Pages 1 through 3 redacted for the following reasons:
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Financial Management Group Clearance Items

March 27, 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*, **paper**

Provider Payment Reassignment, *C. Thompson*, **no paper**

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

Discussion Items:

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1. **Topic:** South Carolina SPA Disapproval Package, *DRSF,* **paper**
   Action Needed By: N/A
   Decision Requested: Yes, FMG requests to move forward with disapproving the SC SPAs. The disapproval package is attached.
   Summary: 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. In late January, we spoke with the State Medicaid Director and informed him of our intention to disapprove the SPAs. The Medicaid Director asked for an opportunity to respond to the request for additional information. We have received a draft response to the RAI but no new arguments have been made by the state to change our disapproval grounds and are recommending disapproval.

2. **Topic:** Bonus Payments Overpayment Recovery Process, *DFO,* **paper**
   Action Needed By: N/A
   Decision Requested: Yes, FMG requests OCD's signature on the MOU agreement, and approval to move forward with issuing final decision/demand letters to states.
   Summary: OGC worked with the DAB to develop a MOU which will allow the DAB to hear states' potential bonus payment overpayment appeals. Now that the MOU will be in place, we would like to move forward with issuing the final decision/demand letters for the return of the bonus payment overpayments to applicable states and would like to discuss strategy/next steps with OCD.

3. **Topic:** Maine Senator Letter re: Riverview Disallowance, *DFO,* **paper**
Action Needed By: N/A
Decision Requested: Yes, FMG wants to discuss our response approach.
Summary: CMS received a letter from Maine Sen. Susan Collins to CMS Administrator Verma regarding the disallowances issued with regards to the Riverview Psychiatric Center's loss of certification due to deficiencies. The Senator has requested CMS enter into negotiations with Maine and consider reducing the amount of the disallowances.

4. **Topic:** Missouri TCM Disallowance, *DFO,* **paper**
Action Needed By: March 27, 2019
Decision Requested: Yes, request to move forward with issuing the disallowance to the state.
Summary: Missouri claimed $15.5M of unallowable Medicaid payments for Targeted Case Management services provided to individuals with developmental disabilities during State fiscal years 2011 through 2014. The State agency's payment rates for TCM services provided were not in accordance with the approved state plan.

5. **Topic:** Missouri ISL Disallowance, *DFO,* **paper**
Action Needed By: March 27, 2019
Decision Requested: Yes, request to move forward with issuing the disallowance to the state.
Summary: The Missouri Department of Social Services Medicaid payment rates for individualized supporting living (ISL) habilitation services provided and paid for during State fiscal years 2011 through 2013 were not always in accordance with Federal requirements. Specifically, the State agency included costs that were not approved in some of its payment rates for ISL habilitation services. The OIG estimated that $1.4M of unallowable Medicaid payments were made in SFYs 2011 through 2013.

6. **Topic:** Territory Funding, *DFO,* **no paper**
Action Needed By: N/A
Decision Requested: N/A
Summary: We have received questions from the Hill, MACPAC, and Puerto Rico regarding the order in which territory Medicaid expenditures apply against various statutory funding streams. The priority order is particularly important as the periods of availability for some of the funding streams approach their end dates. Priority order can have an impact on a territories' ability to maximize use of the available funding and when a territory might completely exhaust its federal Medicaid funding for a particular year. The current available funding streams are identified below:

    1. Section 1108(g)(5) of the Social Security Act – (Sec. 20301 of the Bipartisan Budget Act of 2018) – Only available through 9/30/19
    2. Section 1108(g)(2) of the Social Security Act – (Regular Territory Allotments)
    3. Section 1108(g)(5) of the Social Security Act – (Sec. 2005 of the Affordable Care Act) - Only available through 9/30/19
    4. Section 1108(f) and (g) of the Social Security Act – (Increases through Sec. 1323 of the Affordable Care Act) - Only available through 9/30/19

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>, "Hill, Timothy B. (CMS/CMCS)" <timothy.hill@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>

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, 19 Mar 2019 20:02:21 +0000

Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB); NF Payment Changes Email Update PDPM (002).docx (29.24 kB); AK MMIS Deferral Summary 3-19-19.docx (24.04 kB); IN VIII Group FMR Final Summary_3-19-19SG.DOCX (19.86 kB); FMG CLEARANCE Agenda 03-20-2019.docx (34.75 kB)

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

March 20, 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:

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Standing Items:

Access NPRM, *J. Silanskis*, **no paper**

Provider Payment Reassignment, *C. Thompson*, **no paper**

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

Discussion Items:

1. **Alaska MMIS Deferral,** *DFO,* **paper**

<<...>>

2. **Indiana Financial Management Review (FMR),** *DFO,* **paper**

<<...>>

3. **Nursing Facilities Payment Changes Memo,** *DRSF,* **paper**

<<...>>

4. **South Carolina SPA Disapproval Issues,** *DRSF,* **no paper**

SUBJECT: Update Regarding October 1, 2019 Nursing Facility Case-Mix Payment Changes

This email provides an update regarding Nursing Facility Case-Mix Payment Changes which will occur October 1, 2019.

In December 2018, the Center for Medicare and Medicaid Services (CMS) issued an informational bulletin announcing the following two changes that may impact State's Medicaid payments for Medicaid beneficiaries in the nursing home setting.

First, effective beginning October 1, 2019, CMS will replace the existing Resource Utilization Group (RUG), Version 4 case-mix methodology that is used to classify Skilled Nursing Facility (SNF) patients in a covered Part A stay for payment purposes under the SNF Prospective Payment System with a new case-mix classification model, the Patient Driven Payment Model (PDPM).

Second, as of October 1, 2020 CMS planned to no longer support RUG-III and RUG-IV case-mix methodologies via the Minimum Data Set (MDS).

CMS would like to thank State stakeholders for providing feedback on the impact of these policy changes. CMS acknowledges that states require adequate time for planning changes to any current systems and processes involving Medicaid payments for nursing home care.

In an effort to ensure that States have adequate time to consider their payment system options, CMS will support the use of legacy payment models, specifically RUG-III and RUG-IV, through the continued support for the Optional State Assessment (OSA) item set beyond September 30, 2020. In order for States to attain the information necessary for calculating RUG-III and RUG-IV HIPPS codes, States will need to direct their providers to complete the OSA when such data is necessary, as determined by the State. As of October 1, 2020, OBRA assessments will no longer support RUG-III and RUG-IV HIPPS code calculations.

CMS will communicate updates regarding these changes as more information becomes available.

Any questions regarding these changes can be sent to OSAMedicaidinfo@cms.hhs.gov.

Pages 10 through 13 redacted for the following reasons:
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Financial Management Group Clearance Items

March 20, 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**

Provider Payment Reassignment, *C. Thompson*, **no paper**

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

Discussion Items:

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1. **Topic:** Alaska MMIS Deferral, *DFO,* **paper**
   Action Needed By: March 20, 2019
   Decision Requested: Yes, FMG requests concurrence to move forward with the deferral.
   Summary: Alaska claimed $11.7 million FFP, related to the approval of 75 percent federal medical assistance percentage (FMAP) for costs associated with the operation of its MMIS, retroactive to an implementation date of October 31, 2013. However, CMS approved the state's certification of its MMIS at 75 percent FFP retroactive to September 30, 2017, not October 31, 2013. Alaska returned the previously claimed FFP related to its MMIS at the 50 percent FMAP rate and reclaimed it at the 75 percent enhanced rate. The proposed deferral amount of $11.7 million FFP represents the difference between the 50 percent and 75 percent FMAP rates.

2. **Topic:** Indiana Financial Management Review (FMR), *DFO,* **paper**
   Action Needed By: N/A
   Decision Requested: N/A
   Summary: The CMS Chicago Regional Office performed a FMR of Indiana's Medicaid VIII Group newly eligible claims. The review covered newly eligible claimed expenditures during the review period from July 1, 2015 through June 30, 2016 in the amount of $1,217,277,584 claimed at 100% FMAP on the CMS-64. CMS selected a statistical sample of 200 VIII Group claims representing $85,610 from a universe of 3,350,363 claims paid during state fiscal year (SFY) 2016 (July 1, 2015 to June 30, 2016). The Region's review found that all expenditures in the sample set were properly claimed on the CMS-64, at the appropriate FMAP, in accordance with the approved managed care contracts and the Indiana Health Care Plan Professional Fee Schedule. As such, there were no recommendations, observations, or corrective actions identified for the period under review.

3. **Topic:** Nursing Facilities Payment Changes Memo, *DFO,* **paper**
   Action Needed By: N/A
   Decision Requested: Yes, request to update guidance to states on Medicare nursing facility payment system
   Summary: Effective October 1, 2019, CMS will replace the existing Resource Utilization Group (RUG) case-mix methodology with a new case-mix classification model, the Patient Driven Payment Model (PDPM). In December

2018, we issued an informational bulletin alerting states that, as of October 1, 2020, CMS would no long support RUG-III and RUG-IV case-mix methodologies via the Minimum Data Set (MDS). Many states rely on the RUGs case-mix system to set Medicaid payment rates and to calculate the upper payment limit. The Medicare team received significant concerns from states and stakeholders and now intends to support legacy RUGs payment models beyond September 30, 2020. The Medicare team drafted updated guidance to states on this issue and have asked that we distribute. We would like to do so via an email memo through the ROG Divisions to our state partners.

4. **Topic:** South Carolina SPA Disapproval Issue, *DRSF,* **no paper**
Action Needed By: N/A
Decision Requested: Yes, request to move forward with disapproving SC SPAs. (The disapproval package will be brought to clearance next week.)
Summary: 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. In late January, we spoke with the State Medicaid Director and informed him of our intention to disapprove the SPAs. The Medicaid Director asked for an opportunity to respond to the request for additional information. We have received a draft response to the RAI but no new arguments have been made by the state to change our disapproval grounds.

RE: RE: Partial impact

From: "Cash, Judith (CMS/CMCS)" <judith.cash@cms.hhs.gov>
To: "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>
Cc: "Costello, Anne Marie (CMS/CMCS)" <annemarie.costello@cms.hhs.gov>, "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>, "Cash, Judith (CMS/CMCS)" <judith.cash@cms.hhs.gov>, "Hill, Elizabeth H. (CMS/CMCS)" <elizabeth.hill@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>
Date: Mon, 20 May 2019 17:02:04 +0000
Attachments: Partial expansion state.docx (37.52 kB)

Calder,

Per your request, attached is a description of the states we think might be potentially implicated in the decision to reinterpret the partial expansion question. Each of these states either currently has or (in the case of SC) has proposed a targeted expansion authorized under section 1115(a)(2) expenditure authority.

I did not include Idaho at this time, as the state has submitted a SPA to fully adopt the adult group and anyone eligible for Medicaid with income up to 133% FPL will be able to enroll.

Please let me know if you need more info.

Judith

From: Lynch, Calder (CMS/OA)
Sent: Thursday, May 16, 2019 11:25 AM
To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Shields, Karen (CMS/CMCS) <Karen.Shields1@cms.hhs.gov>
Subject: RE: Partial impact

Thanks – are we definitive that this is it? If we need to do a state by state check and I need to make sure we are comprehensive. For OK – is the $72.3 total or state costs? Total would be most helpful as we can then determine impact of different match rate. Also, can you pull these same figures in terms of spending and costs in the existing UT and WI demos that would potentially convert.

Finally, attached is a recently updated memo on partial decisions that I'd like y'all to review – and in this I want to add the Idaho question so we can resolve all partial related questions in one place, as we talked about.

Calder

--
Calder Lynch
Senior Counselor
Office of the Administrator
Centers for Medicare & Medicaid Services (CMS)
Washington, DC 20201
Office: (202) 619-0630

From: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>
Sent: Wednesday, May 15, 2019 6:52 PM
To: Lynch, Calder (CMS/OA) <Calder.Lynch@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Shields, Karen (CMS/CMCS) <Karen.Shields1@cms.hhs.gov>
Subject: RE: Partial impact

Since the Missouri Gateway is a very limited benefit package, I think only OK (in addition to WI and UT) will fit this category.

Insure Oklahoma (IO)
Insure OK provides coverage to qualifying low-income non-disabled workers and their spouses, working foster parents, disabled workers, and full-time college students ages 19-22, with incomes up to and including 200 percent of the FPL (subject to any enrollment caps). Coverage is provided through either premium assistance (for individuals employed by a qualifying

employer) or through the state plan (for working disabled adults and those non-disabled low income workers and spouses whose employer elects not to participate in the Premium Assistance Program.

Enrollment (Point in time figures as of March 2019):

- Total Ins OK Enrollment was 18,824
- ESI Enrollees: 13,609 which is 72% of the total enrollment
- IP Enrollees: 5,215 which is the remaining 28% of the total enrollment

FMAP is 66%.

For CY 2018, it looks like the state spent $72.3 million on Insure Oklahoma.

From: Lynch, Calder (CMS/OA)
Sent: Tuesday, May 14, 2019 12:54 PM
To: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Shields, Karen (CMS/CMCS) <Karen.Shields1@cms.hhs.gov>
Subject: RE: Partial impact

Great – would like to get list – with state, brief description, number of lives, current FMAP, and annual spend.

Calder

--
Calder Lynch
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Office of the Administrator
Centers for Medicare & Medicaid Services (CMS)
Washington, DC 20201
Office: (202) 619-0630

From: Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>
Sent: Tuesday, May 14, 2019 12:51 PM
To: Lynch, Calder (CMS/OA) <Calder.Lynch@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Shields, Karen (CMS/CMCS) <Karen.Shields1@cms.hhs.gov>
Subject: Re: Partial impact

I'll check with the team and let you know. I know we have a small targeted demo pop in Missouri.

Sent from my iPhone

On May 14, 2019, at 12:26 PM, Lynch, Calder (CMS/OA) <Calder.Lynch@cms.hhs.gov> wrote:

> Judith/Anne Marie-
>
> Have we done a scan to know what the full universe is of states potentially implicated in the decision to reinterpret the partial expansion question. That is, we know that Wisconsin and Utah will have the ability to make a claim for enhanced FMAP. Are there any smaller targeted expansions in any of the other non-expansion states also potentially implicated? I assume it would have to be populations covered under demo authority – e.g., Maine HIV (now not implicated because they've expanded) – but are there any others? I want to make sure we have a comprehensive assessment of the potential impact.
>
> Calder
>
> --
> **Calder Lynch**
> Senior Counselor
> Office of the Administrator
> Centers for Medicare & Medicaid Services (CMS)
> Washington, DC 20201
> Office: (202) 619-0630

Pages 18 through 20 redacted for the following reasons:
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Review and Approval: South Carolina Disapproval

From: "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>
To: "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>
Cc: "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>, "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>
Date: Thu, 16 May 2019 14:48:50 +0000
Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB); SC 16-0012-A SC 17-0006-A and SC 18-0011-A Disapproval Letter Final 03-2....docx (19.34 kB); SC 16-0012-A SC 17-0006-A and SC 18-0011-A Disapproval Letter Final 03-2....docx (19.34 kB)

Good morning!

I just got a disapproval package for a SPA proposal from South Carolina for Chris to sign (more information below). Looks like the proposed IFT are not consistent with statute. The materials are dated for today, but would you like us to see if we could possible get MRG to add this to the night note for tomorrow? Or would we be ok issuing today? I've included night note language below just in case.

<<...>>

Potential Night Note

Tomorrow, CMS will issue a disapproval of South Carolina's proposed Medicaid State plan amendments (SPAs) because the state does not have an allowable source of non-federal share to support the payments. The SPAs propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. CMS and the state discussed the issues associated with the nonfederal share on numerous occasions. There is no social media planned.

Sara Harshman
The Center for Medicaid and CHIP Services
Desk: (202) 260-1219
Cell: b6

From: Harrison, Wendy L. (CMS/CMCS)
Sent: Wednesday, May 15, 2019 12:28 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>; 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>; Shields, Karen (CMS/CMCS) <Karen.Shields1@cms.hhs.gov>
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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**

<<...>>

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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*:Wendy.Harrison@cms.hhs.gov

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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 >>

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 though amounts transferred from the Greenville Health Authority (GHA) to the 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 Medicaid agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded that 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 government providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute, 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 payments. 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 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 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 section 1902(a)(2) of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed funding 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. The state requested time to provide additional information supported the proposals, which CMS granted. The subsequent information did not provide for 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 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
Deputy Administrator and Director

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 though amounts transferred from the Greenville Health Authority (GHA) to the 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 Medicaid agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded that 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 government providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute, 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 payments. 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 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 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 section 1902(a)(2) of the Act.

On November 15, 2017, CMS communicated these concerns to South Carolina and stated that the proposed funding 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. The state requested time to provide additional information supported the proposals, which CMS granted. The subsequent information did not provide for 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 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
Deputy Administrator and Director

Materials for FMG's Tuesday 10:30am 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. (CMS/CMCHO)" <anna.dubois@cms.hhs.gov>, "Michael, Lindsay (CMS/CMCS)" <lindsay.michael@cms.hhs.gov>, "Brooks, Bill D. (CMS/CMCHO)" <bill.brooks@cms.hhs.gov>, "Ferguson, Dorothy A. (CMS/CMCHO)" <dorothy.ferguson@cms.hhs.gov>, "Barraza, Leticia (CMS/CMCHO)" <leticia.barraza@cms.hhs.gov>, "Scott, James G. (CMS/CMCHO)" <james.scott1@cms.hhs.gov>, "Weidler, Timothy A. (CMS/CMCHO)" <timothy.weidler@cms.hhs.gov>, "James-Hailey, Novena M. (CMS/CMCHO)" <novena.jameshailey@cms.hhs.gov>, "Brady, Thomas S. (CMS/CMCHO)" <thomas.brady@cms.hhs.gov>, "Fields, Stanley (CMS/CMCHO)" <stanley.fields@cms.hhs.gov>, "Dasheiff, Sandra (CMS/CMCHO)" <sandra.dasheiff@cms.hhs.gov>, "Couch, Thomas R. (CMS/CMCHO)" <thomas.couch@cms.hhs.gov>, "Storey, Christine B. (CMS/CMCHO)" <christine.storey@cms.hhs.gov>, "Wong, Mark I. (CMS/CMCHO)" <mark.wong@cms.hhs.gov>, "McMillion, Todd (CMS/CMCHO)" <todd.mcmillion@cms.hhs.gov>, "Carroll, Lisa (CMS/CMCS)" <lisa.carroll@cms.hhs.gov>, "Mccullough, Francis T. 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(CMS/CMCS)" <douglas.thomas@cms.hhs.gov>, "Que, Rene R. (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, Jerimiah A. (CMS/CMCS)" <jerimiah.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.whelan@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>

Date: Mon, 17 Jun 2019 19:05:38 +0000

Attachments: Unnamed Attachment (3.54 kB); Unnamed Attachment (3.56 kB); FMG CLEARANCE Agenda 06-18-2019.docx (34.7 kB)

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

June 18, 2019

Conference Room A, 10:30am – 11am EST

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

Meeting ID : b6

Please see attached an agenda and materials for Tuesday's **10:30am – 11am** 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*, **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 Update,** *DRSF,* **no paper**
2. **Program Integrity Strategy Update,** *K. Fan,* **no paper**
3. **Program Integrity CIB,** *K. Fan,* **no paper**
4. **Orlando Hospital Tax Update,** *DFO,* **no paper**
5. **Territory Funding Update – Disaster Relief Act,** *DFO,* **no paper**

Financial Management Group Clearance Items

June 18, 2019

Time: 10:30am – 11am

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:

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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:** 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.

3. **Topic:** Program Integrity CIB**,** *K. Fan,* **no paper**
   Action Needed By: N/A
   Decision Requested: N/A
   Summary: FMG would like to discuss the timing of the Program Integrity CIB release.

4. **Topic:** Orlando Hospital Tax Update**,** *DFO,* **no paper**
   Action Needed By: N/A
   Decision Requested: N/A
   Summary: Florida has requested a waiver of the statutory broad-based and uniformity requirements for a hospital tax imposed by the City of Orlando on two hospitals. The tax will fund the non-federal share of Medicaid DSH payments and Low Income Pool (LIP) payments under the state's 1115 demo. Based on the state's information, FMG has concerns that the proposed tax and increased payments might constitute a prohibited hold harmless arrangement as the two hospitals being taxed receive their full tax cost back. FMG will provide an update upon review of the state's waiver request.

5. **Topic:** Territory Funding Update – Disaster Relief Act**,** *DFO,* **no paper**
   Action Needed By: N/A
   Decision Requested: N/A
   Summary: The Additional Supplemental Appropriations for Disaster Relief Act, 2019 provides increased FMAP for certain expenditures for American Samoa, Guam, and Northern Mariana Islands for the period January 1, 2019 through September 30, 2019. The bill also provides $36 million in new federal funds to CNMI for the same period. FMG will provide an update on implementation.

	A	B	C	D
1	**State's Meeting the DME Complaince 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 Complaince 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	***Plans to Submit by 6/30***		
61	ILLINOIS			
62	MINNESOTA			
63	ARKANSAS	***Plans to Submit by 7/1***		
64	NEW MEXICO	***Has Approved SPA - Needs Work***		
65	IOWA			
66	HAWAII			
67	OREGON			
68	**All Non-Compliant States have been contacted*			

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**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**
2	CONNECTICUT	1	CT	3/19/2019	Demonstration	CMS	$ (1,518,096.79)	CT 18-0019	Yes	Yes	Yes	Nicole.Godburn@ct.gov	
3	MASSACHUSETTS	1	MA	3/26/2019	Demonstration	CMS	$ (5,709,413.27)	MA 18-009	Yes	Yes	Yes	Nathan.Bosdet2@state.ma.us	
4	**MAINE**	**1**	**ME**										
5	NEW HAMPSHIRE	1	NH	2/20/2019	Demonstration	CMS	$ (83,589.30)		Yes	Yes	Yes	Sheri.Lacasse@dhhs.nh.gov	
6	RHODE ISLAND	1	RI	3/6/2019	Demonstration	CMS	$ 15,722.28		Yes	No		Michelle.Amado@ohhs.ri.gov	
7	VERMONT	1	VT		Managed Care								
8	NEW JERSEY	2	NJ	4/22/2019	Demonstration	CMS	$ (293,435.66)		Yes	Yes	Yes	Gregory.H.Lovell@dhs.state.nj.us	
9	NEW YORK	2	NY	5/15/2019	Demonstration	CMS	$ (3,532,120.32)		Yes	No		Thomas Heckert	
10	PUERTO RICO	2	PR		Managed Care								
11	VIRGIN ISLANDS	2	VI		1915j								
12	DISTRICT OF COLUMBIA	3	DC	4/25/2019	SPA								Uses 100% of Competitive Bid Rates & DMEPOS
13	DELAWARE	3	DE	5/16/2019	Demonstration	CMS	$ (960,068.00)		Yes	Yes	Yes		State said they paid Medicare, rates were far less.
14	**MARYLAND**	**3**	**MD**										
15	PENNSYLVANIA	3	PA	3/27/2019	Demonstration	State	$ 278,111.48		Yes	Yes	Yes	Lgates@pa.gov	
16	VIRGINIA	3	VA		SPA			VA 14-016					
17	WEST VIRGINIA	3	WV	4/25/2019	SPA								80% of existing Medicare Rate
18	ALABAMA	4	AL		SPA			AL 18-0001, 100% Medicare					
19	**FLORIDA**	**4**	**FL**										
20	GEORGIA	4	GA	4/1/2019	Demonstration	CMS	$ (4,898,082.62)		Yes	No		peter.dalba@dch.ga.gov	
21	KENTUCKY	4	KY	4/17/2019	Demonstration	State	$ (46,473.68)					Jacob.Wilson@ky.gov	
22	MISSISSIPPI	4	MS	3/27/2019	Demonstration	State	$ (382,627.17)		Yes	Yes	Yes	Michael.Daschbach@medicaid.ms.gov	State Developed - Converted some "UE" to "NU" or "RR"
23	NORTH CAROLINA	4	NC	3/29/2019	Demonstration	CMS	$ 2,704,681.91		Yes	Yes	Yes	Betty.J.Staton@dhhs.nc.gov	
24	SOUTH CAROLINA	4	SC	4/1/2019	Demonstration	State	$ 484,499.15		Yes	No		Brian.Amick@scdhhs.gov	
25	TENNESSEE	4	TN	4/18/2019	Managed Care								Provided an assurance that DME is 100% managed care
26	ILLINOIS	5	IL										
27	INDIANA	5	IN	5/13/2019	Demonstration	CMS	$ 2,596,211.03		No	No		Gabrielle.Koenig@fssa.IN.gov	
28	MICHIGAN	5	MI	3/27/2019	Demonstration	CMS	$ (372,104.20)		Yes	Yes	Yes	Blacke@michigan.gov	
29	MINNESOTA	5	MN										
30	OHIO	5	OH	3/22/2019	Demonstration	State	$ (357,524.04)		Yes	Yes	Yes	Mark.Rogers@medicaid.ohio.gov	
31	WISCONSIN	5	WI	3/19/2019	Demonstration	State	$ 2,398,448.74		Yes	Yes	Yes	Matthew.DeLaBruere@dhs.wisconsin.gov	
32	**ARKANSAS**	**6**	**AR**										
33	LOUISIANA	6	LA	5/7/2019	Demonstration	State	$ 26,756.73		Yes	Yes	Yes	Marjorie.Jenkins@LA.GOV	
34	**NEW MEXICO**	**6**	**NM**										
35	OKLAHOMA	6	OK	3/28/2019	Demonstration	CMS	$ 87,949.39						Not enough information in data file - followed up w/ State
36	TEXAS	6	TX	3/25/2019	Demonstration	CMS	$ (27,162.18)		Yes	Yes	Yes	Berengere.dutra@hhsc.state.tx.us	
37	**IOWA**	**7**	**IA**										
38	KANSAS	7	KS	3/6/2019	Demonstration	CMS	$ 9,135.09	KS 18-0004	Yes	Yes	Yes	William.Stelzer@kansas.gov	
39	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
40	NEBRASKA	7	NE		SPA			NE 18-0005					
41	COLORADO	8	CO		SPA			CO 17-0044					
42	MONTANA	8	MT		SPA			MT 18-0033					
43	NORTH DAKOTA	8	ND		SPA			Yes					
44	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
45	UTAH	8	UT	2/28/2019	Demonstration	State	$ (923,814.56)		Yes	No		jcurless@utah.gov	Call on 4/24 to discuss demonstration
46	WYOMING	8	WY	2/27/2019	Demonstration	CMS	$ 661,999.44	WY 18-0003 (set all rates to 100% Medicare, except oxygen)	Yes	Yes	Yes	amy.guimond@wyo.gov	
47	AMERICAN SAMOA	9	AS		1915j								
48	ARIZONA	9	AZ	5/22/2019	Demonstration	CMS	pending						
49	CALIFORNIA	9	CA	3/29/2019	Demonstration	CMS	$ (11,651,677.28)	Yes- Pending access study- 10% decrease- CA-19-0005	Yes	Yes			
50	FED STATE MICRONESIA	9	FM		1915j								
51	GUAM	9	GU		1915j								
52	**HAWAII**	**9**	**HI**										
53	MARIANA ISLANDS	9	MP		1915j								
54	NEVADA	9	NV	5/27/2019	Demonstration	CMS	$ (2,557,244.87)	No	Yes	Yes	Yes		
55	ALASKA	10	AK	6/6/2019	Demonstration	CMS	$ 519,636.38	AK 18-0002	Yes	No			
56	IDAHO	10	ID	4/1/2019	Demonstration	State	$ (1,351,296.09)	ID 18-0004	Yes	Yes	Yes	Angela.Toomey@dhw.idaho.gov	
57	**OREGON**	**10**	**OR**										
58	WASHINGTON	10	WA		SPA			WA 18-0011					
59						**Total Impact**	***$ (23,161,873.91)***							
60	**Totals**					Total Over	$ 11,502,856.12						
61	**SPA**		**9**			Total Under	$ (34,664,730.04)						
62	**Demonstration**		**30**										
63	**Managed Care**		**3**										
64	**1915j**		**5**										
65	**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.

Pages 38 through 39 redacted for the following reasons:
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b5

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:

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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.

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.

Draft CMCS Issues

From: "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>
To: "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>, "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>
Cc: "Mack, Rosa (CMS/CMCS)" <rosa.mack@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>
Date: Thu, 27 Jun 2019 20:16:17 +0000
Attachments: Summary of Key Proposed NPRM Policy Decisions 6 27 19.docx (36.02 kB); DRAFT_DC SMI-SUD_Preliminary Analysis for OA_06.27.19.docx (41.65 kB); SC 16-0012-A Disapproval Memo 06-05-2019 to OA.docx (86.32 kB); South Carolina SPA Disapproval Talking Points rev.docx (14.9 kB)

Here are the draft issues agenda and materials. (Communications and Dashboard will be updated if needed in the morning and added)

Strategic Initiative Project Management Tracker

Decision Items:

1. **South Carolina State Plan Amendment Disapprovals –** Kristin Fan, Rory Howe (Talking points also attached)
   - **Strategic Initiative**: Strengthening the Fiscal and Programmatic Integrity of Medicaid
   - **OA Decision Needed by:** July 2, 2019
   - **Target Date:** July 8, 2019
   - **Background:** CMCS requests the Administrator's approval to disapprove the South Carolina's proposed SPAs 16-0012-A, 17-0006-A, and 18-0011-A. Payments proposed under these SPAs would be funded by transfers from the state's Setoff Debt Collection Program. Absent a permissible source of the non-federal share of payments, CMS cannot approve the proposed SPAs.

2. **Strengthening the Program Integrity of the Medicaid Eligibility Determination Process (CMS-2421)** - Anne Marie Costello, Sarah Delone, Jessica Stephens
   - **Strategic Initiative:** Transforming Medicaid: Strengthening the Fiscal and Programmatic Integrity of Medicaid
   - **OA Decision Needed By**: July 2, 2019
   - **Target Date:** August 23, 2019
   - **Background:** CMCS seeks the Administrator's approval on key policy decisions related to the development of CMCS' eligibility and verification NPRM. These regulation changes will enhance state program integrity efforts and ensure that Medicaid and CHIP beneficiaries continue to be eligible after enrollment.

Discussion Item:

3. **Washington D.C. SMI Demonstration Request – Preliminary Analysis** - Judith Cash, Alissa Deboy
   - **Strategic Initiative:** Supporting Flexibility through Innovative State Demonstrations
   - **Topic:** This is the first combined SMI/SUD proposal submitted to CMS since the Secretary announced the SMI/SED opportunity via State Medicaid Directors Letter (SMDL) #18-011 on November 13, 2018. To address the SUD and SMI crises, the District is proposing a demonstration to test whether the expenditure authority granted under the demonstration, in addition to other concurrent behavioral health delivery system enhancements and re-design efforts, will result in increased access to health care services and improved health outcomes for individuals with SUD and SMI/SED.
   - **Target Date:** N/A
   - **Decision Requested:** No, discussion only

Informational Items:

4. **State Updates –** Judith Cash
   Strategic Initiative: N/A
   Topic: CMCS will update the Administrator on hot topics concerning states.

Target Date: N/A
Decision Requested: No, informational only

5. Upcoming Announcements/Rollouts

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

Summary of Key Proposed Policy Decisions on Medicaid/CHIP Eligibility & Verifications Proposed Rule Changes to Increase Program Integrity
July 2019

Background: CMCS previously briefed you in March 2019, on six proposed eligibility regulation changes to increase program integrity and ensure that beneficiaries enrolled in Medicaid and CHIP continue to be eligible. The proposed changes focused on Medicaid and CHIP eligibility criteria with the greatest potential to change between regularly scheduled redeterminations, especially income and residency. We also proposed to strengthen regulations related to use of verification data sources, state responsibilities to act on changes in circumstances, and recordkeeping.

CMCS staff have begun drafting the proposed rule, which is scheduled to enter clearance in August. We seek your review and concurrence with the following key proposed decision points for each of the six proposed regulation provision changes outlined below.

	REGULATION PROVISION	BACKGROUND	KEY PROPOSED DECISIONS
1	**Reassign responsibility to the Secretary (instead of states) to determine which data sources must be used for income verification.**	• Section 1137 of the Social Security Act (the Act) requires use of certain financial information from the IRS (unearned income), SSA (wages, retirement benefits, net self-employment) and state unemployment and quarterly wage agencies when the Secretary has determined the information is useful for verifying eligibility. • CMS currently delegates this determination of usefulness of data sources to states. As a result, there is some lack of consistency in the use and frequency of income data sources across states.	• Reassume HHS Secretary's authority to determine which data from §1137 of the Act are considered useful for determining financial eligibility for Medicaid/CHIP and therefore must be used to verify income. Specifically: o Establish that state quarterly wage, unemployment and Title II benefits sources are useful; o Outline specific criteria for the Secretary to determine in subsequent guidance whether the remaining §1137 information is useful, based on current usefulness criteria included in MAGI verification plans. o Seek comment on whether additional specific data should be determined useful in regulation (e.g. annual wage data). • Establish a required frequency with which states must check specific data determined to be useful. Specifically: o Require that states use quarterly wage, unemployment, and Title II data at application and renewal o Require that states use quarterly wage data to conduct a 6-month periodic data match for income-based eligibility groups (see provision #3 for more detail). o Establish exceptions from requirements to use data for §1634 determined cases and from requirements to conduct a 6th month check for institutionalized individuals. Seek comment on other mandatory exceptions to consider, including whether to allow state-defined (at CMS approval) exceptions. o Provide that subsequent guidance will be issued to specify the frequency of any other §1137 data determined to be useful.

	Regulation Provision	Background	Key Proposed Decisions
2	**Require that income be verified as part of the initial eligibility determination at application, prior to enrollment.**	• Section 1137 of the Act and existing regulations do not prescribe when data sources must be called and income verification completed. As such, at initial application, states are currently permitted to enroll individuals based on self-attestation of income, and to conduct income data matching and complete income verification within a reasonable timeframe after enrollment.	• Require that states check relevant income data sources and complete verification of income, consistent with their verification plan, prior to enrolling individuals into Medicaid or CHIP. • Seek comment on whether states should be able to retain post-eligibility verification of income for any specific populations (subject to CMS approval).
3	**Require state agencies to conduct electronic data matches against income sources at least every 6 months.**	• The statute does not require periodic data checks between regularly-scheduled renewals, but there is authority for CMS to require them. • Many states currently check income data sources periodically to identify changes in information that may impact a household's eligibility and/or level of benefits.	• For income-based eligibility groups - require states to conduct periodic data matching with the state's quarterly wage data every six months between initial application and between regularly-scheduled renewals. Seek comment on whether to require use of additional specific data sources (e.g. unemployment data). • Permit states to conduct income data matches with additional data sources and/or at higher frequencies. • Seek comment on alternative approaches to calculate the 6-month period for purposes of the periodic match (e.g. from the last time the state made a determination or processed a change in circumstance). • Seek comment on whether to exclude institutionalized individuals from the 6-month periodic data matching requirements. Additionally, seek comment on what other eligibility groups or populations, if any, should be mandatorily excluded, including whether to provide states flexibility to identify and exclude other groups, at state option, and with prior CMS approval.

	REGULATION PROVISION	BACKGROUND	KEY PROPOSED DECISIONS
4	**Require periodic data matches using PARIS to identify beneficiaries who may have moved out of state and become ineligible based on residency requirements.**	• As a condition of receiving Medicaid funding for automated data systems, section 1903(r)(3) of the Act and implementing regulation at 42 CFR 435.945(d) require states have an eligibility determination system to do data matching through the Public Assistance Reporting System (PARIS). • PARIS provides 3 matching services, which are conducted 4 times per year: (1) the interstate match to identify enrollment in benefit programs in other states; (2) VA match to identify Veterans benefits and CHAMPVA; (3) Federal match to identify federal employee and retiree income and TRICARE. • Effective October 1, 2009 states were required to participate in PARIS, but requirements do not specify use of any particular match. We have not provided guidance to states defining how to conduct data matching through PARIS, and we have not specified how states should treat the matched data.	• Require that states participate in the PARIS quarterly interstate match to identify individuals enrolled in public benefit programs in multiple states. Maintain the option for states to participate in other data matches included in PARIS. • Reiterate that states must treat a positive match as a possible change in circumstance related to residency and reach out to the individual for additional information to confirm continued eligibility. • Require states that receive a match to inform the state in which the match occurred and coordinate closing coverage in one of the states. Both states should treat the data as information indicating a potential change in circumstance related to residency, and should follow procedures consistent with 435.916(d). • Because the PARIS interstate match provides a point in time enrollment snapshot of beneficiaries already enrolled in more than one state on the date the match is run, we will not require states use the PARIS interstate match at application.

	Regulation Provision	Background	Key Proposed Decisions
5	**Prescribe a maximum timeframe for states to act upon changes in circumstances.**	• Medicaid and CHIP regulations at 42 CFR 435.916(d) and 457.343 specify that the agency must promptly redetermine eligibility between regular renewals of eligibility whenever it receives information about a change in a beneficiary's circumstance that may affect eligibility. • Current regulations do not define "promptly." States have latitude to set the timeframe for acting on changes in circumstance. This contributes to state variation in the timeliness of processing of identified changes.	• Define "promptly" as follows, to require states to conduct a redetermination of eligibility following an identified change in circumstances, within a specific time period: o 30 days for changes where the state has sufficient information to redetermine eligibility without requesting additional information from the beneficiary. o 60 days for changes where the state must request additional information from the beneficiary to verify information, including a minimum of 30 days for beneficiaries to respond and provide any necessary information. • Require agencies to act on identified changes in circumstance within the specified standards, except in unusual circumstances when the agency cannot reach a decision because the beneficiary fails to timely take a required action or when there is an administrative or other emergency beyond the agency's control. • Extend the requirement in current regulations at 435.916(a)(3) for states to implement a 90-day reconsideration period for beneficiaries who return renewal form or needed information within 90 days after being terminated, without requiring a new application, to beneficiaries who are terminated after failing to provide information related to a change in circumstances.
6	**Strengthen record keeping regulations to ensure that states maintain complete, auditable records of eligibility decisions and verifications.**	• 42 CFR 431.17 and 435.914 outline states' obligations with respect to records maintenance and case documentation • Current regulations are outdated and unclear. • Deficiencies in record keeping have been highlighted in recent federal and state audits as well as PERM reviews, which inform the regulatory changes proposed.	• More clearly define the records states must maintain with respect to the eligibility determinations made for each applicant/beneficiary at application, renewal, and during a change in circumstance. • Require that states be able to provide records and case documentation within a specified reasonable timeframe, when requested. Seek comment on an appropriate timeframe to prescribe. • Require states to retain Medicaid and CHIP eligibility records and case documentation for a minimum of 7 years, consistent with prior timelines issued by HHS. Seek comment on whether this is the right length of time. • Remove references to outdated technology and processes (eg. use of microfilm)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

DATE: June 6, 2019

TO: Seema Verma, Administrator
Centers for Medicare & Medicaid Services

FROM: Calder Lynch, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: Disapproval of South Carolina Medicaid State Plan Amendments (SPA) 16-0012-A, 17-0006-A, and 18-0011-A

ACTION REQUESTED BY July 9, 2019

The Centers for Medicare & Medicaid Services (CMS) intends to disapprove South Carolina Medicaid state plan amendments (SPA) 16-0012-A, 17-0006-A, and 18-0011-A. We are proposing to disapprove the SPAs because the state does not have an allowable source of non-federal share to support the payments that would be made under the SPAs. The state offered arguments about whether the proposed funding source was allowable and requested more time to provide additional support which resulted in our delayed decision. The additional information provided by the state is not compelling as the proposed intergovernmental transfers (IGTs) would come from medical debt collections rather than state or local tax revenue as required under the statute.

The SPAs propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. The Centers for Medicare & Medicaid Services' (CMS) Atlanta Regional Office received these SPAs 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.

We are proposing to disapprove SPAs 16-0012-A, 17-0006-A, and 18-0011-A for the following reasons:

- Under the statute, IGTs must be derived from state or local tax revenue. Payments proposed under the SPAs would be supported by transfers that are derived from a medical debt collection program that garnishes individual state tax refunds.

- Greenville Health Authority (GHA) would provide the IGTs to the single state Medicaid agency. The Health Authority functions primarily to support providers within the Greenville Health and Palmetto Health systems (since merged into Prisma Health). GHA does not have taxing authority or otherwise have access to state or local tax revenue that could support an allowable IGT.

- Without a permissible source of non-federal share funding, we are unable to approve the SPAs.

Solutions Explored

CMS and the state discussed the issues associated with the nonfederal share on numerous occasions. The state contends that GHA is a unit of government which is eligible to fund IGTs. While CMS has not specifically examined this question, the debt collection program is a form of patient revenue rather than state or local tax revenue and may not be used for IGTs. We received several documents from the state offering arguments about the allow ability of the funding arrangement but we do not find it consistent with the Medicaid statute. 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 disapprovals.

Congressional Interest

We do not anticipate any opposition from Congress for these disapprovals as Congressional offices have not expressed interest in these SPAs.

Decision

We recommend the disapproval of South Carolina SPAs 16-0012-A, 17-0006-A, and 18-0011-A. The proposed SPAs are not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act.

Approve_____ Date_____

Disapprove_____ Date_____

Other_____ Date_____

South Carolina SPA Disapprovals
(16-0012-A, 17-006-A, 18-0011-A)

- South Carolina has proposed several SPAs that include problematic financing arrangements related to intergovernmental transfers (IGTs).
- The SPAs propose supplemental payments to Greenville Memorial Hospital for teaching physician services within the facility. The first SPA initially authorizes the payments and the SPAs that follow make downward adjustments to the supplemental payment amounts.
- The payments would be funded by the Greenville Health Authority through an 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 under a health system.
- The Greenville Health Authority agreed to continue to provide IGTs for the proposed supplemental payments. However, the IGT funds would come from a "Set-off Debt Collection Program."
- The Set-off Debt Collection Program allows Greenville Health Authority to collect medical debt that was owed to Greenville Memorial Hospital from the periods prior to transferring operation to the private health system. The medical debt is collected by garnishing the tax returns of individuals who have outstanding debt.
- The Social Security Act requires IGTs to come from state or local tax revenue and the medical debt collection would clearly not be considered tax revenue.
- Greenville Health Authority does not have access to tax revenue to otherwise support the IGTs associated with the proposed payments.
- At the state's request, we provided several opportunities to further explain and alter the funding source, which is the reason our disapproval action was not taken sooner.
- The Medicaid Director is aware that we intend to issue the disapproval and the state intends to appeal.
- The projected federal impact of taking the disapprovals is approximately $6 million for 2017, which is reduced by $1.5 million in 2018 and $3 million in 2019.
- We must disapprove the SPAs by July 9, 2019 to avoid automatic approval.

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

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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:

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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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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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FY 2020 Medicaid DSH Allotment Reductions - State-by-State Summary

State	Low DSH State	Unreduced FY 2020 DSH Allotment	Total FY 2020 DSH Allotment Reduction	FY 2020 Reduced Allotment	Total Allotment Reduction Percentage	Uninsured Percentage Factor (UPF)		High Volume of Medicaid Inpatients Factor (HMF)		High Level of Uncompensated Care Factor (HUF)	
						UPF Reduction Amount	UPF Reduction Percentage	HMF Reduction Amount	HMF Reduction Percentage	HUF Reduction Amount	HUF Reduction Percentage
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
Idaho	Y	$ 19,225,747	$ 2,708,577	$ 16,517,170	14.09%	$ 492,198	2.56%	$ 738,535	3.84%	$ 1,477,844.42	7.69%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
Oregon	Y	$ 52,944,322	$ 5,239,093	$ 47,705,229	9.90%	$ 2,133,006	4.03%	$ 1,911,721	3.61%	$ 1,194,365.55	2.26%
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%
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%
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%
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%
Tennessee*	N	$ 53,100,000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
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%
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%
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%
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%
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%
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%
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%
Wyoming	Y	$ 264,722	$ 39,617	$ 225,105	14.97%	$ 7,196	2.72%	$ 22,753	8.60%	$ 9,667.41	3.65%
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%**

Key

Low-DSH States

Expansion States

* 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.

FY 2020 Medicaid DSH Allotment Reductions - State-by-State Summary

State	Low DSH State	Unreduced FY 2020 DSH Allotment	Total FY 2020 DSH Allotment Reduction	FY 2020 Reduced Allotment	Total Allotment Reduction Percentage	Uninsured Percentage Factor (UPF)		High Volume of Medicaid Inpatients Factor (HMF)		High Level of Uncompensated Care Factor (HUF)	
						UPF Reduction Amount	UPF Reduction Percentage	HMF Reduction Amount	HMF Reduction Percentage	HUF Reduction Amount	HUF Reduction Percentage
Tennessee*	N	$ 53,100,000	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
Wyoming	Y	$ 264,722	$ 39,617	$ 225,105	14.97%	$ 7,196	2.72%	$ 22,753	8.60%	$ 9,667.41	3.65%
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%
Idaho	Y	$ 19,225,747	$ 2,708,577	$ 16,517,170	14.09%	$ 492,198	2.56%	$ 738,535	3.84%	$ 1,477,844.42	7.69%
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%
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%
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%
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%
Oregon	Y	$ 52,944,322	$ 5,239,093	$ 47,705,229	9.90%	$ 2,133,006	4.03%	$ 1,911,721	3.61%	$ 1,194,365.55	2.26%
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%
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%
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%
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%
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%
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%
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%
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%
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%**

Key
Low-DSH States
Expansion States

* 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.

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, SPAs16-0012-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 SPAs16-0012-A, 17-006-A, and 18-0011-A.

The South Carolina Medicaid SPAs16-0012-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 SPAs16-0012-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

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 though 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,

Calder Lynch
Acting Deputy Administrator and Director

BROWN & PEISCH PLLC
Healthcare & Federal Programs Lawyers

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.

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 though 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,

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.

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

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

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 puroses 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 (D) 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 1908(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 1903(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. 102-310 (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 outstationed 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 no-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.

DEHPG Clearance - Agenda and Materials - 2.7.20

From: "Erwin, Tanesha (CMS/CMCS)" <tanesha.erwin@cms.hhs.gov>

To: CMS CMCS_Scheduling <cmcs_scheduling@cms.hhs.gov>, "Beronio, Kirsten K. (CMS/CMCS)" <kirsten.beronio@cms.hhs.gov>, "Bowdoin, Jennifer (CMS/CMCS)" <jennifer.bowdoin@cms.hhs.gov>, "Brooks, Bill D. (CMS/CMCS)" <bill.brooks@cms.hhs.gov>, "Close, Jean K. (CMS/CMCS)" <jean.close@cms.hhs.gov>, CMS VTC <vtc@cms.hhs.gov>, "Coster, John M. (CMS/CMCS)" <john.coster@cms.hhs.gov>, "Deboy, Alissa M. (CMS/CMCS)" <alissa.deboy1@cms.hhs.gov>, "Delozier, Adrienne M. (CMS/CMCS)" <adrienne.delozier@cms.hhs.gov>, "Costello, Anne Marie (CMS/CMCS)" <annemarie.costello@cms.hhs.gov>, "Denemark, Cynthia (CMS/CMCS)" <cynthia.denemark@cms.hhs.gov>, "Erwin, Tanesha (CMS/CMCS)" <tanesha.erwin@cms.hhs.gov>, "Failla, George P. (CMS/CMCS)" <george.failla@cms.hhs.gov>, "Farkas, Mary Pat P. (CMS/CMCS)" <marypat.farkas@cms.hhs.gov>, "Gibson, Alexis E. (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>, "Glaze, Jackie L. (CMS/CMCS)" <jackie.glaze@cms.hhs.gov>, "Harris, Melissa L. (CMS/CMCS)" <melissa.harris@cms.hhs.gov>, "Harshman, Sara (CMS/CMCS)" <sara.harshman@cms.hhs.gov>, "Hughes, Ruth A. (CMS/CMCS)" <ruth.hughes@cms.hhs.gov>, "Jensen, Kirsten (CMS/CMCS)" <kirsten.jensen@cms.hhs.gov>, "Lee, Hye Sun (CMS/CMCS)" <hyesun.lee@cms.hhs.gov>, "Lollar, Ralph F. (CMS/CMCS)" <ralph.lollar@cms.hhs.gov>, "Lynch, Calder (CMS/OA)" <calder.lynch@cms.hhs.gov>, "Marchioni, Mary A. (CMS/CMCS)" <mary.marchioni@cms.hhs.gov>, "Mccullough, Francis T. (CMS/CMCS)" <francis.mccullough@cms.hhs.gov>, "McKnight, Nicole M. (CMS/CMCS)" <nicole.mcknight@cms.hhs.gov>, "Meacham, David L. (CMS/CMCS)" <david.meacham@cms.hhs.gov>, "Nelson, Barbara A. (CMS/CMCS)" <barbara.nelson@cms.hhs.gov>, "Roberts, Shantrina D. (CMS/CMCS)" <shantrina.roberts@cms.hhs.gov>, "Scott, James G. (CMS/CMCS)" <james.scott1@cms.hhs.gov>, "Shields, Karen (CMS/CMCS)" <karen.shields1@cms.hhs.gov>, "Smith, Carrie A. (CMS/CMCS)" <carrie.smith@cms.hhs.gov>, "Sumeracki, Jodie M. (CMS/CMCS)" <jodie.sumeracki@cms.hhs.gov>, "Teal, Lela (CMS/CMCS)" <lela.teal@cms.hhs.gov>, "Tillman-Boyd, Sabrina (CMS/CMCS)" <sabrina.tillman-boyd@cms.hhs.gov>, "Whelan, Ellen Marie (CMS/CMCS)" <ellenmarie.whelan@cms.hhs.gov>, "Dressel, Rachel (CMS/CMCS)" <rachel.dressel@cms.hhs.gov>, "Conover, Lillian A. (CMS/CMCS)" <lillian.conover@cms.hhs.gov>, "Dorsey, Porsche S. (CMS/CMCS)" <porsche.dorsey@cms.hhs.gov>, "Lewis, Ashley (CMS/CMCS)" <ashley.lewis1@cms.hhs.gov>, "McMillion, Todd (CMS/CMCS)" <todd.mcmillion@cms.hhs.gov>, "Joyce, Tannisse L. (CMS/CMCS)" <tannisse.joyce@cms.hhs.gov>, "Curry, Celestine J. (CMS/CMCS)" <celestine.curry@cms.hhs.gov>, "Kimble, Davida R. (CMS/CMCS)" <davida.kimble@cms.hhs.gov>, "Harris, Monica F. (CMS/CMCS)" <monica.harris@cms.hhs.gov>, "Stegmaier, Jason (CMS/OA)" <jason.stegmaier@cms.hhs.gov>, "Walker, Abigail P. (CMS/CMCS)" <abigail.walker@cms.hhs.gov>, "Gaskins, Sheri P. (CMS/CMCS)" <sheri.gaskins@cms.hhs.gov>, "Siler-Price, Mara (CMS/CMCS)" <mara.siler-price@cms.hhs.gov>, "Hickey, Jessica M. (CMS/CMCS)" <jessica.hickey@cms.hhs.gov>, "Opheim, Michelle D. (CMS/CMCS)" <michelle.opheim@cms.hhs.gov>, "Berman Sandler, Leatrice (CMS/CMCS)" <leatrice.bermansandler@cms.hhs.gov>

Date: Wed, 05 Feb 2020 16:56:03 +0000

Attachments: 02072020 DEH Clearance Agenda.docx (40.68 kB); 1. MS Pediatric Heart Surgery SPA Issue.docx (27.92 kB); 1.a. MS Div of Medicaid Regions Map Exempted counties.pdf (430 kB); 1.b. Ochsner Hospital For Children - Google Maps.pdf (998.89 kB); 2.0 MEMO_Texas UHRIP Directed Payment (01.24.2020).docx (31.34 kB); 3. Joint DEHPG-ACL work plan - for OCD.docx (29.94 kB); 4. HCBS recommended measure set RFI update - INFORMATIONAL ONLY.docx (22.38 kB); 7. 2019 PASRR National Report 2020-02-04_REVISED.docx (217.57 kB); 8a. DRAFT Response Unenrolled Providers to Serve Medicaid Beneficiaries_OEI-05-19-0006.docx (37.87 kB); 8a1. INFO ONLY DRAFT Report Unenrolled Providers to Serve Medicaid Beneficiaries, OEI-05-19-00060.pdf (2.01 MB)

Good morning,

Below and attached are the agenda and materials for our Clearance meeting on 2/7.

Agenda

1. **MS Pediatric Surgery SPA - Paper**
   Action Needed By: At your earliest convenience
   Decision Requested: Concurrence with DEHPG recommendation.
   Summary: See the attached paper outlining disapproval grounds for MS 19-0021 Pediatric Congenital Heart Surgery, which is currently on 2nd clock review. The state is proposing to cover pediatric congenital heart surgery under the inpatient hospital benefit by out-of-state providers only under specific conditions. We believe these conditions are not consistent with several statutory and regulatory provisions, including: the requirements for out-of-state providers, freedom of choice, and sufficiency of amount, duration, and scope of services. We are

recommending OCD contact the State Medicaid Director directly to discuss the potential for the state to withdraw the SPA to prevent a disapproval.

2. **TX State Directed Payment (UHRIP) - Paper**
Action Needed By: At your earliest convenience
Decision Requested: Direction on how to proceed with the state's state-directed payment arrangement request given the concerns raised by the federal review team.
Summary: Texas has submitted an amended preprint which has 2 notable changes affecting the second half of their 2019-2020 rating period (changes would take effect March 1, 2020.)

3. **ACL/DEHPG Workplan Update - Paper**
Action Needed By: At your earliest convenience
Decision Requested: Concurrence with DEHPG recommendation
Summary: In 2019, DEHPG and ACL worked together to develop an 18-month joint work plan. The work plan includes specific activities and deliverables that DEHPG and ACL are working on collaboratively and for which there are clearly defined roles and responsibilities for each entity. The attached paper summarizes the 2019 accomplishments and 2020 planned activities. DEHPG would like to propose dropping one activity related to employment and to add several additional health IT and interoperability-related activities, for which ACL would be the lead in collaboration with the Office of the National Coordinator for Health Information Technology (no additional CMS resources needed). DEHPG is seeking OCD concurrence with DEHPG recommendations related to these activities.

4. **HCBS Recommended Measure Set Update - Paper**
Action Needed By: n/a
Decision Requested: Informational only
Summary: The attached paper provides OCD with an update on the status of the HCBS recommended measure set RFI and briefly describes next steps.

5. **SUPPORT Act Section 1017 Report to Congress - Verbal**
Action Needed By: At your earliest convenience
Decision Requested: OCD advice on whether to hold the section 1017 report to Congress
Summary: Under section 1017 of the SUPPORT Act, HHS is required to issue a report to Congress on innovative state initiatives and strategies for providing housing-related services and supports under Medicaid to individuals with substance use disorders who are experiencing or at risk of experiencing homelessness. The draft report is currently in its third round of CMS clearance. Given the linkage between housing information contained in this report and content of the State Health Official letter on social determinants of health, we had intended to align the release of the two documents. At OGC's direction, we have removed language on the use of section 1915(i) authority for one-time transition costs from the report to Congress. However, OGC concerns about 1915(i) authority need to be discussed further before putting the larger SHO letter into CMS clearance. We are requesting OCD advice on whether to delay moving the report into Departmental clearance until after the discussion with OGC about the SHO letter. The statutory due date for the report to Congress was October 24, 2019.

6. **Home Modifications Joint IB - Verbal**
Action Needed By: At your earliest convenience
Decision Requested: OCD concurrence to move the IB into HHS clearance
Summary: A joint IB with ACL, CDC, HSRA, HUD, and USDA on federal resources, programs, and initiatives to improve home safety, usability, and accessibility for older adults and people with a disability in rural areas is also in its third round of CMS clearance. No substantive policy issues or concerns have been raised during CMS clearance. We are requesting OCD approval to move the IB into Departmental clearance following CMS clearance. HUD and USDA are separately clearing the IB.

7. **PASRR National Report – Report Attached.** ***FYI – Longer than 10 pages***
Action Needed By: At your earliest convenience
Decision Requested: OCD concurrence to release the report
Summary: DLTSS requests permission to release the annual PASRR National Report prepared by its PASRR technical assistance contractor (the PASRR Technical Assistance Center). The document includes updated information from state PASRR programs regarding the types of quality measures they track and data collected from the Minimum Data Set (MDS) about the characteristics of nursing home residents that may be of interest to PASRR programs. The data in the report does not directly measure state PASRR programs' performance. This report has been reviewed to ensure that the information in the report does not pose any potential policy misalignments with the pending PASRR NPRM.

8. **GAO/OIG Decision Items – for discussion if needed**
   a. **Twenty-Three State Reported Allowing Unenrolled Providers To Serve Medicaid Beneficiaries: OEI-05-19-00060 (Draft Report *(information only - longer than 10 pagers)***
   Action Needed By: 2/7/20
   Decision Requested: We plan to move the Draft response back to OL.
   Summary: The draft OIG report released on January 17, 2020 has four recommendations, one of which is a DE lead (*R1): CMS should take steps to disallow Federal reimbursements to States for expenditures associated with unenrolled MCO network providers, including seeking necessary legislative authority.* DE also plays a role on *R2 (*CPI is lead, DE is support): *CMS should work with States to ensure that unenrolled providers do not participate in Medicaid managed care and assist States in establishing ways to do so.*
   b. **Medicare and Medicaid: Alignments of Managed Care Plans for Dual-Eligible Beneficiaries: GAO-20-319_103367**

9. **Other Follow-up**
   a. ID 1915(I) Limited Exception to the IMD Exclusion SPA—Ready for Approval
   b. SC EVV Reach out

10. **TB – Closed Session – Hiring Update (Paper to be provided separately)**

-----Original Appointment-----
From: CMS CMCS_Scheduling <CMCS_Scheduling@cms.hhs.gov>
Sent: Thursday, January 30, 2020 1:33 PM
To: CMS CMCS_Scheduling; Beronio, Kirsten K. (CMS/CMCS); Bowdoin, Jennifer (CMS/CMCS); Brooks, Bill D. (CMS/CMCS); Close, Jean K. (CMS/CMCS); CMS VTC; Coster, John M. (CMS/CMCS); Deboy, Alissa M. (CMS/CMCS); Delozier, Adrienne M. (CMS/CMCS); Costello, Anne Marie (CMS/CMCS); Denemark, Cynthia (CMS/CMCS); Erwin, Tanesha (CMS/CMCS); Failla, George P. (CMS/CMCS); Farkas, Mary Pat P. (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCS); Harris, Melissa L. (CMS/CMCS); Harshman, Sara (CMS/CMCS); Hughes, Ruth A. (CMS/CMCS); Jensen, Kirsten (CMS/CMCS); Lee, Hye Sun (CMS/CMCS); Lollar, Ralph F. (CMS/CMCS); Lynch, Calder (CMS/OA); Marchioni, Mary A. (CMS/CMCS); Mccullough, Francis T. (CMS/CMCS); McKnight, Nicole M. (CMS/CMCS); Meacham, David L. (CMS/CMCS); Nelson, Barbara A. (CMS/CMCS); Roberts, Shantrina D. (CMS/CMCS); Scott, James G. (CMS/CMCS); Shields, Karen (CMS/CMCS); Smith, Carrie A. (CMS/CMCS); Sumeracki, Jodie M. (CMS/CMCS); Teal, Lela (CMS/CMCS); Tillman-Boyd, Sabrina (CMS/CMCS); Whelan, Ellen Marie (CMS/CMCS); Dressel, Rachel (CMS/CMCS); Conover, Lillian A. (CMS/CMCS); Dorsey, Porsche S. (CMS/CMCS); Winiarek, Claire (CMS/CMCS); Lewis, Ashley (CMS/CMCS); McMillion, Todd (CMS/CMCS); Joyce, Tannisse L. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Harris, Monica F. (CMS/CMCS); Stegmaier, Jason (CMS/OA); Walker, Abigail P. (CMS/CMCS); Gaskins, Sheri P. (CMS/CMCS); Siler-Price, Mara (CMS/CMCS); Hickey, Jessica M. (CMS/CMCS); Opheim, Michelle D. (CMS/CMCS); Berman Sandler, Leatrice (CMS/CMCS)
Subject: DEHPG Clearance
When: Friday, February 7, 2020 4:00 PM-4:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: 323H.01 / Conference Room A // WebEx: 1-877-267-1577 Meeting Number: 992 552 611

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

Pages 117 through 121 redacted for the following reasons:
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b5

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Revised 09/01/2018

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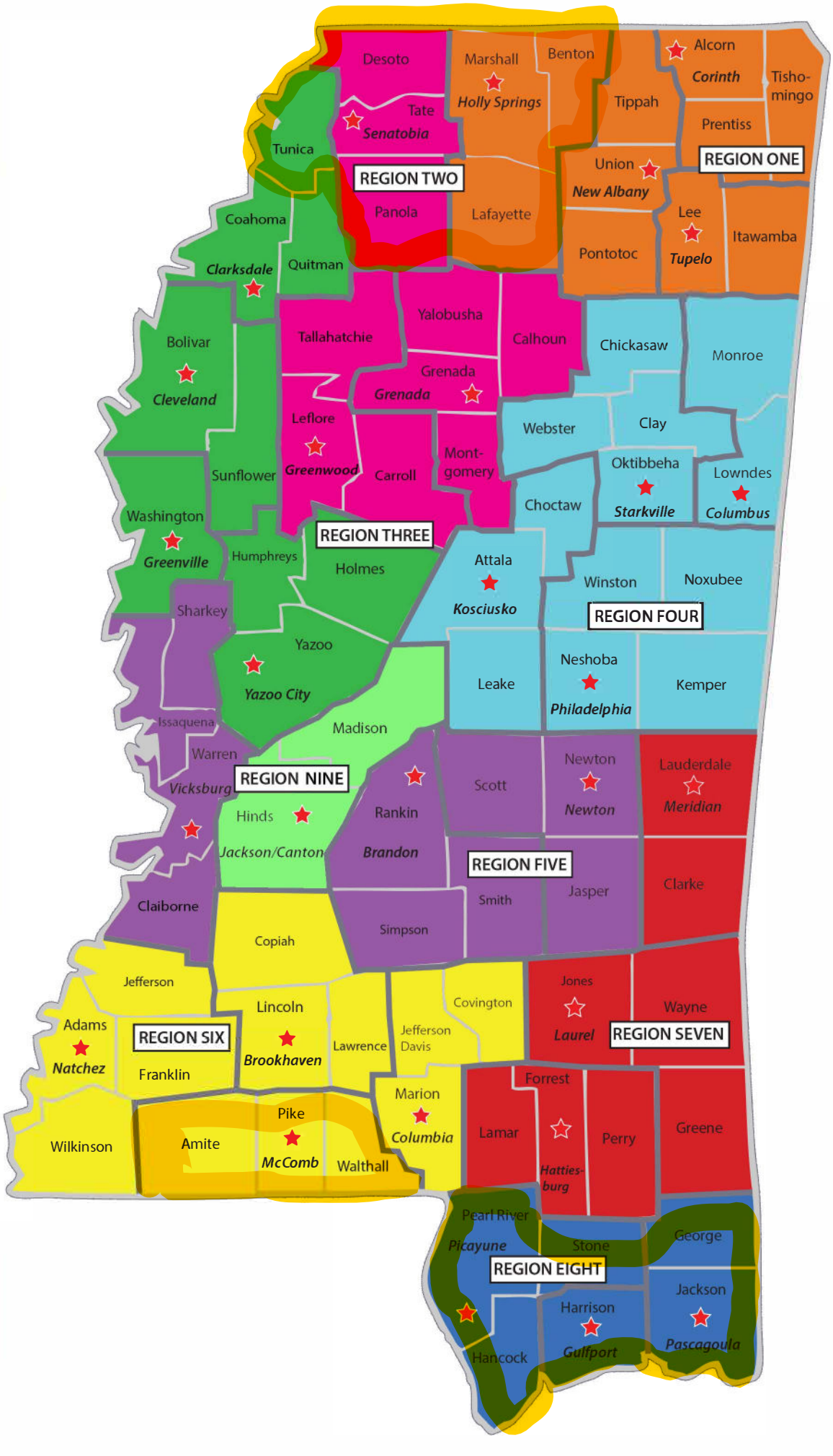
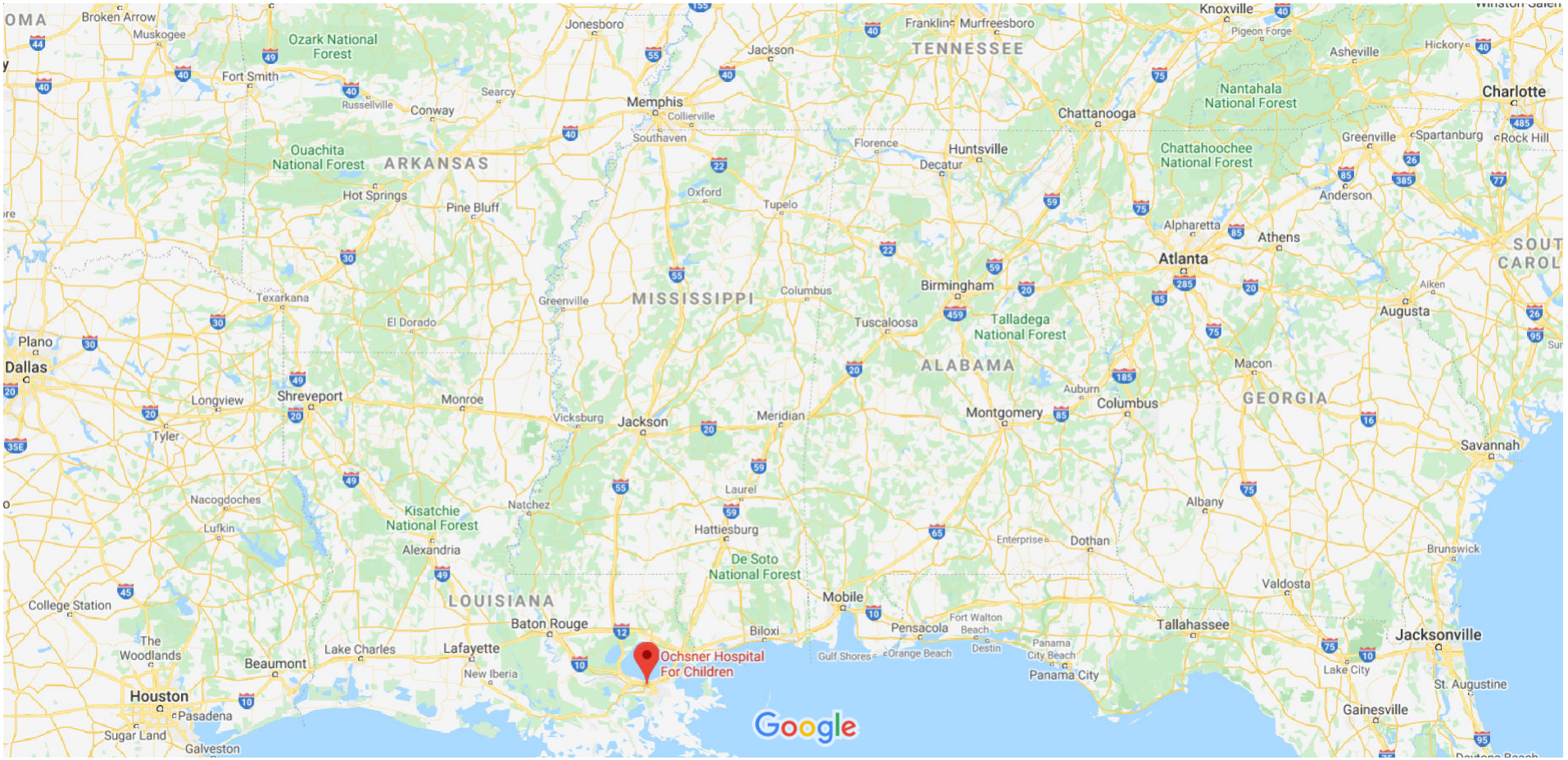


Google Maps Ochsner Hospital For Children



Pages 124 through 126 redacted for the following reasons:
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ACL/CMS CMCS DEPHG Strategic Work Plan
Summary of 2019 Accomplishments & 2020 Planned Activities

Area of Focus	Summary of Joint ACL/DEHPG 2019 Accomplishments	Summary of Joint ACL/DEHPG 2020 Planned Activities	Lead	Keep/Drop /Add?
CMCS Objective: CMCS will advance innovation in state Medicaid Programs by implementing changes that decrease burden while increasing accountability for outcomes.				
HCBS Rule Implementation	Disseminated two pieces of sub-regulatory guidance on heightened scrutiny provisions	Continue to collaborate on review of all HCBS Statewide Transition Plans and Heightened Scrutiny Packages; provide additional technical assistance (TA) to states	DEHPG	Keep
Health & Welfare	Conducted incident management system survey, with a 93% completion rate	Disseminate findings, deliver TA based on findings from national survey on incident management	DEHPG	Keep
	Conducted 7 Special Review Team visits	Continue Special Review Team visits	DEHPG	Keep
		Convene adult protective services stakeholders to identify obstacles and solutions to sharing findings of investigations with Medicaid on abuse/neglect allegations	DEHPG/ ACL	Keep
Workforce Development & Capacity Building	Awarded 3 year contract to assess issues/challenges and potential solutions related to HCBS direct service workforce challenges	Develop interactive, multimedia on-line training series for people who self-direct services; host half-day session on the direct service workforce at the HCBS Conference; develop new reports and materials on direct service workforce challenges for states	DEHPG	Keep
Strengthen State No Wrong Door (NWD) Systems	Conducted assessment of each state's NWD System for the AARP LTSS State Scorecard; identified states for targeted technical assistance	Issue an Emerging Innovation paper on Assistive Technology; develop resources/tools to improve reporting on NWD activities; develop NWD Medicaid Administrative Claiming Dashboard; award infrastructure grants to state NWD Systems; deliver targeted TA to lower ranking NWD System states	ACL	Keep
HCBS Recommended Measure Set	Drafted HCBS recommended measure set and RFI; developed HCBS measure inventory; addressing gaps in available measures through new CMS measure development contract, existing ACL grants	Release recommended measure set RFI; finalize, release, and implement initial measure set; continue addressing gaps in available measures through CMS measure development contract, ACL grants	DEHPG/ ACL	Keep

ACL/CMS CMCS DEPHG Strategic Work Plan
Summary of 2019 Accomplishments & 2020 Planned Activities

Area of Focus	Summary of Joint ACL/DEHPG 2019 Accomplishments	Summary of Joint ACL/DEHPG 2020 Planned Activities	Lead	Keep/Drop /Add?
CMCS Objective: CMCS will use data to accelerate quality improvement and drive accountability for results.				
Health IT/ Interoperability		Develop a strategic national framework for advancing health IT adoption and interoperability in HCBS; award Health IT challenge to improve technology systems used by state Aging & Disability agencies; publish updated Health IT Toolkit, Health Home Toolkit	ACL/ ONC	Add (new proposed activities)
Predictive Analytics	Executed CMS/ACL IAA focused on predictive analytics; awarded contract	Develop and test predictive models focused on abuse, neglect and exploitation	DEHPG/ ACL	Keep
CMCS Objective: Medicaid coverage results in better quality of life for beneficiaries.				
Promoting the Role of HCBS in Addressing SDOH	Housing & Home Modification - Drafted joint CMS/ACL/HUD/USDA/HRSA informational bulletin on federal resources for home modifications in rural communities	Housing & Home Modification - Release joint informational bulletin; conduct 10th HHS/HUD Central Office meeting	DEHPG	Keep
		Employment - Convene working group to develop recommendations related to employment and other meaningful day activities (to support HCBS setting rule implementation and community integration)	ACL	Drop (not started; lower priority activity)
Person-Centered Planning (PCP) Competencies & Measurement	Completed draft definition of PCP, draft definition of PCP competencies, draft system characteristics, and an environmental scan	Provide year two TA to 15 states embedding PCP into state Medicaid systems; draft final report on PCP competencies and measurements	ACL (jointly funded by CMS)	Keep
CMS Strategic Initiative: Fighting the Opioid Epidemic; Objective: Medicaid 5-State Demonstration to Increase Provider Capacity to Treat Substance Use Disorders (SUPPORT Act Section 1003)				
Workforce Development & Capacity Building	Substance Use Provider Capacity—awarded $48.5 million in planning grants to 15 states	Continue implementation of provider capacity demonstration; develop and disseminate new TA resources for states	DEHPG	Keep