

Upper Payment Limit and Managed Care Interaction Background for Accountable Care Collaborative Payment Reform Initiative (HB 12-1281)

Definition of Upper Payment Limit (UPL)

The Upper Payment Limit (UPL) is a federal limit placed on fee-for-service (FFS) reimbursement of Medicaid providers. Specifically, the UPL is the maximum a given state Medicaid program may pay a type of provider, in the aggregate, statewide in Medicaid FFS. To create an upper bound to Medicaid spending on FFS hospital rates, Congress imposed a UPL based on what Medicare would have paid facilities for the same services. In 2001, the Centers for Medicare and Medicaid Services (CMS) adopted UPL regulations that stipulate that states may not receive federal matching dollars for inpatient and outpatient hospital services that, in aggregate, exceed what Medicare would have paid for those services. There are separate UPLs for inpatient and outpatient hospital services.

See: 42 CFR § 447.272(b), 42 CFR § 447.321(b)

UPL in Colorado

In Colorado, the Department of Health Care Policy and Financing (the Department) calculates its hospital inpatient and outpatient services UPLs as estimates of Medicaid costs. CMS accepts this methodology as a reasonable estimate of what Medicare would pay for Medicaid services.

The Department uses hospital provider fees to draw matching federal funds under the UPL to make additional payments to Colorado hospitals for services provided to Medicaid clients.

The estimate of Medicaid costs is compared with all Medicaid payments to determine if the payments are under the limit.

Why Do Managed Care Clients Not Count Towards the UPL?

Managed care refers to arrangements where the Department makes a payment to a contractor for each member enrolled (i.e., a per capita payment) for the provision of medical services under the Medicaid program. Global payment arrangements meet the definition of managed care because they usually involve per member per month payments to an entity which provides or arranges for the provision of medical services.

Managed care contracts may be non-risk, full risk, or shared risk. Under any managed care arrangement, the maximum amount that will be paid for the services is defined and agreed to in the contract. Because the maximum to be paid is defined and agreed to, CMS' position (which is supported by federal regulation) is that no additional federal funds are available for services covered under the contract. Hence, there are no additional funds to be drawn under the UPL for services provided to Medicaid clients under a managed care arrangement.

(Primary care case management [PCCM] arrangements like the Department's Accountable Care Collaborative [ACC] program do not impact the UPL because the payment made to the Regional Care Collaborative Organization [RCCO] is a case management fee and is not a payment for the

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provision of Medicaid services. Under the ACC, the Department continues to pay for the provision of Medicaid services through FFS claims.)

See:

1. Federal Register Vol. 66, No. 9 published Friday, January 12, 2001. The UPL was designed as a federal limit on FFS reimbursement. From the Federal Register Vol. 66, No. 9 published Friday, January 12, 2001, the final rule at 42 CFR Part 447 under the section titled “Managed Care,” it states: *“The upper payment limits we proposed relate to fee-for-service Medicaid payments.”*
2. 42 CFR Part 438, Managed Care. 42 CFR § 438.60, Limit on Payment to Other Providers, states: *“The State agency must ensure that no payment is made to a provider other than the MCO [Managed Care Organization], PIHP [Prepaid Inpatient Health Plan], or PAHP [Prepaid Ambulatory Health Plan] for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are [allowed elsewhere in law or] to make payments for graduate medical education.”*

Loss of UPL Funds resulting from Expanding Managed Care to Inpatient and Outpatient Hospital Services

Any state considering expanding Medicaid managed care must weigh the potential benefits against the actual loss of significant UPL funds that play an important role in state Medicaid programs. Current federal regulations only allow services paid on a FFS basis to be counted towards calculating UPL payments. If hospital inpatient and outpatient services are included in global payments, then the cost of hospital care for those Medicaid clients cannot be included in the UPL. Colorado’s inpatient and outpatient UPLs will be reduced, impacting payments to hospitals financed with hospital provider fees and matching federal funds.

Between October 1, 2011 and September 30, 2012, the Department made approximately \$587 million in supplemental payments under the inpatient UPL and \$127 million in supplemental payments under the outpatient UPL. Between October 1, 2012 and September 30, 2013, the Department will make approximately \$622 million in supplemental payments under the inpatient UPL and approximately \$166 million in supplemental payments under the outpatient UPL. These payments include 50% federal matching funds.

States essentially have three options under the current UPL rules:

1. Maintain the existing FFS client base and continue to receive current UPL funding
2. Transition to managed care and lose the ability to claim UPL funds
3. Seek a federal demonstration waiver to find a mutually agreeable solution that preserves the existing UPL funds and allows for the expansion of Medicaid managed care.

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The Lewin Group produced a report in conjunction with Medicaid Health Plans of America in November of 2006 that provides a detailed analysis of this issue, reviews the demonstrations in four states, and offers some recommendations of policy options.¹

ACC Payment Reform Proposals (HB 12-1281)

The Department will evaluate the impact of payment reform proposals on its ability to finance supplemental payments to hospitals under the UPL.

If the proposed project includes the provision of inpatient or outpatient hospital services under a global payment or managed care arrangement, the project may impact hospital reimbursement financed by provider fees under the upper payment limits. The Department will evaluate the impact, if any, on hospital reimbursement when it reviews HB 12-1281 payment reform proposals.

See: Section 25.5-5-415 (1)(c)(II)(C), C.R.S. For purposes of selecting payment projects for the pilot program, the Department shall consider “[its] ability to ensure that inpatient and outpatient hospital reimbursements are maximized up to the upper payment limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically.”

¹ “Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion”. Conducted by the Lewin Group on behalf of Medicaid Health Plans of America. November 13, 2006.
http://www.lewin.com/~media/lewin/site_sections/publications/upl.pdf