

To: Centers for Medicare and Medicaid Services

From: Manatt Phelps Phillips

Date: April 8, 2016

Subject: Proposed Approach to Funding Expansion in New Hampshire

On March 31, 2016, the New Hampshire Legislature passed legislation authorizing the extension of the New Hampshire Health Protection Program – the State’s Medicaid expansion – for an additional two years. Governor Hassan signed HB 1696 into law on April 4, 2016. The legislation provides that all premium tax revenue attributable to the Medicaid expansion population and any “gifts, grants, donations or any other funding from any source”¹ be deposited into the New Hampshire Health Protection Trust Fund (“Trust Fund”) which is to be used to fund the non-federal share of expansion. The legislation also permits any voluntary provider donations received from “the Foundation for Healthy Communities or any other charitable foundation” to be deposited in the Trust Fund. In the event that the revenue in the Trust Fund is insufficient to cover the non-federal share of expansion, the legislation requires the expansion to terminate.

Issue Presented:

The Centers for Medicare and Medicaid Services (CMS) has expressed concern that provider donations deposited in the Trust Fund, as authorized by the legislation, may not qualify as “bona fide” provider donations, and thus could not be used to draw down federal matching funds. This memo addresses the issue of whether the provider donations contemplated by the New Hampshire expansion legislation (HB 1696) meet the standards for bona fide donations.

Brief Answer:

The use of provider donations as contemplated by the New Hampshire expansion legislation meets all the requirements of the federal provider donation rules; it is also consistent with CMS’ interpretation of similar provisions in the provider tax rules. Thus, the donations should be found to be bona fide and eligible for federal match.

¹ HB 1696 (2016).
Manatt, Phelps & Phillips, LLP
7 Times Square, New York, New York 10036
Telephone: 212.790.4500 Fax: 212.790.4545

April 8, 2016

Page 2

Discussion:

Background on financing the non-federal share of Medicaid Payments through provider donations and taxes

Provider taxes and donations have been and are used to underwrite the costs of state Medicaid programs generally, as well as to fund targeted payments to specified providers. The practice that has long raised issues for federal officials is states' use of provider donations and taxes to fund the non-federal share of enhanced reimbursement or "supplemental payments"² to the same providers that were funding the non-federal share. For example, a group of hospitals would transfer to the state through taxes or donations a sum of money. The state would draw down federal funds to match the hospital funds and pay all or some of the matched dollars back to the hospitals, thereby ensuring the hospitals would receive the value of the donations or taxes they had initially paid to the state plus federal matching funds.

Concern over these types of targeted financing arrangements prompted Congress to sharply limit the use of provider taxes and donations in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.³ The change in law introduced important restrictions on provider taxes or donations and this remains an area of focus for CMS and federal overseers. The GAO has issued a number of reports on provider taxes^{4 5} and CMS continues to wrestle with states' use of provider donations to fund the non-federal share of supplemental payments and special add-ons to the base payment rate, issuing guidance as recently as May of 2014 aimed at clarifying what types public – private partnerships could constitute impermissible provider donations.⁶

Given this backdrop, CMS is closely scrutinizing provider tax and donation arrangements. At the outset it bears noting that the flow of funds established by the New Hampshire legislation

² Supplemental payments take two forms: disproportionate share hospital (DSH) payments and upper payment limit (UPL) payments. Supplemental payments are, by definition, an add-on to regular Medicaid payments to providers. Allocation formulas can be complicated and opaque. Typically, distribution is not connected to a specific service delivered to a specific Medicaid patient or, in most cases, to patient outcomes. For all these reasons, supplemental payments are under increasing scrutiny by CMS, GAO and other federal agencies.

³ Medicaid Voluntary Contribution and Provider-Specific Tax Amendments, Pub. L. No. 102-234.

⁴ GAO, *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, GAO-16-108 (February 2016), available at: <http://www.gao.gov/assets/680/675007.pdf>.

⁵ GAO, *Medicaid Financing: State's Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627 (July 2014), available at: <http://www.gao.gov/assets/670/665077.pdf>.

⁶ State Medicaid Director Letter #14-004, "Accountability #2: Financing and Donations," May 9, 2014.

April 8, 2016

Page 3

bears no resemblance to the situations that has raised concerns for CMS. Moreover, there is little question that states may use provider taxes and provider donations to fund the non-federal share of Medicaid payments as long as such taxes and donations are “bona fide” as defined by the law. The balance of the memorandum focuses on the requirements related to ensuring a bona fide provider donation. Because the restrictions on provider taxes virtually mirror the restrictions on provider donations, we will also consider how these restrictions have been applied in the context of provider taxes (also referred to as assessments and fees).

The provider donations authorized in New Hampshire are “bona fide”

As noted, provider donations are permitted as a source of funding for the non-federal share, provided that they qualify as a “bona fide” donation.⁷ To qualify as a bona fide donation, the provider donation must have no “direct or indirect relationship” to Medicaid payments made to the following:

- The health care provider making the donation;
- Any entity or individual related to, or a supplier of, the health care provider making the donation;⁸ or
- Other providers furnishing the same class of services as the provider or entity (to avoid providers agreeing to “donate” funds for the non-federal share of each other’s Medicaid payments).⁹

A donation is considered to have a direct or indirect relationship to Medicaid payments if the donations are returned to the individual provider, a related entity, or another provider of the same class through a “hold harmless” provision or practice.

A “hold harmless practice” exists if:

1. The donation is **positively correlated with the amount of a non-Medicaid payment**, even if that positive correlation is not consistent over time and even if the correlation is not dollar-for-dollar;

⁷ 42 C.F.R. § 433.54. Providers are also allowed to donate funds to cover the costs of state employees providing Medicaid eligibility determinations on site. 42 C.F.R. § 433.66.

⁸ 42 C.F.R. § 433.52. The preamble to the interim final rule clarifies that this fourth item addresses “suppliers of administrative goods or services” such as, “businesses (*i.e.*, laundry or meal services).” 57 Fed. Reg. 55,118 (Nov. 24, 1992).

⁹ 42 C.F.R. § 433.54.

April 8, 2016

Page 4

2. Any portion of the **Medicaid payment** to the donor, provider class, or related entity **varies only based on the amount of donation**, including if the Medicaid payment is conditional on receipt of the donation; or
3. The State provides for a **payment**, offset, or waiver such that there is, in effect, a **guarantee to return a portion** of the donation (*e.g.*, the State offsets a provider's income taxes to or makes a grant to the provider, in effect, returning a portion of the donation).¹⁰

The language of the hold harmless provision itself as well as the legislative history confirm that the practice the regulations prohibit are "payments" back to the donating providers or class of providers that are correlated to, conditioned on or vary based on the amount of the donations.

The donations authorized in New Hampshire are not returned to or guaranteed to be returned to the donating hospitals or other providers through a targeted payment or any other type of hold harmless practice. Rather the donations to the Trust Fund will be used, along with other funding sources, to cover the cost of premiums for newly eligible adults enrolled in qualified health plans and associated administrative costs. Moreover, the donations will flow through a third party ("the Foundation for Healthy Communities or other charitable foundation") and the State will have no knowledge of which hospitals or other entities donate nor the amount of their donations. Any donations will go into the Trust Fund and will be comingled with other funds, including premium taxes, used to finance the nonfederal share of Medicaid. The legislation specifically provides:

The trust fund shall ... be used solely to provide coverage for the newly eligible Medicaid population... in qualified health plans on the federal marketplace and pay for the administrative costs of the program. The commissioner may accept any gifts, grants or donations or other funding from any source and shall deposit all such revenue received into the fund.

As required by the legislation, monies deposited in the Trust Fund will be used either to fund expansion-related administrative costs or to fund premium payments to commercial carriers (QHPs). The donations go into a Trust Fund and the State uses monies in the Trust Fund to pay the non-federal share of premiums to QHPs. QHPs use the premium dollars to cover the costs of services for its Medicaid enrollees. Some of the services may be rendered by hospitals that donated and some may not, and some hospitals that donated may be in the QHP network and some may not. (The breadth of any one QHP network is determined by the QHP, subject to

¹⁰ The same definition of "hold harmless" is also found in the provider assessment regulations at 42 C.F.R. § 433.68.

minimum network adequacy requirement.) And neither the State nor the QHP will have any information about the source or amounts of any donations deposited into the Trust Fund. To sum up, neither the State nor the QHP will know which providers are donating; the QHP alone decides with which providers it contracts and at what rates; and neither the State nor the QHP will know if the contracted providers are ones that donated or the amounts they donated, if they donated at all. The relationship between any provider donations and payment to a donating provider or a provider class could not be more attenuated.

CMS' interpretation of the provider tax hold harmless rules supports the conclusion that the provider donations in New Hampshire are bona fide

While most of the practice and the regulations in this area focus on provider taxes, the provider donation rules and provider tax rules include nearly identical descriptions of prohibited hold harmless arrangements. In fact, the preamble to the interim final rule implementing the 1991 Medicaid Voluntary Contribution and Provider-Specific Tax Amendments, CMS¹¹ expressly states that CMS had adopted the same definition of “hold harmless” for provider taxes and provider donations, noting that using the same test “establish[es] continuity and consistency.”¹² CMS’s approval of the use of provider taxes to fund the Medicaid program in several states¹³ makes clear that CMS has not previously interpreted the hold harmless language as prohibiting the use of provider funds to finance the non-federal share of the Medicaid program or to limit the use of such funds to finance only the non-federal share of Medicaid administrative costs. Indeed, CMS has approved the use of provider taxes to fund the non-federal share of supplemental payments which are in fact made directly to the same providers paying the tax, a far less attenuated arrangement than the one contemplated by the New Hampshire legislation.

If New Hampshire’s intended use of provider donations violates the ban on hold harmless practices, then in effect no use of provider donations for medical assistance would meet the hold harmless test and it would be impossible for a state to use provider donations for anything but the administrative costs of the state’s Medicaid program. But if that were the case, Congress and CMS could have expressly ended provider taxes and donations or at least limited their use to funding only the non-federal share of administrative costs. Since they did not limit provider donations in this way, it is reasonable to conclude — as CMS has concluded in the context of provider taxes — that under the appropriate circumstances provider donations are permissible sources of funding for the non-federal share of some medical assistance payments.

¹¹ CMS was known as the Health Care Financing Administration at that time.

¹² 57 Fed. Reg. 55,118, 55,1120 (Nov. 24, 1992).

¹³ See, for example, Minnesota’s provider surcharge, Minn. Stat. § 256.9657.

April 8, 2016

Page 6

The fact that the Expansion is contingent on availability of funding does not constitute a hold-harmless practice

CMS also expressed concern that the NH expansion was contingent upon the continued availability of funding of the non-federal share from sources other than the State's general fund. The specific legislative language is as follows:

If the commissioner determines that at any time the sum total of the federal match rate ... and insurance premium tax revenues attributable to the program and revenue from non-general fund sources is insufficient to fully fund the program for newly eligible adults... then [the program] shall be repealed....

It is not uncommon for states to condition optional coverage or optional benefits on the availability of funding, and New Hampshire is no different than other states that have conditioned expansion on the availability of adequate financial resources. As a result of the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* ("NFIB"),¹⁴ as a matter of constitutional principle states are not required to expand Medicaid coverage to include the new adult group. Further, CMS guidance issued in the wake of *NFIB* confirmed that states electing to expand Medicaid could revoke the expansion at any time.¹⁵ Since expansion is optional and may be revoked at the state's discretion, states may decide at the time they elect to expand coverage to also specify the conditions under which they would discontinue coverage for the new adult group. No federal law or regulation prohibits a state from doing so, nor arguably could federal law create such a prohibition given the holding in *NFIB*.

Conditioning expansion on the availability of adequate funding when that funding includes provider donations does not mean that providers are held harmless for the donations by Medicaid payments for the expansion group; it simply ensures that the expansion will not be continued if available funding is not sufficient to cover the costs which is a legitimate legislative objective. Some states have conditioned the expansion on the continued availability of federal funding at the current, statutorily prescribed match rate, while others have conditioned the expansion on the availability of nonfederal financing. Colorado, for example, has expressly conditioned the expansion on the availability of nonfederal funding from provider taxes.¹⁶ And, as is described above, the same hold harmless provisions apply in the provider donation context as with respect to provider taxes. Like Colorado, New Hampshire intends to establish a

¹⁴ 567 U.S. ___, 132 S.Ct. 2566 (2012).

¹⁵ Centers for Medicare and Medicaid Services, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, December 10, 2012, available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>.

¹⁶ See Colorado Rev. Stat. § 25.5-4-402.3 (making expansion "subject to available revenue from the [hospital] provider fee").

April 8, 2016

Page 7

dedicated funding stream for the non-federal share of expansion costs to allay concerns that expansion will compete with other priorities in the State's budget. These provisions do not make specific payments to providers contingent on the receipt of taxes or donations. Providers, of course, have an interest in the perpetuation of the expansion because overall it will provide coverage to tens of thousands of New Hampshire residents and lower uncompensated care costs but that overarching interest in a more robust coverage system does not make donations impermissible. As noted above, in New Hampshire, there is no link between donations made (or not made) by any provider and any specific payments to that provider or the provider's ability to participate in the Medicaid program. Finally, provider donations are only one of several sources of the non-federal share for the New Hampshire expansion.

* * *

For all of these reasons, we believe that the provider donations contemplated in the New Hampshire expansion legislation are fully consistent with the applicable federal rules.

Cc: Jeffrey A. Meyers, Commissioner, DHHS
Maryann Dempsey, Chief Legal Counsel to Governor Hassan