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Medicaid Supplemental Payments

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SUMMARY

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Medicaid Supplemental Payments

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term services and supports. Medicaid is a federal and state partnership that is jointly financed by the federal government and the states. States must follow broad federal rules to receive federal matching funds, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs.

In general, benefits are made available to Medicaid enrollees via two service delivery systems: *fee for service* (FFS) or *managed care*. Under FFS, the state Medicaid program pays health care providers for each covered service provided to a Medicaid enrollee. Under managed care, Medicaid enrollees receive most or all of their services through a managed care organization (MCO), which is under contract with the state and is paid primarily on a capitated basis (i.e., a set amount per enrollee regardless of the services used).

For the most part, states establish their own payment rates for services rendered by Medicaid providers. Payment rates vary by state. Federal statute requires these rates to be "consistent with efficiency, economy, and quality of care and … sufficient to enlist enough providers so that care and services are available" to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area. This requirement is referred to as the *equal access provision*. Low Medicaid provider payment rates in many states and their impact on provider participation have been perennial policy concerns. Some states rely on supplemental payments to offset low Medicaid payments for services or to support safety-net providers.

Supplemental payments are Medicaid payments to providers that are separate from and in addition to the payments for services rendered to Medicaid enrollees. For example, states may provide supplemental payments to providers to support quality initiatives, graduate medical education (GME), and certain types of facilities (e.g., rural or safety-net providers), among other reasons. Often, providers receive supplemental payments in a lump sum. States make supplemental payments through FFS, managed care, and waivers, but the mechanism for making these payments differs according to the service delivery system.

Most states make supplemental payments under FFS. Some of these payments are federally required, whereas others are optional for states. States make supplemental payments to many different Medicaid providers, such as hospitals, nursing facilities, physicians, and mental health facilities. Medicaid disproportionate share hospital (DSH) payments are the only type of FFS supplemental payment that states are required to make. States also are permitted, but not required, to make other non-DSH FFS supplemental payments, which typically are limited by upper payment limits (UPLs) for certain institutional providers. These UPLs are what Medicare would pay for the same or comparable services.

All states and the District of Columbia make either DSH or non-DSH supplemental payments under FFS, and these payments represent a sizeable percentage of total Medicaid spending. In FY2017, states reported $40.6 billion in total FFS Medicaid supplemental payment expenditures (i.e., DSH and non-DSH, including both federal and state expenditures), or 7.2% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures). At the state level, total Medicaid DSH and non-DSH supplemental payment expenditures as a share of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures) varied widely across all 50 states and the District of Columbia. Nationally, the majority of DSH and non-DSH supplemental payment expenditures (80% of the $40.6 billion) were made to hospitals.

States also make supplemental payments through managed care and waivers. Under managed care, states historically have made *pass-through payments*. These payments are included in the payments states make to MCOs, and the MCOs are expected to make the payments to providers as directed by the state. Pass-through payments are not tied to services provided to Medicaid enrollees. The Centers for Medicare & Medicaid Services (CMS) also may provide Medicaid waiver authority to permit states to make certain supplemental payments that they are not otherwise permitted to make under Medicaid rules.

This report provides an overview of the most prevalent types of Medicaid supplemental payments, including FFS supplemental payments, managed care pass-through payments, and Section 1115 waiver payments. The report also presents data about Medicaid FFS supplemental payment spending by state and by provider type.

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All states make supplemental payments, which are Medicaid payments to providers that are separate from and in addition to Medicaid payments for services. These payments are made to many different Medicaid providers, including hospitals, nursing facilities, physicians, and mental health facilities. Disproportionate share hospital (DSH) payments are one type of Medicaid supplemental payment that states are required to make to hospitals serving low-income patients. States are permitted to make other non-DSH fee-for-service (FFS) supplemental payments, managed care pass-through payments, and waiver supplemental payments. In FY2017, supplemental payments accounted for at least 7% of total Medicaid spending on benefits, which is $40 billion. However, data on Medicaid supplemental payments are limited. For example, data are not available at the individual provider level, and some providers may receive supplemental payments that exceed their Medicaid costs.

This report provides an overview of supplemental Medicaid payments to providers. The report begins with a background of Medicaid that includes a summary of Medicaid payments for services and Medicaid supplemental payments. The report breaks down supplemental payments into FFS payments, managed care pass-through payments, and Medicaid waiver supplemental payments. The report also presents data on Medicaid FFS supplemental payment expenditures by state and by provider type.

Medicaid Background

Medicaid is a joint federal-state program that provides primary and acute medical services, as well as long-term services and supports, to a diverse low-income population. This population includes children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.[1]

State participation in Medicaid is voluntary, although all states, the District of Columbia, and the territories participate.[2] States are responsible for administering their Medicaid programs. States must follow broad federal rules to receive federal funds, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs. In addition, several waiver and demonstration authorities (e.g., Section 1115 of the Social Security Act) allow states to operate their Medicaid programs outside of federal rules.

Medicaid enrollees generally receive benefits through either a FFS or managed care service delivery system. Under FFS, state Medicaid programs pay health care providers for each service provided to a Medicaid enrollee. Under managed care, Medicaid enrollees receive most or all of their services through a managed care organization (MCO) under contract with the state, and the MCO is primarily paid on a capitated basis (i.e., a set amount per enrollee regardless of the services used).

States traditionally have used FFS for Medicaid. However, since the 1990s, the share of Medicaid enrollees covered by managed care has increased, as states transition portions of their Medicaid programs to managed care. As of July 2016, about 81% of Medicaid enrollees were covered by some form of managed care.[3] Most states have both FFS and managed care enrollees.

[1] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

[2] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

[3] Congressional Research Service (CRS) analysis of Centers for Medicare & Medicaid Services (CMS), *Medicaid Managed Care Enrollment and Program Characteristics, 2016*, 2018, at https://www.medicaid.gov/medicaid/

Medicaid is financed jointly by the federal government and the states.[4] Federal Medicaid funding is an open-ended entitlement to states, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive. The federal government reimburses states for a share of each dollar spent in accordance with states' federally approved Medicaid state plans. The federal government's share of most Medicaid service costs is determined by the federal medical assistance percentage (FMAP) rate, which varies by state and is determined by a formula set in statute based on per capita income. In FY2019, FMAP rates range from 50% (14 states) to 76.4% (Mississippi).[5]

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). In addition to the Medicaid payments for services provided to enrollees, states may make *supplemental payments*, which are Medicaid payments to providers that are separate from and in addition to Medicaid payments for services.

Payments for Services

For the most part, states establish their own payment rates for Medicaid providers to deliver services to Medicaid enrollees. Payment rates vary by state. Federal statute requires these rates to be "consistent with efficiency, economy, and quality of care and ... sufficient to enlist enough providers so that care and services are available" to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area.[6] This requirement is referred to as the *equal access provision*.

Low Medicaid provider payment rates in many states and their impact on provider participation have been perennial policy concerns. Studies have shown that many providers, particularly physicians, do not accept Medicaid patients in part due to low Medicaid payment rates, which limits patients' access to care.[7]

In 2015, to address concerns over the impact of low provider rates on access to care, the Centers for Medicare & Medicaid Services (CMS) issued a final regulation implementing the Medicaid equal access provision by requiring states to develop an access monitoring review framework to determine whether Medicaid FFS payments to providers are sufficient to provide Medicaid enrollees with adequate access to care.[8] In 2018, CMS issued a proposed rule that would provide

managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf.

[4] For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[5] For more information about the federal medical assistance percentage, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[6] §1902(a)(30)(A) of the Social Security Act.

[7] Sandra L. Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs*, vol. 31, no. 8 (August 2012), pp. 1673-1679. Andrew F. Coburn, Stephen H. Long, and M. Susan Marquis, "Effects of Changing Medicaid Fees on Physician Participation and Enrollee Access," *Inquiry*, vol. 36, no. 3 (Fall 1999), p. 265. The Kaiser Family Foundation, *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians*, April 2011, p. 9, at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8178.pdf. Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?," *Health Affairs*, vol. 28, no. 1 (January 2009), pp. 24-27.

[8] Department of Health and Human Services (HHS), CMS, "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services," 80 *Federal Register* 67576, November 2, 2015.

greater flexibility to states in meeting the access monitoring requirements, particularly for states that use managed care.[9]

Supplemental Payments

Supplemental payments are Medicaid payments to providers that are separate from and in addition to the payments for services rendered to Medicaid enrollees. Often, providers receive supplemental payments in a lump sum, and these supplemental payments are not tied to services provided to Medicaid enrollees. For example, states may provide supplemental payments to providers to support quality initiatives, graduate medical education, and certain types of facilities (e.g., rural or safety net providers), among other reasons. As with most Medicaid expenditures, the federal government reimburses states for a portion of their supplemental payment expenditures based on each state's FMAP.

All states make supplemental payments under FFS. These payments are provided to many different Medicaid providers, such as hospitals, nursing facilities, physicians, and mental health facilities. Disproportionate share hospital (DSH) payments, which are supplemental payments to hospitals treating large numbers of low-income patients, are the one type of FFS supplemental payment that states are required to make. However, states may make other non-DSH FFS supplemental payments. For certain institutional providers, there are upper payment limits (UPLs) on the amount of supplemental payments; these limits are what Medicare would pay for the same or comparable services.

States generally fund the state share of FFS supplemental payments through intergovernmental transfers from local governments, provider taxes, or certified public expenditures from public providers, all of which are allowable sources of funding for the Medicaid state share.[10] Some states have used these funding sources to pay for the state share of Medicaid supplemental payments without expending much, if any, state general funds.[11]

All states make FFS supplemental payments, and these payments represent a sizeable percentage of total Medicaid spending. In FY2017, states reported $40.6 billion in total Medicaid FFS supplemental payment expenditures (i.e., including both federal and state expenditures), or 7.2% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures). Total DSH supplemental payment expenditures (i.e., including both federal and state expenditures) were $16.0 billion, or 2.8% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures). In comparison, total non-DSH supplemental payment expenditures (i.e., including both federal and state expenditures) were $24.6 billion, or 4.3% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures).

[9] HHS, CMS, "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold," 83 *Federal Register* 12696, March 22, 2018.

[10] For more information about funding sources and the state share of Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[11] HHS, CMS, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule," 81 *Federal Register* 27588, May 6, 2016.

States also make supplemental payments through managed care and Section 1115 waivers.[12] Under managed care, states historically have made *pass-through payments*. These payments are included in the payments states make to MCOs (i.e., capitation rates), and the MCOs are expected to make the payments to providers as directed by the state. Pass-through payments are not tied to services provided to Medicaid enrollees. CMS also may provide Medicaid Section 1115 waiver authority to permit states to make certain supplemental payments that they otherwise are not permitted to make under Medicaid rules.

Data on Medicaid FFS non-DSH supplemental payments, managed care pass-through payments, and Section 1115 waiver payments generally are limited.[13] The available state data from the CMS-64 form only reflect non-DSH supplemental payment expenditures by provider type in the aggregate, not at the individual provider level.[14] Several governmental organizations have recommended that CMS collect and publish provider-level data to ensure that supplemental payments are "appropriately spent for Medicaid purposes."[15] The CMS-64 form data do not provide detail about the managed care pass-through payments or the supplemental payments made through Section 1115 waivers.

The remainder of the report provides an overview of supplemental Medicaid payments to providers. The report breaks down supplemental payments into FFS payments, managed care pass-through payments, and Medicaid waiver supplemental payments. The report also presents data on Medicaid FFS supplemental payment expenditures by state and by provider type.

Types of Supplemental Payments

Fee-for-Service (FFS) Supplemental Payments: FFS Medicaid payments to providers that are separate from, and in addition to, the payments for services rendered to Medicaid enrollees. These payments may be, but are not required to be, tied to Medicaid services. Often, providers receive supplemental payments in a lump sum. (For more information, see "FFS Supplemental Payments.")

Disproportionate Share Hospital (DSH) Supplemental Payments: Statutorily required supplemental payments to hospitals and mental health facilities treating large numbers of low-income patients. (For more information, see "Disproportionate Share Hospital Payments.")

Non-DSH Supplemental Payments: Supplemental payments not tied to a specific statutory or regulatory purpose that can be made to different providers, including hospitals, nursing facilities, and clinics. For some providers (e.g., physicians), there are no federal regulations for the non-DSH supplemental payments. However, for certain institutional providers, federal regulations specify upper payment limits (UPLs) that are what Medicare would pay for the same or comparable services. (For more information, see "Non-DSH Supplemental Payments.")

[12] §1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program.

[13] States provide HHS with data on DSH payments through annual reports and audits.

[14] States submit the CMS-64 form to the CMS on a quarterly basis, and the CMS-64 form is a statement of expenditures for which states are entitled to federal Medicaid matching funds. States are required to provide supporting documentation for total Medicaid expenditures. GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, 17-317, February 2017, pp. 566-567, at https://www.gao.gov/products/GAO-17-317.

[15] U.S. Government Accountability Office (GAO), *CMS Oversight of Provider Payments is Hampered by Limited Data and Unclear Policy*, GAO-15-322, April 2015, p. 29, at https://www.gao.gov/assets/670/669561.pdf. Medicaid and CHIP Payment and Access Commission (MACPAC), *Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments*, March 2014 Report to Congress, March 2014, pp. 202-205.

Managed Care Pass-Through Payments: An amount added to the payments states make to the managed care organizations (MCOs) (i.e., capitation rates) that MCOs are directed by the state to make to providers. (For more information, see "Managed Care Pass-Through Payments.")

Section 1115 Waiver Supplemental Payments: Supplemental payments that states would not be permitted to make under authorized Medicaid rules but which the Centers for Medicare & Medicaid Services provides Section 1115 waiver authority to allow. The two main types of Section 1115 waiver supplemental payments are uncompensated care pool payments and Delivery System Reform Incentive Pool (DSRIP) program payments. (For more information, see "Supplemental Payments Through Waivers.")

FFS Supplemental Payments

All states make supplemental payments under FFS, and different federal regulations and requirements apply depending on the type of payment and the type of provider. This section will discuss two types of FFS supplemental payments: DSH payments and non-DSH supplemental payments.

Disproportionate Share Hospital Payments

Federal statute requires that states make Medicaid DSH payments to hospitals and mental health facilities treating large numbers of low-income patients.[16] This provision aims to recognize the disadvantaged financial situation of those hospitals, because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates generally are lower than the rates paid by Medicare and private insurance.[17]

Whereas most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds the state may claim for Medicaid DSH payments.[18] In FY2017, preliminary federal DSH allotments totaled $12.0 billion.[19]

Although states must follow some federal requirements in defining DSH hospitals and calculating DSH payments, for the most part, states have significant flexibility. Because of this flexibility, the proportion and types of hospitals designated as DSH hospitals vary significantly across the states. Some states target their DSH funds to a few hospitals; other states provide DSH payments to all hospitals in the state that meet the criteria to receive Medicaid DSH payments. States also make DSH payments to institutions for mental disease (IMDs) and other mental health facilities; federal statute limits payments to IMDs.[20]

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[16] §1902(a)(13)(A)(iv) and §1923 of the Social Security Act.

[17] For more information on DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[18] Under current law, Medicaid DSH allotments are scheduled to be reduced from FY2020 through FY2025. For more information on DSH allotment reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

[19] HHS, CMS, "Medicaid Program; Final FY2015 and Preliminary FY2017 Disproportionate Share Hospital Allotments, and Final FY2015 and Preliminary FY2017 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 82 *Federal Register* 51259, 2017.

[20] *Institution for mental diseases* is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical

States must submit annual reports to the Secretary of Health and Human Services providing detailed information about each hospital receiving a DSH payment. States also must provide annual independent certified audits of Medicaid DSH payments.

Non-DSH Supplemental Payments

Although states are required to make Medicaid DSH payments, no federal requirement exists for states to make other Medicaid supplemental payments (i.e., non-DSH supplemental payments). However, in FY2017, all states except Alaska, Delaware, and Vermont made non-DSH supplemental payments.[21] Among the states that make non-DSH supplemental payments, most states make such payments to hospitals and nursing homes. Some of these states also make supplemental payments to other providers, including intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), physicians, and freestanding nonhospital clinics.

Unlike DSH payments, non-DSH supplemental payments are not tied to a specific statutory or regulatory purpose, and states have discretion in how these payments are disbursed. Therefore, states can make supplemental payments to providers that are not necessarily tied to any specific Medicaid enrollees or specific services provided to them. States generally have relied on non-DSH FFS supplemental payments to offset low Medicaid payments for services and to support safety-net providers, which are providers that serve the uninsured, the underserved, or those enrolled in Medicaid and tend to have considerable levels of uncompensated care.[22]

For some providers (e.g., physicians), no federal regulations exist for non-DSH supplemental payments. However, for certain institutional providers, federal regulations specify UPLs.[23] Under the UPLs, federal Medicaid matching funds are not available for Medicaid payments that are more than what Medicare would pay for the same or comparable services. The UPLs are aggregate limits (including payments for services and non-DSH supplemental payments) for each class of providers rather than limits for individual providers. The UPL calculation excludes any DSH payments received.[24]

The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, ICF/IIDs, and freestanding nonhospital clinics. These classes of providers are further separated by ownership status (e.g., state-owned or -operated, non-state government owned or operated, and privately owned or operated). Because the UPLs are applied in the aggregate, states may make non-DSH supplemental payments to individual providers that are greater than the total Medicaid costs incurred by those providers, as long as the

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attention, nursing care and related services." (§1905(i) of the Social Security Act.) See also §1923(h) of the Social Security Act.

[21] CRS analysis of CMS-64 data as of September 25, 2018.

[22] HHS, CMS, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," 81 *Federal Register* 27588, May 6, 2016. MACPAC, *Medicaid Base and Supplemental Payments to Hospitals*, June 2018. GAO, *Federal Guidance Needed to Address Concerns About the Distribution of Supplemental Payments*, GAO-16-108, February 2016, p. 7. Marsha Regenstein and Jennifer Huang, *Stresses to the Safety Net: The Public Hospital Perspective*, Kaiser Commission on Medicaid and the Uninsured, June 2005, p. 11, at https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_3BA62711-5056-9D20-3DE6060F45CA11E1.pdf. Robert Nelb, *Uses and Oversight of Upper Payment Limit Supplemental Payments to Hospitals*, MACPAC, April 20, 2018, p. 6, at https://www.macpac.gov/wp-content/uploads/2018/04/Uses-and-Oversight-of-Upper-Payment-Limit-Supplemental-Payments-to-Hospitals.pdf.

[23] 42 C.F.R. §§447.271, 447.321.

[24] 42 C.F.R. §447.272.

total amount of Medicaid payments for services and non-DSH supplemental payments are below the aggregate UPL for each class of provider.

Data on Medicaid non-DSH supplemental payments are limited.[25] In FY2010, CMS began to collect expenditure data about non-DSH supplemental payments made through the FFS delivery system in the CMS-64 form.[26] The CMS-64 data are the only publicly available federal administrative data for Medicaid non-DSH supplemental payment expenditures. On the CMS-64 form, states report non-DSH supplemental payment expenditures in the aggregate, not at the individual provider level. The Medicaid and CHIP Payment and Access Commission (MACPAC) and the U.S. Government Accountability Office (GAO) have raised concerns that CMS does not collect data on supplemental payments at the individual provider level, since individual hospitals may receive non-DSH supplemental payments that are significantly greater than their Medicaid costs.[27]

Since 2013, states have been required to submit additional information annually on non-DSH supplemental payment expenditures for hospitals and nursing facilities to ensure that states comply with UPL requirements in federal regulations.[28] Since 2014, states also have been required to submit supplemental payment expenditure data for ICF/IIDs, physician services for states that make supplemental payments to physicians, private residential treatment facilities, institutions for mental disease, and freestanding nonhospital clinics. This reporting requirement aims to provide additional information on states' Medicaid payments for services and supplemental payment expenditures.[29]

FFS Supplemental Payment Expenditures[30]

In FY2017, states reported $40.6 billion in total Medicaid FFS DSH and non-DSH supplemental payment expenditures (i.e., including both federal and state expenditures), or 7.2% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures).[31] Total DSH supplemental payment expenditures (i.e.,

[25] GAO, *CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322, April 2015, at https://www.gao.gov/assets/670/669561.pdf. GAO, *Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, 17-173, January 2017, at https://www.gao.gov/assets/690/681924.pdf.

[26] States submit the CMS-64 form to the CMS on a quarterly basis, and the CMS-64 form is a statement of expenditures for which states are entitled to federal Medicaid matching funds. States are required to provide supporting documentation for total Medicaid expenditures. For more information, see GAO, *CMS Needs to Better Target Risks to Improve Oversight of Expenditures*, GAO-18-564, August 2018, p. 6-7, at https://www.gao.gov/assets/700/693748.pdf.

[27] GAO, *Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, GAO-16-108, February 2016, p. 9, at https://www.gao.gov/assets/680/675007.pdf. MACPAC, *Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments*, March 2014 Report to Congress, March 2014, pp. 202-205.

[28] CMS, Center for Medicaid and CHIP Services, *Federal and State Oversight of Medicaid Expenditures*, 2013, at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf.

[29] CMS, *Federal and State Oversight of Medicaid Expenditures*, March 18, 2013, p. 3, at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf.

[30] All of the figures in this section are a result of CRS analysis of CMS-64 data as of September 25, 2018. The figures in this section have been adjusted to remove negative DSH and non-DSH supplemental payment expenditures (California, Hawaii, Indiana, Iowa, and Texas) and negative payments for services (Delaware, New York, North Carolina, and Pennsylvania). States may have negative expenditures due to prior period adjustments. Total Medicaid DSH and non-DSH supplemental payment expenditures include both federal and state expenditures but do not include waiver supplemental payments or Medicaid pass-through payments made through the managed care delivery system.

[31] For the purposes of this report, *state* refers to the 50 states and the District of Columbia.

including both federal and state expenditures) were $16.0 billion, or 2.8% of total Medicaid medical assistance expenditures. In comparison, total non-DSH supplemental payment expenditures (i.e., including both federal and state expenditures) were $24.6 billion, or 4.3% of total Medicaid medical assistance expenditures.

These figures include expenditures reported by the states for hospitals (including inpatient and outpatient services), nursing facilities, mental health facilities, ICF/IIDs, physician and surgical services, and other practitioners. Non-DSH supplemental payments include payments for graduate medical education.[32] States may have made additional supplemental payments to other providers that these expenditure estimates do not capture.

FFS Supplemental Payments as a Share of Total Medicaid Expenditures

Total Medicaid DSH and non-DSH supplemental payment expenditures as a share of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures) varied widely across all 50 states and the District of Columbia, ranging from 0.4% of total state Medicaid spending in North Dakota to 19.9% of total state Medicaid spending in Alabama (see **Figure 1**).

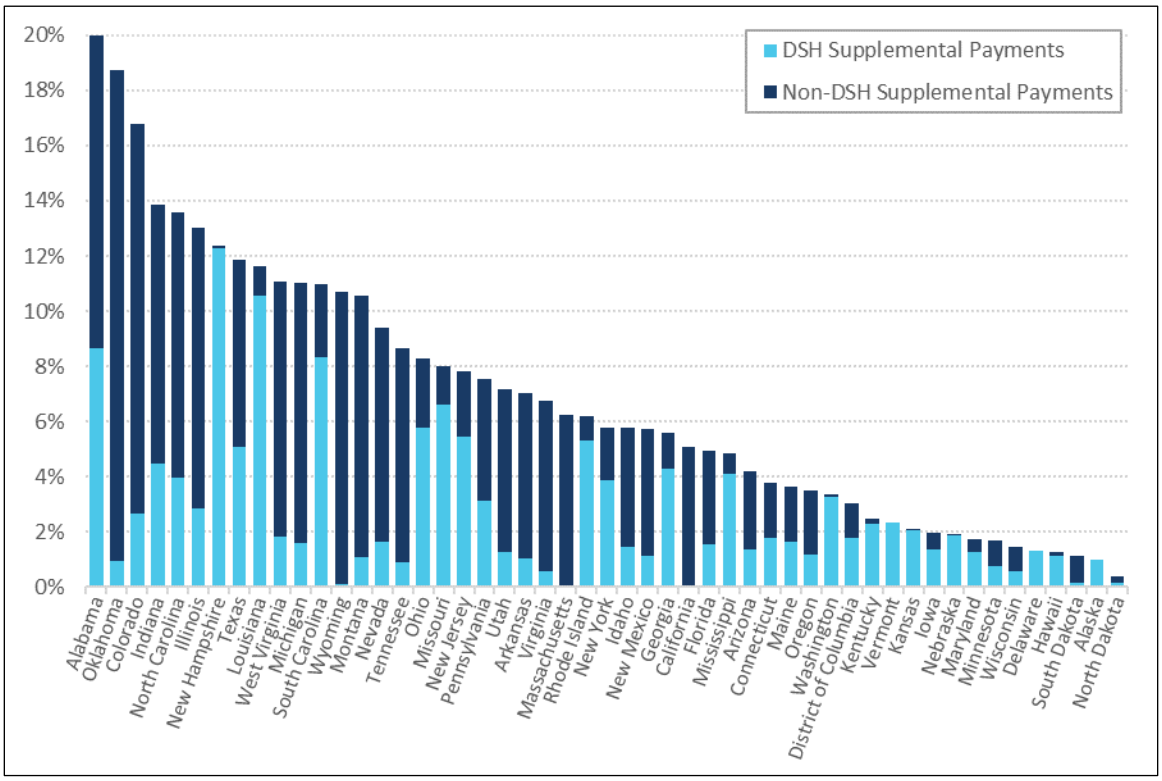
The distribution of supplemental payment expenditures between DSH and non-DSH supplemental payments also differs by state.[33] For example, in FY2017, nearly all of New Hampshire's total Medicaid supplemental payment expenditures (i.e., including both federal and state expenditures) were for DSH payment expenditures. In comparison, Wyoming's total Medicaid supplemental payment expenditures were primarily non-DSH supplemental payment expenditures.

[32] For more information about graduate medical education, see CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*.

[33] MACPAC, *Medicaid Base and Supplemental Payments to Hospitals*, June 2018. GAO, *Federal Guidance Needed to Address Concerns About the Distribution of Supplemental Payments*, GAO-16-108, February 2016, p. 7.

Figure 1. Medicaid FFS Supplemental Payments as a Share of Total Medicaid Medical Assistance Expenditures by State

(FY2017)



Source: Congressional Research Service (CRS) analysis of CMS-64 data as of September 25, 2018.

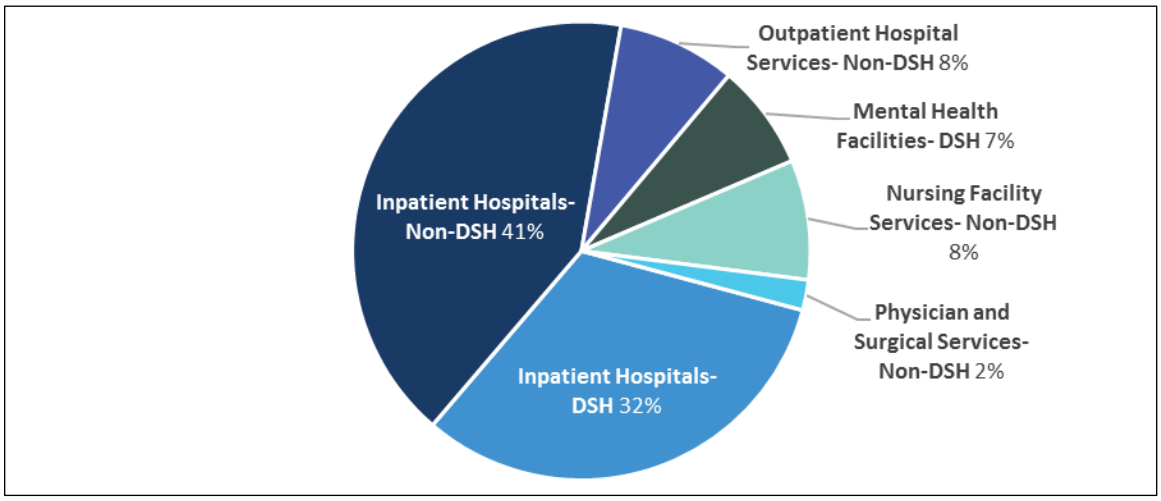
Notes: FFS = fee-for-service. DSH = disproportionate share hospital. Supplemental payments include DSH and non-DSH supplemental payments. Non-DSH supplemental payment expenditures include supplemental payments to hospitals, nursing facilities, mental health facilities, intermediate care facilities for the intellectually disabled, physician and surgical services, and other practitioners. States may have made additional FFS supplemental payments to other providers that these expenditure estimates do not capture. Total Medicaid DSH and non-DSH supplemental payment expenditures include both federal and state expenditures but do not include waiver supplemental payments or managed care pass-through payments. Total Medicaid medical assistance expenditures include both federal and state expenditures but exclude administrative expenditures. Data include adjustments to states with negative supplemental payments (California, Hawaii, Indiana, Iowa, and Texas) and negative payments for services (Delaware, New York, North Carolina, and Pennsylvania). States may have negative expenditures due to prior period adjustments. Alaska, Delaware, and Vermont did not make non-DSH supplemental payments in FY2017.

FFS Supplemental Payments by Provider Type

In FY2017, nationally the majority of supplemental payment expenditures, including both DSH and non-DSH payments, were made to hospitals. Over 80% of the $40.6 billion in total Medicaid DSH and non-DSH supplemental payment expenditures (i.e., including federal and state expenditures) were made to hospitals (see **Figure 2**). In FY2017, nursing facilities received 8% of total Medicaid DSH and non-DSH supplemental payment expenditures and mental health facilities received 7% in the form of DSH payments. In the same year, physicians and surgeons received 2% of total Medicaid DSH and non-DSH supplemental payment expenditures, and ICF/IIDs and other practitioners received less than 0.5%.

Figure 2. Medicaid FFS Supplemental Payments by Provider Type

(FY2017)



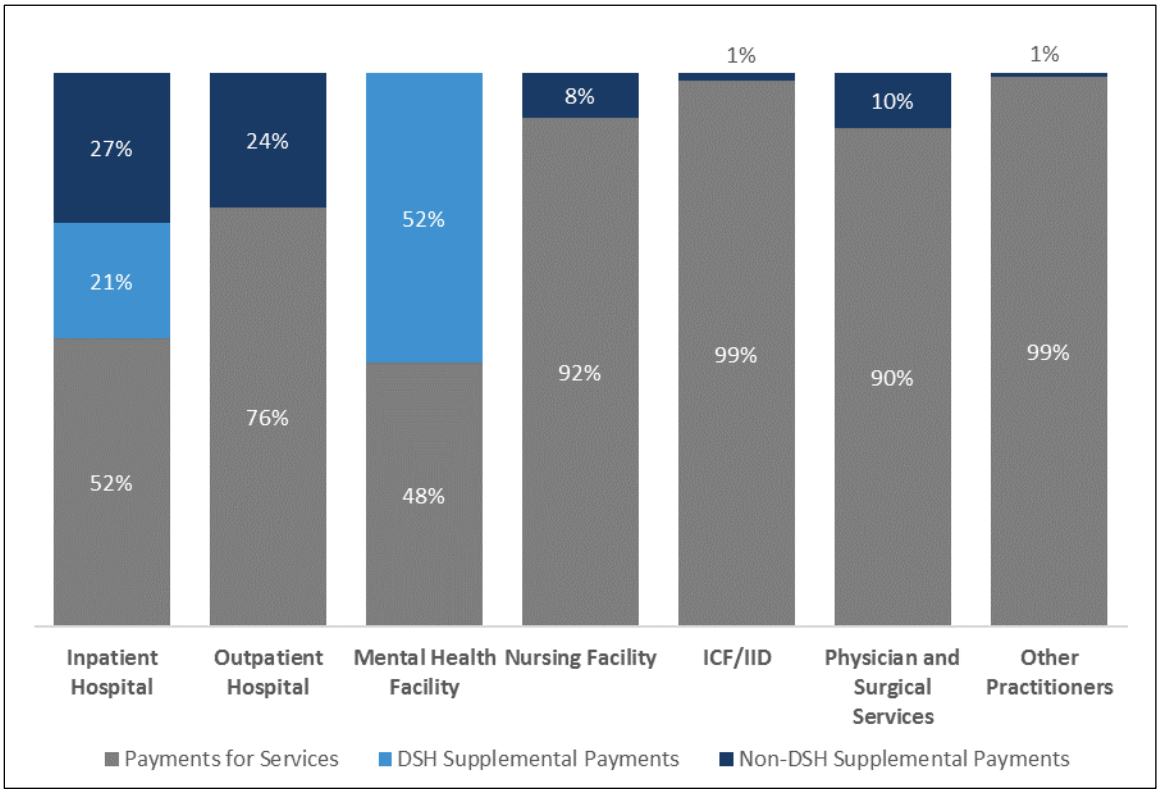
Source: CRS analysis of CMS-64 data as of September 25, 2018.

Notes: FFS = fee-for-service. DSH = disproportionate share hospital. Supplemental payments include DSH and non-DSH supplemental payments. Non-DSH supplemental payment expenditures include supplemental payments to hospitals, nursing facilities, mental health facilities, intermediate care facilities for the intellectually disabled (ICF/IIDs), physician and surgical services, and other practitioners. States may have made additional FFS supplemental payments to other providers that these expenditure estimates do not capture. ICF/IID and other practitioners' services are not shown in this chart as they make up less than 0.5% of total Medicaid FFS DSH and non-DSH supplemental payment expenditures. Total Medicaid DSH and non-DSH supplemental payment expenditures include both federal and state expenditures but do not include waiver supplemental payments or managed care pass-through payments. Data include adjustments to states with negative supplemental payments (California, Hawaii, Indiana, Iowa, and Texas) and negative payments for services (Delaware, New York, North Carolina, and Pennsylvania). States may have negative expenditures due to prior period adjustments. Alaska, Delaware, and Vermont did not make non-DSH supplemental payments in FY2017.

FFS Supplemental Payments as a Share of Medicaid Provider Payments

The distribution between payments for services and supplemental payment expenditures varies by the type of provider. In FY2017, total Medicaid DSH payments made up 52% of total Medicaid FFS medical assistance expenditures to mental health facilities (i.e., including both federal and state expenditures). Total Medicaid DSH and non-DSH supplemental payment expenditures comprised nearly half (48%) of total Medicaid FFS medical assistance expenditures to inpatient hospitals, compared to only 10% of total Medicaid FFS medical assistance expenditures to physicians and surgeons and 8% to nursing facilities (see **Figure 3**). Supplemental payments made up an even smaller share (approximately 1%) of total Medicaid FFS medical assistance expenditures to ICF/IIDs and other practitioners.

Figure 3. Proportion of Medicaid FFS Payments to Providers Receiving Supplemental Payments, by Payments for Services and Supplemental Payments by Provider Type
(FY2017)



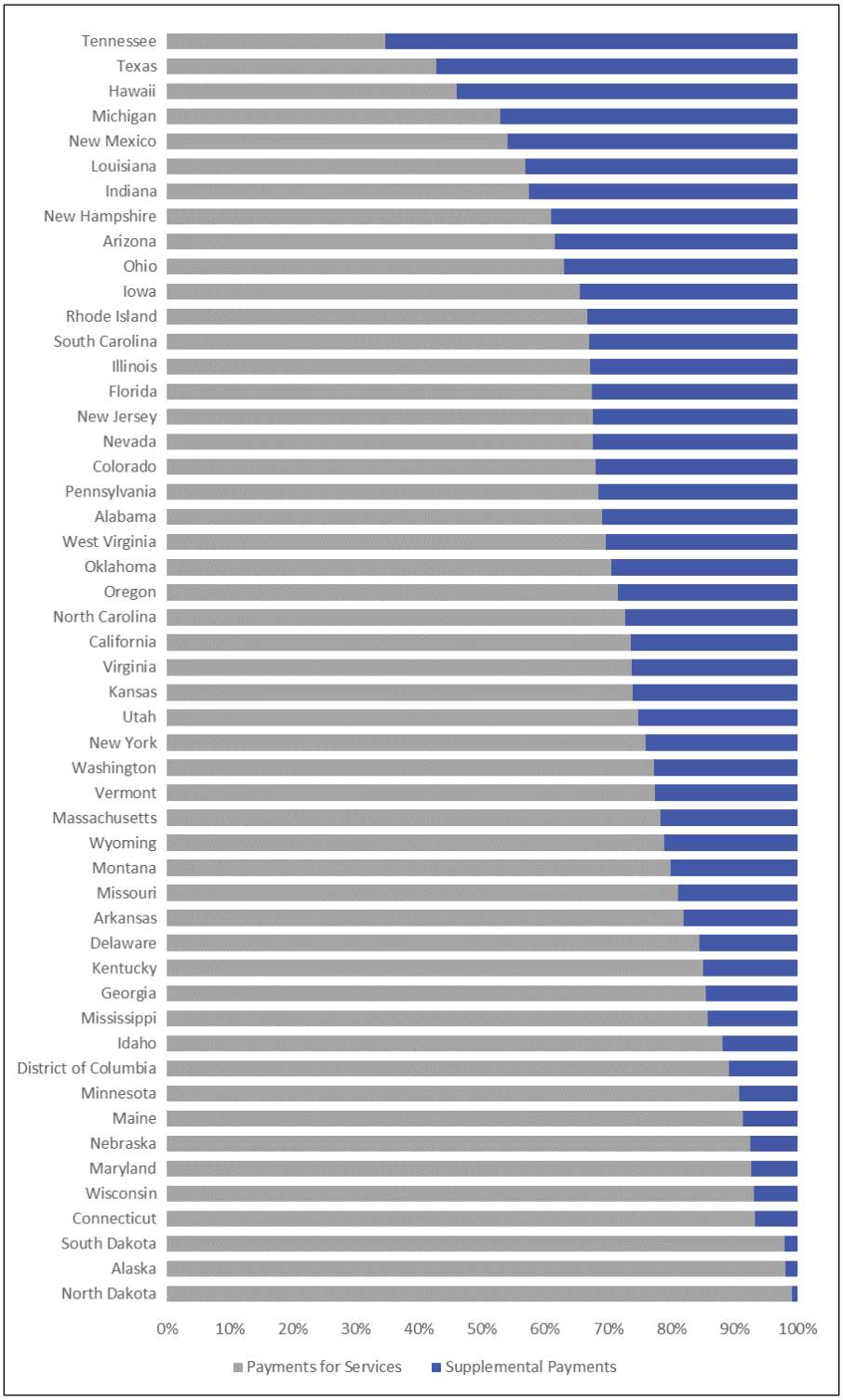
Source: CRS analysis of CMS-64 data as of September 25, 2018.

Notes: FFS = fee-for-service. DSH = disproportionate share hospital. Supplemental payments include DSH and non-DSH supplemental payments. Non-DSH supplemental payments include supplemental payments to hospitals, nursing facilities, mental health facilities, ICF/IIDs, physician and surgical services, and other practitioners. States may have made additional FFS supplemental payments to other providers that these expenditure estimates do not capture. DSH and non-DSH supplemental payments include both federal and state expenditures but do not include waiver supplemental payments or managed care pass-through payments. Total Medicaid FFS medical assistance expenditures include both federal and state expenditures but exclude administrative expenditures. Data include adjustments to states with negative supplemental payments (California, Hawaii, Indiana, Iowa, and Texas) and negative payments for services (Delaware, New York, North Carolina, and Pennsylvania). States may have negative expenditures due to prior period adjustments. Alaska, Delaware, and Vermont did not make non-DSH supplemental payments in FY2017.

The distribution between payments for services and supplemental payments also varies widely by state. For example, Medicaid FFS supplemental payments as a share of total Medicaid FFS medical assistance expenditures for the providers receiving supplemental payments as reported on the CMS-64 form ranged from 1% in North Dakota to 65% in Tennessee (see **Figure 4**).[34] Medicaid DSH and non-DSH FFS supplemental payment expenditures made up an average of 26% of total FFS Medicaid medical assistance expenditures to providers receiving supplemental payments.

[34] These providers include hospitals, mental health facilities, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, physician and surgical services, and other practitioners.

Figure 4. Proportion of Medicaid FFS Payments to Providers Receiving Supplemental, by Payments for Services and Supplemental Payments by State
(FY2017)



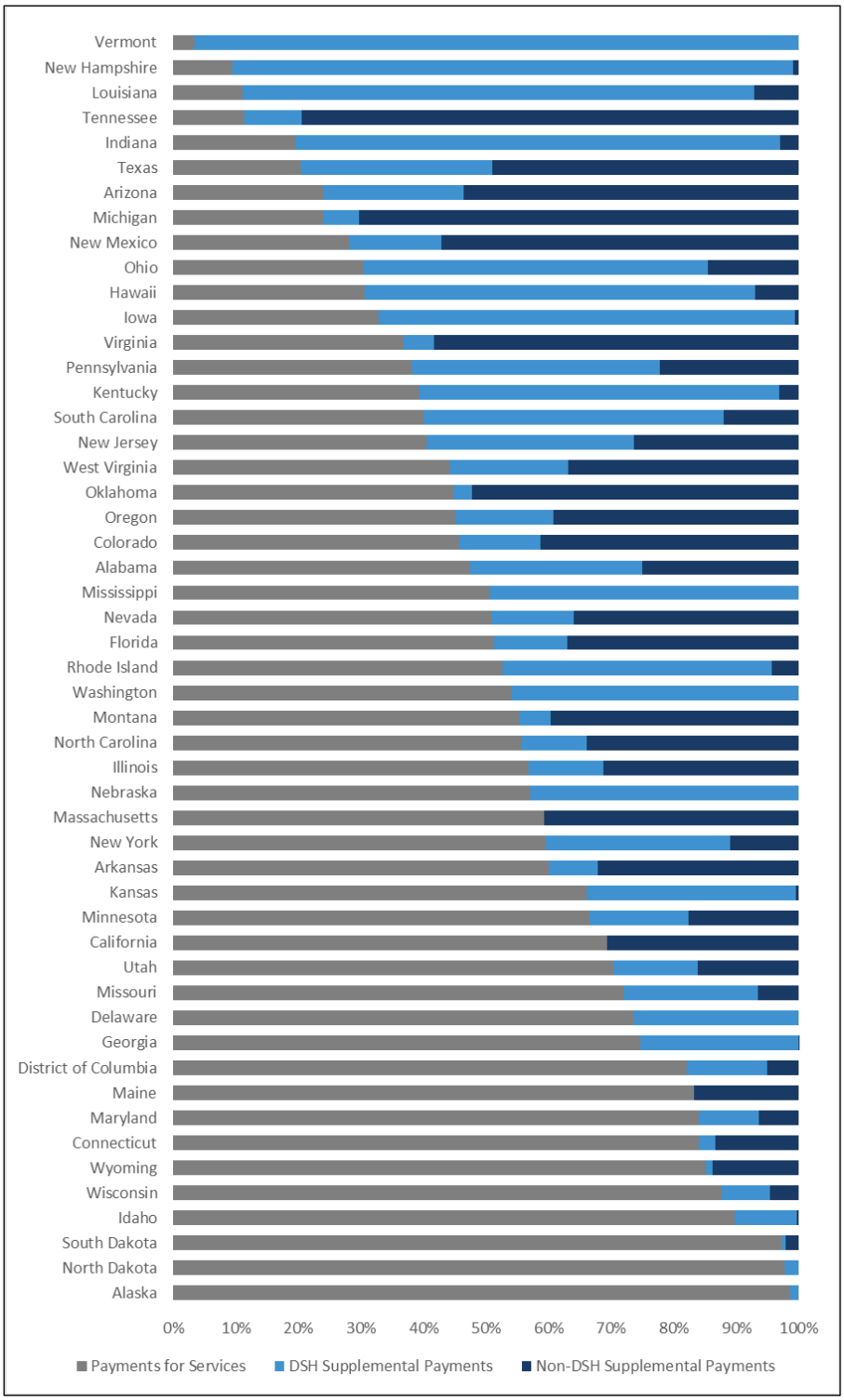
Source: CRS analysis of CMS-64 data as of September 25, 2018.

Notes: FFS = fee-for-service. DSH = disproportionate share hospital. Supplemental payments include DSH and non-DSH supplemental payments. Non-DSH supplemental payment expenditures include supplemental payments to hospitals, nursing facilities, mental health facilities, ICF/IIDs, physician and surgical services, and other practitioners. States may have made additional FFS supplemental payments to other providers that these expenditure estimates do not capture. Total Medicaid DSH and non-DSH supplemental payment expenditures include both federal and state expenditures but do not include waiver supplemental payments or managed care pass-through payments. Medicaid payments for services include payments to providers receiving supplemental payments, and the payments include both federal and state expenditures but exclude administrative expenditures. Data include adjustments to states with negative supplemental payments (California, Hawaii, Indiana, Iowa, and Texas) and negative payments for services (Delaware, New York, North Carolina, and Pennsylvania). States may have negative expenditures due to prior period adjustments. Alaska, Delaware, and Vermont did not make non-DSH supplemental payments in FY2017.

Inpatient hospitals received the largest share of both DSH and non-DSH supplemental payment expenditures in FY2017, but the ratio of supplemental payments relative to payments for services varies by state. FFS supplemental payments as a share of total Medicaid FFS medical assistance expenditures to inpatient hospitals (i.e., including both federal and state expenditures) ranged from 1% in Alaska to 97% in Vermont (see **Figure 5**). In Vermont, all of the total Medicaid FFS supplemental payment expenditures to inpatient hospitals were DSH expenditures.

Figure 5. Proportion of Medicaid FFS Payments to Inpatient Hospitals by Payments for Services and Supplemental Payments by State

(FY2017)



Source: CRS analysis of CMS-64 data as of September 25, 2018.

Notes: FFS = fee-for-service. DSH = disproportionate share hospital. Supplemental payments include DSH and non-DSH supplemental payments. Non-DSH supplemental payments include supplemental payments to hospitals for inpatient services and graduate medical education. States may have made additional FFS supplemental payments to other providers that these expenditure estimates do not capture. DSH and non-DSH supplemental payments include both federal and state expenditures but do not include waiver supplemental payments or managed care pass-through payments. Total Medicaid inpatient hospital FFS expenditures include both federal and state expenditures but exclude administrative expenditures. Data include adjustments to states with negative supplemental payments (California, Hawaii, Indiana, Iowa, and Texas) and negative payments for services (Delaware, New York, North Carolina, and Pennsylvania). States may have negative expenditures due to prior period adjustments. Alaska, Delaware, and Vermont did not make non-DSH supplemental payments in FY2017.

Managed Care Pass-Through Payments

As states move Medicaid enrollees from FFS to managed care, the total FFS payments decrease, which in turn may lower the UPLs for supplemental payments.[35] Therefore, moving from FFS to managed care lessens states' ability to make or maintain prior FFS supplemental payments to providers, and both states and providers may face funding losses from the transition to managed care.[36]

Under managed care, states have been making pass-through payments, which are similar to FFS supplemental payments. These pass-through payments are included in the payments states make to the MCOs (i.e., capitation rates), and the MCOs in turn make the payments to hospitals, physicians, or nursing facilities, as directed by the state.[37] Pass-through payments are similar to FFS supplemental payments because they are not tied to any specific services for Medicaid enrollees. States have used pass-through payments to support safety-net providers that provide care for Medicaid managed care enrollees, among other reasons.[38]

In recent years, there has been a great deal of regulatory activity regarding pass-through payments. Through several regulations, CMS is phasing down states' use of pass-through payments in managed care. The following is a summary of the recent regulatory activity regarding pass-through payments.

In 2016, CMS issued a managed care regulation that included a limit on the use of existing and future pass-through payments.[39] The regulation required states to phase out pass-through payments to physicians and nursing facilities over a 5-year period and to phase out pass-through payments to hospitals over a 10-year period, beginning July 1, 2017. CMS noted that hospitals received a longer phasedown schedule because the pass-through payments from states to hospitals are "significantly larger" than the pass-through payments to physicians and nursing facilities.[40]

[35] MACPAC, *MACFacts: Medicaid UPL Supplemental Payments*, November 2012, p. 3, at https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-UPL-Payments_2012-11.pdf.

[36] MACPAC, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2011, p. 64, at https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_June2011_web.pdf.

[37] CMS noted that states make most managed care pass-through payments to hospitals, physicians, and nursing facilities. "Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems," 82 *Federal Register* 5415, January 18, 2017.

[38] HHS, CMS, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," 81 *Federal Register* 27589, May 6, 2016. Hereinafter CMS, "Medicaid Managed Care," 81 *Federal Register* 27589.

[39] CMS, "Medicaid Managed Care," 81 *Federal Register* 27589.

[40] CMS, "Medicaid Managed Care," 81 *Federal Register* 27589.

The regulation permitted states to eliminate or phase down pass-through payments before the end of the transition period.

In response to the 2016 final rule, states attempted to increase existing or implement new pass-through payments. In a final rule published in January 2017, CMS clarified that the intention of the 2016 final rule was to maintain existing pass-through payments at current levels and prohibit states from implementing new pass-through payments.[41] Therefore, the rule established an aggregate limit on pass-through payments to physicians and nursing facilities; the limit was the amounts in place in managed care contracts and rate certifications as of the effective date of July 5, 2016.

The January 2017 final rule also limited the amount of pass-through payments to hospitals to the lower of a certain percentage of a "base amount," according to a specified phasedown schedule over the 10-year period, or the total aggregate dollar amount identified by the state in managed care contracts and rate certifications as of July 5, 2016. The base amount is essentially the amount of inpatient and outpatient hospital services used by eligible populations, which CMS considers equivalent to the UPL calculations under FFS.[42]

CMS explained that the transition periods for pass-through payments are intended to allow states to integrate existing pass-through payments to MCOs through delivery system and payment models that are tied to outcomes and quality.[43] CMS clarified that examples of permissible payment structures include value-based purchasing models, delivery system reform efforts, and specific types of provider payments.[44]

The regulation permitted states to direct existing pass-through payments to MCOs during the transition period if states also meet several other requirements, including achieving at least one of the goals or objectives within the state's managed care quality strategy and developing an evaluation plan to assess the directed payments' outcomes. CMS has reported that, as an example of a permissible directed payment, one state is directing managed care plans to make quality incentive payments to in-network hospitals to reduce potentially avoidable hospital readmissions for Medicaid enrollees.[45] After July 1, 2022, for physicians and nursing facilities and after July 1, 2027, for hospitals, any payments that states direct MCOs to make to providers must be integrated into value-based purchasing models, delivery system reform or performance improvement efforts, and specific types of provider payments, such as fee schedules or uniform dollar or percentage increases.[46]

On November 8, 2018, CMS published a proposed rule designed to offer additional flexibilities from the requirements of the 2016 and 2017 rules.[47] Although the 2018 rule would not change the

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[41] HHS, CMS, "Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems," 82 *Federal Register* 5416, January 18, 2017. Hereinafter CMS, "New or Increased Pass-Through Payments," 82 *Federal Register* 5416.

[42] CMS, "New or Increased Pass-Through Payments," 82 *Federal Register* 5416.

[43] CMS, "New or Increased Pass-Through Payments," 82 *Federal Register* 5416.

[44] HHS, CMS, *Delivery System and Provider Payment Initiatives Under Medicaid Managed Care Contracts*, CMCS Informational Bulletin, November 2, 2017, pp. 1-2, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf.

[45] HHS, CMS, *Appendix A: Examples of State Directed Payment Arrangements*, at https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/appendix-a.pdf.

[46] HHS, CMS, *Delivery System and Provider Payment Initiatives Under Medicaid Managed*, CMCS Informational Bulletin, November 2, 2017, pp. 1-2, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf.

[47] HHS, CMS, "Medicaid Program: Medicaid and Children's Health Insurance Plan Managed Care," 83 *Federal*

prohibition on states increasing existing pass-through payments, it would allow states to make new pass-through payments under certain circumstances. The proposed rule would allow states that are transitioning new services or populations from FFS to managed care to make new pass-through payments to hospitals, nursing facilities, or physicians, as long as the state had previously been making FFS supplemental payments for those services and the aggregate payment amount is less than or equal to the previous FFS supplemental payments.

There are no national data publicly available regarding the amount of pass-through payments. States report only the aggregate amount of payments to managed care plans in the CMS-64 form, not the amounts to specific providers or a breakout by payment type. As of May 6, 2016, CMS estimated that at least 8 states were making a total of $105 million in pass-through payments to physicians annually; 3 states were making a total $50 million in pass-through payments to nursing facilities annually; and 16 states were making a total of $3.3 billion in pass-through payments to hospitals annually.[48] CMS noted that these estimates of pass-through payments likely did not represent the full amounts because no reporting requirements were in place prior to the final rule.

Supplemental Payments Through Waivers

States also may receive Section 1115 waiver authority to make supplemental payments to certain providers that they otherwise are not permitted to make.

Data on the amount of supplemental payments through these waivers are limited. The Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that supplemental payments to hospitals through Section 1115 waiver authority totaled $15 billion, or nearly 17% of total FFS Medicaid payments to hospitals (including federal and state expenditures) in FY2017.[49] Because states also may have waivers that allow supplemental payments to other providers, this estimate likely understates the full scope of Section 1115 waiver authority supplemental payments.

This section discusses the two main types of Section 1115 waiver authority supplemental payments: uncompensated care pools and Delivery System Reform Incentive Payment (DSRIP) programs.

Uncompensated Care Pools

Uncompensated care pools are dedicated pools of funding that provide payments to health care providers (usually hospitals) to defray the cost of providing uncompensated care (i.e., the costs of services rendered that providers do not receive a payment for). Some of the main reasons for uncompensated care include (1) providers not receiving payment for services provided to uninsured patients and (2) low Medicaid provider payment rates that may not cover the cost of providing care. States obtain the authority for these uncompensated care pools through Section 1115 waiver authority granted by CMS.

Currently, seven states report having waiver authority for an uncompensated care pool: California, Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas.[50]

Register 57264, November 14, 2018.

[48] CMS, "Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems," 82 *Federal Register* 5426, January 18, 2017.

[49] MACPAC, *Exhibit 24: Medicaid Supplemental Payments to Hospital Providers by State, FY2017 (millions)*, MACStats, December 2018.

[50] Arizona and Hawaii previously had uncompensated care pools that expired in December 2017 and June 2016,

Uncompensated care pool arrangements were first awarded under the George W. Bush Administration through the approval of Section 1115 waivers in certain states, including California, Florida, and Massachusetts.

During the Obama Administration, CMS identified these financing arrangements as a policy that would be reviewed as a part of waiver renewals. In negotiating the terms of certain state waivers, CMS identified concerns with a "lack of transparency" and "encouragement of overreliance on supplemental payments."[51] CMS stated that it would work with states that had existing uncompensated care pools to ensure Medicaid payments would support services provided to Medicaid enrollees and uninsured individuals.

Under the Trump Administration, CMS has renewed several Section 1115 waivers that include uncompensated care pools. CMS has not issued any public statements regarding new principles for uncompensated care pools; however, since 2017, CMS has approved uncompensated care pools in Florida, Massachusetts, and Texas.[52]

Delivery System Reform Incentive Payment Programs

Since 2010, states have received approval for DSRIP programs, a type of supplemental payment program authorized under Section 1115 authority that is tied specifically to delivery system transformation efforts. Similar to other Medicaid supplemental payments, DSRIP payments are not tied to services provided. However, unlike uncompensated care pools or DSH payments, these payments are not tied to hospital uncompensated care.[53]

Early DSRIP programs evolved out of states' desires to maintain supplemental payments that supported public hospitals or that would have been eliminated in the transition from FFS to managed care. States expressed that maintaining FFS supplemental payments was a "critical driver in most states' decisions to implement a DSRIP."[54] In 2010, California was the first state to receive approval for a DSRIP, and CMS required the DSRIP supplemental payments to the state's public hospitals to be consistent with CMS's goals of improved care, better health, and lower costs.[55]

CMS worked with early DSRIP states to connect the supplemental payments with improvements in care and lower costs. Over time, DSRIP programs have become less tied to the preservation of prior FFS supplemental payments; they are now primarily focused on implementing payment and

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respectively. Kaiser Family Foundation, "Delivery System Reform Incentive Payment Program (DSRIP) Waivers and Uncompensated Care Pools in Place," accessed November 9, 2018.

[51] Letter from Vikki Wachino, Acting Director of the Center for Medicaid and CHIP Services, to Justin Senior, Deputy Director of Medicaid in Florida, April 14, 2015, p. 1, at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-lip-ltr-04142015.pdf.

[52] CMS, Florida Managed Medical Assistance Section 1115(a) Medicaid Demonstration, August 3, 2017. CMS, Texas Healthcare Transformation and Quality Improvement Program, December 21, 2017. CMS, MassHealth Medicaid Section 1115 Demonstration, December 14, 2017, at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

[53] GAO, *Hospital Uncompensated Care: Federal Action Needed to Better Align Payments with Costs*, GAO-16-568, June 2016, p. 10.

[54] Melanie Schoenberg et al., *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools*, National Academy of State Health Policy, March 2015, pp. 6-7, at https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf.

[55] CMS, *California Bridge to Reform Demonstration*, November 1, 2010, amended December 24, 2013.

delivery system reforms linked to meeting performance metrics and other milestones.[56] CMS has not issued formal guidance outlining the definition of a DSRIP, but special terms and conditions in states' waivers establish the connection between the DSRIP payments and improved health outcomes.

Thirteen states reported having a DSRIP or DSRIP-like program in place as of March 2018: Alabama, Arizona, California, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Texas, and Washington. As of June 2017, the aggregate total approved federal and state funding across all years (i.e., 2010 through 2017) and states was $48.6 billion.[57]

In general, providers receive DSRIP supplemental payments for meeting certain milestones.[58] These milestones initially are tied to reporting or process implementation; they then transition to outcomes-based milestones, such as improving care and lowering costs. For example, California's DSRIP program is assisting providers to better integrate physical and behavioral health and to improve care management for high-risk or high-cost populations.[59] In New Jersey, each of the participating hospitals is focused on improving care for one chronic condition, including asthma, obesity, and diabetes.[60]

CMS has noted that DSRIP programs are intended to be time-limited. In 2017, CMS approved renewals of Texas's and Massachusetts's DSRIP programs, with phasedowns to zero or limited funding in the last year of the demonstration and the agreement that the states would need to find sustainable funding sources to continue DSRIP activities.[61]

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[56] Felicia Heider, Tina Kartika, and Jill Rosenthal, *Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Programs*, National Academy for State Health Policy, August 2017, p. 8, at https://www.macpac.gov/wp-content/uploads/2018/03/Exploration-of-the-Evolving-Promise-of-DSRIP-and-Similar-Programs.pdf.

[57] DSRIP-like programs are similar to DSRIPs in terms of goals and payments, and they also are authorized through Section 1115 waivers. However, CMS does not consider DSRIP-like programs to be formal DSRIPs. MACPAC, *Delivery System Reform Incentive Payment Programs*, March 2018, p. 1, at https://www.macpac.gov/wp-content/uploads/2018/03/Delivery-System-Reform-Incentive-Payment-Programs.pdf.

[58] MACPAC, *Using Medicaid Supplemental Payments to Drive Delivery System Reform*, June 2015 Report to Congress, June 2015.

[59] Felicia Heider, Tina Kartika, and Jill Rosenthal, *Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Programs*, National Academy for State Health Policy, August 2017, p. A2, at https://www.macpac.gov/wp-content/uploads/2018/03/Exploration-of-the-Evolving-Promise-of-DSRIP-and-Similar-Programs.pdf.

[60] Julia B. Baller et al., *Medicaid 1115 Demonstration Interim Evaluation Report: Delivery System Reform Incentive Payments*, Mathematica Policy Research, January 31, 2018, p. 4, at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/dsrip-interim-eval-report.pdf.

[61] CMS, *MassHealth Medicaid Section 1115 Demonstration*, June 27, 2018, p. 67, at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf. CMS, *Texas Healthcare Transformation and Quality Improvement Program*, December 21, 2017, p. 46, at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-demo-ext-12212017.pdf.

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