Chapter 1:

Improving the Transparency of Medicaid and CHIP Financing

Improving the Transparency of Medicaid and CHIP Financing

Recommendations

1.1 In order to improve transparency and enable analyses of net Medicaid payments, Congress should amend Section 1903(d)(6) of the Social Security Act to require states to submit an annual, comprehensive report on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers. The report should include:

- a description of the methods used to finance the non-federal share of Medicaid payments, including the parameters of any health care-related taxes;
- a state-level summary of the amounts of Medicaid spending derived from each source of non-federal share, including state general funds, health care-related taxes, intergovernmental transfers, and certified public expenditures; and,
- a provider-level database of the costs of financing the non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the non-federal share.

This report should be made publicly available in a format that enables analysis.

1.2 In order to provide complete and consistent information on the financing of Medicaid and the State Children's Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act (the Act) to apply the Medicaid financing transparency requirements of Section 1903(d)(6) of the Act to CHIP.

Key Points

- Financing of Medicaid and the State Children's Health Insurance Program (CHIP) is a shared responsibility between states and the federal government. Statute permits states to raise the non-federal share of Medicaid and CHIP expenditures through multiple sources. States are increasingly relying on health care–related taxes, intergovernmental transfers (IGTs), and certified public expenditures (CPEs) as ways to fund the non-federal share of Medicaid expenditures.
- The amount providers pay in health care–related taxes, IGTs, and CPEs can be seen as additional costs that effectively reduce gross payments. As such, the net payment that providers can use to cover the cost of providing services is lower than the gross amount initially received. Stakeholders have stressed the importance of analyzing both gross and net payment amounts when developing payment policy and assessing how these payments are linked to goals of access and quality.
- The Centers for Medicare & Medicaid Services (CMS) does not collect information on the sources of non-federal share in a comprehensive manner, resulting in data that are fragmented, incomplete, and not always publicly available.
- The Commission has long held that analyses of Medicaid payment policy require complete data on all Medicaid payments that providers receive as well as data on the costs of financing the non-federal share necessary to calculate net Medicaid payments at the provider level. The recommendations made in this chapter expand on prior Commission recommendations by including reporting of all types of Medicaid financing for all types of providers, not just hospitals and nursing facilities.
- CMS should make any new financing data publicly available to enable analyses by all stakeholders. In addition, CMS should seek ways to reduce the administrative burden by consolidating reporting when possible and establishing procedures to ensure accuracy and consistency across data sources.

CHAPTER 1: Improving the Transparency of Medicaid and CHIP Financing

Financing of Medicaid and the State Children's Health Insurance Program (CHIP) is a shared responsibility between states and the federal government. The federal government matches allowable state expenditures according to the federal medical assistance percentage (FMAP). The statute permits states to raise the non-federal share of Medicaid and CHIP expenditures through multiple sources, including state general revenue, health care–related taxes, and contributions from local governments (including providers owned by local governments). The extent to which states rely on funding sources other than state general revenue varies considerably by state and type of service.

MACPAC previously recommended that the Centers for Medicare & Medicaid Services (CMS) collect data on provider costs of contributing to the non-federal share so that we can account for these costs when assessing net payments to hospitals and nursing facilities (Box 1-2) (MACPAC 2023a, 2016a). The U.S. Government Accountability Office (GAO) has also recommended that CMS collect provider-level data on the costs of contributing to the non-federal share for all providers (GAO 2020). In addition, GAO has recommended that CMS collect more state-level information about financing methods to improve federal oversight of financing policies (GAO 2014). These recommendations have not yet been implemented.

This report further examines barriers to improving the transparency of Medicaid and CHIP financing based on MACPAC's review of existing policy and interviews with multiple stakeholders. Overall, we heard that mistrust about improving financing transparency stems from concerns from states and providers about how CMS would use any new data that it collects. Stakeholders were generally not opposed to transparency that was intended to improve analyses of Medicaid payments, but they were concerned about using new data as a pretext for changing the rules about permissible sources of non-federal share to reduce federal Medicaid spending.

In the Commission's view, the primary goal of improving transparency of Medicaid and CHIP financing is to better understand how much providers are paid today under currently permissible financing mechanisms. Understanding payment amounts is the first component of MACPAC's provider payment framework for assessing whether payments are consistent with the statutory goals of efficiency, economy, quality, and access (MACPAC 2015). As better financing data become available, the Commission will continue to explore whether there are opportunities to improve current financing policies to better advance these statutory goals. In doing so, it is important to weigh any potential benefits of reduced federal spending against the risk that reducing payments could jeopardize access and quality of care.

The Commission reviewed a variety of policy options that would build on MACPAC's prior recommendations by providing more specificity about how financing data should be collected to best enable analyses of net Medicaid payments. In addition, the Commission aimed to expand MACPAC's prior recommendations to enable analyses of all types of Medicaid financing for all types of providers, not just hospitals and nursing facilities. Finally, in designing policy recommendations, the Commission aimed to reduce administrative burden for states, providers, and CMS.

Based on this review, the Commission recommends that Congress make two complementary statutory changes:

1.1 In order to improve transparency and enable analyses of net Medicaid payments, Congress should amend Section 1903(d)(6) of the Social Security Act to require states to submit an annual, comprehensive report on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers. The report should include:

- a description of the methods used to finance the non-federal share of Medicaid payments, including the parameters of any health care-related taxes;

  - a state-level summary of the amounts of Medicaid spending derived from each source of non-federal share, including state general funds, health care-related taxes, intergovernmental transfers, and certified public expenditures; and,
  - a provider-level database of the costs of financing the non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the non-federal share.

  This report should be made publicly available in a format that enables analysis.

1.2 In order to provide complete and consistent information on the financing of Medicaid and the State Children's Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act (the Act) to apply the Medicaid financing transparency requirements of Section 1903(d)(6) of the Act to CHIP.

To provide context for these recommendations, this chapter begins with background on Medicaid and CHIP financing and the evolution of federal policy in this area. Then we review findings from interviews with stakeholders on barriers to improving the transparency of Medicaid financing. To illustrate how provider-level financing data can inform analyses of net Medicaid payments, the chapter also includes a review of new provider-level financing data being reported in Texas. The chapter concludes with a discussion of the rationale for MACPAC's recommendations and next steps for the Commission's work in this area.

Background

Medicaid and CHIP are jointly financed by states and the federal government. The non-federal share of spending is determined by the FMAP, which differs by state and also varies for some Medicaid services and beneficiary categories.[1] CHIP is matched at a higher enhanced FMAP rate, and unlike Medicaid, total CHIP spending is limited by federal allotments. In fiscal year (FY) 2022, federal funds accounted for 71 percent of total Medicaid benefit spending ($792.7 billion) and 76 percent of CHIP spending ($22.3 billion) nationally (MACPAC 2023b, 2023c). This includes the 6.2 percentage point increase in the FMAP under the Families First Coronavirus Response Act of 2020 (FFCRA, P.L. 116-127). Historically, without this temporary FMAP increase, federal funds accounted for approximately 65 percent of total Medicaid benefit spending in FY 2019 and approximately 71 percent of CHIP spending in FY 2015.[2]

Permissible sources of Medicaid financing

The statute permits states to raise the non-federal share of Medicaid expenditures through multiple sources. Each permissible source of funding is subject to different rules (Box 1-1). Federal regulations in 42 CFR 457.628 apply all Medicaid financing rules to CHIP, so we did not separately examine CHIP financing rules.

State general funds are revenue collected through income taxes, sales taxes, and other sources. States can use state general funds specifically allocated to the state Medicaid agency and interagency funds allocated to other state agencies. By statute, at least 40 percent of the non-federal share of Medicaid spending must come from state sources (§1902(a)(2) of the Social Security Act (the Act)).

States or units of local government can generate state revenue from taxes on health care providers, but if they do so, they must meet certain rules. A health care–related tax is defined as a tax for which at least 85 percent of the tax burden falls on health care providers or services, or a tax that is not limited to health care items or services but treats health care providers differently than other individuals or entities. Federal regulations (42 CFR 433.56, 433.68) define the specific services that states may tax and the parameters that taxes must follow to be consistent with statutory requirements described in Section 1903(w) of the Act. CMS has the authority through rulemaking to include other health care services not currently listed in regulations, but CMS has previously established criteria that would not allow providers or services as a permissible class if the revenue for the class is predominately from Medicaid and Medicare (e.g., not more than 50 percent from Medicaid).

BOX 1-1. Glossary of Permissible Medicaid Financing Sources

State general funds are revenue collected through income taxes, sales taxes, and other sources.

Health care-related taxes (often referred to as provider taxes, fees, or assessments) are defined as taxes for which at least 85 percent of the tax burden falls on health care providers or services. Federal regulations also consider a tax that is not limited to health care items or services to be health care related if it treats health care providers differently than other individuals or entities.

Provider donations are voluntary contributions made directly or indirectly to a state or a local government by or on behalf of a health care provider or entity related to a health care provider. Provider-related donations are permissible if they are bona fide donations, which means there is no direct or indirect relationship to the payments made to the provider under a hold harmless provision. Donations of up to $5,000 per year for individual providers and up to $50,000 per year for health care organizations are presumed to be bona fide donations so long as there is no hold harmless provision.

Intergovernmental transfers are funds transferred to the state from other public agencies in the state or local governments. Public agencies include providers owned by local governments and state-owned providers, such as state university hospitals and state psychiatric hospitals.

Certified public expenditures (CPEs) are costs certified by state or local governments, including government-owned providers, as expenditures eligible for federal Medicaid or CHIP matching funds. Under a CPE arrangement, the non-federal share amount is not transferred to the state. States are not required to pay the federal share associated with CPEs to providers.

In general, taxes must be broadly applied to all non-governmental providers throughout the jurisdiction of the taxing authority, and the tax amount must be uniformly applied. However, states can apply for waivers of these federal requirements if the tax meets certain statistical tests that are intended to ensure that the net costs and benefits of the tax are generally redistributive and the amount of the tax is not an undue burden on Medicaid providers.

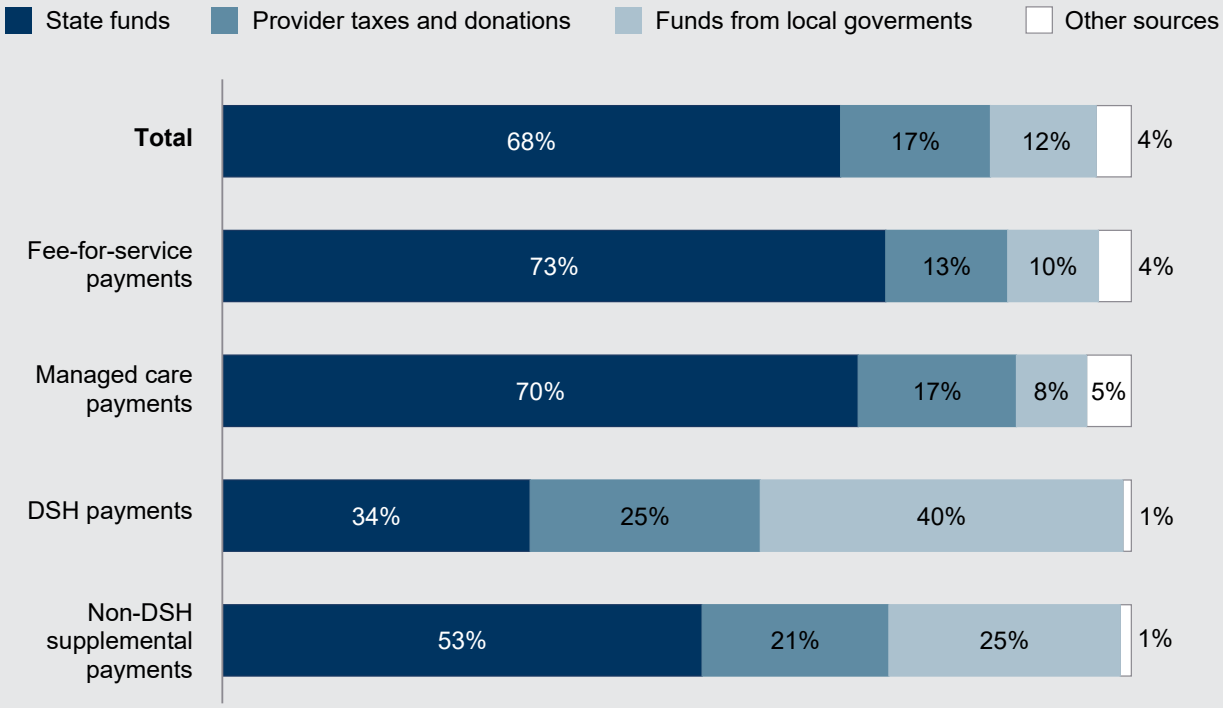
In addition, states cannot hold providers harmless for the cost of the tax, including through direct or indirect guarantees that providers will be repaid for all or a portion of the taxes that they pay. In practice, health care–related taxes are often used to offset low state general funding and increase payments to providers who pay the tax. These arrangements are not considered an indirect guarantee so long as the total tax amount is less than 6 percent of the provider's net patient revenue. This threshold is commonly referred to as the provider tax safe harbor.

Voluntary donations from providers are permissible if they are bona fide donations. CMS presumes donations up to $5,000 a year from health care providers and $50,000 a year from health care organizations to be bona fide donations so long as there is no hold harmless provision.

Local governments, including providers owned by local governments, can contribute up to 60 percent of the non-federal share of total Medicaid spending through intergovernmental transfers (IGTs) or certified public expenditures (CPEs).[3] IGTs involve a transfer of funding from another public agency or local government to the state. In contrast, under CPEs, public agencies or local governments can certify the costs or expenditures for services covered by Medicaid or CHIP, and the state claims federal funding based on those amounts.

Public providers, such as public hospitals, can derive the funds that they use for IGTs or CPEs from any public funds, including local tax revenue or patient revenue. If local governments impose health care-related taxes, the federal rules that apply to statewide taxes also apply.

FIGURE 1-1. Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2018



Notes: SFY is state fiscal year. DSH is disproportionate share hospital. State funds include state general funds and interagency transfers. Funds from local governments include intergovernmental transfers and certified public expenditures. Other sources include funds, such as tobacco settlement funds, that are used to fund the state's non-federal share of Medicaid expenditures and are not considered to fit in the other categories listed. Numbers do not sum to 100 due to rounding. Data reflect all Medicaid payments, not just Medicaid payments to hospitals.

Source: GAO 2021.

IGTs can be used to finance payments for providers transferring the funding, to finance specific payments to other providers, or for overall Medicaid spending. Federal rules on provider donations also apply to local units of government. As a result, public agencies that provide IGTs for payments to a non-governmental provider cannot receive impermissible donations from these providers.

States are not required to pay the federal share associated with CPEs to providers. Any CPE from a public provider can be used only to finance payments to the provider certifying the allowable Medicaid service. Current statute and federal regulations provide little guidance about CPEs, but in 2023, CMS issued subregulatory guidance describing allowable costs and the process for certifying expenditures for school-based services (CMS 2023).

Current uses of Medicaid financing

In state fiscal year (SFY) 2018, 68 percent of the non-federal share of Medicaid spending came from state general funds, 17 percent came from health care–related taxes, and 12 percent came from local governments, according to a GAO survey (Figure 1-1). Between SFY 2008 and SFY 2018, the use of state general funds declined from 75 to 68 percent of the non-federal share, and the use of health care–related taxes more than doubled, from 7 to 17 percent of the non-federal share (GAO 2021, 2014).

States often rely on providers to finance the non-federal share of supplemental payments, which are lump sum payments to providers that are made in addition to base payment rates for Medicaid services. In prior MACPAC interviews with stakeholders about the evolution of hospital and nursing facility payment policy, we heard about the funding dynamics that often lead to this outcome. Although providers generally prefer base payment rate increases financed by state general funds, states often look to providers to help finance additional payments because of state budget constraints. Providers prefer to finance supplemental payments instead of base payment rate increases because it is easier for states to target supplemental payments to providers that contribute the non-federal share (MACPAC 2020, Marks et al. 2018).

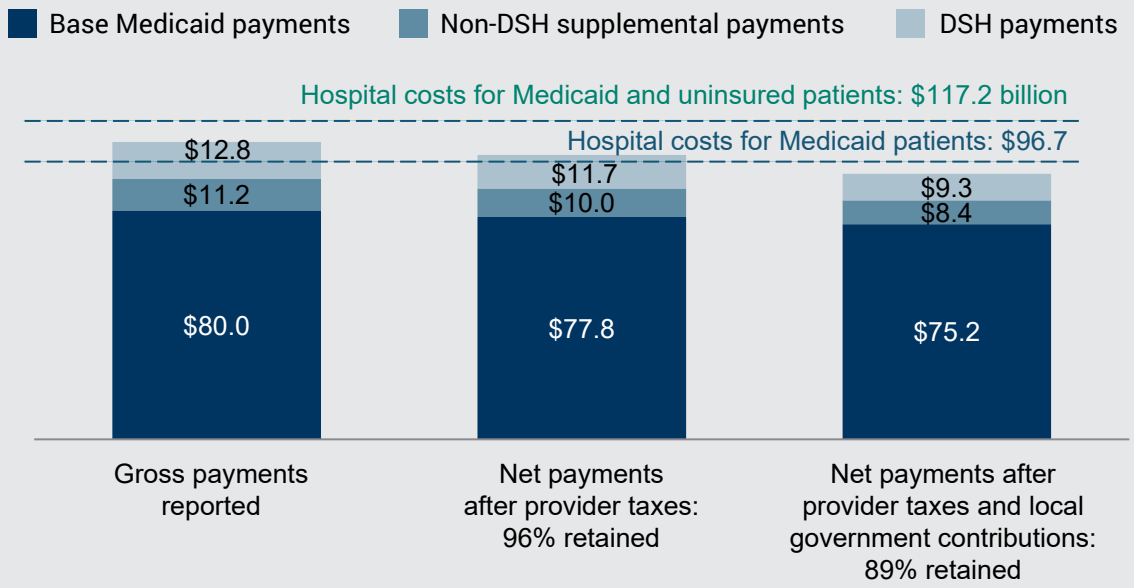
In MACPAC's prior analyses of Medicaid disproportionate share hospital (DSH) payments, we observed that states' financing methods relate to how DSH payments are targeted. States that finance DSH payments with broad-based provider taxes often distribute DSH payments broadly. States that finance DSH payments with funds from local governments (typically through public hospitals) often target DSH funds to public hospitals (MACPAC 2017).

Effects of provider contributions on net payments to providers

The amount providers pay in health care–related taxes, IGTs, and CPEs can be seen as additional costs that effectively reduce the gross payments. As such, the net payment that providers can use to cover the cost of providing services is lower than the gross amount initially received. For example, assuming that DSH hospitals pay provider taxes and contribute local funds at the same rate as other providers, we estimated that these costs reduced total gross Medicaid payments to DSH hospitals by 11 percent in 2011 (Nelb et al. 2016).

Accounting for the costs of provider contributions to the non-federal share can affect calculations of Medicaid payment adequacy. For example, in 2011, gross payments to DSH hospitals exceeded hospitals' Medicaid costs, but net payments were less than Medicaid costs in the aggregate (Figure 1-2).

FIGURE 1-2. Gross and Net Payments to DSH Hospitals, SPRY 2011



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Analysis excludes institutions for mental diseases.

Source: Nelb et al. 2016.

Effects of state financing methods on state general funding

Under current law, states cannot reduce the amount, duration, or scope of Medicaid services because of a lack of available funding from providers or other local sources (§1902(a)(2) of the Act). However, in practice, states have limited state general funds and set payment policies based on state budget constraints. If some currently permissible financing methods were eliminated, it is likely that states would reduce payments to providers instead of offsetting the lost non-federal funding with state general funds.

In recent years, as Medicaid coverage has grown, Medicaid has accounted for a growing share of state budgets (MACPAC 2016b). However, funding from the federal government and providers has offset some of these costs. For example, the coverage expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) are matched at an increased FMAP of 90 percent, which has helped to reduce the state costs of these expansions. In addition, some states have further reduced their state general fund costs by relying on providers to finance the non-federal share. Calculations of Medicaid spending as a share of state budgets differ substantially depending on whether this financing from providers and the federal government is considered (Figure 1-3).

In the future, states may face increased pressure to rely on providers to finance Medicaid payments as enhanced federal funding provided during the COVID-19 pandemic phases out. Between 2020 and 2023, FFCRA provided a 6.2 percentage point increase in FMAP to states that maintained Medicaid coverage and eligibility standards. The Consolidated Appropriations Act, 2023 (P.L. 117-238) phased down the enhanced FMAP beginning April 1, 2023, fully eliminating the increase after December 31, 2023. Congress has also provided enhanced federal funding for HCBS under the American Rescue Plan Act of 2021 (ARPA, P.L. P.L. 117-2), which expires March 31, 2025.

Existing transparency requirements

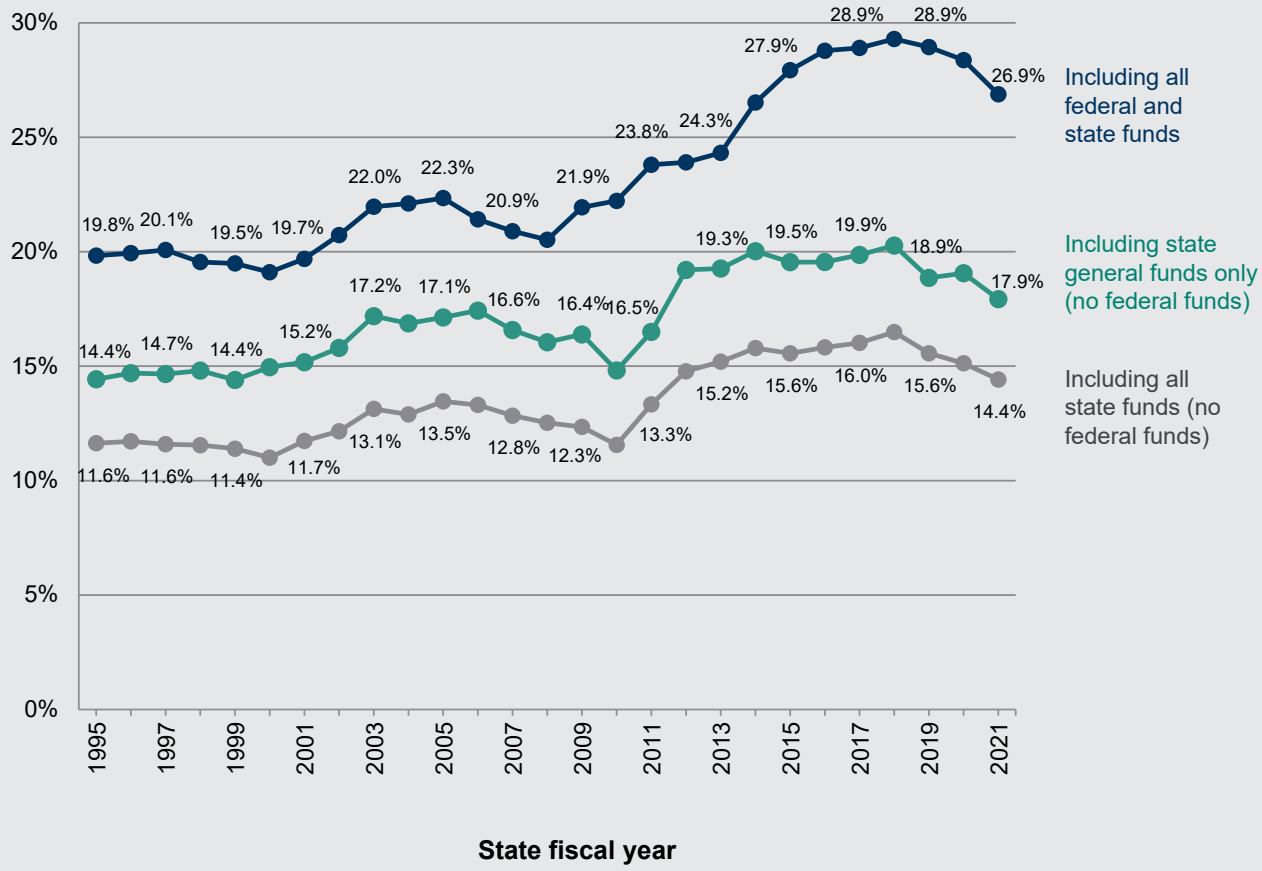
CMS currently collects information on state financing methods when it reviews state plan amendments (SPAs) that make changes to Medicaid payment methods. Specifically, CMS requires states to answer a standard set of five funding questions. These questions are primarily intended to identify impermissible provider donations and require states to describe how the non-federal share of each type of payment is funded.

CMS also requires additional information on health care–related taxes that are not broad based or uniformly applied. To receive waivers of these federal requirements, states must demonstrate that the net effect of the tax is generally redistributive and that the tax amount is not directly correlated with Medicaid payment amounts. In practice, these rules mean that states must submit provider-level information on anticipated taxes and Medicaid payments when the tax waiver is approved. Most health care–related taxes receive federal tax waivers, but states are not required to resubmit information to demonstrate continued compliance with the tax waiver requirements after the tax is approved so long as the parameters of the tax have not changed.[4] CMS has begun to ask states to provide more detail on what a tax funds when reviewing tax waivers and has asked states to provide the total amount of payments funded by the tax compared to the total tax imposed at the provider level when possible. However, not all states are able to provide this information, and these waiver data are not publicly available.

For managed care directed payments, states are required to describe the financing sources on CMS's standard application form, which is referred to as a preprint. The preprint requires states to include a table indicating government entities that are transferring IGTs to finance directed payments. The preprint also collects information to demonstrate that the health care–related taxes used are permissible but does not collect information on the specific entities paying the tax or the amount of taxes collected.

When states submit claims for federal Medicaid funding, they must certify that the non-federal share of Medicaid spending complies with federal requirements, but they do not describe the source of non-federal share for each payment. States submit expenditures for federal Medicaid funding on Form CMS-64 in the Medicaid Budget and Expenditure System (MBES). Form CMS-64 captures fee-for-service (FFS) expenditures for different types of

FIGURE 1-3. Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1995–2021



Notes: SFY is state fiscal year. Amounts shown here reflect the most recent information available in cases in which data for a given year were published and then updated in a subsequent report.

The all federal and state funds category reflects amounts from any source. The state general funds only category reflects amounts from revenues raised through income, sales, and other broad-based state taxes and excludes federal funds. The all state funds category reflects amounts from any non-federal source; these include state general funds, other state funds (amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects) and excludes federal funds.

Source: MACPAC 2023d.

service categories (including supplemental payments), but it reports only the amount of capitation payments paid to managed care organizations (MCOs). It does not separately identify expenditures that MCOs made for specific services or to specific providers, such as directed payments.

States are statutorily required to report annually on the amount of health care–related taxes that they collect each year (§1903(d)(6) of the Act).[5] States currently submit this information on Form CMS-64.11 in MBES. This form is used for informational purposes and is not tied to the amount of federal funding that states claim.

States are not currently required to collect and report provider-level financing data. However, states have the option to include the Medicaid-attributable costs of provider taxes when calculating the upper payment limit (UPL) for FFS supplemental payments. States that select this cost-based approach to demonstrate the UPL include provider-level tax data in their annual UPL demonstrations, a standard reporting template used to calculate the UPL.

CMS occasionally collects more detailed information about Medicaid financing as part of its financial management reviews in selected states with identified issues. These reviews include close examinations of state budget documents and financing records. However, CMS does not currently have the capacity to conduct these reviews for all states at all times. In addition, these reviews are primarily focused on ensuring compliance with federal rules and may not collect information that is needed to calculate net Medicaid payments to providers.

Prior MACPAC transparency recommendations

Understanding Medicaid payment amounts is a key component of MACPAC's provider payment framework. Specifically, MACPAC needs payment amounts to assess whether payments are consistent with the statutory goal of economy. In addition, this information can inform analyses of how payment amounts relate to the other statutory goals of access, quality, and efficiency (MACPAC 2015).

In 2016, MACPAC recommended that CMS collect provider-level data on the sources of non-federal share necessary to calculate net Medicaid payments to hospitals, and in 2023, the Commission similarly recommended that CMS collect provider-level financing data necessary to calculate net payments to nursing facilities (MACPAC 2023a, 2016a). Because provider-financed supplemental payments account for such a large share of Medicaid payments to hospitals and nursing facilities, collecting provider-level financing data is necessary to enable more accurate analyses of Medicaid payment amounts for these providers.

The recommendations discussed in this chapter expand on MACPAC's prior recommendations in the following ways:

- applying recommendations to all Medicaid providers, not just hospitals and nursing facilities;
- specifying a method for collecting provider-level data;
- including state-level financing information about all types of Medicaid financing methods, not just provider contributions to the non-federal share; and
- including state-level financing amounts that could help validate the provider-level data collected and put these data in context.

Taken together, MACPAC's payment and financing recommendations would enable analyses of all types of Medicaid payments to providers and represent a substantial improvement over current law (Table 1-1). Although this chapter focuses on methods for improving transparency of Medicaid financing, the Commission continues to endorse all of its unimplemented payment recommendations (Box 1-2). Policymakers need both payment and financing data to assess whether Medicaid payment policy is consistent with statutory goals.

TABLE 1-1. Payment and Financing Transparency Elements in Current Law and MACPAC Recommendations

Transparency elements	Type of payment				
	FFS base	DSH	Non-DSH	Managed care base	Managed care directed payment
Payment					
Methods[1]	State plan	State plan	State plan	Rate certification	Directed payment preprint
State-level amounts[2]	CMS-64	CMS-64	CMS-64	CMS-64	Directed payment preprint (projected)[4]
Provider-level amounts[2,3]	T-MSIS	DSH audit	New non-DSH report	T-MSIS (not public)	Not available[4]
Financing					
Methods[5]	Standard funding questions	Standard funding questions	Standard funding questions	Not available[6]	Directed payment preprint
State-level amounts[5]	Not available	Not available	Not available	Not available[6]	Not available
Provider-level amounts[5]	Not available	Not available	Not available	Not available[6]	Directed payment preprint (IGTs only)

Notes: FFS is fee for service. Base is base payments for services. DSH is disproportionate share hospital. Non-DSH is non-DSH supplemental payments, including FFS supplemental payments based on the upper payment limit and supplemental payments authorized under Section 1115 demonstration authority. CMS-64 is Form CMS-64 in the Medicaid Budget and Expenditure System (MBES) (Form CMS-64.11 collects information on state-level provider tax amounts). T-MSIS is the Transformed Medicaid Statistical Information System. IGT is intergovernmental transfer. Managed care rate certifications describe how capitation rates are developed, but they do not describe how managed care plans pay providers.

[1] MACPAC March 2023 recommendation would provide information on all nursing facility payment methods though rate studies.

[2] MACPAC June 2022 recommendations would provide state-level and provider-level information on the actual amounts of directed payments.

[3] MACPAC March 2016 and March 2023 recommendations would provide state-level and provider-level information on total payments to hospitals and nursing facilities, including supplemental payments.

[4] The 2024 final managed care rule requires that states report directed payments at the provider level into T-MSIS; however this requirement will not go into effect until CMS releases reporting instructions (CMS 2024a).

[5] The recommendations made in this chapter would build off of the March 2016 and March 2023 MACPAC recommendations to provide information on financing methods, state-level financing amounts from different sources, and provider-level financing amounts for all services, not just hospitals and nursing facilities.

[6] If a state uses a pass-through payment, it must submit a description of the non-federal share for the pass-through payment, including the source and amount of the non-federal share financing. For any payment funded by IGTs, the state would also report a complete list of entities transferring funds and the total amount transferred by each entity.

Sources: MACPAC, 2024, analysis of current law and CMS guidance; MACPAC 2023a, 2022, 2016a.

BOX 1-2. Status of Prior MACPAC Recommendations Related to Payment and Financing Transparency

March 2016

Improving data as the first step to a more targeted disproportionate share hospital policy

- The Secretary of the U.S. Department of Health and Human Services (the Secretary) should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.
  - **Note:** This recommendation was partially implemented under the Consolidated Appropriations Act, 2021 (P.L. 116-260), which requires the U.S. Department of Health and Human Services to establish a system for states to submit non–disproportionate share hospital supplemental payment data in a standard format, beginning October 1, 2021. However, the legislation did not include managed care payments or information on the sources of non-federal share necessary to determine net Medicaid payments at the provider level. Additionally, the Centers for Medicare & Medicaid Services has yet to make these data publicly available.

June 2022

Oversight of managed care directed payments

- To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payment amounts publicly available in a standard format that enables analysis.
  - **Note:** This report also included other recommendations to improve the oversight of directed payments to ensure that these payments advance statutory goals. In April 2024, the Centers for Medicare & Medicaid Services finalized requirements for states to report the total dollars expended by each plan for state directed payments, including amounts paid to individual providers (CMS 2024a).

March 2023

Principles for Assessing Medicaid Nursing Facility Payment Policies

- To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis:
  - facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
  - data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
  - comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.

BOX 1-2. (continued)

- To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS should provide analytic support and technical assistance to help states complete these analyses, including guidance on how states can accurately identify the costs of efficient and economically operated facilities with adequate staff to meet residents' care needs. States and CMS should make facility-level findings publicly available in a format that enables analysis.

Evolution of Permissible Medicaid Financing Methods

Since Medicaid's inception, states have had the flexibility to generate their share of Medicaid expenditures through multiple sources, including state general revenue and contributions from local governments. Medicaid was initially designed to build on existing state and local indigent care programs, so the extent to which states rely on funding sources other than state revenue may reflect how states have historically split financing with localities for indigent care and other social services programs. Medicaid financing has changed over time as policymakers debated permissible sources of non-federal funding, permissible uses of federal Medicaid funding, and permissible limits on Medicaid payments to providers.

History of permissible sources of non-federal funding

In the 1980s, Medicaid costs grew as Congress expanded the number of people that the program served and added new statutory requirements for states to ensure access to care and support safety-net providers. To help offset these costs, states and the federal government began exploring new ways to finance the non-federal share of Medicaid spending (Tudor 1995).

In 1985, CMS (then known as the Health Care Financing Administration) issued regulations permitting states to expand the use of public and private donations to finance the non-federal share of Medicaid spending. This regulation was intended to help states facing budget challenges and provide more flexibility in administering their programs. At the time, CMS acknowledged the possibility that this policy could be abused to create quid pro quo arrangements in which entities that donated funds directed how the state used them. To limit this possibility, CMS required that donated funds be under the administrative control of the state and prohibited states from using donated funds to increase payments to for-profit providers (HCFA 1985).

Many states took advantage of this new financing flexibility to expand Medicaid coverage and increase payments to providers. For example, in Tennessee, which began authorizing provider donations in 1987, Medicaid spending grew from about $1 billion in FY 1988 to $2.3 billion in FY 1992. This growth was largely driven by increased payments to high-volume Medicaid hospitals, statutorily required expansions in coverage for low-income mothers and children, and health care inflation. Provider donations helped support these expenses. For example, 20 percent of Tennessee's hospitals donated $19 million to the Medicaid program in the first year of the donation program, which generated $63 million in state and federal funds.[6] Approximately $24 million of the funding raised was distributed to hospitals (resulting in a net payment of $5 million for these providers), $31 million went to expanded Medicaid coverage, and the

remaining $8 million was used to extend the state's annual inpatient hospital coverage limit from 14 to 20 days (Matherlee 2002).

CMS initially disallowed Tennessee's use of provider donations, which led the state to develop a provider tax instead. In 1987, CMS first issued subregulatory guidance about the use of health care–related taxes, but the specific parameters of permissible taxes were not well defined. The U.S. Department of Health and Human Services Departmental Appeals Board later reversed the disallowance of the provider donation mechanism, thus allowing Tennessee and other states to continue using multiple financing sources. In 1989 and 1990, Congress imposed moratoria to prevent CMS from changing these financing policies that states were relying on (Matherlee 2002).

In the early 1990s, states began using newly permissible financing mechanisms to rapidly increase DSH payments. In 1987, Congress required states to make payments to deemed DSH hospitals, which serve a high share of Medicaid and uninsured patients, and CMS also clarified that the UPL on Medicaid payments to hospitals did not apply to DSH payments. DSH spending increased from $1.3 billion in 1990 to $17.7 billion in 1992 (Matherlee 2002, Klemm 2000, Holahan et al. 1998).

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) to limit federal spending. The law substantially limited the use of provider donations, established parameters for health care–related taxes, required state reporting of provider tax amounts, and established state and federal limits on DSH payments. CMS issued regulations in 1992 and 1993 implementing these provisions. The law prohibited CMS from restricting the use of funds derived from state or local taxes transferred from or certified by units of government (e.g., IGT, CPE) unless the funds are derived from impermissible donations or taxes.[7]

Since the early 1990s, the federal rules on permissible sources of Medicaid financing have been largely unchanged. Under the Deficit Reduction Act of 2005 (P.L. 109-171), Congress expanded the managed care provider class to include all MCOs and not just Medicaid MCOs to align with the broad-based requirement for all provider taxes. In 2006, Congress temporarily changed the provider tax safe harbor from 6 percent to 5.5 percent as part of the Tax Relief and Health Care Act of 2006 (P.L. 109-432), but the threshold reverted back to 6 percent in 2011. Some policymakers continue to propose reducing the provider tax safe harbor to reduce the federal budget deficit. However, this policy would also reduce payments to providers, which could affect access to care for beneficiaries. For example, the Congressional Budget Office (CBO) estimates that reducing the provider tax safe harbor from 6 percent to 5 percent would reduce federal spending on Medicaid services by $42 billion over 10 years because states are unlikely to offset the full amount of lost provider tax revenue with state general funds or other sources of non-federal share (e.g., taxes on other provider classes) (CBO 2022).

CMS has proposed changes to permissible financing sources that were subject to moratoria or were rescinded. In 2007, CMS released regulations that limited payment to government providers to no more than cost and clarified what entities are considered units of government allowed to contribute to the non-federal share (CMS 2007). This rule was vacated in federal court and later rescinded (*Alameda County Medical Center, et al. v. Leavitt, et al.*, 559 F. Supp. 2d 1 (D.D.C. 2008), CMS 2010). In 2008, CMS published regulations clarifying the standard for determining the existence of a hold harmless tax arrangement (CMS 2008). These changes to the hold harmless provisions were subject to moratoria until 2010.[8] In 2019, CMS published the Medicaid Fiscal Accountability Rule (MFAR), which included provider tax policy changes, limits on the permissible state or local funds that could be used for IGTs and CPEs, and other financing and payment policy changes (CMS 2019). MFAR was never finalized and was withdrawn in 2021 (CMS 2021).

History of permissible uses of funding

After Congress clarified permissible Medicaid financing sources in 1991 and CMS implemented the accompanying regulations, states continued to explore creative ways to use these financing mechanisms to support their budgets and providers. In particular, after Congress set new limits on provider taxes, states began exploring greater use of IGTs from government-owned providers.

In 1994, GAO investigated the use of IGTs in three states and identified a financing strategy that became known as recycling. Under these arrangements, states used IGTs from government-owned providers to make payments to these providers and then required the provider to return most of the payment to the state. On net, these arrangements reduce the share of state general funding contributed to Medicaid expenditures and increase the federal share of Medicaid spending (GAO 1994). These recycling practices also raised several policy questions about whether federal funds were being used for services to Medicaid beneficiaries, as required by Section 1903(a)(1) of the Act, or whether funds were being diverted for other purposes.[9]

To address these concerns, CMS introduced a standard set of funding questions in 2002 for states to answer when they submit SPAs to change their payment methodologies. Specifically, states are required to clarify whether any portion of payments is returned to the state or local government and to identify the funding source of the payment. States also are required to provide detailed information on funds transferred from other government entities (e.g., IGTs, CPEs), including the entities making the transfer, the operational nature of each entity, and the total amounts transferred or certified by each entity.

To enforce the new funding questions, CMS created a national institutional reimbursement team that systematically reviewed all state supplemental payment arrangements. Between 2003 and 2005, CMS identified and resolved problematic financing arrangements in 29 states. GAO commended CMS's efforts at the time but also raised concerns about the lack of transparency of CMS's process (GAO 2007).

History of permissible limits on payments

At the same time that CMS was reviewing permissible uses of provider-financed payments, Congress and CMS also established new limits on supplemental payments as a way to control federal spending. The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-166) established hospital-specific DSH limits based on hospitals' unpaid costs of care for Medicaid patients and uninsured individuals. These hospital-specific limits are applied in addition to the state-specific allotments that Congress created in 1991 based on states' DSH spending in 1992.

After DSH payments were limited, states began exploring greater use of non-DSH supplemental payments, such as UPL payments, to support providers. The UPL for Medicaid FFS payments to providers is not defined in statute, but CMS first established a UPL in 1981 when states were given the flexibility to pay institutional providers (e.g., hospitals and nursing facilities) different rates than Medicare. To enforce the statutory goals of economy and efficiency, CMS allowed individual institutional providers to be paid more than Medicare as long as aggregate payments for the class of providers were less than a reasonable estimate of what Medicare would have paid for the same service.[10] The use of UPL payments grew rapidly in the early 2000s, from $4.5 billion in FY 2000 to $19.8 billion in FY 2021. As a result, CMS increased its review of UPL payments and revised the process for calculating the UPL (MACPAC 2019).[11]

States are not permitted to make UPL supplemental payments for services provided in managed care. However, in 2016, CMS permitted states to require MCOs to pay providers according to specific rates or methods, which is referred to as a directed payment. Some of the largest directed payments are used to make large rate increases to providers that are similar to supplemental payments in FFS. More than half of directed payments are financed by IGTs or provider taxes, and these arrangements account for 81 percent of directed payment spending identified in our analysis. Spending on directed payments has increased rapidly in recent years, from $25.7 billion a year as of December 2020 to $69.3 billion a year as of February 2023, according to MACPAC's review of the limited data available (MACPAC 2023e).[12] To manage directed payment spending, CMS has limited directed payments for hospitals, nursing facilities, and academic medical centers to the average commercial rate, which is defined as the average rate paid for services by the highest claiming third-party payers for specific services based on claims volume (CMS 2024a).

When calculating DSH, UPL, and directed payment limits, CMS does not fully account for providers' costs of financing the non-federal share of Medicaid payments.[13] CMS has begun to ask states to report health care–related tax amounts and Medicaid

payments funded by those taxes when submitting a tax waiver. However, not all states are able to provide this information, and not all tax arrangements require a waiver. As a result, CMS also does not collect all of the provider-level financing data needed to determine net payments to providers.

Themes from Stakeholder Interviews

To learn more about barriers to improving the transparency of Medicaid financing, we interviewed 17 national experts, state officials, federal officials, and provider associations between September 2023 and January 2024. The interviews identified several considerations for improving transparency, which are discussed further below:

- mistrust about how CMS would use additional financing data;
- lack of comprehensive tracking of current state financing methods;
- incomplete reporting of state-level financing amounts;
- challenges attributing financing sources to specific payments; and
- challenges tracking financing and payments within health systems.

Mistrust about how financing data would be used

The stakeholders we interviewed noted that states and providers may be reluctant to share additional financing data with CMS because of concerns that CMS would use these data to reconsider financing arrangements that it previously approved. Recent CMS oversight actions, such as MFAR, have added to a general feeling of mistrust and lack of clarity about the purpose of increasing transparency. Although CMS described many of the proposed MFAR policies as codifying existing policies, several of the stakeholders we interviewed viewed this rule as creating new limits on state financing methods.[14] CMS never finalized this rule and ultimately withdrew MFAR.

In contrast to MFAR, the experts we spoke with were generally supportive of new guidance that CMS recently issued on claiming and funding for school-based services with CPEs (CMS 2023). CMS developed this new guidance collaboratively with states and primarily focused on how to help states expand the use of this financing method, rather than limit it.

Overall, many of the stakeholders we interviewed were supportive of improving financing transparency to strengthen payment analyses. Some experts we spoke with questioned why CMS would need to improve the transparency of sources for the non-federal share if they are already permissible. However, the providers we spoke with acknowledged that many providers make internal decisions based on net payment amounts and view taxes and IGTs as considerable costs that affect their overall finances. The state officials we spoke with noted that they currently provide financing data to their state legislatures and were primarily concerned about increased administrative burden of any new federal reporting requirement.

Lack of comprehensive information on state financing methods

The experts we interviewed noted that CMS's current funding questions work well to ensure compliance with existing requirements; however, they had mixed views on whether making these funding questions public would meaningfully improve transparency for external stakeholders. Because states often submit multiple payment SPAs each year, stakeholders cannot easily use the responses to the questions to understand a state's overall approach to Medicaid financing.

The experts we interviewed noted that CMS's current funding questions likely capture information about most state financing policies and do not impose much administrative burden on states. However, adding to the general feeling of mistrust that experts cited, one interviewee raised concerns that some of the standard funding questions refer to financing policies that CMS previously proposed but never went into effect, such as

a 2007 proposal to establish a cost limit on payments to government-owned providers (CMS 2007).

The funding questions also do not include much information on the parameters of health care–related taxes. States that implement health care–related taxes that are not broad based or uniformly applied must submit provider-level data on taxes and payments to ensure that they meet the statutory criteria for waivers of these rules. However, not all states would submit these data because provider taxes that are broad based and uniform would not need a waiver. Furthermore, this waiver information does not need to be updated once it is initially approved unless the parameters of the tax have changed. For example, at least 27 arrangements that are included on KFF's 2020 survey of health care–related taxes were not included on CMS's internal list of states that applied for tax waivers, according to MACPAC's review of CMS's internal documentation (CMS 2020, Gifford et al. 2020).

Incomplete reporting of state-level financing amounts

Stakeholders we interviewed confirmed that the data on health care–related taxes that states currently report on Form CMS-64.11 are unreliable and incomplete. For example, in SFY 2018, MACPAC found that states reported only $29 billion in health care–related taxes on Form CMS-64.11 in MBES, but they reported $37 billion in health care–related taxes on GAO's survey. In addition, MBES does not include any information about local government funds used to finance the non-federal share; in SFY 2018, states reported that $26 billion in local government funds were used to finance Medicaid expenditures (GAO 2020).

The experts we interviewed noted that states have not prioritized submission of Form CMS-64.11 data, which may explain some of the discrepancies we observed. Currently, Form CMS-64.11 is used only for informational purposes. If states don't submit complete and accurate data, CMS's only enforcement mechanism is to withhold federal funding, which is a substantial penalty that is rarely used. In addition, experts noted that differences in definitions and reporting periods may also explain some discrepancies.

The stakeholders we interviewed noted that most state budget officers are already tracking Medicaid financing amounts, but states may do so in different ways that make it difficult to standardize reporting. Some states track financing and supplemental payments through stand-alone spreadsheets, while other states use more sophisticated accounting systems that integrate with their overall Medicaid management information systems. Because state funding for Medicaid can include interagency transfers outside the Medicaid agency, experts noted that state budget officers with responsibility for overseeing multiple state agencies would likely have the most comprehensive understanding of overall Medicaid financing.

Challenges attributing financing sources to specific payments

State officials noted that it could be challenging to attribute specific financing sources to specific types of Medicaid payments, since some states comingle provider contributions with other sources of funding that support the overall Medicaid budget. The GAO survey of state financing methods attempted to separately identify the sources of non-federal share used for FFS base payments, managed care payments, DSH payments, and non-DSH supplemental payments. However, GAO reported challenges collecting financing data at more granular levels of detail (GAO 2020, 2014).

Experts highlighted a number of circumstances in which health care–related taxes and IGTs paid by providers are not returned in the form of increased payments. For example, states may use these funds to pay for other Medicaid services, or they may retain some of the funds as an administrative fee. For CPEs, states are not required to disburse the federal funding that is claimed to the local government entity that incurred the costs of the service.

States' use of taxes and IGTs for other purposes does not change providers' costs of contributing to the non-federal share of Medicaid payments, so this practice would not affect calculations of net provider payments overall. However, some of the experts whom we spoke with suggested that it would be better to characterize taxes and IGTs as provider costs rather than

contributions, a term that may imply that providers are paid back the amount that they contribute.

Challenges using provider-level financing data to determine net payments

Similar to the challenges states have attributing financing to specific Medicaid categories of service, providers reported challenges attributing financing sources to specific payments at their facilities. Some of the experts we interviewed noted that Medicare cost reports already collect some information about the taxes that hospitals, nursing facilities, and other Medicare-certified institutional providers pay.[15] However, CMS does not currently require these providers to separately identify health care–related taxes that are used to finance Medicaid payments or to track how those costs are allocated across specific services. Experts noted that smaller providers would likely face substantial administrative burden tracking how financing related to specific payments.

For hospitals that are part of larger health systems, experts noted that it may be difficult to determine how provider-financed supplemental payments affect net payments for specific services. For example, many states have begun making large directed payments to physicians affiliated with academic medical centers that are financed by state university hospitals. Although this payment is nominally intended to pay for physician services, the hospital finances the payment and often uses it to support overall hospital finances.

Because funding within health systems is fungible, some experts we spoke with noted that it may be more appropriate to examine how financing affects payment rates at the facility level instead of trying to calculate net payments for individual Medicaid services, such as inpatient or outpatient hospital services. Although some experts noted that many facilities are now part of larger health systems, facility-level reporting is likely more useful and feasible to analyze. Many health care–related taxes are imposed based on facility-level characteristics (e.g., number of beds), and CMS currently requests facility-level information for states submitting health care–related tax waivers.

Using Financing Data to Assess Net Payments

Some of the experts we spoke with highlighted new financing transparency requirements in Texas that could be a model for other states to follow. Since 2019, the Texas state legislature has required the state Medicaid agency to collect provider-level information on mandatory payments and all uses for such payments made to local governmental entities that create local provider participation funds (LPPFs), which are accounts into which health care–related taxes imposed by local units of government are deposited and are then transferred to the state by an IGT to finance Medicaid payments. In 2021, the legislature required the state Medicaid agency to expand its review and reporting efforts to all sources of non-federal share and to make this information publicly available (TX HHSC 2023a).

In 2023, Texas released its first public report of Medicaid financing for FY 2022 that includes information on LPPFs, other sources of IGTs, and CPEs used to support Medicaid expenditures. Financing amounts are assigned to specific supplemental payment programs or other specific services, such as school-based care. The tax amounts collected by local government entities and deposited in each LPPF are reported at the hospital level (even for hospitals that are part of a larger health system), and the report also identifies administrative fees collected by local governments for administering the LPPF program. Other IGTs and CPEs are identified by the transferring governmental entity, such as a public hospital district, school district, local mental health authority, and units of local government that do not directly provide services (TX HHSC 2023b).

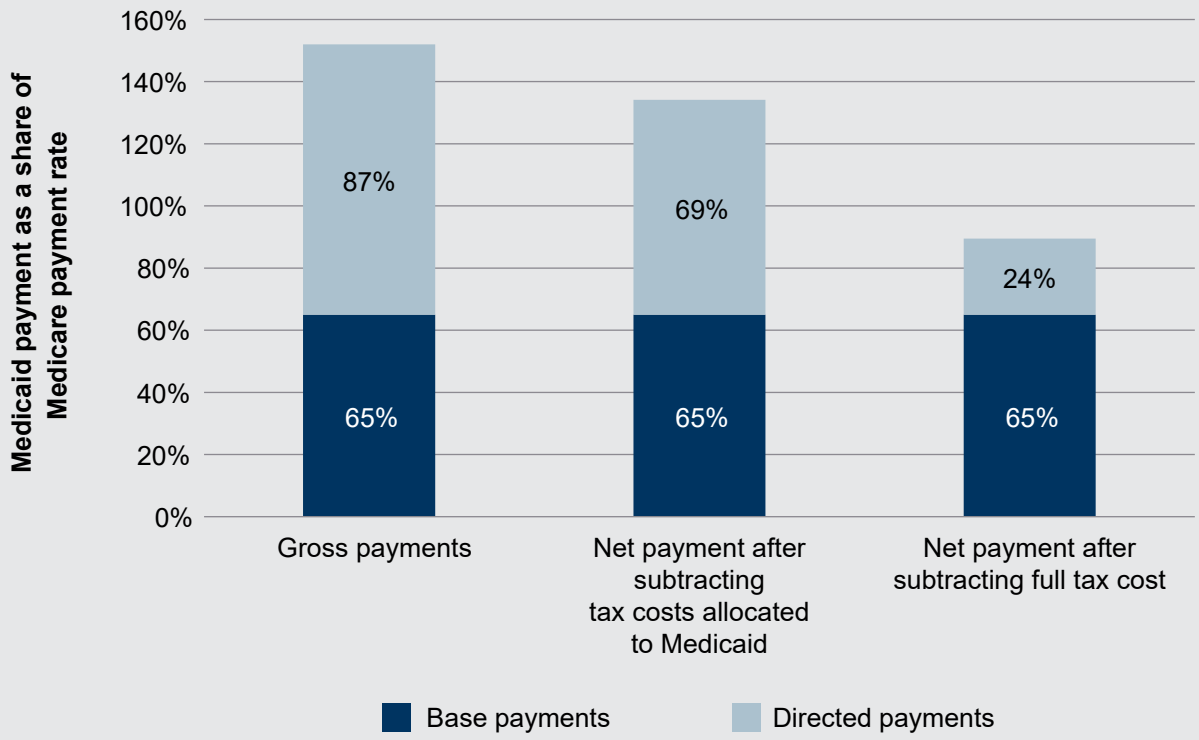
Illustrative examples of net payments

To illustrate how provider-level financing data could be used to enhance our understanding of Medicaid provider payments, we combined available payment and financing data for a public and private hospital in Texas.[16] Texas makes multiple types of supplemental payments to hospitals, and for this example we focused on the state's managed care directed payments because the state has already estimated how managed care directed payments compare to

Medicare payment rates on the directed payment preprints approved by CMS. One limitation of this data source is that it reports only projected spending, not actual spending.

The private hospital that we examined was projected to receive managed care base payments that were 65 percent of what Medicare would have paid and managed care directed payments that were 87 percent of what Medicare would have paid, resulting in total gross payments of 152 percent of what Medicare would have paid (Figure 1-4). According to Texas's provider-level financing report, this provider paid taxes that were equivalent to 63 percent of what Medicare would have paid, which were used to help finance the managed care directed payment.

FIGURE 1-4. Example of Gross and Net Medicaid Managed Care Payments for a Private Texas Hospital, 2022



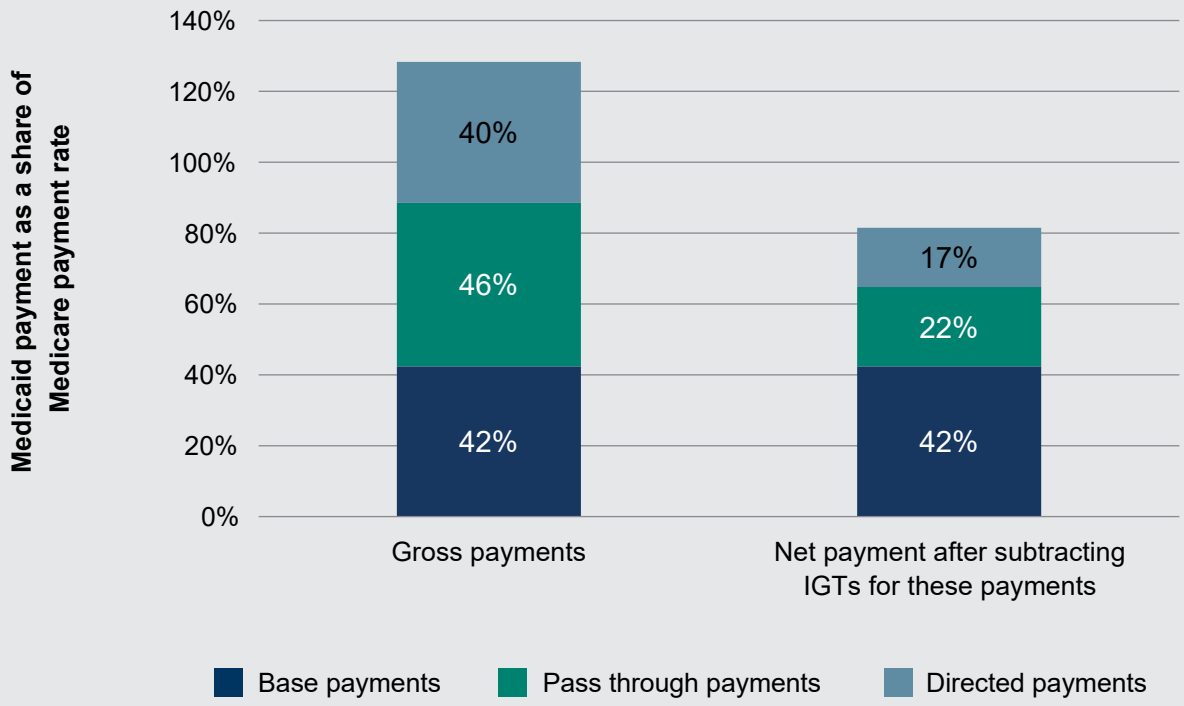
Note: Analysis excludes fee-for-service payments and supplemental payments.

Sources: MACPAC, 2024, analysis of managed care directed payment preprint; TX HHSC 2023b.

There are two potential ways to calculate the effect of this provider tax on net Medicaid payments to this provider. One option is to subtract the Medicaid-attributed share of the tax cost based on Medicaid revenue as a share of total patient revenue that was taxed (29 percent in this example). This approach is similar to the approach of including the Medicaid-attributed share of tax costs in a cost-based methodology when calculating the UPL. Another approach is to subtract the full amount of the provider tax cost. Providers generally believe this approach is more reflective of their costs because the tax dollars attributable to Medicare and commercial revenue are still being used to support the Medicaid program. These different approaches result in different perspectives of Medicaid payment adequacy: total net payments are 134 percent of the Medicare rate if only the Medicaid-attributed share of the tax is subtracted and 89 percent of Medicare if the full amount of the tax is subtracted.

The public hospital we examined was projected to receive managed care base payments that were 42 percent of what Medicare would have paid and managed care pass through and directed payments equal to 86 percent of what Medicare would have paid, resulting in a total gross payment of 128 percent of what Medicare would have paid (Figure 1-5). However, after subtracting the costs of the IGTs to finance this directed payment, the net managed care payments to this hospital were 82 percent of what Medicare would have paid.

FIGURE 1-5. Example of Gross and Net Medicaid Managed Care Payments for a Public Texas Hospital, 2022



Notes: IGTs are intergovernmental transfers. Analysis excludes fee-for-service payments and supplemental payments. Pass through payments will be discontinued by fiscal year 2027 in accordance with federal regulations.

Sources: MACPAC, 2024, analysis of managed care directed payment preprint; TX HHSC 2023b.

Hospitals in Texas receive a variety of supplemental payments in addition to directed payments, and it is difficult to determine how these payments should be accounted for when assessing payment adequacy. Some payments are intended to pay for unpaid costs of care for uninsured individuals (as authorized under Texas's Healthcare Transformation and Quality Improvement Program Section 1115 demonstration waiver), and others are intended to pay for care for non-hospital services.

Payments to private providers that are financed through IGTs from public hospitals are particularly challenging to track from a financing perspective. For example, a subset of public hospitals in Texas provide IGTs for private providers in the state. Because private providers do not finance these payments, the IGT contributions do not reduce the net payments that private providers receive. In contrast, public providers do have an added cost for providing IGT contributions. It is not clear how best to account for the financing costs borne by a small subset of providers when assessing net payments across all providers.

In Texas, it is also important to note that a portion of the managed care directed payments to hospitals includes a portion that is for administration, risk margin, and premium tax associated with the administration of the directed payment program. Although this practice is different from administrative fees retained by government entities, it has a similar effect of reducing the ability of providers to retain the federal funding generated from their contributions to the non-federal share. In 2022, Texas estimated that about 6 percent of the $4.7 billion in directed payments made to hospitals ($274 million) were retained by MCOs as a fee.

State administrative costs

Texas's experience implementing transparency requirements on some elements of provider-level reporting of Medicaid financing can also help inform considerations of the administrative costs of this effort. The Texas state legislature initially required the state Medicaid agency to collect provider-level information from local units of government that created LPPFs in 2019 but did not provide additional administrative funding for this activity, and so the state was not able to complete this request as robustly as the state deemed necessary and appropriate. In 2021, the legislature allowed the Medicaid agency to collect approximately $4 million a year in administrative fees from non-public providers participating in supplemental and directed payment programs to support this reporting activity. The state used this funding to hire about 18 employees and to contract with an external vendor to assist in creating a new reporting database. This new approach was more successful, and in the FY 2022 reporting period that recently finished, 99 percent of the 1,242 local government entities required to report successfully submitted the required information during the month-long reporting period (TX HHSC 2024).

Medicaid administrative activities are typically matched at a 50 percent FMAP. States are eligible for a 90 percent FMAP for the design and development of Medicaid enterprise systems (MES) and 75 percent FMAP for their continued operation, which could reduce the cost to the state of any new reporting requirements. Although the new database used as part of Texas's new local funding reporting system could have potentially been classified as MES and eligible for higher federal match, the state reported that it used its regular 50 percent administrative match for this activity. To receive the enhanced FMAP for MES, states need prior approval from CMS of advanced planning documents describing their project and ongoing review of the system's operation. In addition, it is important to note that the state staff Texas hired to oversee the reporting would likely not be eligible for enhanced MES funding. Texas did not consider pursuing the enhanced FMAP for the system development costs because the primary cost of developing the system was staff resources.

Commission Recommendations

The Commission makes two complementary recommendations to Congress to improve the transparency of Medicaid and CHIP financing and enable analyses of net provider payments. These recommendations build on prior Commission recommendations to enable analyses of all types of Medicaid financing for all types of providers, not just

hospitals and nursing facilities. Stakeholders have stressed the importance of analyzing both gross and net payment amounts when developing payment policy and assessing how these payments are linked to goals of access and quality.

Recommendation 1.1

In order to improve transparency and enable analyses of net Medicaid payments, Congress should amend Section 1903(d)(6) of the Social Security Act to require states to submit an annual, comprehensive report on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers. The report should include:

- a description of the methods used to finance the non-federal share of Medicaid payments, including the parameters of any health care-related taxes;
- a state-level summary of the amounts of Medicaid spending derived from each source of non-federal share, including state general funds, health care-related taxes, intergovernmental transfers, and certified public expenditures; and,
- a provider-level database of the costs of financing the non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the non-federal share.

This report should be made publicly available in a format that enables analysis.

Rationale

The Commission has long held that analyses of Medicaid payment policy require complete data on all Medicaid payments that providers receive as well as data on the costs of financing the non-federal share necessary to calculate net Medicaid payments at the provider level. In 2016, the Commission recommended that CMS improve the transparency of payment and financing data for hospitals, and in 2023, the Commission made a similar recommendation for nursing facility payments.

In 2020, Congress partially implemented MACPAC's recommendations by requiring reporting of provider-level supplemental payment data, but Congress has not taken any action to date on other components of these recommendations related to the transparency of managed care payment data or transparency of the costs of provider contributions to the non-federal share.[17] As a result, our ability to analyze the new data that states are reporting is severely limited.

The current data that CMS collects on the financing of the non-federal share of Medicaid payments are fragmented and incomplete. CMS collects information only on the methods that states use to finance Medicaid payments when a state makes changes to its state plan, and this information is not publicly available. In addition, because a state may make multiple changes to their state plan each year, it is difficult to use the financing data that CMS collects to get a comprehensive view of a state's overall Medicaid financing methods. For managed care directed payments, states are required to describe the financing sources on the preprint, but states do not report information on the specific entities paying the tax or the amount of taxes collected.

In 1991, Congress added Section 1903(d)(6) to the Act to improve the transparency of data on health care–related taxes and donations as part of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments. However, states have not prioritized reporting of these data, and so these data are often incomplete. For example, in SFY 2018, states reported only $29 billion in health care–related taxes on Form CMS-64.11 in MBES, but they reported $37 billion in health care–related taxes on GAO's survey. In addition, MBES does not include any information about local government funds used to finance the non-federal share; in SFY 2018, states reported $26 billion in local government funds used to finance Medicaid expenditures (GAO 2020).

Through interviews with state officials, provider associations, federal officials, and other experts, we learned that many stakeholders would be willing to share additional information on Medicaid financing methods publicly if the purpose and additional value of the reporting were clear. In particular, many stakeholders agreed that it would be helpful to assess how the costs of financing the non-federal share of Medicaid payments affect the net payments that providers receive. However, stakeholders cautioned

that improved transparency should not be used to limit financing methods that are currently permissible.

Stakeholders also noted the importance of limiting the administrative burden for states, which already face a number of other federal reporting requirements. To do so, stakeholders suggested that new reporting align with how states currently collect data on Medicaid financing. Specifically, stakeholders suggested that financing data be reported in the aggregate at the state and provider level rather than tying each source of Medicaid financing to a specific category of service.

In the process of our review, we also learned that the Texas state legislature recently required the state Medicaid agency to report provider-level financing data in a standard way that could be a model for other states. Since 2019, the Texas state legislature has required the state Medicaid agency to collect provider-level information on LPPFs, which are accounts into which health care–related taxes imposed by local units of government are deposited and then transferred to the state by an IGT to finance Medicaid payments. In 2021, the legislature required the state Medicaid agency to expand its review and reporting efforts to all sources of non-federal share and to make this information publicly available (TX HHSC 2023a). Because these data included standard identifiers, we were able to link the new financing data with other available data on Medicaid payments to create the illustrative examples of net payment to providers included in this chapter.

During our interviews, we also heard about the importance of tracking administrative fees and other costs that are not used to finance payments to the providers financing the non-federal share. Texas's provider-level payment data include information on administrative fees collected by local governments (0.7 percent of taxes collected) but do not include information about administrative fees retained by the state. In the process of our review, we also learned that managed care capitation payments include 6 percent for administration, risk margin, and premium tax associated with the administration of the directed payment program, which is another type of administrative fee that could benefit from increased transparency.

It is important that CMS make any new financing data publicly available to enable analyses by all stakeholders, not just CMS and other federal entities. Congress also recognized the importance of transparency when it added the new supplemental payment reporting requirements in 2020. The Commission notes that CMS has not made these data publicly available despite the statutory requirement to do so on a timely basis (§1903(bb)(1)(C) of the Act).

Design considerations

When implementing the new comprehensive transparency requirements that the Commission recommends, CMS should collect information that is most relevant for analyses of net payments to providers and future policy development in this area. Doing so may require updates to the standard funding questions that CMS asks when it reviews state plan amendments and directed payment preprints.

In the Commission's view, CMS should consider collecting the following information about financing methods:

- a summary of all types of health care–related taxes, IGTs, and CPEs used to finance Medicaid payments (currently included in question 2 of the standard funding questions);
- information about whether the financing source is used to finance a specific type of Medicaid payment, such as supplemental payments (currently included in question 3 of the standard funding questions);
- parameters of the health care–related tax, such as the entity that is being taxed, the tax rate, and whether the tax qualifies for a waiver of the statutory requirements for uniform and broad-based health care–related taxes;
- information on any administrative fees charged for IGT or CPE financing (not currently collected by CMS); and
- any other descriptive information that could help inform analyses of state- and provider-level financing information, such as details on the differences between the date of collection of the non-federal share and the time period for which

payments were made using that source of non-federal share (not currently collected by CMS).

CMS should also establish additional process controls to review the accuracy of the data submitted to ensure completeness. For example, CMS could incorporate this information into existing reporting structures, such as Form CMS-64.11, to reduce the administrative burden and consolidate reporting when possible. In doing so, CMS could implement procedures to ensure consistency across data sources. In addition, CMS could implement automated checks that ensure the sum of all sources of non-federal share at the state level match the state share reported on the other CMS-64 forms reported for the same time period. Another possibility would be to assign CMS staff to review state budget documents to validate the information that states are submitting.

Finally, to ensure that provider-level data are most useful for future analyses, CMS should adopt some of the most useful features of Texas's new provider level financing report, including the following:

- the ability to link provider-level financing data with Medicare cost reports and other claims data through provider-level identifiers;
- information to track the timing of the transfer relative to the date of payment; and
- an option to report financing for specific supplemental payment programs when available.

Implications

Federal spending. This recommendation would result in increased administrative effort for the federal government, but CBO does not estimate any change in federal direct spending. Federal administrative burden could be reduced if efforts to collect new financing data are coordinated with existing systems and reporting requirements.

States. Although many states already collect data on their Medicaid financing methods, reporting this information to CMS in a standard format will increase state administrative effort and could result in additional administrative spending. States may be able to claim enhanced FMAP for certain administrative expenses related to MES development and operations.

Additionally, states have the option to offset the costs of any increased administrative burden by retaining additional administrative fees from health care–related taxes, IGTs, or CPEs.

Enrollees. This policy would not have a direct effect on enrollees.

Plans. Health plans would not be directly affected by this policy unless a state imposes a health care–related tax on the health plan or the health plan retains administrative fees for provider-financed payments. If so, health plans may have some administrative burden to report financing information that states do not already collect. To calculate net payments under managed care, plans will have some administrative burden to report directed payments at the provider level; however, this information will be required under the 2024 managed care final rule.

Providers. This policy would not directly affect Medicaid payments to providers or change permissible sources of non-federal share for Medicaid expenditures. However, the data collected could be used to inform analyses of Medicaid provider payments, which could affect payment rates in the future. This recommendation may also increase administrative burden for some providers if they need to report information that states are not already collecting. Provider payments could be reduced if the state retains an administration fee.

Recommendation 1.2

In order to provide complete and consistent information on the financing of Medicaid and the State Children's Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act (the Act) to apply the Medicaid financing transparency requirements of Section 1903(d)(6) of the Act to CHIP.

Rationale

States are permitted to finance the non-federal share of CHIP spending using the same methods that are permissible in Medicaid. However, there is little information available about how states finance CHIP and how sources of non-federal share affect net payments to providers.

States have the option to administer CHIP as expansions of Medicaid, as a separate CHIP, or as a combination of both programs. As of July 2023, 39 states operate a separate CHIP or combination program.

Medicaid expansion CHIP is subject to Medicaid financing rules, but separate CHIP is subject only to Medicaid rules described in Section 2107(e) of the Act and any additional requirements added by regulation. Federal regulations in 42 CFR 457.628 apply many of the federal financing policies to CHIP, but the statute does not explicitly require CHIP to comply with the financing transparency requirements of Section 1903(d)(6) of the Act (which were added before CHIP was created).

Applying consistent requirements for both Medicaid and CHIP will promote overall program transparency without adding substantial additional administrative burden.

Implications

Federal spending. This recommendation would result in increased administrative effort for the federal government, but CBO does not estimate any change in federal direct spending. Federal administrative burden could be reduced if efforts to collect new financing data are coordinated with existing systems and reporting requirements.

States. Although many states already collect data on their CHIP financing methods, reporting this information to CMS in a standard format will increase state administrative effort and could result in additional administrative spending. States have the option to offset the costs of any increased administrative burden by retaining additional administrative fees for health care–related taxes, IGTs, or CPEs.

Enrollees. This policy would not have a direct effect on enrollees.

Plans. Health plans would not be directly affected by this policy unless a state imposes a health care–related tax on the health plan or the health plan retains administrative fees for provider-financed payments. If so, health plans may have some administrative burden to report financing information that states do not already collect.

Providers. This policy would not directly affect CHIP payments to providers or change permissible sources of non-federal share for CHIP expenditures. However, the data collected could be used to inform analyses of CHIP provider payments, which could affect payment rates in the future. This recommendation may also increase administrative burden for some providers if they need to report information that states are not already collecting. Provider payments could be reduced if the state retains an administration fee.

Next Steps

The Commission will continue to examine Medicaid payment policies guided by MACPAC's provider payment framework, which is based on the statutory Medicaid payment goals of efficiency, economy, quality, and access (MACPAC 2015). For example, the Commission is currently engaging in a long-term work plan to further examine all types of payments to hospitals using newly available data on non-DSH supplemental payments and directed payments. However, lack of data on the costs of provider financing of the non-federal share of Medicaid payments will substantially limit our ability to understand the net payments that providers receive.

The Commission will also continue to monitor larger trends in federal Medicaid spending, including the share of Medicaid spending financed by states, providers, and the federal government. The Commission has previously examined alternative approaches to federal Medicaid financing that are intended to alter the trajectory of federal spending (MACPAC 2016c). However, we cannot examine the full effects of these policies until more state- and provider-level financing data are available.

Endnotes

[1] A complete list of statutory exceptions to the FMAP is available on MACPAC's website (MACPAC 2024).

[2] The year 2015 was selected for CHIP because of temporary increases in the CHIP enhanced FMAP (E-FMAP) from FYs 2016–2020. Under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), beginning on October 1, 2015, and ending on September 30, 2019, the E-FMAP was increased by 23 percentage points, not to exceed 100 percent, for all states. Under the HEALTHY KIDS Act (P.L. 115-120), beginning on October 1, 2019, and ending on September 30, 2020, the E-FMAP was increased by 11.5 percentage points, not to exceed 100 percent, for all states.

[3] Federally owned providers, such as the Indian Health Service or Veterans Affairs hospitals, cannot contribute IGTs to state Medicaid or CHIP expenditures. Intragovernmental transfers (i.e., between states) are also not permissible.

[4] For example, in 2020, CMS provided MACPAC with its internal tracking list of states that applied for health care–related tax waivers. Of the 43 states that reported hospital provider taxes in the KFF survey, 38 states were included in CMS's list of hospital tax waivers (CMS 2020, Gifford et al. 2020).

[5] The statutory requirement to report health care–related tax amounts was added by the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234).

[6] Thirty of Tennessee's 150 hospitals donated in the first year of Tennessee's provider donation program. Regional Medical Center in Memphis, the largest public hospital in the state, was the largest donor. Provider donations were matched by the federal government at the state's 70 percent FMAP.

[7] Section 5 of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments prohibited CMS (then the Health Care Financing Administration) from issuing any interim final rules that changed the treatment of public funds as the source of non-federal share and also required the agency to consult with states before issuing any rules under the law.

[8] Congress issued moratoria on CMS implementing provisions in the final rule through the Supplemental Appropriations Act of 2008 (P.L. 110-252) and the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) until July 1, 2009. CMS subsequently issued regulations further delaying enforcement of the changes made in the 2008 rule until June 30, 2010 (CMS 2009).

[9] Section 1903(a)(1) of the Act requires that federal Medicaid funding be based on spending for medical assistance approved in the Medicaid state plan. CMS cites this authority as justification for asking about the retention of payments in its standard funding questions (CMS 2024b). Section 1902(a)(32) of the Act also requires payments to be made to the providers of services and has been cited in CMS's proposed rule to require providers to retain the Medicaid payments that they receive (CMS 2019). Section 1903(i)(17) of the Act prohibits federal match for any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid state plan.

[10] Initially CMS defined two classes of providers: state owned and non-state owned. In 2001, CMS created a third class of providers for non-state government owned providers. At first, the UPL for non-state government owned providers was 150 percent of Medicare to reflect these providers' costs of financing payments through IGTs. However, in 2002, this limit was reduced to 100 percent of Medicare, the same limit as other provider classes.

[11] Specifically, CMS added questions about UPL to its standard funding questions in 2002, and in 2013, CMS issued a state Medicaid director letter requiring states to demonstrate compliance with UPL requirements annually (CMS 2013).

[12] The projected spending reported as of February 2023 is more complete than information on projected spending previously available due to CMS's new preprint template. However, we still found that projected spending amounts were not always reported in a consistent format. Another limitation of this analysis is that actual spending amounts may be higher or lower than the amount projected in approval documents.

[13] States are permitted to include Medicaid's share of the costs of health care–related taxes according to Medicare payment principles when calculating DSH limits and the UPL. Certain California public hospitals have a statutory exemption to receive gross DSH payments up to 175 percent of their costs. Because these hospitals fully finance the non-federal share of these DSH payments, the net payments that these hospitals receive are less than costs, even after applying this statutory exemption.

[14] MFAR proposed new reporting requirements related to DSH and UPL payments, which would have created new

definitions of public funds, new requirements for the use of IGTs and CPEs, and new limitations for provider tax waivers and hold harmless arrangements, including prohibiting private mitigation arrangements.

[15] On the Medicare cost report worksheet S-10, hospitals are instructed to report the amount of Medicaid revenue for inpatient and outpatient services net of associated provider taxes or assessments (CMS 2022).

[16] Data from Texas are being used as an illustrative example, and the state's use of different supplemental and directed payments and financing of non-federal share may not be applicable to other states. For example, Texas makes supplemental payments through an uncompensated care pool and delivery system reform incentive payments program authorized under Section 1115 waiver expenditure authority; these arrangements are used in only a small number of states. Additionally, the LPPF structure of financing the non-federal share may not be applicable to other states.

[17] In 2022, MACPAC recommended additional transparency related to managed care directed payments that have also not yet been fully implemented (MACPAC 2022).

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 12, 2024.

Improving the Transparency of Medicaid and CHIP Financing

1.1 In order to improve transparency and enable analyses of net Medicaid payments, Congress should amend Section 1903(d)(6) of the Social Security Act to require states to submit an annual, comprehensive report on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers. The report should include:

- a description of the methods used to finance the non-federal share of Medicaid payments, including the parameters of any health care-related taxes;
- a state-level summary of the amounts of Medicaid spending derived from each source of non-federal share, including state general funds, health care-related taxes, intergovernmental transfers, and certified public expenditures; and,
- a provider-level database of the costs of financing the non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the non-federal share.

This report should be made publicly available in a format that enables analysis.

1.2 In order to provide complete and consistent information on the financing of Medicaid and the State Children's Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act (the Act) to apply the Medicaid financing transparency requirements of Section 1903(d)(6) of the Act to CHIP.

1.1-1.2 voting results	#	Commissioner
Yes	16	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Snyder, Weno
Not present	1	Medows