Supplemental Payment Methods Part 2: Upper Payment Limit Programs

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Arkansas Center for Health Improvement

FACT SHEET ● JUNE 2016

Medicaid financing and provider reimbursement models are extremely complex. As states expand their Medicaid programs and search for ways to control costs, understanding how public healthcare dollars flow to providers will be essential to the analysis of options. In a separate fact sheet, we have discussed how the federal government and states share in financing the Medicaid program through Federal Medical Assistance Percentages (FMAPs). This fact sheet is one of two discussing supplemental payments to providers in addition to direct payments for services. These supplemental payments—Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments—serve to offset uncompensated care costs and augment Medicaid reimbursement rates that are lower relative to Medicare and private payer rates for comparable services. Estimates show that these payments represent more than one-third of Medicaid fee-for-service (FFS) hospital payments.[1] Consequently, policymakers should carefully consider reform options that disrupt or eliminate the flow of these payments. This fact sheet provides information on the development of Medicaid UPL payments, details the UPL payment methodology for hospitals in Arkansas, and describes changes to UPL payments in relation to managed care.

INTRODUCTION

Upper Payment Limit Development

When Medicare implemented its Diagnosed-Related Group (DRG) payment system for hospitals, the federal government granted state Medicaid programs flexibility to define their own hospital and long-term care reimbursement rates.[2] To control Medicaid spending on fee-for-service (FFS) hospital rates, Congress imposed an Upper Payment Limit (UPL) based on what Medicare would have paid facilities for the same services.[3,4] The UPL is the maximum aggregated amount a state Medicaid program would have paid a class of Medicaid FFS providers at the Medicare rate.[5] Due to this cost containment mechanism, Medicaid payment rates to providers are frequently lower and annual Medicaid rate increases have not been incorporated as experienced with Medicare providers. Thus, the gap between Medicare and Medicaid rates has grown and with this gap the UPL differential has increased.

Upper Payment Limit Supplemental Payments

The UPL gap is the difference between the amounts a state Medicaid program would have paid Medicaid providers the Medicare rate for comparable services. State Medicaid programs cannot claim federal matching dollars for provider payments in excess of the applicable UPL. Medicaid UPL cost containment decreases claims payments to providers but subsequently could increase the supplemental payments available to providers. Therefore, many states maximize federal matching dollars up to the cap to provide supplemental payments to some institutions to close the UPL gap.[6] UPL supplemental payments are more specifically referred to as additional payments to providers under the UPL ruling to supplement or enhance the regular Medicaid payment.[6]

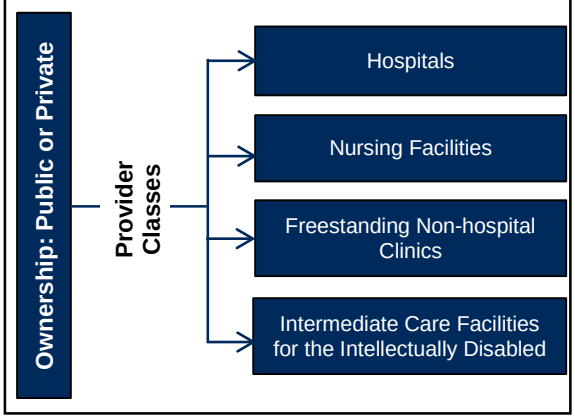
UPPER PAYMENT LIMIT GUIDELINES

When considering the development of a UPL supplemental payment system, state Medicaid agencies generally:[5]

- Have different UPL payments depending on the provider class and type of service—e.g., inpatient or outpatient (see Figure 1).
- Do not pay UPL payments to providers that exceed the sum of Medicare reimbursements and Medicaid disproportionate share hospital (DSH) payments.

All UPL calculations are statewide and aggregated for the type of service (outpatient or inpatient), the provider class as a whole, and for each ownership type (publicly or privately owned). The following sections describe the hospital UPL programs in Arkansas.

Figure 1. UPL Provider Classes[5]



INTERGOVERNMENTAL TRANSFERS

Supplemental payments draw down Medicaid funds at the regular state FMAP thus requiring a source of state funds for the payments; however, state budgetary constraints limit the amount of general revenue available for supplemental payments. Therefore, intergovernmental transfers (IGT)—the shifting of public funds between different levels of government or within the same level of government entities—are available to fund supplemental payments.[7] Examples include transferring funds between counties and the state or between a state university hospital and a state Medicaid agency. States may choose to use IGTs when making supplemental UPL payments to governmentally owned facilities. If these facilities receive UPL supplemental payments, then the excess payments may be returned to the state through an IGT (see the text box for an example). IGTs are useful to states needing to fill budget gaps by increasing the federal share of financing for the state's Medicaid program.

County Hospital Example of IGTs and UPLs[7]

A county operates a tax-supported public hospital that is a Medicaid provider.

Step 1: The County sends the state local tax money via an IGT to help cover the state (non-federal) share of Medicaid expenditures.

Step 2: The state draws down money at the FMAP rate to support UPL payments.

Step 3: The state sends the county hospital a UPL supplemental payment. This amount will typically exceed the amount of the county's initial IGT to the state

ARKANSAS'S UPPER PAYMENT LIMIT FUNDING

Funding Pool

Two funding mechanisms exist in Arkansas to generate a state funding pool to generate UPL supplemental payments:

1) ***Hospital Assessment Account:*** All private hospitals pay assessment fees to a Hospital Assessment Account managed by Arkansas Medicaid, regardless of whether the hospitals receive any UPL payments.[8]
   - The fee is determined annually and calculated as a percentage of each hospital's net patient revenue.
   - Teaching and pediatric hospitals are exempt from the requirement to pay the fee.
2) ***Intergovernmental Transfer:*** Money is transferred using IGTs between public hospitals and Arkansas Medicaid.
   - Public hospitals are government-owned and operated hospitals, including Arkansas's State Operated Teaching Hospitals[a] and city or county hospitals.

A small portion of the Hospital Assessment Account fund is retained by Medicaid as an administrative fee. However, the remaining money and the federal match are available to pay eligible hospitals their UPL supplemental payment.

UPL Supplemental Payment Programs

There are four UPL programs in Arkansas –two for both inpatient and outpatient care in Arkansas hospitals. These programs—Inpatient Rate Adjustments, Inpatient Hospital Access Payments, Outpatient Hospital Access Payments, and Outpatient Rate Adjustments—vary in hospital eligibility, how the UPL gap is calculated, and the reimbursement methodology. Table 1 provides the UPL supplemental payment programs in Arkansas.

Table 1. UPL Supplemental Payment Programs in Arkansas[9]

UPL Program	Eligible Hospitals	UPL Gap Calculation	Reimbursement
Inpatient Rate Adjustment	Private Pediatric Hospitals	The adjustment amount is determined annually by Arkansas Medicaid based on available funding	Equal to their proportionate share of the total adjustment based on the hospital's Medicaid discharges
	Non-state, Government-owned Hospitals	The difference between adjusted* Medicaid and Medicare base rates per discharge	UPL gap multiplied by the number of the hospital's Medicaid discharges
	Arkansas State Operated Teaching Hospitals	The difference is calculated between the trended forward and adjusted* Medicaid and Medicare base rate per discharge for the current fiscal year then multiplied by the hospital's Medicaid CMI	UPL gap multiplied by the number of the hospital's Medicaid discharges

[a] The only Arkansas State Operated Teaching Hospital is the University of Arkansas for Medical Sciences (UAMS)

Table 1 (continued). UPL Supplemental Payment Programs in Arkansas[9]			
UPL Program	**Eligible Hospitals**	**UPL Gap Calculation**	**Reimbursement**
Inpatient Hospital Access Payments	Privately Operated Hospitals (excludes rehab, pediatric, and specialty hospitals)	The number of Medicaid discharges from the most recent audited fiscal year is determined for each eligible hospital and is divided by the aggregate Medicaid discharges for all eligible hospitals	A maximum funding pool for eligible hospitals is determined annually based on the aggregate difference between adjusted* Medicaid and Medicare rates per discharge for the same services† for all eligible hospitals but is limited to 97% of the gap to avoid overpayment. A hospital's UPL reimbursement is the number from the UPL gap calculation multiplied by the amount in the funding pool
Outpatient Hospital Access Payments	Privately Operated Hospitals (excludes rehab, pediatric, and specialty hospitals)	The aggregate gap between Medicaid payments for private hospital outpatient services and the cost of those services (using Medicare principles) is determined. The aggregate gap is the maximum total outpatient access payment that may be made to all private hospitals	Proportionate to the payment a hospital receives for Medicaid outpatient services compared to the total Medicaid payment for outpatient services to all eligible hospitals
	Private Pediatric Hospitals	Uses the same methods and standards as private hospitals to determine reasonable costs for services	Based on the lesser of reasonable costs or customary charges to establish a year-end cost settlement
Outpatient Reimbursement Adjustment	Non-state Government Owned Hospital (excludes rehab, pediatric, and specialty hospitals)	Difference between total Medicaid outpatient expenditures during the most recent FY and these same total outpatient expenditures divided by 80%	Reimbursed the amount from the UPL gap calculation

* Adjustment calculated using Case Mix Indices (CMIs)
† Medicare DSH is included for the calculation of the gap, but Medicaid DSH is not included

In Fiscal Year (FY) 2014, the total amount available in the Hospital Assessment Account for the access payments was $59.5 million. The net UPL dollars available for payout were approximately $132 million, which was 11 percent less than the previous fiscal year.[10]

UPL PROGRAMS AND MANAGED CARE

UPL payments are based on FFS in hospitals and other care settings where Medicaid payment rates are below Medicare payment rates for comparable services. When faced with decisions about transitioning to Medicaid managed care, states have closely analyzed the potential loss in federal matching dollars to fund UPL supplemental payments, while some states have explored other options for funding sources to replace the supplemental payments.[6] For example, as Florida transitioned to Medicaid managed care, the state analyzed options such as increasing hospital assessment fees and imposing a tax on managed care organizations to compensate for the budget deficit resulting from decreases in supplemental payments.[11] The following information should be considered in Arkansas during managed care discussions regarding UPL supplemental payments:[6]

- In a FFS payment model, states can make payments directly to providers for Medicaid services. However, in a managed care delivery model, states do not make direct payments to providers, and therefore the amount of UPL supplemental payments available to providers from the state will decrease.
- If there is a large shift in Medicaid outpatient and inpatient services from FFS to managed care, there could be a significant loss of federal matching dollars paid to the state from reduced UPL supplemental payments.
- Higher-cost populations account for a high rate of inpatient hospital days, and shifting their care to managed care will evoke the most significant decrease in UPL supplemental payments.

As health reform continues in Arkansas, transitioning any of the Medicaid population from FFS to managed care could have significant implications on UPL supplement payment policies. As the state discusses and examines options for the Medicaid population, supplemental payments should be considered in those discussions as well as how changes to the state Medicaid program will effect supplemental payments and, consequently, the federal match received by Arkansas for the Medicaid program.

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