Upper Payment Limit Supplemental Payments

State Medicaid programs have considerable flexibility to determine payment methods and amounts for most provider types. The majority of fee-for-service (FFS) payments are base payments for services. In addition, states may also make different types of supplemental payments, which are typically made in a lump sum for a fixed period of time. Supplemental payments are most often made to physicians and institutional providers such as hospitals and nursing facilities. There are different types of supplemental payments, each governed by different statutory and regulatory requirements: upper payment limit (UPL) supplemental payments, disproportionate share hospital (DSH) payments, uncompensated care pool payments, or other lump sum payments designed to support specific policy objectives.

States can make UPL payments to providers based on the difference between base FFS payments to a class of providers (in the aggregate) and an upper payment limit specified in regulation. For most institutional providers, such as hospitals and nursing facilities, the UPL is defined as a reasonable estimate of the amount that would have been paid for the same service under Medicare payment principles. For physician services, the UPL is defined as the average commercial rate that the provider receives, which is typically higher than Medicare rates.

In fiscal year (FY) 2019, 32 states made a total of $19.1 billion in UPL supplemental payments to providers. Specifically:

- 32 states made $14.3 billion in UPL payments to hospitals (16.3 percent of total FFS hospital payments).
- 25 states made $3.3 billion in UPL payments to nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IDs) (6.7 percent of total FFS ICF/ID payments).
- 26 states made $1.5 billion in UPL supplemental payments to physicians and other practitioners (15.1 percent of total FFS physician and other practitioner payments).

In state fiscal year (SFY) 2018, about half of UPL payments were financed using state general funds and about half were financed using provider taxes or funds from local governments, including intergovernmental transfers (IGTs) from public hospitals (GAO 2020).

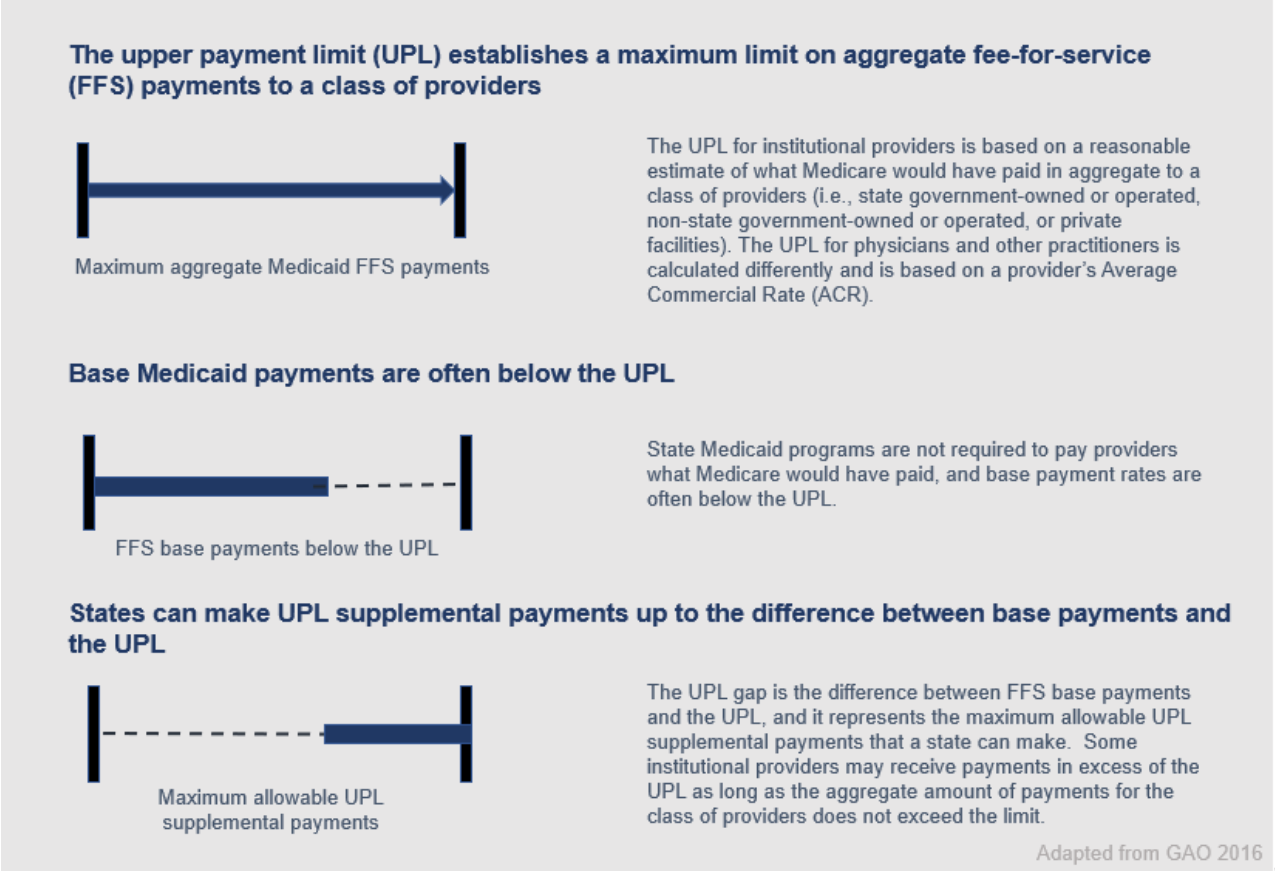
This brief describes the use and oversight of UPL payments for hospitals, nursing facilities, and physicians based on a MACPAC review of provider-level data submitted by states to demonstrate compliance with the UPL requirements (referred to as annual UPL demonstrations). It concludes with a discussion of current policy issues, including the new requirement for the Centers for Medicare & Medicaid Services (CMS) to make provider-level UPL data publicly available.

Background

Historically, Medicaid payments were based on costs using Medicare payment methods. However, in the early 1980's Medicaid payments were de-linked from Medicare and states were given considerable flexibility to design their own payment methods for most provider types.[1] 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 maximum amount of UPL supplemental payments a state can make is the difference between FFS base payments and the UPL (Figure 1). If a state increases FFS base payment rates to providers, the amount of UPL supplemental payments that the state can make to those providers is reduced. If FFS utilization increases, the amount of UPL supplemental payments that the state can make increases correspondingly even if base payment rates do not change. However, if a state transitions the delivery system from FFS to managed care, FFS utilization will decline and the amount of UPL payments that the state can make will also be reduced.[2]

Figure 1. Maximum Allowable Upper Payment Limit Supplemental Payments



States use different methods for calculating what the payment amount would have been under Medicare payment principles for each provider type. For hospitals and nursing facilities, states can calculate the UPL based on cost (as determined using Medicare payment principles) or an estimate of the rate Medicare would have paid for the same service (referred to as a price-based method). For physicians and other practitioners, the UPL can be calculated using the average commercial rate (ACR) or the ACR as a percentage of the Medicare rate, as described below.

Use of UPL Payments

State methods for distributing UPL payments vary widely. MACPAC's review of state UPL demonstrations for hospitals, nursing facilities, and physicians found that states frequently make UPL payments to government-owned facilities, providers serving a high share of Medicaid and low-income patients, and providers located in rural areas.

Hospital UPL payments

States can make UPL payments for both inpatient and outpatient hospital services. In FY 2019, 32 states made $14.3 billion in UPL payments to hospitals, accounting for 16.3 percent of total FFS Medicaid payments to hospitals. UPL payments were the second largest type of supplemental payment to hospitals reported in FY 2019 after DSH payments, which totaled $15.0 billion.3 Additional information about Medicaid supplemental payments to hospitals can be found in MACPAC's issue brief *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2021).

In SFY 2016, about half of states used cost-based methods for calculating inpatient hospital UPLs and about half used a price-based method. Most states used cost-based methods for calculating outpatient hospital UPLs. The cost-based method of calculating the UPL can result in a UPL that is often higher than what Medicare would have actually paid, because Medicare payments to hospitals are typically below hospital costs (MedPAC 2018). More states use cost-based methods for calculating outpatient hospital UPL presumably because this method typically results in a higher UPL, providing the state greater payment flexibility and reducing the risk of exceeding the UPL when making supplemental payments.

State methodologies for distributing UPL payments to hospitals vary widely. According to a 2018 MACPAC review of FFS payment policies, the most common types of hospitals receiving UPL payments include government-owned facilities; safety-net hospitals, which serve a high share of Medicaid or low-income patients; and rural hospitals (MACPAC 2016a, MACPAC 2018a).

Nursing facility UPL payments

MACPAC review of Medicaid state plans in place as of July 2019 found that 25 states reported some type of supplemental payment to nursing facilities. In FY 2019, total Medicaid spending on nursing facility supplemental payments amounted to $3.4 billion (MACPAC 2019a). This represents 6.7 percent of total Medicaid FFS nursing facility payments.

In SFY 2016, most states used the payment-based method to calculate nursing facility UPLs, although about half of states used a cost-based method for at least one class of providers (i.e., state government-owned or operated, non-state government owned or operated, or private facilities). In general, a payment-based method of calculating the nursing facility UPL likely results in a higher limit for states, since Medicare payments to nursing facilities typically exceed nursing facility costs (MedPAC 2019).[4]

Most states make nursing facility supplemental payments to government-owned facilities, which often finance the non-federal share of these payments through IGTs and typically serve a higher share of Medicaid patients than other types of nursing facilities. In some cases, privately owned nursing facilities have entered into arrangements with public hospitals in order to be classified as a government-owned facility for the purposes of receiving IGT-funded supplemental payments (Galewitz 2017, Evans 2020, MACPAC 2020a). CMS has applied greater scrutiny to these types of arrangements in recent years (CMS 2019).

Physician UPL payments

In FY 2019, 26 states made $1.5 billion in UPL supplemental payments to physicians and other practitioners (15.1 percent of total FFS physician and other practitioner payments). Because there is not a federal statute or regulation that establishes a UPL for such non-institutional providers, states are permitted to pay rates greater than Medicare. However, in sub-regulatory guidance CMS has indicated that average commercial rates (ACR) for physician services may be used as upper limits (CMS 2021a). Since ACRs are generally higher than the Medicare rates, the ACR method can result in a UPL that is higher than a reasonable estimate of what Medicare would have paid.

All of the 21 states that submitted physician UPL payment demonstrations between 2017 and 2019 used a method based on the ACR for calculating the UPL.[5] Of these states, 12 made UPL payments that were greater than the amount of base payments made to physicians in the specified year.

MACPAC reviewed state plan amendments (SPAs) for the 26 states that make UPL supplemental payments to physicians and other practitioners and found that 18 make UPL payments to physicians that are contracted or affiliated with government-operated teaching hospitals or academic medical centers, such as a state university health system. These types of arrangements are often financed through IGTs from state-owned universities affiliated with the academic medical center.

Monitoring Compliance with UPL Requirements

Since 2013, states have been required to submit annual UPL calculations to CMS to demonstrate that Medicaid payments to each class of providers does not exceed the UPL (CMS 2013). States have the option to demonstrate UPL compliance prospectively, based on estimates of Medicaid spending for the upcoming year, or retrospectively, based on actual spending. Most states submit UPL demonstrations prospectively, using utilization data from the prior year to estimate spending in the upcoming year and develop the relevant UPLs. CMS uses this information to validate the state's UPL calculations and the amount of projected payments in relation to the calculated limit. If payments exceed the applicable limit,

CMS has the authority to require adjustments to the payments or the methods used for calculating the limit to ensure compliance with federal rules.

MACPAC's review of the UPL demonstrations submitted to CMS between 2016 and 2019 has raised questions about the accuracy and completeness of the data used to monitor compliance, as well as how these data are used in the review of claimed UPL expenditures. For example, there are discrepancies between the number of states that have SPA authority to make UPL payments to certain types of providers, the number of states that submit annual UPL demonstrations for those types of providers, and the number of states that report supplemental payment expenditures on the CMS-64 expenditure reports for those types of providers.

For physician UPL payments, MACPAC found inconsistencies between data submitted on CMS-64 expenditure reports and for state UPL demonstrations. Twenty-one states submitted UPL demonstrations between 2017 and 2019 and reported estimated UPL payments of $546.5 million. However, according to CMS-64 expenditure reports, 26 states made UPL payments amounting to $1.4 billion during the same time period.[6] Unlike other UPL demonstrations, which are required annually for all providers in a class, physician UPL demonstrations are only required once every three years. Base payments reported in the 2017-2019 physician UPL demonstration data only account for 6 percent of total FFS Medicaid payments to physicians in the corresponding years.

MACPAC's review of hospital UPL data submitted to CMS also found large discrepancies between the payments that states reported on UPL demonstrations and spending reported on CMS-64 expenditure reports, some of which may have affected compliance with UPL requirements. Specifically, MACPAC found that 17 states claimed UPL supplemental payment expenditures in SFY 2016 on the CMS-64 reports that exceeded the limits calculated on their state UPL demonstrations by $2.2 billion in the aggregate (MACPAC 2019b). This does not necessarily mean that the supplemental payments exceeded the upper limits, as most state UPL demonstrations are made prospectively using prior year data to estimate an upper limit. However, it is not clear how the discrepancies between the payments reported on UPL demonstrations and spending reported on CMS-64 expenditure reports are investigated or reconciled by CMS.

Our review of nursing facility UPL demonstrations found similarly large discrepancies between actual and reported UPL payments. In SFY 2016, the amount of actual nursing facility supplemental payments reported on CMS-64 expenditure reports was $1.3 billion higher than that estimated in the state UPL demonstrations. However, total FFS spending in SFY 2016 was 71 percent of the state-calculated UPL, suggesting that most states were not at risk of exceeding the limit (MACPAC 2019c). Thus, while spending was higher than anticipated, states were likely not at risk of exceeding the UPL because the UPL for nursing facilities was often much higher than Medicaid payment rates for nursing facilities (MACPAC 2019c). Regardless, it is not clear whether the discrepancies between estimated and reported supplemental payments were reconciled by CMS.

The reliability of UPL demonstrations may improve in future years as CMS standardizes the reporting process. Since SFY 2019, CMS has required states to submit UPL information using a new template and has provided additional guidance to describe allowable methods for calculating the UPL for each type of

service (CMS 2021b). In addition, CMS is in the process of updating its financial management data systems, which may also help improve monitoring and oversight.

Policy Issues

MACPAC has long recommended that CMS collect and report UPL supplemental payment data at the provider level in a standard format that enables analysis (MACPAC 2014). Because UPL payments are a significant source of funding for Medicaid providers, provider-level payment information is needed to assess the total amount of Medicaid payments that providers receive. Although MACPAC's analyses of UPL payments have focused on compliance with existing rules, some policymakers have raised concerns about whether the current limits on payments are consistent with statutory goals of efficiency and economy. In some cases, supplemental payments can result in total payments to providers exceeding a reasonable estimate of what Medicare would have paid. In addition, greater transparency can help to improve federal oversight of compliance with UPL requirements.

The Consolidated Appropriations Act, 2021, (P.L. 116-260) requires the U.S. Department of Health and Human Services (HHS) to report provider-level data on UPL payments beginning October 1, 2021. The statute also requires states to report on their targeting methods and intended goals of their UPL programs. As of October 2021, CMS has not released guidance describing how these requirements will be implemented, but CMS has indicated that guidance will be forthcoming.

MACPAC has also recommended that CMS collect and report data on the sources of the non-federal share, which is necessary to calculate net payments to providers and understand how payment methods relate to financing (MACPAC 2016b). Because many UPL payments are financed through provider taxes and IGTs, the net amount of payments retained by providers is often less that the total amount of payments reported on expenditure reports. While the Consolidated Appropriations Act, 2021 created additional reporting requirements regarding payments, it does not require CMS to collect these data.

The discrepancies that MACPAC found between estimated spending reported on state UPL demonstrations and actual spending reported on CMS expenditure reports also raise concerns about CMS's process to ensure that UPL demonstration data are accurate and complete. Although CMS is now requiring states to use a standard template to submit their UPL demonstrations and taking steps to improve its financial management data systems, it is unclear whether the quality of UPL demonstration data has improved or how this data will be used to enforce compliance.

In addition to requiring that payments are consistent with the principles of efficiency and economy, the Medicaid statute also requires that payments support quality and access goals. As noted above, UPL payments do not typically have a direct tie to quality or value. In contrast, CMS requires that other types of supplemental payments such as delivery system reform incentive payments (DSRIP) authorized under Section 1115 demonstrations, be tied to quality (MACPAC 2015).

Learn more:

- Oversight of Upper Payment Limit Supplemental Payments to Hospitals, in MACPAC's March 2019 Report to Congress on Medicaid and CHIP
- *Medicaid Base and Supplemental Payments to Hospitals* (June 2021 issue brief)
- Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments, in MACPAC's March 2014 Report to Congress on Medicaid and CHIP
- Using Medicaid Supplemental Payments to Drive Delivery System Reform, in MACPAC's June 2015 Report to Congress on Medicaid and CHIP
- Nursing Facility Payment Policy: Payment Methods and Recent Developments (September 2019 presentation to the MACPAC Commission)
- *Directed Payments in Medicaid Managed Care* (August 2020 issue brief)
- *State Medicaid Payment Policies for Inpatient Hospital Services* (December 2018 policy compendium and issue brief)
- *State Medicaid Payment Policies for Outpatient Hospital Services* (July 2016 policy compendium and issue brief)
- MACStats Exhibit 24: Medicaid Supplemental Payments to Hospital Providers by State (Most Current MACStats Compiled)
- MACStats Exhibit 25: Medicaid Supplemental Payments to Non-Hospital Providers by State (Most Current MACStats Compiled)

Endnotes

[1] The Omnibus Budget Reconciliation Act (OBRA) of 1980 (P.L. 97-35) and OBRA 1981 (P.L. 96-499) de-linked Medicaid payments from Medicare for nursing facilities and hospitals, respectively.

[2] In 2020, CMS revised the managed care regulations to allow states to make pass-through payments for new services and populations transitioning from FFS to managed care for a three-year transition period (42 CFR § 438.6(d)(6). Since 2016 states have also had the option to direct payments to providers under certain circumstances where payments are tied to utilization of services and the state's managed care quality strategy. In addition, some states have used Section 1115 demonstration waiver authority to continue making supplemental payments to providers, such as Delivery System Reform Incentive Payments (DSRIP).

[3] DSH payments are not subject to the UPL. Instead DSH payments to a hospital cannot exceed a hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

[4] Since 2000, aggregate Medicare margins for freestanding nursing facilities have been above 10 percent (MedPAC 2019).

[5] Of the 21 states that submitted physician UPL demonstrations between 2017 and 2019, 10 states calculated the UPL using the ACR, 10 states converted the ACR to a Medicare equivalent rate, and one state reported using both methods.

[6] About half of the states making physician UPL payments between 2017-2019 reported expenditures for these payments on the CMS-64 but did not report any payments under a physician UPL demonstration. Conversely, four states reported physician UPL payments under the demonstration, but not on their CMS-64 expenditure reports.

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