

# MACfacts

## Key Findings on Medicaid and CHIP

November 2012

### Medicaid UPL Supplemental Payments

Medicaid payment policies are developed by each state, with federal review limited to the general principles set forth in Section 1902(a)(30)(A) of the Social Security Act. This provision requires that provider payments be consistent with efficiency, economy, quality, and access and safeguard against unnecessary utilization. State flexibility to develop payment policies has led to significant variation in payment methods, reflecting individual state policy decisions, geographic differences in costs, and practice patterns.

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

- Medicaid Disproportionate Share Hospital – payments to hospitals serving low-income patient populations, which accounted for more than \$17 billion (including federal matching funds) in fiscal year (FY) 2011; and
- Upper Payment Limit (UPL) – supplemental payments, which comprise the difference between Medicaid payments for services and the maximum payment level allowed under the UPL for those services. States reported nearly \$26 billion in these payments in FY 2011.

This MACfacts focuses on UPL supplemental payments. Medicaid disproportionate share payments are described in more detail in Chapter 3 of the Commission's March 2012 *Report to the Congress on Medicaid and CHIP*.

**Background on UPL.** As long as a state operates its Medicaid program within federal requirements, it is entitled to receive federal matching funds toward allowable Medicaid expenditures. Through a policy known as UPL, federal regulations prohibit federal matching funds for Medicaid fee-for-service payments in excess of what would have been paid under Medicare payment principles. The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, intermediate care facilities for the intellectually disabled, and freestanding non-hospital clinics. In practice, the UPL rules simply ensure that Medicaid does not pay a class of providers in the aggregate more than Medicare would have paid for the same or comparable services delivered by those same institutions.

Although the UPL regulations were intended to limit Medicaid payments to a group of institutions to the amount that Medicare would have paid, some states have used the provisions to direct supplemental

payments—up to the difference between the Medicare and Medicaid amounts—to providers.<sup>1</sup> Under the UPL requirements, states may make—and receive federal matching dollars for—payments beyond those for services provided by any institution, as long as total Medicaid payments do not exceed the UPL for the specific group of institutions. As a result, the term “UPL payments” is used to refer to the additional payments states make under this rule to supplement or enhance Medicaid payments that are made for Medicaid services.

**States’ Use of UPL Supplemental Payments.** States reported nearly \$26 billion in UPL supplemental payments in FY 2011. The large majority of these payments go to hospitals, and may be an especially important source of revenue for hospitals that serve a significant proportion of Medicaid enrollees and uninsured individuals (Figure 1).

**FIGURE 1. UPL Supplemental Payments FY 2011 (millions)**

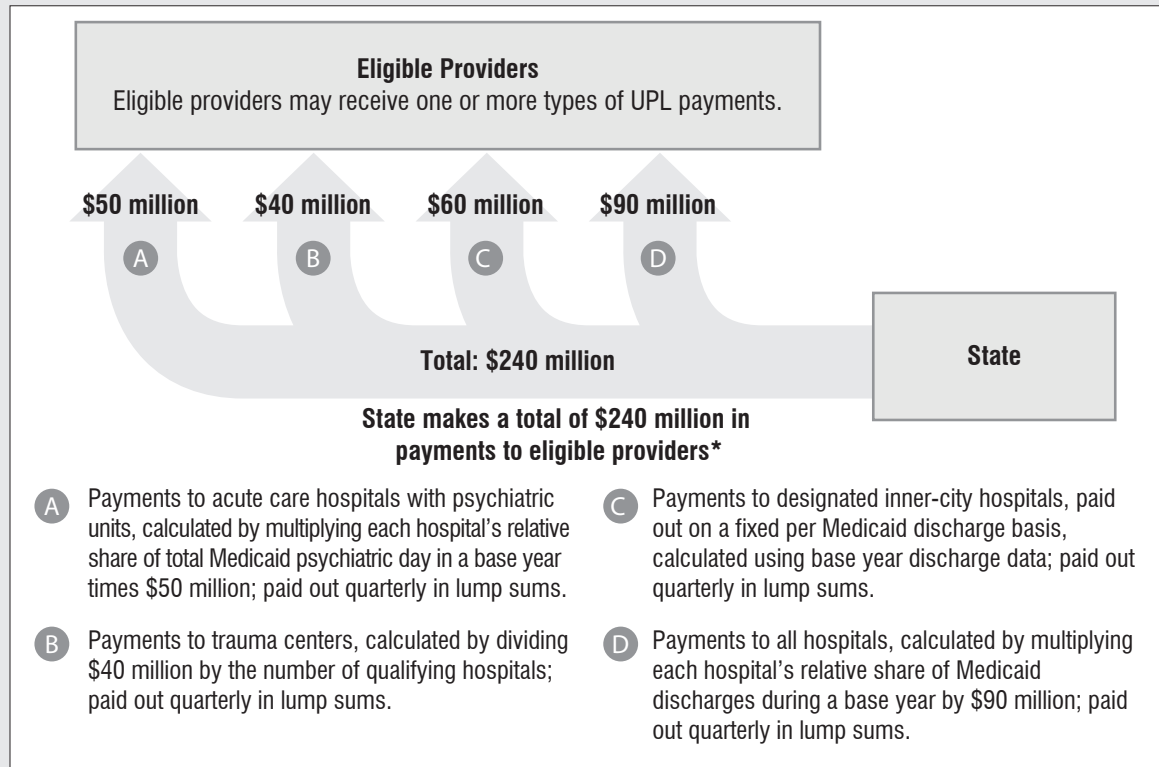
|                                  | UPL Payments | Total Medicaid Payments (including DSH) | Percent of Total Medicaid Payments (including DSH) |
|----------------------------------|--------------|---|--|
| Hospitals                        | \$23,239.6   | \$91,894.9                              | 25%  |
| NFs/ICFs-ID                      | 1,560.6      | 64,566.5                                | 2  |
| Physicians & Other Practitioners | 1,125.3      | 15,420.8                                | 7  |

**Notes:** Excludes payments made under managed care arrangements. CMS only began to require separate reporting of non-DSH supplemental payments in FY 2010 and is continuing to work with states to standardize this reporting. NFs are nursing facilities. ICFs-ID are intermediate care facilities for the intellectually disabled.

**Source:** MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data, February 2012. Includes both federal and non-federal share of payments

Aside from the requirement that total payments to a class of institutions may not exceed the UPL, UPL payments are not subject to restrictions. Because UPLs are tied to the services rendered by entire classes of providers, rather than by individual providers, states have discretion in allocating these supplemental payments among individual institutions within the class. Further, UPL payments are “add-ons” that may not be directly related to specific Medicaid services or patients. Figure 2 provides a hypothetical example of how one state might distribute UPL supplemental payments among hospitals.

As of FY 2010, states are required to provide CMS with aggregate information on their UPL supplemental payments by type of provider (e.g., inpatient hospital, nursing facility). However, because these payments are not necessarily associated with specific services or enrollees and are not reported to CMS at the individual provider level, it is difficult for state and federal policymakers to compare total Medicaid payments across individual providers and enrollment groups. It is also difficult to evaluate the interaction of these lump-sum payments with other payment methods and delivery models. For example, the impact of policies intended to promote certain outcomes through payment rates (e.g., pay for performance) may be muted by providers’ receipt or nonreceipt of supplemental payments. On the other hand, the supplemental payments may promote access, efficiency, and quality if they target providers based on these principles. Without knowing what providers they are going to, and in what amounts, this is difficult to assess.

**FIGURE 2. Illustrative Example of a Distribution of UPL Supplemental Payments**

\* **Note:** This is a hypothetical example of a UPL supplemental payment distribution reflecting the types of allocation formulas that states use.

**Source:** MACPAC analysis 2012

**Interaction of UPLs and managed care.** UPL supplemental payment policies have been shown to have important implications for states' decisions regarding the use of Medicaid managed care.<sup>2</sup> 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.

A few states have delayed implementation or expansion of Medicaid managed care because of the potential loss in federal matching dollars for supplemental payments; some states have applied for Section 1115 demonstration waiver authority to address this issue. In 2005, Florida was granted a waiver that preserved some of its hospital supplemental payments. Texas initially carved out inpatient care from the risk-based STAR+PLUS program to preserve supplemental payments. Recently, Texas was granted an 1115 demonstration waiver that allows the state to expand its managed care program, including inpatient hospital care, while preserving the hospital revenue made through UPL supplemental payments (Box 1).

### **BOX 1. Texas' Section 1115 Demonstration Waiver to Expand Managed Care while Preserving Supplemental Payments**

In 2011, the State of Texas applied for a Section 1115 demonstration waiver to expand risk-based managed care statewide and include inpatient hospital services within its managed care program. The proposed demonstration would also allow the state to continue making supplemental payments to hospitals based on the existing UPL.

Under the pre-existing STAR+PLUS managed care program for enrollees age 65 and over and individuals with disabilities, inpatient services were not included in order to preserve UPL supplemental payments to hospitals. Since higher-need 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. In FY 2011, UPL supplemental payments to Texas hospitals totaled \$2.6 billion.

In December 2011, the Section 1115 demonstration waiver request was approved by the Secretary of Health and Human Services. Under the terms of the agreement, existing UPL supplemental payments (along with DSH payments and managed care savings) will be used to fund an uncompensated care pool and a Delivery System Reform Incentive Payment (DSRIP) pool to incentivize improvements in service delivery. Without approval of this waiver, State law would have required the Medicaid program to remove the inpatient hospital benefit from all existing risk-based Medicaid managed care programs.

Under the pre-existing UPL program, some Texas hospitals were eligible to receive lump-sum supplemental payments based on the difference between the payments they received and their charges. Under the approved waiver, uncompensated care payments will be limited to the actual cost of uncompensated care, and DSRIP payments will be contingent on demonstrated improvements in care coordination and quality based on predefined metrics. This change is intended to improve the transparency of supplemental payments and allow policymakers to determine the effect of these payments on service.<sup>3</sup>

Moving forward, the Commission intends to continue to examine the role of supplemental payments in the Medicaid program and their effect on both total provider payment and state program design. A deeper understanding of how supplemental payments are both financed and used can help policymakers assess the consistency of states' provider payment policies with the principles of efficiency, economy, and quality, as well as the relationship between payment policy and access to appropriate services.

For more information on this topic, see Chapter 3 of MACPAC's March 2012 *Report to the Congress on Medicaid and CHIP*.

- 1 Some states also make supplemental payments to physicians, typically those employed by state university hospitals. Although no federal regulation establishes a UPL for such noninstitutional providers, the Centers for Medicare & Medicaid Services (CMS) has used average commercial rates for physician services as a comparison.
- 2 MACPAC *March 2012 Report to the Congress on Medicaid and CHIP*; MACPAC *June 2011 Report to the Congress: The Evolution of Managed Care in Medicaid*
- 3 B. Millwee, "Payment and financing issues in Medicaid managed care expansion." Presentation before the Medicaid and CHIP Payment and Access Commission, November 18, 2011, Washington, DC. [http://www.macpac.gov/home/transcripts/MACPAC\\_2011-11\\_Transcript.pdf](http://www.macpac.gov/home/transcripts/MACPAC_2011-11_Transcript.pdf).