April 11, 2024

Update on Supplemental Payment Analyses

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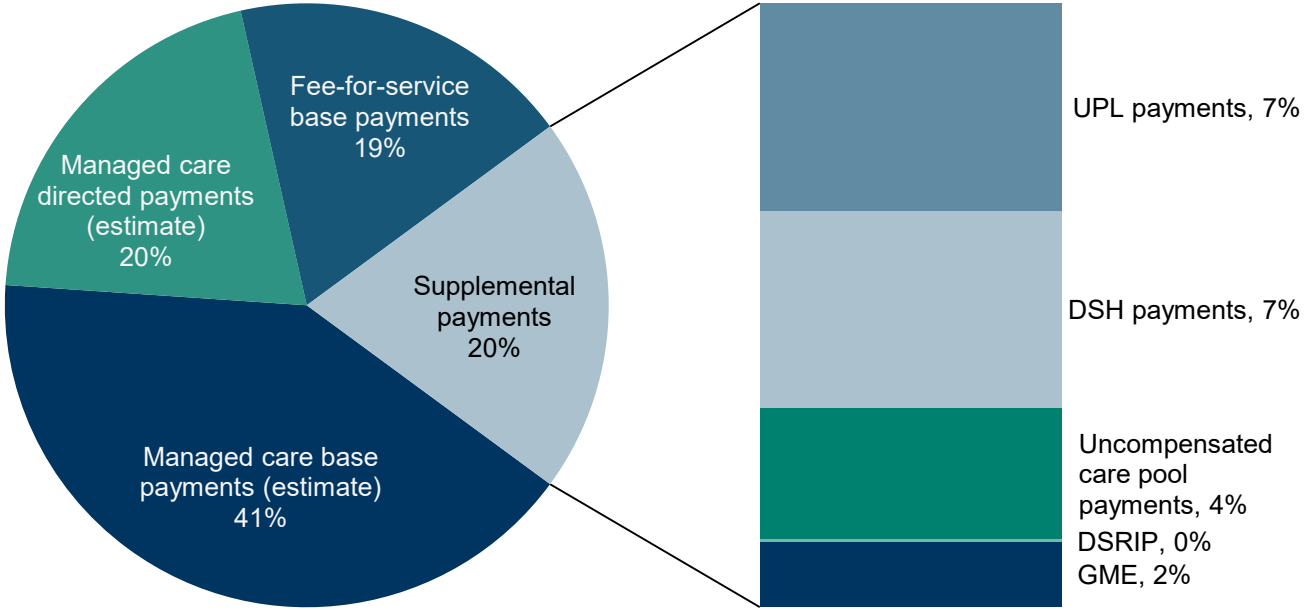
Overview

- Background
  - Types of supplemental payments
  - MACPAC provider payment framework
- Analyses of non-DSH supplemental payment data
- Supplemental payment policy principles
- Next steps

Background

Supplemental Payments are a Large Share of Medicaid Hospital Spending, FY 2022



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. DSRIP spending is a non-zero amount that rounds to 0%.
Sources: MACPAC, 2024, analysis of CMS-64 net expenditure data as of May 30, 2023 and CMS-64 Schedule C waiver report data as of September 29, 2023, and directed payment arrangements approved through February 1, 2023.

Supplemental Payments Have Different Goals

Type of supplemental payment	Total spending (billions)	Number of states reporting spending	Intent of payment implied from federal rules			
			Medicaid-enrolled patients	Uninsured individuals	Quality improvement	Support for specific types of hospitals
DSH	$15.0	47	✓	✓		
UPL	$15.8	35	✓			
GME	$4.9	35				✓
Uncompensated care pools	$10.0	7	✓	✓		
DSRIP	$0.2	7			✓	
Directed payments	$47.8	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 managed care payments and DSH payments to mental health facilities. Number of states reporting spending includes the District of Columbia but excludes the US territories.
Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023; and directed payment arrangements approved through February 1, 2023.

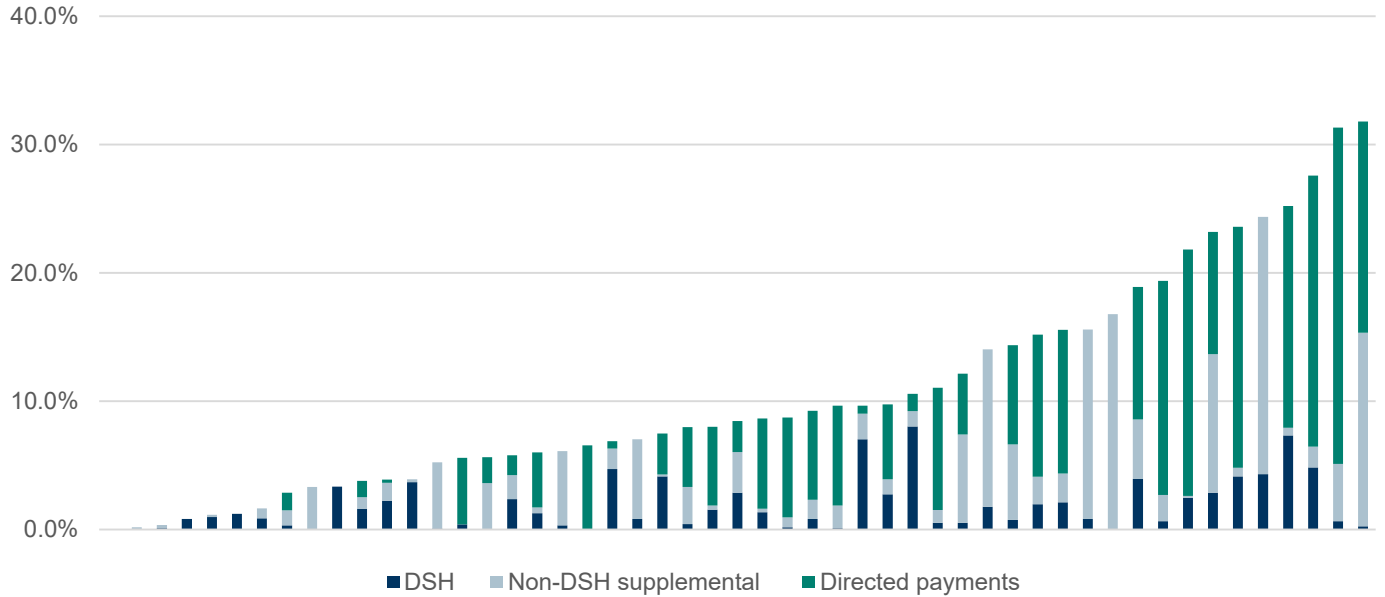
Supplemental Payment Characteristics

Type of supplemental payment	Delivery system	CMS approval	Payment limits
DSH	FFS and managed care	State plan; DSH audit	Total payment limited to DSH allotment Hospital-specific limit of uncompensated care costs for both Medicaid-enrolled and uninsured patients
UPL	FFS	State plan; UPL demonstration	Difference between FFS base payment and estimate of Medicare payment for class of providers
GME	FFS and managed care	State plan	NA
Uncompensated care pools	FFS and managed care	Section 1115 demonstration authority	1115 waiver terms and conditions and budget neutrality
DSRIP	FFS and managed care	Section 1115 demonstration authority	1115 waiver terms and conditions and budget neutrality
Directed payments	Managed care	Managed care rate certification and preprint	Proposed limit of average commercial rate[1]

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. NA is not applicable. 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. DSRIP spending is a non-zero amount that rounds to 0%.
Sources: MACPAC, 2024, analysis of CMS-64 net expenditure data as of May 30, 2023 and CMS-64 Schedule C waiver report data as of September 29, 2023, and directed payment arrangements approved through February 1, 2023.

Supplemental Payments Use Varies by State

Payments as a Share of Medicaid Benefit Spending, FY 2022



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 as of February 1, 2023.
Sources: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023, and directed payment preprint data as of February 1, 2023.

Provider Payment Framework

Analyses of Non-DSH Supplemental Payment Data

New Supplemental Payment Data

- Consolidated Appropriations Act, 2021 requires states to report provider-level data on non-DSH supplemental payments
  - Includes UPL payments, GME, and Section 1115 waiver supplemental payments as reported on the CMS-64 financial management report
  - Also includes narrative information about payment methods
- We analyzed FY 2022 non-DSH supplemental payment data collected by CMS as of June 2023
  - Supplemental payment amounts were reliable but information on base payments was not
  - Most hospitals in the data set could be linked to Medicare cost reports
- We do not have data on provider contributions to the non-federal share necessary to calculate net payments to providers

DSH and Non-DSH Payments by Hospital Characteristics

Hospital characteristics	Number of hospitals		DSH payments (SPRY 2019)		Non-DSH payments (FY 2022)	
	Number	Share of total	Spending (millions)	Share of total	Spending (millions)	Share of total
Total	**6,033**	**100%**	**$17,354.1**	**100%**	**$18,766.9**	**100%**
Receipt of Medicaid supplemental payments						
DSH and non-DSH payments	1,421	24%	$8,999.8	52%	$11,642.7	62%
DSH only	1,107	18%	$8,354.2	48%	—	—
Non-DSH only	1,600	27%	—	—	$7,124.2	38%
No supplemental payments	1,905	32%	—	—	—	—
Urban/ Rural						
Urban	3,578	59%	$15,247.0	88%	$17,320.2	92%
Rural	2,448	41%	$2,069.3	12%	$1,446.6	8%
Deemed DSH status						
Deemed	747	12%	$10,320.6	59%	$7,396.2	39%
Not deemed	5,286	88%	$7,033.4	41%	$11,370.7	61%

Notes: DSH is disproportionate share hospital. Non-DSH payments include upper payment limit supplemental payments, graduate medical education payments, and supplemental payments authorized through Section 1115 demonstration authority. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. FY is fiscal year. Excludes 65 DSH hospitals that did not submit a fiscal year 2021 Medicare cost report. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Total spending includes state and federal funds. Data for DSH hospitals in Montana were estimated using Montana's SPRY 2018 as-filed DSH audit because SPRY 2019 was unavailable.
Source: MACPAC, 2024, analysis of FY 2021 Medicare cost reports, SPRY 2018–2019 as-filed Medicaid DSH audits, and FY 2022 non-DSH supplemental payment data submitted to the Centers for Medicare & Medicaid Services.

Potential Reasons for State Variation

- State DSH allotments
- Federal limits on type of payment
- State delivery system
- State financing methods
- State Medicaid expansion decisions
- Local hospital market characteristics

Use and Distribution of Medicaid Hospital Supplemental Payments in Selected States, FY 2022

State	Supplemental payments as a share of Medicaid benefit spending				Share of hospitals receiving DSH or non-DSH supplemental payments
	DSH (2019)	Non-DSH	Directed payments	Total	
North Dakota	0%	0%	—	0%	71%
New Mexico	0%	3%	5%	8%	64%
Florida	1%	6%	8%	14%	73%
Virginia	0%	15%	16%	32%	69%
New Hampshire	8%	1%	1%	11%	93%

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 as of February 1, 2023. Percentages do not add due to rounding.
— Dash indicates zero. 0% is a non-zero amount that rounds to zero.
Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023, directed payment preprint data as of February 1, 2023, Medicare cost reports, and non-DSH supplemental payment data.

Supplemental Payment Policy Principles

Policy Principles: Areas for Consideration

- To maintain or increase access to services, should states have unlimited flexibility to target supplemental payments to hospitals they identify (e.g. safety net hospitals, teaching hospitals, rural hospitals) or should targeting be tied to specific measures of use or need?
- Given Medicaid's emphasis on economy, should there be limits on supplemental payments (e.g., Medicare, cost), and if so, should there be variation in the limits set for different types of supplemental payments?
- How should policymakers evaluate the efficiency of hospital supplemental payments? How can we measure, quantify, and assess the outcomes that these payments produce?

Next Steps

- Continue reviewing the non-DSH supplemental payment narratives and develop a compendium of supplemental payment methods
- Convene a technical expert panel to discuss the feasibility of developing a payment index to assess total base and supplemental payments across states and relative to external benchmarks
- Update MACPAC's issue brief analyzing managed care directed payment spending

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