

Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?

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As Medicaid assumes an increasingly significant role in the health insurance market, federal and state policymakers are focusing on how to ensure that its payment policies and purchasing strategies create incentives for higher quality, more efficient care. Yet to date, payment reform initiatives have, for the most part, neglected to address a significant component of Medicaid payment policies – supplemental payments. The two most significant forms of supplemental payments are Disproportionate Share Hospital (DSH) Payments and Upper Payment Limit (UPL) payments. Combined, DSH and UPL payments represent more than one-third of Medicaid fee-for-service payments to hospitals, and hospital payments constitute 23 percent of all Medicaid spending.¹

DSH and UPL payments historically have been used to subsidize uncompensated care costs and backfill for low reimbursement rates under Medicaid for hospitals serving large numbers of Medicaid and uninsured patients. More recently, supplemental payments are being used to provide additional Medicaid revenue to a wider array of hospitals, often to compensate for budget-driven cuts to base payment rates and to offset provider taxes used to generate the states' share of Medicaid costs. DSH and UPL payments can be a critical source of revenue to hospitals, especially safety-net hospitals. But supplemental payments are generally disconnected from the specific services provided to specific patients and delinked from the efficiency or quality of the care provided. This paper examines the impact of supplemental payment arrangements for hospitals on efforts to reform Medicaid's payment and purchasing strategies to ensure that beneficiaries have access to quality, cost-effective care.

Introduction

Section 1902(a)(30)(A) of the Social Security Act (Section (30)(A)) requires states to adopt Medicaid payment policies that are consistent with efficiency, economy, and quality care and that assure Medicaid beneficiaries have the same access to care as others in the

IN BRIEF

- Medicaid is rapidly becoming every state's largest health insurer, and with that status comes increasing focus on Medicaid's payment policies and purchasing strategies.
- Supplemental payments (both DSH and UPL) are a significant revenue stream for many hospitals. Yet because they are generally delinked from specific services rendered to specific patients, they may in fact undermine value-based purchasing.
- Supplemental payments should be aligned to the maximum extent possible with broader payment reform objectives of improving access to quality and efficient care.

geographic area.² The federal government historically has given states wide latitude in constructing their payment policies consistent with this overriding requirement. States have responded with a wide range of approaches, at times more reflective of the financial and political circumstances of the state than of a coherent purchasing strategy. As Medicaid assumes an increasingly significant role in the health insurance market, however, its payment policies and purchasing strategies will need to be aligned with broader health system efforts to pay for quality and efficiency. Medicaid currently provides health insurance to more than 40 million people. By 2019, one in four Americans will rely on Medicaid for health insurance coverage. This increasing reliance on Medicaid as a coverage option, and the concomitant growth in program costs, have prompted both federal and state governments to focus on how Medicaid might structure its payment systems to assure that it is receiving maximum value for the dollars it expends.³

In 2009, Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) and charged it with, among other things, evaluating: Medicaid's

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payment methods; their relationship to access and quality; and the factors affecting the efficient provision of services in different sectors.⁶ In MACPAC’s March 2011 report to Congress,⁷ the Commission noted that “promoting value-based purchasing, access to the appropriate amount of efficient, high-quality care, at the appropriate time and in the appropriate setting, is a fundamental goal of payment policy.” It identified several challenges to value-based purchasing within the Medicaid program, including Medicaid’s diverse patient population, its dominant role in the healthcare marketplace, particularly among safety-net providers, its comprehensive benefit package, and a countercyclical financing structure that relies on increased state revenues in times of decreasing state revenues. The Commission pledged to develop “a balanced and data-driven approach to payment evaluation that is appropriate for the Medicaid program that will help inform the Congress, states, and CMS regarding those payment policies and innovations that might best promote access to necessary and higher-quality services while slowing the growth of health care spending.”

Increased focus on Medicaid payment strategies by state and federal policymakers coincides with national efforts, spurred by passage of the Patient Protection and Affordable Care Act of 2010 (the ACA), to use new payment arrangements to support better clinical outcomes at lower costs.

Several ACA provisions focus specifically on Medicaid payment policies with a particular emphasis on beneficiaries with multiple chronic illnesses. Finally, since the passage of the ACA, at least two dozen states are considering or have passed legislation to advance payment and delivery system reform across multiple payers.⁸

Yet, to date, policymakers have largely ignored a significant component of Medicaid payment policies – supplemental payments.⁹ Supplemental payments include two “add-ons” to Medicaid payments to hospitals that are unrelated to the specific care delivered to a specific patient:

- **Disproportionate Share Hospital (DSH) Payments.** Since 1981, Congress has required states to make DSH payments to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by these hospitals. Federal law caps both the total amount of DSH payments a state may make and the total amount any one hospital may receive. A hospital’s DSH payment may not exceed the total of its costs of caring for Medicaid and uninsured patients less any amounts received for or from these patients. So long as a state’s DSH payments comply with these federal rules, it is eligible for federal matching dollars at the state’s regular federal matching rate.

Supplemental Payments within Managed Care

As states turn increasingly to managed care delivery systems, fee-for-service hospital admissions and visits decline, which means that the amount of “UPL room” available to states likewise declines.⁴ Faced with the political tension between shifting Medicaid beneficiaries into capitated programs and the pressure to maintain or increase the use of UPL payments, states have explored making payments to Medicaid managed care plans as “add-ons” or supplements to base premium rates. The plans are then required to pass through the premium add-ons to their contracted hospitals based on a pre-determined allocation formula. Like UPL payments, the allocation formula is unconnected to individual services provided to individual beneficiaries.⁵ Unless the payments are connected to provider quality measures, such as medical home status, the Centers for Medicare & Medicaid Services (CMS) generally will not approve these payment strategies, due to violation of Medicaid managed care regulations.

- **Upper Payment Limit (UPL) Payments.** Unlike DSH payments, UPL payments are not required under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPLs are based on what Medicare would have paid for comparable services to a class of providers. To the extent states' standard Medicaid payments, in the aggregate, for inpatient or outpatient services to state, non-state public, or private hospitals are less than the UPL for the applicable class of hospitals, states are able to direct, and receive federal matching dollars for, supplemental payments to hospitals. In short, UPL payments are "additional payments to providers to supplement or enhance the regular Medicaid payment."¹⁰ Unlike DSH payments, UPL payments are not subject to institution-specific caps, and any one hospital may receive more than its Medicaid costs so long as the aggregate payments to all hospitals in the group are below the aggregate UPL. DSH payments to hospitals are not counted when calculating the UPL.

While supplemental payments have received little attention in the context of payment and purchasing reforms, they have been the subject of considerable attention with respect to how the non-federal share is funded. States often rely on provider assessments and intergovernmental transfers (IGTs) from local subdivisions to fund the non-federal share of supplemental payments, thereby leveraging federal Medicaid matching funds without burdening state coffers.¹¹ This practice strongly influences states' use and allocation of supplemental payments, as county officials, hospital associations, and state legislators seek to ensure local governments and individual hospitals are made whole for their contributions.¹²

While it is impossible to discuss supplemental payments without acknowledging their relationship with

provider assessments and IGTs, this paper will evaluate these payments through a different lens -- namely, that of payment and delivery system reform. This brief focuses on the impact of supplemental payment arrangements on payment reform, and more specifically, national and local efforts to link payment to the delivery of cost-effective, quality care.

Overview of Supplemental Payment Practices

Supplemental payments represent a significant portion of state Medicaid spending on hospital services. According to the Government Accountability Office (GAO), in federal fiscal year 2006, states spent \$23.48 billion on DSH and UPL payments -- \$17.1 billion on DSH and "at least" \$6 billion on UPL payments.¹³ Since states were not required to report UPL payments before 2010,¹⁴ it is likely that the total amount of UPL payments significantly exceeded the \$6 billion found by GAO.¹⁵ In 2006, total Medicaid spending was \$303 billion and fee-for-service hospital spending was \$63 billion.¹⁶ Accordingly, in 2006, at least one-third of fee-for-service Medicaid payments to hospitals were through some form of supplemental payment. More recent data confirms comparable spending patterns.

As of federal fiscal year 2010, states are required to provide CMS with information on their non-DSH supplemental payments for both inpatient and outpatient services on CMS-64 Financial Management Report (FMR). The form defines inpatient UPL as follows:

"These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific

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groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.”

A similar definition applies to outpatient UPL payments.

In 2010, states reported \$10.8 million in inpatient UPL payments and \$1.8 million in outpatient UPL payments. Because this is the first year in which CMS has specifically required states to break out UPL information, the data is likely to be somewhat incomplete or inaccurate; however, even this early data suggest that states continue to rely heavily on supplemental payments. In 2010, in addition to the \$12.6 billion in DSH and UPL payments, states reported total fee-for-service hospital spending of \$89.6 billion and DSH spending of \$17.58 billion – making DSH and UPL payments almost 35 percent of hospital spending.

While a precise calculation of the amount or percentage of Medicaid payments to hospitals that come through supplemental payments is beyond the scope of this paper, it is clear that it is significant enough to influence hospital practices. Accordingly, supplemental payments could be an important factor in state and federal initiatives to improve quality and efficiency by reforming Medicaid's payment policies.¹⁷

A. Disproportionate Share Hospital Payments

In 1981, in an effort to enable states to promote more efficiency in health care delivery and curtail rapidly rising Medicaid expenditures, Congress permitted states to shift from cost-based Medicaid reimbursement rates to prospective payment systems.¹⁸ Concerned, however, that this shift might threaten the viability of

hospitals serving large numbers of Medicaid patients, Congress required states to “take into account” the situation of hospitals serving a disproportionate share of low-income patients when designing their payment systems.¹⁹ In 1987, Congress strengthened this mandate, requiring states to make payments, now referred to as DSH payments, in excess of standard Medicaid rates to these facilities.²⁰

States have considerable discretion in deciding which hospitals receive DSH payments and how much each hospital receives. All hospitals with high Medicaid or low-income inpatient utilization rates must qualify for DSH payments.²¹ In addition, states *may* designate additional hospitals in their State Plans as DSH, so long as their Medicaid inpatient utilization rates meet or exceed one percent. While DSH payments were developed as a mechanism to provide added revenue to safety-net hospitals – those serving disproportionate numbers of low-income patients – the statute's eligibility standards permit states to target DSH dollars to hospitals that serve relatively few low-income patients. As discussed below, with the reduction in DSH allocations under the ACA, in the future, it is likely that states will target their DSH payments to hospitals serving significant numbers of Medicaid and low-income, uninsured patients.

In addition to states having flexibility in determining which hospitals are eligible to receive DSH payments, they have broad latitude in allocating DSH payments among eligible hospitals. States may either apply the methodology used in determining Medicare DSH payments or devise their own payment formula.²² In any case, the payment formula must apply equally to all hospitals of each type and be “reasonably related to the costs, volume, or proportion of services provided” to Medicaid beneficiaries or other low-income patients.²³

While federal law provides states with a great deal of discretion in determining which hospitals qualify for DSH payments

and how these funds are allocated among DSH hospitals, states are subject to both statewide and hospital-specific caps on DSH payments. If a state exceeds either cap, the excess payment is not eligible for federal matching dollars. Under the facility-specific cap, DSH payments to any specific hospital may not exceed the hospital's uncompensated care costs.²⁴

Uncompensated care costs are the sum of costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.²⁵

Seeking more accountability for DSH, Congress imposed new requirements, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, that each state have its DSH payment programs independently audited and that the audit verify that the DSH payments complied with applicable federal law and rules.²⁶

Under the final regulations implementing this law, which were effective January 2009, states must report 18 separate measures for each hospital receiving DSH payments.²⁷

Among other things, states must now report: the Medicaid inpatient utilization rate; the low-income utilization rate; the total cost of inpatient and outpatient care for the uninsured; and the total uncompensated costs of this care for the uninsured.²⁸

Under the final audit rules, CMS requires that the state report the total of all Medicaid payments (*i.e.*, fee-for-service, managed care, and supplemental payments) to the hospital.²⁹ CMS also clarifies that “uninsured uncompensated . . . care costs” cannot include “amounts associated with unpaid co-pays or deductibles for individuals with third-party coverage” or “bad debt . . . related to services furnished to individuals who have health insurance or other third-party payer.” The first audit and reports under these new rules were due at the end of 2010.³⁰ As of May 2011, CMS has started to post to its website the DSH reports for 2005, 2006 and 2007.

While the audit rules have focused attention on how state DSH payments are allocated and the relationship between DSH payments and the statutory DSH cap, it is the DSH provisions of the ACA that have captured the attention of states and hospitals, most especially safety-net hospitals. The ACA significantly reduces state DSH allotments starting in 2014 and requires the Secretary of Health and Human Services (HHS) to develop a “DSH Health Reform methodology” that applies the largest percentage reductions on states that: (i) have the lowest uninsured rates; and (ii) do not target DSH payments to high-volume Medicaid hospitals and hospitals that have the highest levels of uncompensated care (excluding bad debts).³¹ Notably, in response to a 2010 report of the HHS Inspector General calling on HHS to more carefully track DSH payments and potentially seek legislation to assure a more even distribution of payments based on uncompensated care costs, CMS comments that the DSH reductions under the ACA are likely to solve the problem by imposing the largest DSH reductions on states that do not target their DSH payments to hospitals with significant Medicaid volume and uncompensated care costs.³² In short, with the implementation of the coverage provisions of the ACA in 2014 and the reduction in federal DSH allotments, it is likely that states will increasingly target their DSH dollars to high-volume Medicaid hospitals serving the largest number of uninsured patients.

B. Medicaid UPL Payments

In 2001, CMS adopted UPL regulations that stipulate that states may not receive federal matching dollars for inpatient and outpatient hospital services that, in the aggregate, exceed what Medicare would have paid for these services.³³ The UPL calculation is done separately for inpatient and outpatient services for three classes of hospitals: state government hospitals, non-state government hospitals, and private hospitals. UPL payments are used to fill in the gap, in whole or part, between the UPL

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and regular Medicaid payments to each class of hospitals.

In determining whether and how much money to allocate to UPL payments, states start by calculating the difference between the UPL for inpatient or outpatient services for a class of public or private hospitals and the aggregate amount Medicaid pays for the services. That or some lesser amount is then targeted to a subgroup of eligible hospitals, and it is then typically, but not always, allocated among them based on Medicaid days or discharges. (The non-federal share of the targeted amount is often funded, in whole or part, by provider assessments and IGTs.)

Because the UPL calculation is based on aggregate payments for the services provided by the class of hospitals, any one hospital in the class may receive UPL payments in excess of its Medicaid costs. Further, unlike standard Medicaid payments, UPL payments are not based on specific services rendered to specific patients.

While the targeted hospitals vary in every state, supplemental payments are generally allocated to hospitals based on their relative number of Medicaid days or discharges or as an equal share of a fixed amount. For example, as of July 1, 2010, Wisconsin makes four types of supplemental payments to: (1) hospitals in urban zip codes where 30 percent or more of the hospital's discharges are to Medicaid beneficiaries living in those zip codes;³⁴ (2) hospitals with pediatric units;³⁵ (3) trauma centers;³⁶ and, (4) an array of hospitals to promote "inpatient access." The pediatric and urban access payments are based on each hospital's relative number of inpatient days; the trauma payments divide \$4 million equally among qualifying hospitals; and, the access payments are set at \$3,035 per Medicaid discharge for acute, children and rehabilitation hospitals and \$734 per Medicaid discharge at critical access hospitals.³⁷

Illinois targets its supplemental payments to children's hospitals, hospitals with psychiatric units, rural hospitals, safety-net hospitals, and tertiary care hospitals. Forty-two percent of all Medicaid payments to Illinois hospitals are made through these supplemental UPL payments.³⁸ For its 2010/11 Fiscal Year, Pennsylvania allocated \$151 million for supplemental payments to hospitals to be paid quarterly to qualifying hospitals based on a hospital's relative number of fee-for-service Medicaid days.³⁹ In its 2008 report, GAO found that the five states it studied (California, Massachusetts, Michigan, New York, and Texas) made supplemental payments to a range of hospitals including public and private hospitals serving disproportionate numbers of low-income patients; trauma hospitals; and rural hospitals.⁴⁰ In all cases, the GAO noted that the payments were made as quarterly or annual lump sums to a targeted subgroup of hospitals in amounts often based on some formulation of Medicaid days or visits.

Policy Implications

Supplemental payments have been important revenue streams for hospitals, and especially for safety-net hospitals. DSH payments are specifically required by federal law, and when they are targeted to the hospitals with the highest volumes of low-income patients, they make considerable sense. And provider assessments and IGTs are a vital funding stream for state Medicaid programs. However, to the extent supplemental payments – whether DSH or UPL – are being driven by the need to compensate for the inadequacy of underlying Medicaid reimbursement rates, those dollars could be better spent as part of a rational, transparent and enriched reimbursement system that ties payment to the provision of high quality, cost-effective care. Because supplemental payments are unconnected to the care of particular patients and paid without regard to cost and quality, at the very least, their use squanders an opportunity to use these payment streams to advance access to quality, cost-effective

care. At worst, use of supplemental payments undermines such efforts and impedes reform of the delivery system by creating incentives for unnecessary and costly hospital admissions.

The tension between the desire to maintain supplemental payments as a flexible funding alternative for states, and the movement toward payment and delivery system reform has left states in an unsettled position. On the one hand, states are embracing comprehensive reform and are working with their hospitals and CMS to develop and implement payment systems that transform the delivery system and hold providers accountable for quality, cost-effective care. On the other hand, states continue to rely on provider taxes and IGTs to draw down federal dollars, then target supplemental payments to hospitals to offset the taxes/IGTs, providing substantial additional revenue to hospitals without regard for payment reform goals.

For example, while Wisconsin Medicaid has been a leader in developing sound purchasing strategies, it makes a \$3,035 per discharge supplemental “access” payment. The Wisconsin State Plan states that “Access payments are intended to reimburse hospital providers based on Wisconsin Medicaid volume. Therefore, the payment amounts per discharge are not differentiated by hospital based upon acuity or individual hospital cost.” At the same time that Wisconsin Medicaid will not pay for hospital acquired conditions (HACs), it continues to make supplemental payments for the underlying hospital admission.⁴¹

The implications of the tension between a desire to target dollars to specific hospitals and the desire to implement sound payment strategies plays out somewhat differently for DSH and UPL payments. UPL payments are, at least globally, purely a reflection of the differential between Medicaid and Medicare reimbursement rates. In theory, there is no reason why such payments should not be redirected under a more rational reimbursement methodology.

The challenge with UPL payments relates to their current funding mechanisms. Because supplemental payments are generally funded through provider taxes and IGTs, they are paid out to ensure that providers who pay the tax receive the money back in very specific ways that have nothing to do with quality and efficiency and promote neither accountability nor transparency.⁴² Indeed, as one commentator has pointed out, provider fees and associated payment policies are constructed so as to maximally benefit the providers paying the fee, and to thereby secure the support of providers proposed to be taxed.⁴³ Without a draw on the state treasury, and recognizing the burden of such taxes on provider systems, governors and legislators are often happy to agree to these conditions. Unfortunately, by doing so, the state is undermining its efforts to buy cost-effective, quality care for Medicaid patients and drive delivery system reform for all patients.

Given the countercyclical nature of Medicaid funding, states have increasingly relied on provider assessments as a strategy to generate revenue for increased program costs during times of economic downturn. Provider taxes are a vital revenue stream; the issue is how they are spent. A more constructive course would be to maintain the provider tax dollars in the hospital system, but to pay them out consistently with the principles of Section (30)(A); that is, to advance “access,” “efficiency,” “economy,” and “quality of care.” For example, they could be folded into the DRG base rate or to enhance payments for services where Medicaid requires greater capacity, or used to underwrite the cost of additional payments to plans or providers that meet quality benchmarks.

In contrast to UPL payments, DSH payments are more likely to be targeted to hospitals serving disproportionately large numbers of low-income Medicaid and uninsured patients. And as noted above, they are capped at the difference between a hospital’s costs of serving Medicaid and uninsured patients and the revenue it

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As states are forced to reduce their DSH spending, they may want to consider shifting the state share of the DSH payment to Medicaid rates, thereby reducing the gap between Medicaid payments and the costs of serving Medicaid patients, and also driving delivery system reform.

receives for doing so. The audit rules and the ACA reductions discussed above will inevitably drive states to both reduce and better target their DSH payments for these purposes. A first priority for DSH will be supporting the cost of services provided to the remaining uninsured, many, perhaps most, of whom will be undocumented immigrants who do not have access to federal Medicaid or state exchanges. Accordingly, DSH funding will be a critical revenue stream for safety-net hospitals serving significant numbers of undocumented patients.

In response to the reduction of federal DSH allotments under the ACA discussed above, states have already begun to reevaluate their DSH policies. One significant issue that will emerge is how best to use state DSH dollars no longer eligible for federal match. Today, states make DSH payments to cover the difference between a hospital's costs in serving Medicaid patients and the payments it receives for serving these patients as well as the uncompensated costs of serving uninsured patients. State Medicaid payments have traditionally been below Medicaid costs, and DSH payments have played a vital role in sustaining safety-net hospitals, filling in a portion of the difference between Medicaid costs and revenue. However, by using DSH dollars to backfill inadequate Medicaid rates, states are unable to distinguish between hospitals whose costs are reasonable and those whose costs are excessive, or to otherwise tie payments to access to cost-effective, quality care. While hospitals that serve disproportionately large numbers of low-income patients have additional costs, lump sum payments covering reported costs are probably not the most effective way to recognize legitimate additional costs.

As states are forced to reduce their DSH spending, they may want to consider shifting the state share (i.e., the non-federal share) of the DSH payment to Medicaid rates, thereby eliminating or at least reducing the gap between Medicaid payments and the costs of serving Medicaid

patients, and also driving delivery system reform. In order to ensure that state funding (previously invested in DSH payments) continues to serve the purpose of supporting high-volume Medicaid hospitals, the state dollars could be invested in the services utilized disproportionately by Medicaid beneficiaries and disproportionately provided by safety-net hospitals such as maternity, pediatrics and behavioral health, or even to support care transition services for high-risk Medicaid patients.

Finally, it should be noted that state dollars invested in DSH will receive an overall lower federal match than those invested in payment rates. Under the ACA, states will receive up to 100% federal financial participation for the cost of care provided to populations newly eligible due to the Medicaid expansion through 2016, gradually decreasing to 90% federal match in 2020 and beyond.⁴⁴ The same or lesser amount made as a DSH add-on will be subject to the regular match, as little as 50 percent, depending on the state. This provides another incentive for states to direct DSH funds towards increasing underlying Medicaid reimbursement rates.⁴⁵

Ultimately, supplemental payments may hinder state strategies to purchase cost-effective, quality care. While state officials may think they do not have a stake in the allocation of these dollars when they are not responsible for the non-federal share, in fact, they have a significant stake. These payments can weaken or undermine comprehensive payment reform efforts and sound purchasing strategies (e.g., medical homes and accountable care organizations), ultimately costing states dearly. Indeed, the very existence of supplemental payments – which are by and large unique to hospitals and often disbursed on a per discharge basis – creates incentives to drive up inpatient utilization. Even if the supplemental payment itself is not financed with direct state expenditures, the underlying admission is.

No matter how strong the arguments against the use of supplemental payments, it must be acknowledged that restructuring Medicaid payment systems is not easy. The task is technically difficult and politically volatile. Any change produces winners and losers in the hospital community, and the disadvantaged hospitals inevitably oppose the change. However, with the nation focused on value-based purchasing and Medicaid fast becoming the nation's largest purchaser of health care services and already the largest item in many state budgets, the imperative to reform Medicaid payment policies and ensure maximum value for Medicaid spending has never been greater.

Conclusion

Both government and private payers are looking for mechanisms to tie payment to outcomes. Medicare has been a leader in using payment methods to drive efficiency and quality. The ACA both jump-starts Medicare's efforts and expands the focus to Medicaid and private payers, recognizing that multi-payer initiatives have a far

greater ability to drive delivery system reform.

Today, more than 40 states have initiated Medicaid medical home programs. And with Medicaid enrollment at its highest levels and slated to increase significantly in 2014, states and policymakers are searching for strategies to reduce costs and improve patient outcomes.⁴⁶ Across-the-board rate cuts may produce savings, but they are not sound strategies for long-term cost containment or quality improvement. Hence, like Medicare and private payers, state Medicaid agencies are now seeking payment mechanisms that improve outcomes and contain costs, while ensuring accountability and transparency.⁴⁷ Supplemental payments rarely advance these goals as they are paid independent of the patient's experience. Furthermore, when supplemental payments constitute a significant percentage of hospital Medicaid payments, they can undermine efforts to reform Medicaid payment policies.

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

Endnotes

¹ MACPAC, Report to the Congress on Medicaid and CHIP, March 2011, Table 7.

² 42 U.S.C. § 1396(a)(30)(A).

³ D. Bachrach, *Medicaid Payment Reform: What Policymakers Need to Know About Federal Law*, Center for Health Care Strategies, Inc., November 2010; K. Quinn, *Sound Practices in Medicaid Payment for Hospital Care*, Center for Health Care Strategies, November 2010.

⁴ A. McKethan and J. Menges. *Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion*. The Lewin Group, November 2006. Available at <http://www.lewin.com/content/publications/UPL.pdf>.

⁵ DSH payments are paid outside the Medicaid managed care premium consistent with federal DSH rules.

⁶ 42 U.S.C. § 1396-1.

⁷ MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2011.

⁸ States with pending or enacted payment reform legislation include the following: (1) Arkansas, SB 807, “An Act to Amend Arkansas Laws Concerning ACOs” (pending); (2) Iowa, SF 480, “Relating to Health Care and Policy, and Health Care Infrastructure and Integration of Public and Private Programs” (pending); (3) Maine, LD 540, “An Act to Implement the Insurance Payment Reform Recommendations of the Advisory Council on Health Systems Development” (pending); (4) Massachusetts, H01849, “An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments” (pending); (5) New York, S 2809, “An Act to Amend the Elder Law” (enacted as Chapter 59 of the Laws of 2011).

⁹ MACPAC has acknowledged the importance of supplemental payments in payment reform: In its March 2011 Report to Congress, MACPAC observes that supplemental payments “are an important source of Medicaid funding for various providers. In many states, such payments may be particularly important for safety-net providers, who are more dependent on Medicaid payment as a source of revenue and less able to rely on other revenue sources to offset uncompensated care. Because DSH and UPL payments are generally paid in lump sums, their impact on Medicaid rates for services is difficult to isolate. As a result, it is difficult to compare actual payment rates among providers, either within or across states.” The report concludes with a pledge to “Examine the impact of state financing approaches and supplemental payments on providers, payment policy, and states’ ability to adopt payment innovations.”

¹⁰ The Lewin Group, *Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion*, 2006. Available at <http://www.lewin.com/content/publications/UPL.pdf>.

DSH payments are paid outside the Medicaid managed care premium consistent with federal DSH rules.

¹¹ T.A. Coughlin, B.K. Bruen and J. King. “States’ Use of Medicaid UPL and DSH Financing Mechanisms.” *Health Affairs*, Vol 23(2), pp 245-257; P. Thompson. “Medicaid’s Federal-State Partnership: Alternatives for Improving Financial Integrity,” Kaiser Commission on Medicaid and the Uninsured, February 2004.

¹² See, e.g., *Financing Medi-Cal’s Future: The Growing Role of Health Care-Related Provider Fees and Taxes*, California Health Care Foundation, November 2009.

¹³ U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, Pub. No. GAO-08-614, 14; see also T.A. Coughlin et al., “Restoring Fiscal Integrity to Medicaid Financing?” *Health Affairs*, Vol. 26(5): 2007 (suggesting, *inter alia*, that UPL payments are significantly greater than the \$6 billion figure cited by the GAO).

¹⁴ Notably, the proposed access regulations require states to provide data on all supplemental payments and to the extent applicable, stratify them by category of provider. Department of Health and Human Services, “Methods for Assuring Access to Covered Medicaid Services,” *Federal Register*, 76 (88) (May 6, 2001): 26,342.

¹⁵ While UPL payments are made to both hospitals and nursing homes, an Urban Institute study suggests that about 85 percent of UPL payments go to hospitals and in some states UPL payments to hospitals exceed DSH payments to hospitals. See Coughlin et al., “Restoring Fiscal Integrity to Medicaid Financing?” *Health Affairs*, Vol. 26(5): 2007.

¹⁶ Centers for Medicare & Medicaid Services. 2006 Form 64 Quarterly Expense Report.

¹⁷ Also relevant are payment methods and levels. See, e.g., D. Bachrach, op. cit. and K. Quinn, op. cit.

¹⁸ Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35. Among other provisions in OBRA of 1981 was the so-called “Boren Amendment.”

¹⁹ 42 U.S.C. § 1396a (a)(13)(A)(iv).

²⁰ 42 U.S.C. § 1396r-4.

²¹ 42 U.S.C. § 1396r-4 (b).

²² 42 U.S.C. § 1396r-4 (c).

²³ 42 U.S.C. § 1396r-4(c)(3)(B).

²⁴ 42 U.S.C. § 1396r-4 (g). The hospital-specific limits were enacted through the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13621(b)(1).

²⁵ E.g., 42 U.S.C. § 1396r-4 (g); 42 C.F.R. § 447.299(c)(15).

²⁶ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1001(d).

²⁷ Department of Health and Human Services, “Medicaid Program; Disproportionate Share Hospital Payments; Final Rule,” *Federal Register*, 73 (245) (Dec. 19, 2008): 77911.

²⁸ 42 C.F.R. § 447.299(c).

²⁹ Department of Health and Human Services, “Medicaid Program; Disproportionate Share Hospital Payments; Final Rule,” *Federal Register*, 73 (245) (Dec. 19, 2008): 77950. See also 42 C.F.R. § 447.299(c)(15).

³⁰ State Medicaid Director Letter of July 27, 2009, available at <https://www.cms.gov/MedicaidRF/Downloads/CMSDSHReportsandAuditsLetter.pdf>.

³¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2551.

³² U.S. Department of Health and Human Services, Office of the Inspector General. Review of Medicaid Disproportionate Share Hospital Payment Distribution (A-07-09-04150), June 22, 2010, <http://oig.hhs.gov/oas/reports/region7/70904150.pdf>.

³³ 42 C.F.R. § 447.272(b) (defining upper payment limits for inpatient care); 42 C.F.R. § 447.321(b) (defining upper payment limits for outpatient care). UPL limits also apply to nursing facilities and intermediate care facilities; however, these rules are beyond the scope of this paper.

³⁴ Wisconsin Medicaid State Plan, Inpatient Hospital State Plan, Methods and Standards for Determining Payment Rates July 1, 2010, Section 8200.

³⁵ Wisconsin Medicaid State Plan, Sections 8510 and 8515.

³⁶ Wisconsin Medicaid State Plan, Section 8525.

³⁷ Wisconsin Medicaid State Plan, Section 8520.

³⁸ Illinois Department of Healthcare and Family Services. A Partnership for Reimbursement Reform at http://hfs.illinois.gov/assets/032811_hrr.pdf.

³⁹ 40 Pa. Bull. 5536 (Sept. 25, 2010).

⁴⁰ U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, Pub. No. GAO-08-614 (2008).

⁴¹ Wisconsin Medicaid State Plan, Section 1.

⁴² The political imperative to ensure that certain hospitals receive the benefit of the provider tax or IGT payment is particularly acute with respect to IGTs. Where local governments are funding the non-federal share of the supplemental payment, they will generally insist that they flow directly back to their local public hospital through targeted supplemental payments.

⁴³ California Health Care Foundation, *Financing Medi-Cal’s Future: The Growing Role of Health Care-Related Provider Fees and Taxes*, November 2009.

⁴⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(3).

⁴⁵ States use of DSH payments vary widely. However, for states like Alabama, California, Connecticut, Louisiana, Michigan, Minnesota, Missouri, New Jersey, New York, Ohio, Oregon, Pennsylvania, South Carolina, Texas and Washington where DSH payments constitute more than 25 percent of their fee-for-service hospital payments, the impact will be considerable and the opportunity (and challenge) to effectively redeploy the non-federal share to base payment rates considerable. In addition, where the non-federal share of DSH payments are funded with IGTs, the local governments may not be willing to continue their transfer payments if the dollars do not exclusive support payments to their hospitals.

⁴⁶ Medicaid Cost Containment Actions Taken by States, FY2011, Kaiser Family Foundation for Medicaid and the Uninsured, at <http://www.statehealthfacts.org/comparabletable.jsp?ind=187&cat=4>; T.P. Gilmer and R.G. Kronick. “Spending Among US States And Regions Differences in The Volume Of Services and in Prices Drive Big Variations In Medicaid.” *Health Affairs*, 30, no.7 (2011):1316-1324.

⁴⁷ Id. Notably, http://www.health.state.ny.us/facilities/hospital/rate_setting/docs/2009-02-26_commissioner_final_report.pdf.