

3

CHAPTER



State Approaches for Financing Medicaid and Update on Federal Financing of CHIP

3 CHAPTER a

State Financing of Medicaid: Context, Scope, and Relationship to Provider Payment

This section begins the Commission's work on the interaction between state Medicaid financing and provider payment. It outlines the primary approaches that states take to finance their share of Medicaid expenditures, including the use of state general revenue, local government contributions, and health care related taxes, and describes supplemental payments made by states to certain providers. These issues are important to Medicaid policy because:

- ▶ State financing approaches affect Medicaid payment methodologies and payment amounts, which in turn may affect enrollees' access to services.
- ▶ A better understanding of both state financing and provider payment can help policymakers to identify and implement policies that are efficient and effective and promote access to appropriate services.

This section describes:

- ▶ **State flexibility in financing Medicaid.** The law provides states with flexibility in financing the non-federal share of the Medicaid program. While the majority of non-federal spending is state general revenue, states vary in their use of contributions from local governments, including providers operated by local governments. Federal statute allows these contributions in recognition of the historical role of local governments in financing health care for low-income individuals.
- ▶ **Health care related taxes.** These taxes are authorized by federal statute and have been implemented by nearly every state. Information regarding these taxes, including tax rates and the amount of revenue generated, is not readily available, limiting policymakers' understanding of the role of such taxes in total provider payment amounts and making it difficult to assess the potential impact of changes to health care related tax provisions.

- ▶ **Supplemental provider payments.** In many cases, states use local government contributions and health care related taxes to finance lump-sum “supplemental payments” for Medicaid services (most commonly to hospitals) based on fee-for-service (FFS) federal upper payment limit (UPL) requirements, as well as disproportionate share hospital (DSH) payments for uncompensated care costs in hospitals. Such supplemental payments may be a particularly important source of revenue for certain providers such as safety-net hospitals. In fiscal year (FY) 2011, supplemental payments accounted for 41 percent of total FFS Medicaid payments to hospitals.¹
- ▶ **Data limitations regarding UPL supplemental payments.** The amount of lump-sum supplemental payments based on UPLs and the providers that receive them cannot be readily discerned from federal data sources. Thus, it is not possible to compare payment levels across providers and states or to determine the total amount of Medicaid spending on specific services and populations, making it difficult to evaluate the impact of Medicaid payment policies.
- ▶ **UPL supplemental payments and managed care.** Some states have indicated that UPL supplemental payment policies have influenced state decisions regarding the expansion of Medicaid managed care programs for high-cost enrollees.

The Commission’s March 2011 *Report to the Congress on Medicaid and CHIP* provided an overview of Medicaid fee-for-service payment policy, including the statutory and regulatory history and resulting variation in state payment methods. The Commission’s June 2011 report, *The Evolution of Managed Care in Medicaid*, provided an overview

of Medicaid managed care payment policy. In November, the Commission released a MACBasic outlining the process by which Medicaid providers are paid. In the section that follows, the Commission examines the manner in which payment is financed, and the impact of financing on payment policy, particularly payments to certain classes of providers that treat high numbers of Medicaid enrollees. This section includes a description of:

- ▶ Context and History
- ▶ Federal and Non-federal Medicaid Financing
- ▶ Supplemental Provider Payments
- ▶ Looking Forward

Context and History

Financing the Medicaid program is a shared responsibility of the federal and state governments. States are required to cover certain populations and benefits as a condition of participation in the Medicaid program, and may cover others at state option (§1902(a)(10) of the Social Security Act (the Act)). As long as a state operates its program within federal requirements, it is entitled to receive federal matching funds toward allowable state expenditures. As described below, federal contributions for Medicaid provider payments are provided in accordance with a formula that calculates a federal matching rate for each state, while contributions toward administrative costs vary by the type of activity, as specified in the statute.

Federal policy regarding both the permissible sources of non-federal Medicaid expenditures and federal contributions toward those expenditures dates to Medicaid’s 1965 enactment. Prior to 1965, health care services for low-income individuals were provided primarily through a patchwork

¹ MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data, February 2012.

BOX 3a-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.

Federal Medical Assistance Percentage (FMAP) – The rate at which the federal government matches each states’ spending on Medicaid services.

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), including a provider 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.

of programs sponsored by state and local governments, charities, and community hospitals (HCFA 2000). Payments were often in the form of direct investments in hospitals and clinics for low-income individuals. Medicaid’s financing approach was designed to build upon these existing programs by providing federal matching funds for state and local spending on approved health care services provided to certain populations.

Section 1902(a)(2) of the Act, included in the original statute, recognized the role of these local programs, requiring that a state plan for medical assistance must “provide for financial participation by the state equal to not less than 40 per centum of the non-federal share of the expenditures

under the plan with respect to which payments under Section 1903 are authorized under this title.” While the administration of each state’s Medicaid program was required to be centralized at the state level, this provision allowed the pre-existing patchwork of programs to maintain primary responsibility for service delivery and non-federal financing of services that now qualified for federal payments. As a result, states that traditionally relied on local governments to provide health care services to low-income individuals were able to continue to do so under the Medicaid program. In addition, pre-existing programs continued to provide services to low-income populations that were not covered by Medicaid.

Federal and Non-federal Medicaid Financing

In FY 2011, the Medicaid program accounted for \$432 billion in total spending. Generally, the federal share of Medicaid is about 57 percent. From FY 2009–2011, however, the federal share of Medicaid spending was higher due to a temporary increase in states' federal medical assistance percentages (FMAPs) to provide broader federal assistance over this period (Figure 3a-1). The Congressional Budget Office estimates that the federal share of Medicaid will return to about 57 percent in FY 2012 and 2013, and increase to between 60 and 62 percent in FY 2014 when provisions of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) become effective (CBO 2011).

Medicaid now accounts for more than 15 percent of national health care spending (Martin et al. 2012). The non-federal share of Medicaid spending is estimated to account for 17 percent of states' general revenue and about 14 percent of total non-federal funds spent by states for all purposes in state fiscal year (SFY) 2011 (NASBO 2011). Because Medicaid is such a significant component of state budgets, states are continually seeking more efficient ways to finance and pay for services.

Federal Medicaid financing

The federal share of Medicaid expenditures is often referred to as the federal match, or federal financial participation (FFP). Federal Medicaid funds are authorized through Congressional appropriation and funds are withdrawn from the general fund of the U.S. Treasury as needed to

reimburse states for the federal share of their Medicaid expenditures (OACT 2010).

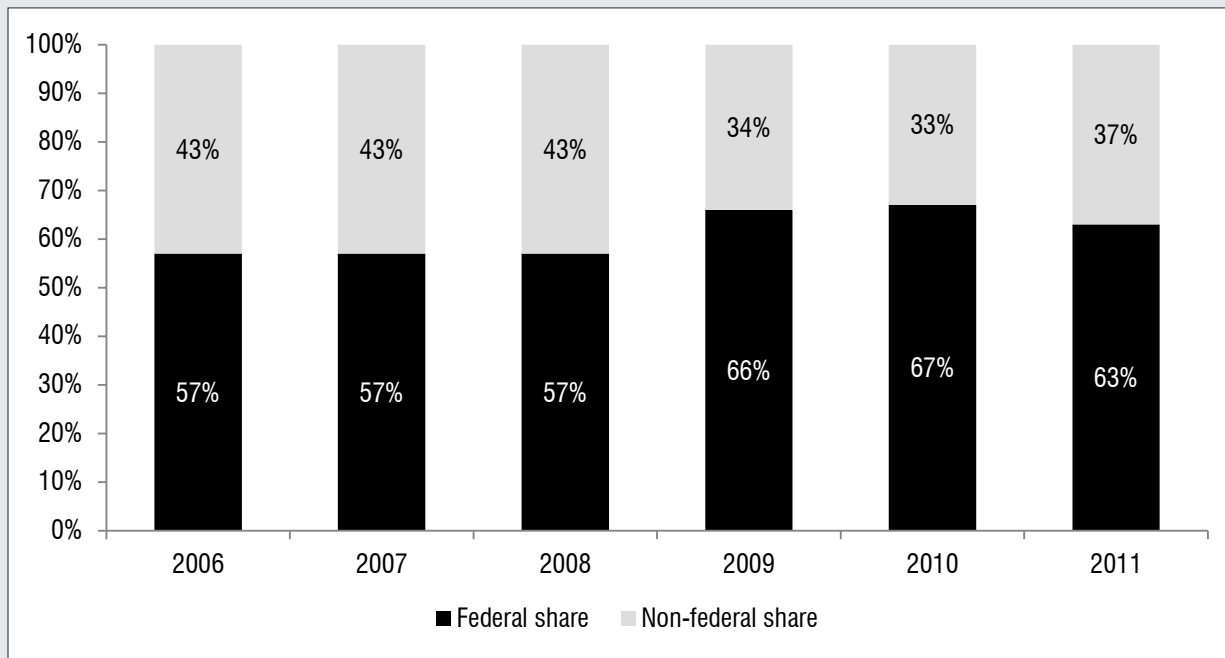
Each quarter, states submit the CMS-64 Quarterly Medicaid Statement of Expenditures (CMS-64)² to the Centers for Medicare & Medicaid Services (CMS), reporting the actual amount of expenditures that are eligible for the federal match in the following two broad categories:

- ▶ **Medical assistance.** The federal share of most health care service costs, including payments to providers and managed care entities, is determined by a state's FMAP. The U.S. Department of Health and Human Services (HHS) calculates each state's FMAP annually based on a statutory formula that takes into account per capita income and other factors. (See Table 14 of MACStats for additional information regarding states' FMAPs.)
- ▶ **Program administration.** The federal share for Medicaid administration (e.g., staff, information technology systems, auditing activities) does not vary by state and is generally 50 percent.³

At times, the Congress has used enhanced matching rates to promote certain policy goals. For example, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provided a temporary increase in each state's FMAP from October 2008 through December 2010. The increase was later extended at lower levels through June 2011. The ARRA also provided 100 percent FFP to states for incentives to eligible Medicaid providers to purchase, implement, and operate certified electronic health records (EHR) technology and established 90 percent FFP for state administrative expenses related to carrying out

² CMS-64 Quarterly Expenditure Report form available at: <https://www.cms.gov/MedicaidBudgetExpendSystem/Downloads/CMS64Forms.pdf>.

³ While most administrative activities garner the standard 50 percent federal match, some are eligible for higher rates such as 90 percent for the design, development, and installation of Medicaid Management Information Systems (MMIS) and 75 percent for skilled professional medical personnel, translation services, utilization review, and MMIS operation (§1903(a)(2) of the Act).

FIGURE 3a-1. Federal and Non-federal Share of Medicaid Expenditures, FY 2006–2011

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data, February 2012

this provision. For additional discussion of federal financing, see the Commission’s March 2011 *Report to the Congress on Medicaid and CHIP*.

Non-federal financing

The non-federal share of Medicaid expenditures is commonly referred to as the “state share.” States generate their share through multiple sources, including state general revenue, contributions from local governments including providers operated by local governments,⁴ and specialized revenue sources such as health care related taxes. As noted, although 40 percent of non-federal financing must come from the state, up to 60 percent may

be derived from local sources (§1902(a)(2) of the Act).^{5,6}

Each state makes its own decisions, within federal requirements, regarding how to finance its share of the Medicaid program. As a result, the extent to which states rely on funding sources other than general revenue varies considerably and may be influenced by states’ traditional sources of general revenue and approaches to financing health care for low-income individuals. The following are the most common sources of non-federal Medicaid financing:

- ▶ state general revenue;

⁴ Federal statute permits the use of funds transferred from or certified by units of government within a state as the non-federal share of Medicaid expenditures regardless of whether the unit of government is also a health care provider (§1903(w)(6)(A) of the Act). “Unit of local government” is defined as “a city, county, special purpose district, or other governmental unit in the state” (§1903(w)(7)(G) of the Act).

⁵ While individual state policies dictate the sources and amounts of each state’s financing, the Act refers to the “non-federal share” in acknowledgement of local government contributions.

⁶ As a condition of receiving increased FMAP under both PPACA and ARRA, Section 1905(cc) of the Act, added by PPACA, requires that states do not increase the percentage of non-federal share that they require political subdivisions to contribute beyond what was required as of December 31, 2009.

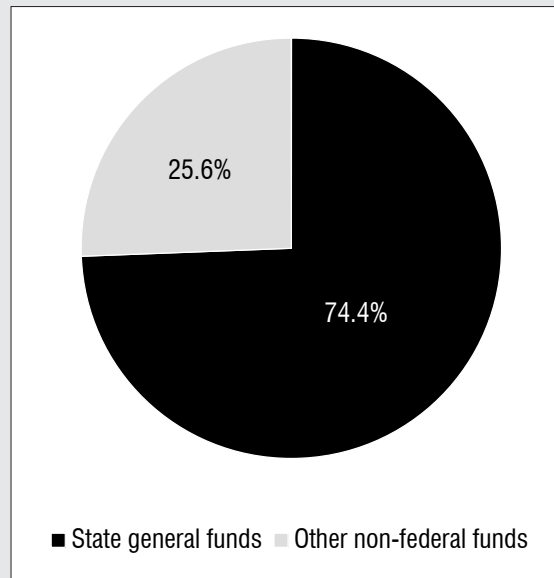
- ▶ local contributions (through intergovernmental transfers and certified public expenditures); and
- ▶ health care related taxes.

Since the program's inception in 1965, flexibility in financing the non-federal share has allowed states to maintain local sources of health care financing while making these local funds eligible for federal match. At various points, particularly beginning in the early 1990s, this multi-source approach to financing has been the subject of federal scrutiny, sometimes because of evidence of state excesses (GAO 2004b, GAO 1994), and sometimes in an effort to control federal spending by limiting states' ability to make expenditures that qualify for federal contributions. At the same time, the fact that Medicaid enrollment increases and state revenues decrease during economic downturns, coupled with the fact that most states operate within one- or two-year budget periods, may increase pressure on states to find ways to finance their share of the Medicaid program during such times.

State general revenue

Nearly three-quarters of state financing for Medicaid nationally is through states' general revenue collected through income taxes, sales taxes, and other sources. As Figure 3a-2 demonstrates, for FY 2011, an estimated 74 percent of all non-federal Medicaid funds were from states' general revenue (down from 80 percent in 2009 and 76 percent in 2010) (NASBO 2011).⁷ In most cases, general revenue is appropriated directly to the state Medicaid agency. At times, however, general revenue may be appropriated to other state government entities (e.g., a department of mental health) to be used for Medicaid purposes. In these cases, the other state government entities

FIGURE 3a-2. State Medicaid Financing, SFY 2011



Source: National Association of State Budget Officers, 2010 State Expenditure Report

either transfer the funds to the Medicaid agency or spend the funds directly on Medicaid services and administration and provide certification that this spending has occurred for the purposes of claiming FFP.

Local sources of non-federal share

Counties, municipalities, and other units of local government, including providers operated by local governments, contribute to the non-federal share of Medicaid spending in many states. As discussed previously, this local-level Medicaid spending is rooted in the history of the program and varies by state. As with state government entities that are outside of the Medicaid agency, these units of local government, which may also be Medicaid providers (e.g., a county hospital or school district), either transfer local government funds in the

⁷ According to the National Association of State Budget Officers (NASBO), a small number of state budget offices were unable to report non-federal Medicaid funding by source. In these cases, the entire amount was reported as general revenue. Therefore, the total percentage of general revenue may be slightly overstated. For the purposes of the NASBO survey, health care related tax revenue is counted as "other state funds" and not general revenue.

amount of the non-federal share of Medicaid payments to the state Medicaid agency through an intergovernmental transfer, or certify the total expenditure incurred to provide Medicaid services or Medicaid program administration, known as a certified public expenditure.

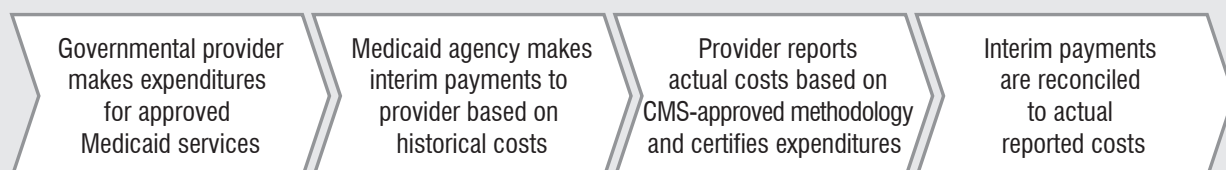
- ▶ **Intergovernmental transfers (IGTs).** An IGT is a transfer of funds from another governmental entity (e.g., a county or other state agency) to the Medicaid agency before a Medicaid payment is made. When these funds are used as the non-federal share of a Medicaid expenditure, they are eligible for FFP. IGTs are commonly used by counties to contribute the non-federal share for certain governmental providers (e.g., community mental health centers, hospitals) located in those counties. IGTs may also be contributed directly by governmental providers themselves, such as hospitals operated by state or local government. The ability of states to use IGTs to finance their Medicaid programs is recognized in both federal statute and regulation (§1903(w)(6) of the Act; 42 Code of Federal Regulations (CFR) 433.51).
- ▶ **Certified public expenditures (CPEs).** A CPE is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider (e.g., county hospital, local education agency), incurs an expenditure eligible for FFP under the state’s approved Medicaid state plan

(§1903(w)(6) of the Act; 42 CFR 433.51). The governmental entity certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims FFP.

CPE-based financing must recognize actual costs incurred. As a result, CMS requires cost reimbursement methodologies for providers using CPEs to document the actual cost of providing the services, typically determined through a statistically valid time study, periodic cost reporting, and reconciliation of any interim payments, as outlined in Figure 3a-3 below.

CPEs are most commonly used by local education agencies (LEAs) for Medicaid school-based health care and related administrative services. The amount of time that school staff members spend on Medicaid-related activities is typically determined based on time studies; LEAs then certify to the state that the full cost of these activities is “spent” by the schools on Medicaid services. Based on this certification, the state is able to claim the federal share of these costs, which may then be paid to the LEAs. While CPEs are most common among LEAs, they are also used by other provider types (e.g., hospitals operated by state or local government or local health departments) in some states.

FIGURE 3a-3. Basic Certified Public Expenditure Process for Medicaid Services



Health care related taxes

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).⁸ These taxes are commonly used by states to:

- ▶ establish supplemental Medicaid payments for the classes of providers that pay the tax;
- ▶ increase or avert reductions in Medicaid rates; and/or
- ▶ finance other areas of the Medicaid program.

Federal regulations specify 18 separate provider classes as eligible for health care related taxes (42 CFR 433.56). According to a recent survey, 47 states have at least one provider tax in place as of SFY 2011 (Table 3a-1),⁹ and they are most commonly assessed on nursing facilities (39 states), hospitals (34 states), intermediate care facilities for the intellectually disabled (ICFs-ID)¹⁰ (32 states), and managed care organizations (MCOs)(9 states). The full amount of revenue generated through health care related taxes is unknown. In FY 2011, states reported \$18 billion in revenue from health care related taxes, although only 39 of the 47 states that indicate having taxes in place reported any revenue from them.¹¹

TABLE 3a-1. State Medicaid Health Care Related Taxes, SFY 2011

Provider Class Taxed	No. of States	States
Nursing facilities	39	AL, AR, CA, CO, CT, DC, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NV, NH, NJ, NY, NC, OH, OK, OR, PA, RI, TN, UT, VT, WV, WI, WY
Hospitals	34	AL, AR, CA, CO, FL, GA, ID, IL, IA, KS, KY, ME, MD, MA, MI, MN, MS, MO, MT, NH, NJ, NY, OH, OR, PA, RI, SC, TN, UT, VT, WA, WV, WI, WY
ICFs-ID	32	AR, CA, CO, DC, FL, IL, IN, IA, KY, LA, ME, MD, MN, MS, MO, MT, NE, NJ, NY, NC, ND, OH, PA, SC, SD, TN, TX, UT, VT, WA, WV, WI
Managed care organizations	9	AZ, DC, MD, MN, NJ, NM, RI, TN, TX
Other*	11	AL, KY, LA, ME, MN, MO, NJ, NY, VT, WV, WI

Note: ICFs-ID are intermediate care facilities for the intellectually disabled.

*States were not asked to specify the provider classes included within the “other” category.

Source: Smith et al. 2011

⁸ Provider donations are also permitted as a source of the non-federal share if they meet stringent conditions, including a requirement that no portion of a Medicaid or non-Medicaid payment to the provider, other providers furnishing the same class of services, or a related entity may vary based on the amount of the provider’s donation or be conditional on the provider having made a donation. In other words, provider donations may not fund the non-federal share unless the provider does not receive a portion of the donation back (§1903(w)(2) of the Act). Without the ability to receive the donations back from the state, few providers are willing to donate funds, and thus the strict requirements imposed on provider donations act as an effective prohibition on such donations.

⁹ States that did not have health care related taxes in SFY 2011 include Alaska, Delaware, Hawaii, and Virginia. According to the survey results, Virginia has enacted a tax on ICFs-ID for SFY 2012.

¹⁰ An institution with the primary purpose of providing health or rehabilitative services for individuals with intellectual disabilities (§1905(d) of the Act).

¹¹ 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.

Federal requirements. Health care related taxes are typically approved by state legislatures and are mandatory for providers. The tax revenue collected is then commonly used as the non-federal share of Medicaid payments. However, federal statute and regulations place limits on states' ability to use such tax revenue as the non-federal share of Medicaid payments. Statutory provisions regarding health care related taxes require that:¹²

- ▶ Health care related taxes must be broad-based and uniform. That is, they must be levied against all non-governmental providers in a particular class, not only those that accept Medicaid payments, and the tax rate must be uniform across all providers in the class.
- ▶ Providers cannot be “held harmless” through a direct or indirect guarantee that they will be repaid for the amount of taxes that they contribute. However, the indirect guarantee test does not apply if the tax rate falls within a “safe harbor” established under regulation.¹³ The safe harbor is currently 6 percent of net patient revenue.
- ▶ The amount of Medicaid funding that may be generated through health care related taxes generally cannot exceed 25 percent of the total non-federal share in a given year.

Federal statute and regulations provide states the opportunity to request waivers of the broad-based and uniform requirements as long as states can demonstrate that the net impact of the tax program is generally redistributive and that the tax amount is not directly correlated to Medicaid payment amounts.¹⁴ States commonly seek these waivers in an effort to develop more targeted tax programs by exempting certain providers or revenue sources from taxation.¹⁵ For example, if a tax is based on each provider's number of beds, states may wish to exempt charity providers that do not take payment for services or other providers that do not typically accept Medicaid payments.

States' use of health care related taxes. While regulations permit health care related taxes for 18 different provider classes, such taxes have historically been used primarily to finance care provided by institutional providers (i.e., nursing facilities, ICFs-ID, and hospitals), nearly all of which typically participate in the Medicaid program.

- ▶ **Nursing facilities and ICFs-ID.** The tax revenue generated is typically used to increase (or mitigate reductions to) the per diem rates paid to these providers, meaning that the net effect of a tax on specific providers is driven by their actual Medicaid volume.

¹² These rules were enacted through the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). Prior to the passage of this Act, states were able to specifically tax providers that accepted Medicaid payment and ensure that the tax revenue could be repaid to these providers after drawing down federal matching funds.

¹³ 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 “safe harbor” of 6 percent of net patient revenue, however, the tax is permissible under this test (42 CFR 433.68(f)).

¹⁴ According to federal regulations (42 CFR 433.55 – 433.74), in order to be granted a waiver of the broad-based and uniform requirements, tax programs must pass statistical tests to show that they are generally redistributive.

¹⁵ Federal statute specifically allows states to exempt Medicare revenue from health care related taxes (§1903(w)(3)(C)(ii) of the Act). A waiver is not required to exclude Medicare revenue.

- ▶ **Hospitals.** Health care related taxes are typically used to finance supplemental payments (described further below) that can be targeted to particular providers, offering predictability with regard to the net effect of a health care provider's tax liability and increased Medicaid revenue (since the payments are not necessarily driven by current Medicaid volume).

Use of health care related taxes for hospitals, nursing facilities, and ICFs-ID has increased over the past decade (Figure 3a-4). In 2008, 18 states had a hospital tax compared to 34 states in 2011 (Figure 3a-5). By contrast, and particularly in recent years, the number of states using provider taxes for MCOs has decreased.¹⁶

States also increasingly use health care related tax programs to support other parts of their Medicaid programs (e.g., capitation payments to MCOs), rather than using them to support only those providers that pay the tax. Box 3a-2 describes several of the most common uses of health care related taxes.

Figure 3a-6 illustrates the scenario in which the health care related tax revenue is used both to support payment to the taxed providers and to fund payments to other Medicaid providers.

Data limitations regarding tax programs and implications for federal policymaking.

States are required to report, for informational purposes, the total amount of revenue generated by health care related taxes by provider type on their CMS-64. However, it is difficult to identify health care related tax rates and other tax program characteristics from existing federal data sources. For states that request waivers of the uniform and broad-based requirements, tax rates can be

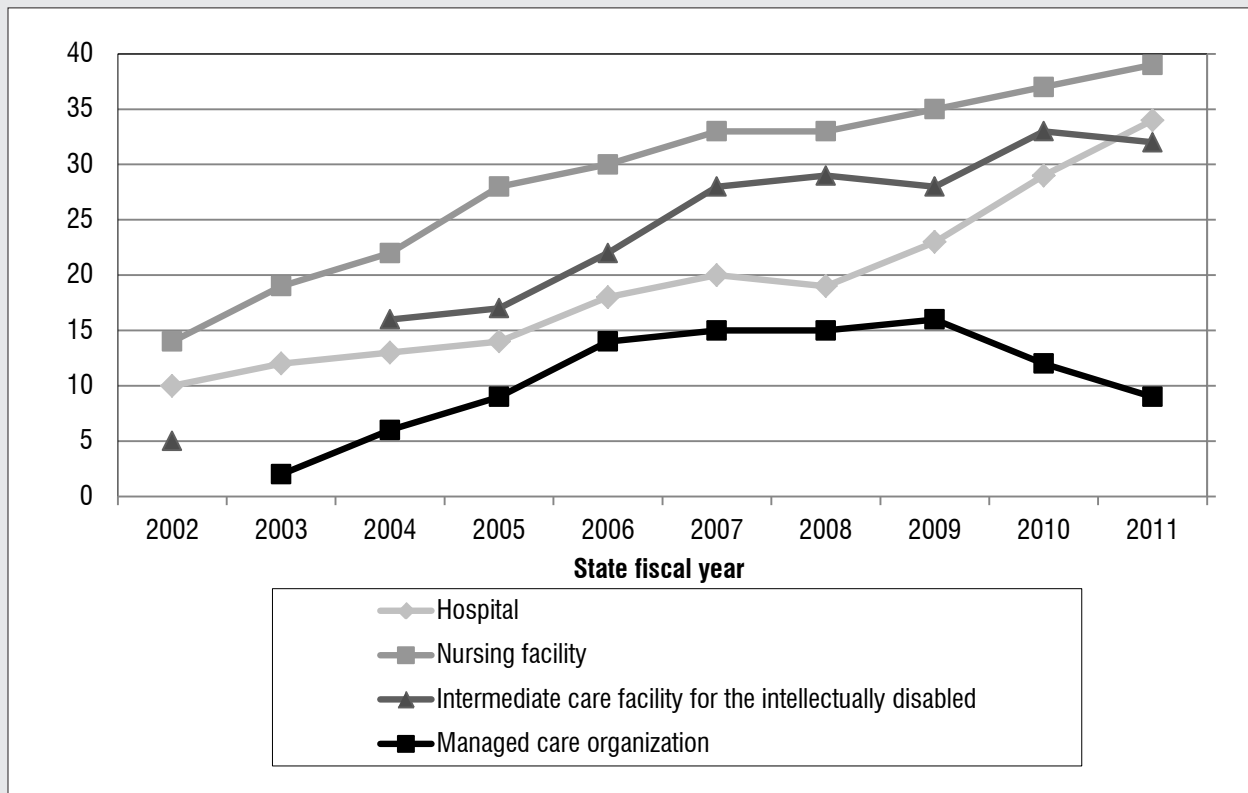
BOX 3a-2. Common Uses of Health Care Related Taxes

- ▶ All of the tax revenue and associated FFP fund the payment rates for the class of providers that pay the tax (taxed providers).
- ▶ All of the tax revenue and associated FFP fund lump-sum supplemental payments for taxed providers.
- ▶ A portion of tax revenue and associated FFP funds payment rates for taxed providers. The remainder is paid to the taxed providers as a lump-sum supplemental payment.
- ▶ A portion of tax revenue and associated FFP funds payment rates for taxed providers, either as a lump-sum supplemental payment or through payment rates. The remainder funds payments to other Medicaid providers.

discerned from the waiver requests that states provide to CMS. However, this information is not readily available for the many tax programs for which waivers are not requested. MACPAC analyses of publically available information (e.g., state statutes, websites, policy guidance) regarding health care related taxes applied to hospitals and nursing facilities indicate that, in the great majority of cases, the actual tax rate as a percent of net patient revenue could not be readily identified (Table 3a-2).

Health care related taxes are an important source of the non-federal share of Medicaid funding for states, and any changes to federal requirements should be carefully analyzed for their potential impact on both Medicaid payment rate levels for providers that pay the taxes as well as on other

¹⁶ Prior to 2005, states could limit a tax to MCOs that participated in Medicaid, allowing all of the companies that paid the tax to be repaid. The Deficit Reduction Act of 2005 required that the taxes apply to all MCOs (not only those participating in Medicaid). As a result, a number of states that had Medicaid managed care taxes have since ended these programs.

FIGURE 3a-4. States' Use of Health Care Related Provider Taxes, SFY 2002–2011

Note: 2003 data point for intermediate care facilities for the intellectually disabled not discernible from survey report.

Source: Kaiser Commission on Medicaid and the Uninsured: State Budget Surveys (2003-2011)

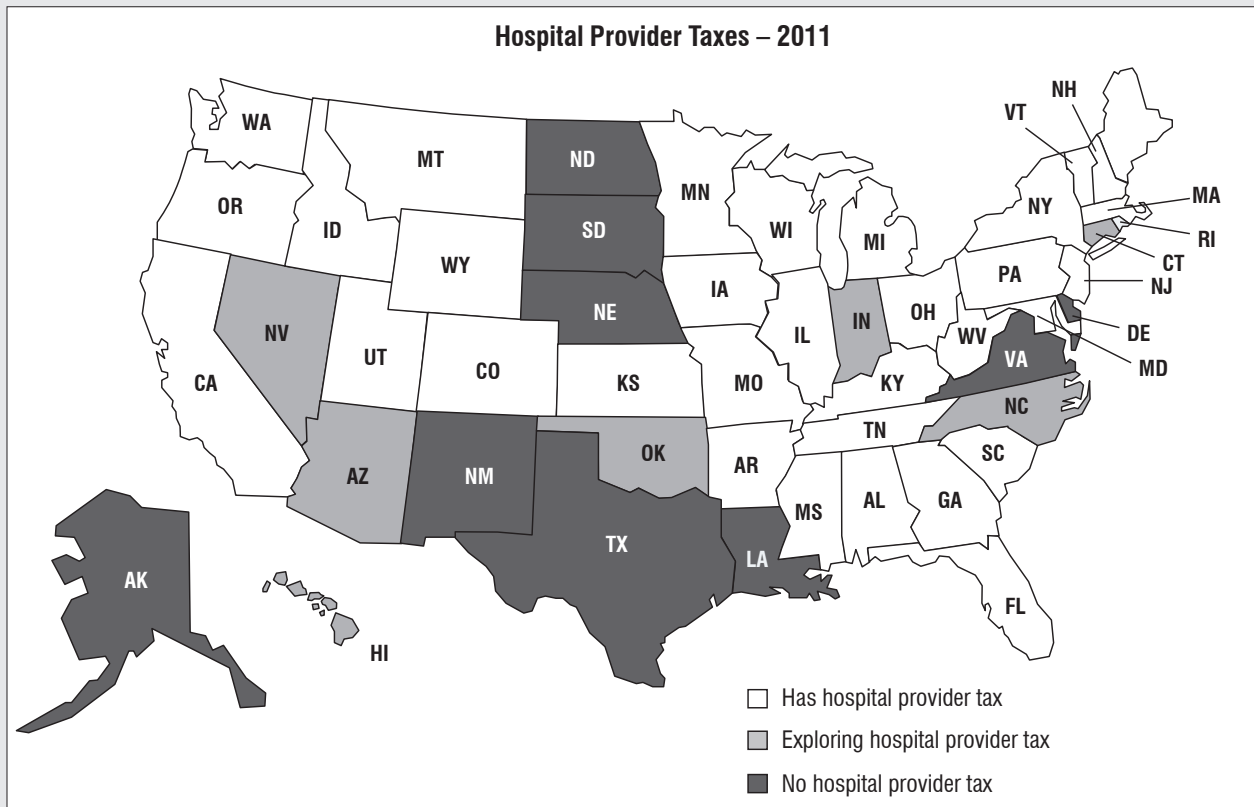
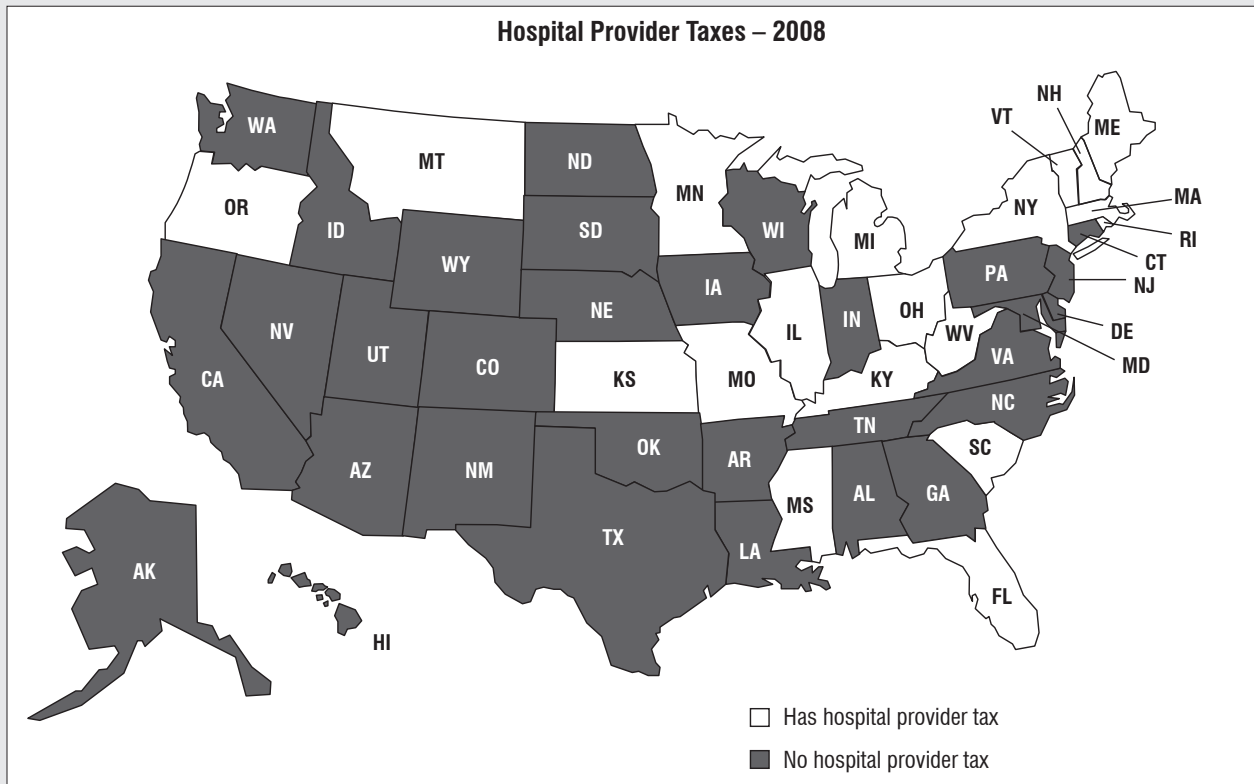
parts of the program financed through health care related tax revenue. However, such analysis is not currently possible based on existing federal data sources.

As an example, over the past decade, federal policymakers have considered reducing the “safe-harbor” percentage under which states can collect a health care related tax without performing the indirect hold-harmless test (currently 6 percent).¹⁷ Changing this threshold, which acts as an effective cap on health care related tax rates, could have a significant impact on many of the states that

have enacted such taxes and rely on them to finance aspects of their Medicaid programs. In fact, a recent survey of states found that at least 38 states have at least one health care related tax that exceeds 3.5 percent of net patient revenue (Smith et al. 2011). Yet, without knowing each state’s actual tax rates as a percentage of net patient revenue, federal policymakers cannot determine the potential reduction in state revenue or federal matching funds that would result, or the potential impact on provider participation and access to services.

¹⁷ Federal statute (§1903 (w)(4)(c)(ii)) temporarily reduced this percentage to 5.5 for fiscal years beginning on or after Jan. 1, 2008 and before Oct. 1, 2011.

FIGURE 3a-5. Health Care Related Taxes on Hospital Services, SFY 2008 and 2011



Source: Kaiser Commission on Medicaid and the Uninsured: State Budget Surveys (2008 and 2011)

FIGURE 3a-6. Illustration of a Permissible Health Care Related Tax on Hospitals

Health care related taxes are specifically authorized by federal statute as a source of non-federal Medicaid financing and have been implemented by nearly every state. The following example is illustrative only, based on an FMAP of 60 percent. Actual health care related tax amounts and the distribution of tax revenue vary across states and by each individual tax.

Tax Assessment (Step 1) – Each hospital is assessed a tax that results in \$40 of tax revenue to the state.

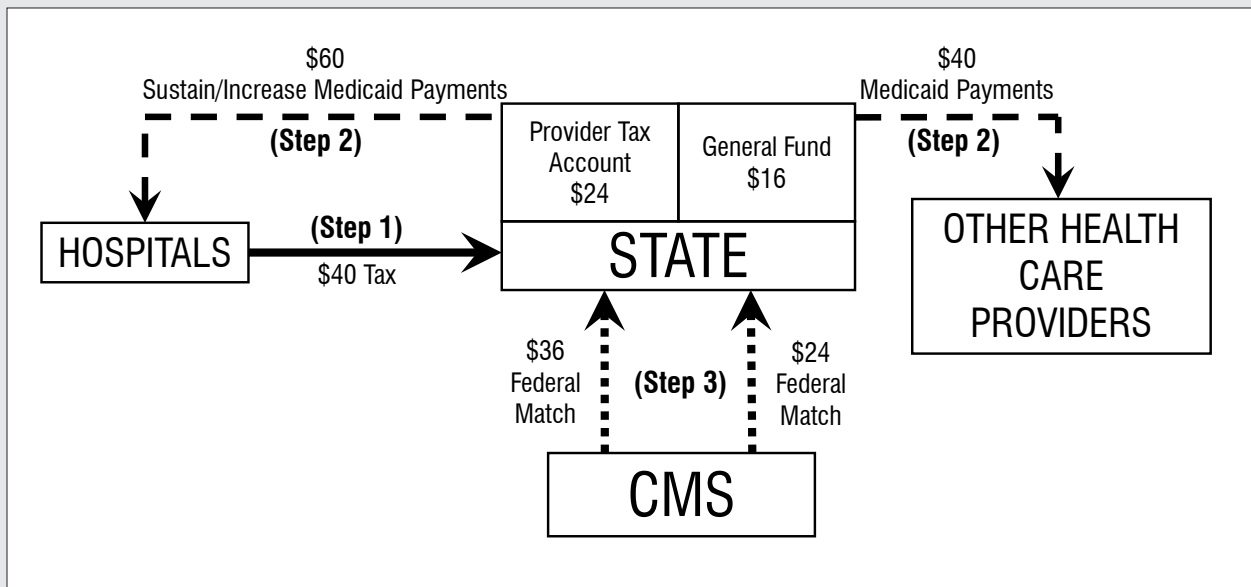
- ▶ \$24 of this tax revenue is deposited into a provider tax account.
- ▶ \$16 of this tax revenue is deposited into the state general fund.

Provider Payment (Step 2) – The state uses the tax revenue that is collected as the non-federal share of Medicaid payments to providers.

- ▶ \$60 is used to sustain or increase Medicaid payment rates to hospitals, of which \$24 is from the health care related tax.
- ▶ \$40 in Medicaid payments is made to other health care providers, of which \$16 is from the health care related tax.

Federal Match (Step 3) – The state may then claim federal matching funds for the Medicaid payments that it made and receive 60 percent of the amount paid to providers from CMS.

- ▶ CMS makes a \$36 payment to the state, which is 60 percent of the \$60 payment to hospitals.
- ▶ CMS makes a \$24 payment to the state, which is 60 percent of the \$40 payment to other health care providers.



Source: MACPAC analysis 2012

TABLE 3a-2. Health Care Related Tax Rates for Hospitals and Nursing Facilities Identified from State Statutes and Other Public Sources, FY 2011

Tax rate	Number of States	
	Hospitals	Nursing facilities
5.0% - 6.0%	4	5
3.6% - 5.0%	–	–
2.0% - 3.5%	5	–
Up to 2.0%	4	–
Unknown	21	34
Total states with taxes	34	39

Note: Public data sources reviewed include state statute and state government websites. States are permitted to tax providers using various provider-specific measures, such as hospital days or nursing facility beds. Thus, tax rates are often not presented as a percent of net patient revenue.

Source: MACPAC analysis of publically available information regarding health care related taxes 2012

Supplemental Payments to Providers

Some states make payments to providers above what they pay for individual services through Medicaid provider rates, with these payments commonly financed through local government contributions (most often IGTs) and health care related taxes. These additional payments fall into two categories:

- ▶ DSH – payments to hospitals serving low-income patient populations, which accounted for over \$17 billion (including federal matching funds) in FY 2011; and
- ▶ UPL – supplemental payments, which comprise the difference between total base 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.

Because DSH and UPL payments are generally paid to providers in lump sums, their impact on

Medicaid rates for services is difficult to isolate. As a result, it is also difficult to compare actual payment rates among providers, either within or across states, and to understand the actual specific uses of the federal Medicaid funds provided to states (i.e., which providers receive the funds, in what amounts, and for what specific Medicaid purposes). The large majority of supplemental payments go to hospitals, and such payments may be an especially important source of revenue for hospitals that serve a significant proportion of Medicaid enrollees and uninsured individuals.

DSH payments

States are statutorily required to “take into account the situation of hospitals serving a disproportionate share of low-income patients” when designing payment systems (§1902(a)(13)(A)(iv) of the Act).¹⁸ In 1987, the Congress further strengthened this requirement to ensure the financial stability of disproportionate share hospitals by requiring states to make additional payments to such hospitals for

¹⁸ As discussed in Chapter 5 of MACPAC’s March 2011 *Report to the Congress on Medicaid and CHIP*, this requirement was enacted in 1981 when states were given broader discretion over Medicaid payment rates to hospitals.

uncompensated care costs, including both the costs of care for the uninsured and Medicaid costs that are not covered by Medicaid payments.

The Congress has refined the DSH program on several occasions, largely in response to concerns about states' use of DSH funds in making large DSH payments to hospitals operated by state or local government that were then transferred back to the state and used for other purposes. The most significant changes occurred in 1991 and 1993, when the Congress first placed state-specific caps on the DSH funds that could be allocated to hospitals (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. 102-234), and then created hospital-specific limits equal to the actual cost of uncompensated care for hospital services provided to Medicaid enrollees and uninsured individuals (OBRA 1993, P.L. 103-166).¹⁹ In 2003, the Congress added a requirement for annual independent audits to verify that DSH payments do not exceed allowable uncompensated care costs (P.L. 108-173; 42 CFR 447.299). In 2010, the Congress reduced state DSH allotments, beginning in 2014, to account for the decrease in uncompensated care anticipated with the implementation of PPACA (§1203 of P.L. 111-148, as amended).

The purpose of DSH payments continues to be to improve the financial stability of safety-net hospitals and preserve access to necessary health services for low-income patients. State methods for determining which hospitals receive DSH payments and in what amounts vary within broad federal guidelines. All hospitals with high Medicaid or low-income inpatient utilization rates must qualify for DSH payments, and states may

designate other DSH hospitals as long as they have a Medicaid utilization rate of at least 1 percent.²⁰ As a result, states may include a wide range of hospitals in their designation of DSH hospitals, as long as those meeting the specified minimum criteria are included (§1923 of the Act).

Non-DSH (UPL) supplemental payments

Before 1980, states were required to pay rates for hospital and long-term care services based on the providers' "reasonable costs" (former §1902(a)(13) of the Act), and state payment methods for these providers mirrored Medicare's. Concerned with rapidly rising Medicaid costs, caused in part by the inflationary nature of cost-based reimbursement (U.S. House of Representatives 1981), the Congress passed the Boren Amendment (OBRA 1980, P.L. 96-499 for long-term care providers and OBRA 1981, P.L. 97-35 for hospitals) affording states more flexibility in determining payment rates. Delinking Medicaid rates from reported provider costs and the Medicare payment methodology gave states significant flexibility when crafting Medicaid payment policies, but necessitated a new measure by which to assess the reasonableness of states' Medicaid payment rates.

When considering the Boren Amendment, the Congress expected that Medicaid payments would not exceed Medicare payments for the same services (U.S. Senate 1979). Citing that opinion and the portion of the Act requiring that payments should be consistent with efficiency, economy, and quality of care, HHS promulgated regulations prohibiting FFP for Medicaid payments in excess of what would have been paid under Medicare

¹⁹ In a 1994 letter to state Medicaid Directors, CMS (then HCFA) instructed states that the cost of "hospital services" includes both inpatient and outpatient costs (HCFA 1994).

²⁰ Statute requires a hospital to be deemed a disproportionate share hospital if its Medicaid inpatient utilization rate is at least one standard deviation above the mean for hospitals that receive Medicaid payments or if its low-income utilization rate exceeds 25 percent (§1923(b) of the Act).

payment principles.²¹ This policy created what is known as a UPL.

The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, ICFs-ID, and freestanding non-hospital clinics. As discussed below, 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. CMS requires that states demonstrate, in conjunction with its review

of State Plan Amendments (SPAs), that any changes in their institutional payment amounts do not exceed the UPL. (See Annex 1 for a further discussion of UPL requirements.)

Payments under the UPL. Although the UPL regulations were intended to limit Medicaid payments to a group of institutions, some states have used the provisions to direct supplemental payments to providers (Box 3a-3). Under the UPL requirements, states may make—and receive federal matching dollars for—payments beyond the standard payment to any institution,

BOX 3a-3. Illustrative Examples of UPL Supplemental Payment Methods

Payments based on overall Medicaid utilization:

- ▶ Dividing supplemental payments among inner-city hospitals with high Medicaid volume based on each hospital's total number of inpatient Medicaid days relative to the total number of inpatient Medicaid days among all qualifying hospitals; and
- ▶ Making a fixed-dollar supplemental payment for each Medicaid discharge to promote access to acute care, and to children's, rehabilitation, and critical access hospitals.

Payments based on specific types of services provided to Medicaid enrollees:

- ▶ Distributing supplemental payments among hospitals with high Medicaid use in pediatric acute care or pediatric intensive care units;
- ▶ Providing enhanced inpatient Medicaid supplemental payments to certain children's hospitals based on the number of days of psychiatric or physical rehabilitation care provided to children and the total number of days of inpatient care provided to children during specified base years; and
- ▶ Making quarterly supplemental payments to general acute care hospitals with psychiatric units based on each hospital's total number of Medicaid days provided and, among other things, the number of total beds and psychiatric beds, and the psychiatric unit occupancy rate.

Payments based on specific types of services regardless of Medicaid use:

- ▶ Distributing supplemental payments each year to trauma hospitals. All eligible hospitals receive an equal share of the total funding, regardless of each hospital's size or Medicaid volume.

Source: MACPAC analysis of state hospital payment methodologies, 2011

²¹ UPL regulations were initially promulgated in September of 1981 (46 Fed. Reg. 47964-47973). For the current UPL regulations, see 42 CFR 447.272(b) (defining upper payment limits for inpatient care); 42 CFR 447.321(b) (defining upper payment limits 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).

TABLE 3a-3. 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. See MACStats Table 20 for additional information. 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

as long as they do not exceed the UPL for the specific group of institutions.²² As a result, the term “UPL payments” is used to refer to the additional payments states make under this rule to supplement or enhance the standard Medicaid payment. If a state makes UPL payments, the payment methodology must be documented in the Medicaid state plan. UPL payments are not subject to provider-specific caps,²³ and individual providers may receive more than their reported Medicaid costs as long as the aggregate payments to all providers in their class fall below the aggregate UPL. 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, CMS has used

average commercial rates for physician services as a comparison (CMS 2011).

As of FY 2010, states are required to provide CMS with aggregate information on their UPL supplemental payments by type of service on the CMS-64.²⁴ In FY 2011, states reported \$25.9 billion in UPL supplemental payments.²⁵ The vast majority of UPL payments are made to hospitals (Table 3a-3). In 2011, states reported total FFS hospital spending of \$91.9 billion, including \$23.2 billion in UPL payments (Table 3a-3). Total supplemental payments, including UPL and DSH, accounted for 41 percent of total FFS Medicaid payments to hospitals in FY 2011 (see MACStats Table 20).

²² It is important to note that the reductions in Medicare payment updates enacted through the PPACA may have a corresponding impact on the amount of Medicaid payments that states are able to make to providers by reducing the UPL. OACT (2011) includes this scenario.

²³ 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).

²⁴ The form defines inpatient “supplemental payments” as follows: “These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the (sic) other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.” Similar definitions are provided for outpatient services.

²⁵ CMS is continuing to work with states on how to break out UPL supplemental payment information; thus, the FY 2011 data may be incomplete or inaccurate in some cases. However, even these data suggest that states rely heavily on supplemental UPL payments.

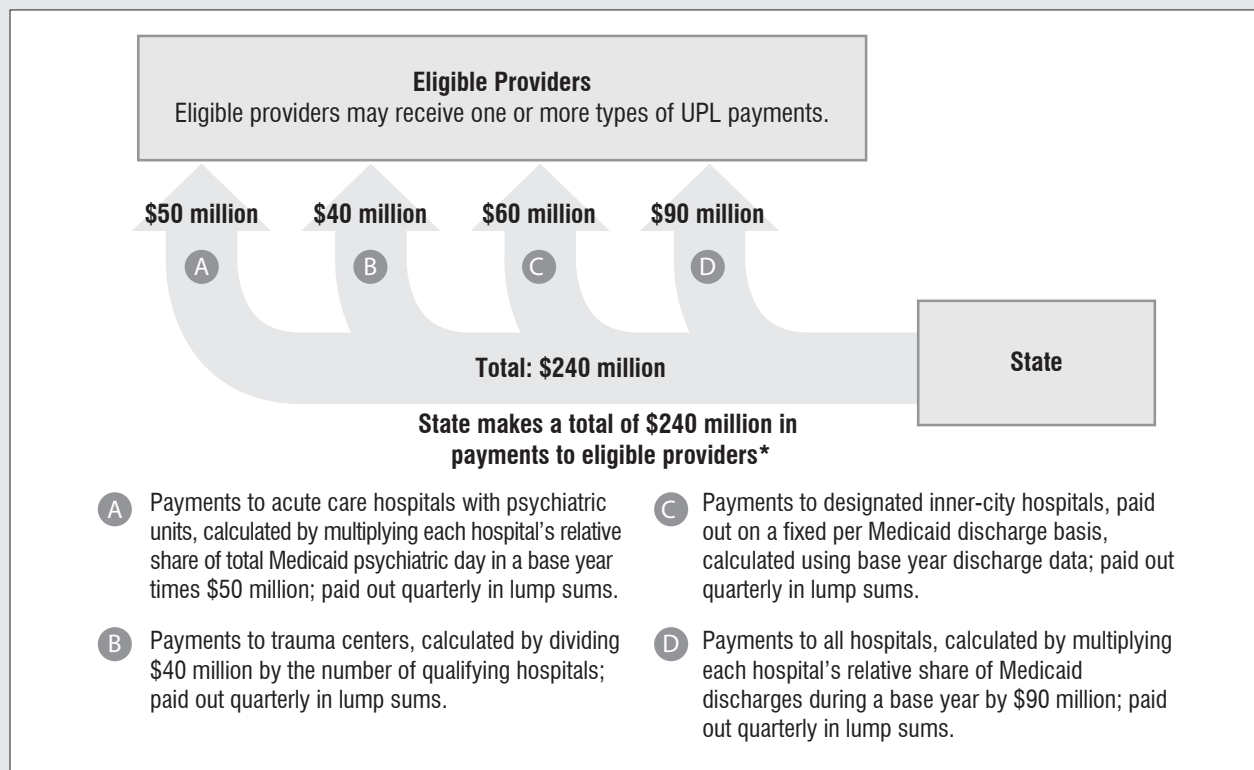
In determining whether and how much money to allocate to UPL payments, states start by calculating the difference between the UPL for services provided by a class of governmental or private institutions and the aggregate amount Medicaid pays for those services. States then target the amount of the difference—or some portion of it—to a subgroup of institutions, allocating it among eligible institutions usually, but not always, based on Medicaid days, visits, or discharges.

Many states make supplemental UPL payments to providers, and these payments can account for more than half of a state’s total payments to a given class of providers. In a 2008 report, the Government Accountability Office (GAO) found that each of the five states it studied made supplemental payments to a range of hospitals

(GAO 2008). The GAO noted that, in all cases, these were quarterly or annual lump sum payments to a targeted subgroup of hospitals in amounts often calculated as a function of Medicaid days or visits.

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 institutions within the class. Further, unlike standard Medicaid payments, UPL payments are “add-ons” that may not be directly related to specific services or Medicaid patients. Figure 3a-7 provides a hypothetical example of how one state

FIGURE 3a-7. 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

might distribute UPL supplemental payments among hospitals.

Federal data limitations regarding UPL payments. UPL payments can be an important source of revenue for providers, particularly safety-net hospitals, and CMS has maintained aggregate (rather than provider-specific) UPLs in order to preserve states' flexibility to address their own unique programmatic challenges (HCFA 2001). However, because these payments are not necessarily associated with specific services or enrollees and are not reported at the provider level, it is difficult for state and federal policymakers to compare total Medicaid payments across providers and enrollment groups and to evaluate the impact of these lump-sum payments on payment methods and delivery models (Box 3a-4).²⁶

Both the GAO and the HHS Office of Inspector General (OIG) have noted that CMS has limited information regarding supplemental payments to providers, especially hospitals (GAO 2008, 2004a; OIG 2001). Furthermore, supplemental payments are not directly associated with specific services or enrollees. As a result, it is not possible to:

- ▶ identify how much Medicaid actually spends on specific services and populations or to make meaningful intra- or cross-state comparisons of payment amounts or methods;
- ▶ determine the ultimate disposition of federal funds that are provided to states for their Medicaid programs (i.e., which providers receive supplemental payments and in what amounts); or
- ▶ assess fully the extent to which payment policies affect efficiency, quality, and access to appropriate services.

Furthermore, the impact of policies intended to promote certain outcomes through payment

rates (e.g., pay for performance) may be muted by providers' ability to access supplemental payments. On the other hand, the supplemental payments themselves may be promoting access, efficiency, and quality. Without knowing what providers they are going to, and in what amounts, this is difficult to assess.

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, due to the fact that UPLs are only based on FFS days in a hospital or institutional setting. Transitioning populations from FFS to managed care, therefore, means fewer FFS days and lower potential UPL supplemental payments. Under managed care arrangements, the state makes a capitated payment to a managed care entity, which then directly contracts with and pays providers. In response to comments on changes in the UPL regulations in 2001, CMS specifically stated that the UPL for institutional payments applies to FFS payments, and that managed care payments are subject to separate regulatory requirements that provide adequate flexibility for MCOs to pay appropriate rates. In the case of DSH, CMS pointed out that, as of January 1, 2001, states must consider managed care payment shortfalls to providers in the calculation and allocation of DSH payments (HCFA 2001).

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 supplemental UPL 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 to the

²⁶ The previously mentioned DSH audit reports are required to include UPL supplemental payments, by provider. However, the audit reports include only hospitals that receive DSH payments.

BOX 3a-4. Health Care Related Taxes and Supplemental Payments Complicate Analysis of Provider Payment

As discussed above in detail, Medicaid health care related taxes are often used to finance payments to Medicaid providers. However, the net Medicaid payments actually retained by providers are effectively reduced by the health care related taxes they pay, making it difficult to make comparisons across states and other payers such as Medicare and private insurance.

If health care related tax revenue is used to finance rates such as per diem nursing facility rates, it may be misleading to compare these rates to those that are not partially financed by these taxes. Consider the following example of three hypothetical states' average nursing facility rates:

	State A	State B	State C
Average daily rate	\$150	\$150	\$150
Bed tax per day	–	5	10
Net average daily rate	150	145	140

Although claims data would indicate that all three states paid nursing facilities the same average daily amount, after accounting for health care related tax payments, the net amounts are actually different. This is an important consideration when comparing rates across states and payers; however, the lack of consistent and reliable national data regarding existing tax programs makes accounting for the impact of such taxes difficult.

The same “net payment” issues arise when health care related tax revenue is used to finance lump-sum supplemental Medicaid payments, which typically go to hospitals. Consider the following example of three hypothetical states' Medicaid payments to hospitals:

	State A	State B	State C
A) “Standard” Medicaid payments for services*	\$500,000,000	\$500,000,000	\$500,000,000
B) Medicaid enrollees served	100,000	100,000	100,000
C) Average standard payment per enrollee (A/B)	5,000	5,000	5,000
D) Health care related taxes paid	–	50,000,000	100,000,000
E) Net standard payments per enrollee ((A-D)/B)	5,000	4,500	4,000
F) Supplemental payments	–	100,000,000	250,000,000
G) Net total Medicaid payment per enrollee ((A-D+F)/B)	5,000	5,500	6,500

Claims data would indicate that each state made the same average payment of \$5,000 per enrollee to hospitals. However, similar to the previous example, after accounting for health care related tax payments, the net hospital payments per enrollee in states B and C are lower than those in state A. If, however, the tax payments are used to finance supplemental payments, the net total Medicaid payment per enrollee may actually be higher. Such lump-sum supplemental payments are not included in claims data that reflect service use by individual Medicaid enrollees and are generally not reported to the federal government at the provider-specific level. As a result, it is difficult to account for these lump-sum payments in any comparison of payments for individual Medicaid services or populations.

* Includes payments made based on a state's standard fee schedule or other standard payments for specific services provided to specific enrollees and included in a state's claims data. These payments are reported on the CMS-64 as “regular payments.”

Source: MACPAC analysis 2012

state realized 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. On the other hand, enrolling populations such as children and parents, who typically use fewer inpatient days, has less of an impact on supplemental payment amounts and has posed less of a deterrent to enrolling these populations in managed care.

Faced with the choice between the potential benefits of shifting Medicaid beneficiaries into capitated programs and the desire to maintain or increase the use of UPL payments, states have explored alternative ways of maintaining supplemental payments to particular hospitals. However, CMS considers strategies that require MCOs to “pass through” supplemental payments to contracted providers to be inconsistent with the statute that requires capitation rates to be actuarially sound. According to federal regulations, the services covered by Medicaid managed care plans must be considered “paid in full” through the rate paid to the plan (42 CFR 438.60). Thus, supplemental payments are not permitted within risk-based managed care.

A few states have delayed implementation or expansion of Medicaid managed care because of the potential loss in federal matching dollars for supplemental payments; in some cases, 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. In Texas, the state 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 3a-5). As states expand the use of managed care, the Commission will assess the role of financing approaches and supplemental payments in state decisions regarding program design and populations served, and evaluate changes to federal Medicaid program policy.

Looking Forward

The Commission will continue to consider how non-federal financing approaches interact with payments to providers and access to high-quality and appropriate services. These issues are especially important at a time when states are seeking ways to reduce growth in Medicaid spending, introduce quality improvements and health care efficiencies, and prepare for implementation of PPACA in 2014.

The Commission intends to continue its analysis of:

- ▶ states’ approaches to financing their share of the Medicaid program and the need for additional information regarding these approaches;
- ▶ the effect of state financing approaches on Medicaid payment methods and rates;
- ▶ the effect of variable federal matching rates and incentives on state financing and payment policies; and
- ▶ the potential interaction among financing, payment, and access to services.

This information will allow policymakers to 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.

BOX 3a-5. 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 receive 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 services (Millwee 2011).

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Chapter 3a Annex 1

UPL Requirements and Calculations for Institutional Providers

UPL requirements. Under the current UPL regulations, states may not make aggregate FFS Medicaid payments for FFS Medicaid services rendered by all institutions within a given class (e.g., inpatient hospital, nursing facility) that exceed what those institutions would have received under Medicare payment principles. To determine the applicable UPL, each class of institutions is then divided into the following three classes of ownership:

- ▶ state-owned or operated government institutions;
- ▶ non-state-owned or operated government institutions (e.g., local government hospitals); and
- ▶ private institutions.

There is a separate UPL for each pairing of institution and class of ownership. In other words, state-owned government nursing facilities are subject to a different UPL than are private nursing facilities. Therefore, with five institutional provider classes (inpatient hospital, outpatient hospital, nursing facilities, ICFs-ID, and freestanding non-hospital clinics) and three ownership classes (private, state-owned, and other governmental), there are a total of 15 different UPLs.

Any payments that exceed the aggregate UPL for a given class of institutions are not eligible for FFP. Notably, Medicaid payments to any one institution may exceed the amount that institution would have received under Medicare payment principles as long as all payments to the entire class of institutions do not.

Methods for calculating the UPL. Although UPLs are based on Medicare payment principles, states are not required to determine exactly what Medicare would have paid for each individual service rendered by an institution; instead, they must develop, through discussions with CMS, an acceptable methodology that applies general Medicare payment principles.

CMS's State Medicaid Manual highlights the basic Medicare payment principles that states must consider when creating their processes for estimating UPLs. Specifically, states must consider the following:

- ▶ **Cost-based reimbursement.** Under Medicare payment principles, reimbursable costs may not exceed the costs necessary for the efficient delivery of needed health services. When CMS establishes limits on reimbursable costs for Medicare, it relies on facility cost reports from prior years, and then adjusts those costs to reflect growth in health care costs going forward. Although states are permitted to use Medicare’s cost-based reimbursement principles when calculating UPLs, Medicare generally no longer uses cost-based reimbursement methodologies to determine payments for institutional providers. One exception is critical access hospitals, which continue to be reimbursed under a cost-based system (MedPAC 2010, 42 CFR 413.70).

States may apply Medicare cost-based reimbursement principles to calculate UPLs by using data from each provider’s Medicare cost reports. The state Medicaid agency uses these data to calculate each provider’s cost-to-charges ratio for all payers, including Medicare, Medicaid, and commercial payers. The state then multiplies each provider’s total Medicaid charges by the cost-to-charges ratio to determine Medicaid costs (based on Medicare cost-based reimbursement principles) for that provider. Next, the state tallies the Medicaid costs for each provider type within a class of ownership to determine the total for the class. This total is the UPL for that class of ownership, which is then compared to the total Medicaid payment for the same services rendered by the same group of providers.

- ▶ **Prospective payment.** Prospective payment is another core aspect of Medicare payment. As noted above, rates in prospective payment systems are fixed in advance and do not vary based on specific providers’ costs or charges.

In applying Medicare payment principles to calculate the UPL for inpatient hospital services paid on the basis of diagnosis-related groups (DRGs), a state Medicaid program may run each DRG-based, Medicaid-paid claim through the software that calculates Medicare payments based on the applicable DRG in order to calculate what Medicare would have paid the hospital for the particular DRG. The state Medicaid agency then adds up, for all hospitals within a given class of ownership, what Medicare would have paid for each Medicaid discharge. This total is the UPL for inpatient hospital services for hospitals in the given class of ownership.

Once UPLs are calculated, CMS will generally permit states to simply trend those amounts forward for several years rather than require new UPL calculations every year.

State flexibility in UPL calculations. States must consider the Medicare payment principles and describe in their Medicaid State Plans the specific processes by which they will determine their UPLs based on these broad principles. States may deviate from specific Medicare payment policies when calculating their UPLs as long as they describe how their methodologies differ and demonstrate that they are nonetheless in compliance with broad Medicare payment principles. CMS must approve each state’s methodologies for calculating UPLs, and states work with their regional CMS officials to develop these methodologies.

In a 2004 report, the GAO reviewed several states’ UPL calculation methods and identified wide variations and several potential errors (GAO 2004). As a result, the report recommended that CMS provide states with uniform guidance regarding how to calculate UPLs. CMS indicated that it concurred with the recommendation, but contended that “an exhaustive ‘laundry’ list of acceptable methods” could not be compiled.

Instead, CMS indicated that it would issue guidance on the characteristics and principles underlying acceptable methods, along with extensive examples of how these methods could be applied. A similar recommendation to provide definitive guidance for calculating UPLs can be found on the HHS OIG March 2011 list of unimplemented recommendations (OIG 2011).

Chapter 3a Annex 2

Key Statutory Provisions for Medicaid Financing and Supplemental Payments

TABLE 3a-A2. Provisions of the Social Security Act

Section 1101(a)(8)	Procedure for determining FMAP annually
Section 1902(a)(13)(A)	Public process for determination of payment rates to hospitals, nursing facilities, and ICFs-ID
Section 1902(a)(13)(A)(iv)	Requirement to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs
Section 1902(a)(30)(A)	Payment methods and procedures to safeguard against unnecessary utilization, consistent with efficiency, economy, and quality, and provide access equal to the general population
Section 1903(a)	Federal payment to states, including FMAP and other matching rates
Section 1903(d)	Quarterly payment estimates based on state reporting (CMS-37)
Section 1903(m)(2)(A)(iii)	Managed care capitation rates must be actuarially sound
Section 1903(w)(1)–1903(w)(5)	Requirements for the use of health care related taxes
Section 1903(w)(6)	Use of funds transferred from or certified by units of government (IGTs and CPEs)
Section 1905(b)	General FMAP formula
Section 1923	Payment for inpatient hospital services provided by disproportionate share hospitals

Chapter 3a Annex 3

Key Regulatory Requirements for Medicaid Financing and Supplemental Payments

TABLE 3a-A3. Federal Regulations

42 CFR 433.51	Public funds as the state share of financial participation
42 CFR 433.53	General requirements regarding state and local sources of non-federal financing
42 CFR 433.54	Bona fide provider-related donations
42 CFR 433.55	Health care related taxes defined
42 CFR 433.56	Classes of health care services and providers eligible for health care related taxes
42 CFR 433.57	General rules regarding revenue from provider-related donations and health care related taxes
42 CFR 433.66	Permissible provider-related donations
42 CFR 433.67	Limitations on level of FFP for permissible provider-related donations
42 CFR 433.68	Permissible health care related taxes
42 CFR 433.70	Limitation on level of FFP for revenue from health care related taxes
42 CFR 433.72	Waiver provisions applicable to health care related taxes
42 CFR 433.74	Reporting requirements for provider-related donations and health care related taxes
42 CFR 438.6(c)	Managed care capitation rates must be actuarially sound
42 CFR 438.60	Prohibition on direct payments to providers other than the managed care entity for services covered under a managed care contract
42 CFR 447.257	Restriction on FFP for payments to inpatient hospitals and nursing facilities in excess of upper limits
42 CFR 447.272	Upper payment limits for inpatient services in hospitals, nursing facilities, and ICFs-ID
42 CFR 447.297	Limitations on aggregate DSH payments
42 CFR 447.298	State DSH allotments
42 CFR 447.299	DSH audit reporting requirements
42 CFR 447.304	Restriction on FFP for payments for other institutional and non-institutional services
42 CFR 447.321	Upper payment limits for outpatient hospital and clinic services
42 CFR 447.325	Upper payment limits for other inpatient and outpatient services

CHAPTER 3b

Update on Federal Financing of CHIP

As part of the Commission's focus on the State Children's Health Insurance Program (CHIP), Chapter 3 of MACPAC's March 2011 *Report to the Congress on Medicaid and CHIP* provided a broad overview of CHIP. In September 2011, the Commission published a MACBasic that explored federal CHIP financing in detail. This section provides a brief overview of federal CHIP financing, which differs from federal Medicaid funding in several ways:

- ▶ Federal CHIP allotments to states, which are based on a formula using each state's previous CHIP spending, are capped; states can exhaust their federal CHIP funding, unlike typical federal Medicaid funding.
- ▶ Under current law, there are no appropriations for new federal CHIP allotments after FY 2015, while federal Medicaid funding will continue automatically.
- ▶ The federal matching rate—that is, the percentage of spending paid for by the federal government—is higher under CHIP than under Medicaid; although the amounts vary by state, the federal government pays for 70 percent of CHIP spending on average, compared to 57 percent historically under Medicaid.

Federal CHIP Allotments

States' CHIP spending is generally matched by the federal government, drawing on states' federal CHIP allotments and using a federal matching rate known as the Enhanced Federal Medical Assistance Percentage (E-FMAP). The E-FMAP lowers the state share by 30 percent relative to the state share under the Medicaid FMAP. For example, states with a 50 percent FMAP under Medicaid have an E-FMAP under CHIP of 65 percent, with the state share reduced to 35 percent, from 50 percent.

From FY 1998 to FY 2008, the annual appropriations for federal CHIP allotments ranged from \$3.1 billion to \$5.0 billion. From FY 2009 to FY 2015, allotment appropriations range from \$10.6 billion to \$21.1 billion, as set by Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) and the

Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). There are currently no appropriations for CHIP allotments beyond FY 2015.

Every year, CHIP allotment amounts are calculated for each state and territory, which they will receive unless the national appropriation is inadequate (MACPAC 2011a, 2011b). Every other year, the allotment is updated to reflect actual spending; for FY 2011, FY 2013 and FY 2015, the federal allotment for a state is based on its prior-year CHIP *spending* plus a state growth factor. For intervening years, the allotment is calculated primarily as the prior-year *allotment* plus a state growth factor; in these years, a state can also have its allotment increased to reflect an expansion of CHIP eligibility or benefits (§2104(m)(6) of the Act). Table 21 of MACStats shows states' federal CHIP allotments for FY 2011 and FY 2012. Table 8 of MACStats displays states' federal CHIP spending in FY 2011.

CHIPRA Contingency Fund

CHIPRA increased total CHIP appropriations over prior years and overhauled the allotment formula to align more closely with states' actual use of federal CHIP funds. In the event shortfalls still occur, CHIPRA created a child enrollment contingency fund, which was appropriated at \$2.1 billion in FY 2009. The purpose of this fund was to ensure that the limited federal funds available for reducing CHIP funding shortfalls would first go to states with sizeable enrollment growth.

If a state is projected to exhaust its federal CHIP funding, the statutory contingency fund formula may provide funding in the amount derived by multiplying two numbers:

- ▶ CHIP child enrollment growth;¹ and
- ▶ the federal share of the state's per capita CHIP expenditures for those children.

As currently constructed and as described in previous Commission analyses (MACPAC 2011a, 2011b), this formula can provide states with federal funds beyond what they would need to eliminate potential shortfalls of federal CHIP funds. This occurred in FY 2011, when payments were made to a state from the contingency fund for the first time. In this case, the state's contingency fund payment (\$28.9 million) significantly exceeded its projected shortfall (\$3.8 million). A change in federal statute would be required to ensure that contingency funds pay only up to the amount of a state's shortfall. Such a change in policy could result in minimal federal savings that could affect a limited number of states in FY 2013–2015. The Commission's future work will follow this and other CHIP financing and coverage issues.

¹ Enrollment growth is the amount by which the average monthly unduplicated child enrollment in CHIP during the fiscal year exceeds the target number (that is, the FY 2008 average monthly unduplicated child enrollment in CHIP, as adjusted by the state's annual growth in child population plus one percentage point (§2104(n)(3)(B) of the Act).

References

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011a. *MACBasic: Federal CHIP financing*. Washington, DC: MACPAC. <http://www.macpac.gov/reports>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011b. *Report to the Congress on Medicaid and CHIP*. March 2011. Washington, DC: MACPAC. <http://www.macpac.gov/reports>.