MEDICAID SUPPLEMENTAL PAYMENT METHODS

Upper Payment Limits Program

Introduction

Medicaid financing and provider reimbursement models are extremely complex. As states search for ways to control Medicaid costs, understanding how public healthcare dollars flow to providers will be essential in analyzing options.

Supplemental payments are Medicaid payments to providers that are separate from and in addition to the payments for services provided to Medicaid enrollees. The extra 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 nationally.[1] Consequently, policymakers should carefully consider reform options that disrupt or eliminate the flow of these payments.

There are several different types of supplemental payments; this explainer discusses upper payment limit (UPL) supplemental payments.

Background

UPPER PAYMENT LIMIT DEVELOPMENT

When Medicare implemented its diagnosis-related group[a] 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-

[a] A method used to categorize the patients a hospital admits for the purpose of determining the hospital's reimbursement.

1401 W. Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas

501-526-2244
achi@achi.net
achi.net

for-services (FFS) hospital rates, Congress imposed[3] an upper payment limit based on what Medicare would have paid facilities for the same services.[b] UPL payments cannot exceed a reasonable estimate of what Medicaid providers would have been paid based on Medicare payment rates.[4] Medicaid payment rates to providers are frequently lower compared to other payers, and annual increases in payment rates to Medicare providers have not been incorporated into Medicaid rates. 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 regular amounts a state Medicaid program pays to Medicaid providers and the amounts Medicare would pay 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 UPL cap to provide supplemental payments to some institutions and close the UPL gap.[5] UPL supplemental payments are more specifically referred to as additional payments to providers under the UPL rule to supplement or enhance the regular Medicaid payment. UPL supplemental payments in Arkansas usually total approximately $470 million annually.[6]

Upper Payment Limit Guidelines

When developing of a UPL supplemental payment system, state Medicaid agencies generally:[6]

- Select a calculation for the UPL, using a variety of methods.
- Set UPL payments that differ based on provider class and whether services are inpatient or outpatient.
- Establish that UPL payments to providers will not exceed the sum of Medicare reimbursements.

[b] For physician services, the UPL is tied to the average commercial rate that the provider receives, which is typically higher than Medicare rates. However, for most institutional providers, such as hospitals, the UPL is an estimate of the amount that would have been paid under Medicare payment principles.

All UPL calculations are statewide and aggregated for the type of service (inpatient or outpatient), the provider class, and the ownership type (publicly or privately owned).

Intergovernmental Transfers

Supplemental payments draw down Medicaid funds at the regular state Federal Medical Assistance Percentage (FMAP), the rate at which the federal government provides matching funds for Medicaid. This means a source of state funds for the payments is required; 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 between different entities at the same level of government — 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 UPL supplemental payments to government-owned facilities. These facilities may receive amounts that exceed their costs (as long as the total payment is under the UPL), in which case the excess payment is 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 their Medicaid programs.

IGT AND UPL: A COUNTY HOSPITAL EXAMPLE

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.

Upper Payment Limit Guidelines

FUNDING POOL

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

- **Hospital Assessment Account.** All private hospitals pay assessment fees to Arkansas Medicaid's Hospital Assessment Account, regardless of whether the hospitals receive any UPL payments.[8] The fee is calculated as a percentage of a hospital's net patient revenue and is determined annually. Teaching and pediatric hospitals are exempt from the requirement to pay the fee.
- **Intergovernmental Transfer.** Money is transferred using IGTs between public hospitals and Arkansas Medicaid. Public hospitals are government-owned and -operated and include state-operated teaching hospitals 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 payments.

UPL SUPPLEMENTAL PAYMENT METHODS

There are four UPL supplemental payment methods in Arkansas: inpatient rate adjustments, inpatient hospital access payments, outpatient hospital access payments, and outpatient rate adjustments. They vary in hospital eligibility, UPL gap calculation, and reimbursement methodology. The appendix explains the differences.

UPL Programs and Managed Care

UPL payments are based on FFS payments in hospitals and other care settings where Medicaid payment rates are lower than Medicare 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, and some states have explored other options for funding sources to replace the supplemental payments. 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.[9] The following information regarding supplemental UPL payments should be considered in Arkansas during discussions of managed care:[5]

- In an 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 may 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 because of reduced UPL supplemental payments.
- Higher-cost populations account for a high rate of inpatient hospital days, and shifting their care to managed care will result in the most significant decrease in UPL supplemental payments.

As health reform continues in Arkansas, transitioning additional Medicaid populations from FFS to managed care could have significant implications for UPL supplemental payments. Supplemental payments are an integral tool for states to ensure that provider payments are sufficient to ensure beneficiary access consistent with federal law. Despite their complexity, policymakers should devote considerable attention to supplemental payment methods and the impacts of programmatic changes on the state's ability to fund and distribute the payments to providers.

APPENDIX: UPPER PAYMENT LIMIT (UPL) SUPPLEMENTAL PAYMENT PROGRAMS IN ARKANSAS[10]

UPL Program	Eligible Hospitals	UPL Gap Calculator	Reimbursement
Inpatient Rate Adjustment	Private pediatric hospitals.	The adjustment amount is determined annually by Arkansas Medicaid based on available funding.	Equal to the hospital's proportionate share of the total Medicaid discharges.
	Non-state, government-owned hospitals.	The difference between adjusted* Medicaid and Medicare base rates per discharge.	The 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 rates per discharge for the current fiscal year, multiplied by the hospital's Medicaid case mix index — the average diagnosis-related group relative weight for that hospital.	The UPL gap multiplied by the number of the hospital's Medicaid discharges.
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 resulting from the UPL gap calculation multiplied by the amount in the funding pool.
Outpatient Hospital Access Payments	Privately operated hospitals (excludes rehab 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 fiscal year and these same total outpatient expenditures divided by 80%.	The amount from the UPL gap calculation.

*Adjustment calculated using case mix indices.

†Medicare disproportionate-share hospital (DSH) payment — payments intended to offset uncompensated care costs — is included in the calculation of the gap, but Medicaid DSH is not included.

References

[1] Bachrach, D. & Dutton, M. (2011). *Medicaid supplemental payments: Where do they fit in payment reform?* Center for Health Care Strategies, Inc. jdsupra.com/legalnews/medicaid-supplemental-payments-where-do-32956

[2] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248.

[3] 42 CFR § 447.272(b) and 42 CFR § 447.321(b).

[4] The Commonwealth Fund. (2016). *Integrating Medicaid supplemental payments into value-based purchasing.* commonwealthfund.org/publications/fund-reports/2016/nov/integrating-medicaid-supplemental-payments-value-based

[5] The Medicaid and CHIP Payment and Access Commission. (2023). Supplemental payments. macpac.gov/subtopic/supplemental-payments

[6] The Medicaid and CHIP Payment and Access Commission. (2023). *Medicaid base and supplemental payments to hospitals*. macpac.gov/wp-content/uploads/2023/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals-Issue-Brief.pdf

[7] Kaiser Commission on Medicaid and the Uninsured. (2005). *Medicaid financing issues: Intergovernmental transfers and fiscal integrity.* kff.org/medicaid/fact-sheet/medicaid-financing-issues-intergovernmental-transfers-and-fiscal

[8] Ark. Code Ann. § 20-77-1901, et seq.

[9] Navigant Healthcare. (2015). *Study of hospital funding and payment methodologies for Florida Medicaid.* ahca.myflorida.com/medicaid/finance/finance/lip-dsh/lip/docs/fl_medicaid_funding_and_payment_study_2015-02-27.pdf

[10] Arkansas Medicaid. (1982). Arkansas Medicaid State Plan, Section II. humanservices.arkansas.gov/wp-content/uploads/ARMedicaidSP.pdf