

# Medicaid Inpatient Hospital Services Payment Policy

## Overview

State Medicaid programs are required to cover inpatient hospital services, that is, services and items furnished by a hospital for the care and treatment of a patient who is admitted to a hospital.

In fiscal year (FY) 2014, Medicaid hospital spending, including inpatient and outpatient services, was about \$85.4 billion, or about 18 percent of total program benefit spending.

States have broad flexibility to determine payments for inpatient hospital services. MACPAC has documented each state's fee-for-service (FFS) inpatient hospital services payment policy, including how individual states set their payment rates and various adjustments and supplemental payments, in [State Medicaid Payment Policies for Inpatient Hospital Services](#).

## Payment Method

States have selected, and the Centers for Medicare & Medicaid Services (CMS) has approved, a wide range of payment methods for inpatient hospital services, including:

- **Diagnosis-related groups (DRGs):** Most states have adopted payment methods based on DRGs, a classification system adopted by Medicare in 1983. Under this method, hospitals are paid a fixed amount per discharge, with outlier payments for especially costly cases. Among states using DRGs, states can choose from multiple DRG software products. Each product uses a distinct and proprietary grouper.

- **Per diem:** Some states pay hospitals for the number of days that a patient is in the hospital. Under this method, every procedure has the same base rate, which is multiplied by the total number of days during the stay to determine the total payment.
- **Cost-based:** Some states pay for inpatient services based on each individual hospital's reported costs. This approach is less common than DRGs or per diem-based payment. Many states use cost-based reimbursement for certain types of hospitals, such as small hospitals (such as critical access hospitals) and government-owned hospitals.

As of April 2014, 36 states used DRGs and 10 established per diem rates for inpatient hospital services. Five states used some other method, such as a per stay payment or cost-based reimbursement.

## Base payment rate

For each of these payment methods, a state establishes a base payment. For DRG payments, states typically establish either a base rate specific to each hospital, a statewide base rate, or a rate based on hospital peer groups. For per diem and cost-based payment methods, base payments are determined using hospitals' reported costs.

## Payment adjustments

States adjust hospitals' base payments according to a variety of factors. These include:

- **Hospital type:** Some states adjust the base payment or use a different payment method



entirely for certain hospitals. For example, many states have separate payment policies for small hospitals, critical access hospitals, teaching and academic medical centers, government-owned hospitals, and children's hospitals.

- **Geography:** Some states adjust payments for different geographic areas, generally to reflect significant underlying differences in the cost to provide care in rural versus urban areas.
- **Outlier:** States may adjust payments to account for cases that are extraordinarily costly.

Other less common adjustments to inpatient hospital rates include those for hospitals that provide certain services, such as trauma and transplant centers, or adjustments based on maintaining certain occupancy levels.

As of April 2014, every state made some type of adjustment to the base hospital payment rate. The most common adjustments were for certain types of hospitals, outlier payments, and geographic adjustment.

## Additional payments

States may also make supplemental payments or incentive-based payments to hospitals:

- **Supplemental Payments:** Some states make payments to hospitals above Medicaid rates for individual inpatient hospital services. These additional payments fall into two categories: disproportionate share hospital (DSH) payments or upper payment limit (UPL) supplemental payments. Federal statute requires that states make DSH payments to hospitals. Forty-two states and the District of Columbia make UPL payments to hospitals (MACPAC 2015).<sup>1</sup> UPL payments policies vary widely by state.

- **Incentive payments:** As of April 2014, 39 states made additional incentive payments to hospitals. For example, 11 states made incentive payments based on measures of quality of care. Other states made incentive payments to hospitals for reducing readmission rates, adopting electronic health records, or improving efficiency, for example, to reward providers for keeping costs below a specified amount.

## Inpatient hospital services payment process

In most cases, hospital payment is triggered when a hospital submits a claim indicating that a service has been provided. There are many state and federal requirements that providers must comply with in order to receive payment for services.

Hospitals typically submit claims to the state Medicaid agency (or its fiscal agent) for payment. Most claims are submitted electronically in a standardized format consistent with the requirements of the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) and federal regulations, including the use of a provider's national provider identifier. Because hospitals may provide long-term care, inpatient claims typically cover multiple days. For ongoing stays, claims may be submitted monthly.

Many inpatient hospital patients are responsible for a portion of the payment for their stay. In such cases, hospitals typically collect these amounts from residents and the balance is paid by Medicaid.

More information can be found in a separate brief on the [Medicaid fee-for-service payment process](#).



## Payment policy issues

Federal rules do not prescribe how inpatient hospital services should be paid or how much they should be paid, but require that Medicaid payment policies should promote efficiency, economy, quality, access, and safeguard against unnecessary utilization. Rates are required to be developed through a public process and published. While DRGs are the predominant method of Medicaid inpatient hospital services, the basis for individual rates varies and there is considerable variation in rates both within and across states.

As noted above, many states also make supplemental payments, which comprise the difference between Medicaid payments for services and the maximum payment level allowed under the upper payment limit (UPL) for those services. In FY 2014, states reported making about \$14 billion in supplemental payments to hospitals for both inpatient and outpatient services. The UPLs are applied in the aggregate and are based on what Medicare would have paid for the same services. 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. See MACPAC's March 2015 report for more information on [MACPAC's framework for evaluating these payment factors](#).

Policymakers and stakeholders have raised concerns that Medicaid fee-for-service payments create incentives for the delivery of episodic, uncoordinated care. State and federal Medicaid officials have explored alternative payment models that link Medicaid payments to value instead of volume. Alternative payment methods that target hospital payments include shared savings/risk programs, such as accountable care organizations, global budgets, and enhanced payments, such as those

made to providers in Delivery System Reform Incentive Payment (DSRIP) programs. Efforts to evaluate the effect of these alternative payment models on cost containment and service delivery are underway, although comparability across state models continues to be a challenge.

Providers often question the adequacy of Medicaid payments particularly when states reduce rates. In some cases, providers have contested payment reductions in federal court. However, on March 31, 2015, the U.S. Supreme Court precluded future lawsuits when it decided, in *Armstrong v. Exceptional Child Center, Inc.*, that that Medicaid providers do not have the right to sue Medicaid agencies regarding payment rates under the Supremacy Clause of the Constitution or under 1902(a)(30)(A) of the Social Security Act.

CMS implemented a rule in January 2016 creating a standardized, transparent process for states to follow prior to implementing Medicaid provider payment rate reductions or changes in the provider payment structure for services provided on a fee-for-service basis (CMS 2015). States are now required to consider input from providers, beneficiaries, and other stakeholders when evaluating the potential impacts of provider rate changes. In addition, states will need to perform an analysis of the effect that rate changes will have on beneficiary access to care and then monitor the effect the changes have on access to care for at least three years after the changes are effective.

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<sup>1</sup> Eight states do not make UPL payments to hospitals. However, these states may make supplemental payments to hospitals through Section 1115 waivers, or make UPL payments to other providers such as mental health facilities,

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nursing facilities, or physicians and other practitioners (MACPAC 2015).

## References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services. Final rule. *Federal Register* 80, no. 211 (November 2): 67576-67612

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. *MACStats: Medicaid and CHIP Data Book*. December 2015. Washington, DC: MACPAC.

<https://www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2/>.

