Medicaid Fiscal Accountability Rule (MFAR) Explained

- Indiana's Medicaid program is financed with federal and state dollars.
    - Federal law provides that states may use up to 60% non-state funds to fund the state share.
    - Indiana is currently financing its state share of Medicaid with:
        - State General Funds (state funds);
        - Health Care Related Taxes, such as the Hospital Assessment Fee (HAF) and Quality Assessment Fee (QAF) (each, non-state funds);
        - Other Local Sources, including:
            - Intergovernmental Transfers (IGT); and Certified Public Expenditures (CPE) (each, non-state funds).
- The MFAR proposed rule ***significantly*** restricts states ability to use these otherwise permissible non-state sources of funds by limiting sources of IGT and placing additional requirements on provider taxes and CPEs.
- The impact would be devastating to the Indiana Medicaid program, healthcare providers, and most importantly the roughly 1.4 million Hoosiers who rely on the program for their healthcare.

Program	Program Description	Current Financing	Proposed Rule Changes	Fiscal Impact (Fed/State $)
Long-Term Care Industry	Medicaid is the primary payor for most individuals in nursing facilities (NF). However, general reimbursement is well below cost, so Indiana has a program to increase Medicaid funding up to the federal upper payment limit (UPL).	Through the NF UPL program, NFs owned by county hospitals receive Medicaid funding equal to what Medicare would pay. The county hospitals, as a non-state governmental entity, are eligible to provide the IGT for the state share of the increased rate.	MFAR limits the definition of non-state governmental entity as well as limits sources of non-state dollars for Medicaid. As a result, most county hospitals would no longer qualify for the NF UPL program. Medicaid reimbursement would drop below costs, resulting in the imminent closure of NFs in the state.	$1.01 Billion ($669M/$341M)
Healthy Indiana Plan (HIP) & Other Medicaid	Indiana expanded Medicaid eligibility for adults with income up to 138% FPL, covering approximately 418,000 adults. To ensure sufficient provider access, HIP reimburses providers at Medicare rates.	The state share of HIP is provided jointly through the cigarette tax and the HAF.	The proposed rule expands the scope of impermissible health care related taxes. The new requirements jeopardize the continuation of the HAF. Per Indiana law, the continuation of HIP is contingent upon the continuation of the HAF.	$4.81B ($3.66B/$1.15B)
Provider Access	There are several programs operating in Indiana that are aimed at improving access to quality healthcare providers serving the Medicaid population.	*QAF*: The quality assessment fee funds enhanced NF rates. It also funds other non-NF Medicaid services. *GME*: The graduate medical education (GME) supports enhanced funding for residency programs and teaching hospitals. *PFAC*: The Physician Faculty Access to Care (PFAC) program provides enhanced funding for faculty physicians.	Due to the limitations in the rule regarding supplemental payments, healthcare related taxes, and sources of IGT, all of these programs are in jeopardy of being eliminated. With reduced Medicaid rates, provider access may be negatively impacted for Medicaid beneficiaries.	QAF $488 Million ($320M/$168M) GME $32 Million ($21M/$11M) PFAC $62 Million ($40M/$22M)

Medicaid Fiscal Accountability Rule (MFAR) Next Steps

An immediate change to Indiana Medicaid financing would be devastating

Supplemental Payments

- Analysis of nursing facility cost reports shows that without these dollars 49 to 152 county operated nursing facilities are at significant risk for closure over a 5-year period as these facilities would have a total negative asset position.
- Proposed rule allows for 2-year window to transition existing supplemental payment programs to a proposed new framework – however the "transition" is not guaranteed by the language of the proposed rule.
- Definitions and other prohibitive language would effectively end the county hospital nursing facility program immediately regardless of updated SPA language or time frames
    - Lead to high risk of immediate facility closures
    - Disruption in patient care
    - Reduced access, including rural communities

Provider Taxes

- The HAF and the QAF are both at-risk due to the proposed rule. If the rule stands then both tax structures would have to be significantly changed first with legislative action. This is due to new language regarding "hold harmless" arrangements for provider taxes, potentially impacting the HAF, and "undue burden" tests concerning entities exempted from provider taxes or those that pay a lower tax rate, which do impact the QAF.
- The proposed rule only provides 3 years to reform current provider tax structures to new tests, and this is not a long enough period – 5 years is a more reasonable time frame if the new tests are to be implemented at all.

Alternatives

- Sunset approach – Need more time than just 2 years to transition.
    - **Proposed Rule Timing -** Proposed rule permits a 2 or 3 year sunset period for state plans depending on the state plan's effective date. Indiana's NSGO NF UPL program will be subject to 2 year sunset period.
        - **Note:** Limitations on State Share of Financial Participation and Inter-Governmental Transfers, Definition of Non-State Government Providers, and UPL Demonstration Methodologies are all effective upon the regulation effective date and are not aligned with the sunset periods. Any sunset in the proposed rule must align all of these definitions with the sunset period for existing state plans.
    - **5 Years Needed –** The proposed rule asks for comments on why longer than 2 or 3 years is needed, offering up to 5 years to be commented upon. Given the administrative burden to the state and providers, and to avoid patient disruption, recommend at least a 5-year sunset period
        - Time for legislature to amend provider tax and other Medicaid financing laws
        - Time for state and industry to plan future of LTC services
        - Align with transition period allowed in 2016 Medicaid managed care rule
- Support proposed transparency requirements into supplemental payment programs
    - Allows policy makers to measure and understand the full intent of the impact of supplement payment programs on access and quality of patient care before making significant changes to those programs.
    - Delay publication of programmatic changes to allow the state and industry to assess impact and respond in a way to mitigate impact to patient safety
- Remove the new tests for provider taxes concerning hold harmless provisions and undue burden tests.
    - Based on analysis of the nursing facility provider tax, the QAF, the total "burden" on Medicaid days from the current, approved, tax structure is a modest 3.7%. This figure comes from analysis of the QAF as if it were a uniform tax per non-Medicare patient day. There is no reasonable correlation to a nominal 3.7% impact on Medicaid days and an undue burden on the Medicaid program as asserted by the proposed rule.