Florida TaxWatch



AN INDEPENDENT ANALYSIS OF

The Medicaid Fiscal Accountability Regulation (MFAR) and its Impacts on Florida's Medicaid Program

MARCH 2020

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Dear Fellow Taxpayer

The federal Centers for Medicare & Medicaid Services (CMS) proposed a rule in November 2019 that, if enacted, will significantly change the way states finance their Medicaid programs and supplemental payments to providers. The stated intent of the proposed Medicaid Fiscal Accountability Regulation (MFAR) is to increase Medicaid program transparency and accountability and strengthen the fiscal integrity of the Medicaid program; however, the proposed rule could make it much harder for states like Florida to pay for their share of Medicaid costs.

If finalized, the rule could require many states to change how they finance their Medicaid programs and, in the process, eliminate some financing options that have long been available to states. These changes would dramatically affect state budgets and could lead to significant cuts to benefits, coverage, and provider payments.

Florida TaxWatch has undertaken an independent review to assess the impacts of certain key changes proposed by MFAR that would have a far-reaching and dramatic impact on Florida's Medicaid program, Florida's safety-net providers, the 3.8 million Medicaid-eligible Floridians, and Florida taxpayers. Florida TaxWatch is pleased to present this summary report and its recommendations, and we look forward to a continued discussion with Florida lawmakers and policymakers.

Sincerely,

Dominic M. Calabro

Dominic M. Calabro
President & CEO

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Executive Summary

The Centers for Medicare & Medicaid (CMS) proposed the Medicaid Fiscal Accountability Regulation (MFAR) in November of 2019 to strengthen the fiscal integrity of the Medicaid program.[1]

Florida TaxWatch applauds CMS in its attempts to increase transparency and accountability within the Medicaid system; however, MFAR goes too far and is likely to do much more harm than good for the taxpayers of Florida. MFAR proposes significant policy changes with respect to Medicaid financing (e.g., restrictions related to the sources of intergovernmental transfers and the permissibility of health care-related taxes (provider taxes) used to fund the non-federal share) and Medicaid fee-for-service supplemental payments, with the imposition of new limits on the amounts of Medicaid practitioner supplemental payments.

These proposed changes would add greater stress and uncertainty for providers who administer Medicaid services, Medicaid beneficiaries, and individual taxpayers in the state of Florida.

The proposed MFAR would require all intergovernmental transfers from local units of government or other units of state government used to fund a state's non-federal share of Medicaid expenditures to be derived from state or local taxes or from funds appropriated to state university teaching hospitals. As a result, government funding from currently valid sources – such as general funds, operating expenses, and hospital services – would no longer be permitted.

Restricting the use of these funds and limiting eligible intergovernmental transfers to only tax revenues would have a significant negative impact on the state's ability to finance Medicaid supplemental payment programs. In its comments on MFAR, Florida's Agency for Health Care Administration (AHCA) stated that "[I]f this provision is finalized in its current form, this would have immediate and negative consequences to Florida's health care safety net and access to critical health care services."[2]

There are many special hospital districts in Florida with taxing authority that have been able to save taxpayers money by limiting millage rates or by levying no property taxes at all, relying instead on general funds, operating expenses, and other sources to fund IGTs.

Should MFAR take effect, those hospital districts with taxing authority will have little choice but to impose new or increased taxes and those without taxing authority will no longer have the means to provide IGTs to draw federal matching funds for Medicaid.

MFAR also seeks to significantly increase CMS' discretion to determine that a "hold harmless" arrangement exists with respect to a provider tax. When a hold harmless arrangement is found to exist, the provider tax cannot be used as a source of the non-federal share of Medicaid expenditures. Under MFAR, CMS would be authorized to apply new vague and subjective criteria that would give CMS broad discretion to determine whether a provider tax is acceptable as the source of the state's non-federal share; these new criteria would make it exceedingly difficult for the state to be certain of its compliance with federal requirements.

1 Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722, November 18, 2019.

2 Florida Agency for Health Care Administration, Comment letter on MFAR, January 31, 2020.

MFAR would also grant CMS with more leeway to deny state requests for waivers related to provider taxes. Currently, when states request waivers of either the "broad-based" or "uniform" tax requirements, the tax is analyzed pursuant to established objective, quantitative tests. MFAR would permit CMS to deny a state's waiver request when the tax would otherwise be acceptable under the currently-applied tests, based on a determination that the tax results in an "undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid."[3] In light of the current legitimate provider tax waiver and class exemptions that Florida has negotiated with CMS and that are consistent with the intent of the current test, AHCA has deemed the proposed new test to be "too sweeping and unnecessary."[4]

These proposed changes would open the door for subjective and arbitrary application by CMS, in contrast with the waiver approval process under the currently-applied tests.

MFAR would also restrict a state's ability to make "fee for service" (FFS) supplemental payments to providers. These payments are vital to Florida's healthcare providers, especially critical care providers in rural and low-income areas, because the base payment levels under Medicaid are often set below the cost of providing care. Providers that serve areas with high levels of Medicaid recipients could be unable to cover their basic operational costs and would shut down. Florida (like other states) is currently permitted to make supplemental payments for practitioner services up to the Medicare payment amounts or up to the average commercial rate of payments to providers, which helps these providers continue to provide services at all.

MFAR includes a number of vague and subjective criteria and affords CMS broad discretion, at the expense of the states, in interpreting and applying these criteria to critical Medicaid decisions. As a result, states will experience a high level of uncertainty regarding the impacts of the proposed changes.

CMS acknowledges that "[T]he fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." MFAR adds unnecessary complexity and uncertainty to the Medicaid process, and there is nothing in MFAR that suggests that implementing the proposed MFAR revisions will improve patient outcomes.

Although the impact at the individual state level is unknown and will vary significantly, MFAR would force Florida, and nearly every state, to consider cuts in Medicaid program enrollment and covered services. Preempting Florida's authority and reducing the state's flexibility within the Medicaid programs will pressure Florida's state and local policymakers to choose between raising taxes to support the program or decreasing access to health care (along with the downstream effects of potential hospital closures and loss of jobs) across the state. The new rule will likely have significant negative impacts on both the 3.8 million Floridians who rely on Medicaid as their primary or sole source of healthcare coverage and Florida's state budget.

It is clear to Florida TaxWatch that CMS has not sufficiently evaluated the significant adverse impacts MFAR would have on Medicaid

3 Supra, see footnote 1

4 Florida Agency for Health Care Administration, Comment letter on MFAR, January 31, 2020.

providers, Medicaid beneficiaries, state budgets, and (ultimately) the taxpayers. Florida TaxWatch concurs with AHCA's assessment "that the impact (of MFAR) will be immediate and crippling."[5] Therefore, prior to implementing such drastic and disruptive changes to current Medicaid rules and policy upon which states and providers have relied to design and implement various supplemental payment programs, CMS should first obtain the data necessary to understand the full impact of its MFAR proposals.

Florida TaxWatch recommends that stakeholders urge CMS to not move forward with the finalization of MFAR. Instead, Florida TaxWatch believes CMS should gather more data to understand the impact of its MFAR policies. Once more complete and reliable data are obtained, CMS should seek to identify more narrowly-tailored, evidence-based policies to address its concerns, and work in cooperation with states to determine best practices for how to strengthen accountability and transparency in the Medicaid program.

Introduction

Medicaid provides medical coverage to low-income individuals and families, as well as certain long-term care residents and individuals with disabilities. Each state and the federal government share the cost of the state-administered Medicaid program.

Since the inception of the Medicaid program in 1965, states have been able to draw down federal matching funds from the Centers for Medicare & Medicaid (CMS) for Medicaid services rendered to Medicaid beneficiaries. With the Medicaid program, Congress sought to create a partnership between the federal government and the states, including shared financing, "so as to make medical services for the needy more generally available."

The federal matching payments are considered federal financial participation (FFP). This FFP structure assumes that both the federal government and states will pay a matching percentage of the total Medicaid spending; however, local government entities also play an important and significant role in funding certain portions of the Medicaid program.

Medicaid in Florida

Florida's Medicaid program, administered by the Agency for Health Care Administration, served more than 3.8 million individuals during fiscal year 2018-19.[6]

5 Florida Agency for Health Care Administration, Comment letter on MFAR, January 31, 2020.

6 Social Services Estimating Conference, "Medicaid Caseloads and Expenditures," December 20, 2019 and January 7, 2020.

In Florida, Medicaid covers:

- 1 in 9 adults aged 19 to 64;
- 3 in 7 children;
- 4 in 7 nursing home residents;
- 1 in 3 individuals with disabilities; and
- 1 in 5 Medicare beneficiaries.[7]

More than 80 percent of Medicaid beneficiaries in Florida receive services through the state's Medicaid managed care program.[8] Florida is currently operating under a section 1115 Medicaid demonstration, titled the "Managed Medical Assistance" (MMA) program, which is currently approved to operate from August 1, 2017 through June 30, 2022. The MMA program allows the state to operate a capitated Medicaid managed care program.

The federal government's share of the costs of covered services in state Medicaid programs is known as the Federal Medical Assistance Percentage (FMAP).[9] For the 2020-21 federal fiscal year, the FMAP to be used for Florida's Medicaid program is 61.96 percent.[10] In addition, the Medicaid program has a "multiplier." For every dollar a state spends on Medicaid, the federal government matches at a rate that changes from year to year. For the 2020-21 federal fiscal year, the multiplier to be used for Florida's Medicaid program is 1.63.[11]

7 Kaiser Family Foundation, "Medicaid in Florida," retrieved from http://files.kff.org/attachment/fact-sheet-medicaid-state-FL, February 19, 2020.

8 Ibid.

9 The FMAP is calculated using a formula that takes into account the average per capita income for each state relative to the national average. The lower a state's per capita income, the higher the state's FMAP.

10 Kaiser Family Foundation, "State Health Facts," retrieved from https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&selectedDistributions=multiplier&selectedRows=%7B%22states%22:%7B%22florida%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, February 19, 2020.

11 Ibid.

The state's reconciled program expenditures for state fiscal year 2018-19 totaled $25.95 billion.[12] For fiscal year 2019-20, Medicaid expenditures are estimated to increase to $28.3 billion.[13]

In addition to funding appropriated from the state's general revenue, Florida has a provider tax on hospitals, referred to as the Public Medical Assistance Trust Fund (PMATF).[14] Under the PMATF, hospitals are assessed 1 percent of their annual inpatient net operating revenues and 1.5 percent of their annual outpatient net operating revenues. The assessments are leveraged to draw federal Medicaid matching funds and used to help fund various Medicaid payments to hospitals in the state.

Florida also has a provider tax on nursing home facility providers, referred to as the Nursing Facility Quality Assessment, under which taxes on a per-resident-day basis are imposed on facilities.[15] Pursuant to waivers obtained from CMS, certain nursing home facilities are exempt from the tax, including certain nursing home facilities that are located on the campus of continuing care retirement communities, nursing home facilities that have 45 or fewer beds, and skilled nursing facility units of acute care hospitals.

Medicaid Programs Funded by Local Governments

While most of Florida's Medicaid program is funded by federal and state dollars, local governments play an important and significant part in funding certain aspects of the overall program.

12 Social Services Estimating Conference, "Medicaid Caseloads and Expenditures," December 20, 2019 and January 7, 2020.

13 Ibid.

14 Section 395.701, Florida. Statutes.

15 Section 409.9082, Florida Statutes.

Each year, local entities contribute hundreds of millions of dollars in funding to allow Florida to draw federal dollars for expenditures that would otherwise be funded by state general revenue or not exist.[16]

Local governments specifically help to fund Medicaid expenditures for various supplemental payments programs.[17] For state fiscal year 2018-19, local government contributions of nearly $780 million (combined with state funding of nearly $50 million) were used to leverage a federal draw of over $1.2 billion, which supported approximately $2.1 billion in Medicaid expenditures;[18] Those local funds came from local entities such as counties, health care taxing districts, hospital taxing authorities, and Florida schools that are enrolled as service providers.[19]

16 The [Florida] Agency for Health Care Administration, "Local Funding Revenue Maximization and Funding for Special Medicaid Reimbursement Programs: A Report to the Florida Legislature for State Fiscal Year 2018-2019," [*undated*], available at https://ahca.myflorida.com/Medicaid/recent_presentations/2020/Local_Funding_Revenue_Maximization-Funding-Special_Medicaid_Reimb_Prgms_SFY2018-2019.pdf.

17 In fiscal year 2018-19, the following programs were funded in part or in whole by local government funds: Two school-based service reimbursement programs; Multi-Visceral Transplant program; Low Income Pool (LIP) program; Graduate Medical Education (GME) Startup Bonus program; Physician Supplemental Payment (PSP) program; Public Emergency Medical Transportation (PEMT) program; Disproportionate Share Hospital (DSH) program; and, Florida Cancer Hospital program (FCHP). Source: Florida Agency for Health Care Administration, "Local Funding Revenue Maximization and Funding for Special Medicaid Reimbursement Programs: A Report to the Florida Legislature For State Fiscal Year 2018-2019," retrieved from https://ahca.myflorida.com/Medicaid/recent_presentations/2020/Local_Funding_Revenue_Maximization-Funding-Special_Medicaid_Reimb_Prgms_SFY2018-2019.pdf, March 11, 2020.

18 The [Florida] Agency for Health Care Administration, "Local Funding Revenue Maximization and Funding for Special Medicaid Reimbursement Programs: A Report to the Florida Legislature for State Fiscal Year 2018-2019," [*undated*], available at https://ahca.myflorida.com/Medicaid/recent_presentations/2020/Local_Funding_Revenue_Maximization-Funding-Special_Medicaid_Reimb_Prgms_SFY2018-2019.pdf.

19 The [Florida] Agency for Health Care Administration, "Local Funding Revenue Maximization and Funding for Special Medicaid Reimbursement Programs: A Report to the Florida Legislature for State Fiscal Year 2018-2019," [*undated*], available at https://ahca.myflorida.com/Medicaid/recent_presentations/2020/Local_Funding_Revenue_Maximization-Funding-Special_Medicaid_Reimb_Prgms_SFY2018-2019.pdf.

The Medicaid Fiscal Accountability Regulation (MFAR)

The last several years have seen a dramatic increase in national Medicaid program spending, from $456 billion in 2013 to nearly $597 billion in 2018.[20] In November 2019, there were 64.5 million individuals enrolled in Medicaid in the U.S.[21] Nationally, "supplemental payments" (i.e., additional payments to providers beyond the base Medicaid payment for particular services) have steadily increased from 9.4 percent of all other payments in FY 2010 to 17.5 percent in FY 2017.[22] Expenditures for hospital "Upper Payment Limit" (UPL) supplemental payments (the maximum payment a state Medicaid program may pay a certain provider type in the aggregate) increased for Medicaid benefits nationally between 2001 and 2016, resulting in a total of $16.4 billion in supplemental payments for 2016.[23]

Information on how states are financing the state share of Medicaid expenditures, especially as related to "supplemental payments," is not always available to CMS; therefore, in order to exercise more oversight of state Medicaid funding and spending decisions, CMS proposed MFAR in November of 2019. MFAR proposes to establish regulations to three main features

20 CMS National Health Expenditure Data.

21 Medicaid.gov, "November 2019 Medicaid & CHIP Enrollment Data Highlights," retrieved from https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html, February 17, 2020.

22 Centers for Medicare & Medicaid Services, "Fact Sheet: 2019 Medicaid Fiscal Accountability Regulation (MFAR)," November 12, 2019, retrieved from https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar, February 17, 2020.

23 Centers for Medicare & Medicaid Services, "Fact Sheet: 2019 Medicaid Fiscal Accountability Regulation (MFAR)," November 12, 2019, retrieved from https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar, February 17, 2020.

of the Medicaid program: Improving reporting on supplemental payments; clarifying Medicaid financing definitions; and, reducing the usage of certain financing mechanisms.

Improved Reporting on Supplemental Payments

The regulations proposed to increase reporting on supplemental payments are intended to keep states consistent in reporting and help the CMS track and analyze details of these payments by adding thorough review and reporting requirements. Currently, states report details of base and supplemental payments on an aggregate level; MFAR would require states to report provider-specific payment information to support the aggregate level information received through UPL demonstrations.[24]

States would also be required to report provider-specific payment information on payments received for state plan services and through demonstration programs, as well as identify the specific authority for these payments (i.e., state plan amendment or demonstration), and the source of the non-federal share for these payments.[25] Existing and new supplemental payment methodologies would sunset after three years and states would be required to request CMS approval to continue a supplemental payment beyond this period. MFAR would mandate the use of templates approved by the Executive Office of the President of the United States (specifically though the Office of Management and Budget) and CMS guidelines on acceptable UPL calculations.

Other Medicaid financing changes include adding health insurers as a permissible class of health care items and services for imposing taxes. The CMS plans to examine parameters of the taxes to determine if certain taxes are receiving differential treatment and need to be subject to health-related tax rules. Changes in the rule also affect the use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs) to limit and prevent financial arrangements involving public-private partnerships and would restrict which entities can make IGTs to the state that would qualify for use as non-federal share for drawing federal funding under the program.

Clarifying Medicaid Financing Definitions

The proposed rule also plans to clarify many Medicaid financing definitions and other finance changes that were previously confusing. There will be new definitions for Medicaid "base" and "supplemental" payments. A "base payment" is to mean a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the state plan or is paid to the provider through its participation with a Medicaid MCO entity. "Supplemental payments" are payments made to providers in addition to the base payment the provider receives for services furnished. Unlike base payments that are directly attributable to a covered service furnished to individual entity, supplemental payments are often made to a provider in lump sum on a routine bases and are unable to be linked to a single claim for specific services.[26] Clearly defining these terms is necessary for states and other stakeholders to

24 Centers for Medicare & Medicaid Services, "Fact Sheet: 2019 Medicaid Fiscal Accountability Regulation (MFAR)," November 12, 2019, retrieved from https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar, February 17, 2020.

25 Centers for Medicare & Medicaid Services, "Fact Sheet: 2019 Medicaid Fiscal Accountability Regulation (MFAR)," November 12, 2019, retrieved from https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar, February 17, 2020.

26 CMS, "Medicaid Program, Medicaid Fiscal Accountability Regulation," Federal Register, 84 FR 63722, November 18, 2019.

understand what is required and expected of them with respect to the added reporting requirements for supplemental payments and UPL demonstrations.

Reducing the Usage of Certain Financing Mechanisms

MFAR also clarifies methods to reduce specific financing mechanisms from being used. The proposed rule changes what is meant by "public funds" as qualifying for use as non-federal share. MFAR also states that providers must receive and retain 100 percent of payments in order to prevent states and other government entities from reusing Medicaid payments in later additional payments. Another clarification through MFAR states that facilities that undergo certain transactions to change ownership on paper without considerably changing operations can no longer qualify for additional Medicaid payments based on the purported change of ownership.

Lastly, major provisions of MFAR are directed at healthcare-related taxes and donations. The intent is to clarify ways to prevent impermissible donations that are used to fund the state share of Medicaid expenditures. MFAR would also prohibit states from structuring healthcare- related taxes that would place higher taxes on Medicaid services than non-Medicaid services. Much of the proposed rule is made to codify and clarify existing policies that are not always carried out the intended route. For example, another change would specify certain prohibitions on states circumventing healthcare-related tax requirements by placing healthcare taxes into a program that taxes non-healthcare services as well. The CMS' goal is to strengthen the oversight it currently lacks and ensure that states' healthcare-related taxes are transparent and well accounted.

Analysis of MFAR and the Potential Impacts on Florida's Medicaid Program

State Medicaid programs will be substantially impacted if MFAR is finalized as proposed. Of particular importance are MFAR's proposals related to Medicaid program financing and Medicaid FFS payment policy. MFAR also sets forth proposed new annual and quarterly reporting requirements for supplemental payments.

CMS claims to be clarifying existing policies through the proposed rule rather than creating new policies, including revisions to several provisions regulating provider involvement in a state's funding of the non-federal share of Medicaid; however, it is clear that several changes set forth in MFAR go well beyond clarification and attempt to impose new regulatory standards and empower CMS with new authority.

If MFAR is promulgated as-is, the changes are likely to impart stress on, and create uncertainty for, most state Medicaid programs, providers who administer Medicaid services, Medicaid beneficiaries, and state taxpayers. Florida, and many other states, will likely need to restructure longstanding Medicaid financing mechanisms and payment designs.

Florida TaxWatch applauds CMS in its attempts to increase transparency and accountability within the Medicaid system; however, several of the proposals in MFAR go too far, particularly in light of the fact that CMS' concerns with purported inappropriate state Medicaid financing practices seem to be grounded more in speculation rather than any evidence or data,

and the fact that Congress has specifically adopted statutes setting forth clear directives to determine which state practices are and are not permissible.

There are already laws on the books that were specifically designed to identify state Medicaid revenue maximization strategies that Congress deemed problematic. In the 1990s, Congress considered and enacted legislation to make sure that state revenue maximization strategies are limited in ways that are consistent with the core statutory purpose of the Medicaid program and ensure that states do not enter into "hold harmless" schemes with Medicaid providers to increase their share of federal funds.[27] Florida's Medicaid financing mechanisms are grounded in statute and have been acknowledged and routinely approved by CMS.

MFAR effectively would restrict state access to crucial non-federal share funding streams and introduce significant uncertainty with respect to how CMS would evaluate a state's means of procuring the non-federal share, apparently without any consideration of limitations on CMS' statutory authority or an understanding of the financial and Medicaid program impact.

Among various new proposals, MFAR proposes significant policy changes with respect to Medicaid financing (e.g., restrictions related to the sources of intergovernmental transfers (IGTs) and the permissibility of health care-related taxes (provider taxes) used to fund the non-federal share) and Medicaid fee-for-service (FFS) supplemental payments such as new limits on the amounts of Medicaid practitioner supplemental payments.

Restriction of the Sources of IGTs and CPEs

MFAR would require all IGTs to come from local units of government and be derived from state or local taxes or from funds appropriated to state university teaching hospitals in order to qualify for matching federal funds.[28] MFAR represents a substantial new limitation on the ability of states to use IGTs and would be a substantial change from previous guidance. As a result, government funding from valid sources such as an eligible providers' general funds, operating expenses, and hospital services would no longer be allowed.

Limiting qualifying IGTs to tax revenues (and specified appropriations) will likely pose challenges for many states that have historically received IGTs from public and nonprofit providers that have no taxing authority. In its comment letter to CMS, AHCA wrote that disallowing the use of these funds would "substantially impact all of the supplemental payment programs in Florida" and that "[i]f this provision is finalized in its current form, this would have immediate and negative consequences to Florida's health care safety net and access to critical health care services."[29]

In Florida, there are only 31 special hospital districts for a state of more than 20 million residents, and 14 of those 31 public hospital districts derive their state share of Medicaid dollars solely from other governmental funding sources in place of an ad valorem tax or sales tax (many districts do not have taxing authority under state law).

27 Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, 105 Stat. 1793 (1991) (codified at 42 U.S.C. §1396b(w)).

28 §433.51(b)(2).

29 Florida Agency for Health Care Administration, Comment letter on MFAR, January 31, 2020.

There are 16 hospital districts that levy an ad valorem tax and some hospital districts (e.g., South Broward Hospital District) have been able to significantly lower their millage rate, which positively impacts local taxpayers. There are two hospital districts that assess a sales tax. Table 1 is a comprehensive list of the special hospital districts in Florida and the details of their taxing authority.

There are many special hospital districts in Florida with taxing authority that have been able to save taxpayers money by limiting millage rates or by levying no property taxes at all, relying instead on general funds, operating expenses, and other sources to fund IGTs. Should MFAR take effect, those hospital districts with taxing authority will have little choice but to impose new or increased taxes on Floridians seen throughout the special hospital districts.

Table 1. Taxing Authority of Special Hospital Districts in Florida

Special Hospital Districts	Taxing Authority	If Yes, What Type of Tax Is Levied	Maximum Authorized Millage Rate	Current Millage Rate
Baker County Hospital District	Yes	Ad Valorem	5.00 Mills	1.1366
Campbellton / Graceville	Yes	Ad Valorem		
Gadsden County Hospital	Yes	Ad Valorem		
Halifax Hospital Medical Center	Yes	Ad Valorem		0.3546
Healthcare District of Palm Beach	Yes	Ad Valorem	2.00 Mills	0.7261
Hendry County Hospital Authority	Yes	Ad Valorem		3.37
Indian River County Hospital District	Yes	Ad Valorem	5.00 Mills	0.8011
Lakeshore Hospital Authority	Yes	Ad Valorem	3.00 Mills	0.962
Lower Florida Keys Hospital District	Yes	Ad Valorem	2.00 Mills	0
Madison County Health & Hospital District	Yes	Ad Valorem		
North Broward Hospital District	Yes	Ad Valorem		1.0324
North Lake County Hospital District	Yes	Ad Valorem	1.00 Mills	0.95
Sarasota County Hospital District	Yes	Ad Valorem	2.00 Mills	1.042
South Broward Hospital District	Yes	Ad Valorem	2.50 Mills	0.126
Southeast Volusia Hospital District	Yes	Ad Valorem	4.00 Mills	1.1213
West Volusia Hospital Authority	Yes	Ad Valorem	4.00 Mills	1.908
Bay Medical	No			
Cape Canaveral Hospital District	Yes	None		
Carabelle Hospital Taxing District	No			
Citrus County Hospital Board	Yes	Sales/Lease		
Desoto County Hospital District	Yes	Sales Tax		
Doctor Memorial / Holmes County	No			
George E. Weems Hospital / Franklin	No			
Hamilton County Memorial Hospital	No			
Highlands County Hospital District	No			
Hillsborough County Hospital Authority	No			
Jackson County Hosptial District	No			
Lee Memorial Health Systems	No			
Marion County Hospital District	No			
North Brevard County Hospital District	No			
West Orange Healthcare District	No			

Source: Telephone calls with hospital districts

There are nine special hospital districts that do not have the authority to levy taxes. If MFAR takes effect, those special hospital districts with no taxing authority will no longer have the means to draw down federal matching funds for Medicaid because MFAR requires the state portion of the Medicaid funds to come from local or state taxes. Similarly, the nonprofit hospitals that serve parts of the state that do not have a special hospital taxing district or any public hospital will be excluded.

Of the special hospital districts that do not have taxing authority, four are based in and serve rural areas (i.e., Hospital District for the City of Carrabelle, Franklin County Hospital District, Hamilton County Hospital District, and Highlands County Hospital District). By restricting the current funding mechanisms for state Medicaid dollars on special hospital districts, patients in rural areas will have reduced access to care and the vitality of their local economies will diminish as a result. As of January 2020, there are approximately 27,508 Medicaid beneficiaries living in the four rural special hospital districts.[30] The special hospital districts with no taxing authority will have to decide to either forego participating in the Medicaid program, leaving hundreds of thousands of impoverished Floridians without access to health care or try to gain taxing authority, which hurts the taxpayers as well in these communities.

If taxing authority is ultimately sought in these special hospital districts, the taxes assessed in these rural areas would almost certainly have negative implications on their local economies and taxpayers. Local governments, and especially rural governments, have limited capacity to increase tax revenues without substantially straining taxpayers. Higher tax rates often reduce economic activity, leading to lower tax revenues than expected and raising taxes may not be feasible or desirable during an economic downturn, when citizens are already struggling with job losses, limited income gains, reduced property values, and lower wealth.[31] Putting limitations on how special hospital districts fund their portion of state Medicaid dollars can have an even bigger effect on rural economies in poor rural regions, where unemployment is already high, and poverty is the norm.

Ultimately, MFAR's limitations on the source of funds used to support IGTs is likely to result in either increased local taxation of Florida taxpayers or significant reductions in services to vulnerable Florida Medicaid beneficiaries.

Additionally, MFAR would codify certain regulatory standards for Certified Public Expenditures (CPEs), many of which CMS has abided by informally in the past. Under MFAR, CPE-funded payments made to state government providers or non-state government providers would be capped so that such payments would not be allowed to exceed the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods. It is unclear whether the focus by CMS on "government providers" under MFAR is intended to eliminate the ability of non-provider governmental entities from serving as a certifying entity of a CPE. CMS has previously allowed for CPEs by governmental entities that are not providers. MFAR would

30 Florida Agency for Health Care Administration. Florida Statewise Medicaid MOnthly Enrollment Report. Accessed February 25, 2020 at: https://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml

31 https://www.kansascityfed.org/publicat/mse/MSE_0310.pdf.

also stipulate that the certifying entity of a CPE must receive and retain the full federal financial participation associated with the Medicaid payment. Further, MFAR would require specific cost protocols, attestation processes, and reconciliation requirements be included in the state plan when CPEs are utilized as a source of the non-federal share. The impact of these changes in Florida is uncertain at this time, but it should be noted that several millions of dollars in certified public funds are used to support various Medicaid initiatives in Florida.

New Standards Regarding Provider Taxes Used for the Non-Federal Share

MFAR would significantly broaden CMS' discretion to determine that a "hold harmless" arrangement exists with respect to a provider tax. When a hold harmless arrangement is found to exist, the tax does not qualify as a source of the non-federal share of Medicaid expenditures. MFAR includes new language that would enable CMS to find that a "guarantee" to hold a taxpayer harmless exists where there is a "reasonable expectation" (but not an actual guarantee) that the taxpayer will receive a return of all or any portion of the tax amount. MFAR would allow CMS to consider the "totality of the circumstances" and the "the net effect of an arrangement" when determining whether there is a "reasonable expectation" that a taxpayer will receive back all or part of the taxes it pays. Florida's AHCA expressed concern about how CMS would determine if a reasonable expectation exists and what would constitute a direct guarantee of a return;[32] AHCA specifically identified nine programs[33] that would likely be adversely affected.

These vague and subjective criteria will essentially give CMS nearly unfettered discretion to determine the use of a provider tax as the source of the state's non-federal share is acceptable, making it difficult for the state to be certain of its compliance with federal requirements. Without clear and explicit standards on how CMS would exercise such discretionary authority, there will be a high level of uncertainty regarding the impact of the proposed changes related to provider taxes in Florida.

MFAR proposes a new test for approval of a non-uniform, non-broad-based tax to make sure the test does not impose an undue burden on Medicaid providers or Medicaid services.[34] Currently, when states request waivers of either the broad-based or uniform tax requirements, the tax is analyzed pursuant to objective, quantitative tests.[35] If the tax satisfies the applicable tests and other clearly-defined criteria, CMS grants the waiver.

MFAR would permit CMS to deny a state's waiver request when the tax would otherwise be granted under the current objective, quantitative tests based on a determination that the tax results in an "undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid." MFAR would allow CMS to find an undue burden where a tax excludes or favorably treats a taxpayer group

32 Supra, footnote 2.

33 Low Income Pool, Disproportionate Share Hospital, Physician Supplemental Payment, Graduate Medical Education, Florida Cancer Hospital, Public Emergency Medical Transportation, Multi-Visceral Transplant, Nursing Facility Quality Assessment, and Intermediate Care Facility Quality Assessment.

34 §443.68(e)(3).

35 Commonly referred to as the P1/P2 and B1/B2 tests.

that is "defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group." Such a standard would undoubtedly result in subjective and arbitrary application by CMS, in contrast with the current objective, quantitative tests.

In its comment letter to CMS, AHCA pointed out that these changes could require revisions to the tax structure of Florida's Nursing Facility Quality Assessment, which currently provides for waiver and class exemptions that Florida has negotiated with CMS.[36] In light of the current legitimate provider tax waiver and class exemptions that Florida has negotiated with CMS and that are consistent with the intent of the current test, AHCA deemed the proposed new test to be "too sweeping and unnecessary."

MFAR would also profoundly and adversely impact many skilled nursing facilities and all continuing care retirement communities in Florida. The Florida Health Care Association has estimated based on its analysis that "[t]he impact on the state budget from the changes to the nursing facility quality assessment alone could be over $660 million (over $40 per patient day) if changes to the proposed rule are not made, and that is to say nothing of the state budget pressures that would result in additional Medicaid cuts if other supplemental funding programs are eliminated and the state is forced to backfill these huge budget holes which could total over $1 billion."[37]

Practitioner FFS Supplemental Payment Limitations

Although a supermajority (more than 80 percent) of Florida's Medicaid beneficiaries receive services through the managed care program, supplemental payments to providers to offset base payments set below the cost of providing care though Fee For Service (FFS) arrangements are still an important funding sources for some critical access providers. The MFAR proposal would restrict a state's ability to make these vital supplemental payments. CMS currently allows states to make Medicaid FFS supplemental payments for practitioner services up to Medicare payment amounts or up to the average commercial rate of payments to providers. Citing concerns with respect to average commercial rates calculations, MFAR would prohibit the use of such data for calculating practitioner supplemental payments.

MFAR would implement a new limitation on a state's practitioner supplemental payments based on the FFS base payments authorized under the state plan. Medicaid FFS supplemental payments to practitioners would be limited to 50 percent of the FFS base payments authorized under the state's approved plan for practitioner services. For services provided within Health Resources and Services Administration (HRSA) designated geographic health professional shortage areas (HPSAs) or Medicare-defined rural geographic areas, Medicaid FFS supplemental payments to practitioners would be capped at 75 percent of the FFS base payments authorized under the state's approved plan for practitioner services within a defined geographical area that would otherwise be paid to the targeted practitioners.

36 Florida Agency for Health Care Administration, Comment Letter on MFAR, January 31, 2020.

37 Ibid.

CMS analyzed the impacts of this proposed change on the 21 states that made supplemental payments to physicians and other practitioners in 2017. CMS estimated that this proposed change would result in a reduction in payments of $222 million in total computable Medicaid reimbursement.[38] CMS pointed out that the estimated decrease in Medicaid reimbursements could be reduced if the states took action to mitigate the impact (e.g., increase Medicaid provider base payments). Depending on the extent to which states take mitigative actions, CMS concluded that "the impact on Medicaid reimbursements could range from $0 to $222 million."

MFAR would prohibit the use of the average commercial rate for calculating physician (practitioners) supplemental payments.[39] In Florida, Supplemental payments are paid monthly to medical school faculty physician practice plans at eligible universities. Supplement payments are based on the calculation of the differential amount between the base Medicaid payment and supplemental payment for allowable Current Procedural Terminology (CPT) codes.[40] An average of the payments from the top five commercial payers for each CPT code is used to generate the average commercial rate.[41] MFAR's new limitations would likely force Florida to substantially reduce the supplemental payments it makes to practitioners, as the rates derived from the average commercial rate data used by Florida are substantially higher that the state's FFS base payment rates.

38 CMS, "Medicaid Program, Medicaid Fiscal Accountability Regulation," Federal Register, 84 FR 63722, November 18, 2019.

39 §447.406(c).

40 https://ahca.myflorida.com/medicaid/stateplanpdf/Florida_Medicaid_State_Plan_Part_III.pdf.

41 Ibid.

Uncertain Impacts of MFAR and Lack of Supplemental Payment Data

MFAR includes a number of vague and subjective criteria and affords CMS broad discretion, at the expense of the states, in interpreting and applying these criteria to critical Medicaid decisions (e.g., funding sources of the state's share, governmental character of providers, etc.). MFAR includes vague and undefined terms such as "undue burden," "net effect," and "totality of circumstances," that are to be used by CMS in evaluating permissible state financing arrangements.

These vague standards for determining compliance will make it impossible for a state to know whether its Medicaid program complies with federal requirements. As a result, states will experience a high level of uncertainty regarding the impacts of the proposed changes.

CMS acknowledges in its proposed rule[42] that "[T]he fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown." In its comment letter, AHCA stated that "[I]t is abundantly clear the CMS has not sufficiently assessed the substantial consequences this proposed rule would have on both the providers serving and the recipients relying on Medicaid program services that would be impacted by a myriad of the draft positions."[43]

CMS goes on to say that it does "not currently have the necessary data at the state and provider level to perform adequate analysis and oversight of supplemental payments …."[44]

42 84 FR 63722, Federal Register, November 18, 2019.

43 Florida Agency for Health Care Administration, Comment letter on MFAR, January 31, 2020.

44 *Id.* at 63774.

Despite its admitted lack of fiscal impact analysis and its need for data, CMS is nevertheless attempting to impose dramatic changes that would upend current state Medicaid initiatives and add complexity and uncertainty to the Medicaid supplemental payment funding.

Conclusions and Recommendations

States rely on a mix of general revenue, state and local taxes, and other funding sources to provide the match needed to draw down federal Medicaid funds; the proposed changes through MFAR will make it harder for Florida to finance the Medicaid programs. MFAR adds unnecessary complexity and uncertainty to the Medicaid process, and there is nothing in MFAR that suggests that implementing the proposed revisions will improve patient outcomes.

Although the impact at the individual state level is unknown and will vary significantly, MFAR would force Florida, and nearly every state, to consider cuts in Medicaid program enrollment and covered services. Preempting Florida's authority and reducing the state's flexibility within the Medicaid programs will pressure Florida's state and local policymakers to choose between raising taxes to support the program or decreasing access to health care (along with the downstream effects of potential hospital closures and loss of jobs) across the state. The new rule will likely have significant negative impacts on both the 3.8 million Floridians who rely on Medicaid as their primary or sole source of healthcare coverage and Florida's state budget.

It is clear to Florida TaxWatch that CMS has not sufficiently evaluated the significant adverse impacts MFAR would have on Medicaid providers, Medicaid beneficiaries, state budgets, and (ultimately) the taxpayers.

"… IT IS CLEAR THAT THE IMPACT WILL BE IMMEDIATE AND CRIPPLING."

— Beth Kidder, Deputy Secretary for Medicaid

Florida TaxWatch concurs with AHCA's assessment "that the impact (of MFAR) will be immediate and crippling."[45] Therefore, prior to implementing such drastic and disruptive changes to current Medicaid rules and policy upon which states and providers have relied to design and implement various supplemental payment programs, CMS should first obtain the data necessary to understand the full impact of its MFAR proposals.

Florida TaxWatch recommends that stakeholders urge CMS to not move forward with the finalization of MFAR. Instead, Florida TaxWatch believes CMS should gather more data to understand the impact of its MFAR policies. Once more complete and reliable data are obtained, CMS should seek to identify more narrowly-tailored, evidence-based policies to address its concerns, and work in cooperation with states to determine best practices for how to strengthen accountability and transparency in the Medicaid program.

45 Florida Agency for Health Care Administration, Comment letter on MFAR, January 31, 2020.

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As an independent, nonpartisan, nonprofit taxpayer research institute and government watchdog, it is the mission of Florida TaxWatch to provide the citizens of Florida and public officials with high quality, independent research and analysis of issues related to state and local government taxation, expenditures, policies, and programs. Florida TaxWatch works to improve the productivity and accountability of Florida government. Its research recommends productivity enhancements and explains the statewide impact of fiscal and economic policies and practices on citizens and businesses.

Florida TaxWatch is supported by voluntary, tax-deductible donations and private grants, and does not accept government funding. Donations provide a solid, lasting foundation that has enabled Florida TaxWatch to bring about a more effective, responsive government that is accountable to the citizens it serves since 1979.

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