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Hospital Supplemental Payment Work Plan

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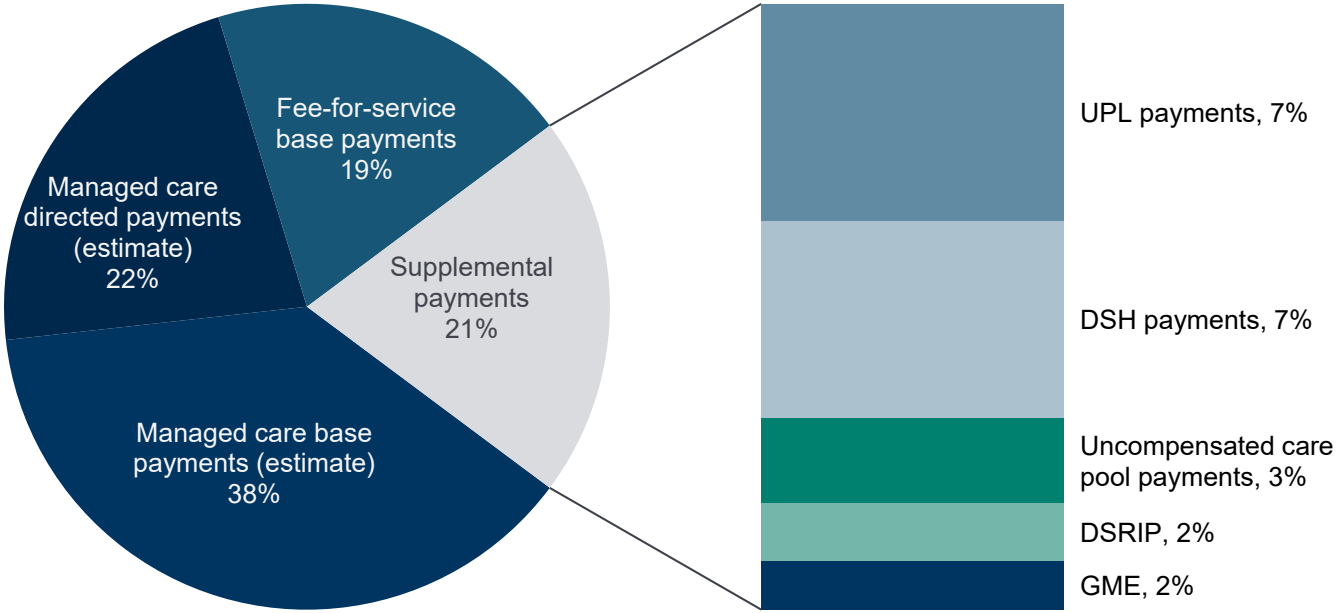
Overview

- Background
  - Types of supplemental payments
  - Newly available supplemental payment data
  - MACPAC provider payment framework
- Proposed areas of work
  - Documenting payment methods and policy goals
  - Characterizing payment targeting
  - Calculating overall payment rates
- Next steps

Background

Supplemental Payments are a Large Share of Medicaid Hospital Spending, FY 2021



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. Directed payment spending is estimated based on projections from the most recently approved preprints.
Source: MACPAC 2023, analysis of CMS-64 net expenditure data and directed payment preprints approved as of February 1, 2023.

Supplemental Payments Have Different Goals

Type of supplemental payment to hospitals	Total spending, FY 2021 (billions)	Number of states reporting spending, FY 2021	Intent of payment implied from federal rules			
			Reducing Medicaid shortfall	Paying for unpaid costs of care for uninsured individuals	Quality improvement	Support for specific types of hospitals
DSH	$14.1	48	✓	✓		
UPL	$15.4	32	✓			
Uncompensated care pool	$6.1	7	✓	✓		
DSRIP	$4.1	7			✓	
GME	$3.4	36				✓
Directed payments[1]	$47.9	35	✓		✓	

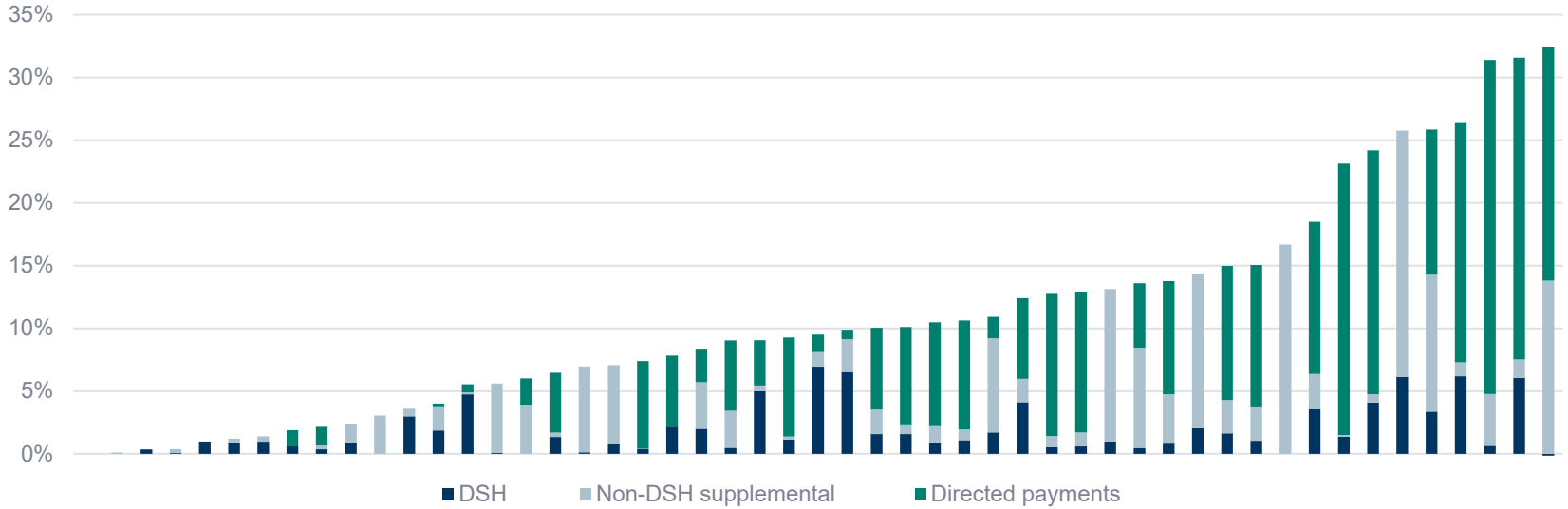
Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. DSRIP is delivery system reform incentive payment. Analysis excludes DSH payments to mental health facilities.

[1] Managed care directed payments are not classified as supplemental payments by CMS, but many states use directed payments to make large uniform rate increases that are similar to FFS supplemental payments. Spending is based on projections in the most recently approved preprints.

Source: MACPAC 2023, analysis of CMS-64 FMR net expenditure data as of June 8, 2022, CMS-64 Schedule C waiver report data as of September 19, 2022, and analysis of directed payment preprints approved through February 1, 2023.

Use of Supplemental Payments Varies by State

Payments as a Share of Medicaid Benefit Spending, FY 2021



Notes: FY is fiscal year. DSH is disproportionate share hospital. Non-DSH supplemental payments include upper payment limit supplemental payments, graduate medical education payments, and supplemental payments authorized through Section 1115 demonstrations. Directed payment spending is estimated based on annual spending projected in the most recently approved preprint approved as of February 1, 2023.
Source: MACPAC 2023, analysis of CMS-64 FMR net expenditure data as of June 8, 2022 and CMS-64 Schedule C waiver report data as of September 19, 2022 and directed payment preprint data as of February 1, 2023.

New Supplemental Payment Data

- MACPAC has long recommended that CMS collect provider-level data on all Medicaid payments to hospitals to enable further analyses
- Consolidated Appropriations Act, 2021 requires states to report provider-level data on non-DSH supplemental payments
  - Effective October 1, 2021, but data are not yet publicly available
  - Data include payment amounts and narrative information about payment methods
- In 2021, CMS began requiring states to submit more data on directed payment amounts on its standard application form (preprint)
  - Directed payment amounts are aggregated by classes of providers
  - States often compare payment amounts to Medicare or average commercial rates
- We do not have data on provider contributions to the non-federal share necessary to calculate net payments to providers

MACPAC Provider Payment Framework

- MACPAC's analyses of provider payments are guided by the statutory goals of Section 1902(a)(30)(A) of the Social Security Act
  - Economy: what is spent on payments
  - Access and quality: measures of what is obtained by payments
  - Efficiency: compares what is spent to what is obtained
- To apply the framework, we aim to collect information that can inform discussion about these principles
  - Payment methods
  - Payment amounts
  - Outcomes related to payment
- Specific analyses are informed by Commissioner feedback and are limited by available data

Proposed Work Plan

Documenting Payment Methods

- We plan to develop a compendium of supplemental payment methods and identify payments that appear to advance similar goals, such as:
  - Supporting providers that serve a high share of Medicaid and uninsured patients
  - Supporting specific types of hospitals (e.g., rural, teaching, or children's hospitals)
  - Offsetting Medicaid shortfall by increasing payments for all providers
- This information can continue to inform discussion about whether payments that advance similar goals should be subject to similar rules and what the balance should be between base and supplemental payments

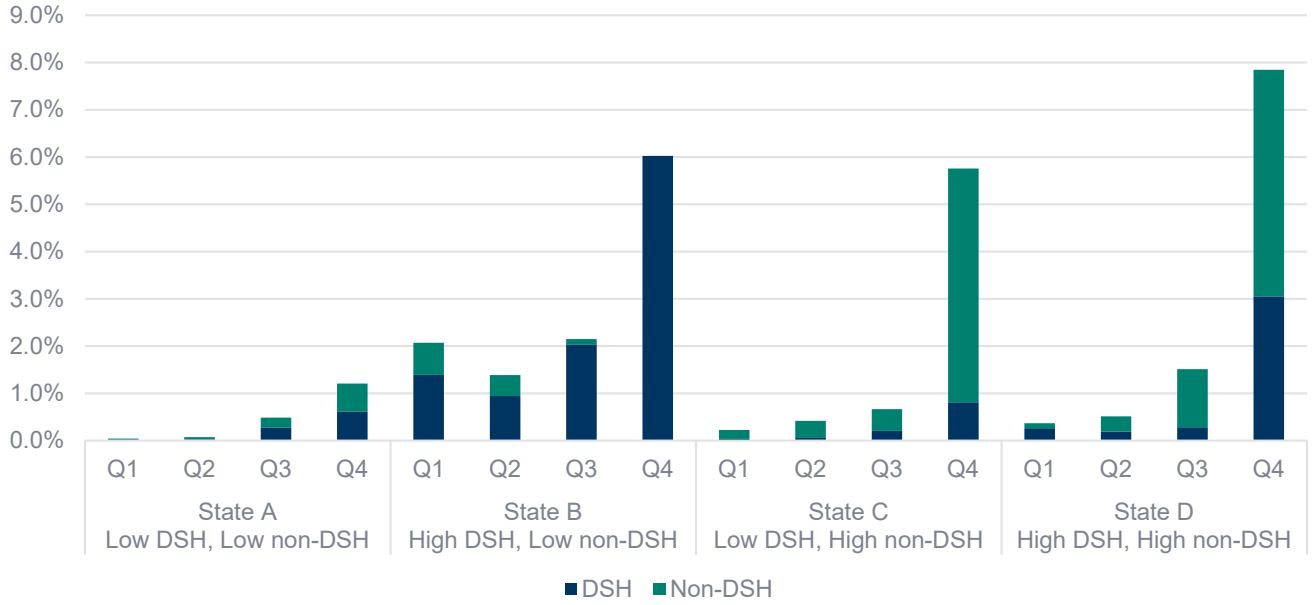
Payment Methods: Areas for Consideration

- It is not clear how to assess whether variations in supplemental payment methods raise federal policy concerns
  - The statute provides states with considerable flexibility to design their own payment methods
  - Payment methods are often influenced by Medicaid financing
- Some physician supplemental payments to physicians affiliated with academic medical centers (AMC) indirectly benefit hospital systems
  - Half of states make about $1 billion a year in physician supplemental payments
  - We can identify states that make supplemental payments to physicians affiliated with AMCs but don't have data to understand the extent to which these payments may indirectly support hospital systems

Characterizing Payment Targeting

- We plan to link new non-DSH supplemental payment data with hospital-level DSH data we have already collected to inform discussion of how these payments are targeted and how they interact
- The Commission has previously said that DSH payments should be targeted to hospitals that serve a high share of Medicaid and uninsured patients
  - Supporting financial stability of these providers helps ensure access to care
  - Commission has not said how other supplemental payments should be targeted
- Preliminary analyses of provider-level data in four states show many but not all supplemental payments are targeted to hospitals with high Medicaid utilization

Supplemental Payments as a Share of Medicaid Benefit Spending, by Quartile of Hospital Medicaid Utilization in Selected States



Notes: These findings are confidential, and are not available for attribution or dissemination. DSH is disproportionate share hospital. Q is quartile. Quartiles were calculated based on the hospital's Medicaid inpatient utilization rate (MIUR). Q1 represents the quarter of hospitals in the state with the lowest MIUR and Q4 represents the quarter of hospitals in the state with the highest MIUR. Analysis does not include directed payments to hospitals.
Source: MACPAC, 2023, analysis of state plan rate year 2019 Medicaid DSH audits, fiscal year (FY) 2022 supplemental payment data, FY 2021 Medicare cost reports, and Medicaid and Budget Expenditure System.

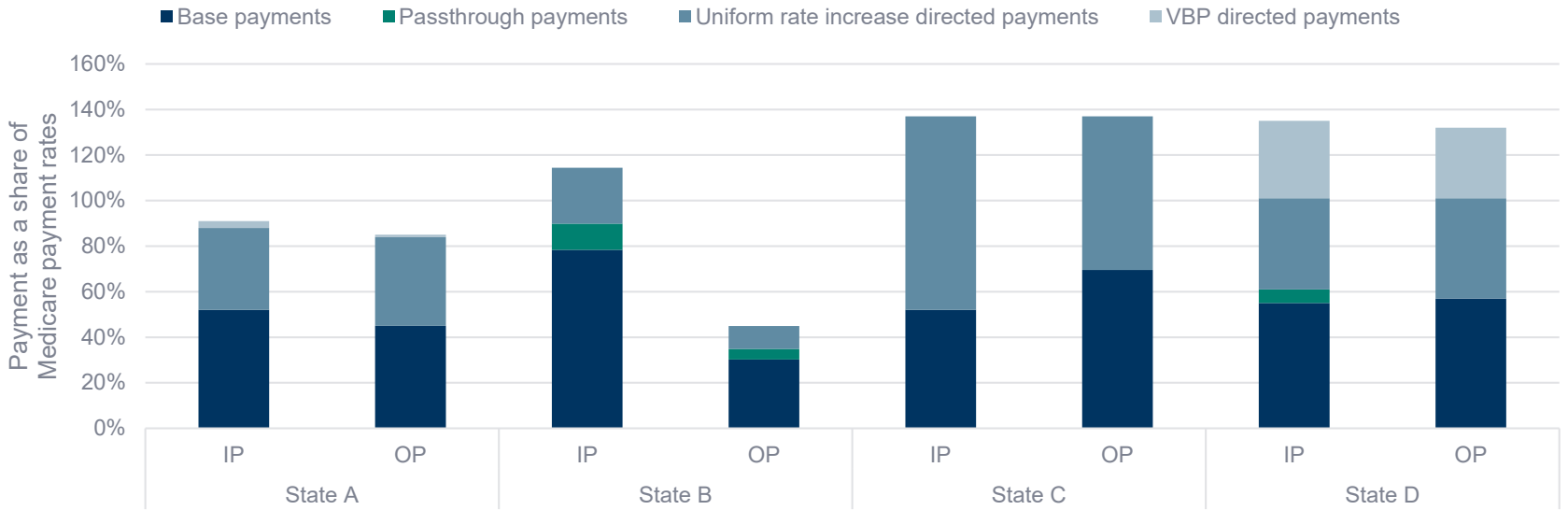
Targeting: Areas for Consideration

- We can assess hospital targeting on multiple dimensions, including:
  - Medicaid utilization
  - Unpaid costs of care for uninsured individuals
  - Hospital finances
  - Other hospital characteristics
  - Geographic factors and racial/ethnic composition of surrounding community
- To what extent does variation in supplemental payment targeting raise federal policy concerns?
  - There is wide variation in targeting policies, which may be the result of a difference in local needs or the methods states use to finance Medicaid payments
  - In 2017, MACPAC examined options to raise the minimum Medicaid utilization threshold for DSH payments but did not arrive at a recommendation

Overall Payment Rates

- We plan to calculate overall hospital payment rates using new supplemental payment data and the Transformed Medicaid Statistical Information System (T-MSIS)
  - Analysis will update MACPAC's prior fee-for-service (FFS) inpatient hospital payment index and potentially include managed care and outpatient hospital data
  - Plan to convene a technical expert panel to inform analysis
- Intended to inform analyses of how payment rates vary by state and how they compare to other payers, such as Medicare
  - Many directed payment preprints currently include analyses of managed care payments to Medicare rates for hospitals receiving directed payments
  - Payments vary widely by state and also vary within states

Medicaid Managed Care Hospital Payments as a Share of Medicare Payment Rates for Hospitals Receiving Directed Payments in Selected States, 2023



Notes: These findings are confidential, and are not available for attribution or dissemination. IP is inpatient hospital payment. OP is outpatient hospital payment. VBP is value-based payment. Payment amounts as a share of Medicare payment rates are reported on the most recent directed payment pre-print approved as of February 1, 2023.
Source: MACPAC, 2023, analysis of directed payment preprint data as of February 1, 2023.

Payment Rates: Areas for Consideration

- How should we account for supplemental payments not intended to pay for Medicaid shortfall?
  - DSH payments also pay for care to uninsured individuals
  - DSRIP and other value-based payment initiatives support quality improvement goals and are difficult to tie to specific Medicaid services
- How should we interpret payment rates without data on provider contributions to the non-federal share?
  - Provider taxes and intergovernmental transfers (IGTs) from public hospitals reduce net payments, but provider-level financing data is not available

Next Steps

- We will present findings from the new supplemental payment analyses as they are ready over the next two years
  - Analyses of payment methods and targeting expected for spring 2024
  - Payment rate analysis will likely not be complete until the next meeting cycle
- At the December 2023 meeting, staff will return with a draft of MACPAC's statutorily required DSH report
  - Due March 2024
  - Will include an extended discussion of next steps for our hospital payment work
- We are also beginning new analyses of barriers to collecting data on the non-federal share of Medicaid payments this report cycle

Summary of Areas for Feedback

- How can we best use the information we are collecting to assess whether hospital payments are consistent with statutory goals?
  - To what extent does variation in supplemental payment methods and targeting raise federal policy concerns?
  - How should we account for supplemental payments not intended to pay for Medicaid shortfall and payments intended to support the overall hospital system?
  - How should we interpret payment rates without data on provider contributions to the non-federal share?

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