CHAPTER 6

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

Recommendations

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

6.1 As a first step toward improving transparency and facilitating understanding of Medicaid payments, the Secretary should collect and make publicly available non-DSH (UPL) supplemental payment data at the provider level in a standard format that enables analysis.

Key Points

- Non-disproportionate share hospital (non-DSH) supplemental payments, also known as upper payment limit (UPL) payments, account for more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states.
- These payments are not reported to the federal government at the provider level in a readily usable format, and, therefore, it is often not possible to determine total payment to individual providers or the effect of these payments on policy objectives such as efficiency, quality, and access to necessary services.
- MACPAC conducted an analysis of five state Medicaid programs, using data supplied by the states. The analysis shows that:
  - Lump-sum supplemental payments can be a significant source of Medicaid payments, particularly to hospitals.
  - Net Medicaid payments are effectively reduced by the health care related taxes that providers pay.
  - Without data on both health care related taxes and supplemental payments, it is not possible to meaningfully analyze Medicaid payments at either the provider or state level.
- Provider-level non-DSH supplemental payment data would provide greater transparency to Medicaid payments, support program integrity efforts, and facilitate Medicaid payment analysis, including assessments of Medicaid payment adequacy and analysis of the relationship between payment and desired outcomes.

CHAPTER 6

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

The Medicaid program is a major purchaser of health care services, accounting for about $431 billion in benefit spending (not including the territories) in fiscal year (FY) 2013 and representing about 15 percent of national health care spending (OACT 2013). Of this, 65 percent was for fee-for-service (FFS) payments from state Medicaid agencies to providers (MACStats Table 7). Federal statute requires that these Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization (§1902(a)(30)(A) of the Social Security Act (the Act)). Federal statute also provides states with considerable flexibility in determining both provider payments and methods for financing their share of Medicaid spending.[1]

The Commission is charged with examining all aspects of Medicaid payment and the relationships among payment, access, and quality of care. Therefore, it has begun to take a closer look at states' payments to providers and their methods for determining them. In MACPAC's March 2012 report to the Congress, the Commission provided an overview of state approaches to financing their share of Medicaid expenditures and began to explore the interaction between non-federal financing and provider payment policies (MACPAC 2012). In that report, the Commission made two observations. First, statutorily authorized financing approaches, such as health care related taxes, are important to states' ability to finance their Medicaid programs. Second, lump-sum supplemental payments are often a large component of overall provider payments. At the same time, the Commission highlighted that the lack of data regarding states' use of health care related taxes and supplemental payments makes it difficult to analyze Medicaid payments at the federal level.

Over the past year, the Commission continued its examination of the role of non-federal financing approaches and supplemental payments in the Medicaid program,

working directly with five states to better understand Medicaid payments to hospitals and nursing facilities. This analysis confirmed that supplemental payments play an especially important role in Medicaid payment to providers, and that incomplete Medicaid payment and financing data limit policymakers' ability to fully understand spending in the program. For example, in working with state-specific data, we found that supplemental payments can account for more than half of total payments to providers. For this reason, the Commission is now recommending that the Secretary of the U.S. Department of Health and Human Services (HHS) collect certain supplemental payment data at the provider level and make those data publicly available.

For purposes of Medicaid policy analysis as well as oversight and program integrity, federal and state Medicaid policymakers should fully understand what the program is purchasing, and for what amount. The wide variation in state payment and financing methods, combined with limitations in the payment and financing data reported to the federal government, make it difficult to analyze payment and financing both within and across states. Other health care payers, including Medicare, commonly conduct assessments of payment adequacy and compare payment levels across providers and geographic areas. In the Medicaid program, however, despite the fact that the federal government is responsible for the majority of Medicaid spending, existing federal

BOX 6-1. Glossary of Key Terms

Certified Public Expenditure (CPE) – An expenditure made by a governmental entity, including a provider operated by state or local government, under the state's approved Medicaid state plan, making the expenditure eligible for federal match.

Disproportionate Share Hospital (DSH) Payments – Supplemental payments to hospitals that serve a disproportionate share of low-income patients. Payments to each hospital are limited to the actual cost of uncompensated care to Medicaid enrollees and uninsured individuals for hospital services.

Federal Financial Participation (FFP) – Federal matching funds provided to a state for Medicaid expenses.

Health Care Related Tax – A licensing fee, assessment, or other mandatory payment that is related to health care items or services; the provision of, or the authority to provide, the health care items or services; or the payment for the health care items or services. A tax is considered to be related to health care items or services if at least 85 percent of the burden of the tax revenue falls on health care providers.

Intergovernmental Transfer (IGT) – A transfer of funds from another governmental entity (e.g., counties, other state agencies, providers operated by state or local government) to the Medicaid agency.

Supplemental Payment – A Medicaid payment to a provider, typically in a lump sum, that is made in addition to the standard payment rates for services. Includes both UPL payments and DSH payments for uncompensated care.

Upper Payment Limit (UPL) – The maximum aggregate amount of Medicaid payments that a state may make to a class of institutional providers.

UPL Payment – A supplemental payment to a Medicaid provider based on the difference between the amount paid in standard payment rates and the UPL.

data sources are not sufficient for comparable analyses of the effects of state payment methods and rates on policy goals such as efficiency, quality, and access to necessary services. This is of particular importance at a time of growing interest in payment reforms that incentivize greater value in the delivery of health services and, thus, a need for data to both design and evaluate these approaches.

This chapter begins with background information regarding supplemental payments and health care related taxes and then describes the Commission's analysis of state-supplied data in detail. It then raises several policy questions about the balance between providing flexibility to states in designing payment and financing methods and offering accountability to the federal government for how Medicaid dollars are used. The chapter concludes with discussion of the Commission's recommendation for improved federal collection of provider-level supplemental payment data as an important first step toward greater understanding of Medicaid payments to providers, and the need for continued examination of related issues, including states' approaches to financing their programs.

Background

The federal Medicaid statute affords states considerable flexibility both in how they finance their Medicaid programs and in how they pay providers. Both health care related taxes and supplemental payments are allowable under federal Medicaid requirements and both are used by the vast majority of states.[2] However, as the Commission previously noted, there is little systemic information on how such taxes and payments flow through the system, making it difficult to assess Medicaid payments within and across states.

Supplemental payments

Some states make payments to providers above what they pay for individual services through Medicaid provider rates. These additional payments fall into two categories:

- disproportionate share hospital (DSH) payments to hospitals serving low-income patient populations, which accounted for about $16 billion (including federal matching funds) in FY 2013; and
- upper payment limit (UPL) supplemental payments, which comprise the difference between total base Medicaid payments for services and the maximum payment level allowed under the regulatory UPL for those services. States reported about $24 billion (including federal matching funds) in these payments in FY 2013.

DSH payments. Medicaid DSH payments are statutorily required payments to hospitals serving low-income patient populations. They are intended to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients. In FY 2013, Medicaid DSH payments accounted for about $16 billion total (including federal matching funds). Each state is allotted DSH funding according to a statutory formula, generally based on historical DSH spending levels increased to account for inflation (§1923(f)(3)(B) of the Act). Approximately $11.5 billion in federal funds were allotted to states for DSH in FY 2013, and state allotments ranged from about $10 million or less in four states (WY, DE, ND, and HI) to over $1 billion in three states (CA, NY, and TX) (CMS 2013a).

In 2010, with the passage of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the Congress reduced state DSH allotments from FY 2014 to FY 2020 to account for the decrease in uncompensated care anticipated

under the health insurance coverage expansions to begin in 2014. The onset of the reduction was later delayed to FY 2016, and the reduction was extended to FY 2023 in the Bipartisan Budget Act of 2013 (P.L. 113-67).

State distribution of Medicaid DSH funding to hospitals is subject to two rules. First, hospitals meeting specified minimum criteria must be included in the distribution. Second, federal statute limits the amount of DSH payments that a state can make to any single hospital (§1923(g) of the Act). In general, DSH payments may not exceed a hospital's uncompensated costs of providing inpatient and outpatient hospital services to Medicaid and uninsured patients, known as the hospital-specific DSH limit.[3] Within these limitations, states have broad flexibility in determining which hospitals receive DSH payments and how the payments are calculated. This flexibility results in significant variation across states, with some providing DSH payments to relatively few hospitals and others providing DSH payments to nearly all of the hospitals in a state (Mitchell 2012).

Non-DSH supplemental payments. Federal regulations, first promulgated in 1981, prohibit federal financial participation (FFP) for Medicaid FFS payments in excess of an upper payment limit, intended to prevent Medicaid from paying more than Medicare would pay for the same services. Rather than applying a UPL on a claim-by-claim basis, however, the regulations limit the aggregate amount of Medicaid payments that a state can make to a class of providers.[4] The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, intermediate care facilities for persons with intellectual disabilities (ICFs/ID), and freestanding non-hospital clinics. Separate UPLs apply to three separate ownership categories (governmentally operated, non-state governmentally operated, and private) for each provider type.

When FFS Medicaid rates result in aggregate provider payments that are lower than the UPL, some states make supplemental payments (UPL payments) to providers. In determining whether and how much money to allocate to UPL payments, states start by calculating the difference between the UPL for services provided by a class of institutions and the aggregate amount Medicaid paid for those services under FFS. States then target the amount of the difference—or some portion of it—to a subgroup of institutions, allocating it among eligible institutions based on state-defined criteria that sometimes, but not always, include Medicaid days, visits, or discharges.

Hospitals receive the large majority of supplemental payments (Table 6-1). Such payments may be an especially important source of revenue for hospitals that serve a significant proportion of Medicaid enrollees and uninsured individuals. Some states also make supplemental payments to physicians, typically those employed by state university hospitals. Although there is not a federal regulation that establishes a UPL for such non-institutional providers, the Centers for Medicare & Medicaid Services (CMS) has indicated that Medicare rates and average commercial rates for physician services may be used as upper limits (CMS 2013b).

UPL payments are subject to the same broad federal requirements as most Medicaid payments. If a state makes UPL payments, the payment methodology must be documented in the Medicaid state plan, subject to CMS approval. UPL payments are not required to be tied to specific policy objectives in the same manner as, for example, DSH payments are tied to uncompensated care. However, CMS has indicated that, as part of an oversight initiative that began in 2003, state plans must demonstrate a link between supplemental payments and general Medicaid purposes (GAO

2008). In response to comments on changes in the UPL regulations in 2001, CMS specifically stated that the UPL for institutional payments applies only to FFS payments, and that managed care payments are subject to separate regulatory requirements (HCFA 2001) (Box 6-2).

TABLE 6-1. Upper Payment Limit (UPL) Supplemental Payments Reported on CMS-64, Fiscal Year 2013 (Millions)

Provider Type	UPL Payments	Total Medicaid Payments (including DSH)	Percent of Total Medicaid Payments (including DSH)
Hospitals (inpatient and outpatient)	$20,598.8	$89,465.4	23%
Nursing Facilities/ Intermediate Care Facilities for Persons with Intellectual Disabilities	$2,393.8	$62,953.8	4%
Physicians and Other Practitioners	$846.3	$13,163.5	6%

Source: MACStats, Table 20.

BOX 6-2. The Interaction between Upper Payment Limits (UPLs) and Medicaid Managed Care

The ability to make UPL supplemental payment policies has important implications for states' decisions regarding the use of Medicaid managed care (MACPAC 2012, MACPAC 2011). Since UPLs are computed based only on fee-for-service (FFS) days in a hospital or other institutional setting, transitioning populations from FFS to managed care means fewer FFS days and lower potential UPL supplemental payments.

As states increasingly turn to managed care delivery models for broader groups of Medicaid enrollees, FFS payments for acute and long-term care services are declining, along with the amount of UPL supplemental payments that states may make to providers. If the shift in inpatient days from FFS to managed care is large enough in a particular state, the loss of federal matching dollars for UPL payments may outweigh the savings the state realizes through managed care. Furthermore, since higher-cost populations, such as individuals with disabilities, account for a significant share of hospital days, transitioning these populations into managed care has the most significant effect on the UPL.

States' decisions to implement or expand Medicaid managed care have been influenced by the potential loss in federal matching dollars for supplemental payments. Some of these states (e.g., California, Florida, Texas) have received Section 1115 demonstration waiver authority to allow for the continued use of supplemental payments while expanding the use of Medicaid managed care. In the 1115 waivers that have been approved by the Centers for Medicare & Medicaid Services, states' supplemental payments have been contingent upon additional requirements that do not typically apply to FFS UPL payments. For example, payments from uncompensated care pools created under the waivers may not exceed the cost of uncompensated care as defined for disproportionate share hospital payments, while payments from delivery system reform incentive pools have been contingent upon providers' achieving metrics related to delivery system improvements.

While the mechanisms for targeting providers vary by state, UPL payments are generally allocated to providers based on their relative number of Medicaid days or discharges or as an equal share of a fixed amount (Bachrach and Dutton 2011). These payments are not subject to provider-specific limits and, therefore, individual providers may receive more than their reported Medicaid costs as long as the aggregate payments to all providers in their class do not exceed the aggregate UPL.[5]

Health care related taxes

States generate their share of Medicaid spending through a combination of sources, including state general revenue, contributions from local governments (including providers operated by local governments), and other revenue sources such as health care related taxes. As long as a state operates its program within federal requirements, it is entitled to receive federal matching funds toward allowable state expenditures.

According to a recent survey, every state but Alaska has at least one health care related tax in place as of state fiscal year (SFY) 2014 (Smith et al. 2013). In general, health care related taxes (sometimes referred to as provider taxes, fees, or assessments) are defined by federal statute as taxes of which at least 85 percent of the tax burden falls on health care providers (§1903(w)(3)(A) of the Act).[6] The statute includes several other requirements, including that such taxes be broad-based and uniform and that providers cannot be held harmless through increased Medicaid payments.[7]

These taxes are commonly used by states to:

- fund the non-federal share of supplemental Medicaid payments for the classes of providers that pay the tax;
- increase or avert reductions in Medicaid rates; and
- finance other areas of the Medicaid program, including enrollment expansions.

Federal regulations specify that states may assess health care related taxes on 18 separate provider classes (42 CFR 433.56). They are most commonly assessed on nursing facilities (44 states), hospitals (40 states), ICFs/ID (37 states), and managed care organizations (12 states) (Smith et al. 2013). Use of health care related taxes has increased over the past decade, likely due, at least in part, to declines in other state revenues during a period of economic downturn. In 2008, 18 states had a hospital tax, compared to 40 states in state fiscal year (SFY) 2014.

The total amount of non-federal Medicaid share raised through health care related taxes and other local government contributions known as intergovernmental transfers (IGTs) and certified public expenditures (CPEs) was estimated to be about $41 billion in SFY 2012, accounting for about 24 percent of non-federal Medicaid spending (NASBO 2012). While the total amount of health care related tax revenue is uncertain, those states that reported revenue on the CMS-64 reported $23.0 billion for FY 2013.[8] A recent survey asked all states to estimate the proportion of their non-federal Medicaid share that is financed through provider taxes. Among the 30 states that responded, estimates ranged from less than one-half of 1 percent to slightly more than 40 percent (Smith et al. 2013).

Insufficient data on health care related taxes and supplemental payments complicate Medicaid payment analysis

All health care payers should know what they pay, to whom, and for what. This information allows payers to assess whether payments are set at appropriate levels and to evaluate the effects of payment on the delivery of services, including, for example, effects on service integration, enrollee access, and quality. For the Medicaid program, the primary statutory obligation is to assure consistency with efficiency, economy, quality,

and access to care. At the federal level, this has historically been addressed through review of payment methods outlined in Medicaid state plans and through enforcement of aggregate UPLs.

Analyzing whether Medicaid payments are consistent with efficiency, economy, quality, access, and appropriate utilization requires an understanding of net Medicaid payment—the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures. Currently, however, there are insufficient data at the federal level to determine provider-specific net Medicaid payments and by extension, the relationship of payment to program objectives. This is because neither UPL supplemental payment data nor data regarding provider-contributed non-federal Medicaid share (e.g., health care related taxes, IGTs, CPEs) are reported to the federal government at the provider level in a readily usable format.

Supplemental payment data. States are required to submit claims-level Medicaid data to the federal government each quarter. However, because supplemental payments are typically paid in lump sums, they are not included on claims. As of FY 2010, states are required to report the aggregate amount of UPL supplemental payments on the CMS-64, but not the providers that receive them nor their specific amounts. Thus, it is not possible to determine or compare the total amount of Medicaid payments to individual providers nor what those payments are for.

In March 2013, CMS issued guidance in a State Medicaid Director letter requiring states to demonstrate their compliance with UPL requirements annually, including provider-level reporting of non-DSH supplemental payments (CMS 2013c). Beginning in 2013, states must submit these UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. Beginning in 2014, states will also be required to submit annual UPL demonstrations for clinics, physician services (for states that make targeted physician supplemental payments), ICFs/ID, private residential treatment facilities, and institutes for mental disease.

The UPL demonstration data will be collected by CMS regional offices and maintained separately from other Medicaid payment data. At this time they are not required to be submitted in a standardized format and are not expected to be available for analysis outside of CMS. While these data will allow CMS to assure compliance with UPL regulations and may provide them with an improved understanding of total Medicaid payments at the provider level, it may not be possible for analysts to combine these supplemental payment data with claims-based data, such as those in the Medicaid Statistical Information System (MSIS), to obtain complete and consistent total Medicaid payments by provider.

Since MACPAC first discussed this issue in its March 2012 report, the U.S. Government Accountability Office (GAO) has also reported that federal Medicaid payment data sources provide incomplete and inconsistent information regarding program expenditures (GAO 2012a). The GAO further recommended that:

- CMS issue guidance to states on permissible methods for calculation of non-DSH supplemental payments;
- CMS issue facility-specific reporting requirements for non-DSH supplemental payments as is required for DSH;[9] and
- non-DSH supplemental payments be subject to an annual independent audit as is the case for DSH (GAO 2012b).

In response, CMS agreed about the need to improve reporting and oversight of non-DSH supplemental payments and noted that supplemental payments

are subject to CMS' oversight through the state plan amendment (SPA) process. CMS also indicated that it was scrutinizing supplemental payment methods in approved SPAs and identifying states that are not reporting aggregate supplemental payment amounts on the CMS-64.

Health care related taxes. There are no consistent reliable national data on health care related tax rates and amounts of revenue generated at either the provider or state level. Health care related taxes effectively reduce the amount of Medicaid payment actually received by providers. Therefore, if health care related tax revenue is used to finance provider payments, it may be misleading to compare these payments to those that are not financed, in any part, by these taxes.

Health care related taxes and supplemental payments often, but not always, go hand in hand. In many cases, health care related taxes are used as the source of non-federal financing for supplemental payments to the providers that pay them. At the same time, health care related taxes can also be used to finance claims-based payments to these providers or to finance other types of state Medicaid spending or other state activities. Supplemental payments may also be financed through other sources of non-federal share (e.g., general revenue, IGTs, or CPEs). Unless specified by state law or policy documentation, it can be difficult to know the types and amounts of Medicaid payments that are financed through particular types of revenue (e.g., health care related taxes and IGTs).

Understanding Medicaid Payments to Hospitals and Nursing Facilities: State Analysis

MACPAC conducted an analysis of five state Medicaid programs, using data supplied by the states, to demonstrate the effects of provider-contributed financing (such as health care related taxes) and supplemental payments on net Medicaid payments to hospitals and nursing facilities. MACPAC asked selected states to participate in this study based on a number of factors, including their use of supplemental payments and health care related taxes, the size of the state, and geographic region. Provider-specific payment and financing data were requested and interviews were conducted with Medicaid officials in each of the states to better understand their payment and financing policies and to provide context for the data.

The analysis focused on FFS payments for hospital and nursing facility services but did not examine managed care arrangements. It included hospitals and nursing facilities because both are frequently subject to health care related taxes (40 states impose a hospital tax, 44 states impose a nursing facility tax, and 39 states impose both (Smith et al. 2013)), and both are subject to UPLs. All five states agreed to participate anonymously in order to allow MACPAC to analyze actual state data without drawing policy conclusions specific to individual state programs. The five states selected used a variety of rate-setting practices, supplemental payment approaches, and non-federal financing sources.

Methods

Interviews with state officials. Interviews were conducted with Medicaid officials in each of the five study states in order to better understand each state's payment and financing methodologies. Interviews focused specifically on the following topics:

- rate-setting methodologies for inpatient hospital services, outpatient hospital services, and nursing facilities;
- health care related taxes assessed on inpatient hospital services, outpatient hospital services, and nursing facilities, including the amount and basis of the tax and the use of revenue generated;

- IGTs or CPEs used by the state to finance the state matching share for hospital and nursing facility services;
- payments made to hospitals and nursing facilities outside the rate itself, including DSH and non-DSH supplemental payments;
- anticipated policy developments regarding provider payments and financing approaches; and
- state-specific issues that led to current payment and financing policies and perspectives on the strengths and weaknesses of their approach.

Data. States supplied provider-specific payment and financing data for dates of service July 1, 2011, to June 30, 2012, including data related to:

- Medicaid claims;[10]
- supplemental payments, as well as the intended purpose of the supplemental payments;
- non-federal Medicaid share contributed by providers, including through health care related taxes, IGTs, and CPEs;
- provider characteristics, including ownership type (state, non-state public, private for-profit, private non-profit) and urban and rural designation;
- provider cost data; and
- supplemental documentation regarding payment and financing policies and data.

Four of the five states were able to provide the requested data for analysis of the effect of supplemental payments and non-federal financing on net provider payment. These data, along with hospital and nursing facility Medicare cost reports collected for this study, were also used to estimate payment-to-cost ratios for providers in each of the four states. Data were analyzed as reported by the states; no attempts were made to audit or independently verify the information.

Metrics for state comparison. A primary goal of this project was to illustrate the difference between claims-based Medicaid payment and net Medicaid payment, which takes into account both supplemental payments and the provider-contributed non-federal share. The following metrics were determined to be most appropriate for comparison of net payments across states:

- hospitals: payment per unduplicated recipient served for inpatient and outpatient services combined;[11] and
- nursing facilities: payment per resident day.

For both hospitals and nursing facilities, payment-to-cost ratios were also estimated with and without supplemental payments, in order to illustrate the extent to which this measure is affected by supplemental payments.

This project focused solely on Medicaid payments and associated Medicaid costs (as estimated using Medicare cost reports). Unless otherwise noted, results are presented for total payment excluding DSH payments. This is because DSH payments are intended to account for both unpaid Medicaid costs and the costs of serving the uninsured. For this project, it was not possible to identify the portion of DSH payments attributable to unpaid Medicaid costs and, therefore, including them would have included payment for, at least in part, the costs of services to the uninsured.

Limitations of the data and associated metrics. MACPAC selected a small number of states because of the considerable effort required to obtain and understand each state's data. The results, therefore, are illustrative but may not be generalizable across all state Medicaid programs. Also, the data themselves have a number of limitations, including:

- inconsistency between claims and cost report time periods;

- inability to standardize payments for case mix; and
- uncertainty regarding reliability and consistency of cost reporting (e.g., whether or not health care related taxes are included).[12]

There are also other differences among state Medicaid programs that affect net FFS provider payments in the aggregate and per recipient, per discharge (for inpatient hospital), per visit (for outpatient hospital) and per day (for nursing facility). These include, for example, state eligibility levels for Medicaid and the acuity and service use of the enrolled population. States with higher acuity enrollees might be reasonably expected to spend more per person for hospital services than states with a higher proportion of enrollees with fewer health care needs. Payments might also be affected by the extent to which enrollees are enrolled in Medicaid managed care plans and the types of utilization controls that a state has in place (e.g., cost sharing, prior authorization, service limits), among other factors.

Finally, it is important to mention that MACPAC originally assumed that the entire amount of health care related taxes could be subtracted from Medicaid payments for the purpose of estimating net Medicaid payments. Health care related taxes are generally used to support Medicaid expenditures and, therefore, for this project we chose to subtract the full amount contributed by providers from their total Medicaid payments. However, as discussed previously, it is not necessarily the case that such taxes are used entirely to finance payments back to the contributing providers. Thus, it is not possible to determine the portion of Medicaid payments to providers that are financed with health care related taxes. This is one reason why the Commission is choosing to focus its recommendation on non-DSH supplemental payments and intends to continue to examine health care related taxes in the future.

State payment and financing policies

Payment methodologies. Four of the five states selected for this analysis make payments to hospitals for inpatient services using a diagnosis-related group (DRG)-based methodology (as do 35 states nationally (Xerox 2013)). DRG-based methodologies typically pay hospitals a per discharge amount based on the diagnoses that are the reason for the hospital stay. The fifth state currently makes a tiered per diem payment but is contemplating conversion to DRGs (Table 6-2). Each DRG system, however, had numerous state-specific features (Box 6-3).

For outpatient services, the five study states used a variety of payment methodologies, including calculating payment based on a hospital's cost-to-charge ratio, fee schedules, and ambulatory classification groups (Table 6-2). This appears consistent with the variation at the national level, with 15 states using ambulatory care groups, 13 using fee schedules, and 23 paying based on providers' reported costs, typically via cost-to-charge ratio (Xerox 2013).

Nursing facility payment systems were similar across the study states. Each calculates per diem rates based on reported costs, and each adjusts the direct care and nursing components of the rate based on patient acuity. However, there were significant differences among the states, for example, in the ceilings applied to each of the cost centers, the use of cost settlement, definitions of allowable costs, the manner of paying for capital expenses, and the number of acuity groups used for adjustment (Table 6-3).

Non-federal financing. All five states collect health care related taxes from nursing facilities, and four collect health care related taxes from hospitals. In addition, in several of the states, publicly owned and operated providers contribute non-federal Medicaid share through IGTs, and others certify

TABLE 6-2. Summary of Hospital Payment and Financing in Study States

State	Inpatient	Outpatient	Financing	Non-Disproportionate Share Hospital Supplemental Payments
One	Diagnosis-related group (DRG)	Combination of cost-to-charge ratio (CCR) and fee schedule	Health care related tax on both inpatient and outpatient charges; limited use of certified public expenditures (CPE)	UPL payments, including some based on quality incentives
Two	DRG	Combination of fees and ambulatory care groups	Health care related tax on both inpatient and outpatient gross receipts; limited use of intergovernmental transfers (IGTs)	UPL payments, payments for graduate medical education (GME), and for safety-net tertiary and rural providers
Three	Provider-specific rate per discharge, adjusted using DRGs	Ambulatory care groups	Health care related tax on net operating revenue	Limited supplemental payments for graduate medical education
Four	Tiered per diem	Combination of fees, ambulatory care groups, and CCR	Significant use of both IGTs and CPEs by public providers	UPL payments, payments for GME, behavioral health services, and services to low-income individuals
Five	DRG	Ambulatory care groups	Health care related tax per day; CPEs	Variety of payments, including those for high Medicaid volume, safety net providers, tertiary care, and trauma centers, among others

Notes: Identifies the most prominent base payment methodology, but there are commonly exceptions for particular types of providers (e.g., psychiatric hospitals, critical access hospitals) and services (e.g., neonatal intensive care units). UPL payments refers to non-disproportionate share hospital supplemental payments for which state officials did not identify specific purposes.

Source: Burns & Associates analysis for MACPAC.

their direct spending on Medicaid services as eligible for federal match through CPEs.

States reported a variety of uses for health care related tax revenue (Table 6-4). These ranged from very broad—such as general Medicaid financing—to specifically targeted purposes such as supporting mental health capacity in emergency departments. The proportion of tax revenue that is used for each of the purposes is not known. As mentioned previously, for the purposes of this analysis, MACPAC assumed that the entire amount of health care related taxes paid could be subtracted from Medicaid payments in order to estimate net Medicaid payments.

BOX 6-3. State-Specific Features of Diagnosis-Related Group (DRG) Hospital Payment Methods in Study States

Policy Features

- Payment for readmissions (e.g., within 7, 10, or 30 days)
- Certain hospitals excluded from DRG methodology
- Treatment of out-of-state hospitals
- Payment for transfers among hospitals or distinct units
- Payment for short stay or same-day discharges
- Payment for psychiatric services
- Payment for substance abuse services
- Payment for rehabilitation services
- Payment for transplants
- Payment for nursery and neonatal intensive care unit

Technical Features

- Type of DRG grouper and included updates
- Basis of relative weights (e.g., costs based on claims or charges)
- Peer groups
- Frequency of rebasing
- Inflation indices and timing
- Source of average cost per discharge (e.g., claims or cost reports)
- Treatment of capital expenses
- Treatment of graduate medical education
- Outlier criteria and payment
- Special pricing for specific DRGs

Source: Burns & Associates analysis for MACPAC.

TABLE 6-3. Summary of Nursing Facility Payment and Financing in Study States

State	Method	Financing	Supplemental Payments
One	Prospective per diem with case mix adjustment	Health care related tax per non-Medicare day calculated monthly; public facilities use certified public expenditures (CPEs)	Upper payment limit (UPL) payments, including for quality incentives and treating complex patients
Two	Prospective per diem with case mix adjustment	Health care related tax on gross receipts; limited use of CPEs by state-owned facilities	None
Three	Prospective per diem with case mix adjustment	Health care related tax on net operating revenue; limited use of CPEs.	None
Four	Prospective per diem with case mix adjustment	Health care related tax per bed day	None
Five	Prospective per diem with case mix adjustment	Health care related tax per patient day; CPEs	None

Note: UPL payments refers to non-DSH supplemental payments for which state officials did not identify specific purposes.
Source: Burns & Associates analysis for MACPAC.

TABLE 6-4. Uses of Health Care Related Taxes in Study States

Hospital Tax	Nursing Facility Tax
Payment rate increases (or avoidance of payment reductions) Upper payment limit supplemental payments General Medicaid program financing Quality incentives	
Eligibility expansion	Pay-for-performance
Support emergency department mental health capacity	Payments for high resident acuity
Support inpatient psychiatric capacity	Payments for residents with mental illness, dementia, or brain injury
Support hospitals with high Medicaid utilization	Change management

Source: Burns & Associates analysis for MACPAC.

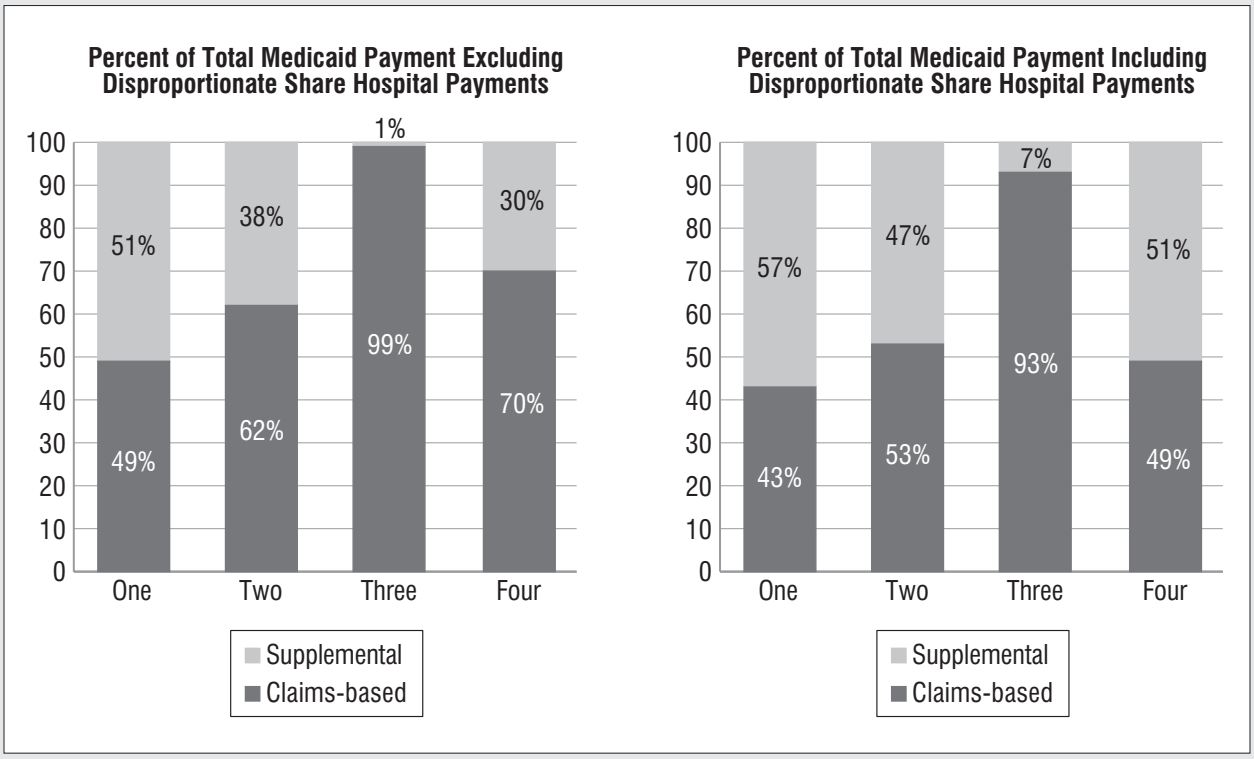
Findings

In each of the states that were able to provide data, net payments to hospitals and nursing facilities were substantially different from payments based on claims alone. In three of the four states studied, supplemental payments represent a large portion of total Medicaid payment (Figure 6-1). For example, even when DSH payments are excluded, non-DSH supplemental payments account for between 30 and 51 percent of total Medicaid payment in three of the four states.

These results show why both health care related taxes and supplemental payments are important to Medicaid payment analysis. In State Three, for example, non-DSH supplemental payments are only about 1 percent of total FFS Medicaid payment. As a result, claims-based payment metrics should be reasonably reflective of the actual amount that hospitals receive from Medicaid. However, after accounting for the non-federal share that hospitals contribute through a health care related tax, the net Medicaid payment to State Three hospitals is only 89 percent of that which is indicated by claims data (Table 6-5). In State Two, however, both supplemental payments and health care related taxes play important roles. Claims-based payments represent only about 62 percent of total payments to hospitals and, because hospitals in State Two also contribute a large amount of non-federal share, net payment is only about 77 percent of the total payment.

Both supplemental payments and provider-contributed financing also have significant effects on comparative analyses of Medicaid payments in the examined states (Table 6-5). Based on claims data alone, State Three paid nearly $3,300 per recipient served by hospitals, a figure that is $400 higher than State Two and approximately double the amounts paid by States One and Four. After including supplemental payments, however, State Three is only the third-highest payer and pays about $1,400 less per recipient than State Two. After accounting for non-federal share contributed by the hospitals, the picture changes yet again. Hospitals in States One and Two contribute more than $1,000 in health care related taxes per

FIGURE 6-1. Proportion of Claims-Based and Supplemental Payments to Hospitals in Each Study State, Including and Excluding DSH Payments (SFY 2012)



Source: Burns & Associates analysis for MACPAC.

recipient served, while State Three's hospitals are taxed at a rate of about $367 per recipient. State Four does not have a health care related tax on hospitals, but government-owned providers contribute non-federal share through IGTs and CPEs. While significant differences remain among the states after accounting for these financing arrangements, the differences in Medicaid payment across states are somewhat moderated.

For nursing facilities, only State One makes supplemental payments. Thus, for the other three states, total Medicaid payments are identical to claims-based payments. All four states, however, assess health care related taxes on nursing facilities, resulting in net Medicaid payments that are 9 to 17 percent lower than total payments (Table 6-6).

Cost coverage of hospitals and nursing facilities. The ratio of payment to cost is a common measure of payment adequacy, allowing policymakers to consider payment levels relative to the cost of providing care. For this analysis, payment-to-cost ratios were estimated with and without non-DSH supplemental payments to demonstrate the effect that these payments can have on results. It is important to note that payment-to-cost ratios depend heavily on the method used to determine provider costs. Furthermore, reported costs may or may not reflect efficient service delivery. Thus, while payment-to-cost ratios are a useful benchmark, they alone may not be sufficient to fully assess the appropriateness of payment. Because of the data limitations described previously, as well as the use of Medicare cost reports to estimate Medicaid costs, this analysis was not intended as an assessment of payment adequacy in

TABLE 6-5. Comparison among Average Claims-Based, Total, and Net Medicaid Payment to Hospitals across Four Study States (SFY 2012)

	State			
	One	Two	Three	Four
Claims payment per recipient	$1,886	$2,878	$3,278	$1,512
Supplemental payment per recipient	1,985	1,799	36	652
Total payment per recipient	3,872	4,677	3,315	2,165
Claims payment as a percent of total payment	48.7%	61.5%	98.9%	69.9%
Health care related tax paid per recipient	$1,542	$1,044	$367	$0
Intergovernmental transfers/certified public expenditures paid per recipient	18	16	0	208
Net payment per recipient	2,311	3,618	2,948	1,957
Difference between total payment and net payment	1,560	1,059	367	208
Net payment as a percent of total payment	59.7%	77.3%	88.9%	90.4%

Source: Burns & Associates analysis for MACPAC.

TABLE 6-6. Comparison among Claims-Based, Total, and Net Medicaid Payment to Nursing Facilities across Four Study States (SFY 2012)

	State			
	One	Two	Three	Four
Claims payment per diem	$77	$203	$90	$126
Supplemental payment per diem	12	0	0	0
Total payment per diem	88	203	90	126
Claims payment as a percent of total payment	86.8%	100%	100%	100%
Health care related tax paid per diem	$6	$17	$14	$11
Intergovernmental transfers/certified public expenditures paid per diem	2	3	0	0
Net payment per recipient	81	183	75	115
Difference between total payment and net payment	8	20	15	11
Net payment as a percent of total payment	91.4%	90.0%	83.6%	91.3%

Source: Burns & Associates analysis for MACPAC.

TABLE 6-7. Medicaid Payment to Cost Ratios with and without Supplemental Payments (SFY 2012) across Four Study States

	Payment-to-Cost Ratio (Claims-Based Payment)				Payment-to-Cost Ratio (Total Payment)			
	State One	State Two	State Three	State Four	State One	State Two	State Three	State Four
Hospitals	40%	49%	117%	60%	83%	80%	118%	86%
Nursing facilities	98	92	77	79	113	92	77	79

Note: Medicaid costs include both the cost of Medicaid services (using the claims provided by the states and hospital-specific cost-to-charge ratios (CCRs) calculated using Medicare cost report data), as well as any non-federal Medicaid share contributed by the provider. When establishing a CCR, the actual assignment of costs can vary and lead to different results. For example a total facility CCR, revenue center-specific CCRs, or different CCRs for inpatient and outpatient services, among others, all may lead to different results. Therefore, the cost coverage values shown in this table should be considered estimates due to the variability in the costing methodologies that can be employed. SFY is state fiscal year.

Source: Burns & Associates analysis for MACPAC.

the participating states and should not be considered reflective of Medicaid payment adequacy in general.

For hospitals in the study states, the estimated payment-to-cost ratio can differ dramatically depending on whether supplemental payments are included (Table 6-7). The three states that make supplemental payments to hospitals had estimated payment-to-cost ratios of 40, 49, and 60 percent based on claims payments alone. Including supplemental payments, these same states were estimated to cover 83, 80, and 86 percent of their hospitals' Medicaid costs—ratios that are far more similar than claims-based payments alone would suggest. Cost coverage in State Three, which generally does not make lump-sum supplemental payments, does not change when supplemental payments are included, yet remains the highest of the four states by far.

Unlike for hospitals, cost coverage for nursing facilities generally did not vary when including supplemental payments. As discussed earlier, only State One makes lump-sum supplemental payments to nursing facilities, accounting for the significant increase in cost coverage when such payments are included (Table 6-7).

Interpreting the results

This analysis helps illustrate several of the issues MACPAC has raised previously:

- Lump-sum supplemental payments can be a significant source of Medicaid payments, particularly to hospitals.
- Net Medicaid payments are effectively reduced by the health care related taxes that providers pay.
- Without data on both health care related taxes and supplemental payments, it is not possible to meaningfully compare Medicaid payments across providers and states.

The results confirmed that supplemental payments can have a significant effect on total Medicaid payment. For three of the four states that provided data, supplemental payments are a large source of Medicaid revenue for hospitals and contribute greatly to the proportion of estimated costs that are covered, particularly when base payment rates may be relatively low. This analysis also demonstrated that provider-contributed financing, such as health care related taxes, has significant effects on the net amount of Medicaid payments

that providers receive. Yet uncertainty regarding the ultimate use of tax revenue by the state makes the relationship between health care related taxes and provider payment less clear.

Despite the apparent importance of non-DSH supplemental payments and health care related taxes in Medicaid payment, our ability to conduct analyses that take these factors into account is hampered by lack of data. CMS does not routinely collect health care related tax data at the provider level, and provider-level supplemental payment data are collected only for DSH audit and UPL compliance purposes in formats that cannot be readily combined with claims-based payment data for analysis. While states are required to report Medicaid provider payments to MSIS (§1903(r)(1)(F) of the Act), payment data that are not claims-based, including most supplemental payments, are often not included. Even when working directly with the state Medicaid programs that agreed to participate, multiple data limitations left MACPAC unable to conclusively determine net Medicaid payments to individual providers.

Policy implications. As with most Medicaid payments, states have considerable flexibility in establishing UPL payment methodologies. UPL payments are typically made in lump-sum amounts and distributed among a group of providers based on the volume of Medicaid services that they provide. However, because provider-level data regarding these payments are generally not available, we cannot assess their effects on policy goals such as efficiency, quality, and access to necessary services. For example, without knowing the full amount of Medicaid payments to individual providers, we cannot evaluate the relationship between their Medicaid payment and the cost of providing services to Medicaid enrollees.

While states' methods for distributing UPL payments are subject to CMS approval, their use (beyond supplementing payment rates) and effectiveness in promoting program objectives can be difficult to discern. Since its inception, the Medicaid statute has allowed states the flexibility to adapt their financing and payment approaches to meet changing needs and program objectives. Moreover, the reasons for individual state approaches may stem from a variety of factors, including their historic approaches to health care delivery, local health care markets, state politics, and budget conditions. However, the state-level characteristics that drive each state's policies, and the effect of these policies on the Medicaid program, are not always well understood. Further, without a detailed understanding of each state's distribution methods, it is difficult to identify the services and enrollees with which these payments are associated, an issue that takes on greater importance now that different federal matching rates apply to different enrollees.

A primary goal of Medicaid payment policy is to assure sufficient access to high quality health care services while guarding against unnecessary expenditures. In pursuit of that goal, states have adopted a wide variety of approaches to both financing the payments and determining how they are distributed. For example, among the study states, two of the four that provided data use a DRG-based inpatient hospital payment methodology, but at least half of their total hospital payments are made as lump-sum supplemental payments. The one study state that does not have a health care related tax on hospitals makes significant use of IGTs and CPEs, pays for inpatient hospital services based on per diem rates, and still makes a large amount of supplemental payments. Another state pays hospitals based on a per discharge rate, assesses a health care related tax on hospitals, and makes almost no supplemental payments.

While the results indicate that these state policies have a profound effect on the net amount of Medicaid payment that providers receive, they provide little insight into the specific reasons

for these policies or the effect that they have on provider incentives, enrollee access to needed services, or states' ability to develop new approaches. It is possible, for example, that the effect of payment policies intended to promote certain outcomes (e.g., using DRGs to encourage inpatient hospital efficiency) may be muted by providers' ability to access supplemental payments. On the other hand, the supplemental payments themselves may promote improved access. Without knowing which providers receive these payments, and the payment amounts, these effects cannot be measured. In recent years, states have undertaken payment reforms designed to encourage providers to produce desired outcomes rather than service volume—including the use of bundled payments, shared savings, and non-payment for services deemed inefficient. As states increasingly pursue these types of reforms, it will be even more important to understand the role of non-DSH supplemental payments and the effects that they have on provider incentives.

Participating state officials indicated a number of ways in which some supplemental payments were associated with policy objectives, such as rewarding quality outcomes and promoting access to particular types of specialty care that are important to Medicaid enrollees. However, the analysis did not attempt to identify the extent to which supplemental payments were associated with specific objectives or the extent to which they may help achieve them. Regardless, after accounting for both supplemental payments and health care related taxes, net Medicaid payments still varied dramatically among states and providers. While the analysis did not attempt to account for known differences among study states (e.g., geographic variation in input costs, or eligibility levels), such characteristics may not explain the full amount of the differences in net payment percent that were observed among the study states.

The results of this analysis, while illustrative, are not conclusive. For example, estimates of cost coverage among the study states suggest that net Medicaid payments are generally within about 20 percent of estimated costs, though the extent to which costs appear to be covered differs significantly. While supplemental payments are a significant component of total payments in several of the states, they do not appear to result in very high payment levels relative to cost. In the three states that make supplemental payments to hospitals, including these payments still results in estimated payment-to-cost ratios of less than 90 percent. However, because data regarding their use are generally not available at the federal level, without other sources of these data it is not possible to determine what Medicaid pays to individual providers, nor for what types of services or enrollees. It is also not possible to determine the effect that payment policies, including supplemental payments, have on access to services. MACPAC is charged with assessing the link between Medicaid payment and enrollee access to services. Without the information required to determine net payment, this is far more difficult to accomplish.

Commission Recommendation

Recommendation 6.1

As a first step toward improving transparency and facilitating understanding of Medicaid payments, the Secretary should collect and make publicly available non-DSH (UPL) supplemental payment data at the provider level in a standard format that enables analysis.

Rationale

For purposes of Medicaid policy analysis as well as oversight and program integrity, federal

and state Medicaid policymakers should fully understand what the program is purchasing and for what amount. Non-DSH supplemental payments account for more than 20 percent of total Medicaid FFS payments to hospitals nationally and more than 50 percent in some states (MACStats Table 20). Even so, non-DSH supplemental payments are not reported to the federal government at the provider level in a readily usable format, and, therefore, it is often not possible to determine total payment to individual providers or the effect of these payments on policy objectives. While the Commission discussed a range of options related to non-DSH supplemental payments, including requiring supplemental payments to be tied to measurable outcomes or requiring all payments to be claims-based, ultimately the Commission agreed that obtaining provider-level supplemental payment data was an essential first step toward understanding the role of these payments in the Medicaid program. Health care related taxes have also been shown to play an important role in net Medicaid payments, and data regarding their use are also unavailable; however, their direct relationship to provider payments is less clear and thus requires further examination.

The federal government has historically financed about 57 percent of national Medicaid expenditures, and this percentage is expected to increase as a result of the ACA. It is reasonable, therefore, to expect federal interest in overseeing and understanding states' use of Medicaid funds and the extent to which state policies are consistent with statutory requirements. At the same time, the program is largely administered at the state level with broad federal oversight. This relationship has always raised questions regarding the federal government's role in overseeing payment policy and its need to be able to analyze and compare data at the state and provider level, rather than simply assuring compliance with broad parameters such as aggregate UPLs. Federal policymakers must remain sensitive both to the administrative effort required for states to provide, and for the federal government to collect, various sources of administrative data and to preserving the flexibility that the Medicaid statute affords to states.

Health care policymakers commonly assess provider payments for their consistency with efficiency and economy and their effect on enrollees' access to services. Potential analyses of these issues in the Medicaid program will often be incomplete—and possibly misleading—without the inclusion of provider-level data on UPL payments.

Payment and access to care. In the Medicaid program, the wide variation in state Medicaid payment methods, combined with limitations in the supplemental payment data reported to the federal government, make it difficult to analyze both the adequacy and effects of payment both within and across states. MACPAC is charged with assessing the link between Medicaid payment and enrollee access to services, and might wish, for example, to examine whether higher payment relative to cost is related to higher Medicaid utilization. Without the information required to determine total Medicaid payment, however, this cannot be done.

Efficiency and economy. At the same time, the lack of data on payment levels hinders the ability to evaluate the efficiency and economy of state Medicaid programs. For example, provider margins are typically considered as part of assessments of payment adequacy, but without total payments, this is not possible.[13] Further, states themselves frequently attempt to benchmark their Medicaid payment rates against those of other states but have to rely on rough estimates for comparison due to a lack of consistent and complete Medicaid payment data. A number of states are pursuing value-based approaches to Medicaid payment and may be increasingly seeking to tie payment to policy objectives, yet existing data sources cannot be used to determine the extent to which such payments are made, or their effects on program objectives.

Provider-level non-DSH supplemental payment data would provide greater transparency to Medicaid payments, support program integrity efforts, and facilitate Medicaid payment analysis, including assessments of Medicaid payment adequacy and analysis of the relationship between payment and desired outcomes (e.g., efficiency, quality, access). For these reasons, the GAO recommended that CMS issue facility-specific reporting requirements for non-DSH supplemental payments and that such payments should be subject to an annual independent audit (GAO 2012b). CMS has not generally collected non-DSH supplemental payment data at the individual provider level in a standard format. In response to an earlier GAO report, CMS indicated that, while requiring provider-specific reporting of supplemental payments through the same system as the CMS-64 was not feasible, they could request provider-specific data as back-up during their review of state expenditure reports (GAO 2008). However, it does not appear that these data have been routinely collected, and, if they have, they have not been made publicly available for analysis.

In March 2013, CMS issued guidance in a State Medicaid Director letter requiring states to demonstrate their compliance with UPL requirements annually, including provider-level reporting of non-DSH supplemental payments (CMS 2013c). Beginning in 2013, states must submit these UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. Beginning in 2014 states will also be required to submit annual UPL demonstrations for clinics, physician services (for states that make targeted physician supplemental payments), ICFs/ID, private residential treatment facilities, and institutes for mental disease. While these data will provide CMS with an improved understanding of total Medicaid payments at the provider level and allow them to assure compliance with UPL regulations, they are not required to be submitted in a standardized format at this time and are not expected to be available for analysis outside of CMS regional offices.

Options for data collection. Transparency and improved understanding of Medicaid payments ultimately depend on data being both standardized and available in a format that makes it suitable for analysis. For example, payment data should be available for each provider and should include data elements, such as provider identification numbers, that will allow analysis of payments based on different provider characteristics, such as location, ownership, and role in serving low-income populations. Data should also indicate the time period for which payments were made.

One option for data collection could be to develop standardized templates for the submission of UPL compliance data. CMS could also consider collecting these data through the MSIS. MSIS is a federal data source compiled by CMS that contains detailed demographic, enrollment, and claims data that are required to be reported by all states. As discussed previously, states are required to report Medicaid provider payments to MSIS. However, payment data that are not claims-based, including most supplemental payments, are often not included, and CMS has not emphasized their inclusion. Therefore, while the MSIS is intended to facilitate national and cross-state examinations of the Medicaid program, data regarding total Medicaid payments may not be complete.

A review of MSIS data from FY 2008–2010 confirmed that most states do not appear to include supplemental payments of the type discussed in this chapter in their submissions.[14] Further, the CMS MSIS State Data Characteristics/Anomalies Report includes very few entries related to state reporting of supplemental payments (CMS 2013d). Enforcing the collection of supplemental payment data through the MSIS would enhance the system's analytic utility, both for payment analyses and program integrity purposes, by including the total amount of Medicaid payments made to a common

set of providers for a common time period (e.g., total Medicaid inpatient hospital payments for FY 2013). Further, including supplemental payment data would allow for greater continuity between MSIS data and state-reported Medicaid expenditure data on the CMS-64. Supplemental payment data were identified as a major component of the discrepancy between the two systems in a recent GAO report on the subject (GAO 2012a).

MSIS currently has the capability to accept records for supplemental payments, mitigating any potential federal administrative burden (CMS 2012). Also, the Commission has previously reported on a CMS effort to expand and enhance MSIS—an initiative known as the Transformed Medicaid Statistical Information System (T-MSIS). CMS has added the submission of T-MSIS data as a condition for enhanced federal match for systems upgrades, and data specifications for T-MSIS include values to specifically identify supplemental payments for inpatient and outpatient hospitals and for nursing facilities. CMS has indicated that it is implementing T-MSIS with states on a rolling basis and expects monthly submissions from all states by July 2014 (CMS 2013e). It remains to be seen, however, whether CMS will enforce the requirement to submit supplemental data through T-MSIS.

In January 2014, CMS issued a solicitation seeking support for oversight of Medicaid DSH and UPL payments (CMS 2014). While the solicitation does not indicate plans for making data publicly available, specific tasks include:

- the compilation of a database to enable analysis of DSH and UPL payments at both aggregate and provider-specific levels;
- analysis of supplemental payments at national, regional, state, and provider-specific levels; and,
- an assessment of the utility of T-MSIS data in assisting CMS in oversight and analysis of state UPL submissions and Medicaid DSH payments.

Improved collection of non-DSH supplemental payment data is a reasonable first step. However, there are many other factors related to variation in states' Medicaid payments, including differences in the methodologies used to determine them, as well as the role of states' approaches to Medicaid financing. With so much variation, and a lack of complete and consistent data at the federal level, it remains difficult to assess the extent to which individual state approaches are more or less effective at fulfilling the program's objectives. Moving forward, the Commission intends to continue to examine the many factors involved in Medicaid payment, as well as their effects.

Implications

Federal spending. The Congressional Budget Office has estimated that this recommendation will not affect federal Medicaid spending. Depending on the method of collection, it could result in increased administrative effort for development of reporting standards, required changes to information technology systems, and making the data publicly available, but these activities are not expected to result in increased spending.

States. Reporting of provider-specific supplemental payments could result in some increased administrative effort by the states. However, because the payments are calculated in accordance with the Medicaid state plan and paid to enrolled Medicaid providers, states should already have records for them and reporting should not be excessively burdensome.

Providers and enrollees. State reporting of provider-level supplemental payment data would not have a direct effect on Medicaid payments to providers or on services provided to Medicaid enrollees. Over time, however, increased transparency could lead to modifications in state payment methodologies.

Endnotes

[1] The non-federal share of Medicaid spending has historically averaged about 43 percent.

[2] See Chapter 3 of MACPAC's March 2012 *Report to the Congress on Medicaid and CHIP* for a full discussion of how states finance their share of Medicaid expenditures, including the use of health care related taxes and their use of supplemental payments to certain providers.

[3] Total annual uncompensated care costs are defined in federal regulation as "the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental or enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services" (42 CFR 447.299).

[4] The federal government first promulgated regulations prohibiting FFP for Medicaid payments in excess of what would have been paid under Medicare payment principles in September of 1981 (HCFA 1981). For the current UPL regulations, see 42 CFR 447.272(b) (defining UPLs for inpatient care); 42 CFR 447.321(b) (defining UPLs for outpatient care); 42 CFR 447.257 (establishing that FFP is not available for state expenditures in excess of the UPLs for inpatient care); and 42 CFR 447.304 (establishing that FFP is not available for state expenditures in excess of the UPLs for outpatient care).

[5] However, payments for inpatient hospital services may not exceed a provider's customary charges to the general public for the services (42 CFR 447.271).

[6] Specifically, the term "health care related tax" means a tax that is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or is not limited to such items or services but provides for treatment of individuals or entities providing or paying for such items or services that is different from the treatment provided to other individuals or entities. A tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

[7] Providers that pay a health care related tax cannot be "held harmless" through any direct or indirect payment, offset, or waiver that directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. Three tests are used to determine whether a hold-harmless arrangement exists: (1) a non-Medicaid payment to the providers is correlated to the tax amount, (2) any portion of Medicaid payments varies solely based on the tax amount, and (3) providers are directly or indirectly guaranteed to be held harmless. An indirect guarantee exists if 75 percent or more of the providers paying the tax receive 75 percent or more of their total tax costs back through enhanced Medicaid payments or other state payments. If the tax amount falls within the so-called safe harbor of 6 percent of net patient revenue, however, the tax is permissible under this test (42 CFR 433.68(f)).

[8] States report revenue from health care related taxes in Section 64.11 of their CMS-64 Quarterly Expenditure Reports. Reporting of tax collection amounts does not automatically generate a Medicaid expenditure claim for FFP, and this information is used solely for informational purposes.

[9] The guidance that CMS issued in March 2013 requiring states to submit annual UPL demonstrations, including provider-specific non-DSH supplemental payment data, may address the second recommendation.

[10] States were asked to advise if date-of-service data were not substantially complete. This appears to have been the case for one state (State Two). In the case of State Two, date-of-payment claims data were substituted as a result.

[11] Payment per claim and payment per visit were also considered, but variations in state payment policies limit the comparability of these metrics. Separate metrics for inpatient and outpatient were also considered, but states were not always able to separate supplemental payments between inpatient and outpatient.

[12] For this project, it was assumed that health care related taxes were not included in the hospital and the nursing facility costs extracted from Medicare cost reports. Some of the study states make it explicit that taxes are not allowable costs for either nursing facilities or hospitals. Per diem taxes for nursing facilities, for example, typically exclude Medicare days and consequently would not be an allowable cost on the Medicare cost report. While health care related taxes are an allowable cost under Medicare, they are required to be net of any offsetting payments.

[13] For fiscal years beginning on or after May 1, 2010, the Medicare cost report for hospitals (CMS-2552-10) was redesigned to include additional Medicaid payment information. Specifically, Worksheet S-10 now requires that hospitals report their total amount of Medicaid revenue, including DSH and non-DSH supplemental payments, as well as Medicaid charges, which are multiplied by the hospital's cost-to-charge ratio (CCR) to calculate Medicaid costs. Instructions indicate the Medicaid revenue should be "net of associated provider taxes or assessments" (CMS 2013f). While these data may allow for estimates of Medicaid margins for hospitals, limitations include the applicability of the CCR to Medicaid costs, the fact that revenue may not be reported net of IGTs and CPEs, and the fact that DSH payments are not reported separately from other Medicaid revenue.

[14] MSIS claims records contain several fields, including claim type and claim adjustment indicator, that may be used to identify supplemental payments. Two relevant claim types described in MSIS documentation include: (1) service tracking (also referred to as gross adjustment) claims (TYPE-OF-CLAIM=4) used for special purposes, such as tracking individual services covered in a lump-sum billing or for all non-claims based service expenditures such as DSH payments, drug rebates, and year-end settlements, and (2) supplemental payment claims (TYPE-OF-CLAIM=5) used to identify payments above a capitation fee or above negotiated rate. Additionally, claims of any type (service tracking, supplemental, or other) may be categorized as gross adjustments (ADJUSTMENT-INDICATOR=5) when they reflect an aggregate claim, such as one paid at a provider level rather than a patient encounter level.

To determine whether states appear to be reporting supplemental payments, MACPAC analyzed FY 2008–2010 MSIS claims counts and payment amounts by state, claim type, adjustment indicator, type of service, and whether claims could be linked to individual enrollees. The analysis showed that MSIS includes a variety of claims flagged as supplemental payments, but only a small number of states appear to include the aggregate, lump-sum type discussed in this chapter. These cannot be separated into DSH and non-DSH amounts. The vast majority of MSIS claims with at least one of the supplemental payment values described above had a TYPE-OF-CLAIM value of 5, had payment amounts less than $1,000, and could be linked to individual enrollees; as such, they were not of interest for this analysis.

To the extent supplemental payment data of the type discussed in this chapter are reported, they represent a small number of claims and are most likely to be reported as gross adjustment claims (TYPE-OF-CLAIM value of 4, often with an ADJUSTMENT-INDICATOR value of 5 as well) that have large payment amounts and cannot be linked to individual enrollees. For FY 2010, 6,037 claims had a paid amount of $100,000 or more and were not linked to an actual Medicaid enrollee. Of these, 5,527 (92 percent) were gross adjustments. The most common types of service among these claims were inpatient hospitals and nursing facilities, also the most likely to receive supplemental payments. However, while it appears that most supplemental payments of the type discussed in this chapter have these characteristics when they are reported in MSIS, only 16 states reported any inpatient hospital or nursing facility claims with these characteristics in FY 2010 (compared to 35 that reported making supplemental payments on the CMS-64).

On the other hand the vast majority of MSIS claims reported as gross adjustments do not appear to be supplemental payments of the type discussed in this chapter. In FY 2010, about half of these claims had negative or zero payment amounts and, among those with positive payments, 96 percent had payment amounts of less than $1,000. Further, claims with these characteristics were identified for 28 different types of service, most of which are not typically associated with supplemental payments of the type discussed in this chapter. Because states appear to use the gross adjustment category for more than one purpose, we cannot definitively identify specific types of supplemental payments in MSIS.

References

Bachrach, D., and M. Dutton. 2011. *Medicaid supplemental payments: Where do they fit in payment reform?* Hamilton, NJ: Center for Health Care Strategies, Inc. http://www.chcs.org/usr_doc/Medicaidsupplementalpaymentbrief.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Solicitation Number APP140426, "Medicaid Upper Payment Limit and Disproportionate Share Hospital Demonstration." January 23, 2014.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. Medicaid program: Disproportionate share hospital allotments and institutions for mental diseases, disproportionate share hospital limits for FY 2012, and preliminary FY 2013 disproportionate share hospital allotments and limits. Notice. *Federal Register* 78, no. 144 (July 26): 45217–45231. http://www.gpo.gov/fdsys/pkg/FR-2013-07-26/pdf/2013-17965.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. *Medicaid qualified practitioner services—methodologies for enhanced payment made to physicians and practitioners associated with academic medical centers and safety net hospitals and upper payment calculation.* Baltimore, MD: CMS. http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/UPL-Instructions-Qualified-Practitioner-Services-Replacement-New.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013c. Letter from Cindy Mann to State Medicaid Directors regarding "Federal and state oversight of Medicaid expenditures." March 18, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013d. MSIS state data characteristics/anomalies report. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013e. Letter from Cindy Mann to State Medicaid Directors regarding "Transformed Medicaid Statistical Information System (T-MSIS) data." August 23, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013f. Part 2, Chapter 40, Revision 3. In *Provider reimbursement manual.* Baltimore, MD: CMS. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/P152_40.zip.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. *Medicaid and CHIP Statistical Information System (MSIS) file specs and data dictionary.* Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MSIS/Downloads/msis-data-dictionary.pdf.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 2001. Medicaid program: Revision to Medicaid upper payment limit requirements for hospital services, nursing facility services, intermediate care facility services for the mentally retarded, and clinic services. Final rule. *Federal Register* 66, no. 9 (January 12): 3148–3177.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 1981. Medicaid program: Payment for long-term care facility services and inpatient hospital services. Interim final rule with comment period. *Federal Register* 46, no. 189 (September 30): 47964–47973.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2012. *Report to the Congress on Medicaid and CHIP.* March 2012. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011. *Report to the Congress: The evolution of managed care in Medicaid.* June 2011. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Mitchell, A. 2012. *Medicaid disproportionate share hospital payments.* Washington DC: Congressional Research Service. http://www.fas.org/sgp/crs/misc/R42865.pdf.

National Association of State Budget Officers (NASBO). 2012. *State expenditure report: Examining fiscal 2010–2012 state spending.* Washington, DC: NASBO. http://www.nasbo.org/publications-data/state-expenditure-report.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2013. *National health expenditure projections, 2012–2022.* Baltimore, MD: CMS. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf.

Smith, V.K., K. Gifford, E. Ellis, et al. 2013. *Medicaid in a historic time of transformation: Results from a 50-state Medicaid budget survey for state fiscal years 2013 and 2014*. Washington, DC: Kaiser Family Foundation. http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf.

U.S. Government Accountability Office (GAO). 2012a. *Medicaid data sets provide inconsistent picture of expenditures*. Report no. GAO-13-47. Washington, DC: GAO. http://www.gao.gov/products/GAO-13-47.

U.S. Government Accountability Office (GAO). 2012b. *More transparency of and accountability for supplemental payments are needed*. Report no. GAO-13-48. Washington, DC: GAO. http://www.gao.gov/products/GAO-13-48.

U.S. Government Accountability Office (GAO). 2008. *CMS needs more information on the billions of dollars spent on supplemental payments*. Report no. GAO-08-614. Washington, DC: GAO. http://www.gao.gov/products/GAO-08-614.

Xerox Corporation. 2013. Government healthcare solutions, payment method development: Overview of hospital finances nationwide. Unpublished Presentation. Norwalk, CT: Xerox Corporation.