Themes from Interviews on the Development of Hospital Payment Policies

Medicaid and CHIP Payment and Access Commission

Robert Nelb

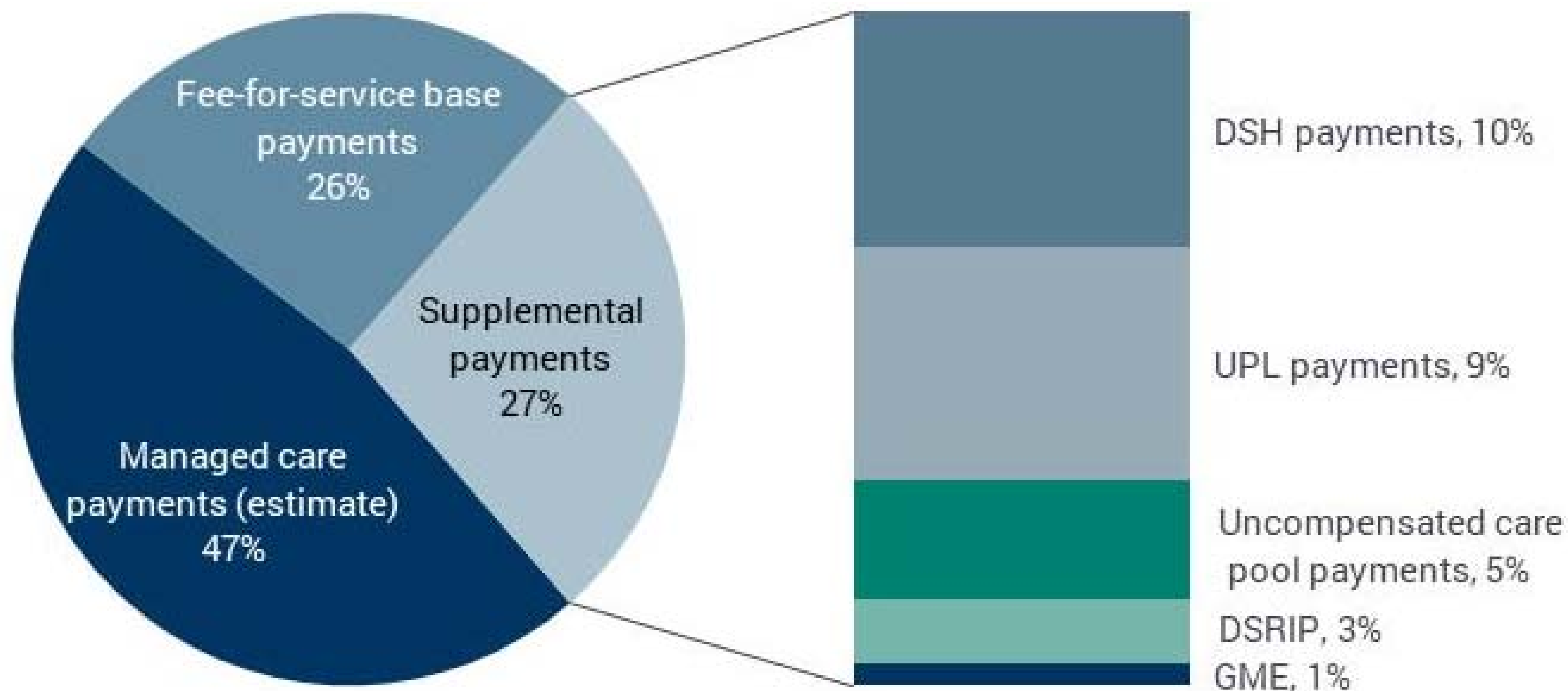
Overview

- Context for study
- Methodology
- Key findings

Hospital Payment Work Plan

- MACPAC is undertaking an analysis of Medicaid hospital payment policy that broadly considers all types of Medicaid payments to hospitals
- We plan to collect information about:
  - Payment methods
  - Payment amounts
  - Outcomes related to payments
- This information can help the Commission evaluate whether payment policies are consistent with efficiency, economy, quality, and access

Base and Supplemental Payments as a Share of Total Payments to Hospitals, FY 2016



Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. Totals do not sum due to rounding.
Source: MACPAC, 2018, analysis of CMS-64 net expenditure data.

Policy Questions

- What are the factors that affect the structure and mix of base payments and supplemental payments?
- How have state financing methods and state payment policy choices affected each other?
- Why do states target payments to particular types of hospitals, and how do they determine which hospitals to target?
- How do fee-for-service (FFS) payments policies affect managed care payments to hospitals?
- What are the drivers and barriers to changing hospital payment methods?
- How are states planning to change hospital payment policies in the future?

Methodology

- MACPAC contracted with Health Management Associates (HMA) to conduct structured interviews in five states
- We selected states that varied in their use of supplemental payments and financing approaches and recently made changes to hospital payment policies
- For each state, we researched current payment policies and interviewed state, hospital, and managed care representatives
- We also interviewed national experts and staff from the Centers for Medicare & Medicaid Services (CMS)

Payments as a Share of Total Medicaid Payments to Hospitals in Study States, FY 2016

Type of payment	Arizona	Louisiana	Michigan	Mississippi	Virginia
FFS base	19%	7%	10%	15%	26%
Managed care base	63%	34%	40%	40%	52%
Subtotal base	**82%**	**41%**	**50%**	**56%**	**78%**
DSH	5%	41%	7%	13%	9%
UPL	4%	3%	13%	0%	0%
GME	8%	2%	3%	0%	13%
Managed care supplemental	1%	12%	27%	31%	0%
Subtotal supplemental	**18%**	**59%**	**50%**	**45%**	**22%**

Notes: FY is fiscal year. FFS is fee-for-service. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. Managed care supplemental payments include directed payments and pass-through payments. Arizona, Louisiana, and Virginia have made or are planning to make policy changes that will affect the distribution of base and supplemental payments in future years. Totals do not sum due to rounding

Source: HMA and MACPAC analysis of FY 2016 financial management reports submitted by the states to CMS, schedules prepared by the state's Medicaid agency, and other publicly available information.

Key Findings

- The availability of financing for the non-federal share of Medicaid payments has affected states' use of base and supplemental payments
- The use of Medicaid managed care has not substantially affected Medicaid payments to hospitals
- The adoption of prospective payment systems and value-based payment models is slow

Supplemental Payments and Sources of Non-Federal Share

- In study states, we observed a common narrative that explained the growth of supplemental payments
  - States reported challenges increasing base rates with state general funds, particularly during the 2007-2011 recession
  - States have increased the use of provider-based financing (i.e., provider assessments/ taxes, intergovernmental transfers, and certified public expenditures)
  - When using provider financing to pay for increased hospital payments, states and providers preferred supplemental payments rather than increases in base payments
- Louisiana was the only state in our study planning to decrease the use of supplemental payments because of concerns about pending DSH allotment reductions

Managed Care Base Payments

- In study states, managed care organizations (MCOs) used FFS methods and rates for most base payments to hospitals
  - Capitation rates are initially developed based on FFS rates
  - Some states require the use of FFS rates as a rate floor for non-contracted providers
  - MCO representatives noted the complexity of developing alternative payment models that differ from FFS rates

Managed Care Directed Payments

- States cannot make upper payment limit (UPL) payments for services provided in managed care, but make similar payments by requiring MCOs to direct payments to providers
- The 2016 managed care rule issued specific guidelines for directed payments
  - States must phase-out payments that do not comply with the new criteria, referred to as pass-through payments
- Study states were able to make directed payments that were similar to previous pass-through payments
- States were uncertain about how directed payment policies may change in the future

Prospective Payment Systems

- Three of our study states recently converted their inpatient payment methods from per diem to diagnostic-related groups (DRGs)
- Adoption has been slow due to:
  - Resistance from hospitals concerned that the new system will create winners and losers in the state
  - Operational and administrative costs involved in making changes to payment methods

Value-Based Payments

- Value-based payment models for hospital services were used sparingly in the states we studied
- Barriers to adopting value-based payments include:
  - Low base payments relative to hospital costs make hospitals reluctant to put Medicaid payments at risk
  - Lack of agreement on the measures to use and hospitals' ability to influence these measures
  - Administrative challenges associated with establishing and managing value-based payments
- Some states plan to increase the use of value-based payments by adding targets for managed care plans

Next Steps

- The findings from these interviews can provide additional context for the Commission's discussion of DSH and UPL policy options at this meeting
- These findings can also help inform MACPAC's ongoing work on its long-term hospital payment work plan

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