



Uses and Oversight of Upper Payment Limit Supplemental Payments to Hospitals

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Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Uses of upper payment limit (UPL) payments
- Oversight of UPL payments
 - Current process
 - MACPAC findings
 - Status of prior recommendations
- Policy questions
 - Are there opportunities to improve CMS's oversight of UPL payments without adding undue state administrative burden?
 - What limits should be placed on the total amount of Medicaid payments to hospitals?

Hospital Payment Work Plan

- At the March public meeting, Commissioners reviewed all types of base and supplemental payments to hospitals
 - Most payments are made under fee-for-service (FFS)
 - About half of FFS payments are supplemental payments
 - UPL payments are nearly as large as disproportionate share hospital (DSH) payments
- This summer, MACPAC will be interviewing states and other stakeholders to learn more about the development of hospital payment policies
- After examining payment methods, we plan to examine payment amounts and outcomes

UPL Background

- UPL payments are lump sum payments that supplement low fee-for-service (FFS) base payment rates
 - The UPL is an upper limit on all FFS payments that is established in regulation
 - If base payments are below the UPL, states can make UPL supplemental payments to make up the difference
- States make UPL payments to hospitals, nursing facilities, physicians, and other providers

UPL Requirements

- In the aggregate for a class of providers, FFS base payments and UPL payments cannot exceed a reasonable estimate of what providers would have been paid according to Medicare payment principles
 - Classes of providers are based on ownership
 - States do not use actual Medicare payment rates when calculating the UPL
 - Some providers can receive UPL payments that exceed what Medicare would have paid as long as total payments for each class of providers are below the UPL in the aggregate

Uses of UPL Payments

- UPL payments to hospitals grew rapidly in the early 2000s after Congress established new limits on disproportionate share hospital (DSH) payments
 - In FY 2000, \$4.5 billion reported by 15 states
 - In FY 2016, \$16.4 billion reported by 36 states
- States often target UPL payments to government-owned hospitals, safety-net hospitals, rural hospitals, and specialty hospitals
- Most states allocate UPL payments based on the relative number of Medicaid days or discharges, or as an equal share of a fixed amount

Oversight of UPL Payments

- In 2013, CMS issued guidance requiring states to demonstrate compliance with UPL requirements annually
- States submit hospital-specific data to CMS in a standard format
 - Medicaid FFS base and supplemental payments
 - Estimates of what would have been paid according to Medicare payment principles
 - Some hospitals paid on a cost basis, such as critical access hospitals, are not included
- MACPAC obtained state-level data for state fiscal years (SFYs) 2014, 2015, and 2016

UPL Demonstration Process

- States develop an estimate of what Medicare would have paid based on one of four methods
 - **Cost-based method:** An estimate of facility costs for services provided to Medicaid patients
 - **Payment-based method:** An estimate based on the hospital's aggregate Medicare payments relative to its charges
 - **Price-based method:** An estimate of what Medicare would have paid for specific diagnostic-related groups, with Medicaid acuity adjustments
 - **Per diem method:** An estimate of average Medicare payments per hospital day

UPL Demonstration Process (Continued)

- States apply a variety of adjustments to baseline data used in UPL calculations
 - Adjustments for inflation and changes in the volume of hospital services provided
 - Adjustments for provider taxes
- States compare the Medicare estimate to actual or projected Medicaid spending
 - UPL demonstrations are not reconciled to actual spending reported on CMS-64 expenditure reports

MACPAC Findings

- States reported the ability to make \$12.4 billion more in UPL payments to hospitals in SFY 2015
- UPL spending reported on FY 2015 expenditure reports was \$11.0 billion higher than what states reported on SFY 2015 UPL demonstrations
 - Some differences may be explained by data lag and differences in reporting periods
 - Based on CMS-64 expenditure data, 15 states may have had hospital payments that exceeded the UPL in 2015
- Some states make large adjustments to their baseline Medicare estimate

Prior UPL Recommendations

Recommendation	MACPAC	GAO	OIG
Collecting and reporting hospital-specific UPL data	✓	✓	
Making hospital-specific UPL data publicly available	✓		
Auditing UPL calculations		✓	✓
Establishing hospital-specific UPL limits			✓

Notes: UPL is upper payment limit. GAO is the U.S. Governmental Accountability Office. OIG is the U.S. Department of Health and Human Services Office of Inspector General.

Sources: MACPAC analysis of [GAO 2012](#), [MACPAC 2014](#), and [OIG 2001](#).

CMS Actions Relating to Prior Recommendations

- CMS is collecting hospital-level data but these data are not publicly available and are incomplete
- UPL demonstrations are not audited or reconciled with other sources
- CMS currently plans to release a supplemental payment regulation in November 2018
- The FY 2019 president's budget proposes limiting Medicaid payments to public providers to provider-specific costs

Policy Questions

- Are there opportunities to improve CMS's oversight of UPL payments without adding undue state administrative burden?
- What limits should be placed on the total amount of Medicaid payments to hospitals?
 - Are there reasons why states should be allowed to pay more than what Medicare would have paid?
 - To what extent should the source of non-federal share be considered when calculating UPLs?



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