's a draft of the FR notice for publication of the final FY 2018 and preliminary FY 2020 DSH allotments and IMD limits. I've included both a clean and a track changes version of the notice. In the past we've had OSORA insert the tables, so I've included them as a separate attachment.

If you have a chance to look it over, please let me know if you have any comments.

Thanks,

Rich

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS--N]

RIN 0938-ZB50

**Medicaid Program; Final FY 2018 and Preliminary FY 2020 Disproportionate Share
Hospital Allotments, and Final FY 2018 and Preliminary FY 2020 Institutions for Mental
Diseases Disproportionate Share Hospital Limits**

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2018 and the preliminary federal share DSH allotments for FY 2020. This notice also announces the final FY 2018 and the preliminary FY 2020 limitations on aggregate DSH payments that states may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of states' FY DSH allotments.

DATE: This notice is effective [insert date 30 days after the date of publication in the **Federal Register**]. The final allotments and limitations set forth in this notice are applicable for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT:

Stuart Goldstein, (410) 786-0694 and Richard Cuno, (410) 786-1111.

SUPPLEMENTARY INFORMATION:

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I. Background

A. Fiscal Year DSH Allotments

A state's federal fiscal year (FY) disproportionate share hospital (DSH) allotment represents the aggregate limit on the federal share amount of the state's DSH payments to DSH hospitals in the state for the FY. The amount of such allotment is determined in accordance with the provisions of section 1923(f)(3) of the Social Security Act (the Act), with some state-specific exceptions as specified in section 1923(f) of the Act. Under such provisions, in general a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the previous FY.

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively, the Affordable Care Act), amended Medicaid DSH provisions, adding section 1923(f)(7) of the Act. Section 1923(f)(7) would have required reductions to states' FY DSH allotments from FY 2014 through FY 2020, the calculation of which was described in the Disproportionate Share Hospital Payment Reduction final rule published in the September 18, 2013 **Federal Register** (78 FR 57293). Subsequent legislation, most recently by the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94, enacted December 20, 2019), delayed the start of these reductions, beginning with the FY 2020 DSH allotment reductions, until May 22, 2020. A proposed rule delineating a revised methodology for the calculation of DSH allotment reductions previously scheduled to begin in FY 2018 was published in the July 28, 2017 **Federal Register** (82 FR 35155).

Because there are no reductions to DSH allotments for FY 2018 and are not currently in

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effect for FY 2020 under section 1923(f)(7) of the Act, as amended, this notice contains only the state-specific final FY 2018 DSH allotments and preliminary FY 2020 DSH allotments, as calculated under the statute without application of the reductions that would have been imposed under the Affordable Care Act provisions beginning with FY 2014. This notice also provides information on the calculation of such FY DSH allotments, the calculation of the states' institutions for mental diseases (IMDs) DSH limits, and the amounts of states' final FY 2018 IMD DSH limits and preliminary FY 2020 IMD DSH limits.

B. Determination of Fiscal Year DSH Allotments

Generally, in accordance with the methodology specified under section 1923(f)(3) of the Act, a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the CPI-U for the previous FY. Also in accordance with section 1923(f)(3) of the Act, a state's DSH allotment for a FY is subject to the limitation that an increase to a state's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the state's DSH allotment for the previous FY or 12 percent of the state's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Furthermore, under section 1923(h) of the Act, federal financial participation (FFP) for DSH payments to IMDs and other mental health facilities is limited to state-specific aggregate amounts. Under this provision, the aggregate limit for DSH payments to IMDs and other mental health facilities is the lesser of a state's FY 1995 total computable (state and federal share) IMD and other mental health facility DSH expenditures applicable to the state's FY 1995 DSH allotment (as reported on the Form CMS-64 as of January 1, 1997), or the amount equal to the

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product of the state's current year total computable DSH allotment and the applicable percentage specified in section 1923(h) of the Act.

In general, we determine states' DSH allotments for a FY and the IMD DSH limits for the same FY using the most recent available estimates of or actual medical assistance expenditures, including DSH expenditures in their Medicaid programs and the most recent available change in the CPI-U used for the FY in accordance with the methodology prescribed in the statute. The indicated estimated or actual expenditures are obtained from states for each relevant FY from the most recent available quarterly Medicaid budget reports (Form CMS-37) or quarterly Medicaid expenditure reports (Form CMS-64), respectively, submitted by the states. For example, as part of the initial determination of a state's FY DSH allotment (referred to as the preliminary DSH allotments) that is determined before the beginning of the FY for which the DSH allotments and IMD DSH limits are being determined, we use estimated expenditures for the FY obtained from the August submission of the CMS-37 submitted by states prior to the beginning of the FY; such estimated expenditures are subject to update and revision during the FY before such actual expenditure data become available. We also use the most recent available estimated CPI-U percentage change that is available before the beginning of the FY for determining the states' preliminary FY DSH allotments; such estimated CPI-U percentage change is subject to update and revision during the FY before the actual CPI-U percentage change becomes available. In determining the final DSH allotments and IMD DSH limits for a FY we use the actual expenditures for the FY and actual CPI-U percentage change for the previous FY.

II. Provisions of the Notice

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A. Calculation of the Final FY 2018 Federal Share State DSH Allotments, and the Preliminary FY 2020 Federal Share State DSH Allotments

1. Final FY 2018 Federal Share State DSH Allotments

Addendum 1 to this notice provides the states' final FY 2018 DSH allotments determined in accordance with section 1923(f)(3) of the Act. As described in the background section, in general, the DSH allotment for a FY is calculated by increasing the FY DSH allotment for the preceding FY by the CPI-U increase for the previous fiscal year. For purposes of calculating the states' final FY 2018 DSH allotments, the preceding final fiscal year DSH allotments (for FY 2017) were published in the February 11, 2019 **Federal Register** (84 FR3169). For purposes of calculating the states' final FY 2018 DSH allotments we are using the actual Medicaid expenditures for FY 2018. Finally, for purposes of calculating the states' final FY 2018 DSH allotments, the applicable historical percentage change in the CPI-U for the previous FY (FY 2017) was 2.1 percent; we note that this is lower than the estimated 2.4 percentage change in the CPI-U for FY 2017 that was available and used in the calculation of the preliminary FY 2018 DSH allotments which were published in the July 6, 2018 **Federal Register** (83 FR 31536).

2. Calculation of the Preliminary FY 2020 Federal Share State DSH Allotments

Addendum 2 to this notice provides the preliminary FY 2020 DSH allotments determined in accordance with section 1923(f)(3) of the Act. The preliminary FY 2020 DSH allotments contained in this notice were determined based on the most recent available estimates from states of their FY 2020 total computable Medicaid expenditures. Also, the preliminary FY 2020 allotments contained in this notice were determined by increasing the preliminary FY 2019 DSH allotments. The estimated percentage increase in the CPI-U for FY 2019 was 1.9 percent (CMS

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originally published the preliminary FY 2019 DSH allotments in the February 11, 2019 **Federal Register** (84 FR 3169)).

We will publish states' final FY 2020 DSH allotments in a future notice based on the states' four quarterly Medicaid expenditure reports (Form CMS-64) for FY 2020 available following the end of FY 2020 utilizing the actual change in the CPI-U for FY 2019.

B. Calculation of the Final FY 2018 and Preliminary FY 2020 IMD DSH Limits

Section 1923(h) of the Act specifies the methodology to be used to establish the limits on the amount of DSH payments that a state can make to IMDs and other mental health facilities. FFP is not available for DSH payments to IMDs or other mental health facilities that exceed the IMD DSH limits. In this notice, we are publishing the final FY 2018 and the preliminary FY 2020 IMD DSH limits determined in accordance with the provisions discussed above.

Addendums 3 and 4 to this notice detail each state's final FY 2018 and preliminary FY 2020 IMD DSH limit, respectively, determined in accordance with section 1923(h) of the Act.

III. Collection of Information Requirements

As it relates to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), this notice does not impose any new or revised collection of information requirements or burden. While discussed in section I.B. and in Addendums 3 and 4 of this notice, the requirements and burden associated with Form CMS-37 and Form CMS-64 are unaffected by this notice. Both forms are approved by the Office of Management and Budget (OMB) under control number 0938-1265. Since this notice will not impose any new or revised requirements/burden, we are not making any changes under that control number.

IV. Regulatory Impact Analysis

We have examined the impact of this notice as required by Executive Order 12866 on

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Regulatory Planning and Review (September 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4; enacted on March 22, 1995) (UMRA '95), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This notice reaches the \$100 million economic threshold and thus is considered a major rule under the Congressional Review Act.

The final FY 2018 DSH allotments being published in this notice are \$36 million less than the preliminary FY 2018 DSH allotments published in the July 6, 2018 **Federal Register** (83 FR31536). This is due to the actual percentage change in the CPI-U for FY 2017 used in the calculation of the final FY 2018 allotments (2.1 percent) being less than the estimated percentage change in the CPI-U for FY 2017 used in the calculation of the preliminary FY 2018 allotments (2.4 percent). The final FY 2018 IMD DSH limits being published in this notice are \$2.4 million less than the preliminary FY 2018 IMD DSH limits published in the July 6, 2018 **Federal Register** (83 FR 31536). Since the final FY 2018 DSH allotments were less than the preliminary FY 2018 DSH allotments, the associated FY 2018 IMD DSH limits also decreased.

The preliminary FY 2020 DSH allotments being published in this notice have been

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increased by approximately \$201 million more than the preliminary FY 2019 DSH allotments published in the February 11, 2019 **Federal Register** (84 FR3169). The increase in the DSH allotments is due to the application of the statutory formula for calculating DSH allotments under which the prior fiscal year allotments are increased by the percentage increase in the CPI-U for the prior fiscal year. The preliminary FY 2020 IMD DSH limits being published in this notice are approximately \$20 million more than the preliminary FY 2019 IMD DSH limits published in the February 11, 2019 **Federal Register** (84 FR 3169). The increases in the IMD DSH limits are because the DSH allotment for a FY is a factor in the determination of the IMD DSH limit for the FY. Since the preliminary FY 2020 DSH allotments are greater than the preliminary FY 2019 DSH allotments, the associated preliminary FY 2020 IMD DSH limits for some states also increased.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any one year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have significant economic impact on a substantial number of small entities. Specifically, any impact on providers is due to the effect of the various controlling statutes; providers are not impacted as a result of the independent regulatory action in publishing this notice. The purpose of the notice is to announce the latest DSH allotments and IMD DSH limits, as required by the statute.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis

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if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area for Medicaid payment regulations and has fewer than 100 beds. We are not preparing analysis for section 1102(b) of the Act because the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

The Medicaid statute specifies the methodology for determining the amounts of states' DSH allotments and IMD DSH limits; and as described previously, the application of the methodology specified in statute results in the decreases or increases in states' DSH allotments and IMD DSH limits for the applicable FYs. The statute applicable to these allotments and limits does not apply to the determination of the amounts of DSH payments made to specific DSH hospitals; rather, these allotments and limits represent an overall limit on the total of such DSH payments. For this reason, we do not believe that this notice will have a significant economic impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately \$150 million. This notice will have no consequential effect on spending by state, local, or tribal governments, in the aggregate, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has

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Federalism implications. Since this notice does not impose any costs on state or local governments or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017. It has been determined that this notice is a transfer rule and is not a regulatory action for the purposes of Executive Order 13771.

A. Alternatives Considered

The methodologies for determining the states’ fiscal year DSH allotments and IMD DSH limits, as reflected in this notice, were established in accordance with the methodologies and formula for determining states’ allotments and limits as specified in statute. This notice does not put forward any further discretionary administrative policies for determining such allotments and limits, or otherwise.

B. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 1, we have prepared an accounting statement showing the classification of the estimated expenditures associated with the provisions of this notice. Table 1 provides our best estimate of the change (decrease) in the federal share of states’ Medicaid DSH payments resulting from the application of the provisions of the Medicaid statute relating to the calculation of states’ FY DSH allotments and the increase in the FY DSH allotments from FY 2019 to FY 2020.

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TABLE 1: Accounting Statement: Classification of Estimated Expenditures, from the FY 2019 to FY 2020 (in Millions)

Category	TRANSFERS
Annualized Monetized Transfers	\$201
From Whom To Whom?	Federal Government to States

C. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

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Dated: _____.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: _____.

Alex M Azar II,

Secretary,

Department of Health and Human Services.

Key to ADDENDUM 1: Final DSH Allotments for FY 2018.

The Final FY 2018 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Final FY 2018 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.	
Column	Description
Column A	State.
Column B	FY 2018 FMAPs. This column contains the States' FY 2018 Federal Medical Assistance Percentages.
Column C	Prior FY (2017) DSH Allotments This column contains the States' prior FY 2017 DSH Allotments.
Column D	Prior FY (2017) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 102.1 percent. This column contains the amount in Column C increased by 1 plus the percentage increase in the CPI-U for the prior FY (102.1 percent).
Column E	FY 2018 TC MAP Exp. Including DSH. This column contains the amount of the States' FY 2018 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2018 TC DSH Expenditures. This column contains the amount of the States' FY 2018 total computable DSH expenditures.
Column G	FY 2018 TC MAP Exp. Net of DSH. This column contains the amount of the States' FY 2018 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2017 Allotment or 12 percent Limit. This column contains the greater of the State's prior FY (FY 2017) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2018 DSH Allotment. This column contains the States' final FY 2018 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 1: FINAL DSH ALLOTMENTS FOR FISCAL YEAR: 2018

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Key to ADDENDUM 2: Preliminary DSH Allotments for FY 2020.

The Preliminary FY 2020 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Preliminary FY 2020 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.	
Column	Description
Column A	State.
Column B	FY 2020 FMAPs. This column contains the States' FY 2020 Federal Medical Assistance Percentages.
Column C	Prior FY (2019) DSH Allotments This column contains the States' prior preliminary FY 2019 DSH Allotments.
Column D	Prior FY (2019) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 101.9percent. This column contains the amount in Column C increased by 1 plus the estimated percentage increase in the CPI-U for the prior FY (101.9 percent).
Column E	FY 2020 TC MAP Exp. Including DSH. This column contains the amount of the States' projected FY 2020 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2020 TC DSH Expenditures. This column contains the amount of the States' projected FY 2020 total computable DSH expenditures.
Column G	FY 2020 TC MAP Exp. Net of DSH. This column contains the amount of the States' projected FY 2020 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2019 Allotment or 12 percent Limit. This column contains the greater of the State's preliminary prior FY (FY 2019) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2020 DSH Allotment. This column contains the States' preliminary FY 2020 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 2: PRELIMINARY DSH ALLOTMENTS FOR FISCAL YEAR: 2019

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Key to ADDENDUM 3: Final IMD DSH Limits for FY 2018

The final FY 2018 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2018 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.

Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2018 Federal Share DSH Allotment. This column contains the states' FY 2018 DSH allotments from Addendum 1, Column J.
Column G	FY 2018 FMAP.
Column H	FY 2018 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2018 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2018 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2018 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2018 TC IMD DSH Limit. Lesser of Col. I or C This column contains the total computable FY 2018 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2018 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2018 Federal Share IMD DSH limit determined by converting the total computable FY 2018 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2018 FMAP in Column G.

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ADDENDUM 3: FINAL IMD DSH LIMIT FOR FY: 2018

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Key to ADDENDUM 4: Preliminary IMD DSH Limits for FY 2020

The preliminary FY 2020 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2020 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.	
Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2020 Federal Share DSH Allotment. This column contains the states' preliminary FY 2020 DSH allotments from Addendum 1, Column J.
Column G	FY 2020 FMAP.
Column H	FY 2020 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2020 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2020 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2020 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2020 TC IMD DSH Limit. Lesser of Col. I or C. This column contains the total computable FY 2020 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2020 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2020 Federal Share IMD DSH limit determined by converting the total computable FY 2020 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2020 FMAP in Column G.

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ADDENDUM 4: PRELIMINARY IMD DSH LIMIT FOR FISCAL YEAR: 2020

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS--N]

RIN 0938-ZB50

**Medicaid Program; Final FY 2018 and Preliminary FY 2020 Disproportionate Share
Hospital Allotments, and Final FY 2018 and Preliminary FY 2020 Institutions for Mental
Diseases Disproportionate Share Hospital Limits**

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2018 and the preliminary federal share DSH allotments for FY 2020. This notice also announces the final FY 2018 and the preliminary FY 2020 limitations on aggregate DSH payments that states may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of states' FY DSH allotments.

DATE: This notice is effective **[insert date 30 days after the date of publication in the Federal Register]**. The final allotments and limitations set forth in this notice are applicable for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT:

Stuart Goldstein, (410) 786-0694 and Richard Cuno, (410) 786-1111.

SUPPLEMENTARY INFORMATION:

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I. Background

A. Fiscal Year DSH Allotments

A state's federal fiscal year (FY) disproportionate share hospital (DSH) allotment represents the aggregate limit on the federal share amount of the state's DSH payments to DSH hospitals in the state for the FY. The amount of such allotment is determined in accordance with the provisions of section 1923(f)(3) of the Social Security Act (the Act), with some state-specific exceptions as specified in section 1923(f) of the Act. Under such provisions, in general a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the previous FY.

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively, the Affordable Care Act), amended Medicaid DSH provisions, adding section 1923(f)(7) of the Act. Section 1923(f)(7) would have required reductions to states' FY DSH allotments from FY 2014 through FY 2020, the calculation of which was described in the Disproportionate Share Hospital Payment Reduction final rule published in the September 18, 2013 **Federal Register** (78 FR 57293). Subsequent legislation, most recently by the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94, enacted December 20, 2019), delayed the start of these reductions, beginning with the FY 2020 DSH allotment reductions, until May 22, 2020. A proposed rule delineating a revised methodology for the calculation of DSH allotment reductions previously scheduled to begin in FY 2018 was published in the July 28, 2017 **Federal Register** (82 FR 35155).

Because there are no reductions to DSH allotments for FY 2018 and are not currently in

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effect for FY 2020 under section 1923(f)(7) of the Act, as amended, this notice contains only the state-specific final FY 2018 DSH allotments and preliminary FY 2020 DSH allotments, as calculated under the statute without application of the reductions that would have been imposed under the Affordable Care Act provisions beginning with FY 2014. This notice also provides information on the calculation of such FY DSH allotments, the calculation of the states' institutions for mental diseases (IMDs) DSH limits, and the amounts of states' final FY 2018 IMD DSH limits and preliminary FY 2020 IMD DSH limits.

B. Determination of Fiscal Year DSH Allotments

Generally, in accordance with the methodology specified under section 1923(f)(3) of the Act, a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the CPI-U for the previous FY. Also in accordance with section 1923(f)(3) of the Act, a state's DSH allotment for a FY is subject to the limitation that an increase to a state's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the state's DSH allotment for the previous FY or 12 percent of the state's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Furthermore, under section 1923(h) of the Act, federal financial participation (FFP) for DSH payments to IMDs and other mental health facilities is limited to state-specific aggregate amounts. Under this provision, the aggregate limit for DSH payments to IMDs and other mental health facilities is the lesser of a state's FY 1995 total computable (state and federal share) IMD and other mental health facility DSH expenditures applicable to the state's FY 1995 DSH allotment (as reported on the Form CMS-64 as of January 1, 1997), or the amount equal to the

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product of the state's current year total computable DSH allotment and the applicable percentage specified in section 1923(h) of the Act.

In general, we determine states' DSH allotments for a FY and the IMD DSH limits for the same FY using the most recent available estimates of or actual medical assistance expenditures, including DSH expenditures in their Medicaid programs and the most recent available change in the CPI-U used for the FY in accordance with the methodology prescribed in the statute. The indicated estimated or actual expenditures are obtained from states for each relevant FY from the most recent available quarterly Medicaid budget reports (Form CMS-37) or quarterly Medicaid expenditure reports (Form CMS-64), respectively, submitted by the states. For example, as part of the initial determination of a state's FY DSH allotment (referred to as the preliminary DSH allotments) that is determined before the beginning of the FY for which the DSH allotments and IMD DSH limits are being determined, we use estimated expenditures for the FY obtained from the August submission of the CMS-37 submitted by states prior to the beginning of the FY; such estimated expenditures are subject to update and revision during the FY before such actual expenditure data become available. We also use the most recent available estimated CPI-U percentage change that is available before the beginning of the FY for determining the states' preliminary FY DSH allotments; such estimated CPI-U percentage change is subject to update and revision during the FY before the actual CPI-U percentage change becomes available. In determining the final DSH allotments and IMD DSH limits for a FY we use the actual expenditures for the FY and actual CPI-U percentage change for the previous FY.

II. Provisions of the Notice

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A. Calculation of the Final FY 2018 Federal Share State DSH Allotments, and the Preliminary FY 2020 Federal Share State DSH Allotments

1. Final FY 2018 Federal Share State DSH Allotments

Addendum 1 to this notice provides the states' final FY 2018 DSH allotments determined in accordance with section 1923(f)(3) of the Act. As described in the background section, in general, the DSH allotment for a FY is calculated by increasing the FY DSH allotment for the preceding FY by the CPI-U increase for the previous fiscal year. For purposes of calculating the states' final FY 2018 DSH allotments, the preceding final fiscal year DSH allotments (for FY 2017) were published in the February 11, 2019 **Federal Register** (84 FR3169). For purposes of calculating the states' final FY 2018 DSH allotments we are using the actual Medicaid expenditures for FY 2018. Finally, for purposes of calculating the states' final FY 2018 DSH allotments, the applicable historical percentage change in the CPI-U for the previous FY (FY 2017) was 2.1 percent; we note that this is lower than the estimated 2.4 percentage change in the CPI-U for FY 2017 that was available and used in the calculation of the preliminary FY 2018 DSH allotments which were published in the July 6, 2018 **Federal Register** (83 FR 31536).

2. Calculation of the Preliminary FY 2020 Federal Share State DSH Allotments

Addendum 2 to this notice provides the preliminary FY 2020 DSH allotments determined in accordance with section 1923(f)(3) of the Act. The preliminary FY 2020 DSH allotments contained in this notice were determined based on the most recent available estimates from states of their FY 2020 total computable Medicaid expenditures. Also, the preliminary FY 2020 allotments contained in this notice were determined by increasing the preliminary FY 2019 DSH allotments. The estimated percentage increase in the CPI-U for FY 2019 was 1.9 percent (CMS

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originally published the preliminary FY 2019 DSH allotments in the February 11, 2019 **Federal Register** (84 FR 3169)).

We will publish states' final FY 2020 DSH allotments in a future notice based on the states' four quarterly Medicaid expenditure reports (Form CMS-64) for FY 2020 available following the end of FY 2020 utilizing the actual change in the CPI-U for FY 2019.

B. Calculation of the Final FY 2018 and Preliminary FY 2020 IMD DSH Limits

Section 1923(h) of the Act specifies the methodology to be used to establish the limits on the amount of DSH payments that a state can make to IMDs and other mental health facilities. FFP is not available for DSH payments to IMDs or other mental health facilities that exceed the IMD DSH limits. In this notice, we are publishing the final FY 2018 and the preliminary FY 2020 IMD DSH limits determined in accordance with the provisions discussed above.

Addendums 3 and 4 to this notice detail each state's final FY 2018 and preliminary FY 2020 IMD DSH limit, respectively, determined in accordance with section 1923(h) of the Act.

III. Collection of Information Requirements

As it relates to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), this notice does not impose any new or revised collection of information requirements or burden. While discussed in section I.B. and in Addendums 3 and 4 of this notice, the requirements and burden associated with Form CMS-37 and Form CMS-64 are unaffected by this notice. Both forms are approved by the Office of Management and Budget (OMB) under control number 0938-1265. Since this notice will not impose any new or revised requirements/burden, we are not making any changes under that control number.

IV. Regulatory Impact Analysis

We have examined the impact of this notice as required by Executive Order 12866 on

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Regulatory Planning and Review (September 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4; enacted on March 22, 1995) (UMRA '95), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This notice reaches the \$100 million economic threshold and thus is considered a major rule under the Congressional Review Act.

The final FY 2018 DSH allotments being published in this notice are \$36 million less than the preliminary FY 2018 DSH allotments published in the July 6, 2018 **Federal Register** (83 FR31536). This is due to the actual percentage change in the CPI-U for FY 2017 used in the calculation of the final FY 2018 allotments (2.1 percent) being less than the estimated percentage change in the CPI-U for FY 2017 used in the calculation of the preliminary FY 2018 allotments (2.4 percent). The final FY 2018 IMD DSH limits being published in this notice are \$2.4 million less than the preliminary FY 2018 IMD DSH limits published in the July 6, 2018 **Federal Register** (83 FR 31536). Since the final FY 2018 DSH allotments were less than the preliminary FY 2018 DSH allotments, the associated FY 2018 IMD DSH limits also decreased.

The preliminary FY 2020 DSH allotments being published in this notice have been

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increased by approximately \$201 million more than the preliminary FY 2019 DSH allotments published in the February 11, 2019 **Federal Register** (84 FR3169). The increase in the DSH allotments is due to the application of the statutory formula for calculating DSH allotments under which the prior fiscal year allotments are increased by the percentage increase in the CPI-U for the prior fiscal year. The preliminary FY 2020 IMD DSH limits being published in this notice are approximately \$20 million more than the preliminary FY 2019 IMD DSH limits published in the February 11, 2019 **Federal Register** (84 FR 3169). The increases in the IMD DSH limits are because the DSH allotment for a FY is a factor in the determination of the IMD DSH limit for the FY. Since the preliminary FY 2020 DSH allotments are greater than the preliminary FY 2019 DSH allotments, the associated preliminary FY 2020 IMD DSH limits for some states also increased.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any one year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have significant economic impact on a substantial number of small entities. Specifically, any impact on providers is due to the effect of the various controlling statutes; providers are not impacted as a result of the independent regulatory action in publishing this notice. The purpose of the notice is to announce the latest DSH allotments and IMD DSH limits, as required by the statute.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis

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if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area for Medicaid payment regulations and has fewer than 100 beds. We are not preparing analysis for section 1102(b) of the Act because the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

The Medicaid statute specifies the methodology for determining the amounts of states' DSH allotments and IMD DSH limits; and as described previously, the application of the methodology specified in statute results in the decreases or increases in states' DSH allotments and IMD DSH limits for the applicable FYs. The statute applicable to these allotments and limits does not apply to the determination of the amounts of DSH payments made to specific DSH hospitals; rather, these allotments and limits represent an overall limit on the total of such DSH payments. For this reason, we do not believe that this notice will have a significant economic impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately \$150 million. This notice will have no consequential effect on spending by state, local, or tribal governments, in the aggregate, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has

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Federalism implications. Since this notice does not impose any costs on state or local governments or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017. It has been determined that this notice is a transfer rule and is not a regulatory action for the purposes of Executive Order 13771.

A. Alternatives Considered

The methodologies for determining the states’ fiscal year DSH allotments and IMD DSH limits, as reflected in this notice, were established in accordance with the methodologies and formula for determining states’ allotments and limits as specified in statute. This notice does not put forward any further discretionary administrative policies for determining such allotments and limits, or otherwise.

B. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 1, we have prepared an accounting statement showing the classification of the estimated expenditures associated with the provisions of this notice. Table 1 provides our best estimate of the change (decrease) in the federal share of states’ Medicaid DSH payments resulting from the application of the provisions of the Medicaid statute relating to the calculation of states’ FY DSH allotments and the increase in the FY DSH allotments from FY 2019 to FY 2020.

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TABLE 1: Accounting Statement: Classification of Estimated Expenditures, from the FY 2019 to FY 2020 (in Millions)

Category	TRANSFERS
Annualized Monetized Transfers	\$201
From Whom To Whom?	Federal Government to States

C. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

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Dated: _____.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: _____.

Alex M Azar II,

Secretary,

Department of Health and Human Services.

Key to ADDENDUM 1: Final DSH Allotments for FY 2018.

The Final FY 2018 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Final FY 2018 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.	
Column	Description
Column A	State.
Column B	FY 2018 FMAPs. This column contains the States' FY 2018 Federal Medical Assistance Percentages.
Column C	Prior FY (2017) DSH Allotments This column contains the States' prior FY 2017 DSH Allotments.
Column D	Prior FY (2017) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 102.1 percent. This column contains the amount in Column C increased by 1 plus the percentage increase in the CPI-U for the prior FY (102.1 percent).
Column E	FY 2018 TC MAP Exp. Including DSH. This column contains the amount of the States' FY 2018 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2018 TC DSH Expenditures. This column contains the amount of the States' FY 2018 total computable DSH expenditures.
Column G	FY 2018 TC MAP Exp. Net of DSH. This column contains the amount of the States' FY 2018 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2017 Allotment or 12 percent Limit. This column contains the greater of the State's prior FY (FY 2017) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2018 DSH Allotment. This column contains the States' final FY 2018 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 1: FINAL DSH ALLOTMENTS FOR FISCAL YEAR: 2018

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Key to ADDENDUM 2: Preliminary DSH Allotments for FY 2020.

The Preliminary FY 2020 DSH Allotments for the NON-Low DSH States are presented in the top section of this addendum, and the Preliminary FY 2020 DSH Allotments for the Low-DSH States are presented in the bottom section of this addendum.

Column	Description
Column A	State.
Column B	FY 2020 FMAPs. This column contains the States' FY 2020 Federal Medical Assistance Percentages.
Column C	Prior FY (2019) DSH Allotments This column contains the States' prior preliminary FY 2019 DSH Allotments.
Column D	Prior FY (2019) DSH Allotments (Col C) x (100percent + Percentage Increase in CPIU): 101.9percent. This column contains the amount in Column C increased by 1 plus the estimated percentage increase in the CPI-U for the prior FY (101.9 percent).
Column E	FY 2020 TC MAP Exp. Including DSH. This column contains the amount of the States' projected FY 2020 total computable (TC) medical assistance expenditures including DSH expenditures.
Column F	FY 2020 TC DSH Expenditures. This column contains the amount of the States' projected FY 2020 total computable DSH expenditures.
Column G	FY 2020 TC MAP Exp. Net of DSH. This column contains the amount of the States' projected FY 2020 total computable medical assistance expenditures net of DSH expenditures, calculated as the amount in Column E minus the amount in Column F.
Column H	12 percent Amount. This column contains the amount of the "12 percent limit" in Federal share, determined in accordance with the provisions of section 1923(f)(3) of the Act.
Column I	Greater of FY 2019 Allotment or 12 percent Limit. This column contains the greater of the State's preliminary prior FY (FY 2019) DSH allotment or the amount of the 12 percent Limit, determined as the greater of the amount in Column C or Column H.
Column J	FY 2020 DSH Allotment. This column contains the States' preliminary FY 2020 DSH allotments, determined as the lesser of the amount in Column I or Column D. For states with "na" in Columns I or D, refer to the footnotes in the addendum.

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ADDENDUM 2: PRELIMINARY DSH ALLOTMENTS FOR FISCAL YEAR: 2019

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Key to ADDENDUM 3: Final IMD DSH Limits for FY 2018

The final FY 2018 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2018 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.

Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2018 Federal Share DSH Allotment. This column contains the states' FY 2018 DSH allotments from Addendum 1, Column J.
Column G	FY 2018 FMAP.
Column H	FY 2018 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2018 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2018 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2018 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2018 TC IMD DSH Limit. Lesser of Col. I or C This column contains the total computable FY 2018 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2018 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2018 Federal Share IMD DSH limit determined by converting the total computable FY 2018 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2018 FMAP in Column G.

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ADDENDUM 3: FINAL IMD DSH LIMIT FOR FY: 2018

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Key to ADDENDUM 4: Preliminary IMD DSH Limits for FY 2020

The preliminary FY 2020 IMD DSH Limits for the Non-Low DSH States are presented in the top section of this addendum and the preliminary FY 2020 IMD DSH Limits for the Low-DSH States are presented in the bottom section of the addendum.	
Column	Description
Column A	State.
Column B	Inpatient Hospital Services FY 95 DSH Total Computable. This column contains the States' total computable FY 1995 inpatient hospital DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column C	IMD and Mental Health Services FY 95 DSH Total Computable This column contains the total computable FY 1995 mental health facility DSH expenditures as reported on the Form CMS-64 as of January 1, 1997.
Column D	Total Inpatient Hospital & IMD & Mental Health FY 95 DSH Total Computable, Col. B + C This column contains the total computation of all inpatient hospital DSH expenditures and mental health facility DSH expenditures for FY 1995 as reported on the Form CMS-64 as of January 1, 1997 (representing the sum of Column B and Column C).
Column E	Applicable Percentage, Col. C/D. This column contains the "applicable percentage" representing the total Computable FY 1995 mental health facility DSH expenditures divided by total computable all inpatient hospital and mental health facility DSH expenditures for FY 1995 (the amount in Column C divided by the amount in Column D) Per section 1923(h)(2)(A)(ii)(III) of the Act, for FYs after FY 2002, the applicable percentage can be no greater than 33 percent.
Column F	FY 2020 Federal Share DSH Allotment. This column contains the states' preliminary FY 2020 DSH allotments from Addendum 1, Column J.
Column G	FY 2020 FMAP.
Column H	FY 2020 DSH Allotments in Total Computable, Col. F/G. This column contains states' FY 2020 total computable DSH allotment (determined as Column F/Column G).
Column I	Applicable Percentage Applied to FY 2020 Allotments in TC, Col E x Col H. This column contains the applicable percentage of FY 2020 total computable DSH allotment (calculated as the percentage in Column E multiplied by the amount in Column H).
Column J	FY 2020 TC IMD DSH Limit. Lesser of Col. I or C. This column contains the total computable FY 2020 TC IMD DSH Limit equal to the lesser of the amount in Column I or Column C.
Column K	FY 2020 IMD DSH Limit in Federal Share, Col. G x J. This column contains the FY 2020 Federal Share IMD DSH limit determined by converting the total computable FY 2020 IMD DSH Limit from Column J into a federal share amount by multiplying it by the FY 2020 FMAP in Column G.

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ADDENDUM 4: PRELIMINARY IMD DSH LIMIT FOR FISCAL YEAR: 2020

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	A	B	C	D	E	F	G	H	I	J
1								FINAL DSH ALLOTMENTS FOR FISCAL YEAR:		2018
2	A	B	C	D	E	F	G	H	I	J
3		FY 2018	Prior FY 2017	Prior FY 2017	FY 2018	FY 2018	FY 2018	"12% Amount"	Greater of	FY 2018
4	STATE	FMAPs	DSH Allotments	DSH Allotment (Col C) x	TC MAP Exp.	TC DSH	TC MAP EXP.	=Col G x	Col H Or Col C	Allotment
5				100% + Pct Increase in CPIU:	Including DSH	Expenditures	Net Of DSH	12/(1-.12/Col B)	(12% Limit, 2017	
6				102.1%			Col E - F	(In FS)	Allotment)	MIN Col I, Col D
7	ALABAMA	71.44%	\$337,526,148	\$344,614,197	\$5,546,416,592	\$483,800,080	\$5,062,616,512	\$730,161,488	\$730,161,488	\$344,614,197
8	ARIZONA	69.89%	\$111,136,659	\$113,470,529	\$12,132,120,126	\$145,392,453	\$11,986,727,673	\$1,736,574,325	\$1,736,574,325	\$113,470,529
9	CALIFORNIA	50.00%	\$1,203,294,436	\$1,228,563,619	\$82,452,158,773	\$590,799,895	\$81,861,358,878	\$12,925,477,718	\$12,925,477,718	\$1,228,563,619
10	COLORADO	50.00%	\$101,532,256	\$103,664,433	\$8,925,796,867	\$172,633,510	\$8,753,163,357	\$1,382,078,425	\$1,382,078,425	\$103,664,433
11	CONNECTICUT	50.00%	\$219,529,202	\$224,139,315	\$8,175,809,143	\$65,953,090	\$8,109,856,053	\$1,280,503,587	\$1,280,503,587	\$224,139,315
12	DISTRICT OF COLUMBIA	70.00%	\$67,230,818	\$68,642,665	\$2,804,976,949	\$45,672,974	\$399,623,975	\$399,623,334	\$399,623,334	\$68,642,665
13	FLORIDA	61.79%	\$219,529,202	\$224,139,315	\$22,893,250,365	\$354,298,478	\$22,538,951,887	\$3,356,533,851	\$3,356,533,851	\$224,139,315
14	GEORGIA	68.50%	\$294,992,365	\$301,187,205	\$10,839,404,783	\$440,929,969	\$10,398,474,814	\$1,512,840,053	\$1,512,840,053	\$301,187,205
15	ILLINOIS	50.74%	\$235,993,892	\$240,949,764	\$22,194,828,973	\$335,211,129	\$21,859,617,844	\$3,435,695,434	\$3,435,695,434	\$240,949,764
16	INDIANA	65.59%	\$234,621,836	\$239,548,895	\$11,241,808,216	\$70,804,957	\$11,171,003,259	\$1,640,692,899	\$1,640,692,899	\$239,548,895
17	KANSAS	54.74%	\$45,277,897	\$46,228,733	\$3,437,703,549	\$105,885,545	\$3,331,818,004	\$512,074,078	\$512,074,078	\$46,228,733
18	KENTUCKY	71.17%	\$159,158,672	\$162,501,004	\$9,801,380,491	\$219,723,609	\$9,581,666,882	\$1,382,984,324	\$1,382,984,324	\$162,501,004
19	LOUISIANA	63.69%	\$752,615,495	\$768,420,420	\$10,835,742,015	\$1,249,458,291	\$9,586,283,724	\$1,417,412,444	\$1,417,412,444	\$768,420,420
20	MAINE	64.34%	\$155,252,830	\$117,673,139	\$2,686,772,711	\$34,445,330	\$2,643,327,381	\$389,923,616	\$389,923,616	\$117,673,139
21	MARYLAND	50.00%	\$83,695,509	\$85,453,115	\$11,417,338,026	\$100,737,115	\$11,316,600,911	\$1,786,831,723	\$1,786,831,723	\$85,453,115
22	MASSACHUSETTS	50.00%	\$334,782,032	\$341,812,455	\$17,655,414,020	\$0	\$17,655,414,020	\$2,787,696,951	\$2,787,696,951	\$341,812,455
23	MICHIGAN	64.78%	\$290,876,193	\$296,984,593	\$16,286,594,101	\$602,706,754	\$15,683,887,347	\$2,309,970,949	\$2,309,970,949	\$296,984,593
24	MISSISSIPPI	75.65%	\$167,391,016	\$170,906,227	\$5,278,728,403	\$226,511,022	\$5,052,217,381	\$720,566,055	\$720,566,055	\$170,906,227
25	MISSOURI	64.61%	\$520,009,796	\$530,930,002	\$10,296,294,908	\$782,436,584	\$9,513,858,324	\$1,402,068,929	\$1,402,068,929	\$530,930,002
26	NEVADA	65.75%	\$50,766,127	\$51,832,216	\$3,922,474,284	\$79,057,657	\$3,843,416,627	\$564,177,808	\$564,177,808	\$51,832,216
27	NEW HAMPSHIRE	50.00%	\$175,731,503	\$179,421,865	\$2,150,375,296	\$227,711,926	\$1,922,663,370	\$303,578,427	\$303,578,427	\$179,421,865
28	NEW JERSEY	50.00%	\$706,609,619	\$721,448,421	\$14,843,185,053	\$781,281,583	\$14,061,903,470	\$2,220,300,548	\$2,220,300,548	\$721,448,421
29	NEW YORK	50.00%	\$1,763,093,901	\$1,800,118,873	\$73,030,082,745	\$4,061,662,631	\$68,968,420,114	\$10,889,750,544	\$10,889,750,544	\$1,800,118,873
30	NORTH CAROLINA	67.61%	\$323,805,572	\$330,605,489	\$13,339,097,405	\$536,974,390	\$12,802,123,015	\$1,867,760,914	\$1,867,760,914	\$330,605,489
31	OHIO	62.78%	\$445,918,692	\$455,282,985	\$21,743,887,373	\$93,432,758	\$21,650,454,615	\$3,212,009,943	\$3,212,009,943	\$455,282,985
32	PENNSYLVANIA	51.82%	\$616,053,822	\$628,990,952	\$29,863,557,849	\$942,990,144	\$28,920,567,705	\$4,516,314,872	\$4,516,314,872	\$628,990,952
33	RHODE ISLAND	51.45%	\$71,346,990	\$72,845,277	\$2,620,033,271	\$138,519,196	\$2,481,514,075	\$388,361,670	\$388,361,670	\$72,845,277
34	SOUTH CAROLINA	71.58%	\$359,479,068	\$367,028,128	\$6,006,492,924	\$526,108,667	\$5,480,384,257	\$790,102,528	\$790,102,528	\$367,028,128
35	TENNESSEE /1	na	\$53,100,000	na	na	na	na	na	na	\$53,100,000
36	TEXAS	56.88%	\$1,049,623,997	\$1,071,666,101	\$37,585,413,327	\$1,885,527,269	\$35,699,886,058	\$5,429,437,217	\$5,429,437,217	\$1,071,666,101
37	VERMONT	53.47%	\$24,697,037	\$25,215,675	\$1,595,969,592	\$27,448,780	\$1,568,520,812	\$242,687,652	\$242,687,652	\$25,215,675
38	VIRGINIA	50.00%	\$96,162,104	\$98,181,508	\$9,562,002,903	\$207,704,058	\$9,354,298,845	\$1,476,994,554	\$1,476,994,554	\$98,181,508
39	WASHINGTON	50.00%	\$203,064,512	\$207,328,867	\$12,093,602,904	\$342,498,885	\$11,751,104,019	\$1,855,437,477	\$1,855,437,477	\$207,328,867
40	WEST VIRGINIA	73.24%	\$74,091,106	\$75,647,019	\$3,854,175,868	\$71,874,400	\$3,782,301,468	\$542,813,376	\$542,813,376	\$75,647,019
41	TOTAL	0.00%	\$11,507,990,304	\$11,695,443,000	\$507,112,889,805	\$15,959,193,129	\$491,153,696,676	\$75,409,437,712	\$75,409,437,712	\$11,748,543,001
42										
43	LOW DSH STATES									
44										
45										
46	ALASKA	50.00%	\$22,358,712	\$22,828,245	\$2,033,389,399	\$17,641,931	\$2,015,747,468	\$318,275,916.00	\$318,275,916	\$22,828,245
47	ARKANSAS	70.87%	\$47,350,016	\$48,344,366	\$6,308,079,740	\$44,512,042	\$6,263,567,698	\$904,839,224	\$904,839,224	\$48,344,366
48	DELAWARE	56.43%	\$9,937,205	\$10,145,886	\$2,237,920,184	\$14,364,693	\$2,223,555,491	\$338,893,278	\$338,893,278	\$10,145,886
49	HAWAII	54.78%	\$10,697,430	\$10,922,076	\$2,213,115,909	\$0	\$2,213,115,909	\$340,068,694.24	\$340,068,694	\$10,922,076
50	IDAHO	71.17%	\$18,042,558	\$18,421,452	\$1,901,290,685	\$25,162,099	\$1,876,128,586	\$270,794,128.37	\$270,794,128	\$18,421,452
51	IOWA	58.48%	\$43,226,550	\$44,134,308	\$4,828,425,247	\$82,663,801	\$4,745,761,446	\$716,520,127	\$716,520,127	\$44,134,308
52	MINNESOTA	50.00%	\$81,981,945	\$83,703,566	\$12,324,543,789	\$67,255,268	\$12,257,288,521	\$1,935,361,345	\$1,935,361,345	\$83,703,566
53	MONTANA	65.38%	\$12,459,133	\$12,720,775	\$1,830,172,657	\$841,464	\$1,829,331,193	\$268,868,505	\$268,868,505	\$12,720,775
54	NEBRASKA	52.55%	\$31,061,430	\$31,713,720	\$2,126,639,801	\$39,634,823	\$2,087,004,978	\$324,553,721	\$324,553,721	\$31,713,720
55	NEW MEXICO	72.16%	\$22,358,712	\$22,828,245	\$5,112,309,656	\$52,117,849	\$5,060,191,807	\$728,344,629	\$728,344,629	\$22,828,245
56	NORTH DAKOTA	50.00%	\$10,484,694	\$10,704,873	\$1,222,239,306	\$972,026	\$1,221,267,280	\$192,831,676	\$192,831,676	\$10,704,873
57	OKLAHOMA	58.57%	\$39,748,819	\$40,583,544	\$4,433,479,661	\$44,049,535	\$4,389,430,126	\$662,458,035	\$662,458,035	\$40,583,544
58	OREGON	63.62%	\$49,686,028	\$50,729,435	\$8,877,365,993	\$60,890,048	\$8,816,475,945	\$1,303,922,975	\$1,303,922,975	\$50,729,435
59	SOUTH DAKOTA	55.34%	\$12,123,113	\$12,377,698	\$865,504,172	\$1,667,785	\$863,836,387	\$132,361,898	\$132,361,898	\$12,377,698
60	UTAH	70.26%	\$21,533,602	\$21,985,808	\$2,421,929,601	\$24,699,656	\$2,397,229,945	\$346,919,415	\$346,919,415	\$21,985,808
61	WISCONSIN	58.77%	\$103,763,574	\$105,942,609	\$8,768,743,868	\$70,518,104	\$8,698,225,764	\$1,311,596,480	\$1,311,596,480	\$105,942,609
62	WYOMING	50.00%	\$248,430	\$253,647	\$595,439,375	\$496,860	\$594,942,515	\$93,938,292	\$93,938,292	\$253,647
63	TOTAL LOW DSH STATES	0.00%	\$537,061,951	\$548,340,252	\$68,100,589,043	\$547,487,984	\$67,553,101,059	\$10,190,548,341	\$10,190,548,341	\$548,340,253
64										
65	TOTAL	0.00%	\$12,045,052,255	\$12,243,783,252	\$575,213,478,848	\$16,506,681,113	\$558,706,797,735	\$85,599,986,053	\$85,599,986,053	\$12,296,883,254
66	FOOTNOTES:									
67	/1 Tennessee's DSH allotment for FY 2018, determined under section 1923(f)(6)(A) of the Social Security Act, is \$53,100,000.									

	A	B	C	D	E	F	G	H	I	J	K	L
1									FINAL IMD DSH LIMIT FOR FY:			2018
2	A	B	C	D	E	F	G	H	I	J	K	L
3		Inpatient Hospital	IMD And	Total Inpatient & IMD &	Applicable	FY 2018	FY 2018	FY 2018	Applicable Percentage	FY 2018	FY 2018	MMA
4		Services FY 95 DSH	Mental Health	Mental Health FY 95 DSH	Percent	Allotment	FMAPs	Allotments	Applied to FY 2018	TC IMD Limit	IMD Limit	LOW DSH
5	STATE	Total Computable	Services FY 95 DSH	Total Computable				in TC	Allotments in TC	(Lesser Of	In FS	STATUS
6			Total Computable	Col B + C	Col C/D	In FS		Col F/G	Col E x Col H	Col I or Col C)	Col G x J	
7	ALABAMA	\$413,006,229	\$4,451,770	\$417,457,999	1.07%	\$344,614,197	71.44%	\$482,382,695	\$5,144,127	\$4,451,770	\$3,180,344	N/A
8	ARIZONA	\$93,916,100	\$28,474,900	\$122,391,000	23.27%	\$113,470,529	69.89%	\$162,355,886	\$37,772,938	\$28,474,900	\$19,901,108	N/A
9	CALIFORNIA	\$2,189,879,543	\$1,555,919	\$2,191,435,462	0.07%	\$1,228,563,619	50.00%	\$2,457,127,238	\$1,744,560	\$1,555,919	\$777,960	N/A
10	COLORADO	\$173,900,441	\$594,776	\$174,495,217	0.34%	\$103,664,433	50.00%	\$207,328,866	\$706,691	\$594,776	\$297,388	N/A
11	CONNECTICUT	\$303,359,275	\$105,573,725	\$408,933,000	25.82%	\$224,139,315	50.00%	\$448,278,630	\$115,731,537	\$105,573,725	\$52,786,863	N/A
12	DISTRICT OF COLUMBIA	\$39,532,234	\$6,545,136	\$46,077,370	14.20%	\$68,642,665	70.00%	\$98,060,950	\$13,929,229	\$6,545,136	\$4,581,595	N/A
13	FLORIDA	\$184,468,014	\$149,714,986	\$334,183,000	33.00%	\$224,139,315	61.79%	\$362,743,672	\$119,705,412	\$119,705,412	\$73,965,974	N/A
14	GEORGIA	\$407,343,557	\$0	\$407,343,557	0.00%	\$301,187,205	68.50%	\$439,689,350	\$0	\$0	\$0	N/A
15	ILLINOIS	\$315,868,508	\$89,408,276	\$405,276,784	22.06%	\$240,949,764	50.74%	\$474,871,431	\$104,761,579	\$89,408,276	\$45,365,759	N/A
16	INDIANA	\$79,960,783	\$153,566,302	\$233,527,085	33.00%	\$239,548,895	65.59%	\$365,221,673	\$120,523,152	\$120,523,152	\$79,061,135	N/A
17	KANSAS	\$11,587,208	\$76,663,508	\$88,250,716	33.00%	\$46,228,733	54.74%	\$84,451,467	\$27,868,984	\$27,868,984	\$15,255,482	N/A
18	KENTUCKY	\$158,804,908	\$37,443,073	\$196,247,981	19.08%	\$162,501,004	71.17%	\$228,327,953	\$43,563,761	\$37,443,073	\$26,648,235	N/A
19	LOUISIANA	\$1,078,512,169	\$132,917,149	\$1,211,429,318	10.97%	\$768,420,420	63.69%	\$1,206,500,895	\$132,376,406	\$132,376,406	\$84,310,533	N/A
20	MAINE	\$99,957,958	\$60,958,342	\$160,916,300	33.00%	\$117,673,139	64.34%	\$182,892,662	\$60,354,579	\$60,354,579	\$38,832,136	N/A
21	MARYLAND	\$22,226,467	\$120,873,531	\$143,099,998	33.00%	\$85,453,115	50.00%	\$170,906,230	\$56,399,056	\$56,399,056	\$28,199,528	N/A
22	MASSACHUSETTS	\$469,653,946	\$105,635,054	\$575,289,000	18.36%	\$341,812,455	50.00%	\$683,624,910	\$125,527,786	\$105,635,054	\$52,817,527	N/A
23	MICHIGAN	\$133,258,800	\$304,765,552	\$438,024,352	33.00%	\$296,984,593	64.78%	\$458,451,054	\$151,288,848	\$151,288,848	\$98,004,916	N/A
24	MISSISSIPPI	\$182,608,033	\$0	\$182,608,033	0.00%	\$170,906,227	75.65%	\$225,917,022	\$0	\$0	\$0	N/A
25	MISSOURI	\$521,946,524	\$207,234,618	\$729,181,142	28.42%	\$530,930,002	64.61%	\$821,745,863	\$233,541,681	\$207,234,618	\$133,894,287	N/A
26	NEVADA	\$73,560,000	\$0	\$73,560,000	0.00%	\$51,832,216	65.75%	\$78,832,268	\$0	\$0	\$0	N/A
27	NEW HAMPSHIRE	\$92,675,916	\$94,753,948	\$187,429,864	33.00%	\$179,421,865	50.00%	\$358,843,730	\$118,418,431	\$94,753,948	\$47,376,974	N/A
28	NEW JERSEY	\$736,742,539	\$357,370,461	\$1,094,113,000	32.66%	\$721,448,421	50.00%	\$1,442,896,842	\$471,293,833	\$357,370,461	\$178,685,231	N/A
29	NEW YORK	\$2,418,869,368	\$605,000,000	\$3,023,869,368	20.01%	\$1,800,118,873	50.00%	\$3,600,237,746	\$720,316,777	\$605,000,000	\$302,500,000	N/A
30	NORTH CAROLINA	\$193,201,966	\$236,072,627	\$429,274,593	33.00%	\$330,605,489	67.61%	\$488,989,039	\$161,366,383	\$161,366,383	\$109,099,811	N/A
31	OHIO	\$535,731,956	\$93,432,758	\$629,164,714	14.85%	\$455,282,985	62.78%	\$725,203,863	\$107,694,846	\$93,432,758	\$58,657,085	N/A
32	PENNSYLVANIA	\$388,207,319	\$579,199,682	\$967,407,001	33.00%	\$628,990,952	51.82%	\$1,213,799,599	\$400,553,868	\$400,553,868	\$207,567,014	N/A
33	RHODE ISLAND	\$108,503,167	\$2,397,833	\$110,901,000	2.16%	\$72,845,277	51.45%	\$141,584,601	\$3,061,255	\$2,397,833	\$1,233,685	N/A
34	SOUTH CAROLINA	\$366,681,364	\$72,076,341	\$438,757,705	16.43%	\$367,028,128	71.58%	\$512,752,344	\$84,231,712	\$72,076,341	\$51,592,245	N/A
35	TENNESSEE	\$0	\$0	\$0	0.00%	\$53,100,000	65.82%	\$80,674,567	\$0	\$0	\$0	N/A
36	TEXAS	\$1,220,515,401	\$292,513,592	\$1,513,028,993	19.33%	\$1,071,666,101	56.88%	\$1,884,082,456	\$364,249,284	\$292,513,592	\$166,381,731	N/A
37	VERMONT	\$19,979,252	\$9,071,297	\$29,050,549	31.23%	\$25,215,675	53.47%	\$47,158,547	\$14,725,683	\$9,071,297	\$4,850,423	N/A
38	VIRGINIA	\$129,313,480	\$7,770,268	\$137,083,748	5.67%	\$98,181,508	50.00%	\$196,363,016	\$11,130,373	\$7,770,268	\$3,885,134	N/A
39	WASHINGTON	\$171,725,815	\$163,836,435	\$335,562,250	33.00%	\$207,328,867	50.00%	\$414,657,734	\$136,837,052	\$163,837,052	\$68,418,526	N/A
40	WEST VIRGINIA	\$66,962,606	\$18,887,045	\$85,849,651	22.00%	\$75,647,019	73.24%	\$103,286,481	\$22,723,172	\$18,887,045	\$13,832,872	N/A
41	TOTAL	\$13,402,460,846	\$4,118,758,904	\$17,521,219,750		\$11,748,543,001		\$20,850,241,279	\$3,967,542,995	\$3,507,464,529	\$1,971,951,501	
42												
43	LOW DSH STATES											
44	ALASKA	\$2,506,827	\$17,611,765	\$20,118,592	33.00%	\$22,828,245	50.00%	\$45,656,490	\$15,066,642	\$15,066,642	\$7,533,321	LOW DSH
45	ARKANSAS	\$2,422,649	\$819,351	\$3,242,000	25.27%	\$48,344,366	70.87%	\$68,215,558	\$17,240,125	\$819,351	\$580,674	LOW DSH
46	DELAWARE	\$0	\$7,069,000	\$7,069,000	33.00%	\$10,145,886	56.43%	\$17,979,596	\$5,933,267	\$5,933,267	\$3,348,142	LOW DSH
47	HAWAII	\$0	\$0	\$0	0.00%	\$10,922,076	54.78%	\$19,938,072	\$0	\$0	\$0	LOW DSH
48	IDAHO	\$2,081,429	\$0	\$2,081,429	0.00%	\$18,421,452	71.17%	\$25,883,732	\$0	\$0	\$0	LOW DSH
49	IOWA	\$12,011,250	\$0	\$12,011,250	0.00%	\$44,134,308	58.48%	\$75,469,063	\$0	\$0	\$0	LOW DSH
50	MINNESOTA	\$24,240,000	\$5,257,214	\$29,497,214	17.82%	\$83,703,566	50.00%	\$167,407,132	\$29,836,551	\$5,257,214	\$2,628,607	LOW DSH
51	MONTANA	\$237,048	\$0	\$237,048	0.00%	\$12,720,775	65.38%	\$19,456,676	\$0	\$0	\$0	LOW DSH
52	NEBRASKA	\$6,449,102	\$1,811,337	\$8,260,439	21.93%	\$31,713,720	52.55%	\$60,349,610	\$13,233,374	\$1,811,337	\$951,858	LOW DSH
53	NEW MEXICO	\$6,490,015	\$254,786	\$6,744,801	3.78%	\$22,828,245	72.16%	\$31,635,595	\$1,195,040	\$254,786	\$183,854	LOW DSH
54	NORTH DAKOTA	\$214,523	\$988,478	\$1,203,001	33.00%	\$10,704,873	50.00%	\$21,409,746	\$7,065,216	\$988,478	\$494,239	LOW DSH
55	OKLAHOMA	\$20,019,969	\$3,273,248	\$23,293,217	14.05%	\$40,583,544	58.57%	\$69,290,668	\$9,736,978	\$3,273,248	\$1,917,141	LOW DSH
56	OREGON	\$11,437,908	\$19,975,092	\$31,413,000	33.00%	\$50,729,435	63.62%	\$79,738,188	\$26,313,602	\$19,975,092	\$12,708,154	LOW DSH
57	SOUTH DAKOTA	\$321,120	\$751,299	\$1,072,419	33.00%	\$12,377,698	55.34%	\$22,366,639	\$7,380,991	\$751,299	\$415,769	LOW DSH
58	UTAH	\$3,621,116	\$934,586	\$4,555,702	20.51%	\$21,985,808	70.26%	\$31,292,069	\$6,419,456	\$934,586	\$656,440	LOW DSH
59	WISCONSIN	\$6,609,524	\$4,492,011	\$11,101,535	33.00%	\$105,942,609	58.77%	\$180,266,478	\$59,487,938	\$4,492,011	\$2,639,955	LOW DSH
60	WYOMING	\$0	\$0	\$0	0.00%	\$253,647	50.00%	\$507,294	\$0	\$0	\$0	LOW DSH
61	TOTAL LOW DSH STATES	\$98,662,480	\$63,238,167	\$161,900,647		\$548,340,253		\$936,862,605	\$198,909,179	\$59,557,310	\$34,058,354	
62												
63	TOTAL	\$13,501,123,326	\$4,181,997,071	\$17,683,120,397		\$12,296,883,254		\$21,787,103,884	\$4,166,452,175	\$3,567,021,839	\$2,006,009,855	
64	FOOTNOTES											
65	* Tennessee's DSH allotment for FY 2018, determined under section 1923(f)(6)(A) of the Act, is \$53,100,000.											

	A	B	C	D	E	F	G	H	I	J	K	L	
1								PRELIMINARY IMD DSH LIMIT FOR FISCAL YEAR:				2020	
2	A	B	C	D	E	F	G	H	I	J	K	L	
3		Inpatient Hospital Services FY 95 DSH	IMD And Mental Health	Total Inpatient & IMD & Mental Health FY 95 DSH	Applicable Percent	FY 2020 Allotment	FY 2020 FMAPs	FY 2020	Applicable Percentage	FY 2020	FY 2020	MMA	
4	STATE	Total Computable	Services FY 95 DSH	Total Computable				Allotments in TC	Applied to FY 2020 Allotments in TC	TC IMD Limit (Lesser Of	IMD Limit in FS	LOW DSH STATUS	
6			Total Computable	Col B + C	Col C/D	In FS		Col F/G	Col E x Col H	Col I or Col C)	Col G x J		
7	ALABAMA	\$413,006,229	\$4,451,770	\$417,457,999	1.07%	\$359,589,752	71.97%	\$499,638,394	\$5,328,141	\$4,451,770	\$3,203,939	N/A	
8	ARIZONA	\$93,916,100	\$28,474,900	\$122,391,000	23.27%	\$118,401,505	70.02%	\$169,096,694	\$39,341,222	\$28,474,900	\$19,938,125	N/A	
9	CALIFORNIA	\$2,189,879,543	\$1,555,919	\$2,191,435,462	0.07%	\$1,281,952,080	50.00%	\$2,563,904,160	\$1,820,372	\$1,555,919	\$777,960	N/A	
10	COLORADO	\$173,900,441	\$594,776	\$174,495,217	0.34%	\$108,169,274	50.00%	\$216,338,548	\$737,401	\$594,776	\$297,388	N/A	
11	CONNECTICUT	\$303,359,275	\$105,573,725	\$408,933,000	25.82%	\$233,879,514	50.00%	\$467,759,028	\$120,760,768	\$105,573,725	\$52,786,863	N/A	
12	DISTRICT OF COLUMBIA	\$39,532,234	\$6,545,136	\$46,077,370	14.20%	\$71,625,601	70.00%	\$102,322,287	\$14,534,538	\$6,545,136	\$4,581,595	N/A	
13	FLORIDA	\$184,468,014	\$149,714,986	\$334,183,000	33.00%	\$233,879,514	61.47%	\$380,477,491	\$125,557,572	\$125,557,572	\$77,180,240	N/A	
14	GEORGIA	\$407,343,557	\$0	\$407,343,557	0.00%	\$314,275,596	67.30%	\$466,977,111	\$0	\$0	\$0	N/A	
15	ILLINOIS	\$315,868,508	\$89,408,276	\$405,276,784	22.06%	\$251,420,477	50.14%	\$501,436,931	\$110,622,205	\$89,408,276	\$44,829,310	N/A	
16	INDIANA	\$79,960,783	\$153,566,302	\$233,527,085	33.00%	\$249,958,731	65.84%	\$379,645,703	\$125,283,082	\$125,283,082	\$82,486,381	N/A	
17	KANSAS	\$11,587,208	\$76,663,508	\$88,250,716	33.00%	\$48,237,649	59.16%	\$121,537,608	\$26,907,411	\$76,663,508	\$15,918,424	N/A	
18	KENTUCKY	\$158,804,908	\$37,443,073	\$196,247,981	19.08%	\$169,562,648	71.82%	\$236,093,913	\$45,045,465	\$37,443,073	\$26,891,615	N/A	
19	LOUISIANA	\$1,078,512,169	\$132,917,149	\$1,211,429,318	10.97%	\$801,812,898	66.86%	\$1,199,241,547	\$131,579,916	\$131,579,916	\$87,974,332	N/A	
20	MAINE	\$99,957,958	\$60,958,342	\$160,916,300	33.00%	\$122,786,743	63.80%	\$192,455,710	\$63,510,384	\$60,958,342	\$38,891,422	N/A	
21	MARYLAND	\$22,226,467	\$120,873,531	\$143,099,998	33.00%	\$89,166,566	50.00%	\$178,333,132	\$58,849,934	\$58,849,934	\$29,424,967	N/A	
22	MASSACHUSETTS	\$469,653,946	\$105,635,054	\$575,289,000	18.36%	\$356,666,257	50.00%	\$713,332,514	\$130,982,721	\$105,635,054	\$52,817,527	N/A	
23	MICHIGAN	\$133,258,800	\$304,765,552	\$438,024,352	33.00%	\$309,890,355	64.06%	\$483,750,164	\$159,637,554	\$159,637,554	\$102,263,817	N/A	
24	MISSISSIPPI	\$182,608,033	\$0	\$182,608,033	0.00%	\$178,333,128	76.98%	\$231,661,637	\$0	\$0	\$0	N/A	
25	MISSOURI	\$521,946,524	\$207,234,618	\$729,181,142	28.42%	\$554,002,096	65.65%	\$843,872,195	\$239,830,026	\$207,234,618	\$136,049,527	N/A	
26	NEVADA	\$73,560,000	\$0	\$73,560,000	0.00%	\$54,084,637	63.93%	\$84,599,776	\$0	\$0	\$0	N/A	
27	NEW HAMPSHIRE	\$92,675,916	\$94,753,948	\$187,429,864	33.00%	\$187,218,822	50.00%	\$374,437,644	\$123,564,423	\$94,753,948	\$47,376,974	N/A	
28	NEW JERSEY	\$736,742,539	\$357,370,461	\$1,094,113,000	32.66%	\$752,799,683	50.00%	\$1,505,599,366	\$491,774,378	\$357,370,461	\$178,685,231	N/A	
29	NEW YORK	\$2,418,869,368	\$605,000,000	\$3,023,869,368	20.01%	\$1,878,344,839	50.00%	\$3,756,689,678	\$751,618,863	\$605,000,000	\$302,500,000	N/A	
30	NORTH CAROLINA	\$193,201,966	\$236,072,627	\$429,274,593	33.00%	\$344,972,281	67.03%	\$514,653,560	\$169,835,675	\$169,835,675	\$113,840,853	N/A	
31	OHIO	\$535,731,956	\$93,432,758	\$629,164,714	14.85%	\$475,067,763	63.02%	\$753,836,501	\$111,946,875	\$93,432,758	\$58,881,324	N/A	
32	PENNSYLVANIA	\$388,207,319	\$579,199,862	\$967,407,001	33.00%	\$656,324,383	52.25%	\$1,256,123,221	\$414,520,663	\$414,520,663	\$216,587,046	N/A	
33	RHODE ISLAND	\$108,503,167	\$2,397,833	\$110,901,000	2.16%	\$76,010,842	52.95%	\$143,552,110	\$2,397,833	\$2,397,833	\$1,269,653	N/A	
34	SOUTH CAROLINA	\$366,681,364	\$72,076,341	\$438,757,705	16.43%	\$382,977,702	70.70%	\$541,694,062	\$88,986,075	\$72,076,341	\$50,957,973	N/A	
35	TENNESSEE*	\$0	\$0	\$0	0.00%	\$53,100,000	65.21%	\$81,429,229	\$0	\$0	\$0	N/A	
36	TEXAS	\$1,220,515,401	\$292,513,592	\$1,513,028,993	19.33%	\$1,118,236,423	60.89%	\$1,836,486,160	\$355,047,501	\$292,513,592	\$178,111,526	N/A	
37	VERMONT	\$19,979,252	\$9,071,297	\$29,050,549	31.23%	\$26,311,447	53.86%	\$48,851,554	\$15,254,340	\$9,071,297	\$4,885,801	N/A	
38	VIRGINIA	\$129,313,480	\$7,770,268	\$137,083,748	5.67%	\$102,448,083	50.00%	\$204,896,166	\$11,614,055	\$7,770,268	\$3,885,134	N/A	
39	WASHINGTON	\$171,725,815	\$163,836,435	\$335,562,250	33.00%	\$216,338,550	50.00%	\$432,677,100	\$142,783,443	\$142,783,443	\$71,391,722	N/A	
40	WEST VIRGINIA	\$66,962,606	\$18,887,045	\$85,849,651	22.00%	\$78,934,335	74.94%	\$105,330,044	\$23,172,759	\$18,887,045	\$14,153,952	N/A	
41	TOTAL	\$13,402,460,846	\$4,118,758,904	\$17,521,219,750		\$12,256,780,174		\$21,548,730,937	\$4,103,551,554	\$3,556,104,381	\$2,018,840,621		
42													
43	LOW DSH STATES												
44	ALASKA	\$2,506,827	\$17,611,765	\$20,118,592	33.00%	\$23,820,269	50.00%	\$47,640,538	\$15,721,378	\$15,721,378	\$7,860,689	LOW DSH	
45	ARKANSAS	\$2,422,649	\$819,351	\$3,242,000	25.27%	\$50,445,219	71.42%	\$70,631,782	\$17,850,778	\$819,351	\$585,180	LOW DSH	
46	DELAWARE	\$0	\$7,069,000	\$7,069,000	33.00%	\$10,586,785	57.86%	\$18,297,243	\$6,038,090	\$6,038,090	\$3,493,639	LOW DSH	
47	HAWAII	\$0	\$0	\$0	0.00%	\$11,396,706	53.47%	\$21,314,206	\$0	\$0	\$0	LOW DSH	
48	IDAHO	\$2,081,429	\$0	\$2,081,429	0.00%	\$19,221,975	70.34%	\$27,327,232	\$0	\$0	\$0	LOW DSH	
49	IOWA	\$12,011,250	\$0	\$12,011,250	0.00%	\$46,052,208	61.20%	\$75,248,706	\$0	\$0	\$0	LOW DSH	
50	MINNESOTA	\$24,240,000	\$5,257,214	\$29,497,214	17.82%	\$87,340,989	50.00%	\$174,681,978	\$31,133,128	\$5,257,214	\$2,628,607	LOW DSH	
51	MONTANA	\$237,048	\$0	\$237,048	0.00%	\$13,273,569	64.78%	\$20,490,227	\$0	\$0	\$0	LOW DSH	
52	NEBRASKA	\$6,449,102	\$1,811,337	\$8,260,439	21.93%	\$33,091,871	54.72%	\$60,474,910	\$13,260,850	\$1,811,337	\$991,164	LOW DSH	
53	NEW MEXICO	\$6,490,015	\$254,786	\$6,744,801	3.78%	\$23,820,269	72.71%	\$32,760,651	\$1,237,539	\$254,786	\$185,255	LOW DSH	
54	NORTH DAKOTA	\$214,523	\$988,478	\$1,203,001	33.00%	\$11,170,064	50.05%	\$22,317,810	\$7,364,877	\$988,478	\$494,733	LOW DSH	
55	OKLAHOMA	\$20,019,969	\$3,273,248	\$23,293,217	14.05%	\$42,347,142	66.02%	\$64,142,899	\$9,013,595	\$3,273,248	\$2,160,998	LOW DSH	
56	OREGON	\$11,437,908	\$19,975,092	\$31,413,000	33.00%	\$52,933,933	61.23%	\$86,450,977	\$28,528,822	\$19,975,092	\$12,230,749	LOW DSH	
57	SOUTH DAKOTA	\$321,120	\$751,299	\$1,072,419	33.00%	\$12,915,583	57.62%	\$22,415,104	\$7,396,984	\$751,299	\$432,898	LOW DSH	
58	UTAH	\$3,621,116	\$934,586	\$4,555,702	20.51%	\$22,941,223	68.19%	\$33,643,090	\$6,901,760	\$934,586	\$637,294	LOW DSH	
59	WISCONSIN	\$6,609,524	\$4,492,011	\$11,101,535	33.00%	\$110,546,451	59.36%	\$186,230,544	\$61,456,080	\$4,492,011	\$2,666,458	LOW DSH	
60	WYOMING	\$0	\$0	\$0	0.00%	\$264,670	50.00%	\$529,340	\$0	\$0	\$0	LOW DSH	
61	TOTAL LOW DSH STATES	\$98,662,480	\$63,238,167	\$161,900,647		\$572,168,926		\$964,597,238	\$205,903,881	\$60,316,870	\$34,367,664		
62													
63	TOTAL	\$13,501,123,326	\$4,181,997,071	\$17,683,120,397		\$12,828,949,100		\$22,513,328,175	\$4,309,455,435	\$3,616,421,251	\$2,053,208,285		
64	FOOTNOTES												
65	* Tennessee's DSH allotment for FY 2020, determined under section 1923(f)(6)(A) of the Act, is \$53,100,000.												

RE: RE: Today's 3pm Managers Mtg and tomorrow's Clearance Meeting Agenda

From: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Date: Tue, 15 Jan 2019 17:07:55 +0000
Attachments: SC 16-0012-A Disapproval Letter Final 01-09-2019.docx (18.32 kB)

Attached is the proposed disapproval letter and below a brief summary of the SC issue. Thanks.

South Carolina Disapproval Issue: South Carolina has proposed several SPAs that are pending on RAI and that include problematic financing arrangements. The SPAs propose quarterly supplemental physician payments to Greenville Memorial Hospital for teaching physician services within the facility. The payments would be funded by the Greenville Health Authority through an intergovernmental transfer (IGT). Prior to 2016, the Greenville Health Authority operated Greenville Memorial Hospital as a governmental provider. In 2016, the Greenville Health Authority entered into an agreement with a private entity to lease and operate the hospital as a private provider. The source of the IGTs that would fund the non-federal share of the proposed physician supplemental payments would come from the "Setup Debt Collection Program," which allows Greenville Health Authority to continue to collect patient revenue owed to Greenville Memorial Hospital from periods prior to the hospital lease and ownership transfer to the private entity. Section 1903(w)(6)(A) of the Act requires that IGTs must be derived from state or local tax revenue. Greenville Health Authority does have access to tax revenue to support the IGTs associated with the proposed payments and the debt collection funds do not qualify as a permissible source of the IGTs under the Act. We have had several discussion with the state informing them that the funding source is problematic. The state and provider disagree and the state has no intention of withdrawing the proposed SPAs.

From: Fan, Kristin A. (CMS/CMCS)
Sent: Tuesday, January 15, 2019 11:34 AM
To: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: RE: Today's 3pm Managers Mtg and tomorrow's Clearance Meeting Agenda

I don't think we'll be ready for TX – but DRSF was going to add a discussion about a SC SPA.

From: Harrison, Wendy L. (CMS/CMCS)
Sent: Tuesday, January 15, 2019 11:14 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: Today's 3pm Managers Mtg and tomorrow's Clearance Meeting Agenda
Importance: High

Good Morning!!

Below is what I currently have for today's Managers' Meeting and tomorrow's Clearance Meeting Agenda... **Today's Managers meeting is not until 3pm today**, and I will need to have **Clearance agenda and paper up to OCD by 3:30pm!!**

FMG's Manager's Meeting – 01/15/18 – 3pm

DISCUSSION:

- Senior Staff Updates
- Reminder - CMCS Employee of the Month (February is FMG) – need nomination by Jan.17th
- 2018 HHS Awards Nominations, needed ASAP (possible nominees below)
SPA Workgroup

NEXT ISSUES MEETING:

CLEARANCE MEETING – 01/16 @ 1pm:

Standing Items:

- ACCESS NPRM – no paper
- Provider Payment Reassignment Rule – no paper

Signature or Discussion Items (Paper/Presenter): Possible items....

- Kansas – Hawkins Letter to the Secretary re: HMO Privilege Fee, K. Fan, paper
- Texas Financing Update, DFO, no paper (?)
-

Round Robin

THANKS!!

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
Baltimore, MD 21244
☎: 410-786-2075 7: 410-786-8533 ☎BB: 443-847-0369
✉: Wendy.Harrison@cms.hhs.gov

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Joshua D. Baker, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Dear Mr. Baker:

I am responding to your request to approve South Carolina Medicaid State Plan Amendments (SPA) 16-0012-A, 17-0006-A, and 18-0011-A which were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the State has proposed to fund the non-federal share of payment in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under these SPAs would be funded through transfers from the "Setoff Debt Collection Program". This program garnishes State Individual Income Tax refunds to satisfy outstanding liabilities owed to governmental entities for previously rendered medical services at governmental providers. The patient revenue funds generated from the debt collection program are applicable to medical services previously rendered.

Section 1903(w)(6)(A) of the Act allows states to use funds derived from state or local taxes, as the non-federal share of Medicaid payments. The revenue collected through the Setoff Debt Collection program is not derived from state or local taxes, but rather from the collection of previously uncollected patient revenue. As such, this is not a permissible source of the non-federal share of the payments.

Section 1902(a)(2) of the Social Security Act (the Act) provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources for the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states receive a certain calculated Federal Medicaid Assistance Percentage (FMAP) for state expenditures on medical assistance. The non-federal share of the payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A do not originate from a permissible source. The state has failed to propose a permissible alternative to the impermissible source that is discussed above. Absent a permissible source of the non-federal share of payments, CMS cannot not determine whether the state's proposal meets the requirements detailed within section 1902(a)(2) of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that this funding arrangement is not permissible. In subsequent e-mails, CMS indicated that if the

funding arrangement remained the same, then CMS would begin the disapproval process. CMS also asked the state if it intended to withdraw the SPA because of the likelihood of disapproval, to which the state responded that it would not withdraw SPAs 16-0012-A, 17-0006-A and 18-0011-A.

For the reasons stated above, after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15, I am disapproving these SPAs. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations at 42 CFR 430.18. Your request for reconsideration may be sent to Ms. Maritza Bodon, Centers for Medicare and Medicaid Services, Center for Medicaid & CHIP Services, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Shantrina Roberts, Associate Regional Administrator, Centers for Medicare and Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

Chris Traylor
Acting Deputy Administrator and Director

RE: RE: REVIEW and UPDATE: NGA Hot Topics

From: "Howe, Rory (CMS/CMCS)" [b6]
[b6]
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>
Cc: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Date: Wed, 20 Feb 2019 15:46:56 +0000

Should we include the Colorado deferrals? If so, do you need anything from DFO?

From: Boston, Beverly A. (CMS/CMCS)
Sent: Wednesday, February 20, 2019 10:36 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>
Subject: RE: REVIEW and UPDATE: NGA Hot Topics

Hello,

I checked the listing and still nothing added for Colorado on the deferrals and the SC SPA Disapprovals are also not listed.

Beverly

From: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Wednesday, February 20, 2019 10:27 AM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: FW: REVIEW and UPDATE: NGA Hot Topics

If you think we should mention something let me know.

From: Harshman, Sara (CMS/CMCS)
Sent: Wednesday, February 20, 2019 10:06 AM
To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Nardone, Michael P. (CMS/CMCS) <Michael.Nardone@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boughn, Julie (CMS/CMCS) <Julie.Boughn1@cms.hhs.gov>; McGuigan, Gregory M. (CMS/CMCS) <Gregory.McGuigan@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; Glaze, Jackie L. (CMS/CMCHO) <Jackie.Glaze@cms.hhs.gov>; Baldi, Michelle L. (CMS/CMCHO) <Michelle.Baldi@cms.hhs.gov>
Cc: Hill, Timothy B. (CMS/CMCS) <timothy.hill@cms.hhs.gov>; Gifford, Deidre S. (CMS/CMCS) <Deidre.Gifford@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Hill, Elizabeth H. (CMS/CMCS) <Elizabeth.Hill@cms.hhs.gov>; Delozier, Adrienne M. (CMS/CMCS) <Adrienne.Delozier@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Guarisco, Victoria M. (CMS/CMCS) <Victoria.Guarisco@cms.hhs.gov>; Setala, Ashley (CMS/CMCS) <Ashley.Setala@cms.hhs.gov>; Sheppard, Brenda D. (CMS/CMCS) <Brenda.Sheppard@cms.hhs.gov>
Subject: RE: REVIEW and UPDATE: NGA Hot Topics

Thank you all for your help in pulling this together! Calder has provided another list of Governors the Secretary is scheduled to meet (below). I've add them to the document.

- Louisiana
- Idaho
- Missouri
- Georgia
- Massachusetts
- Michigan

Calder is looking to receive the updated document by tomorrow at 3pm. If everyone could have their updates included by **2:30 tomorrow**, I will work to finalize the document and send it up.

Thanks again, everyone!

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

From: Harshman, Sara (CMS/CMCS)

Sent: Tuesday, February 19, 2019 11:45 AM

To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Nardone, Michael P. (CMS/CMCS) <Michael.Nardone@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boughn, Julie (CMS/CMCS) <julie.boughn1@cms.hhs.gov>; McGuigan, Gregory M. (CMS/CMCS) <Gregory.McGuigan@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; Glaze, Jackie L. (CMS/CMCHO) <Jackie.Glaze@cms.hhs.gov>; Baldi, Michelle L. (CMS/CMCHO) <Michelle.Baldi@cms.hhs.gov>

Cc: Hill, Timothy B. (CMS/CMCS) <timothy.hill@cms.hhs.gov>; Deidre S. Gifford (CMS/CMCS) (Deidre.Gifford@cms.hhs.gov) <Deidre.Gifford@cms.hhs.gov>; Rosa Mack (CMS/CMCS) (Rosa.Mack@cms.hhs.gov) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Hill, Elizabeth H. (CMS/CMCS) <Elizabeth.Hill@cms.hhs.gov>; Delozier, Adrienne M. (CMS/CMCS) <Adrienne.Delozier@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Guarisco, Victoria M. (CMS/CMCS) <Victoria.Guarisco@cms.hhs.gov>; Setala, Ashley (CMS/CMCS) <Ashley.Setala@cms.hhs.gov>; Sheppard, Brenda D. (CMS/CMCS) <Brenda.Sheppard@cms.hhs.gov>

Subject: REVIEW and UPDATE: NGA Hot Topics

Good morning!

We received a tentative list of Governors that the Secretary is meeting with at NGA. Calder wanted us to go through and update to ensure we have everything (Calder mentioned that there might be a correction pharmacy rebate issue in FL). Can you all take a look at the document in the link below and be sure we've captured everything for the states listed below? I've followed up with Calder to determine when updates are needed, but I assume it will be ASAP because NGA begins Friday. Can we aim to have updates by **noon tomorrow**? I will keep you updated on what I hear from Calder.

b6

- Governor Sununu (NH)
- Governor Polis (CO)
- Governor Hogan (MD)
- Governor Holcomb (IN)
- Governor Herbert (UT)
- Governor McMaster (SC)
- Governor Lee (TN)
- Governor Reynolds (IA)
- Governor Noem (SD)
- Governor DeSantis (FL)
- Governor Ricketts (NE)
- Governor Kelly (KS)
- Governor (WY) *tentative

Thanks!
Sara

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

RE: RE: FMG Clearance | Materials [NEW TIME]

From: "Howe, Rory (CMS/CMCS)" [b6]
[b6]
To: "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>
Date: Fri, 27 Sep 2019 15:34:27 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

They are working on it.

From: Clark, Jennifer (CMS/CMCS)
Sent: Friday, September 27, 2019 11:34 AM
To: Dunn, Victoria (CMS/CMCS) <Victoria.Dunn@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Is there a new call in #? The PIN # is not working for me.

-----Original Appointment-----

From: Dunn, Victoria (CMS/CMCS) **On Behalf Of** CMS CMCS_Scheduling

Sent: Friday, September 27, 2019 9:34 AM

To: Adams, Lia (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Barraza, Leticia (CMS/CMCS); Beasley, Michelle (CMS/CMCS); Benson, Deborah J. (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Brandt, John (CMS/OL); Brooks, Bill D. (CMS/CMCS); Brown, Sharon J. (CMS/CMCS); Buck, Megan K. (CMS/CMCS); Burdullis, Brian M. (CMS/CMCS); Carroll, Lisa (CMS/CMCS); Chan, Jeanie (CMS/CMCS); Cheng, Irene T. (CMS/CMCS); Cieslicki, Mary E. (CMS/CMCS); Clark, Jennifer (CMS/CMCS); CMS VTC; Cooley, Mark S. (CMS/CMCS); Cuno, Richard A. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); D'Angelo, Laura (CMS/CMCS); Davidson, Timothy G. (CMS/CMCS); Dillon, Kristin C. (CMS/CMCS); Dunn, Victoria (CMS/CMCS); Endelman, Jonathan (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Ferretti, Ross H. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Friedrich, Charles A. (CMS/CMCS); Gavens, Jay C. (CMS/CMCS); Gillaspie, Cynthia D. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Halter, Mark D. (CMS/CMCS); Harris, Byron J. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Hines, Charles (CMS/CMCS); Hoang, Dzung A. (CMS/CMCS); Holligan, Ricardo E. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Holzbaur, Charlene M. (CMS/CMCS); Howe, Rory (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Hunt, Trinia J. (CMS/CMCS); Ihrig, Jocelyn B. (CMS/CMCS); James-Hailey, Novena M. (CMS/CMCS); Johns, Hamilton J. (CMS/CMCS); Joyce, Tannisse L. (CMS/CMCS); Kessler, Christopher G. (CMS/CMCS); Kimball, Richard M. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Knight, Gary L. (CMS/CMCS); Lambert, Diana (CMS/OFM); Lane, Robert (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lyles, Tia (CMS/CMCS); Lynch, Calder (CMS/OA); MacCarroll, Amber L. (CMS/CMCS); Mannix, Norma J. (CMS/CMCS); Marchioni, Mary A. (CMS/CMCS); McClure, Deborah A. (CMS/CMCS); McMillion, Todd (CMS/CMCS); Meacham, David L. (CMS/CMCS); Michael, Lindsay (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); Motley, Danielle O. (CMS/CMCS); Nanes, Cynthia (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Pellanda, Manning J. (CMS/CMCS); Powell, Eric M. (CMS/CMCS); Richards, Barbara K. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Sam-Louie, Henrietta C. (CMS/CMCS); Sampson, Tamara L. (CMS/CMCS); Savage, Courtenay (CMS/CMCS); Shields, Karen (CMS/CMCS); Shuman, Stacey S. (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Solomon, Alma (CMS/CMCS); Stahlecker, Avery (CMS/CMCS); Storey, Christine B. (CMS/CMCS); Ta, Anh-Dung (CMS/CMCS); Teal, Lela (CMS/CMCS); Thomas, Douglas A. (CMS/CMCS); Thomas, Stephanie D. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Tilahun, Negussie (CMS/CMCS); VERMA, RAJENDER (CMS/CMCS); Weaver, Robert K. (CMS/CMCS); Weidler, Timothy A. (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Yablochnikov, Daniil (CMS/CMCS); Zolynas, Brian (CMS/CMCS); Kennedy, Jocelyn (CMS/CMCS); Juhring, Heather (CMS/CMCS); Giles, John (CMS/CMCS); Young, Cheryl (CMS/CMCS); Lewis, Ashley (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Wiley, Evelyn S. (CMS/CMCS)

Cc: Wigfall, Cheryl (CMS/CMCS); Mathias, Natasha C. (CMS/CMCS); McAllister, Lisa (CMS/CMCS); Le-Yuen, Mai (CMS/CMCS)

Subject: FMG Clearance | Materials [NEW TIME]

When: Friday, September 27, 2019 11:30 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: Conference Room A // WebEx: 1-877-267-1577 Meeting Number: 990 091 886

NO VTC for DC necessary

Agenda:

<< File: Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF >>

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

<< File: SC Disapproval Letter Final_ Signed.pdf >> << File: Letter to Administrator SC SPAs.docx >>

Discussion Items:

1. Arkansas FMR Follow-up, J. Gavens, verbal only

<< File: Joshua D Baker SC SMD Letter.docx >>

2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only

<< File: Federal Register Notice SC SPAs.docx >>

3. Oregon CHIP Contingency Fund, DFO, paper

<< File: FMG Cover Page SC ReconsDis.docx >> << File: FMG Cover Page PRR CIB.DOCX >>

4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only

<< File: Oregon CHIP Contingency Fund Issue Paper 9-25-19.docx >>

5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

<< File: FMG Cover Page OR CHIP CF.docx >> << File: FMG Cover Page WI CALL.docx >> << File: FMG Cover Page AR FMR FU.docx >> << File: DSH Allotment Reductions FY 2020.xlsx >> << File: FMG Cover Page DSHRule.docx >> << File: FMG CLEARANCE Agenda 09-26-2019.docx >>

Access Information

1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number:

b6

RE: RE: REVIEW and UPDATE: NGA Hot Topics

From: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>
Cc: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Wed, 20 Feb 2019 15:52:23 +0000

I just added the SC issue.

From: Boston, Beverly A. (CMS/CMCS)
Sent: Wednesday, February 20, 2019 10:36 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>
Subject: RE: REVIEW and UPDATE: NGA Hot Topics

Hello,

I checked the listing and still nothing added for Colorado on the deferrals and the SC SPA Disapprovals are also not listed.

Beverly

From: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Wednesday, February 20, 2019 10:27 AM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: FW: REVIEW and UPDATE: NGA Hot Topics

If you think we should mention something let me know.

From: Harshman, Sara (CMS/CMCS)
Sent: Wednesday, February 20, 2019 10:06 AM
To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Nardone, Michael P. (CMS/CMCS) <Michael.Nardone@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boughn, Julie (CMS/CMCS) <Julie.Boughn1@cms.hhs.gov>; McGuigan, Gregory M. (CMS/CMCS) <Gregory.McGuigan@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; Glaze, Jackie L. (CMS/CMCHO) <Jackie.Glaze@cms.hhs.gov>; Baldi, Michelle L. (CMS/CMCHO) <Michelle.Baldi@cms.hhs.gov>
Cc: Hill, Timothy B. (CMS/CMCS) <timothy.hill@cms.hhs.gov>; Gifford, Deidre S. (CMS/CMCS) <Deidre.Gifford@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Hill, Elizabeth H. (CMS/CMCS) <Elizabeth.Hill@cms.hhs.gov>; Delozier, Adrienne M. (CMS/CMCS) <Adrienne.Delozier@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Guarisco, Victoria M. (CMS/CMCS) <Victoria.Guarisco@cms.hhs.gov>; Setala, Ashley (CMS/CMCS) <Ashley.Setala@cms.hhs.gov>; Sheppard, Brenda D. (CMS/CMCS) <Brenda.Sheppard@cms.hhs.gov>
Subject: RE: REVIEW and UPDATE: NGA Hot Topics

Thank you all for your help in pulling this together! Calder has provided another list of Governors the Secretary is scheduled to meet (below). I've add them to the document.

- Louisiana
- Idaho
- Missouri
- Georgia
- Massachusetts
- Michigan

Calder is looking to receive the updated document by tomorrow at 3pm. If everyone could have their updates included by **2:30 tomorrow**, I will work to finalize the document and send it up.

Thanks again, everyone!

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

From: Harshman, Sara (CMS/CMCS)
Sent: Tuesday, February 19, 2019 11:45 AM
To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Nardone, Michael P. (CMS/CMCS) <Michael.Nardone@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boughn, Julie (CMS/CMCS) <julie.boughn1@cms.hhs.gov>; McGuigan, Gregory M. (CMS/CMCS) <Gregory.McGuigan@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; Glaze, Jackie L. (CMS/CMCHO) <Jackie.Glaze@cms.hhs.gov>; Baldi, Michelle L. (CMS/CMCHO) <Michelle.Baldi@cms.hhs.gov>
Cc: Hill, Timothy B. (CMS/CMCS) <timothy.hill@cms.hhs.gov>; Deidre S. Gifford (CMS/CMCS) (Deidre.Gifford@cms.hhs.gov) <Deidre.Gifford@cms.hhs.gov>; Rosa Mack (CMS/CMCS) (Rosa.Mack@cms.hhs.gov) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Hill, Elizabeth H. (CMS/CMCS) <Elizabeth.Hill@cms.hhs.gov>; Delozier, Adrienne M. (CMS/CMCS) <Adrienne.Delozier@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Guarisco, Victoria M. (CMS/CMCS) <Victoria.Guarisco@cms.hhs.gov>; Setala, Ashley (CMS/CMCS) <Ashley.Setala@cms.hhs.gov>; Sheppard, Brenda D. (CMS/CMCS) <Brenda.Sheppard@cms.hhs.gov>
Subject: REVIEW and UPDATE: NGA Hot Topics

Good morning!

We received a tentative list of Governors that the Secretary is meeting with at NGA. Calder wanted us to go through and update to ensure we have everything (Calder mentioned that there might be a correction pharmacy rebate issue in FL). Can you all take a look at the document in the link below and be sure we've captured everything for the states listed below? I've followed up with Calder to determine when updates are needed, but I assume it will be ASAP because NGA begins Friday. Can we aim to have updates by **noon tomorrow**? I will keep you updated on what I hear from Calder.

<https://share.cms.gov/center/CMCS/Collaborations/Shared%20Documents/UPDATE%20-%20NGA%20Hot%20Issues%202.19.19.docx?Web=1>

- Governor Sununu (NH)
- Governor Polis (CO)
- Governor Hogan (MD)
- Governor Holcomb (IN)
- Governor Herbert (UT)
- Governor McMaster (SC)
- Governor Lee (TN)
- Governor Reynolds (IA)
- Governor Noem (SD)
- Governor DeSantis (FL)
- Governor Ricketts (NE)
- Governor Kelly (KS)
- Governor (WY) *tentative

Thanks!
Sara

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

RE: RE: TODAY's MANAGERS' Meeting and TOMORROW's CLEARANXCE Meeting

From: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>
To: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>
Date: Tue, 26 Mar 2019 14:13:58 +0000

Please add/modify for clearance:

Standing Items:

Access NPRM – Medicaid Access Strategy (paper)

Signature or Discussion:

South Carolina SPA Disapproval Package – Set-off Debt Collection Financing, DRSF (paper)

Papers will be forthcoming. Thanks.

From: Harrison, Wendy L. (CMS/CMCS)
Sent: Tuesday, March 26, 2019 10:06 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>
Subject: TODAY's MANAGERS' Meeting and TOMORROW's CLEARANXCE Meeting
Importance: High

Good Morning!

Here is what I currently have for today's Managers' Meeting and tomorrow's Clearance Meeting. Please provide additional items or edits by 12:30pm today!!

Thanks!!

DISCUSSION:

- Senior Staff Updates
-

NEXT ISSUES MEETING:

CLEARANCE MEETING – 03/27 @ 1pm:

Standing Items:

- ACCESS NPRM – no paper
- Provider Payment Reassignment Rule – no paper
- MFAR – no paper

Signature or Discussion Items (Paper/Presenter):

- Maine Senator Letter Re: Riverview Disallowance, DFO, paper
- Recovery of Bonus Payments Identified by the OIG, DFO, paper

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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✉ Wendy.Harrison@cms.hhs.gov

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Today's 1pm FMG Managers' Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>
Date: Tue, 26 Mar 2019 16:48:56 +0000

FMG's Managers' Meeting – 3/26/19 – 1pm

Dial – in

b6

DISCUSSION:

- Senior Staff Updates
-

NEXT ISSUES MEETING:

CLEARANCE MEETING – 03/27 @ 1pm:

Standing Items:

- ACCESS NPRM – Medicaid Strategy Paper - **paper**
- Provider Payment Reassignment Rule – **no paper**
- MFAR – **no paper**

Signature or Discussion Items (Paper/Presenter):

- South Carolina SPA Disapproval Package, *DRSF*, **paper**
- Bonus Payments Overpayment Recovery Process, *DFO*, **paper**
- Maine Senator Letter Re: Riverview Disallowance, *DFO*, **paper**
- Missouri TCM Disallowance, *DFO*, **paper**
- Missouri ISL Disallowance, *DFO*, **paper**

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group

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RE: RE: Materials for FMG's Wednesday 1pm EST Meeting with the CMCS OCD

From: "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>

To: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Nelson, Barbara A. (CMS/CMCS)" <barbara.nelson@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Dunn, Victoria (CMS/CMCS)" <victoria.dunn@cms.hhs.gov>, "Gifford, Deidre S. (CMS/CMCS)" <deidre.gifford@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>, "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>, "Traylor, Christopher (CMS/CMCS)" <christopher.traylor@cms.hhs.gov>

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Date: Wed, 15 May 2019 16:29:15 +0000

Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

Thank you Wendy.

Karen M. Shields
Deputy Director, Center for Medicaid & CHIP Services
Centers for Medicare and Medicaid Services

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b6 Mobile

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Subject: RE: Materials for FMG's Wednesday 1pm EST Meeting with the CMCS OCD

Good Afternoon,

Here is an updated version of "Item #2" Under **1. South Carolina SPA Disapprovals, DRSF, paper**

<< File: SC 16-0012-A SC 17-0006-A and SC 18-0011-A Disapproval Letter Final 03-2....docx >>

Sorry for any inconvenience!!

Thanks,

Wendy L. Harrison, LSW

Technical Advisor to the Director

Financial Management Group

Centers for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

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(CMS/CMCHO) <Rene.Que@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Slaven, Kevin R. (CMS/CMCHO) <Kevin.Slaven@cms.hhs.gov>; Marchioni, Mary A. (CMS/CMCHO) <Mary.Marchioni@cms.hhs.gov>; Kessler, Christopher G. (CMS/CMCS) <Christopher.Kessler@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Dickstein, Ari A. (CMS/CMCS) <Ari.Dickstein@cms.hhs.gov>; Carrington, Khia (CMS/CMCS) <Khia.Carrington@cms.hhs.gov>; Ponte, Grace (CMS/CMCS) <Grace.Ponte@cms.hhs.gov>; Gibson, Jennifer (CMS/CMCS) <Jennifer.Gibson@cms.hhs.gov>; Watkins, Vernell A. (CMS/CMCS) <Vernell.Watkins@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Hiltner, Tavon (CMS/CMCS) <Tavon.Hiltner@cms.hhs.gov>; Beasley, Michelle (CMS/CMCS) <Michelle.Beasley@cms.hhs.gov>; Davies, Edgar W. (CMS/CMCS) <Edgar.Davies@cms.hhs.gov>; Hunt, Trinia J. (CMS/CMCHO) <TRINIA.HUNT@cms.hhs.gov>; Burnette, Olivia L. (CMS/CMCS) <Olivia.Burnette@cms.hhs.gov>; Hughes, Ruth A. (CMS/CMCHO) <Ruth.Hughes@cms.hhs.gov>; Sabir, Jeremiah A. (CMS/CMCS) <Jeremiah.Sabir@cms.hhs.gov>; Johns, Hamilton J. (CMS/CMCS) <Hamilton.Johns@cms.hhs.gov>; Kimball, Richard M. (CMS/CMCS) <Richard.Kimball@cms.hhs.gov>; Tilahun, Negussie (CMS/CMCS) <Negussie.Tilahun@cms.hhs.gov>; Williams, Melissa (CMS/CMCS) <Melissa.Williams@cms.hhs.gov>; Yablochnikov, Daniil (CMS/CMCS) <Daniil.Yablochnikov@cms.hhs.gov>; Giacalone, Diana L. (CMS/CMCHO) <Diana.Giacalone@cms.hhs.gov>; Whelan, Ellen Marie (CMS/CMCS) <EllenMarie.Whelehan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Miller, Teia N. (CMS/CMCHO) <Teia.Miller@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Motley, Danielle O. (CMS/CMCS) <Danielle.Motley@cms.hhs.gov>; Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>; VERMA, RAJENDER (CMS/CMCHO) <Rajender.Verma@cms.hhs.gov>; Parris, Robert J. (CMS/CMCHO) <Robert.Parris@cms.hhs.gov>; Ihrig, Jocelyn B. (CMS/CMCS) <Jocelyn.Ihrig@cms.hhs.gov>; Meacham, David L. (CMS/CMCHO) <David.Meacham@cms.hhs.gov>; Friedrich, Charles A. (CMS/CMCHO) <Charles.Friedrich@cms.hhs.gov>; Hall, Candice J. (CMS/CMCS) <Candice.Hall@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Pellanda, Manning J. (CMS/CMCHO) <Manning.Pellanda@cms.hhs.gov>; Holt,

Kathryn (CMS/CMCHO) <Kathryn.Holt@cms.hhs.gov>; Wiley, Evelyn S. (CMS/CMCS) <Evelyn.Wiley@cms.hhs.gov>; McClure, Deborah A. (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Lyles, Tia (CMS/CMCS) <Tia.Lyles@cms.hhs.gov>; Dubois, Anna M. (CMS/CMCHO) <Anna.Dubois@cms.hhs.gov>; Michael, Lindsay (CMS/CMCS) <Lindsay.Michael@cms.hhs.gov>; Staton, Sidney H. (CMS/CMCHO) <Sidney.Staton@cms.hhs.gov>; Endelman, Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Stahlecker, Avery (CMS/CMCS) <Avery.Stahlecker@cms.hhs.gov>; Roberts, Shantrina D. (CMS/CMCHO) <Shantrina.Roberts@cms.hhs.gov>; Jordan, Charlamia C. (CMS/CMCHO) <Charlamia.Jordan@cms.hhs.gov>; Kennedy, Jocelyn (CMS/CMCS) <Jocelyn.Kennedy@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Subject: Materials for FMG's Wednesday 1pm EST Meeting with the CMCS OCD

CMCS CENTER DIRECTOR CLEARANCE WITH THE FINANCIAL MANAGEMENT GROUP (FMG)

May 15, 2019

Conference Room A, 1pm – 1:30pm EST

Conference Dial in Number: **877-267-1577**

Meeting ID : b6

Please see attached an agenda and materials for Wednesday's **1pm – 1:30pm** EST clearance meeting with the Office of the Center Director. **For those participating by phone, please be sure to dial into the call at the start of the meeting and plan to stay until completion.** This will help with any disruption while discussions are still ongoing.

Agenda:

<< File: SC 16-0012-A Disapproval Memo 05-02-2019.docx >>

Standing Items:

ACCESS NPRM, J. Silanskis, no paper

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, no paper

DSH Allotment Reduction Rule, R. Howe, no paper

Discussion Items:

1. South Carolina SPA Disapprovals, DRSF, paper

<< File: SC 16-0012-A SC 17-0006-A and SC 18-0011-A Disapproval Letter Final 03-2....docx >> << File: SC-16-0012-A SC-17-0006-A and SC-18-0011-A Disapproval Agnew Memo 05-02-....docx >> << File: SC-16-0012-A SC-17-0006-A and SC-18-0011-A Qs and As 03-26-2019.docx >> << File: Provider Reassignment Regulation - Enforcement Plan 5-13.docx >>

2. Enforcement of the Provider Payment Reassignment Rule, C. Thompson, paper

<< File: DRAFT 5-14-19- OCD Briefing CA Financing Issues.docx >>

3. State-only Findings, K. Fan, no paper

4. California Medicaid Financing Issues (deferrals, disallowances and negative balances), DFO, paper

<< File: CaliforniaDeferral-Disallowance5_19.xlsx >> << File: FMG CLEARANCE Agenda 05-15-2019.docx >>

Today's 11am FMG Managers' Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>
Date: Tue, 21 May 2019 14:38:34 +0000

FMG's Managers' Meeting – 05/21/19 – 11am

DISCUSSION:

- Senior Staff Updates
- Time Off and Cash Awards

NEXT ISSUES MEETING:

CLEARANCE MEETING – 05/22 @ 1pm:

Standing Items:

- ACCESS NPRM – no paper
- MFAR – no paper
- DSH Allotment Reduction Rule – no paper

Signature or Discussion Items (Paper/Presenter):

1. South Carolina SPA Disapprovals, *DRSF*, paper

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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☎: 410-786-2075 7: 410-786-8533 ☎ BB:

✉: Wendy.Harrison@cms.hhs.gov

b6

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Today's 1pm FMG Managers' Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>
Date: Tue, 04 Jun 2019 16:52:28 +0000

FMG's Managers' Meeting – 06/04/19 – 1pm

DISCUSSION:

- Senior Staff Updates

NEXT ISSUES MEETING:

CLEARANCE MEETING – 06/06 @ 10:30am:

Standing Items:

- ACCESS NPRM – **no paper**
- MFAR – **no paper**
- DSH Allotment Reduction Rule – **no paper**

Signature or Discussion Items (Paper/Presenter):

1. Oklahoma FQHC SPA Disapproval, *DRSF*, **paper**
2. South Carolina SPA Disapproval, *DRSF*, **paper**
3. Louisiana SPA Disapproval, *DRSF*, **paper**

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
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7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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Today's Managers' Meeting and Thursday's Clearance Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>
Date: Tue, 04 Jun 2019 15:39:17 +0000

Good Morning!

This is what I currently have for today's **1pm** Managers' Meeting and tomorrow's Clearance Meeting. Please provide me with edits and additional items by **12:30pm** today!

Thanks!

FMG's Managers' Meeting – 06/04/19 – 1pm

DISCUSSION:

· Senior Staff Updates

NEXT ISSUES MEETING:

CLEARANCE MEETING – 06/06 @ 10:30am:

Standing Items:

- ACCESS NPRM – no paper
- MFAR – no paper
- DSH Allotment Reduction Rule – no paper

Signature or Discussion Items (Paper/Presenter):

1. OK FQHC SPA Disapproval, *DRSF*, **paper**
2. SC SPA Disapproval, *DRSF*, **paper**
3. LA SPA Disapproval, *DRSF*, **paper**

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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✉ Wendy.Harrison@cms.hhs.gov

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distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Today's 1pm FMG Managers' Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>
Date: Tue, 25 Jun 2019 16:44:41 +0000

FMG's Managers' Meeting – 06/25/19 – 1pm

DISCUSSION:

- FEET Update
- Senior Staff Updates

NEXT ISSUES MEETING:

CLEARANCE MEETING – 06/26 @ 1pm:

Standing Items:

- ACCESS NPRM – **no paper**
- MFAR – **no paper**
- DSH Allotment Reduction Rule – **no paper**

Signature or Discussion Items (Paper/Presenter):

1. Maryland Deferral, *DFO*, **paper** (possible)
2. South Carolina Disapproval, *DRSF*, **paper** (?)
3. New Hampshire SPA, RAI Responses (donations), *DRSF*, **paper**
4. Durable Medical Equipment FFP Limit Update, *DRSF*, **paper** (?)
5. PRR Update, *DRSF*, **no paper**

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
Baltimore, MD 21244
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✉: Wendy.Harrison@cms.hhs.gov

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RE: RE: Missouri Reconsideration Night Note

From: "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Cc: "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Date: Thu, 11 Jul 2019 19:32:14 +0000

Thanks!!!!

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6 b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, July 11, 2019 3:31 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Subject: RE: Missouri Reconsideration Night Note

It's out the door. Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Thursday, July 11, 2019 2:00 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>
Subject: RE: Missouri Reconsideration Night Note

Yes. Please let us know when you send the letter. Thanks!

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, July 11, 2019 1:59 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Subject: Missouri Reconsideration Night Note

Hello,

Checking whether we are still on target to release the MO reconsideration letter today? Has it cleared night notes.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

It will be on the NN on July 10th to be issued on July 11th.

Lela normally handles the signing of the letter, etc. So not sure if she's been able to get that in front of him yet...

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:22 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Great, thank you. Please let me know if Calder is okay with us sending the letter as soon as NN clears? Thurs is the latest, but folks here and in the ROG would greatly appreciate if we can close this out as soon as practicable.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:20 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Ok, that works. I sent it up yesterday as well.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:19 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

We would like to get it out by Thurs 7/11. We want to avoid any Friday mishaps with folks not being in the office etc...

Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 7:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Welcome.

When are we sending MO?

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:19 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Thanks!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:10 PM
To: Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: FW: Night Note

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824

From: Mack, Rosa (CMS/CMCS)
Sent: Monday, July 8, 2019 4:02 PM
To: Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Cc: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>
Subject: Re: Night Note

Letter/email to the state.

Also, the 90th day is tomorrow. So we have to send it tomorrow.

Sent from my iPhone

On Jul 8, 2019, at 3:58 PM, Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov> wrote:

Hey Rosa,

Can you clarify how Disapproval of South Carolina Medicaid State Plan Amendment will be notified? Is it a letter to the state?

Disapproval of South Carolina Medicaid State Plan Amendment	CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21, 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.	Disapproval to South Carolina's Medicaid state plan amendments

From: Mack, Rosa (CMS/CMCS)
Sent: Monday, July 8, 2019 2:26 PM

To: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>
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Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

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Brittney Manchester
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Integrated Communications Management Staff
Office of Communications
Centers for Medicare & Medicaid Services
brittney.manchester1@cms.hhs.gov
202-205-8028 (office)
b6 cell)

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Jason Stegmaier

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Sent: Monday, July 8, 2019 1:25 PM

To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>

Subject: Night Note

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Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6)

RE: RE: Missouri Reconsideration Night Note

From: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Cc: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Date: Fri, 12 Jul 2019 11:41:17 +0000

Yeah – and I know this process is frustrating.

From: Boston, Beverly A. (CMS/CMCS)
Sent: Thursday, July 11, 2019 3:31 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Subject: RE: Missouri Reconsideration Night Note

It's out the door. Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Thursday, July 11, 2019 2:00 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>
Subject: RE: Missouri Reconsideration Night Note

Yes. Please let us know when you send the letter. Thanks!

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
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Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, July 11, 2019 1:59 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Subject: Missouri Reconsideration Night Note

Hello,

Checking whether we are still on target to release the MO reconsideration letter today? Has it cleared night notes.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

It will be on the NN on July 10th to be issued on July 11th.

Lela normally handles the signing of the letter, etc. So not sure if she's been able to get that in front of him yet...

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From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:22 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Great, thank you. Please let me know if Calder is okay with us sending the letter as soon as NN clears? Thurs is the latest, but folks here and in the ROG would greatly appreciate if we can close this out as soon as practicable.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:20 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Ok, that works. I sent it up yesterday as well.

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From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:19 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

We would like to get it out by Thurs 7/11. We want to avoid any Friday mishaps with folks not being in the office etc...

Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 7:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Welcome.

When are we sending MO?

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Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:19 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Thanks!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:10 PM
To: Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: FW: Night Note

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From: Mack, Rosa (CMS/CMCS)
Sent: Monday, July 8, 2019 4:02 PM
To: Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Cc: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Lewis, Ashley (CMS/CMCS)

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The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

Today's 1pm FMG Managers' Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>
Date: Tue, 27 Aug 2019 16:40:54 +0000

FMG's Managers' Meeting – 08/27/19 – 1pm

DISCUSSION:

- Senior Staff Updates
-

CLEARANCE MEETING – 08/28 @ 1pm:

Standing Items:

- ACCESS NPRM – **no paper**
- MFAR – **no paper**
- DSH Allotment Reduction Rule – **no paper**
- Provider Payment Reassignment CIB – **no paper**

Signature or Discussion Items (Paper/Presenter):

1. Kentucky SBS SPA 19-0003, currently on RAI, per OCD request, *DRSF*, **paper**
2. California Clinical Labs SPA, per OCD request, *DRSF*, **paper**
- 3.
- 4.

FOLLOW-UP Items requested by OCD, for a future Clearance Meeting:

1. Broader View of the Maine PNMI Issue (and letter)
2. 2020 FMR Work Plan: Edit letter to say how we track FMR work now, not how we “don’t”
 Copy of the FMR Tracking Sheet
 Explanation/Justification for 3 FMRs – SC, KS, and WA
3. Calculating Overpayments related to Legal Settlements: Send Reg. cite
 Create a paper with background context on how often these settlements tend to happen and examples of how they played out, we can provide WV

4. Write-up on the “regulatory-gap” related to disallowances and precedence

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
Baltimore, MD 21244

☎: 410-786-2075 7: 410-786-8533 ☎B

b6

✉: Wendy.Harrison@cms.hhs.gov

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Today's 1pm FMG Managers' Meeting and tomorrow's Clearance Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>
Date: Tue, 10 Sep 2019 16:57:16 +0000

FMG's Managers' Meeting – 09/11/19 – 1pm

DISCUSSION:

- Senior Staff Updates
- CMS Honor Awards

CLEARANCE MEETING – 09/11 @ 1pm:

Standing Items:

- ACCESS NPRM – **no paper**
- MFAR – **no paper**
- DSH Allotment Reduction Rule – **no paper**
- Provider Payment Reassignment CIB – **no paper**

Signature or Discussion Items (Paper/Presenter):

1. EOP Questions on DSH Reduction Rule, *K. Fan/DFO*, **paper (email)**
2. Arkansas FMR, *DFO*, **paper**
3. VII Group Reporting Issues/CIB proposal, *A. MacCarroll*, **paper**
4. Wisconsin Cost Reporting Issue, *DRSF*, **paper**
5. National Alliance for Medicaid in Education (NAME) Conference Presentation, *DRSF*, **paper**
6. California Clinical Diagnostic Laboratory SPA, *DRSF*, **no paper**
7. (If ready?...)
2020 FMR Work Plan: Edit letter to say how we track FMR work now, not how we "don't", Copy of the FMR Tracking Sheet and Explanation/Justification relating 3 FMRs – SC, KS, and WA to the 6 priorities, *J. Gavens/DFO*, **paper**

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
Baltimore, MD 21244

☎: 410-786-2075 7: 410-786-8533 ☎BB:

b6

✉: Wendy.Harrison@cms.hhs.gov

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Tomorrow's Clearance Meeting (NO Managers' Meeting TODAY)

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>
Date: Tue, 17 Sep 2019 11:47:54 +0000

Good Morning!

Due to the Integration Meeting today it looks like we won't be having an official "Managers' Meeting". I will still need to have all Clearance Items and materials for upstairs no later than 2:30pm TODAY!

The only item I currently have down is: the NAME Conference/Slide Deck, DRSF, Paper

Thanks!!

Wendy L. Harrison, LSW

Technical Advisor to the Director
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7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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✉: Wendy.Harrison@cms.hhs.gov

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From: Harrison, Wendy L. (CMS/CMCS)
Sent: Tuesday, September 10, 2019 12:57 PM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; McCullough, Francis T. (CMS/CMCS) <Francis.McCullough@cms.hhs.gov>
Subject: Today's 1pm FMG Managers' Meeting and tomorrow's Clearance Meeting

FMG's Managers' Meeting – 09/11/19 – 1pm

DISCUSSION:

- Senior Staff Updates
- CMS Honor Awards

CLEARANCE MEETING – 09/11 @ 1pm:

Standing Items:

- ACCESS NPRM – no paper
- MFAR – no paper

- DSH Allotment Reduction Rule – **no paper**
- Provider Payment Reassignment CIB – **no paper**

Signature or Discussion Items (Paper/Presenter):

1. EOP Questions on DSH Reduction Rule, *K. Fan/DFO*, **paper (email)**
2. Arkansas FMR, *DFO*, **paper**
3. VII Group Reporting Issues/CIB proposal, *A. MacCarroll*, **paper**
4. Wisconsin Cost Reporting Issue, *DRSF*, **paper**
5. National Alliance for Medicaid in Education (NAME) Conference Presentation, *DRSF*, **paper**
6. California Clinical Diagnostic Laboratory SPA, *DRSF*, **no paper**
7. **(If ready?...)2020 FMR Work Plan:** Edit letter to say how we track FMR work now, not how we “don’t”, Copy of the FMR Tracking Sheet and Explanation/Justification relating 3 FMRs – SC, KS, and WA to the 6 priorities, *J. Gavens/DFO*, **paper**

Round Robin

Wendy L. Harrison, LSW

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RE: RE: Today's 1pm Managers Meeting and Thursday's Clearance Meeting

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "McCullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>
Date: Tue, 24 Sep 2019 16:05:31 +0000

THANKS!!

Wendy L. Harrison, LSW

Technical Advisor to the Director
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Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
Baltimore, MD 21244
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✉: Wendy.Harrison@cms.hhs.gov

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From: Boston, Beverly A. (CMS/CMCS)
Sent: Tuesday, September 24, 2019 11:41 AM
To: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; McCullough, Francis T. (CMS/CMCS) <Francis.McCullough@cms.hhs.gov>
Subject: RE: Today's 1pm Managers Meeting and Thursday's Clearance Meeting

Hi Wendy,

Per the OCD, we'll need to add the SC SPA disapproval reconsideration package to our clearance meeting.

Thanks

Beverly

From: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Sent: Tuesday, September 24, 2019 11:34 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; McCullough, Francis T. (CMS/CMCS) <Francis.McCullough@cms.hhs.gov>
Subject: Today's 1pm Managers Meeting and Thursday's Clearance Meeting

Hello All!!

Here is what I currently have for today's Managers Meeting and **THURSDAY's** Clearance Meeting. Please provide me any edits and additional items by 12:30pm today!!

Thanks!!

FMG's Managers' Meeting – 09/24/19 – 1pm

DISCUSSION:

- Senior Staff Updates
-

CLEARANCE MEETING – 09/26 @ 4:30pm:

Standing Items:

- ACCESS NPRM – no paper
- MFAR (OCD suggested changing compliance timeline to 3 years, through OMB comments) – no paper
- DSH Allotment Reduction Rule (Bring our answers to EOP questions back to Clearance when we have them completed.)– paper

Signature or Discussion Items (Paper/Presenter):

1. Maine PNMI Follow-up from 9/4 Clearance (OCD request – combined briefing memo and updated letter), *DRSF*, paper
2. Arkansas FMR Follow-up from 9/11 Clearance (OCD additional information request), *DFO/J. Gavens*, no paper
3. VII Group Reporting Issues/CIB proposal follow-up from 9/18 Clearance (OCD wants to know what options we have regarding the supp payment approach only being by claims and wants FMG to check into our ability to require that.), *A. MacCarroll*, paper
4. Wisconsin Cost Reporting Issue (OCD requested additional information to confirm that we told the state it needed to submit a cost report in order to claim for the CRS services), *DRSF*, no paper (?)
5. (Possible item) Briefing memo on “Ensuring Appropriate Cost Allocation – Oversight of Undocumented Immigrants”, *K. Fan*, paper

Round Robin

Wendy L. Harrison, LSW

Technical Advisor to the Director
Financial Management Group
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28
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✉ Wendy.Harrison@cms.hhs.gov

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FW: FW: HEADS UP: FMG Clearance MOVING TO TOMORROW

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Thu, 26 Sep 2019 16:09:57 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

Beverly

From: Dunn, Victoria (CMS/CMCS) <Victoria.Dunn@cms.hhs.gov>
Sent: Thursday, September 26, 2019 12:08 PM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Nelson, Barbara A. (CMS/CMCS) <Barbara.Nelson@cms.hhs.gov>
Subject: HEADS UP: FMG Clearance MOVING TO TOMORROW
Importance: High

Ladies – Calder has just been made aware that he has to be downstairs for the ceremony at 12:45 so we will need to move you all to tomorrow morning at 11:30 am. Please adjust calendars accordingly and we apologize for the inconvenience this has caused.

-----Original Appointment-----

From: Dunn, Victoria (CMS/CMCS) **On Behalf Of** CMS CMCS_Scheduling
Sent: Wednesday, September 25, 2019 10:31 AM
Subject: FMG Clearance | Materials
When: Thursday, September 26, 2019 12:30 PM-1:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Conference room A // WebEx: 1-877-267-1577 Meeting Number: b6

Agenda:

<< File: Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF >>

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

<< File: SC Disapproval Letter Final_Signed.pdf >> << File: Letter to Administrator SC SPAs.docx >>

Discussion Items:

1. **Arkansas FMR Follow-up, J. Gavens, verbal only**

- << File: Joshua D Baker SC SMD Letter.docx >>
2. **Wisconsin Rehabilitation Cost Reporting Issue, *DRSF*, verbal only**
<< File: Federal Register Notice SC SPAs.docx >>
3. **Oregon CHIP Contingency Fund, *DFO*, paper**
<< File: FMG Cover Page SC ReconsDis.docx >> << File: FMG Cover Page PRR CIB.DOCX >>
4. **Provider Payment Reassignment Rule/CIB, *C. Thompson*, verbal only**
<< File: Oregon CHIP Contingency Fund Issue Paper 9-25-19.docx >>
5. **South Carolina SPA Disapproval Reconsideration Package, *OSG/DRSF*, paper**
<< File: FMG Cover Page OR CHIP CF.docx >> << File: FMG Cover Page WI CALL.docx >> <<
File: FMG Cover Page AR FMR FU.docx >> << File: DSH Allotment Reductions FY 2020.xlsx >>
<< File: FMG Cover Page DSHRule.docx >> << File: FMG CLEARANCE Agenda 09-26-2019.docx
>>
-

Access Information

1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number:

b6

FW: FW: Materials for FMG's Thursday 12:30pm EST Meeting with the CMCS OCD

From: "Thomas, Douglas A. (CMS/CMCS)" <douglas.thomas@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Kimball, Richard M. (CMS/CMCS)" <richard.kimball@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>
Date: Thu, 26 Sep 2019 16:25:25 +0000

DSH/DHRM team

Reminder:

Even if clearance is moved to 11:30 tomorrow, we still have a 10 o'clock deadline with MPR tomorrow to send in any changes. Should we inform them of our dilemma? Or we pretty sure how this will go?

Doug

Douglas A. Thomas
Technical Director
Division of Reimbursement and State Financing
Financial Management Group, CMCS
Centers for Medicare and Medicaid Services
Office: 410-786-0292
Cell: b6

-----Original Message-----

From: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Sent: Thursday, September 26, 2019 12:19 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Nelson, Barbara A. (CMS/CMCS) <Barbara.Nelson@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Dunn, Victoria (CMS/CMCS) <Victoria.Dunn@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Lynch, Calder (CMS/OA) <Calder.Lynch@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Shields, Karen (CMS/CMCS) <Karen.Shields1@cms.hhs.gov>; Giles, John (CMS/CMCS) <John.Giles@cms.hhs.gov>; CMS OCD Briefing Binder <OCDBriefingBinder@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Cooley, Mark S. (CMS/CMCS) <Mark.Cooley@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Hall, Melissa R. (CMS/CMCS) <Melissa.Hall@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Cieslicki, Mary E. (CMS/CMCS) <Mary.Cieslicki@cms.hhs.gov>; Weaver, Robert K. (CMS/CMCS) <Robert.Weaver@cms.hhs.gov>; Badaracco, Andrew (CMS/CMCS) <Andrew.Badaracco@cms.hhs.gov>; Mikow, Asher S. (CMS/CMCS) <Asher.Mikow@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; Kimble, Davida R. (CMS/CMCS) <Davida.Kimble@cms.hhs.gov>; Glaze, Jackie L. (CMS/CMCS) <Jackie.Glaze@cms.hhs.gov>; Ruiz, Susan F. (CMS/CMCS) <Susan.Ruiz@cms.hhs.gov>; Holzbaur, Charlene M. (CMS/CMCS) <Charlene.Holzbaur@cms.hhs.gov>; Dubois, Anna M. (CMS/CMCS) <Anna.Dubois@cms.hhs.gov>; Bodon, Maritza (CMS/CMCS) <Maritza.Bodon@cms.hhs.gov>; Michael, Lindsay (CMS/CMCS) <Lindsay.Michael@cms.hhs.gov>; Brooks, Bill D. (CMS/CMCS) <Bill.Brooks@cms.hhs.gov>; Ferguson, Dorothy A. (CMS/CMCS) <Dorothy.Ferguson@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Scott, James G. (CMS/CMCS) <james.scott1@cms.hhs.gov>; Weidler, Timothy A. (CMS/CMCS) <Timothy.Weidler@cms.hhs.gov>; James-Hailey, Novena M. (CMS/CMCS) <novena.jameshailey@cms.hhs.gov>; Brady, Thomas S. (CMS/CMCS) <THOMAS.BRADY@CMS.HHS.GOV>; Dasheiff, Sandra (CMS/CMCS) <SANDRA.DASHEIFF@cms.hhs.gov>; Couch, Thomas R. (CMS/CMCS) <Thomas.Couch@cms.hhs.gov>; Storey, Christine B. (CMS/CMCS) <Christine.Storey@cms.hhs.gov>; Wong, Mark I. (CMS/CMCS) <Mark.Wong@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>; Carroll, Lisa (CMS/CMCS) <Lisa.Carroll@cms.hhs.gov>; McCullough, Francis T. (CMS/CMCS) <Francis.McCullough@cms.hhs.gov>; Allen, Richard C. (CMS/CMCS) <Richard.Allen@cms.hhs.gov>; Schneider, Frank A. (CMS/CMCS) <Frank.Schneider@cms.hhs.gov>; Sam-Louie, Henrietta C. (CMS/CMCS) <Henrietta.Sam-Louie@cms.hhs.gov>; Curry, Celestine J. (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Burns, James P. (CMS/CMCS) <James.Burns@cms.hhs.gov>; Branch, Geoffrey A. (CMS/CMCS) <Geoffrey.Branch@cms.hhs.gov>; Lynch, Keith (CMS/CMCS) <Keith.Lynch@cms.hhs.gov>; Brown, Sharon J. (CMS/CMCS) <Sharon.Brown@cms.hhs.gov>; Levesque, Ginger L. (CMS/CMCS) <Ginger.Levesque@cms.hhs.gov>; Cuno, Richard A. (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Thomas, Stephanie D. (CMS/CMCS) <Stephanie.Thomas@cms.hhs.gov>; Thomas, Douglas A. (CMS/CMCS) <Douglas.Thomas@cms.hhs.gov>; Que, Rene R. (CMS/CMCS) <Rene.Que@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <AmberMacCarroll@cms.hhs.gov>; Slaven, Kevin R. (CMS/CMCS) <Kevin.Slaven@cms.hhs.gov>; Marchioni, Mary A. (CMS/CMCS) <Mary.Marchioni@cms.hhs.gov>; Kessler, Christopher G. (CMS/CMCS) <Christopher.Kessler@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Dickstein, Ari A. (CMS/CMCS) <Ari.Dickstein@cms.hhs.gov>; Carrington, Khia (CMS/CMCS) <Khia.Carrington@cms.hhs.gov>; Ponte, Grace (CMS/CMCS) <Grace.Ponte@cms.hhs.gov>; Gibson, Jennifer (CMS/CMCS) <Jennifer.Gibson@cms.hhs.gov>; Watkins, Vernell A. (CMS/CMCS) <Vernell.Watkins@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Hiltner, Tavon (CMS/CMCS) <Tavon.Hiltner@cms.hhs.gov>; Beasley, Michelle (CMS/CMCS) <Michelle.Beasley@cms.hhs.gov>; Davies, Edgar W. (CMS/CMCS) <Edgar.Davies@cms.hhs.gov>; Hunt, Trinia J. (CMS/CMCS) <TRINIA.HUNT@cms.hhs.gov>; Burnette, Olivia L. (CMS/CMCS) <Olivia.Burnette@cms.hhs.gov>; Hughes, Ruth A. (CMS/CMCS) <Ruth.Hughes@cms.hhs.gov>; Johns, Hamilton J. (CMS/CMCS) <Hamilton.Johns@cms.hhs.gov>; Kimball, Richard M. (CMS/CMCS) <Richard.Kimball@cms.hhs.gov>; Tilahun, Negussie (CMS/CMCS)

<Negussie.Tilahun@cms.hhs.gov>; Williams, Melissa (CMS/CMCS) <Melissa.Williams@cms.hhs.gov>; Yablochnikov, Daniil (CMS/CMCS) <Daniil.Yablochnikov@cms.hhs.gov>; Giacalone, Diana L. (CMS/CMCS) <Diana.Giacalone@cms.hhs.gov>; Whelan, Ellen Marie (CMS/CMCS) <EllenMarie.Whelehan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Motley, Danielle O. (CMS/CMCS) <Danielle.Motley@cms.hhs.gov>; Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>; VERMA, RAJENDER (CMS/CMCS) <Rajender.Verma@cms.hhs.gov>; Parris, Robert J. (CMS/CMCS) <Robert.Parris@cms.hhs.gov>; Ihrig, Jocelyn B. (CMS/CMCS) <Jocelyn.Ihrig@cms.hhs.gov>; Meacham, David L. (CMS/CMCS) <David.Meacham@cms.hhs.gov>; Friedrich, Charles A. (CMS/CMCS) <Charles.Friedrich@cms.hhs.gov>; Hall, Candice J. (CMS/CMCS) <Candice.Hall@cms.hhs.gov>; Hines, Charles (CMS/CMCS) <Charles.Hines@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Pellanda, Manning J. (CMS/CMCS) <Manning.Pellanda@cms.hhs.gov>; Holt, Kathryn (CMS/CMCS) <Kathryn.Holt@cms.hhs.gov>; Wiley, Evelyn S. (CMS/CMCS) <Evelyn.Wiley@cms.hhs.gov>; McClure, Deborah A. (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>; Lyles, Tia (CMS/CMCS) <Tia.Lyles@cms.hhs.gov>; Staton, Sidney H. (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>; Endelman, Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Stahlecker, Avery (CMS/CMCS) <Avery.Stahlecker@cms.hhs.gov>; Roberts, Shantrina D. (CMS/CMCS) <Shantrina.Roberts@cms.hhs.gov>; Jordan, Charlamia C. (CMS/CMCS) <Charlamia.Jordan@cms.hhs.gov>; Kennedy, Jocelyn (CMS/CMCS) <Jocelyn.Kennedy@cms.hhs.gov>; Aguilera, Gorge H. (CMS/CMCS) <Gorge.Aguilera@cms.hhs.gov>; Juhring, Heather (CMS/CMCS) <Heather.Juhring@cms.hhs.gov>; Holligan, Ricardo E. (CMS/CMCS) <Ricardo.Holligan@cms.hhs.gov>; Corbin, Angela T. (CMS/CMCS) <Angela.Corbin@cms.hhs.gov>; Taylor, Kenneth L. (CMS/CMCS) <Kenneth.Taylor@cms.hhs.gov>
Subject: Re: Materials for FMG's Thursday 12:30pm EST Meeting with the CMCS OCD

In case you missed the meeting invite change....FMG Clearance has been moved to tomorrow at 11:30am!

Thanks,
Wendy

> On Sep 25, 2019, at 3:47 PM, Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov> wrote:

>
> CMCS CENTER DIRECTOR CLEARANCE
> WITH THE FINANCIAL MANAGEMENT GROUP (FMG)

>
> September 26, 2019

>
> Conference Room A, 12:30pm – 1pm EST
>
> Conference Dial in Number: 877-267-1577

> Meeting ID : b6

>
> Please see attached an agenda and materials for Thursday's 12:30pm – 1pm EST clearance meeting with the Office of the Center Director. For those participating by phone, please be sure to dial into the call at the start of the meeting and plan to stay until completion. This will help with any disruption while discussions are still ongoing.

>
> Agenda:

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>
> Standing Items:

>
> ACCESS NPRM, J. Silanskis, verbal only
>
> Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal
> only
>
> DSH Allotment Reduction Rule, DFO, paper

>
> Discussion Items:

- >
> 1. Arkansas FMR Follow-up, J. Gavens, verbal only
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> 2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only
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> 5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

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> <DSH Allotment Reductions FY 2020.xlsx> <FMG Cover Page DSHRule.docx>
> <FMG Cover Page AR FMR FU.docx> <FMG Cover Page WI CALL.docx> <Oregon
> CHIP Contingency Fund Issue Paper 9-25-19.docx> <FMG Cover Page OR
> CHIP CF.docx> <FMG Cover Page PRR CIB.DOCX> <Federal Register Notice
> SC SPAs.docx> <Joshua D Baker SC SMD Letter.docx> <Letter to
> Administrator SC SPAs.docx> <SC Disapproval Letter Final Signed.pdf>
> <Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF> <FMG
> Cover Page SC ReconsDis.docx> <FMG CLEARANCE Agenda 09-26-2019.docx>

Re: Re: Materials for FMG's Thursday 12:30pm EST Meeting with the CMCS OCD

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>

To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Nelson, Barbara A. (CMS/CMCS)" <barbara.nelson@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Dunn, Victoria (CMS/CMCS)" <victoria.dunn@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>, "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>, "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>, "Giles, John (CMS/CMCS)" <john.giles@cms.hhs.gov>, CMS OCD Briefing Binder <ocdbriefingbinder@cms.hhs.gov>

Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Cooley, Mark S. (CMS/CMCS)" <mark.cooley@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Hall, Melissa R. (CMS/CMCS)" <melissa.hall@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Cieslicki, Mary E. (CMS/CMCS)" <mary.cieslicki@cms.hhs.gov>, "Weaver, Robert K. (CMS/CMCS)" <robert.weaver@cms.hhs.gov>, "Badaracco, Andrew (CMS/CMCS)" <andrew.badaracco@cms.hhs.gov>, "Mikow, Asher S. (CMS/CMCS)" <asher.mikow@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "Kimble, Davida R. (CMS/CMCS)" <davida.kimble@cms.hhs.gov>, "Glaze, Jackie L. (CMS/CMCS)" <jackie.glaze@cms.hhs.gov>, "Ruiz, Susan F. (CMS/CMCS)" <susan.ruiz@cms.hhs.gov>, "Holzbaur, Charlene M. (CMS/CMCS)" <charlene.holzbaur@cms.hhs.gov>, "Dubois, Anna M. (CMS/CMCS)" <anna.dubois@cms.hhs.gov>, "Bodon, Maritza (CMS/CMCS)" <maritza.bodon@cms.hhs.gov>, "Michael, Lindsay (CMS/CMCS)" <lindsay.michael@cms.hhs.gov>, "Brooks, Bill D. (CMS/CMCS)" <bill.brooks@cms.hhs.gov>, "Ferguson, Dorothy A. (CMS/CMCS)" <dorothy.ferguson@cms.hhs.gov>, "Barraza, Leticia (CMS/CMCS)" <leticia.barraza@cms.hhs.gov>, "Scott, James G. (CMS/CMCS)" <james.scott1@cms.hhs.gov>, "Weidler, Timothy A. (CMS/CMCS)" <timothy.weidler@cms.hhs.gov>, "James-Hailey, Novena M. (CMS/CMCS)" <novena.jameshailey@cms.hhs.gov>, "Brady, Thomas S. (CMS/CMCS)" <thomas.brady@cms.hhs.gov>, "Dasheiff, Sandra (CMS/CMCS)" <sandra.dasheiff@cms.hhs.gov>, "Couch, Thomas R. (CMS/CMCS)" <thomas.couch@cms.hhs.gov>, "Storey, Christine B. (CMS/CMCS)" <christine.storey@cms.hhs.gov>, "Wong, Mark I. (CMS/CMCS)" <mark.wong@cms.hhs.gov>, "McMillion, Todd (CMS/CMCS)" <todd.mcmillion@cms.hhs.gov>, "Carroll, Lisa (CMS/CMCS)" <lisa.carroll@cms.hhs.gov>, "Mccullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>, "Allen, Richard C. (CMS/CMCS)" <richard.allen@cms.hhs.gov>, "Schneider, Frank A. (CMS/CMCS)" <frank.schneider@cms.hhs.gov>, "Sam-Louie, Henrietta C. (CMS/CMCS)" <henrietta.sam-louie@cms.hhs.gov>, "Curry, Celestine J. (CMS/CMCS)" <celestine.curry@cms.hhs.gov>, "Burns, James P. (CMS/CMCS)" <james.burns@cms.hhs.gov>, "Branch, Jeoffrey A. (CMS/CMCS)" <jeoffrey.branch@cms.hhs.gov>, "Lynch, Keith (CMS/CMCS)" <keith.lynch@cms.hhs.gov>, "Brown, Sharon J. (CMS/CMCS)" <sharon.brown@cms.hhs.gov>, "Levesque, Ginger L. (CMS/CMCS)" <ginger.levesque@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <richard.cuno@cms.hhs.gov>, "Thomas, Stephanie D. (CMS/CMCS)" <stephanie.thomas@cms.hhs.gov>, "Thomas, Douglas A. (CMS/CMCS)" <douglas.thomas@cms.hhs.gov>, "Que, Rene R. (CMS/CMCS)" <rene.que@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Slaven, Kevin R. (CMS/CMCS)" <kevin.slaven@cms.hhs.gov>, "Marchioni, Mary A. (CMS/CMCS)" <mary.marchioni@cms.hhs.gov>, "Kessler, Christopher G. (CMS/CMCS)" <christopher.kessler@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Dickstein, Ari A. (CMS/CMCS)" <ari.dickstein@cms.hhs.gov>, "Carrington, Khia (CMS/CMCS)" <khia.carrington@cms.hhs.gov>, "Ponte, Grace (CMS/CMCS)" <grace.ponte@cms.hhs.gov>, "Gibson, Jennifer (CMS/CMCS)" <jennifer.gibson@cms.hhs.gov>, "Watkins, Vernell A. (CMS/CMCS)" <vernell.watkins@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>, "Hiltner, Tavon (CMS/CMCS)" <tavon.hiltner@cms.hhs.gov>, "Beasley, Michelle (CMS/CMCS)" <michelle.beasley@cms.hhs.gov>, "Davies, Edgar W. (CMS/CMCS)" <edgar.davies@cms.hhs.gov>, "Hunt, Trinia J. (CMS/CMCS)" <trinia.hunt@cms.hhs.gov>, "Burnette, Olivia L. (CMS/CMCS)" <olivia.burnette@cms.hhs.gov>, "Hughes, Ruth A. (CMS/CMCS)" <ruth.hughes@cms.hhs.gov>, "Johns, Hamilton J. (CMS/CMCS)" <hamilton.johns@cms.hhs.gov>, "Kimball, Richard M. (CMS/CMCS)" <richard.kimball@cms.hhs.gov>, "Tilahun, Negussie (CMS/CMCS)" <negussie.tilahun@cms.hhs.gov>, "Williams, Melissa (CMS/CMCS)" <melissa.williams@cms.hhs.gov>, "Yablochnikov, Daniil (CMS/CMCS)" <daniil.yablochnikov@cms.hhs.gov>, "Giacalone, Diana L. (CMS/CMCS)" <diana.giacalone@cms.hhs.gov>, "Whelan, Ellen Marie (CMS/CMCS)" <ellenmarie.whelan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>, "Motley, Danielle O. (CMS/CMCS)" <danielle.motley@cms.hhs.gov>, "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>, "VERMA, RAJENDER (CMS/CMCS)" <rajender.verma@cms.hhs.gov>, "Parris, Robert J. (CMS/CMCS)" <robert.parris@cms.hhs.gov>, "Ihrig, Jocelyn B. (CMS/CMCS)" <jocelyn.ihrig@cms.hhs.gov>, "Meacham, David L. (CMS/CMCS)" <david.meacham@cms.hhs.gov>, "Friedrich, Charles A. (CMS/CMCS)" <charles.friedrich@cms.hhs.gov>, "Hall, Candice J. (CMS/CMCS)" <candice.hall@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <charles.hines@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Pellanda, Manning J. (CMS/CMCS)" <manning.pellanda@cms.hhs.gov>, "Holt, Kathryn (CMS/CMCS)" <kathryn.holt@cms.hhs.gov>, "Wiley, Evelyn S. (CMS/CMCS)" <evelyn.wiley@cms.hhs.gov>, "McClure, Deborah A. (CMS/CMCS)" <deborah.mcclure@cms.hhs.gov>, "Lyles, Tia (CMS/CMCS)" <tia.lyles@cms.hhs.gov>, "Staton, Sidney H. (CMS/CMCS)" <sidney.staton@cms.hhs.gov>, "Endelman, Jonathan (CMS/CMCS)" <jonathan.endelman@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)"

<lia.adams@cms.hhs.gov>, "Stahlecker, Avery (CMS/CMCS)" <avery.stahlecker@cms.hhs.gov>, "Roberts, Shantrina D. (CMS/CMCS)" <shantrina.roberts@cms.hhs.gov>, "Jordan, Charlamia C. (CMS/CMCS)" <charlamia.jordan@cms.hhs.gov>, "Kennedy, Jocelyn (CMS/CMCS)" <jocelyn.kennedy@cms.hhs.gov>, "Aguilera, Gorge H. (CMS/CMCS)" <gorge.aguilera@cms.hhs.gov>, "Juhring, Heather (CMS/CMCS)" <heather.juhring@cms.hhs.gov>, "Holligan, Ricardo E. (CMS/CMCS)" <ricardo.holligan@cms.hhs.gov>, "Corbin, Angela T. (CMS/CMCS)" <angela.corbin@cms.hhs.gov>, "Taylor, Kenneth L. (CMS/CMCS)" <kenneth.taylor@cms.hhs.gov>

Date: Thu, 26 Sep 2019 16:18:44 +0000

In case you missed the meeting invite change....FMG Clearance has been moved to tomorrow at 11:30am!

Thanks,
Wendy

> On Sep 25, 2019, at 3:47 PM, Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov> wrote:

>
> CMCS CENTER DIRECTOR CLEARANCE
> WITH THE FINANCIAL MANAGEMENT GROUP (FMG)

>
> September 26, 2019

>
> Conference Room A, 12:30pm – 1pm EST

>
> Conference Dial in Number: 877-267-1577

> Meeting ID b6

>
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>
> DSH Allotment Reduction Rule, DFO, paper

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> 2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only

> 3. Oregon CHIP Contingency Fund, DFO, paper

> 4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only

> 5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

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> <DSH Allotment Reductions FY 2020.xlsx>

> <FMG Cover Page DSHRule.docx>

> <FMG Cover Page AR FMR FU.docx>

> <FMG Cover Page WI CALL.docx>

> <Oregon CHIP Contingency Fund Issue Paper 9-25-19.docx>

> <FMG Cover Page OR CHIP CF.docx>

- > <FMG Cover Page PRR CIB.DOCX>
- > <Federal Register Notice SC SPAs.docx>
- > <Joshua D Baker SC SMD Letter.docx>
- > <Letter to Administrator SC SPAs.docx>
- > <SC Disapproval Letter Final_Signed.pdf>
- > <Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF>
- > <FMG Cover Page SC ReconsDis.docx>
- > <FMG CLEARANCE Agenda 09-26-2019.docx>

RE: RE: FMG Clearance | Materials [NEW TIME]

From: "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>
To: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>
Date: Fri, 27 Sep 2019 15:35:06 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

Ok, thanks Rory. I'll stand by for the new #.

From: Howe, Rory (CMS/CMCS)
Sent: Friday, September 27, 2019 11:34 AM
To: Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

They are working on it.

From: Clark, Jennifer (CMS/CMCS)
Sent: Friday, September 27, 2019 11:34 AM
To: Dunn, Victoria (CMS/CMCS) <Victoria.Dunn@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Is there a new call in #? The PIN # is not working for me.

-----Original Appointment-----

From: Dunn, Victoria (CMS/CMCS) **On Behalf Of** CMS CMCS_Scheduling

Sent: Friday, September 27, 2019 9:34 AM

To: Adams, Lia (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Barraza, Leticia (CMS/CMCS); Beasley, Michelle (CMS/CMCS); Benson, Deborah J. (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Brandt, John (CMS/OL); Brooks, Bill D. (CMS/CMCS); Brown, Sharon J. (CMS/CMCS); Buck, Megan K. (CMS/CMCS); Burdullis, Brian M. (CMS/CMCS); Carroll, Lisa (CMS/CMCS); Chan, Jeanie (CMS/CMCS); Cheng, Irene T. (CMS/CMCS); Cieslicki, Mary E. (CMS/CMCS); Clark, Jennifer (CMS/CMCS); CMS VTC; Cooley, Mark S. (CMS/CMCS); Cuno, Richard A. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); D'Angelo, Laura (CMS/CMCS); Davidson, Timothy G. (CMS/CMCS); Dillon, Kristin C. (CMS/CMCS); Dunn, Victoria (CMS/CMCS); Endelman, Jonathan (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Ferretti, Ross H. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Friedrich, Charles A. (CMS/CMCS); Gavens, Jay C. (CMS/CMCS); Gillaspie, Cynthia D. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Halter, Mark D. (CMS/CMCS); Harris, Byron J. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Hines, Charles (CMS/CMCS); Hoang, Dzung A. (CMS/CMCS); Holligan, Ricardo E. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Holzbaur, Charlene M. (CMS/CMCS); Howe, Rory (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Hunt, Trinia J. (CMS/CMCS); Ihrig, Jocelyn B. (CMS/CMCS); James-Hailey, Novena M. (CMS/CMCS); Johns, Hamilton J. (CMS/CMCS); Joyce, Tannisse L. (CMS/CMCS); Kessler, Christopher G. (CMS/CMCS); Kimball, Richard M. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Knight, Gary L. (CMS/CMCS); Lambert, Diana (CMS/OFM); Lane, Robert (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lyles, Tia (CMS/CMCS); Lynch, Calder (CMS/OA); MacCarroll, Amber L. (CMS/CMCS); Mannix, Norma J. (CMS/CMCS); Marchioni, Mary A. (CMS/CMCS); McClure, Deborah A. (CMS/CMCS); McMillion, Todd (CMS/CMCS); Meacham, David L. (CMS/CMCS); Michael, Lindsay (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); Motley, Danielle O. (CMS/CMCS); Nanes, Cynthia (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Pellanda, Manning J. (CMS/CMCS); Powell, Eric M. (CMS/CMCS); Richards, Barbara K. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Sam-Louie, Henrietta C. (CMS/CMCS); Sampson, Tamara L. (CMS/CMCS); Savage, Courtenay (CMS/CMCS); Shields, Karen (CMS/CMCS); Shuman, Stacey S. (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Solomon, Alma (CMS/CMCS); Stahlecker, Avery (CMS/CMCS); Storey, Christine B. (CMS/CMCS); Ta, Anh-Dung (CMS/CMCS); Teal, Lela (CMS/CMCS); Thomas, Douglas A. (CMS/CMCS); Thomas, Stephanie D. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Tilahun, Negussie (CMS/CMCS); VERMA, RAJENDER (CMS/CMCS); Weaver, Robert K. (CMS/CMCS); Weidler, Timothy A. (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Yablochnikov, Daniil (CMS/CMCS); Zolynas, Brian (CMS/CMCS); Kennedy, Jocelyn (CMS/CMCS); Juhring, Heather (CMS/CMCS); Giles, John (CMS/CMCS); Young, Cheryl (CMS/CMCS); Lewis, Ashley (CMS/CMCS); Lewis, Clarence (CMS/CMCS);

Lewis, Clarence (CMS/CMCS); Wiley, Evelyn S. (CMS/CMCS)

Cc: Wigfall, Cheryl (CMS/CMCS); Mathias, Natasha C. (CMS/CMCS); McAllister, Lisa (CMS/CMCS); Le-Yuen, Mai (CMS/CMCS)

Subject: FMG Clearance | Materials [NEW TIME]

When: Friday, September 27, 2019 11:30 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: Conference Room A // WebEx: 1-877-267-1577 Meeting Number: b6

NO VTC for DC necessary

Agenda:

<< File: Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF >>

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DSH Allotment Reduction Rule, DFO, paper

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Access Information

1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number: b6

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To: "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>
Cc: "Dunn, Victoria (CMS/CMCS)" <victoria.dunn@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Date: Fri, 27 Sep 2019 15:35:31 +0000

I sent a message too, I can't get in

Sent from my iPhone

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Sent: Friday, September 27, 2019 9:34 AM

To: Adams, Lia (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Barraza, Leticia (CMS/CMCS); Beasley, Michelle (CMS/CMCS); Benson, Deborah J. (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Brandt, John (CMS/OL); Brooks, Bill D. (CMS/CMCS); Brown, Sharon J. (CMS/CMCS); Buck, Megan K. (CMS/CMCS); Burdullis, Brian M. (CMS/CMCS); Carroll, Lisa (CMS/CMCS); Chan, Jeanie (CMS/CMCS); Cheng, Irene T. (CMS/CMCS); Cieslicki, Mary E. (CMS/CMCS); Clark, Jennifer (CMS/CMCS); CMS VTC; Cooley, Mark S. (CMS/CMCS); Cuno, Richard A. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); D'Angelo, Laura (CMS/CMCS); Davidson, Timothy G. (CMS/CMCS); Dillon, Kristin C. (CMS/CMCS); Dunn, Victoria (CMS/CMCS); Endelman, Jonathan (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Ferretti, Ross H. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Friedrich, Charles A. (CMS/CMCS); Gavens, Jay C. (CMS/CMCS); Gillaspie, Cynthia D. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Halter, Mark D. (CMS/CMCS); Harris, Byron J. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Hines, Charles (CMS/CMCS); Hoang, Dzong A. (CMS/CMCS); Holligan, Ricardo E. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Holzbaur, Charlene M. (CMS/CMCS); Howe, Rory (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Hunt, Trinia J. (CMS/CMCS); Ihrig, Jocelyn B. (CMS/CMCS); James-Hailey, Novena M. (CMS/CMCS); Johns, Hamilton J. (CMS/CMCS); Joyce, Tannis L. (CMS/CMCS); Kessler, Christopher G. (CMS/CMCS); Kimball, Richard M. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Knight, Gary L. (CMS/CMCS); Lambert, Diana (CMS/OFM); Lane, Robert (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lyles, Tia (CMS/CMCS); Lynch, Calder (CMS/OA); MacCarroll, Amber L. (CMS/CMCS); Mannix, Norma J. (CMS/CMCS); Marchioni, Mary A. (CMS/CMCS); McClure, Deborah A. (CMS/CMCS); McMillion, Todd (CMS/CMCS); Meacham, David L. (CMS/CMCS); Michael, Lindsay (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); Motley, Danielle O. (CMS/CMCS); Nanes, Cynthia (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Pellanda, Manning J. (CMS/CMCS); Powell, Eric M. (CMS/CMCS); Richards, Barbara K. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Sam-Louie, Henrietta C. (CMS/CMCS); Sampson, Tamara L. (CMS/CMCS); Savage, Courtenay (CMS/CMCS); Shields, Karen (CMS/CMCS); Shuman, Stacey S. (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Solomon, Alma (CMS/CMCS); Stahlecker, Avery (CMS/CMCS); Storey, Christine B. (CMS/CMCS); Ta, Anh-Dung (CMS/CMCS); Teal, Lela (CMS/CMCS); Thomas, Douglas A. (CMS/CMCS); Thomas, Stephanie D. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Tilahun, Negussie (CMS/CMCS); VERMA, RAJENDER (CMS/CMCS); Weaver, Robert K. (CMS/CMCS); Weidler, Timothy A. (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Yablochnikov, Daniil (CMS/CMCS); Zolynas, Brian (CMS/CMCS); Kennedy, Jocelyn (CMS/CMCS); Juhring, Heather (CMS/CMCS); Giles, John (CMS/CMCS); Young, Cheryl (CMS/CMCS); Lewis, Ashley (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Wiley, Evelyn S. (CMS/CMCS)

Cc: Wigfall, Cheryl (CMS/CMCS); Mathias, Natasha C. (CMS/CMCS); McAllister, Lisa (CMS/CMCS); Le-Yuen, Mai (CMS/CMCS)

Subject: FMG Clearance | Materials [NEW TIME]

When: Friday, September 27, 2019 11:30 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: Conference Room A // WebEx: 1-877-267-1577 Meeting Number: b6

NO VTC for DC necessary

Agenda:

<< File: Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF >>

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

<< File: SC Disapproval Letter Final_ Signed.pdf >> << File: Letter to Administrator SC SPAs.docx >>

Discussion Items:

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<< File: Joshua D Baker SC SMD Letter.docx >>

- **Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only**

<< File: Federal Register Notice SC SPAs.docx >>

- **Oregon CHIP Contingency Fund, DFO, paper**

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- **Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only**

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- **South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper**

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Re: Re: FMG Clearance | Materials [NEW TIME]

From: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
To: CMS CMCS_Scheduling <cmcs_scheduling@cms.hhs.gov>
Cc: "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Badaracco, Andrew (CMS/CMCS)" <andrew.badaracco@cms.hhs.gov>, "Barraza, Leticia (CMS/CMCS)" <leticia.barraza@cms.hhs.gov>, "Beasley, Michelle (CMS/CMCS)" <michelle.beasley@cms.hhs.gov>, "Benson, Deborah J. (CMS/CMCS)" <deborah.benson@cms.hhs.gov>, "Blunt, Ford J. (CMS/CMCS)" <ford.blunt@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Branch, Jeoffrey A. (CMS/CMCS)" <jeoffrey.branch@cms.hhs.gov>, "Brandt, John (CMS/OL)" <john.brandt@cms.hhs.gov>, "Brooks, Bill D. (CMS/CMCS)" <bill.brooks@cms.hhs.gov>, "Brown, Sharon J. (CMS/CMCS)" <sharon.brown@cms.hhs.gov>, "Buck, Megan K. (CMS/CMCS)" <megan.buck@cms.hhs.gov>, "Burdullis, Brian M. (CMS/CMCS)" <brian.burdullis@cms.hhs.gov>, "Carroll, Lisa (CMS/CMCS)" <lisa.carroll@cms.hhs.gov>, "Chan, Jeanie (CMS/CMCS)" <jeanie.chan@cms.hhs.gov>, "Cheng, Irene T. 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Date: Fri, 27 Sep 2019 15:36:49 +0000

It appears the PIN number for this meeting is not working, trying to get more information about it now.

Sent from my iPhone

> On Sep 27, 2019, at 9:34 AM, CMS CMCS_Scheduling <CMCS_Scheduling@cms.hhs.gov> wrote:

>
> NO VTC for DC necessary

> Agenda:

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> Standing Items:

>
> ACCESS NPRM, J. Silanskis, verbal only
>
> Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only
>
> DSH Allotment Reduction Rule, DFO, paper

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>
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> Discussion Items:

> 1. Arkansas FMR Follow-up, J. Gavens, verbal only
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> 2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only
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> 3. Oregon CHIP Contingency Fund, DFO, paper
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> 4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only
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> 5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

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> <Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF>
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> <Letter to Administrator SC SPAs.docx>
> <Joshua D Baker SC SMD Letter.docx>
> <Federal Register Notice SC SPAs.docx>
> <FMG Cover Page SC ReconsDis.docx>
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> <FMG Cover Page AR FMR FU.docx>
> <DSH Allotment Reductions FY 2020.xlsx>

> <FMG Cover Page DSHRule.docx>
> <FMG CLEARANCE Agenda 09-26-2019.docx>
> <meeting.ics>

RE: RE: FMG Clearance | Materials [NEW TIME]

From: "Clark, Jennifer (CMS/CMCS)" <jennifer.clark@cms.hhs.gov>
To: "Dunn, Victoria (CMS/CMCS)" <victoria.dunn@cms.hhs.gov>
Cc: "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>
Date: Fri, 27 Sep 2019 15:33:58 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

Is there a new call in #? The PIN # is not working for me.

-----Original Appointment-----

From: Dunn, Victoria (CMS/CMCS) **On Behalf Of** CMS CMCS_Scheduling

Sent: Friday, September 27, 2019 9:34 AM

To: Adams, Lia (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Barraza, Leticia (CMS/CMCS); Beasley, Michelle (CMS/CMCS); Benson, Deborah J. (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Brandt, John (CMS/OL); Brooks, Bill D. (CMS/CMCS); Brown, Sharon J. (CMS/CMCS); Buck, Megan K. (CMS/CMCS); Burdullis, Brian M. (CMS/CMCS); Carroll, Lisa (CMS/CMCS); Chan, Jeanie (CMS/CMCS); Cheng, Irene T. (CMS/CMCS); Cieslicki, Mary E. (CMS/CMCS); Clark, Jennifer (CMS/CMCS); CMS VTC; Cooley, Mark S. (CMS/CMCS); Cuno, Richard A. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); D'Angelo, Laura (CMS/CMCS); Davidson, Timothy G. (CMS/CMCS); Dillon, Kristin C. (CMS/CMCS); Dunn, Victoria (CMS/CMCS); Endelman, Jonathan (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Ferretti, Ross H. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Friedrich, Charles A. (CMS/CMCS); Gavens, Jay C. (CMS/CMCS); Gillaspie, Cynthia D. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Halter, Mark D. (CMS/CMCS); Harris, Byron J. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Hines, Charles (CMS/CMCS); Hoang, Dzung A. (CMS/CMCS); Holligan, Ricardo E. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Holzbaur, Charlene M. (CMS/CMCS); Howe, Rory (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Hunt, Trinia J. (CMS/CMCS); Ihrig, Jocelyn B. (CMS/CMCS); James-Hailey, Novena M. (CMS/CMCS); Johns, Hamilton J. (CMS/CMCS); Joyce, Tannis L. (CMS/CMCS); Kessler, Christopher G. (CMS/CMCS); Kimball, Richard M. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Knight, Gary L. (CMS/CMCS); Lambert, Diana (CMS/OFM); Lane, Robert (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lyles, Tia (CMS/CMCS); Lynch, Calder (CMS/OA); MacCarroll, Amber L. (CMS/CMCS); Mannix, Norma J. (CMS/CMCS); Marchioni, Mary A. (CMS/CMCS); McClure, Deborah A. (CMS/CMCS); McMillion, Todd (CMS/CMCS); Meacham, David L. (CMS/CMCS); Michael, Lindsay (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); Motley, Danielle O. (CMS/CMCS); Nanes, Cynthia (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Pellanda, Manning J. (CMS/CMCS); Powell, Eric M. (CMS/CMCS); Richards, Barbara K. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Sam-Louie, Henrietta C. (CMS/CMCS); Sampson, Tamara L. (CMS/CMCS); Savage, Courtenay (CMS/CMCS); Shields, Karen (CMS/CMCS); Shuman, Stacey S. (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Solomon, Alma (CMS/CMCS); Stahlecker, Avery (CMS/CMCS); Storey, Christine B. (CMS/CMCS); Ta, Anh-Dung (CMS/CMCS); Teal, Lela (CMS/CMCS); Thomas, Douglas A. (CMS/CMCS); Thomas, Stephanie D. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Tilahun, Negussie (CMS/CMCS); VERMA, RAJENDER (CMS/CMCS); Weaver, Robert K. (CMS/CMCS); Weidler, Timothy A. (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Yablochnikov, Daniil (CMS/CMCS); Zolynas, Brian (CMS/CMCS); Kennedy, Jocelyn (CMS/CMCS); Juhring, Heather (CMS/CMCS); Giles, John (CMS/CMCS); Young, Cheryl (CMS/CMCS); Lewis, Ashley (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Wiley, Evelyn S. (CMS/CMCS)
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Where: Conference Room A // WebEx: 1-877-267-1577 Meeting Number:

b6

NO VTC for DC necessary

Agenda:

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DSH Allotment Reduction Rule, *DFO*, paper

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Discussion Items:

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<< File: Joshua D Baker SC SMD Letter.docx >>

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RE: RE: FMG Clearance | Materials [NEW TIME]

From: "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>

To: CMS CMCS_Scheduling <cmcs_scheduling@cms.hhs.gov>, "Barraza, Leticia (CMS/CMCS)" <leticia.barraza@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Adams, Lia (CMS/CMCS)" <lia.adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <charlie.arnold@cms.hhs.gov>, "Badaracco, Andrew (CMS/CMCS)" <andrew.badaracco@cms.hhs.gov>, "Beasley, Michelle (CMS/CMCS)" <michelle.beasley@cms.hhs.gov>, "Benson, Deborah J. (CMS/CMCS)" <deborah.benson@cms.hhs.gov>, "Blunt, Ford J. (CMS/CMCS)" <ford.blunt@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Branch, Jeoffrey A. (CMS/CMCS)" <jeoffrey.branch@cms.hhs.gov>, "Brandt, John (CMS/OL)" <john.brandt@cms.hhs.gov>, "Brooks, Bill D. (CMS/CMCS)" <bill.brooks@cms.hhs.gov>, "Brown, Sharon J. (CMS/CMCS)" <sharon.brown@cms.hhs.gov>, "Buck, Megan K. (CMS/CMCS)" <megan.buck@cms.hhs.gov>, "Burdullis, Brian M. 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Date: Fri, 27 Sep 2019 15:36:00 +0000

We are working on fixing the dial in number. Thank you for your patience.

Karen M. Shields
Deputy Director, Center for Medicaid & CHIP Services
Centers for Medicare and Medicaid Services

410.786.1685 Desk
b6 obile

-----Original Appointment-----

From: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov> **On Behalf Of** CMS CMCS_Scheduling

Sent: Friday, September 27, 2019 11:34 AM

To: Barraza, Leticia (CMS/CMCS); Teal, Lela (CMS/CMCS); Harshman, Sara (CMS/CMCS); Fan, Kristin A. (CMS/CMCS)

Cc: Lynch, Calder (CMS/OA); Shields, Karen (CMS/CMCS)

Subject: Fwd: FMG Clearance | Materials [NEW TIME]

When: Friday, September 27, 2019 11:30 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: Conference Room A // WebEx: 1-877-267-1577 Meeting Number: b6

The dial in pin number is not working ‘

b6

Begin forwarded message:

From: "CMS CMCS_Scheduling" <CMCS_Scheduling@cms.hhs.gov>
To: "Adams, Lia (CMS/CMCS)" <Lia.Adams@cms.hhs.gov>, "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>, "Badaracco, Andrew (CMS/CMCS)" <Andrew.Badaracco@cms.hhs.gov>, "Barraza, Leticia (CMS/CMCS)" <Leticia.Barraza@cms.hhs.gov>, "Beasley, Michelle (CMS/CMCS)" <Michelle.Beasley@cms.hhs.gov>, "Benson, Deborah J. (CMS/CMCS)" <Deborah.Benson@cms.hhs.gov>, "Blunt, Ford J. (CMS/CMCS)" <Ford.Blunt@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>, "Branch, Jeffrey A. (CMS/CMCS)" <Jeffrey.Branch@cms.hhs.gov>, "Brandt, John (CMS/OL)" <John.Brandt@cms.hhs.gov>, "Brooks, Bill D. (CMS/CMCS)" <Bill.Brooks@cms.hhs.gov>, "Brown, Sharon J. (CMS/CMCS)" <Sharon.Brown@cms.hhs.gov>, "Buck, Megan K. (CMS/CMCS)" <Megan.Buck@cms.hhs.gov>, "Burdullis, Brian M. (CMS/CMCS)" <Brian.Burdullis@cms.hhs.gov>, "Carroll, Lisa (CMS/CMCS)" <Lisa.Carroll@cms.hhs.gov>, "Chan, Jeanie (CMS/CMCS)" <Jeanie.Chan@cms.hhs.gov>, "Cheng, Irene T. (CMS/CMCS)" <Irene.Cheng@cms.hhs.gov>, "Cieslicki, Mary E. (CMS/CMCS)" <Mary.Cieslicki@cms.hhs.gov>, "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>, "CMS VTC" <VTC@cms.hhs.gov>, "Cooley, Mark S. (CMS/CMCS)" <Mark.Cooley@cms.hhs.gov>, "Cuno, Richard A. (CMS/CMCS)" <Richard.Cuno@cms.hhs.gov>, "Curry, Celestine J. (CMS/CMCS)" <Celestine.Curry@cms.hhs.gov>, "D'Angelo, Laura (CMS/CMCS)" <Laura.DAngelo@cms.hhs.gov>, "Davidson, Timothy G. (CMS/CMCS)" <Timothy.Davidson@cms.hhs.gov>, "Dillon, Kristin C. (CMS/CMCS)" <kristin.dillon@cms.hhs.gov>, "Dunn, Victoria (CMS/CMCS)" <Victoria.Dunn@cms.hhs.gov>, "Endelman, Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>, "Farrell, Billy B. (CMS/CMCS)" <Billy.Farrell@cms.hhs.gov>, "Ferguson, Dorothy A. (CMS/CMCS)" <Dorothy.Ferguson@cms.hhs.gov>, "Ferretti, Ross H. (CMS/CMCS)" <Ross.Ferretti@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <Janet.Freeze@cms.hhs.gov>, "Friedrich, Charles A. (CMS/CMCS)" <Charles.Friedrich@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <Jay.Gavens@cms.hhs.gov>, "Gillaspie, Cynthia D. (CMS/CMCS)" <Cynthia.Gillaspie@cms.hhs.gov>, "Glaze, Jackie L. (CMS/CMCS)" <Jackie.Glaze@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>, "Halter, Mark D. (CMS/CMCS)" <Mark.Halter@cms.hhs.gov>, "Harris, Byron J. (CMS/CMCS)" <Byron.Harris@cms.hhs.gov>, "Harrison, Wendy L. (CMS/CMCS)" <Wendy.Harrison@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <Sara.Harshman@cms.hhs.gov>, "Hickey, Jessica M. (CMS/CMCS)" <Jessica.Hickey@cms.hhs.gov>, "Hines, Charles (CMS/CMCS)" <Charles.Hines@cms.hhs.gov>, "Hoang, Dzung

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Subject: FMG Clearance | Materials [NEW TIME]

NO VTC for DC necessary

Agenda:

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

Discussion Items:

1. Arkansas FMR Follow-up, J. Gavens, verbal only
2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only
3. Oregon CHIP Contingency Fund, DFO, paper
4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only
5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

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NEW DIAL IN RE: FMG Clearance | Materials [NEW TIME]

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<timothy.weidler@cms.hhs.gov>, "Whelan, Ellen Marie (CMS/CMCS)" <ellenmarie.whelan@cms.hhs.gov>, "Yablochnikov, Daniil (CMS/CMCS)" <daniil.yablochnikov@cms.hhs.gov>, "Zolynas, Brian (CMS/CMCS)" <brian.zolynas@cms.hhs.gov>, "Kennedy, Jocelyn (CMS/CMCS)" <jocelyn.kennedy@cms.hhs.gov>, "Juhring, Heather (CMS/CMCS)" <heather.juhring@cms.hhs.gov>, "Giles, John (CMS/CMCS)" <john.giles@cms.hhs.gov>, "Young, Cheryl (CMS/CMCS)" <cheryl.young@cms.hhs.gov>, "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>, "Lewis, Clarence (CMS/CMCS)" <clarence.lewis@cms.hhs.gov>, "Wiley, Evelyn S. (CMS/CMCS)" <evelyn.wiley@cms.hhs.gov>, "Wigfall, Cheryl (CMS/CMCS)" <cheryl.wigfall@cms.hhs.gov>, "Mathias, Natasha C. (CMS/CMCS)" <natasha.mathias@cms.hhs.gov>, "McAllister, Lisa (CMS/CMCS)" <lisa.mcallister@cms.hhs.gov>, "Le-Yuen, Mai (CMS/CMCS)" <mai.le-yuen@cms.hhs.gov>

Date: Fri, 27 Sep 2019 15:37:41 +0000

NEW Meeting Number: b6

Apologies for the delay everyone.

-----Original Message-----

From: Harrison, Wendy L. (CMS/CMCS) <Wendy.Harrison@cms.hhs.gov>

Sent: Friday, September 27, 2019 11:37 AM

To: CMS CMCS Scheduling <CMCS_Scheduling@cms.hhs.gov>

Cc: Adams, Lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Badaracco, Andrew (CMS/CMCS) <Andrew.Badaracco@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Beasley, Michelle (CMS/CMCS) <Michelle.Beasley@cms.hhs.gov>; Benson, Deborah J. (CMS/CMCS) <Deborah.Benson@cms.hhs.gov>; Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Branch, Jeffrey A. (CMS/CMCS) <Jeffrey.Branch@cms.hhs.gov>; Brandt, John (CMS/OL) <John.Brandt@cms.hhs.gov>; Brooks, Bill D. (CMS/CMCS) <Bill.Brooks@cms.hhs.gov>; Brown, Sharon J. (CMS/CMCS) <Sharon.Brown@cms.hhs.gov>; Buck, Megan K. (CMS/CMCS) <Megan.Buck@cms.hhs.gov>; Burdullis, Brian M. (CMS/CMCS) <Brian.Burdullis@cms.hhs.gov>; Carroll, Lisa (CMS/CMCS) <Lisa.Carroll@cms.hhs.gov>; Chan, Jeanie (CMS/CMCS) <Jeanie.Chan@cms.hhs.gov>; Cheng, Irene T. (CMS/CMCS) <Irene.Cheng@cms.hhs.gov>; Cieslicki, Mary E. 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Subject: Re: FMG Clearance | Materials [NEW TIME]

It appears the PIN number for this meeting is not working, trying to get more information about it now.

Sent from my iPhone

> On Sep 27, 2019, at 9:34 AM, CMS CMCS_Scheduling <CMCS_Scheduling@cms.hhs.gov> wrote:

>
> NO VTC for DC necessary

> Agenda:

>
>
> Standing Items:

> ACCESS NPRM, J. Silanskis, verbal only
>
> Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal
> only

> DSH Allotment Reduction Rule, DFO, paper

> Discussion Items:

- > 1. Arkansas FMR Follow-up, J. Gavens, verbal only
>
> 2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only
>
> 3. Oregon CHIP Contingency Fund, DFO, paper
>
> 4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only
>
> 5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

> Access Information

- > 1. Please call the following number:
> WebEx: 1-877-267-1577
> 2. Follow the instructions you hear on the phone.

> Your WebEx Meeting Number: b6

>
>
> <Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF> <SC
> Disapproval Letter Final_Signed.pdf> <Letter to Administrator SC
> SPAs.docx> <Joshua D Baker SC SMD Letter.docx> <Federal Register
> Notice SC SPAs.docx> <FMG Cover Page SC ReconsDis.docx> <FMG Cover
> Page PRR CIB.DOCX> <Oregon CHIP Contingency Fund Issue Paper
> 9-25-19.docx> <FMG Cover Page OR CHIP CF.docx> <FMG Cover Page WI
> CALL.docx> <FMG Cover Page AR FMR FU.docx> <DSH Allotment Reductions
> FY 2020.xlsx> <FMG Cover Page DSHRule.docx> <FMG CLEARANCE Agenda
> 09-26-2019.docx> <meeting.ics>

RE: RE: Notes for folks

From: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Cc: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Thu, 03 Oct 2019 16:43:56 +0000

She did mention 10 – so if we could pull together for example SC, TX, GA, OK and some of the tax examples that would be great. I do not think we need the 10 mark but just from previous briefing documents what we have found.

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, October 3, 2019 12:06 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>
Subject: FW: Notes for folks

Hello,

John Giles reached out to find out if we were working on putting together 10 examples? (not sure if she requested 10?) of bad financing in states as requested by Administrator?

Beverly

From: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Sent: Tuesday, October 1, 2019 12:46 PM
To: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: RE: Notes for folks

I'm attaching the brief that we used for HHS and a PP that describes each proposed provision. The team is working to update the comms documents to highlight bad financing arrangements. Re: the transition periods, the 5 year transition/renewal applies to states updating SPA methodologies for supplemental payments to add in the proposed comprehensive methodology requirements and there is a new 3 year approval period for tax waivers. There is no transition to the extent we find problematic financing so I think we could address those issues quickly through FMRs and disallowances.

From: Freeze, Janet G. (CMS/CMCS)
Sent: Monday, September 30, 2019 5:36 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
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Subject: Re: Notes for folks

From today's CMCS OA Issues De-Brief:

SC Reconsideration Hearing letters – good to go

MFAR – wants more examples included in the comms documents of schemes that MFAR will curtail. One example cited by ASV: Indiana nursing homes (ASV is, of course, familiar with that one). Add other examples/scenarios – will not use state names however

MFAR – for the proposed rule ASV wants to go with a THREE YEAR compliance transition timeline instead of the FIVE. Will discuss this with OMB once we have their passback

MFAR ACTION ITEM: – ASV wants options on how existing “egregious” arrangements could be terminated more quickly (i.e., fast than even the 3 years).

MFAR ACTION ITEM: – ASV needs a refresh on all the issues; send Calder current versions of all relevant briefing papers.

Janet Freeze, J.D. | Deputy Director | Financial Management Group | Center for Medicaid and CHIP Services | Centers for Medicare & Medicaid Services | 410-786-5917 | janet.freeze@cms.hhs.gov

RE: RE: Notes for folks

From: "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
Cc: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Badaracco, Andrew (CMS/CMCS)" <andrew.badaracco@cms.hhs.gov>
Date: Thu, 03 Oct 2019 17:04:55 +0000

I'm copying in Andrew. He's added the NF ownership, TX 1115, and ACR payments as examples and will add a few more. He's been putting them directly into the comms documents on SharePoint.

b6

From: Fan, Kristin A. (CMS/CMCS)
Sent: Thursday, October 3, 2019 12:44 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>
Subject: RE: Notes for folks

She did mention 10 – so if we could pull together for example SC, TX, GA, OK and some of the tax examples that would be great. I do not think we need the 10 mark but just from previous briefing documents what we have found.

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, October 3, 2019 12:06 PM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>
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Hello,

John Giles reached out to find out if we were working on putting together 10 examples? (not sure if she requested 10?) of bad financing in states as requested by Administrator?

Beverly

From: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Sent: Tuesday, October 1, 2019 12:46 PM
To: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>
Cc: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
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I'm attaching the brief that we used for HHS and a PP that describes each proposed provision. The team is working to update the comms documents to highlight bad financing arrangements. Re: the transition periods, the 5 year transition/renewal applies to states updating SPA methodologies for supplemental payments to add in the proposed comprehensive methodology requirements and there is a new 3 year approval period for tax waivers. There is no transition to the extent we find problematic financing so I think we could address those issues quickly through FMRs and disallowances.

From: Freeze, Janet G. (CMS/CMCS)

Sent: Monday, September 30, 2019 5:36 PM

To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>

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SC Reconsideration Hearing letters – good to go

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MFAR – for the proposed rule ASV wants to go with a THREE YEAR compliance transition timeline instead of the FIVE. Will discuss this with OMB once we have their passback

MFAR ACTION ITEM: – ASV wants options on how existing “egregious” arrangements could be terminated more quickly (i.e., fast than even the 3 years).

MFAR ACTION ITEM: – ASV needs a refresh on all the issues; send Calder current versions of all relevant briefing papers.

Janet Freeze, J.D. | Deputy Director | Financial Management Group | Center for Medicaid and CHIP Services | Centers for Medicare & Medicaid Services | 410-786-5917 | janet.freeze@cms.hhs.gov

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Cc: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>
Date: Thu, 03 Oct 2019 16:08:10 +0000

I did not hear mention of any specific number.

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From: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>
To: "Harrison, Wendy L. (CMS/CMCS)" <wendy.harrison@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Gavens, Jay C. (CMS/CMCS)" <jay.gavens@cms.hhs.gov>, "MacCarroll, Amber L. (CMS/CMCS)" <amber.maccarroll@cms.hhs.gov>, "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Date: Tue, 15 Jan 2019 16:33:34 +0000

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Sent: Tuesday, January 15, 2019 11:14 AM
To: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Gavens, Jay C. (CMS/CMCS) <Jay.Gavens@cms.hhs.gov>; MacCarroll, Amber L. (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
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CLEARANCE MEETING – 01/16 @ 1pm:

Standing Items:

- ACCESS NPRM – no paper
- Provider Payment Reassignment Rule – no paper

Signature or Discussion Items (Paper/Presenter): Possible items....

- Kansas – Hawkins Letter to the Secretary re: HMO Privilege Fee, K. Fan, paper
- Texas Financing Update, DFO, no paper (?)
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Round Robin

THANKS!!

Wendy L. Harrison, LSW

Technical Advisor to the Director

Financial Management Group

Centers for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

7500 Security Boulevard, South Building, S3-14-18 Mail Stop: S3-14-28

Baltimore, MD 21244

☎: 410-786-2075 7: 410-786-8533 ☎BB:

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✉: Wendy.Harrison@cms.hhs.gov

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Date: Tue, 15 Jan 2019 16:34:44 +0000

Ok, I will take off Texas and add SC. Is this a verbal update on the SC SPA disapproval?

Wendy L. Harrison, LSW

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Date: Tue, 15 Jan 2019 17:14:07 +0000

Thanks Jeremy

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Attached is the proposed disapproval letter and below a brief summary of the SC issue. Thanks.

South Carolina Disapproval Issue: South Carolina has proposed several SPAs that are pending on RAI and that include problematic financing arrangements. The SPAs propose quarterly supplemental physician payments to Greenville Memorial Hospital for teaching physician services within the facility. The payments would be funded by the Greenville Health Authority through an intergovernmental transfer (IGT). Prior to 2016, the Greenville Health Authority operated Greenville Memorial Hospital as a governmental provider. In 2016, the Greenville Health Authority entered into an agreement with a private entity to lease and operate the hospital as a private provider. The source of the IGTs that would fund the non-federal share of the proposed physician supplemental payments would come from the "Setup Debt Collection Program," which allows Greenville Health Authority to continue to collect patient revenue owed to Greenville Memorial Hospital from periods prior to the hospital lease and ownership transfer to the private entity. Section 1903(w)(6)(A) of the Act requires that IGTs must be derived from state or local tax revenue. Greenville Health Authority does have access to tax revenue to support the IGTs associated with the proposed payments and the debt collection funds do not qualify as a permissible source of the IGTs under the Act. We have had several discussion with the state informing them that the funding source is problematic. The state and provider disagree and the state has no intention of withdrawing the proposed SPAs.

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Date: Wed, 20 Feb 2019 15:36:27 +0000

I don't think we have anything urgent in those states on the SPA side. We could bring up the SC potential funding disapproval but I don't think that'll get raised after our conversation with the Medicaid director. We are still waiting on them to provide more info.

From: Fan, Kristin A. (CMS/CMCS)
Sent: Wednesday, February 20, 2019 10:27 AM
To: Silanskis, Jeremy D. (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Thompson, Christopher C. (CMS/CMCS) <Christopher.Thompson@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: FW: REVIEW and UPDATE: NGA Hot Topics

If you think we should mention something let me know.

From: Harshman, Sara (CMS/CMCS)
Sent: Wednesday, February 20, 2019 10:06 AM
To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Nardone, Michael P. (CMS/CMCS) <Michael.Nardone@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boughn, Julie (CMS/CMCS) <Julie.Boughn1@cms.hhs.gov>; McGuigan, Gregory M. (CMS/CMCS) <Gregory.McGuigan@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; Glaze, Jackie L. (CMS/CMCHO) <Jackie.Glaze@cms.hhs.gov>; Baldi, Michelle L. (CMS/CMCHO) <Michelle.Baldi@cms.hhs.gov>
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Subject: RE: REVIEW and UPDATE: NGA Hot Topics

Thank you all for your help in pulling this together! Calder has provided another list of Governors the Secretary is scheduled to meet (below). I've add them to the document.

- Louisiana
- Idaho
- Missouri
- Georgia
- Massachusetts
- Michigan

Calder is looking to receive the updated document by tomorrow at 3pm. If everyone could have their updates included by **2:30 tomorrow**, I will work to finalize the document and send it up.

Thanks again, everyone!

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

From: Harshman, Sara (CMS/CMCS)
Sent: Tuesday, February 19, 2019 11:45 AM

To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Nardone, Michael P. (CMS/CMCS) <Michael.Nardone@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Freeze, Janet G. (CMS/CMCS) <Janet.Freeze@cms.hhs.gov>; Boughn, Julie (CMS/CMCS) <julie.boughn1@cms.hhs.gov>; McGuigan, Gregory M. (CMS/CMCS) <Gregory.McGuigan@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; Glaze, Jackie L. (CMS/CMCHO) <Jackie.Glaze@cms.hhs.gov>; Baldi, Michelle L. (CMS/CMCHO) <Michelle.Baldi@cms.hhs.gov>
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b6

- Governor Sununu (NH)
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- Governor Reynolds (IA)
- Governor Noem (SD)
- Governor DeSantis (FL)
- Governor Ricketts (NE)
- Governor Kelly (KS)
- Governor (WY) *tentative

Thanks!
Sara

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

RE: RE: REVIEW and UPDATE: NGA Hot Topics

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Silanskis, Jeremy D. (CMS/CMCS)" <jeremy.silanskis@cms.hhs.gov>, "Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>
Cc: "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Wed, 20 Feb 2019 15:36:00 +0000

Hello,

I checked the listing and still nothing added for Colorado on the deferrals and the SC SPA Disapprovals are also not listed.

Beverly

From: Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Wednesday, February 20, 2019 10:27 AM
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Desk: (202) 260-1219
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- Governor Noem (SD)
- Governor DeSantis (FL)
- Governor Ricketts (NE)
- Governor Kelly (KS)
- Governor (WY) *tentative

Thanks!
Sara

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell b6

WI 1915(i) Backcasting FAR_Prep Call

Where: WebEx Online
When: Fri Sep 27 13:30:00 2019 +00:00
Until: Fri Sep 27 14:00:00 2019 +00:00
Organisers "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
Required Attendees: "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
"Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
"Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>
"Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>
"Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>
"Curry, Celestine J. (CMS/CMCS)" <celestine.curry@cms.hhs.gov>
"Hughes, Ruth A. (CMS/CMCS)" <ruth.hughes@cms.hhs.gov>
Optional Attendees: "Motley, Danielle O. (CMS/CMCS)" <danielle.motley@cms.hhs.gov>
"Mathias, Natasha C. (CMS/CMCS)" <natasha.mathias@cms.hhs.gov>
"Le-Yuen, Mai (CMS/CMCS)" <mai.le-yuen@cms.hhs.gov>
Attachments: RE: FMG Clearance | Materials [NEW TIME] (141.82 kB)

Good afternoon,

The purpose of this call is to have a "pre-call" for the 11am call with Wisconsin regarding their 1915(i) Backcasting methodology. To summarize, they are attempting to use 2017 cost reports to cover costs back to 2010. This was discovered in a FAR, but there was discussion of moving straight to disallowance. This is also the issue that has been discussed at clearance recently, including the next meeting that has been rescheduled to 11:30 tomorrow (the second half of the call with the state to which we are preparing). Some additional context has been provided in a well-described summary email by Celestine attached here. Please let me know if you have any comments or questions prior to the call – or if this time does not work.

<<...>>

Thanks,
Tim Davidson

DO NOT DELETE OR CHANGE ANY OF THE TEXT BELOW THIS LINE

TIMOTHY DAVIDSON has scheduled this WebEx meeting.

WI 1915(i) Backcasting FAR_Prep Call
Host: TIMOTHY DAVIDSON

Access Information

1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number: b6

=====

To join from a Cisco VoIP enabled CMS Region or from CMS Central Office

1. Dial ext. 63100
Enter Meeting Number: Use Meeting WebEx Number provided above.

=====

To join this meeting online

1. Go to <https://meetings.cms.gov>. b6 ?MTID b6
2. If requested, enter your name and email address.
3. If a password is required, enter the meeting password: (This meeting does not require a password.)
4. Click "Join".
5. Follow the instructions that appear on your screen.

+++++

This meeting may be recorded by the host. If you have questions, please contact the host.
+++++

Hosts, need your host access code or key? Go to the meeting information page:
<https://meetings.cms.gov/orio> b6 MTID= b6

Delivering the power of collaboration
The meetings.cms.gov team

RE: RE: FMG Clearance | Materials [NEW TIME]

From: "Curry, Celestine J. (CMS/CMCS)" <celestine.curry@cms.hhs.gov>
To: "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
Date: Thu, 26 Sep 2019 17:52:11 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

Hi Tim,

We should keep this meeting, given the efforts it took to coordinate and the importance to advising the state regarding their proposed alternative methodology.

During my visit last week in Baltimore, I had a discussion with Kristen, Janet and Robert and we reached a consensus to advise the state regarding CMS's position to not approve the states proposed alternative method and request that the state voluntarily return the FFP.

Since there is no need for a disallowance if the state voluntarily returns the FFP, I think it is still important to talk with the state and request that they voluntarily return the FFP. During the call with WI, we plan to advise the state that we are not able to approve their proposed alternate methodology. Additionally, we will advise the state that given our decision to not approve the proposed alternative methodology, that we request that the state voluntarily return the \$9.5M FFP. I'm sure we will have to advise the state that if they decide not to voluntarily return the FFP, the region will recommend disallowance.

Recommending disallowance does not mean CMS is issuing a disallowance. We can hold off on sending any official documents such as the Demand Letter until the OCD reaches a decision on the item for discussion tomorrow but I think it is important to advise the state of our decision on the methodology and ask that they voluntarily return the FFP.

I'm thinking that we should have an internal call tomorrow morning to discuss this further before meeting with the state. Would you be able to coordinate a call? On our end, myself, Natasha and Ruth should be on the call.

Celestine

From: Davidson, Timothy G. (CMS/CMCS)
Sent: Thursday, September 26, 2019 11:49 AM
To: Curry, Celestine J. (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Hmmmm well you all know the state pretty well – is there any possibility of pushing the call back an hour or even till next week? I imagine we could still have the call with them tomorrow (I see it now), but then we'd have to preface everything with "This might change after our call with OCD."

Do you think the state would be okay with us pushing it back for the sake of getting complete information from OCD?

From: Curry, Celestine J. (CMS/CMCS)
Sent: Thursday, September 26, 2019 12:47 PM
To: Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Cc: Mathias, Natasha C. (CMS/CMCS) <Natasha.Mathias@cms.hhs.gov>; McAllister, Lisa (CMS/CMCS) <lisa.mcallister@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Hi Tim,

Oh, I see (phew). I saw the new appointment, but did not realize the day had changed as well. Thank you for the clarification.

Our call with the state is 10-11am central/ 11am-12pm eastern which overlaps with the clearance meeting that is scheduled for 10:30am-11am central. The appointment with the state should be on your calendar as well. While I'm thinking we will not be on the call with the state for the full hour scheduled, the overlap currently exist.

Thanks.

Celestine

From: Davidson, Timothy G. (CMS/CMCS)
Sent: Thursday, September 26, 2019 11:42 AM
To: Curry, Celestine J. (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>
Cc: Mathias, Natasha C. (CMS/CMCS) <Natasha.Mathias@cms.hhs.gov>; McAllister, Lisa (CMS/CMCS) <lisa.mcallister@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Good afternoon Celestine,

The meeting actually got pushed until tomorrow. What time is your call with the state?

Thanks,
Tim

From: Curry, Celestine J. (CMS/CMCS)
Sent: Thursday, September 26, 2019 12:40 PM
To: Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Cc: Mathias, Natasha C. (CMS/CMCS) <Natasha.Mathias@cms.hhs.gov>; McAllister, Lisa (CMS/CMCS) <lisa.mcallister@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Hi Tim,

It seems that the meeting was changed and therefore I did not see the notice until after the meeting was done.

Can you please advise what was discussed regarding the WI Cost Reporting Issue and if there is anything we should know? We are scheduled to meet with WI tomorrow on this issue and advise them that CMS is not able to approve their alternative methodology and therefore I want to be sure we are up to speed on the latest discussion. Thanks.

Celestine

-----Original Appointment-----

From: Dunn, Victoria (CMS/CMCS) **On Behalf Of** CMS CMCS_Scheduling
Sent: Thursday, September 26, 2019 11:12 AM
To: Adams, Lia (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Barraza, Leticia (CMS/CMCS); Beasley, Michelle (CMS/CMCS); Benson, Deborah J. (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Brandt, John (CMS/OL); Brooks, Bill D. (CMS/CMCS); Brown, Sharon J. (CMS/CMCS); Buck, Megan K. (CMS/CMCS); Burdullis, Brian M. (CMS/CMCS); Carroll, Lisa (CMS/CMCS); Chan, Jeanie (CMS/CMCS); Cheng, Irene T. (CMS/CMCS); Cieslicki, Mary E. (CMS/CMCS); Clark, Jennifer (CMS/CMCS); CMS VTC; Cooley, Mark S. (CMS/CMCS); Cuno, Richard A. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); DAngelo, Laura (CMS/CMCS); Davidson, Timothy G. (CMS/CMCS); Dillon, Kristin C. (CMS/CMCS); Dunn, Victoria (CMS/CMCS); Endelman, Jonathan (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Ferretti, Ross H. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Friedrich, Charles A. (CMS/CMCS); Gavens, Jay C. (CMS/CMCS); Gillaspie, Cynthia D. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Halter, Mark D. (CMS/CMCS); Harris, Byron J. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Hines, Charles (CMS/CMCS); Hoang, Dzong A. (CMS/CMCS); Holligan, Ricardo E. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Holzbaur, Charlene M. (CMS/CMCS); Howe, Rory (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Hunt, Trinia J. (CMS/CMCS); Ihrig, Jocelyn B. (CMS/CMCS); James-Hailey, Novena M. (CMS/CMCS); Johns, Hamilton J. (CMS/CMCS); Joyce, Tannisse L. (CMS/CMCS); Kessler, Christopher G. (CMS/CMCS); Kimball, Richard M. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Knight, Gary L. (CMS/CMCS); Lambert, Diana (CMS/OFM); Lane, Robert (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lyles, Tia (CMS/CMCS); Lynch, Calder (CMS/OA); MacCarroll, Amber L. (CMS/CMCS); Mannix, Norma J. (CMS/CMCS); Marchioni, Mary A. (CMS/CMCS); McClure, Deborah A. (CMS/CMCS); McMillion, Todd (CMS/CMCS); Meacham, David L. (CMS/CMCS); Michael, Lindsay (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); Motley, Danielle O. (CMS/CMCS); Nanes, Cynthia (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Pellanda, Manning J. (CMS/CMCS); Powell, Eric M. (CMS/CMCS); Richards, Barbara K. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Sam-Louie, Henrietta C. (CMS/CMCS); Sampson, Tamara L. (CMS/CMCS); Savage, Courtenay (CMS/CMCS); Shields, Karen (CMS/CMCS); Shuman, Stacey S. (CMS/CMCS); Silanskis, Jeremy D.

(CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Solomon, Alma (CMS/CMCS); Stahlecker, Avery (CMS/CMCS); Storey, Christine B. (CMS/CMCS); Ta, Anh-Dung (CMS/CMCS); Teal, Lela (CMS/CMCS); Thomas, Douglas A. (CMS/CMCS); Thomas, Stephanie D. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Tilahun, Negussie (CMS/CMCS); VERMA, RAJENDER (CMS/CMCS); Weaver, Robert K. (CMS/CMCS); Weidler, Timothy A. (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Yablochnikov, Daniil (CMS/CMCS); Zolynas, Brian (CMS/CMCS); Kennedy, Jocelyn (CMS/CMCS); Juhring, Heather (CMS/CMCS); Giles, John (CMS/CMCS); Young, Cheryl (CMS/CMCS); Lewis, Ashley (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Wiley, Evelyn S. (CMS/CMCS)

Subject: FMG Clearance | Materials [NEW TIME]

When: Friday, September 27, 2019 11:30 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: 323H.01 / Conference Room A // WebEx: 1-877-267-1577 Meeting Number: 990 091 886

Agenda:

^ << File: Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF >>

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

<< File: SC Disapproval Letter Final_ Signed.pdf >> << File: Letter to Administrator SC SPAs.docx >>

Discussion Items:

1. Arkansas FMR Follow-up, J. Gavens, verbal only

<< File: Joshua D Baker SC SMD Letter.docx >>

2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only

<< File: Federal Register Notice SC SPAs.docx >>

3. Oregon CHIP Contingency Fund, DFO, paper

<< File: FMG Cover Page SC ReconsDis.docx >> << File: FMG Cover Page PRR CIB.DOCX >>

4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only

<< File: Oregon CHIP Contingency Fund Issue Paper 9-25-19.docx >>

5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

<< File: FMG Cover Page OR CHIP CF.docx >> << File: FMG Cover Page WI CALL.docx >> << File: FMG Cover Page AR FMR FU.docx >> << File: DSH Allotment Reductions FY 2020.xlsx >> << File: FMG Cover Page DSHRule.docx >> << File: FMG CLEARANCE Agenda 09-26-2019.docx >>

Access Information

1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number: b6

RE: RE: Sending of MO Reconsideration

From: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
To: "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>, "Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>
Cc: "Wiley, Evelyn S. (CMS/CMCS)" <evelyn.wiley@cms.hhs.gov>, "Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>, "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>, "Fan, Kristin A. (CMS/CMCS)" <kristin.fan@cms.hhs.gov>, "Freeze, Janet G. (CMS/CMCS)" <janet.freeze@cms.hhs.gov>
Date: Thu, 11 Jul 2019 18:03:46 +0000
Attachments: RE: Missouri Reconsideration Night Note (156.16 kB)

Hello,

We've been cleared to send the MO reconsideration letter **today**. Please circle back with me once the letter has been issued electronically to the state so I can close the loop with the OCD.

Thanks

Beverly

From: Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Sent: Thursday, July 11, 2019 1:55 PM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Wiley, Evelyn S. (CMS/CMCS) <Evelyn.Wiley@cms.hhs.gov>; Goldstein, Stuart S. (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>
Subject: Sending of MO Reconsideration

Hey Beverly,

Just wanted to pass on that Evelyn now has the ready-to-go envelope of the Missouri reconsideration, but we're still waiting for some official clearance from you. It's my understanding that the clearance may not come until tomorrow, but we just wanted to get everything ready to go.

Thanks,
Tim

RE: RE: Missouri Reconsideration Night Note

From: "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>
To: "Boston, Beverly A. (CMS/CMCS)" <beverly.boston@cms.hhs.gov>
Cc: "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>
Date: Thu, 11 Jul 2019 17:59:45 +0000

Yes. Please let us know when you send the letter. Thanks!

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk: (410) 786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Thursday, July 11, 2019 1:59 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Subject: Missouri Reconsideration Night Note

Hello,

Checking whether we are still on target to release the MO reconsideration letter today? Has it cleared night notes.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

It will be on the NN on July 10th to be issued on July 11th.

Lela normally handles the signing of the letter, etc. So not sure if she's been able to get that in front of him yet...

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk: (410) 786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:22 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Great, thank you. Please let me know if Calder is okay with us sending the letter as soon as NN clears? Thurs is the latest, but folks here and in the ROG would greatly appreciate if we can close this out as soon as practicable.

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:20 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Ok, that works. I sent it up yesterday as well.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 10:19 AM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

We would like to get it out by Thurs 7/11. We want to avoid any Friday mishaps with folks not being in the office etc...

Thank you!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Tuesday, July 9, 2019 7:24 AM
To: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Welcome.

When are we sending MO?

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6) 6

From: Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:19 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: RE: Night Note

Thanks!

Beverly

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 5:10 PM
To: Khan, Farooq A. (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Boston, Beverly A. (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>
Subject: FW: Night Note

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6)

From: Mack, Rosa (CMS/CMCS)
Sent: Monday, July 8, 2019 4:02 PM
To: Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Cc: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>
Subject: Re: Night Note

Letter/email to the state.

Also, the 90th day is tomorrow. So we have to send it tomorrow.

Sent from my iPhone

On Jul 8, 2019, at 3:58 PM, Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov> wrote:

Hey Rosa,

Can you clarify how Disapproval of South Carolina Medicaid State Plan Amendment will be notified? Is it a letter to the state?

Disapproval of South Carolina Medicaid State Plan Amendment	CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that	Disapproval to South Carolina's Medicaid state plan amendments

would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21, 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.	

From: Mack, Rosa (CMS/CMCS)

Sent: Monday, July 8, 2019 2:26 PM

To: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>

Subject: RE: Night Note

FYI there's no rollout for these—they do not get posted, etc. The regions just send the state the letter. That's it.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: (b6)

From: Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>

Sent: Monday, July 8, 2019 2:24 PM

To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>; Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>; Fetalvo, Ninio (CMS/OA) <Ninio.Fetalvo@cms.hhs.gov>; Corry, Thomas (CMS/OA) <Thomas.Corry@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>

Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Williams, Tamika M. (CMS/OC) <Tamika.Williams@cms.hhs.gov>

Subject: RE: Night Note

Plus OC leadership – we have a handful of rollouts slated for the 11th so flagging

Brittney Manchester
Senior Advisor
Integrated Communications Management Staff

From: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>
Sent: Monday, July 8, 2019 2:22 PM
To: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>; Joy-Bush, Keya A. (CMS/OC) <keya.joy-bush@cms.hhs.gov>
Subject: RE: Night Note

Adding Keya.

We can add this to the NN on the 10th (To go out the 11th). This won't make the NN today.

Jason Stegmaier

From: Mack, Rosa (CMS/CMCS) <Rosa.Mack@cms.hhs.gov>
Sent: Monday, July 8, 2019 1:25 PM
To: Stegmaier, Jason (CMS/OA) <Jason.Stegmaier@cms.hhs.gov>
Cc: Lewis, Ashley (CMS/CMCS) <Ashley.Lewis1@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Mengel, Jonathan P. (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Leshak, Brian (CMS/OC) <Brian.Leshak@cms.hhs.gov>; Manchester, Brittney (CMS/OC) <Brittney.Manchester1@cms.hhs.gov>
Subject: Night Note

Hi Jason,

We have a two items that we need to get added to the next possible (earliest) night note. Let me know if you need anything. Thanks!

Disapproval of South Carolina Medicaid State Plan Amendment

Tomorrow CMS will disapprove South Carolina's Medicaid state plan amendments 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the state plan amendments because the state does not have an acceptable source of nonfederal funds to support the payments that would be made under the state plans. The proposed to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. However, the proposed intergovernmental transfers used to fund the non-federal share would come from medical debt collections rather than state or local tax revenue as required under the statute. The Atlanta Regional Office received these state plans on December 21, 2016, June 28, 2017, and June 29, 2018 with proposed effective dates of October 1, 2016, April 1, 2017, and April 1, 2018, respectively. The state is aware of this disapproval, and there will be no planned social media covering this item.

Missouri Disallowance Reconsideration

Tomorrow CMS will notify the state of Missouri of a Medicaid disallowance in the amount \$4,824,901 for unallowable outpatient prescription drugs were no longer eligible for reimbursement or were inadequately documented in accordance with federal requirements. After careful consideration, CMS determined that the state did not provide any additional or new information for CMS to consider. For these reasons, as well as those stated in the March 12, 2019 disallowance letter, CMS is affirming the \$4,824,901 disallowance. The letter outlines the states options regarding an appeal. The state is aware of the disallowance reconsideration, and there will be no planned media covering this item.

Rosa Mack
Office of the Center Director
The Centers for Medicaid & CHIP Services
Desk:(410)786-4824
Cell: b6

WI 1915(i) Backcasting FAR_Prep Call

Where: WebEx Online
When: Fri Sep 27 13:30:00 2019 +00:00
Until: Fri Sep 27 14:00:00 2019 +00:00
Organisers "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
Required Attendees: "Lane, Robert (CMS/CMCS)" <robert.lane@cms.hhs.gov>
"Howe, Rory (CMS/CMCS)" <rory.howe@cms.hhs.gov>
"Goldstein, Stuart S. (CMS/CMCS)" <stuart.goldstein@cms.hhs.gov>
"Thompson, Christopher C. (CMS/CMCS)" <christopher.thompson@cms.hhs.gov>
"Curry, Celestine J. (CMS/CMCS)" <celestine.curry@cms.hhs.gov>
"Hughes, Ruth A. (CMS/CMCS)" <ruth.hughes@cms.hhs.gov>
"Hughes, Ruth A. (CMS/CMCHO)" <"hughes, ruth a. (cms/cmcho)">
Attachments: RE: FMG Clearance | Materials [NEW TIME] (141.82 kB)

Good afternoon,

The purpose of this call is to have a "pre-call" for the 11am call with Wisconsin regarding their 1915(i) Backcasting methodology. To summarize, they are attempting to use 2017 cost reports to cover costs back to 2010. This was discovered in a FAR, but there was discussion of moving straight to disallowance. This is also the issue that has been discussed at clearance recently, including the next meeting that has been rescheduled to 11:30 tomorrow (the second half of the call with the state to which we are preparing). Some additional context has been provided in a well-described summary email by Celestine attached here. Please let me know if you have any comments or questions prior to the call – or if this time does not work.

<<...>>

Thanks,
Tim Davidson

DO NOT DELETE OR CHANGE ANY OF THE TEXT BELOW THIS LINE

TIMOTHY DAVIDSON has scheduled this WebEx meeting.

WI 1915(i) Backcasting FAR_Prep Call
Host: TIMOTHY DAVIDSON

Access Information

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WebEx: 1-877-267-1577
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3. If a password is required, enter the meeting password: (This meeting does not require a password.)
4. Click "Join".
5. Follow the instructions that appear on your screen.

++++
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++++

Hosts, need your host access code or key? Go to the meeting information page:
<https://meetings.cms.gov/ori> b6 MTID= b6

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The meetings.cms.gov team

RE: RE: FMG Clearance | Materials [NEW TIME]

From: "Curry, Celestine J. (CMS/CMCS)" <celestine.curry@cms.hhs.gov>
To: "Davidson, Timothy G. (CMS/CMCS)" <timothy.davidson@cms.hhs.gov>
Date: Thu, 26 Sep 2019 17:52:11 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB)

Hi Tim,

We should keep this meeting, given the efforts it took to coordinate and the importance to advising the state regarding their proposed alternative methodology.

During my visit last week in Baltimore, I had a discussion with Kristen, Janet and Robert and we reached a consensus to advise the state regarding CMS's position to not approve the states proposed alternative method and request that the state voluntarily return the FFP.

Since there is no need for a disallowance if the state voluntarily returns the FFP, I think it is still important to talk with the state and request that they voluntarily return the FFP. During the call with WI, we plan to advise the state that we are not able to approve their proposed alternate methodology. Additionally, we will advise the state that given our decision to not approve the proposed alternative methodology, that we request that the state voluntarily return the \$9.5M FFP. I'm sure we will have to advise the state that if they decide not to voluntarily return the FFP, the region will recommend disallowance.

Recommending disallowance does not mean CMS is issuing a disallowance. We can hold off on sending any official documents such as the Demand Letter until the OCD reaches a decision on the item for discussion tomorrow but I think it is important to advise the state of our decision on the methodology and ask that they voluntarily return the FFP.

I'm thinking that we should have an internal call tomorrow morning to discuss this further before meeting with the state. Would you be able to coordinate a call? On our end, myself, Natasha and Ruth should be on the call.

Celestine

From: Davidson, Timothy G. (CMS/CMCS)
Sent: Thursday, September 26, 2019 11:49 AM
To: Curry, Celestine J. (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Hmmmm well you all know the state pretty well – is there any possibility of pushing the call back an hour or even till next week? I imagine we could still have the call with them tomorrow (I see it now), but then we'd have to preface everything with "This might change after our call with OCD."

Do you think the state would be okay with us pushing it back for the sake of getting complete information from OCD?

From: Curry, Celestine J. (CMS/CMCS)
Sent: Thursday, September 26, 2019 12:47 PM
To: Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Cc: Mathias, Natasha C. (CMS/CMCS) <Natasha.Mathias@cms.hhs.gov>; McAllister, Lisa (CMS/CMCS) <lisa.mcallister@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Hi Tim,

Oh, I see (phew). I saw the new appointment, but did not realize the day had changed as well. Thank you for the clarification.

Our call with the state is 10-11am central/ 11am-12pm eastern which overlaps with the clearance meeting that is scheduled for 10:30am-11am central. The appointment with the state should be on your calendar as well. While I'm thinking we will not be on the call with the state for the full hour scheduled, the overlap currently exist.

Thanks.

Celestine

From: Davidson, Timothy G. (CMS/CMCS)
Sent: Thursday, September 26, 2019 11:42 AM
To: Curry, Celestine J. (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>
Cc: Mathias, Natasha C. (CMS/CMCS) <Natasha.Mathias@cms.hhs.gov>; McAllister, Lisa (CMS/CMCS) <lisa.mcallister@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Good afternoon Celestine,

The meeting actually got pushed until tomorrow. What time is your call with the state?

Thanks,
Tim

From: Curry, Celestine J. (CMS/CMCS)
Sent: Thursday, September 26, 2019 12:40 PM
To: Davidson, Timothy G. (CMS/CMCS) <Timothy.Davidson@cms.hhs.gov>
Cc: Mathias, Natasha C. (CMS/CMCS) <Natasha.Mathias@cms.hhs.gov>; McAllister, Lisa (CMS/CMCS) <lisa.mcallister@cms.hhs.gov>; McMillion, Todd (CMS/CMCS) <TODD.MCMILLION@cms.hhs.gov>
Subject: RE: FMG Clearance | Materials [NEW TIME]

Hi Tim,

It seems that the meeting was changed and therefore I did not see the notice until after the meeting was done.

Can you please advise what was discussed regarding the WI Cost Reporting Issue and if there is anything we should know? We are scheduled to meet with WI tomorrow on this issue and advise them that CMS is not able to approve their alternative methodology and therefore I want to be sure we are up to speed on the latest discussion. Thanks.

Celestine

-----Original Appointment-----

From: Dunn, Victoria (CMS/CMCS) **On Behalf Of** CMS CMCS_Scheduling
Sent: Thursday, September 26, 2019 11:12 AM
To: Adams, Lia (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Barraza, Leticia (CMS/CMCS); Beasley, Michelle (CMS/CMCS); Benson, Deborah J. (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Brandt, John (CMS/OL); Brooks, Bill D. (CMS/CMCS); Brown, Sharon J. (CMS/CMCS); Buck, Megan K. (CMS/CMCS); Burdullis, Brian M. (CMS/CMCS); Carroll, Lisa (CMS/CMCS); Chan, Jeanie (CMS/CMCS); Cheng, Irene T. (CMS/CMCS); Cieslicki, Mary E. (CMS/CMCS); Clark, Jennifer (CMS/CMCS); CMS VTC; Cooley, Mark S. (CMS/CMCS); Cuno, Richard A. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); D'Angelo, Laura (CMS/CMCS); Davidson, Timothy G. (CMS/CMCS); Dillon, Kristin C. (CMS/CMCS); Dunn, Victoria (CMS/CMCS); Endelman, Jonathan (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Ferretti, Ross H. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Friedrich, Charles A. (CMS/CMCS); Gavens, Jay C. (CMS/CMCS); Gillaspie, Cynthia D. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Halter, Mark D. (CMS/CMCS); Harris, Byron J. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Hines, Charles (CMS/CMCS); Hoang, Dzong A. (CMS/CMCS); Holligan, Ricardo E. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Holzbaur, Charlene M. (CMS/CMCS); Howe, Rory (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Hunt, Trinia J. (CMS/CMCS); Ihrig, Jocelyn B. (CMS/CMCS); James-Hailey, Novena M. (CMS/CMCS); Johns, Hamilton J. (CMS/CMCS); Joyce, Tannisse L. (CMS/CMCS); Kessler, Christopher G. (CMS/CMCS); Kimball, Richard M. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Knight, Gary L. (CMS/CMCS); Lambert, Diana (CMS/OFM); Lane, Robert (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lyles, Tia (CMS/CMCS); Lynch, Calder (CMS/OA); MacCarroll, Amber L. (CMS/CMCS); Mannix, Norma J. (CMS/CMCS); Marchioni, Mary A. (CMS/CMCS); McClure, Deborah A. (CMS/CMCS); McMillion, Todd (CMS/CMCS); Meacham, David L. (CMS/CMCS); Michael, Lindsay (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); Motley, Danielle O. (CMS/CMCS); Nanes, Cynthia (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Pellanda, Manning J. (CMS/CMCS); Powell, Eric M. (CMS/CMCS); Richards, Barbara K. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Sam-Louie, Henrietta C. (CMS/CMCS); Sampson, Tamara L. (CMS/CMCS); Savage, Courtenay (CMS/CMCS); Shields, Karen (CMS/CMCS); Shuman, Stacey S. (CMS/CMCS); Silanskis, Jeremy D.

(CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Solomon, Alma (CMS/CMCS); Stahlecker, Avery (CMS/CMCS); Storey, Christine B. (CMS/CMCS); Ta, Anh-Dung (CMS/CMCS); Teal, Lela (CMS/CMCS); Thomas, Douglas A. (CMS/CMCS); Thomas, Stephanie D. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Tilahun, Negussie (CMS/CMCS); VERMA, RAJENDER (CMS/CMCS); Weaver, Robert K. (CMS/CMCS); Weidler, Timothy A. (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Yablochnikov, Daniil (CMS/CMCS); Zolynas, Brian (CMS/CMCS); Kennedy, Jocelyn (CMS/CMCS); Juhring, Heather (CMS/CMCS); Giles, John (CMS/CMCS); Young, Cheryl (CMS/CMCS); Lewis, Ashley (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Lewis, Clarence (CMS/CMCS); Wiley, Evelyn S. (CMS/CMCS)

Subject: FMG Clearance | Materials [NEW TIME]

When: Friday, September 27, 2019 11:30 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: 323H.01 / Conference Room A // WebEx: 1-877-267-1577 Meeting Number: 990 091 886

Agenda:

<< File: Reconsideration Request SC-16-0012A SC-17-006A SC-18-0011A.PDF >>

Standing Items:

ACCESS NPRM, J. Silanskis, verbal only

Medicaid Fiscal Accountability Regulation (MFAR), DRSF/DFO, verbal only

DSH Allotment Reduction Rule, DFO, paper

<< File: SC Disapproval Letter Final_ Signed.pdf >> << File: Letter to Administrator SC SPAs.docx >>

Discussion Items:

1. Arkansas FMR Follow-up, J. Gavens, verbal only

<< File: Joshua D Baker SC SMD Letter.docx >>

2. Wisconsin Rehabilitation Cost Reporting Issue, DRSF, verbal only

<< File: Federal Register Notice SC SPAs.docx >>

3. Oregon CHIP Contingency Fund, DFO, paper

<< File: FMG Cover Page SC ReconsDis.docx >> << File: FMG Cover Page PRR CIB.DOCX >>

4. Provider Payment Reassignment Rule/CIB, C. Thompson, verbal only

<< File: Oregon CHIP Contingency Fund Issue Paper 9-25-19.docx >>

5. South Carolina SPA Disapproval Reconsideration Package, OSG/DRSF, paper

<< File: FMG Cover Page OR CHIP CF.docx >> << File: FMG Cover Page WI CALL.docx >> << File: FMG Cover Page AR FMR FU.docx >> << File: DSH Allotment Reductions FY 2020.xlsx >> << File: FMG Cover Page DSHRule.docx >> << File: FMG CLEARANCE Agenda 09-26-2019.docx >>

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