Chapter 2:

Oversight of Upper Payment Limit Supplemental Payments to Hospitals

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Recommendations

2.1 The Secretary of the U.S. Department of Health and Human Services should establish process controls to ensure that annual hospital upper payment limit demonstration data are accurate and complete and that the limits calculated with these data are used in the review of claimed expenditures.

2.2 To help inform development of payment methods that promote efficiency and economy, the Secretary of the U.S. Department of Health and Human Services should make hospital-specific upper payment limit demonstration data and methods publicly available in a standard format that enables analysis.

Key Points

- The upper payment limit (UPL) is an upper limit on fee-for-service (FFS) Medicaid payments that is based on an estimate of the amount that would have been paid for the same services under Medicare payment principles.
- States can make UPL supplemental payments to certain types of providers to make up the difference between Medicaid base payments and the UPL.
  - States reported $13.0 billion in UPL payments to hospitals in fiscal year (FY) 2017.
  - States can target UPL payments to particular types of hospitals as long as total payments for each class of hospitals are below the UPL in the aggregate.
- In 2013, the Centers for Medicare & Medicaid Services (CMS) began requiring states to annually demonstrate compliance with UPL requirements by submitting data on Medicaid spending relative to the UPL.
- MACPAC's analysis of UPL demonstrations for state FY 2016 found large discrepancies between spending reported on UPL demonstrations and actual spending reported on CMS expenditure reports.
  - In 17 states, the actual amount of UPL payments made appears to exceed the limit calculated on state UPL demonstrations by $2.2 billion in the aggregate.
  - State and CMS officials with whom we spoke were not able to fully explain these discrepancies, but it is possible that some differences may be a result of differences in how spending is reported in different sources.
- The limits calculated on UPL demonstrations are not routinely used in the review of claimed expenditures.
- The hospital-level data reported on UPL demonstrations can also help inform analyses of whether payment policies are economic and efficient.

CHAPTER 2: Oversight of Upper Payment Limit Supplemental Payments to Hospitals

States make several different types of Medicaid payments to hospitals and have broad flexibility to design their own payment methods. The two major categories of payments are (1) base payments for services and (2) supplemental payments, which are typically made in a lump sum for a fixed period of time. Because development of Medicaid hospital payment policy must be considered in terms of all types of Medicaid payments that hospitals receive, MACPAC is undertaking a long-term work plan to examine how state hospital payment policies relate to the statutory goals of efficiency, economy, quality, and access (MACPAC 2018a).

Upper payment limit (UPL) supplemental payments were the largest type of Medicaid hospital supplemental payment reported in fiscal year (FY) 2017 in the aggregate. The UPL is an upper limit on fee-for-service (FFS) payments that is defined as a reasonable estimate of the amount that would have been paid for the same services under Medicare payment principles. States can make FFS supplemental payments (referred to as UPL payments in this chapter) as long as they do not exceed the difference between FFS base payments and the UPL. UPL payments are often targeted to specific groups of hospitals and may result in some hospitals being paid more than what Medicare would have paid as long as total payments to each class of hospitals are below the UPL in the aggregate.[1]

In 2013, the Centers for Medicare & Medicaid Services (CMS) began requiring states to demonstrate compliance with UPL requirements annually. Previously, states only demonstrated compliance when amending their Medicaid state plans. To better understand the methods that states use to make UPL payments, MACPAC examined hospital-level data from state UPL demonstrations for state fiscal year (SFY) 2016 and aggregate, state-level UPL data for SFYs 2014–2016, the first and only years for which data were available when MACPAC requested them in the summer of 2018.

Our analyses raise concerns about the accuracy and completeness of the data used to monitor compliance with UPL requirements. We find large discrepancies between spending reported on state UPL demonstrations and actual spending reported on CMS expenditure reports. In 17 states, the actual aggregate amount of UPL payments made in SFY 2016 appears to exceed the limit calculated on state UPL demonstrations by $2.2 billion.

Although more information is needed to verify the potential overpayments that we observed, state and CMS officials with whom we spoke were not able to fully explain these discrepancies. Some UPL spending that appears to be in excess of the UPL could be explained by differences in how spending is reported in different sources. For example, spending reported on UPL demonstrations comes from claims data that are recorded based on the date of service, whereas spending reported on CMS expenditure reports is based on the date the claim was paid. Also, UPL estimates are often submitted prospectively, whereas expenditure reports are submitted after payments have been made. However, we also find that many state UPL demonstrations are missing data on UPL payments entirely, which cannot be explained by differences in data sources.

States and the federal government both have a responsibility to ensure that claimed expenditures do not exceed the UPL. CMS already has many processes in place to promote effective financial management, and it has developed standardized templates to improve the accuracy and completeness of UPL demonstration data in 2019 and subsequent years. However, based on our conversations with state and CMS officials, it does not appear that the limits calculated on UPL demonstrations are routinely used in the review of claimed expenditures.

To address these concerns, the Commission makes two recommendations:

- The Secretary of the U.S. Department of Health and Human Services should establish process controls to ensure that annual hospital upper payment limit demonstration data are accurate and complete and that the limits calculated with these data are used in the review of claimed expenditures.
- To help inform development of payment methods that promote efficiency and economy, the Secretary of the U.S. Department of Health and Human Services should make hospital-specific upper payment limit demonstration data and methods publicly available in a standard format that enables analysis.

Better data and process controls will help ensure proper enforcement of existing limits and can help inform development of new payment policies that promote efficiency and economy. For example, it would be useful to know whether states apply adjustments to their UPL that result in a limit that is different from the amount that Medicare would have paid for the same service under the current prospective payment system.

Background

Before 1981, Medicaid paid hospitals based on costs using Medicare payment methods. However, after the passage of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), Medicaid payments to hospitals were delinked from Medicare and states were given considerable flexibility to design their own payment methods. To ensure that payments were consistent with the statutory goals of economy and efficiency, CMS established an upper limit on aggregate FFS payments to institutional providers based on an estimate of what would have been paid for the same service under Medicare payment principles (42 CFR 447.272 and 447.321). This limit is referred to as the UPL.

The UPL does not apply to services provided under managed care arrangements.[2]

If FFS base payments are below the UPL, then states can make UPL supplemental payments as long as these payments do not exceed the difference between base payments and the UPL (Figure 2-1). Although the term UPL payment is not defined in statute or regulation, we use this term to distinguish supplemental payments that are subject to the UPL from those that are not, such as disproportionate share hospital (DSH) payments and supplemental payments authorized under Section 1115 demonstrations.[3]

In FY 2017, states made a total of $13.0 billion in UPL payments to hospitals. States also made $4.4 billion in UPL payments to other provider types that are subject to UPL requirements, such as nursing facilities.[4] This chapter focuses on UPL payments to hospitals because they are the only provider type for which we have complete provider-level data.

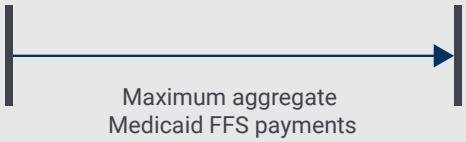
UPL payments were the largest type of supplemental payments to hospitals reported in FY 2017, surpassing DSH payments ($12.1 billion).[5] Although the majority of Medicaid enrollees are covered under managed care arrangements, FFS payments (base and supplemental) still account for about half of Medicaid payments to hospitals, and supplemental payments account for about half of FFS payments to hospitals. More information about the amounts and types of supplemental payments to hospitals is available in MACPAC's issue brief, *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2019).

Uses of UPL Payments

Although UPL payments have been permitted since 1981, their use grew rapidly in the early 2000s. In FY 2000, 15 states made hospital UPL payments totaling $4.5 billion (OIG 2001). By FY 2011, 36 states reported UPL payments to hospitals totaling $19.8 billion.[6] Since that time, such spending has declined, in part because of the expanded use of

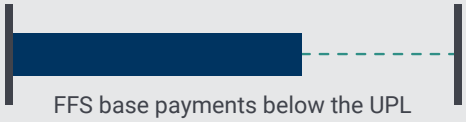
FIGURE 2-1. Maximum Allowable Upper Payment Limit Supplemental Payments

The upper payment limit (UPL) establishes a maximum limit on aggregate fee-for-service (FFS) payments to a class of providers



The UPL is based on a reasonable estimate of what Medicare would have paid in the aggregate to a class of providers (i.e., state government-owned or operated, non-state government-owned or operated, or private facilities).

Base Medicaid payments are often below the UPL



State Medicaid programs are not required to pay providers what Medicare would have paid, and base payment rates are often below the UPL.

States can make UPL supplemental payments, up to the difference between base payments and the UPL

The UPL gap is the difference between FFS base payments and the UPL, and it represents the maximum allowable UPL supplemental payments that a state can make.

Adapted from GAO 2016.

managed care.[7] Even so, most states continue to make such payments; in FY 2017, 35 states reported UPL payments to hospitals totaling $13.0 billion.[8]

States can make UPL payments for both inpatient and outpatient hospital services. Of the 35 states reporting UPL payments to hospitals, 32 states reported $9.9 billion in inpatient hospital UPL payments and 24 states reported $3.2 billion in outpatient hospital UPL payments.

State methodologies for distributing UPL payments to hospitals vary widely. According to MACPAC's most recent reviews of FFS payment policies, the most common types of hospitals targeted to receive UPL payments include government-owned facilities; safety-net hospitals, which serve a high share of Medicaid or low-income patients; and rural hospitals (Table 2-1). These state-defined categories of hospitals are similar to the types of hospitals that states target for Medicaid DSH payments (MACPAC 2017).

The non-federal share of UPL payments is often financed by providers, which can affect how these payments are distributed. In SFY 2012, 75 percent of UPL payments were financed by provider taxes or funds from local governments, including public hospitals (GAO 2014a). A recent review of UPL payments in seven states by the HHS Office of Inspector General found that UPL payments to hospitals in these states were greater than the taxes that the hospitals paid to finance these payments (OIG 2018). The U.S. Government Accountability Office (GAO) has also noted that the targeting of UPL payments is often related to the methods that states use to finance them (GAO 2016).

Most states allocate UPL payments to eligible providers based on their relative number of Medicaid days or discharges, or as an equal share of a fixed amount (Bachrach and Dutton 2011; MACPAC 2018b). UPL payments are primarily intended to offset low Medicaid base payment rates, and states rarely use UPL payments to encourage

TABLE 2-1. Targeting of UPL Payments T 2-1

Hospital Type	Number of states[1]	
	Inpatient UPL	Outpatient UPL
Government-owned	23	10
Safety-net	20	3
Specialty	14	3
Children's	12	3
Teaching	12	4
Rural	9	0

Notes: UPL is upper payment limit. Safety-net hospitals are defined broadly as hospitals that serve a high share of Medicaid or low-income patients. States can target UPL payments to multiple hospital types. Analysis excludes graduate medical education payments. Analysis of inpatient UPL payment policies based on MACPAC review of state policies as of March 2018 and analysis of outpatient UPL payment policies based on MACPAC review of state policies as of November 2015.

[1] Number of states includes the District of Columbia.

Source: MACPAC 2018b, 2016a.

delivery system reforms. For example, MACPAC's 2018 review of inpatient hospital payment policies identified only four states that were making UPL payments to hospitals for the attainment of quality metrics (Colorado, Massachusetts, Washington, and Wisconsin) (MACPAC 2018b). Instead of using UPL authority, states often implement hospital value-based payment initiatives through adjustments to base payment rates or through other payment authorities, such as health homes or primary care case management.[9]

History of UPL Policy

Although states have flexibility in establishing payment methods and amounts, statute requires Medicaid payment policies to be consistent with the principles of efficiency, economy, quality, and access (§ 1902(a)(30)(A) of the Social Security Act). CMS recognized that it was neither economic nor efficient to allow states to make unlimited payments to providers, so it established the UPL via regulation. Medicare payment principles were used to establish an upper limit on Medicaid payments because the Medicare program is also a large federal program and is the largest single payer for hospital services.[10] Other payers also often use Medicare payment rates as a benchmark for hospital payment rates, even though commercial payment rates are often much higher than Medicare.

The regulations establishing the UPL have changed little since 1981. In 1987, CMS required states to calculate the UPL for state government-owned or operated facilities separately from other facilities, and in 2001, CMS required states to calculate the UPL separately for private institutions and non-state, government-owned or operated facilities (CMS 2001, 1987). However, the methods that states can use to calculate the UPL have not changed.[11]

Since UPL requirements were established, CMS has reviewed compliance with UPL requirements prospectively when states submitted changes to their payment methodologies in their Medicaid state plans. Although this process provides certainty for providers that UPL payments will not change unless the state changes its payment policies, the data and assumptions used to calculate the UPL could become several years old in states that do not make frequent changes to their Medicaid payment policies.

As the use of UPL payments grew in the early 2000s, GAO and OIG made several recommendations to improve CMS's oversight of UPL requirements, which would increase transparency and accountability for these payments. Specifically, GAO

recommended that CMS collect hospital-specific data and audit state UPL demonstrations; OIG recommended that CMS use more recent data to assess UPLs and that UPLs be established at the facility level (GAO 2012, OIG 2001).

In response to these concerns, CMS issued a state Medicaid director letter in 2013 requiring states to demonstrate compliance with UPL requirements annually (CMS 2013). CMS provides states with the option of demonstrating UPL compliance prospectively based on estimates of Medicaid spending for the upcoming year, or demonstrating UPL compliance retrospectively based on actual spending.

To help states demonstrate UPL compliance in a standard way, CMS has developed templates for each provider type subject to UPL requirements as well as additional guidance documents that describe allowable methods for calculating the UPL for each type of service (CMS 2019). The templates were issued in 2018, and beginning in SFY 2019, states are required to use them.

Current UPL Requirements

Under CMS's current rules, the calculation of the UPL and the maximum allowable amount of UPL supplemental payments involves several steps:

- identifying hospitals subject to the UPL requirements;
- choosing a method for calculating the UPL;
- adjusting the UPL for inflation and other factors; and
- comparing the UPL to Medicaid spending.

Below, we review each of these steps in more detail.

Identifying hospitals subject to UPL requirements

States are generally required to include all hospitals participating in Medicaid in the state in their UPL calculations. However, hospitals paid based on actual costs may be excluded, since CMS assumes that payments to these hospitals already comply with the UPL requirements.[12] According to MACPAC's most recent reviews of state FFS payment policies, only 1 state (Idaho) primarily used cost-based payment methods for inpatient services in 2018, and 16 states primarily used cost-based payment methods for outpatient services in 2015 (MACPAC 2018b, 2016a). However, many states use cost-based payment methods for particular types of hospitals. For example, 17 states used cost-based payment methods for inpatient hospital services at critical access hospitals, and 7 states used cost-based payment methods for inpatient hospital services at government-owned hospitals (MACPAC 2018b).[13]

Choosing a method for calculating the UPL

For hospitals that are included in the UPL demonstrations, states develop an estimate of what Medicare would have paid for hospital services using one of four methods:

- a **cost-based method,** which is an estimate of facility costs for services provided to Medicaid patients calculated using cost-to-charge ratios from Medicare cost reports;
- a **payment-to-charge-based method,** which is based on the hospital's aggregate Medicare payments relative to its charges;
- a **price-based method,** which is based on what Medicare would have paid for specific diagnosis-related groups (DRGs), after adjusting for differences in acuity between Medicare and Medicaid patients; and
- a **per diem method,** which is based on average Medicare payments per hospital day.

In SFY 2016, about half of states used cost-based methods for calculating inpatient hospital UPLs and about half used a price-based method (Table 2-2). Most states used cost-based methods for

TABLE 2-2. Number of States Using Each Method for Determining UPL Limits, SFY 2016 T 2-2

Type of service	Method for determining UPL limits				Total states submitting UPL demonstrations[1]
	Cost-based	Payment-to-charge-based	Price-based	Per diem	
Inpatient hospital	32	9	20	10	47
Outpatient hospital	44	6	N/A	N/A	48

Notes: UPL is upper payment limit. SFY is state fiscal year. N/A is not applicable. Number of states includes the District of Columbia.

[1] Totals do not add because some states use different methods for different classes of hospitals in the state. States are not required to submit a UPL demonstration if they do not make UPL payments.

Source: MACPAC, 2019, analysis of SFY 2016 state UPL demonstrations.

calculating outpatient hospital UPLs. The price-based and per diem methods do not apply to outpatient hospital UPLs.

Although all methods approximate what Medicare would have paid, the cost-based method is the only one that does not use current Medicare payment rates. In 2016, Medicare payments to hospitals were 90.4 percent of costs, so the cost-based method of calculating the UPL appears to result in a UPL that is higher than what Medicare would have actually paid (MedPAC 2018a). When the UPL was established in 1981, Medicare and Medicaid paid hospitals based on costs. However, since 1983, Medicare has used a prospective payment system that assigns payment based on factors other than costs for most hospitals.

The price-based method of calculating the UPL most closely resembles how Medicare currently pays hospitals, but even using this method, states must make several approximations. Medicare does establish payment rates for all types of DRGs (including perinatal services which are more frequently used by Medicaid enrollees than by Medicare enrollees), but Medicare also makes several types of special payments to hospitals, which are more difficult to calculate in a non-Medicare context (Box 2-1). As a result, many states using the price-based approach estimate Medicare special payments by using aggregate data from CMS about average total Medicare payments per hospital by DRG.

BOX 2-1. Medicare Hospital Payment Methods

Currently, most Medicare payments to hospitals are made under the prospective payment system (PPS). Specifically, Medicare assigns base payment rates for each service based on the complexity of services (measured by diagnosis-related groups for inpatient hospital services and ambulatory patient classifications for outpatient services) and adjusts those base payment amounts for geographic differences in input prices. Medicare also makes some additional payments to hospitals, referred to as special payments. These include indirect medical education payments, Medicare disproportionate share hospital payments, additional payments for rural sole community hospitals, adjustments for patients with short lengths of stay who are discharged to another hospital or post-acute care setting, and outlier payments for high-cost patients. In 2016, 80.9 percent of inpatient Medicare payments to PPS hospitals were base payments and 19.1 percent were special payments (MedPAC 2018b).

The payment-to-charge and per diem methods use aggregate payment data to estimate what Medicare would have paid for Medicaid services, but they do not account for differences in patient acuity. In 2015, the average hospital cost per Medicare patient day was 41 percent higher than the average hospital cost per Medicaid patient day, so assuming that Medicaid and Medicare patients have the same level of acuity may result in a UPL that is higher than what Medicare would have actually paid (AHRQ 2017).

Adjusting the UPL for inflation and other factors

Because data on hospital costs and charges often lag behind the year for which the UPL is being calculated, states adjust historical data to trend it forward. For example, states make adjustments for inflation to better reflect current costs. States are required to use the most recent data available when calculating the UPL, and CMS's guidance instructs states to use Medicare cost report data that are no more than two years old.

States that choose a cost-based method for determining the UPL can also make adjustments to account for the costs of Medicaid provider taxes. Specifically, the costs of provider taxes can be added to the costs of the services provided, increasing the state's UPL. However, states cannot make adjustments to account for intergovernmental transfers, which are often used by public hospitals to finance the non-federal share of UPL payments.

Comparing the UPL to Medicaid spending

To demonstrate compliance with UPL requirements, the adjusted UPL amount reported on state UPL demonstrations must be less than total FFS spending for each class of providers. States have the option of submitting UPL demonstrations prospectively or retrospectively for each state fiscal year. Most states submit UPL demonstrations prospectively, and thus they must estimate FFS spending for the upcoming year based on prior years' data. Retrospective UPL demonstrations are based on actual spending.

CMS primarily uses UPL demonstrations to approve UPL payments before they are made and does not routinely use these data in the review of claimed UPL expenditures. When states claim any Medicaid expenditure to draw down federal funds, states must certify that the payments they make are consistent with federal rules. For all payments, CMS can request additional information about expenditures that are reported and can defer payments if they are not sufficiently justified.

Analysis of State UPL Demonstrations

To better understand the methods that states use to make UPL payments and how the UPL is enforced, MACPAC reviewed data from state UPL demonstrations and compared them with other sources. CMS shared hospital-specific data from the SFY 2016 inpatient hospital UPL demonstrations for 46 states and the District of Columbia and outpatient hospital UPL demonstrations for 47 states and the District of Columbia.[14] CMS also provided aggregate, state-level data for SFYs 2014, 2015, and 2016 state UPL demonstrations. We compared UPL demonstration data to spending reported on CMS-64 expenditure reports, which are quarterly reports of expenditures claimed for federal matching funds. We also discussed the UPL review process with CMS staff and with state officials in several states that used various methods for calculating their UPL. Additional information about our methods for comparing UPL demonstration data and CMS expenditure reports is provided in Appendix 2A.

Although the state-reported data on UPL demonstrations indicate that aggregate Medicaid hospital spending is below the UPL in most states, the data reported on UPL demonstrations do not match actual spending reported on CMS expenditure reports. In some states, actual FFS spending appears to have exceeded the state-

calculated UPL in SFY 2016. We found similar results based on the aggregate state-level data provided for SFYs 2014 and 2015, but we do not have hospital-level data for these years that would permit us to explore the potential reasons for the discrepancies observed.[15]

Missing spending data

CMS requires states to report all Medicaid FFS payments for all hospitals that are subject to UPL requirements, but in practice, we found that these data were missing for many states.

Missing payments. Ten states did not report inpatient hospital UPL payments and 11 states did not report outpatient hospital UPL payments on their hospital-specific UPL demonstrations, despite the fact that these states reported UPL spending on their CMS-64 expenditure reports (Table 2-3). In addition, 13 states did not report graduate medical education (GME) payments, which are also subject to UPL requirements.[16] This may be because states submit UPL demonstration information prospectively, before they have finalized Medicaid payments for the year under review.

Missing hospitals. About half of states reported hospital-specific UPL data for fewer than the number of hospitals in their state; we do not have reliable hospital identifiers that we can use to characterize these missing hospitals. These hospitals may be missing because CMS does not require submission of UPL information for hospitals that are paid based on actual costs, for example, critical access hospitals and government-owned hospitals. However, of the nine states with missing inpatient hospital data on government-owned hospitals, only two pay these hospitals on a cost basis (MACPAC 2018b).[17]

Actual versus reported spending

Overall, FFS hospital payments reported on CMS-64 expenditure reports for SFY 2016 were about $10.8 billion higher than Medicaid payments projected on state UPL demonstrations for the same time period (Table 2-4). This includes differences in both supplemental payments (which some states did not report on their UPL demonstrations) and base payments (which were reported by all states). Spending reported on CMS-64 reports was higher than spending reported on UPL demonstrations in almost two-thirds of states.

To measure actual spending, we used CMS-64 expenditure reports for the relevant state fiscal year and made adjustments to account for prior period adjustments.[18] We could not account for the difference between date of service and date of payment or for cross-over claims for hospital services provided to patients who were dually eligible for Medicaid and Medicare. (See Appendix 2A for more discussion about this methodology and its limitations.)

TABLE 2-3. State Hospital-Specific UPL Demonstrations with Missing Payment Data, SFY 2016 T 2-3

Missing payment data	Inpatient hospital UPL demonstrations (N = 47)	Outpatient hospital UPL demonstrations (N = 48)
Base payments	0	0
UPL payments	10	11
GME payments	13	N/A

Notes: UPL is upper payment limit. SFY is state fiscal year. GME is graduate medical education. N/A is not applicable. Number of states includes the District of Columbia. Hospital-specific UPL data were not available for Arizona, New York, and Tennessee. Inpatient hospital UPL data were not available for North Dakota, but outpatient hospital UPL data were available.

Source: MACPAC, 2019, analysis of SFY 2016 state UPL demonstrations.

TABLE 2-4. State-Reported Hospital Spending, by Source, SFY 2016 (millions) T 2-4

Type of service	Type of payment	Reported on UPL demonstrations	Actual spending reported on CMS-64 expenditure reports	Difference	Number of states with actual spending exceeding spending reported on UPL demonstrations[1]
Inpatient	Base	$24,216.8	$28,283.8	$4,067.0	30
	Supplemental	6,056.2	11,543.6	5,487.5	30
Outpatient	Base	9,286.7	9,229.6	-57.1	22
	Supplemental	2,404.8	3,695.7	1,290.9	14
Total		**$41,964.5**	**$52,752.7**	**$10,788.3**	**28**

Notes: SFY is state fiscal year. UPL is upper payment limit. Analysis limited to states that submitted hospital-specific UPL demonstrations and excludes Arizona, New York, and Tennessee. CMS-64 spending is adjusted to account for prior period adjustments. Supplemental payments subject to the UPL include UPL supplemental payments and graduate medical education payments but exclude disproportionate share hospital payments. Numbers do not add due to rounding.

[1] Number of states includes the District of Columbia.

Source: MACPAC, 2019, analysis of SFY 2016 state UPL demonstrations and the CMS Medicaid Budget and Expenditure System.

UPL compliance

In many states, the actual spending reported on CMS-64 expenditure reports appears to have exceeded the UPL calculated on state UPL demonstrations. Below we examine potential UPL overpayments in three ways:

- whether UPL payments exceeded the difference between base payments and the UPL (referred to as the UPL gap);
- whether base payments and supplemental payments exceeded the UPL; and
- whether base payments and supplemental payments exceeded the UPL after making adjustments to the UPL to account for circumstances where FFS utilization was higher than projected.

UPL payments compared to the UPL gap. Seventeen states reported hospital UPL spending on CMS-64 expenditure reports that appear to have exceeded the UPL gap calculated on SFY 2016 UPL demonstrations. Of these, 12 states appear to have exceeded their inpatient hospital UPL by $1.4 billion in the aggregate, and 7 states appear to have exceeded their outpatient hospital UPL by $759 million in the aggregate. (Two appear to have exceeded both their inpatient and outpatient UPLs.)

Total FFS spending versus the UPL. Twenty-seven states reported total base and supplemental FFS spending on CMS-64 expenditure reports that appears to have exceeded the state-calculated UPL. Of these, 24 states appear to have exceeded their inpatient hospital UPL by $3.8 billion in the aggregate, and 12 states appear to have exceeded their outpatient UPL by $867 million in the aggregate. (Nine appear to have exceeded both their inpatient and outpatient UPLs.)

Total FFS spending versus the UPL, adjusted for increased utilization. Because increased FFS utilization would increase a state's UPL, we also compared total FFS spending to an adjusted UPL amount, assuming that the state-calculated UPL would increase proportionally if actual base payment spending was higher than what was projected. After making these adjustments, we find that eight states appear to have exceeded their inpatient hospital UPL by $1.6 billion in the aggregate and that five appear to have exceeded their outpatient UPL by $501 million in the aggregate in SFY 2016.

State and CMS Perspectives

To better understand the factors that have contributed to the UPL reporting and compliance issues that we observed, we spoke with Medicaid officials in several states that used various methods for calculating their UPL and with CMS officials overseeing the UPL reporting process. They described several common problems with the current process, including:

- use of different reporting processes for tracking claims in state Medicaid Management Information Systems (MMIS) and payments in the Medicaid Budget and Expenditure System (MBES);
- confusion about reporting requirements; and
- the lack of a process to use state UPL demonstrations in the review of claimed expenditures.

Different reporting processes

States typically use claims data from their MMIS to populate UPL demonstrations because these data can be used to track the date a service was performed and allow states to exclude certain claims, such as cross-over payments for services that are also paid for by Medicare. However, MMIS data do not always include all types of Medicaid spending; spending reported on MMIS is generally lower than that reported on CMS-64 expenditure reports (MACPAC 2018c). It is difficult to identify the spending that is missing because CMS-64 data do not include claims-level detail and only record spending based on the date that the service was paid for. Neither CMS nor the states we contacted have processes to reconcile spending reported on UPL demonstrations with spending reported on CMS-64 expenditure reports.

Confusion about UPL requirements

CMS has updated its UPL demonstration template and revised guidance multiple times, which has been confusing for state staff. However, because the UPL templates are now required for all states in SFY 2019, state and CMS officials were optimistic that reporting compliance would improve as the process becomes routine. CMS has provided several trainings to help state staff understand how to use the new templates and to emphasize the importance of accurate reporting. However, there were still questions from some of the state staff we spoke with about which data from Medicare cost reports should be used when calculating the UPL.

Even so, state staff generally appreciated the use of standard templates, noting that these were not particularly burdensome to complete. However, staff in one state that tried to use a hybrid of two different UPL calculation methods expressed frustration that the templates did not support the state's preferred UPL approach. CMS noted that it has been willing to work with states in such circumstances to help states properly submit their UPL demonstrations.

Lack of a process to use state UPL demonstrations in the review of claimed expenditures

It is important to note that CMS does not currently have a process to formally review the accuracy and completeness of UPL demonstrations or use these limits in its review of claimed expenditures. CMS reviews UPL payment methodologies when Medicaid state plans are approved, but does not formally approve UPL demonstrations. As a result, states tend to assume that the UPL calculations they submit are correct and make payments to hospitals accordingly. The state officials we contacted were not aware that actual spending reported on their CMS-64 expenditure report exceeded their state-calculated UPL.

CMS staff described a few instances where they have used UPL demonstration data to issue deferrals in some states, but they noted that states are ultimately responsible for complying with UPL requirements. A deferral is a formal process by which CMS can withhold federal funds for expenditures that do not appear to be proper

and request additional information from states to support the expenditures that are claimed (42 CFR 430.40). The deferrals that CMS described were instances where states self-reported spending in excess of the UPL on their UPL demonstrations and did not involve using actual spending reported on expenditure reports to verify whether the UPL demonstration data that states submit are correct.

CMS also noted that it is drawing on the experience from its first years of collecting annual UPL demonstration data to improve the process. For example, CMS has made changes to the guidance that it provides states and notes that it is in the process of implementing measures to ensure states are provided with an indication of whether CMS believes their UPL estimate and demonstration data are reasonable and accurate.

Commission Recommendations

In this chapter, the Commission makes two recommendations to improve the oversight of UPL payments. The rationale and implications of these recommendations are described below.

Recommendation 2.1

The Secretary of the U.S. Department of Health and Human Services should establish process controls to ensure that annual hospital upper payment limit demonstration data are accurate and complete and that the limits calculated with these data are used in the review of claimed expenditures.

Rationale

The UPL is intended to provide an upper limit of Medicaid payments to providers based on a reasonable estimate of what would have been paid using Medicare payment principles. CMS currently monitors compliance with UPL requirements when it approves state payment policies, but it is equally important to monitor whether actual UPL payments are consistent with the amounts initially approved.

The information that CMS is currently collecting to monitor UPL compliance is not reliable enough for CMS to ensure that claimed expenditures are consistent with UPL requirements. MACPAC's analyses found that billions of dollars of payments are currently missing from these reports, including information on the UPL payments that these demonstrations are intended to monitor. Moreover, available payment data do not match the actual amounts of payments that states claimed on CMS expenditure reports in SFY 2016. These discrepancies are so large and widespread that they suggest an underlying problem with the existing process.

Consistent with the types of internal controls that are expected for other types of federal payments, CMS should establish safeguards in the process to ensure that UPL limits are properly calculated and enforced. The Office of Management and Budget Circular A-123, for example, requires federal agencies to manage reporting and data integrity risks, especially those risks that could affect the agency's decisions or actions based on the report (OMB 2018). Specifically, federal agencies are expected to follow the internal control standards outlined by GAO, which include principles for ensuring data quality and for using available data to monitor performance (GAO 2014b).

Given that the discrepancies we identified have the potential to materially affect CMS's ability to enforce compliance with UPL requirements, CMS should implement process controls such as:

- requiring states to certify that UPL demonstration data are accurate and complete;
- establishing a process to finalize the limits calculated by states by providing CMS feedback on the state-submitted UPL demonstrations and requiring states to correct any errors identified;
- tracking actual spending against the UPL in CMS's expenditure reporting systems (either the CMS-64 expenditure reports, which are currently used to track DSH spending against DSH

limits, or the Transformed Medicaid Statistical Information System (T-MSIS), which captures more detailed claims information); and,

- using this information in its review of claimed expenditures by making final limits and aggregate UPL spending data available to state and federal staff who certify that claimed expenditures comply with federal requirements.

Both states and CMS have responsibilities to ensure that claimed expenditures do not exceed the UPL. However, because CMS is also responsible for defining the UPL requirements, CMS should establish controls to ensure that the UPL is properly enforced.

Because UPL payments are an important source of revenue for many safety-net hospitals, CMS should consider implementing process controls in a way that minimizes the risk that UPL payments are recouped from providers retrospectively. For example, most states currently submit UPL demonstration data prospectively, and if payment limits were finalized on a prospective basis as well, it could provide more certainty from providers about the level of UPL payments that they can receive. CMS could also provide states the opportunity to provide additional information or revise their UPL calculation based on more current data before recouping payments that appear to be made in excess of the UPL, consistent with the standards used in the existing claims review and deferral process (42 CFR 430.40).

Although accurate and complete data are important for all types of providers subject to UPL requirements, our recommendation focuses on the concerns we were able to identify. Complete, facility-specific UPL data were only available for hospital payments at the time of our review.

Implications

Federal spending. According to MACPAC's review of SFY 2016 UPL demonstrations, 17 states appear to have made UPL payments that exceeded the limit calculated on their state UPL demonstrations by $2.2 billion in the aggregate. It is possible that some of the potential overpayments that the Commission identified could be explained by differences in how spending is reported in different sources. However, if CMS determines that overpayments were made, it could recoup the federal funds associated with these expenditures.

The Congressional Budget Office (CBO) estimates that this recommendation will not affect federal spending because it enforces existing policy. Depending on how the recommendation is implemented, it could result in increased administrative effort for the federal government, but these changes are not expected to result in increased federal spending.

States. Depending on how the recommendation is implemented, it could affect state administrative effort. Currently, CMS estimates that the administrative burden associated with completing inpatient and outpatient state UPL demonstrations is 80 hours of staff time per response (CMS 2019).

Enrollees. We do not have enough information to assess how this policy would affect Medicaid enrollees. UPL payments are an important source of revenue for many hospitals, but we do not know whether hospitals would receive reduced UPL payments as a result of increased oversight of UPL payments, and if UPL payments were reduced for particular hospitals, we do not know whether these reductions would affect patient care.

Providers. The extent to which providers are affected depends on the extent to which states currently comply with existing UPL requirements. If CMS determines that a state made payments in excess of the UPL, it could result in reduced funding for providers in that state. However, if CMS implements this recommendation by finalizing payment limits on a prospective basis, it could provide more certainty for providers about the UPL payments that they are eligible to receive and reduce the risk that UPL payments are made in error and need to be recouped retrospectively.

Recommendation 2.2

To help inform development of payment methods that promote efficiency and economy, the Secretary of the U.S. Department of Health and Human Services should make hospital-specific upper payment limit demonstration data and methods publicly available in a standard format that enables analysis.

Rationale

Complete data on Medicaid payments is important to understanding whether payments are consistent with federal requirements and for analyzing changes in payment policy. UPL payments were the largest type of hospital supplemental payment reported in FY 2017, but we do not have provider-level data on how the $13.0 billion in UPL payments to hospitals were spent.

CMS already publicly reports hospital-specific data on DSH payments from DSH audits; these data have been useful in MACPAC's review of DSH policies (MACPAC 2017). Hospital-specific data on UPL payments could help inform similar analyses.

This recommendation builds on the Commission's prior recommendations that the Secretary of HHS collect and report hospital payment data. In March 2014, the Commission recommended that the Secretary collect and report non-DSH supplemental payment data, and in February 2016, the Commission recommended that the Secretary collect and report data on all Medicaid payments to hospitals for all hospitals that receive them, as well as data on sources of non-federal share necessary to determine net Medicaid payment at the provider level (MACPAC 2016b, 2014).

UPL demonstration data provide useful information that is not otherwise available in other sources. Although the Commission would prefer that CMS collect information on all Medicaid payments to hospitals, UPL demonstrations are an existing data source that can be reported publicly now, without creating a new reporting system.

In addition to data on UPL payments, UPL demonstrations include information on the methods that states use to calculate the UPL, which would be useful in interpreting the data. For example, it would be useful to know whether particular types of payments are intentionally missing and whether states apply adjustments to their UPL that result in a limit that is different from the amount that Medicare would have paid for the same service.

Implications

Federal spending. CBO assumes that this policy would not affect federal Medicaid spending. There may be some additional administrative effort to make reports available, but this activity is not expected to increase federal spending.

States. This policy should have a limited effect on states because states are already required to provide this information to CMS.

Enrollees and providers. This policy would not directly affect Medicaid payments to enrollees or providers.

Next Steps

During the next year, the Commission plans to continue analyzing Medicaid hospital payments. In particular, we plan to further examine how Medicaid hospital payment amounts compare to Medicare payment rates and the extent to which cost-based payment methods are consistent with the statutory goals of efficiency and economy. As part of this work, the Commission may explore the potential effects of changing the allowable methods of calculating the UPL.

In the future, as data on UPL payments to other providers become available, the Commission may also apply a similar framework to examine payments to other provider types. For example, nursing facility UPL payments are the second-largest type of UPL payments. MACPAC is in the process of updating its compendium of state methods for payment for nursing facility services, which will provide more information on UPL payments to these facilities.

Endnotes

[1] Federal rules describe three separate classes of hospital providers, based on ownership (state government-owned or operated, non-state government-owned or operated, and private). UPL payments can be targeted to other groups of hospitals, such as rural hospitals and specialty hospitals.

[2] Although managed care payments are not subject to the UPL, they are required to be actuarially sound, meaning that they are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and the operation of the managed care plan (42 CFR 438.4).

[3] DSH payments offset hospital uncompensated care costs for Medicaid and uninsured patients. Supplemental payments authorized under Section 1115 demonstrations include uncompensated care pools and delivery system reform incentive payments.

[4] Other services for which states are required to submit UPL demonstrations include services provided in nursing facilities, institutions for mental diseases (IMDs), clinics, intermediate care facilities for individuals with intellectual disabilities, psychiatric residential treatment facilities, and other qualified practitioners (CMS 2019). More information about UPL payments for other provider types is available in Chapter 6 of MACPAC's March 2014 report to Congress (MACPAC 2014).

[5] Analysis excludes DSH payments to IMDs.

[6] Although the use of supplemental payments grew rapidly during this period, the overall Medicaid payment-to-cost ratio for inpatient hospital services declined from 94.5 percent in 2000 to 88.1 percent in 2016 (AHA 2018).

[7] In FY 2011, Texas reported $3.0 billion in UPL payments to hospitals. These payments were transitioned to Section 1115 waiver supplemental payments when the state expanded managed care in FY 2012.

[8] Analysis excludes graduate medical education (GME) payments to hospitals, which are also subject to UPL requirements.

[9] Shared savings payments to hospitals for health homes or primary care case management generally are not considered to be payments for hospital services so they are not included in hospital UPL calculations.

[10] In 2016, Medicare accounted for about one-quarter of national health spending on hospital care (OACT 2017).

[11] When CMS first required that states calculate a separate UPL for non-state government-owned hospitals in 2001, CMS allowed public hospitals to receive UPL payments up to 150 percent of the Medicare estimate. However, in 2002, the UPL for public hospitals was lowered to 100 percent of the Medicare estimate, the same limit that applies to other classes of providers. The regulations provided a transition period for hospitals that were receiving UPL payments in excess of the new limit (CMS 2002).

[12] Hospitals with Medicaid payments that are based on actual, reconciled costs are not required to be included in the UPL demonstration, but hospitals that receive cost-based payments that are not reconciled to actual costs are required to be included in the UPL demonstration. Although Medicare currently does not pay most hospitals based on costs, CMS considers cost-based payment to be consistent with Medicare payment principles. Medicare payments to most hospitals are based on the prospective payment system. However, Medicare pays critical access hospitals 101 percent of their costs.

[13] Critical access hospitals receive a special payment designation from Medicare because they are small (fewer than 25 beds) and are often the only hospital providers in their communities.

[14] Hospital-specific data were not available for Arizona, New York, and Tennessee. Inpatient hospital UPL data were not available for North Dakota, but outpatient hospital UPL data were available.

[15] For example, actual UPL payments reported in FY 2014 were $7.5 billion larger than hospital UPL payments reported on SFY 2014 UPL demonstrations and aggregate actual UPL payments reported in FY 2015 were $11.0 billion larger than hospital UPL payments reported in SFY 2015.

[16] Medicaid GME payments are a component of Medicaid payments for inpatient hospital services that are subject to the UPL. Some states incorporate GME costs into the calculation of base payments to teaching hospitals, while other states make GME payments as a supplemental payment.

[17] Hospital payments that are financed using certified public expenditures (CPEs) are considered to be cost-based by CMS and are excluded from state UPL demonstrations. We do not have complete information on how hospital payments are financed, but we know that California public hospitals are financed using CPEs, which explains why these payments are excluded. In SFY 2014, these hospitals received $3.7 billion in Medicaid FFS payments (Navigant 2017).

[18] Prior period adjustments are retrospective changes to Medicaid spending reported in a prior calendar quarter.

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on oversight of upper payment limit supplemental payments to hospitals. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on the recommendations in this chapter on January 24, 2019.

Oversight of Upper Payment Limit Supplemental Payments to Hospitals

2.1 The Secretary of the U.S. Department of Health and Human Services should establish process controls to ensure that annual hospital upper payment limit demonstration data are accurate and complete and that the limits calculated with these data are used in the review of claimed expenditures.

2.2 To help inform development of payment methods that promote efficiency and economy, the Secretary of the U.S. Department of Health and Human Services should make hospital-specific upper payment limit demonstration data and methods publicly available in a standard format that enables analysis.

Yes:	Bella, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno	17	Yes
		0	No
		0	Not voting

APPENDIX 2A: Methods

Form CMS-64 expenditure reports are the official record of state-level Medicaid spending, but states use claims-level data from their Medicaid Management Information Systems (MMIS) to report spending on their annual upper payment limit (UPL) demonstrations. These data sources differ in how spending is reported and how services are defined (Table 2A-1).

In order to compare spending reported in these two data sources, we used CMS-64 data that was as closely aligned with the UPL demonstration data as possible. We made several adjustments to the approach that MACPAC usually uses to report CMS-64 spending in MACStats and other publications:

Time period alignment. We used CMS-64 spending data from the calendar quarters that match the state fiscal years (SFY) of most states (July 1, 2015—June 30, 2016 for SFY 2016).[1]

Prior period adjustments. We accounted for all prior period adjustments that were applied to SFY 2016 spending as reported through December 2017, and we excluded spending reported in SFY 2016 that was an adjustment to a prior period.

Critical access hospital spending. We did not include hospital spending reported on the critical access hospital line of the CMS-64 expenditure report because this spending is often excluded from UPL demonstrations, and the CMS-64 does not distinguish between inpatient and outpatient

TABLE 2A-1. Data Sources and Definitions for State UPL Demonstrations and CMS-64 Expenditure Reports T 2A-1

Data sources and definitions	State UPL demonstrations	Form CMS-64 expenditure reports
Data source	State Medicaid Management Information System	Federal Medicaid Budget and Expenditure System
Time period	State fiscal year	Federal calendar quarters
Dates of service	Date service was performed	Date federal payment was made
Method of reporting payments	Adjudicated claim amount	Final paid amount (including prior period adjustments)
Excluded hospitals	Hospitals paid on a cost-basis (typically critical access hospitals and some government-owned hospitals)	None, although spending on critical access hospitals is reported separately
Excluded payments	Cross-over payments for patients dually eligible for Medicare and Medicaid	None
Definition of supplemental payments	UPL and GME payments for FFS only	UPL and GME payments are reported on separate lines • Section 1115 supplemental payments are sometimes reported on the UPL spending line • Some states appear to report UPL payments on the base payment spending line (e.g., Missouri) • Managed care supplemental payments are supposed to be reported as part of managed care capitation payments, but some managed care GME payments may be included on the GME line

Notes: UPL is upper payment limit. GME is graduate medical education. FFS is fee for service.

hospital services. In fiscal year (FY) 2016, states reported $0.8 billion in fee-for-service (FFS) payments for critical access hospitals, which was 1 percent of total non-disproportionate share hospital (DSH) FFS spending on hospitals.

Emergency hospital services. We also did not include emergency hospital services provided to undocumented immigrants because this spending is not reported separately for inpatient and outpatient hospital services, and the Centers for Medicare & Medicaid Services (CMS) guidance does not clarify whether this spending is included in UPL demonstrations or not. In FY 2016, states reported $3.5 billion in FFS payments for emergency hospital services, which was 5 percent of total non-DSH FFS spending on hospitals.

Section 1115 supplemental payments. We excluded supplemental payments authorized under Section 1115 demonstrations from spending reported on the UPL spending line of CMS-64 expenditure reports. In SFY 2016, $7.6 billion in Section 1115 supplemental payments were reported on the UPL spending line of CMS-64 expenditure reports.[2]

Despite these adjustments, several limitations remain, which may explain some of the differences that we observe between spending reported on UPL demonstrations and spending reported on CMS-64 expenditure reports. These include:

Different methods for tracking dates. The date that a service was performed (used for UPL demonstrations) is earlier than the date that federal payment for the service was made (used on CMS-64 expenditure reports). The CMS-64 reports include a method for tracking the date of service for DSH payments, and it is common for states to report making DSH payments a year or two after the date of service.

Cross-over payments. UPL demonstrations do not include Medicaid payments for cross-over claims for patients who are dually eligible for Medicare and Medicaid, but CMS-64 expenditure reports do not identify this spending separately. Medicaid FFS spending was $1.1 billion on inpatient hospital services and $1.1 billion on outpatient hospital services for full-benefit dually eligible beneficiaries in calendar year 2013 (MedPAC and MACPAC 2018).

Managed care graduate medical education (GME) payments. Only GME payments attributable to FFS are included in state UPL demonstrations, but CMS-64 expenditure reports do not distinguish whether these payments are for managed care or FFS. States reported a total of $2.0 billion in GME payments in SFY 2016 on CMS-64 expenditure reports.

Endnotes

[1] Four states have state fiscal years that do not end June 30. The state fiscal year ends March 31 in New York, August 31 in Texas, and September 30 in Alabama and Michigan.

[2] Section 1115 supplemental payments were identified based on a review of the special terms and conditions for waivers that authorize supplemental payments, and spending on these payments was tracked using the additional spending forms identified in the waiver terms and conditions.