

Factors Affecting the Development of Medicaid Hospital Payment Policies: Findings from Structured Interviews in Five States

Final Report

to the Medicaid and CHIP Payment and Access Commission

By

Thomas Marks

Kathy Gifford

Steven Perlin

Melisa Byrd

Timothy Beger

Health Management Associates

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About Health Management Associates

Health Management Associates (HMA) is a consulting and health policy research firm specializing in health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, providers, and foundations, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, HMA has offices in Albany, New York, Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Indianapolis, Indiana; Harrisburg, Pennsylvania; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento, California; San Francisco, California; Seattle, Washington; Southern California; Tallahassee, Florida; and Washington, DC.

About the Authors

Thomas Marks is a principal in HMA's Lansing office. Tom has nearly 40 years of experience in hospital and health care system finance including over 20 years on the leadership team for a large academic health system and 13 years with an international certified public accounting firm specializing in hospital audit and advisory services. Tom's primary area of expertise is in Medicaid and Medicare payment methods for hospitals including analysis of DSH and non-DSH supplemental payments and provider financing programs. Tom also has extensive experience in health care financial reporting and accounting, developing financial plans and forecasts, cost report analysis, and regulatory evaluation and analysis.

Kathy Gifford is a principal in HMA's Indianapolis office and a leading expert on state Medicaid programs, advising clients on the challenges, opportunities and complexities that arise in a program designed and administered differently in every state. She assists public and private sector clients with projects involving program and policy analysis and market research and analysis. Since 2002, she has also played an integral role in (and currently leads) HMA's annual Medicaid Budget Survey conducted on behalf of the Kaiser Family Foundation, which includes structured interviews of Medicaid officials in all 50 states and the District of Columbia as well as preparation of a survey report with key findings, data, and analysis.

Steve Perlin, MBA, is a managing principal in HMA's Chicago office. With over 20 years of experience in health finance, policy development, and legislative advocacy, Steve has worked with hospitals, health systems, and hospital associations in over 25 states on issues related to preserving and enhancing Medicaid rates to ensure the delivery system has the resources to serve the state's most vulnerable and neediest citizens. Steve has worked on the redesign of Medicaid inpatient and outpatient reimbursement systems, the development of provider tax and intergovernmental financing structures, and helped facilitate coverage expansion efforts. He has also worked on Medicare and uncompensated care issues affecting hospitals.

Melisa Byrd is a senior consultant in HMA’s Washington, DC office. She has more than 15 years of experience in health policy at the state and local levels, focusing on expanding health insurance coverage to the uninsured. Melisa’s expertise is in Medicaid policy and program development, analysis, and implementation. She follows federal and state developments related to health reform and Medicaid expansion, 1115 Medicaid demonstration waivers, and reproductive health.

Timothy Beger is a consultant in HMA’s Washington DC office. He has experience conducting policy research, analysis, and evaluation support throughout a variety of healthcare environments, from state and local governments to health systems. Tim also specializes in structured project management support, assisting staff and clients, ensuring projects objectives are accomplished.

About the Funder

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children’s Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC’s 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

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SUMMARY OF KEY FINDINGS

States make different types of Medicaid payments to hospitals and have broad flexibility to design their own payment methods. The two broad categories of payments are (1) base payments, which are typically made for individual hospital encounters and (2) supplemental payments, which are typically made in a lump sum manner for a fixed time interval (such as a month, quarter or year). States vary in the mix of base and supplemental payments that they make, as well as in the methods they use to finance the non-federal share of these payments. States may use several models and methods to pay hospitals to meet their program goals, and often seek to change models and methods as goals change. Most states use comprehensive managed care as their primary Medicaid delivery system, requiring different paths from fee-for-service to meet the goals. All these factors make Medicaid hospital payments complex.

To better understand the factors that affect the development of Medicaid hospital payment policies, MACPAC contracted with Health Management Associates (HMA) to perform research on hospital payment policies and conduct structured interviews in five states that vary in their use of supplemental payments and financing approaches, and have recently made or are making significant changes in hospital policy (Arizona, Louisiana, Michigan, Mississippi, and Virginia). This report reviews findings from the policy research and interviews with state officials, representatives from hospital associations and managed care organizations, national experts, and staff from the Centers for Medicare & Medicaid Services (CMS).

Three overarching themes emerged from this work:

- 1. The availability of financing for the non-federal share of Medicaid payments has affected states' use of base and supplemental payments**

All study states reported challenges with providing increases in base payment rates for hospitals using state general funds. Many states reduced hospital payment rates during the 2007-2011 recession, and even after state budgets improved in recent years, all five states surveyed for this report have kept base rates frozen with no adjustment for inflation in most, if not all recent years. Consequently, base payments to hospitals in these states are lower today relative to hospital cost than they were before the most recent recession.

In addition to freezing or reducing base payments to hospitals, many states have increased the use of permissible provider financing of the non-federal share of Medicaid payments, including provider assessments (sometimes referred to as provider taxes), intergovernmental transfers (IGTs), and certified public expenditures (CPEs). In the study states, use of these financing mechanisms varied based on their willingness to impose new or increased assessments, hospital market characteristics, and the role of public hospitals in the state. In addition, the desire to offset state costs of expanding Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) was a factor in some states' decisions to impose new or additional provider assessments.

To address the growing gap between base payments and cost, many states collaborated with hospitals to establish or increase supplemental payments, using the provider financing plus federal match to fund the additional payments. Hospitals and Medicaid administrations often prefer increased supplemental payments rather than increases to base payment rates. Supplemental payments offer hospitals more

certainty and predictability than base payments. Hospitals view the supplemental payment they receive and the assessment or IGT that they pay as two parts of the same transaction, and they prefer that this transaction is separate from base payments to measure the extent to which their assessments or IGT payments are recouped through the supplemental payment. Hospital representatives interviewed expressed concerns that if provider taxes or IGTs were used to increase base payment rates in lieu of increased supplemental payments, then a portion of the funds could be diverted to non-hospital providers or retained by managed care organizations (MCOs).

2. The use of Medicaid managed care does not substantially affect Medicaid rates and methods used to pay hospitals

Although Medicaid managed care plans usually can pay rates different than fee-for-service (FFS) Medicaid, the managed care plans in the study states used FFS methods and rates for most base payments to hospitals. Managed care plan representatives interviewed cited a variety of reasons for using FFS rates, including the fact that capitation rates from states to plans are often initially developed based on FFS rates, the use of FFS rates as a rate floor for non-contracted providers, and the complexity of developing alternative payment models that differ from FFS rates.

Four of the study states have developed or are developing methods to make supplemental payments in managed care that are similar in purpose to upper payment limit (UPL) supplemental payments in FFS. Prior to the 2016 revisions to the Medicaid managed care rule, many states required managed care plans to make lump-sum payments to providers, referred to as pass-through payments. The managed care rule requires states to phase out the use of pass-through payments, but it provides a new option for states to direct health plans to make additional payments to providers for rate improvements or quality improvement activities.

Four of the five study states have or are developing a directed payment, and in three of the four states it is intended to fill a large part of the gap between base payments and the amount that Medicare would have paid for the same service (referred to as the UPL gap in FFS). The study states that have or had pass-through payments have been able to make payments to hospitals under the new directed payment option, although the size and distribution may vary. These directed payments are only approved for one year at a time, however, and CMS may require changes to these programs when it reconsiders them in the future.

3. States expressed a desire to adopt more sophisticated payment models and adopt value-based payment approaches, but progress is slow

Most states have adopted or are adopting prospective payments systems for hospital services, such as diagnostic-related groups (DRGs), which have long been used by Medicare and commercial payers. These systems create incentives for providers to be more efficient and increase appropriateness of care and are generally considered more equitable and accurate than methodologies based on a percentage of charges or per-diem payments.

Interviewees noted several reasons why adoption of prospective payment systems has been slower in Medicaid than with Medicare and commercial payers. The most commonly cited barrier to change is the financial risk for providers associated with making a significant change. While states may work to implement new payment methods in a budget neutral manner, hospitals may nevertheless resist the

change, fearing that the new system will redistribute payments within the state, creating winners and losers. There are also significant operational and administrative costs involved in making changes in payment methods, which are a barrier for resource-constrained Medicaid agencies.

States that use similar prospective payment models differ in their use of payment adjustments to target payments to certain types of hospitals and services. Payment adjustments frequently reflect policy goals, such as increasing rates or DRG weights to hospitals with a high-percentage of Medicaid patients, and services that are critical in the Medicaid population, such as neonatal care, obstetrics, pediatrics, and behavioral health. Also, rural hospitals are frequently prioritized in hospital payment models, in recognition of their vulnerability and concerns about access to services in remote areas.

Currently, value-based payment models for hospital services are used sparingly in the five states studied for this report, but states and key stakeholders expect to see an increase in the use of value-based payments in the future. According to the stakeholders interviewed, barriers to adopting value-based payments include the complexity of measuring value and the fact that hospitals are reluctant to put any of their Medicaid base payment at risk, especially because they believe that base payments are already well below cost. Some state officials acknowledged that value-based payment was not a top priority, and some health plans noted that they were prioritizing value-based payments to physicians rather than value-based payments to hospitals to meet statewide value-based payment goals.

INTRODUCTION

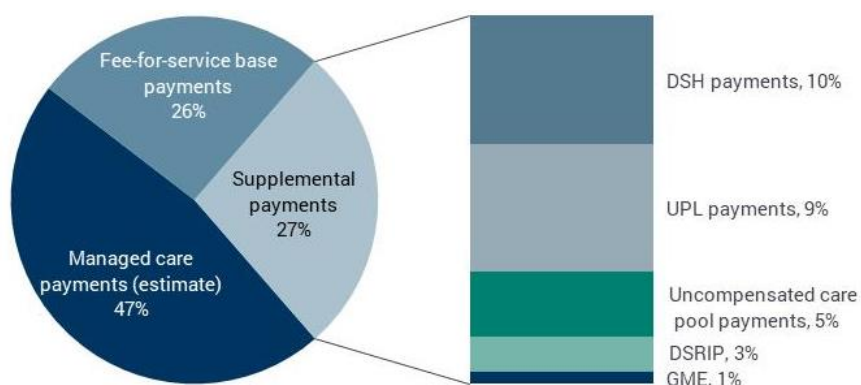
Background

States are required to provide access to hospital services for Medicaid enrollees, but they have considerable flexibility to design their own hospital payment methods. Nationwide, Medicaid spent \$189.8 billion on hospital care in 2016 and Medicaid payments to hospitals accounted for 18 percent of total payments to hospitals in 2016.¹

Medicaid hospital payment policy is an important focus area for state and federal policymakers, since Medicaid consumes a significant share of state budgets and hospital spending accounts for the largest share of total Medicaid spending (34 percent in 2016).² As states have struggled to assure access to cost-effective, high quality hospital services within often difficult budget constraints, Medicaid hospital payment methodologies have become increasingly complex.

For fiscal year (FY) 2016, MACPAC estimated that 53 percent of Medicaid payments to hospitals were made on a fee-for-service (FFS) basis and 47 percent were made through managed care delivery systems (Figure 1). About half of FFS payments were base payments, which are typically made for individual hospital encounters and the other half were supplemental payments, which are typically made in a lump sum manner for a fixed time interval (such as a month, quarter or year). There are several different types of Medicaid supplemental payments to hospitals (Box 1).

FIGURE 1. Base and Supplemental Payments as a Share of Total Medicaid 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 demonstrations. 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.

¹ Estimates of Medicaid hospital spending in National Health Expenditures Accounts data include both fee-for-service (FFS) and managed care payments for inpatient and outpatient hospital services. They also include payments for nursing facility services and home health services provided by hospitals.

² Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS). 2017. *National health expenditures by type of service and source of funds: Calendar years 1960–2016*. Baltimore, MD: OACT. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

Box 1. Types of Medicaid Payments to Hospitals

Base payment: A payment for a defined unit of service, such as an inpatient stay or outpatient visit.

Supplemental payment: A payment to a provider, typically in a lump sum manner for a fixed time interval (such as a month, quarter or year), that is made in addition to the base payment.

Disproportionate share hospital (DSH) payments: Statutorily required payments to hospitals that serve a high share of Medicaid and low-income patients. State DSH spending is limited by federal allotments and federal statute limits the amount of DSH payments that an individual hospital can receive to hospital uncompensated care costs for Medicaid-enrolled and uninsured patients.

Upper payment limit (UPL) payments: Payments that are intended to fill in the difference between fee-for-service base payments and the amount that Medicare would have paid for the same service. In the aggregate for each class of providers, FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles.

Graduate medical education (GME) payments: Payments to support the direct costs of graduate medical education incurred by teaching hospitals and the higher costs borne by teaching hospitals associated with treating more resource-intensive patient populations. GME payments may be made as part of base payments or a supplemental payment.

Managed care supplemental payments: Payments to providers for rate increases or quality improvement activities that states require managed care plans to make in addition to their base payments.

Section 1115 supplemental payments: Uncompensated care pool payments and delivery system reform incentive payments (DSRIP) are examples of supplemental payments authorized under Section 1115 demonstration authority. These payments are not otherwise permitted without a waiver.

Like other Medicaid payments, states must provide non-federal share to draw down federal matching funds for Medicaid hospital payments. States can use a variety of sources to finance the non-federal share, including state general funds, funds provided by local units of government, and funding from providers (Box 2). The most recent nationally available data on the sources of funds that states used to finance the non-federal share of Medicaid payments is from a 2014 survey by the U.S. Government Accountability Office (GAO), which found that states were more likely to use funds from providers to finance the non-federal share of supplemental payments than they were to use these sources to finance base payments: in FY 2012, approximately 63 percent of DSH payments and 75 percent of non-DSH supplemental payments were financed by non-state sources, compared to approximately 30 percent of total Medicaid payments.³

States vary widely in the methods used to pay hospitals, the mix of base and supplemental payments, the approaches that they use to finance Medicaid payments, and the overall level of payment to hospitals, but there is little publicly available information to explain this variation. In particular, there is limited information on managed care payments to hospitals, despite the fact that managed care payments account for nearly half of Medicaid payments to hospitals.

³ United States Government Accountability Office, "MEDICAID FINANCING: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection", July 2014

Box 2. Sources of Non-Federal Share for Medicaid Payments

Non-federal share: State or local funds that states are required to draw down federal matching funds for Medicaid expenditures. The statute allows states to provide up to 60 percent of the non-federal share from non-state sources.

State general funds: State funds from revenues raised through income, sales, and other broad-based state taxes, and fees.

Provider assessments: Funds from health care-related assessments or taxes levied on providers, such as hospitals. Provider assessments must be levied uniformly against all providers in a class and providers generally cannot be held harmless through a guarantee that they will be repaid for taxes that they pay.

Intergovernmental transfers (IGTs): Transfers of public funds between governmental entities, including local governments and hospitals owned by state or local governments.

Certified public expenditures (CPEs): Expenditures by hospitals or other providers that are owned and operated by local governments that can be used to document state Medicaid spending to obtain federal matching funds. The governmental provider certifies that the funds expended are public funds used to provide Medicaid-covered services. Based on this certification, the state then claims federal matching funds. Unlike IGTs, CPEs do not involve a transfer of money to finance the non-federal share.

Objectives

To better understand how states develop their hospital payment policies, MACPAC contracted with HMA to research state payment policies and conduct structured interviews in states that used a variety of methods to pay hospitals and had made recent changes in their hospital payment policies. Specifically, this project was intended to inform six key 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 types of hospitals or services, and how do they determine which hospitals or services to target?
- How do FFS payment policies affect managed care payments to hospitals?
- What are the drivers and what are the barriers to changing hospital payment methods?
- How are states planning to change hospital payment policies in the future?

Methodology

In consultation with MACPAC, HMA identified five states that met the study criteria (Arizona, Louisiana, Michigan, Mississippi, and Virginia). These states were selected from among over 20 states that made significant changes in hospital policy since 2014 or are making significant changes, which HMA identified using several sources, including MACPAC compendia on inpatient and outpatient hospital policies by state, CMS' website on state plan amendments, and internet searches (Box 3). To better understand how hospitals are paid in managed care, the list of potential states was limited to those that use managed care as the predominant delivery system. To narrow the list to five states, HMA and MACPAC staff selected states that reflected a range of uses of supplemental payments, variations in approaches

to financing Medicaid payments, geographic diversity (region and urban/rural mix), and Medicaid expansion status (Table 1).

Table 1. Characteristics of Selected States

State	Rural hospitals' share of adjusted patient days	Share of enrollees in comprehensive managed care	Medicaid expansion status
Arizona	3%	93%	Adopted in 2014
Louisiana	12%	92%	Adopted in 2016
Michigan	21%	75%	Adopted in 2014
Mississippi	63%	70%	No expansion
Virginia	14%	76%	Adopting in 2019

Source: Rural hospitals' share is from HMA analysis of the American Hospital Association annual hospital survey database, 2016 information. Share of enrollees in managed care is from Henry J. Kaiser Family Foundation (KFF). Share of Medicaid Population Covered under Different Delivery Systems FY 2017. <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/>

Box 3: Recent and Planned Changes in Hospital Policy in Study States

Arizona

- Implemented the All-Patient Refined Diagnostic Related Groups (APRDRG) system with a statewide base rate in FY 2015, replacing per diem rates.
- A directed quality incentive used in managed care and in FFS is increased in FY 2019.

Louisiana

- Implementing the APRDRG system with a statewide rate in 2019, replacing per diem rates. A significant portion of DSH payments will be eliminated and included in the new inpatient rates.

Michigan

- Implemented the APRDRG system with statewide rates in FY 2015, replacing Medicare Severity Diagnosis Related Groups (MS-DRGs) with hospital-specific rates.
- Replaced a managed care pass-through payment with a percentage add-on to inpatient and outpatient managed care encounters, a directed payment, in FY 2018.

Mississippi

- Converted its UPL payments to a managed care pass-through payment in 2016, coinciding with the transition of inpatient services from FFS to managed care.
- In FY 2018, began a multi-year transition of the pass-through payment to directed payments consisting of rate adjustments and quality incentive payments.

Virginia

- Adopted Enhanced Ambulatory Patient Groups (EAPGs) for hospital outpatient services in FY 2014 with a three-year transition, replacing legacy fee schedules.
- Converted to the APRDRG system in FY 2015, replacing another, less sophisticated DRG model.
- Planned for FY 2019: a UPL payment and a directed payment to supplement managed care payments with a percentage add-on to managed care encounters. The state share of both new payments will be financed by two new hospital assessments, also under development.

For each state, HMA researched methods and payment amounts for hospital base payments and supplemental payments in both FFS and managed care, as well as the extent of hospital financing of the state share of Medicaid payments. These findings are documented in state-by-state profiles provided in Appendix B.

HMA conducted structured interviews for each state with the department or agency responsible for administering the Medicaid program, the state's primary hospital association, and one contracted managed care plan. Interviewees responded to a series of questions regarding the payment environment, payment methods, payment outcomes, and recent/future changes in policy.

To supplement the state interviews, HMA also interviewed representatives from two firms with national expertise in Medicaid hospital payments to gain perspective on trends, similarities and variations in hospital payment policy, and interviewed representatives from CMS to better understand the review processes employed by CMS and the agency's goals for hospital payment policy. A listing of organizations interviewed is in Appendix A.

Interview and research findings for the five states cannot be extrapolated to all states as each state's Medicaid program is unique. However, common themes that emerged from these state interviews provide insight into the six key policy questions listed above and can help inform broader discussions about the factors that influence state decision-making about Medicaid hospital payment policy.

FINDINGS

Overall Hospital Payments

Summary of FY 2016 Hospital Payments

The study states varied widely in their use of base and supplemental payments in FY 2016 (Table 2). Supplemental payments as a share of total payments to hospitals ranged from 18.1 percent in Arizona to 61.2 percent in Louisiana. Managed care base payments are significantly larger than FFS base payments in all states. Three states make large supplemental payments in managed care (Louisiana, Michigan, and Mississippi) and a fourth state (Virginia) is planning to implement a managed care supplemental payment in FY 2019. The fifth state, Arizona, relies primarily on base payments in FFS and managed care.

Table 2. FY 2016 Hospital Payment Distribution in Study States

Type of payment		Arizona ¹	Louisiana ²	Michigan	Mississippi	Virginia ³
Base payments	Fee-for-service base payments	18.6%	6.5%	10.0%	15.3%	25.5%
	Managed care base payments	63.3%	32.4%	40.3%	40.2%	52.2%
	Subtotal base payments	81.9%	38.8%	50.3%	55.5%	77.7%
Supplemental payments	Disproportionate share hospital	4.9%	38.9%	6.8%	13.1%	8.8%
	Upper payment limit	4.7%	2.9%	12.9%	0.0%	0.1%
	Graduate medical education ⁴	8.1%	0.7%	3.0%	0.0%	13.4%
	Supplemental payments in managed care	0.4%	18.7%	27.0%	31.4%	0.0%
	Subtotal supplemental	18.1%	61.2%	49.7%	44.5%	22.3%
Grand Total		100.0%	100.0%	100.0%	100.0%	100.0%

Notes: FY is fiscal year. Some states have made or are planning to make policy changes that will affect the distribution of base and supplemental payments in subsequent years.

(1) Arizona eliminated uncompensated care pool payments in FY 2017 (classified as other supplemental payments above) and added new directed managed care payments since FY 2016.

(2) Louisiana is planning to shift a significant portion of DSH payments to base payments in 2019.

(3) Virginia is planning to implement a new UPL payment and a new directed managed care payment in FY 2019.

(4) Some states, such as Mississippi, make GME payments as adjustments to base rates rather than as supplemental payments.

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.

Sources of Non-Federal Match

Many states frequently use permissible provider financing of the non-federal share of Medicaid payments, including provider assessments (sometimes referred to as provider taxes), intergovernmental transfers (IGTs), and certified public expenditures (CPEs). Hospitals contribute a significant portion of the state share of Medicaid hospital payments in the study states. Four of the five states analyzed for this report rely heavily on provider-related financing, and the fifth state is adding a significant hospital assessment in FY 2019, to pay the state share of hospital supplemental payments. Furthermore, hospitals in each of the states pay or will pay an additional assessment that helps the state finance the Medicaid program more generally (Table 3).

Table 3. Provider-Related Financing of State Share of Medicaid Hospital Costs in Study States

State	IGTs	CPEs	Provider assessment	Tied to specific hospital supplemental payments	Used for broader Medicaid purposes
Arizona	✓	✓	✓	IGTs used to fund state share of GME and part of DSH; CPEs from state and large county hospitals finance most of DSH	Assessment helps fund state share of services to the ACA expansion population
Louisiana	✓	✓	✓	IGTs fund the state share of most of DSH and managed care supplemental payments; CPEs from rural hospitals used for a portion of managed care supplemental payments	Assessment funds the state share of hospital services to the expansion population and certain base rate adjustments; CPEs from large public hospitals generate additional federal funds
Michigan		✓	✓	Assessment funds the state share of nearly all the UPL and managed care directed payments, and the outpatient DSH pool; CPE is used for a portion of DSH	The assessment provides the state with a portion of the federal share of assessment-funded supplemental payments, plus additional fixed annual amounts
Mississippi			✓	The hospital assessment funds the state share of all hospital supplemental payments	The assessment provides the state with a fixed annual amount in addition to financing supplemental payments
Virginia	✓	✓	Planned	Assessments will fund the state share of new UPL and managed care directed payments	Assessments will fund the state share of services to the expansion population; a small CPE is used for general Medicaid purposes

Notes: IGT is intergovernmental transfer. CPE is certified public expenditures. Provider assessment is a health care-related tax used to fund the non-federal share of Medicaid payments.

Source: HMA review of state hospital payment policies.

Payment Adequacy

Medicaid payments to hospitals must be sufficient to enlist enough providers so that services are available to Medicaid-enrolled patients at least to the extent that they are available to the general population in the geographic area (§1902(a)(30)(A) of the Social Security Act). CMS assesses the adequacy of FFS payments when it reviews state plan amendments and requires states to submit access monitoring review plans for certain services every three years; whenever a state proposes reductions in provider payments, the state must demonstrate that access is sufficient and monitor access after the reduction (42 CFR §447.203). Under managed care, payment adequacy is addressed more broadly by requiring states to pay actuarially sound rates to MCOs and by requiring MCOs to meet network adequacy requirements.

The Medicaid agencies and hospital associations in the study states generally believe that hospital payment adequacy should be measured by comparing payments (including supplemental payments) to the hospitals' costs. The difference between Medicaid costs and the Medicaid payments that a hospital receives is often referred to as Medicaid shortfall. When calculating Medicaid shortfall, these stakeholders believe that payments should be reduced by the full amount of provider financing of the

state share, from assessments, IGTs and CPEs, as a reduction of revenue. As required in statute, CMS uses the gross payment that hospitals receive for UPL calculations, DSH limits, and other purposes, an amount which is higher and not reflective of hospitals' net patient service revenue.

None of the five study states or their hospital associations routinely measures payment adequacy, but most have access to past studies performed on this topic. In one state the Medicaid agency cited its access monitoring work as a measure of payment adequacy, and indeed ensuring access is one of the most important goals of Medicaid payment policy, but this is not a quantitative analysis. Two of the study states cited ranges of hospital payment to cost ratios from previous analyses they had seen or had performed. Four of the five hospital associations quoted cost coverage percentages from work they have seen or previously performed.

Most interviewees noted that Medicaid hospital payments do not cover the costs of hospital services. The cost coverage percentages cited by interviewees range from 70 percent to 90 percent of cost. In some states, there was a difference between the percentage referenced by the Medicaid agency and the percentage referenced by the hospital association. These differences may be caused by timing or whether provider financing is included in or excluded from the estimate.

Impact of Medicaid shortfall

Most interviewees expressed concerns about the impact of low levels of payment from Medicaid, including supplemental payments. One frequently noted concern is the challenge faced by managed care organizations in getting providers to accept value-based payments; when payments are perceived to be too low there is hesitancy to put more of that payment at risk. Some interviewees also noted the impact that low Medicaid payment levels have on private insurance payment rates, as hospitals must receive payment above cost from other sources to offset below-cost payment from Medicaid.

Despite the low level of payment relative to cost, none of the interviewees reported that low levels of Medicaid payment have directly resulted in an inability to meet access requirements. Several interviewees expressed concerns about access in rural areas. Several rural hospitals have closed in recent years and many report financial difficulties. With fewer rural hospitals, significant travel is often required for enrollees in less-populated regions. However, these concerns were generally attributed to issues in the larger health care market and not Medicaid payment levels specifically. Several respondents raised concerns about access to physician services, which affects hospitals that employ or are affiliated with physician groups, but access to physician services was outside the scope of this study.

Factors Affecting Overall Hospital Payment

Interviewees described several factors that affected the mix of base and supplemental payments, their use of different methods to finance hospital payments, and overall hospital payment adequacy. These factors include:

- Challenges financing rate increases with state general funds
- State and provider willingness to use provider funding for Medicaid hospital payments
- State and provider preferences for supplemental payments
- Medicaid policy changes related to:
 - Expansion of managed care
 - ACA Medicaid expansion
 - Pending DSH allotment reductions

Challenges financing rate increases with state general funds

Because hospital payments account for a large portion of state general funds, when state budgets are constrained, it is not uncommon for states to reduce the rate of growth in hospital payments. This was the case during the 2007–2011 recession, when hospital base payment rates were frequently either frozen or reduced in study states. While each of the study states recovered economically from the recession, hospital base payment rates continue to be held in check in nearly all recent years in all five study states.

In recent years, hospital payment rates have decreased or stayed the same in all five study states (Table 4). In Arizona and Louisiana there were specific rate reductions that were related to the 2007-2011 recession, and respondents noted that state financial challenges related to that recession also affected their ability to increase rates.

Table 4. Summary of Recent Hospital Rate Changes in Study States

State	Recent changes
Arizona	No inflation increases in hospital rates from 2007-2017, and three 5% rate reductions occurred during the 2007-2011 recession.
Louisiana	A series of rate reductions during the 2007-2011 recession that hospitals estimate reduced rates by 20% or more, and rates were frozen in most years since then.
Michigan	No rate reductions but only one increase in hospital base rates since the 1990s.
Mississippi	No inflationary rate increases for hospitals since 2012.
Virginia	Eliminated inflation increases in seven of the past eight years.

Source: HMA interviews with state officials and hospital associations.

There is a general expectation in the hospital industry that payment rates will be updated annually to account for the impact of inflation on hospitals' operating expenses. Consequently, a rate freeze or withhold of inflation can have a negative impact on hospital financial results.

State and provider willingness to use provider funding for Medicaid hospital payments

As base rates have been frozen or even reduced, states have increased their reliance on assessment-financed and IGT-financed Medicaid payments that do not require state general funds. However, there are differences among states in their use of provider-financing mechanisms; one important factor appears to be the willingness of states and providers to use these funding sources.

Hospitals are reluctant to support and may opt to oppose additional provider financing if they believe the payment to the state will exceed the additional Medicaid payment. Differences in the distribution of Medicaid patients among hospitals may affect individual providers' willingness to pay an assessment in exchange for higher Medicaid payments. Because provider assessments must be broad-based and uniform, it is difficult to minimize the number of hospitals who pay more in their assessment than they receive in increased payments in states where the Medicaid patient volume is concentrated in relatively few hospitals.⁴

⁴ In addition, provider assessments must comply with other regulatory requirements, such as the hold harmless provision and requirements for defining the class of providers that are taxed, which can affect the number of hospitals that receive more in payments than they pay in assessments.

Another variable is the state political context. Interviewees noted that state legislators may oppose increasing a provider assessment, even if the hospital industry supports the assessment, because of concerns about the rising cost of health care and growth of the Medicaid program or political concerns about raising taxes or assessments more generally.

State and provider preferences for supplemental payments

Providers and states prefer to use provider funding for UPL and managed care supplemental payments rather than base rate increases. State and hospital stakeholders interviewed provided several reasons why there is a preference for supplemental payments.

The primary reason is increased certainty and predictability. As noted above, most of the UPL and managed care supplemental payments in the five-state sample are financed by provider assessments and IGTs. Hospitals view the supplemental payment they receive and the assessment or IGT they pay as two parts of the same transaction and are interested in measuring the extent to which their assessment or IGT payments are generating positive or negative results when the two parts of the transaction are netted together. Also, supplemental payments are often disbursed in monthly or quarterly installments, which further increases the certainty and predictability of this revenue source. Lastly, hospital association representatives interviewed expressed concerns that if base payment rates were increased in lieu of supplemental payments, a portion of the funds may be diverted to non-hospital providers or retained by the MCOs, which reduces the net value of the provider-financed program to the entities providing the financing.

Supplemental payments to hospitals may offer an advantage to states because they can be more easily changed than base payment rates. Some states only have authority to implement provider assessments for a certain number of years, and supplemental payments can be more easily eliminated in the future if the provider assessment is no longer available.

Supplemental payments are also the preferred mechanisms for targeting increases for specific types of providers that are intended to support the hospital's overall operations. For example, small and rural hospitals have Medicaid patient volume that is more unpredictable than large, urban hospitals; if increases to small and rural hospitals are added to base rates, states cannot be as certain that the funds will get to providers as they could be with a supplemental payment. Lastly, it is common to use supplemental payments for GME instead of base rate adjustments. Recognizing the higher costs that teaching hospital incur may be a state policy objective and using a supplemental payment may achieve that objective without causing the teaching hospital to have less competitive base rates. In one study state, an informant noted that GME adjustments to the base payment rates create challenges for MCOs who may prefer not to pay the higher rate for services that are also available at hospitals with smaller or no GME adjustments.

Recent policy changes

Respondents noted that state Medicaid hospital payment policies were affected by the use of managed care, state decisions to expand Medicaid under the ACA, and pending DSH allotment reductions. The following section explores each of these factors in more detail.

Managed care expansion

States that rely on UPL payments to fill or reduce the base payment shortfall in FFS have a special challenge when a significant portion of hospital services is transitioned from FFS to managed care.

Federal regulations do not allow states to continue to make UPL payments for services covered by managed care. As explained further below, federal regulations do permit states to direct payments to providers under managed care in certain circumstances.

Four of the study states direct (or in the case of Virginia, will direct) payments to hospitals pursuant to federal regulations on managed care. States want to preserve payments to hospitals when making the transition from FFS to managed care, and generally want to ensure parity between FFS and managed care when considering payment increases.

In one study state, Mississippi, the transition from FFS to managed care for hospital inpatient services was delayed because of concerns by the hospitals and the state about the UPL payment that was in place. However, in FY 2016 the UPL was eliminated and replaced with a managed care supplemental payment.

Medicaid expansion

All states in the study that expanded Medicaid relied on hospitals to help finance the state costs of the expansion. Arizona and Louisiana implemented hospital assessments, and Michigan increased its hospital assessment, to support the non-federal share of expansion. Virginia is planning to use a hospital assessment to fund the non-federal share of expansion as well.

Hospitals have an incentive to support Medicaid expansion because reductions in the number of uninsured significantly reduce hospital charity care and bad debt costs. Medicaid expansion can also increase hospital patient volume as access to health care may improve when previously uninsured persons gain coverage. In all five study states, hospitals receive or will receive additional base payments for services to expansion enrollees and in Louisiana and Michigan, supplemental payments were increased in connection with expansion too. Virginia's new supplemental payments will apply to traditional Medicaid and the expansion program.

The changing federal match rate for Medicaid expansion populations may affect hospital assessments and hospital provider payments in the future. From calendar year (CY) 2014 – 2016, the federal matching rate for the expansion population was 100 percent but decreases in each of the next four years as follows: 95 percent in CY 2017, 94 percent in CY 2018, 93 percent in CY 2019, and 90 percent in CY 2020 and beyond. In states where the hospital assessment is linked to the non-federal share of expansion costs (Arizona, Louisiana and Virginia), the increase in non-federal share will cause the assessments to grow significantly. One state indicated that the additional assessment may cause the program to consider rate improvements to mitigate some of the effect on hospitals.

Pending DSH allotment reductions

In Louisiana, pending federal DSH allotment reductions are one of the reasons why the state is currently planning to shift supplemental payments into base rate increases. Under current law, federal DSH allotments are scheduled to decrease by \$4 billion (31 percent) in FY 2020 and \$8 billion a year in FYs 2021 – 2025.

DSH payments account for a larger share of hospital spending in Louisiana than other states because the state has a very large DSH allotment relative to other states. (DSH allotments are based on state DSH spending in 1992, when DSH allotments were established.)

Louisiana determined the amount it would increase Medicaid base payments based on the portion of DSH payments allocable to Medicaid shortfall. DSH payments also pay for unpaid costs of care for the uninsured, and this portion of DSH payments will continue.

In contrast, the other study states are not currently planning to make other changes to hospital payment policies in response to DSH reductions. Most of the other study states indicated that they have a tentative plan for reducing DSH payments in the state and will generally reduce payments in proportion to what payments would have been without the reduction. One state noted that it is taking a “wait and see” approach.

Base Payments in FFS

Background

State policies for base payments in FFS include decisions about the unit of payment, the weights for different services, the rates for different types of hospitals, and rules to account for special circumstances.⁵

Unit of payment. Units of payment for hospital services can be classified along a “risk” continuum ranging from a low-risk percentage of charges approach to a population-based approach where the hospital assumes much greater risk for the cost of services, even when rendered by other non-hospital providers (Table 5). The more services and items that are aggregated into the payment unit, the more risk the provider has for delivering cost effective care. Many payers pay hospitals based on groups of services, such as DRGs or ambulatory patient groups, but there have been efforts in recent years to increase the use of alternative payment models including bundled payments, shared savings and shared risk models that apply to services provided across hospital and non-hospital settings. Table 5 describes payment models along the risk continuum for inpatient care.

Table 5. Continuum of Hospital Payment Methods by Unit of Service

Payment system	Unit of Service
Percentage of charges	Each item (supplies, drugs) or service (tests, procedures)
Inpatient per diem	Each inpatient day, which includes many items and services
Inpatient DRG	Each inpatient discharge, which may include many patient days
Bundled payments	Each injury/illness, which may include multiple inpatient/outpatient visits
Population-based	Each person covered, not solely based on services rendered

Note: DRG is diagnostic-related group

There is an analogous risk continuum for outpatient payment models, moving from percentage of charges, to fee schedules, and from fee schedules to ambulatory payment groupings that bundled several services into a single per-visit payment.

Weights. Weights differentiate payments for services based on the cost for a service relative to the average cost for all services. For example, it costs a hospital more to deliver a neonatal intensive care day than a newborn nursery day, and to deliver an MRI costs more than an x-ray. Weights are designed to reflect those cost differences. Weights may be developed from the payer’s own claims history or from the supplier of the payment system.

⁵ The Design of Health Care Payment Methods by Kevin Quinn, 3M Health Information Systems, presented at the National Health Policy Conference, February 2018.

For inpatient services, the most common system for classifying inpatient stays is the diagnostic related group (DRG) system. Each inpatient stay is assigned to a DRG based upon the patient's principal diagnosis, gender, age, sex, treatment procedure, discharge status, and the presence of complications or comorbidities, and each DRG has a unique relative weight. There are different DRG models used in the hospital industry. The most commonly used DRG model in Medicaid is the All-Patient Refined Diagnostic Related Groups (APRDRG) model developed and maintained by 3M Health Information Systems.

There are also systems for classifying outpatient care in payment groups based primarily on the service provided. Like DRGs, each service or bundle of services is assigned to a group and each group has a relative weight. Two commonly used outpatient classification systems are the Outpatient Prospective Payment System (OPPS) developed and maintained by CMS and Enhanced Ambulatory Payment Groups (EAPG) developed and maintained by 3M Health Information Systems.

Rules. Rates reflect the dollar amount paid for a service. In a DRG or outpatient prospective payment model, a standardized base rate (or conversion factor) is multiplied by the weight for the service to derive the payment amount. Hospital rates may be applied uniformly across a state or vary by hospital type. The reasons for varying rates include recognizing geographic cost of living differences or recognizing costs differences for different hospital peer groups. In addition, states may use policy adjustments to target additional payment to meet program goals, such as enhancing access to rural hospitals, behavioral health facilities or safety net hospitals

Rules. Payers often build other rules into their payment systems to meet specific objectives. One common rule is an adjustment to increase payments for outlier cases that have unusually high resource usage and costs. Payers may also make quality adjustments to incentivize improved performance in a target area, such as a payment reduction for a potentially preventable admission.

Current methods

As shown in Table 6 below, all five study states have implemented or are implementing APRDRGs for inpatient acute care hospital payment. Four of the five states recently made or are making significant changes in inpatient payment including the conversion to APRDRG.

Table 6. Inpatient Payment Methods in Study States

	Arizona	Louisiana	Michigan	Mississippi	Virginia
Method	APRDRG	APRDRG	APRDRG	APRDRG	APRDRG
Effective Date	10/1/14	1/1/19	10/1/15	10/1/12	10/1/14
Prior Method	Per diems	Per diems	Medicare DRG	Per diems	APDRG

Note: APRDRG is All-Patient Refined Diagnostic Related Groups

Source: HMA analysis of state policies

There is more diversity in the five-state sample for outpatient payment methods. Michigan and Mississippi use Medicare’s OPPS. In both states, the amount that would be paid by Medicare is discounted for Medicaid purposes (5 percent in Mississippi and currently 49 percent in Michigan). Virginia replaced its cost reimbursement model with the EAPG model in 2014 subject to a three-year transition. Arizona uses state-developed fee schedules that include many of the same types of bundling features as OPPS and EAPG. Louisiana uses Medicare fee schedules for certain services (lab, outpatient surgery and physical therapy), and hospital-specific percentage of charges for other services.

Arizona, Michigan and Mississippi adjust their DRG weights to increase payment for certain services prioritized by the program. DRG weights for neonatal intensive care services are increased in all three states and weights for obstetrical and newborn care are increased in Arizona and Mississippi.

Arizona, Louisiana and Virginia utilize policy adjustments to increase payment for rural hospitals. Arizona, Louisiana and Virginia also have higher rates for hospitals where Medicaid comprises a very high share of the hospital's patient population including public hospitals, children's hospitals or other hospitals with high Medicaid percentages.

Value-based payments are used sparingly in the study states. Two states, Arizona and Virginia, have provisions in their FFS base payment programs to incentivize quality or reduce unnecessary costs. Both states have policies to reduce payment for hospital acquired conditions and Arizona also has a payment reduction for preventable readmissions. Only Arizona currently has a specific quality incentive, Arizona's differential adjusted payment, discussed in the managed care supplemental payment section below, that is applicable for FFS payments as well. All five study states, however, are considering more robust value-based payment strategies, as discussed later in this report.

Factors Affecting Base Payments in FFS

Stakeholders interviewed described several drivers and barriers to making changes to base FFS payment policies.

Drivers

More equitable and rational payment

Stakeholders and experts interviewed described how the adoption of new payment models, including DRGs and APRDRGs, is designed and intended to produce more equitable payments across hospitals while also improving efficiency and economy.

In general, DRGs create strong incentives to increase efficiency by reducing length of stay, one of the key drivers of hospital efficiency. In contrast, per diems, the most common predecessor models to DRGs, gave hospitals no incentive to control inpatient length of stay since the hospital would be paid more if length of stay increased.

APRDRGs include four severity levels for every type of case, providing better recognition of complex care. In addition, APRDRGs are superior to other DRG models for reimbursing obstetrics and neonatal admissions, which are among the highest volume inpatient services in Medicaid.

State officials noted, and other stakeholders interviewed generally agree, that standardizing rates is a positive change. In the previous models used by the study states, rates were often based on hospital-specific costs whereas each of the current models uses or will use a statewide rate with certain policy adjusters. There was significantly more variation in payment rates in the previous models, and the variations were not always rational or justified.

Concerns about specific types of hospitals

As illustrated in the five study states, policy adjustments may be made to rates or weights to prioritize certain services or types of hospitals and sometimes to improve overall fairness of payment. For example, in most DRG systems and in many OPDS and EAPG systems, an area wage adjustment increases or decreases the base rate to reflect differences in average wage rates from one geographic area to another. Another example is GME, an adjustment that increases payments to teaching hospitals to

compensate for the additional costs they bear for residency training. Mississippi uses higher base payment rates for GME while the other four states recognize GME through supplemental payments.

States also often target rural hospitals and hospitals with high Medicaid patient percentages for policy adjustments because they are more vulnerable financially, in part because of their dependence on Medicaid payments and the fact that they may not have as large a commercial insurance base as other hospitals to subsidize Medicaid shortfalls.

Alignment with other payers

Medicare implemented DRGs for inpatient care in 1984 and OPSS for outpatient care in 2000. Most private insurers have followed Medicare's lead, especially for their largest hospital contracts.

In more recent years, Medicare and commercial payers have been encouraging the use of value-based payment models, and Medicaid officials in the study states expressed a desire to meet similar goals. For example, Medicare has also introduced significant penalties for preventable readmissions and hospital-acquired complications, that have been adopted in Arizona and in Virginia to a lesser extent. In addition, several study states have value-based payment goals for managed care, based on the multi-payer framework established by the Healthcare Learning and Action Network (HCP-LAN).

Barriers

Despite the benefits of DRGs over less sophisticated methods, and the fact that DRGs have been used for over three decades by Medicare and many private insurers, states have often been slow to adopt DRGs for Medicaid. Interviewees in the applicable study states were asked about the barriers to changing base payment models.

Concern about redistribution effects

Many providers are resistant to change, concerned that a significant change in a payment model will lead to payment redistribution. Although the study states aimed to achieve budget neutrality in the aggregate as part of their payment change, there may be significant increases or decreases for individual hospitals. Hospitals that expect to experience decreases in payment will naturally resist the change, advocate for different features, or if their influence is significant, advocate to delay or terminate the change initiative.

Each of the study states interviewed described extensive modeling of payments under the new systems, often using external consultants, to help ensure their budget-neutrality objectives were met. Budget neutrality success cannot be guaranteed, however, due to the inherent complexities of the payment models and the potential for hospital behavior changes which can be difficult to predict and model. For example, when Medicare implemented DRGs in the 1980s and MS-DRGs more than a decade ago, hospitals were able to increase payments by improving their medical documentation and coding. States are therefore concerned about the effects of provider behavior change on their Medicaid budgets.

State administrative challenges

Lastly, implementing a significant policy change can be costly and time-intensive. There are often substantial resources required including time spent by Medicaid agency staff, information technology changes, and often consulting expenses. Like Medicaid provider expenditures, Medicaid agency administrative and operating expenses are also constrained by state budget pressures. Also, when policy changes require years to design and implement, another challenge is overcoming the impact of changes

in state leadership. One national expert interviewed noted that changes in state and Medicaid program leadership can disrupt policy change efforts, particularly changes in the state governor.

Base Payments in Managed Care

Background

Under managed care the MCOs (and not the state) are generally responsible for establishing payment methods and rates, and for paying provider claims. MCOs submit encounter data to states but are not always required to submit information on the payments to specific providers. MCOs have some flexibility to review provider claims for criteria such as medical necessity, but in general, MCOs must pay providers promptly according to the terms developed by the state.

The state is responsible for overseeing the managed care program to ensure that federal requirements are met and that MCO contract terms are followed. Among its responsibilities, the state must develop managed care capitation rates required to be actuarially sound, meaning that they cover reasonable, appropriate, and attainable costs in providing covered services to Medicaid enrollees. States may require a minimum level of payments to providers, or a maximum level of payment, but cannot dictate the payment methods or rates.

CMS’s role in overseeing managed care payments to hospitals is also very different from its role in reviewing FFS payments to hospitals. Managed care payment policies are not included in state plans. CMS reviews capitation rates for managed care contracts, but CMS does not review the rates that managed care plans pay providers. (In fact, CMS has separate staff divisions to review managed care and FFS payment policies.)

Current methods

While the potential exists for there to be big differences between FFS and managed care payment practices, interviewees in all five states reported that MCOs use FFS methods and rates for a substantial majority of hospital payments.

Some states have specific requirements for plans to pay according to FFS payments methods. Two of the states in our sample have statutory rate floors, where plans are prohibited from paying less than FFS for in-network providers. Two of the states in our sample require plans to pay non-contracted providers (out-of-network services) at FFS rates. (Table 7).

Table 7. Hospital Payment Rate Requirements in Managed Care, Study States

State	FFS is a Minimum for In-Network Hospitals	FFS is required for Out-of-Network Services
Arizona		
Louisiana	✓	
Michigan		✓
Mississippi	✓	
Virginia		✓

Sources: HMA interviews with Medicaid agency officials

None of the study states have implemented maximum fee schedules and none of the study states preclude MCOs from paying less than FFS for all hospitals. However, each of the MCOs interviewed stated that most hospital payments are made at FFS rates.

MCOs interviewed reported that they occasionally pay more than FFS rates to ensure access to a hospital or provider system, but the instances are not common. Generally, the Interviewees said that the capitation rates are frequently built from FFS payment data and they do not have enough flexibility to allow for payments above that level. All MCO Interviewees reported that it is also uncommon for a hospital to agree to payments lower than FFS, although two MCOs interviewed noted that a provider may agree to a discount from FFS in exchange for exclusivity for specific services. In these cases, increases or decreases to the FFS payment rates often are based on a percentage of the FFS rate and do not involve different payment methods.

Three study states (Arizona, Louisiana and Michigan) noted that they have value-based payment requirements in their managed care contracts, but the MCOs interviewed noted that they have not made substantial changes to Medicaid payments to hospitals. Instead, these plans have been prioritizing value-based payment models for physicians and other provider types to meet statewide targets.

Each of the five states has plans to increase the use of value-based payments and quality incentives but in general such provisions are yet not common in MCO contracts with hospitals. Several reasons were offered by Interviewees. One consistent concern expressed by hospitals is, when reimbursement is so far below cost, hospitals are not willing to place any portion of the reimbursement at risk. Another commonly reported factor is the administrative difficulty of managing value-based payments. Lastly, there is not always agreement on the accuracy of the measures and the hospital's ability to influence the outcomes.

Nationally there is a lack of data to measure the extent to which managed care payments differ from FFS and most study states did not state that they have this information. All states are required to submit data to CMS' Transformational Medicaid Statistical Information System (T-MSIS). However, these data are not available for analysis. One expert interviewed for this report highlighted the lack of consistent quality of data and the inability to evaluate information across states, and sometimes within a state. To better understand the extent to which managed care payments differ from FFS and the evolution of value-based payments, and to improve information about managed care utilization and quality, the T-MSIS data needs to be improved nationally, and states may also need to make improvements to their own state-level data systems.

Interviewees also noted opportunities to improve the effectiveness of managed care oversight. The feedback on state oversight performance was mixed. Generally, in states where managed care is relatively new or has increased dramatically in recent years, stakeholders believe there is room for improvement in monitoring the managed care program. For example, all states receive encounter data from the plans, but some do a better job than others in producing useful information on quality, cost and value. Also, several interviewees would like to see the Medicaid agency take a more active role in establishing common value-based payments and quality performance measures used by all plans.

In addition, most hospital associations interviewed cited concerns about MCO claim payment practices. Health plans are typically allowed to develop their own payment standards such as requirements for pre-authorizing services, coding, and medical necessity. Plans then deny claims that do not meet these standards. States exercise varying degrees of involvement in ensuring that health plans adhere to fair

and reasonable claim payment practices. In some states, the hospitals noted that the state was willing to address hospital complaints, but in most states, hospitals noted that this was an area for improvement.

Factors affecting base payments to hospitals in managed care

As described below, interviewees noted several reasons for the high usage of FFS methods and rates in MCO payments.

Capitation rate development process

States develop capitation rates using either FFS payment data, or actual historical payment data that generally mirrors FFS. Accordingly, capitation rates are generally insufficient to support hospital payment rates that exceed FFS. Also, when states set FFS rates and weights, they typically include managed care encounters in the data they use for rate-setting purposes, establishing an unwritten expectation that plans will use the rates and methods developed by the state.

Provider negotiating position

As noted above, FFS base payments have been reduced or inflationary increases have been withheld in most recent years. FFS rates therefore generally lag well below cost. Hospitals are not willing to further discount a payment that is already considered to be too low. Low rates also affect hospital's willingness to participate in shared risk models.

Alignment with other plans

Lastly, there is a significant administrative burden on hospitals to maintain unique billing practices for each health plan they contract with, and a burden on plans to maintain unique payment terms with each hospital under contract. Accordingly, work is streamlined for all parties when nearly all plans use the same rates and methods for nearly all hospitals.

Supplemental Payments

The five study states employ three types of FFS supplemental payments (DSH, UPL and GME) and managed care supplemental payments.⁶ A discussion of each of these supplemental payment types follows.

DSH

There is wide variation in use of DSH payments in the five-state sample that is reflective of the size of state DSH allotments and the methods used to finance DSH payments.

Background

State DSH payments are limited by federal DSH allotments. Prior to 1991, there were no limits to the amount of DSH for which the state could pay and receive federal match, and there was more flexibility in the methods that states use to finance the state share. As a result, some states implemented used provider funds to increase federal DSH payments substantially. The amount spent annually on Medicaid DSH increased from \$1.3 billion in 1990 to \$17.7 billion in 1992.⁷ In response, Congress enacted state-specific DSH allotments in 1991 that capped the amount of DSH funds that may be claimed by a state for

⁶ Two other types of FFS supplemental payments – uncompensated care pools and delivery system reform incentive payments – are not currently utilized by the study states and are not addressed in this report.

⁷ Holahan, J, B.K. Bruen, and D. Lisaka, 1998, *The decline in Medicaid spending growth in 1996: Why did it happen?* Washington, DC: The Urban Institute. <http://webarchive.urban.org/UploadedPDF/410365.pdf>.

federal match in a given year. Importantly, the limits were based on the state's actual DSH spending at the time, essentially locking-in state by state differences in DSH payments.

Prior MACPAC analyses have found that states with larger DSH allotments make more DSH payments. Based on FY 2016 data, there were 14 states that reported DSH payments of less than 3 percent of total hospital payments; in 16 states DSH payments exceeded 10 percent of total hospital payments including Louisiana (which had the highest percentage of any state) and Mississippi.

States can make DSH payments to any hospital that meets federal eligibility requirements and has a hospital-specific DSH limit greater than zero.⁸ Prior MACPAC analyses have found that state DSH targeting policies appear to be related to the methods that states use to finance the non-federal share of DSH payments: states that predominately fund DSH payments with provider assessments tend to distribute DSH payments to most of the hospitals in their state, and states that finance DSH with IGTs tend to target DSH payments to public hospitals. In addition, many states target DSH payments to state-owned institutions, which reduces the amount of funds the state would otherwise need to provide to support those institutions.

Findings

Consistent with MACPAC's previous findings, the study states exhibit wide variation in the use of DSH payments, which appears to be related to the size of state DSH allotments and the methods that states use to finance the non-federal share of DSH payments (Table 8).

⁸ Sec. 1923 of the Social Security Act. [42 U.S.C. 1396r-4]. Generally, two eligibility criteria must be met: a hospital must have a Medicaid inpatient utilization rate greater than 1 percent and must have at least two obstetricians with staff privileges.

Table 8. Distribution and Financing of FY 2016 DSH payments in Study States

State	Share of Medicaid hospital payments	Distribution of DSH Payments	Financing of state share
Arizona	4.9%	Over 88% was allocated to two public hospitals, 11% was paid to hospitals with IGT agreements, and 1% was paid to all other eligible hospitals	Most of the amount allocated to two public hospitals was retained by the state via CPE, the remainder was primarily financed by IGT (state funds paid < 1% of the state share)
Louisiana	38.9%	Several DSH pools are used and several hospitals receive DSH. The largest amounts are paid to low-income academic hospitals and public hospitals. There are significant amounts paid to hospitals with low-income care agreements and rural hospitals.	A significant amount is from IGTs, the remainder is from state general funds
Michigan	6.8%	Several DSH pools are used. The largest is allocated to all eligible hospitals based on outpatient uncompensated care. Other pools are used for hospitals with at least 20% indigent volume, and public hospitals.	The outpatient uncompensated care pool is financed by the hospital assessment, the 20% indigent volume pool is funded by state general funds, the public hospital payment is retained by the state via CPE
Mississippi	13.1%	All eligible hospitals receive DSH based on uncompensated care cost, except the state university hospital receives a 2X multiplier	Entirely from the hospital assessment
Virginia	8.8%	About 15% is paid to hospitals with Medicaid representing at least 14% of patient days; the remainder is paid to two state university-owned hospitals and a freestanding children’s hospital	Entirely from state general funds

Note: DSH is disproportionate share hospital. IGT is intergovernmental transfer. CPE is certified public expenditure.
Source: Share of Medicaid hospital payments is from 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. Distribution and financing information is from HMA review of state policies and data provided by the states.

UPL

Four of the five study states make UPL payments that vary widely in amount and differ in the degree to which they are broad based or targeted at specific hospital types (e.g., rural hospitals).

Background

UPL payments are supplemental payments that are intended to fill in the difference between FFS base payments and the amount that Medicare would have paid for the same service. In the aggregate for each class of providers, FFS base and supplemental payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles. Classes of providers are defined based on ownership (i.e., government, non-state government, and privately owned). States can use a variety of methods to estimate what Medicare would have paid. States may distribute UPL payments broadly across all hospitals, generally in proportion to a previous period’s FFS base payments, or they may target certain types of hospitals.

Findings

As with each of the other payment types, there is a wide variation from state to state in the size and use of UPL payments (Table 9).

Table 9. Distribution and Financing of FY 2016 UPL Payments in Study States

State	Share of Medicaid hospital payments	Distribution of UPL payments	Financing of state share
Arizona	4.3%	Critical access and rural hospitals, hospitals with level 1 trauma centers and emergency rooms	State general funds
Louisiana	2.9%	Approximately 50 hospitals, primarily with low-income care agreements with local governments	Primarily intergovernmental transfers
Michigan	12.9%	About 2% to rural hospitals, remainder is broad-based	Primarily hospital assessment, about 2% is state general funds
Mississippi	0.0%		
Virginia	0.1%	FY 2016 paid to two private hospitals; new payments be broad-based (1)	FY 2016 by IGTs; new program will be hospital assessment (1)

Notes: UPL is upper payment limit. IGT is intergovernmental transfer.

(1) Virginia is expecting to implement a broad-based UPL payment in FY 2019.

Source: HMA analysis of FY 2016 financial management reports submitted by the states to CMS (the CMS-64 report) and review of state agency data.

Size of UPL Payments. UPL payments are larger than base FFS payments to hospitals in Michigan, but smaller than FFS base payments in other states. There are two primary reasons for the large Michigan UPL program: first, Michigan has increased base rates only once since the 1990s resulting in an ever-increasing UPL gap. Second, Michigan’s legislature, administration and hospitals have been willing to use the entire UPL gap for this program and finance the entire state share with the provider assessment. Louisiana also has a relatively large UPL payment (45% of FFS base payments) although this percentage will decrease when the payment reform initiative is implemented in 2019 (a large portion of DSH will move into base payments, resulting in a smaller UPL gap). Conversely, Virginia is expected to have a significant UPL payment for the first time after it implements payment reforms in October 2018.

Use of UPL Payments. A key factor in the use of UPL payments is the source of funding for the state share. For the broad-based portion of Michigan’s UPL payment and in Virginia’s proposed model, the state share is financed by a hospital assessment. The assessment is paid by most hospitals and there is an interest in allocating most of the payment to the hospitals paying the assessment. In Louisiana, the state share of UPL payments is also financed by a local source, IGTs. In contrast, Arizona’s UPL payments are financed by state funds and result from legislation to enhance the financial condition of rural hospitals and hospitals with trauma centers.

GME

Background

Most state Medicaid programs recognize the extra costs borne by teaching hospitals by making higher base payments or supplemental payments for GME although Medicaid GME payments are not required by statute.

States can pay for the direct costs related to the training of interns and residents, and the indirect costs of treating sicker and more resource-intensive patients than other hospitals.

GME differs from other supplemental payments in two ways. First, unlike DSH and UPL payments, GME may be paid on a per claims-basis or as a lump sum amount. Second, GME supplemental payments may be applicable to both FFS and managed care. In fact, GME is an exception to the general rule prohibiting states from making payments directly for managed care purposes and GME is an allowable supplemental payment under the managed care regulations.

Findings

The study states varied in whether GME was included in base rates or made as a separate supplemental payment (Table 10). For the three states that use a lump sum methodology, each makes payments to teaching hospitals using formulas like Medicare or linked directly to the size of the hospital’s GME program, except that in Virginia a significant portion of the payment is paid to three hospitals (two state university hospitals and a freestanding children’s hospital) to fund their Medicaid shortfall. Arizona requires teaching hospitals to identify a public entity to provide the state share by IGT. Each of the other four states use state general funds for the non-federal match.

Table 10. GME Payment and Financing Methods in Study States

State	Share of Medicaid hospital payments	Payment method	Financing method
Arizona	8.2%	Separate lump sum payments are made by the state for FFS and managed care	IGT
Louisiana	2.2%	Separate per-claim add on payments for inpatient and cost settlement for outpatient are made by the state for FFS and managed care	State general funds
Michigan	3.0%	Separate lump sum payments are made by the state for FFS; GME is added to capitation and the state directs the MCOs the amounts to pay each hospital for managed care	State general funds
Mississippi	GME portion of base payments is not available	The state makes a per-admission adjustment to the DRG payment for teaching hospitals for FFS; MCOs are required to pay the adjustment under the payment floor provision	State general funds
Virginia	13.4%	Separate lump sum payments are made by the state for FFS and managed care	Primarily state general funds

Notes: GME is graduate medical education. FFS is fee-for-service, IGT is intergovernmental transfer, MCO is managed care organization.

Source: HMA review of state policies and data provided by the states.

Managed Care Directed Payments

Most states that have adopted managed care and had significant UPL payments in FFS, including three of the five study states, implemented a supplemental managed care payment to offset the impact of eliminating or reducing their hospital UPL payments.

Background

Federal regulations do not allow states to make UPL payments for services covered by managed care, but states have found a variety of ways to preserve these supplemental payments when expanding managed care. As part of a project to modernize managed care regulations, CMS issued specific

regulatory guidance to define an approach for states to require managed care plans to direct payments to providers, referred to as directed payments. The regulations provide for three different types of allowable directed payments:

- Adopt a minimum/ maximum fee schedule
- Provide a uniform dollar or percentage increase
- Implement value-based purchasing models

Directed payments must be based on utilization and delivery of services, distributed based on the same terms for all providers in the class, and advance at least one of the goals in the state's quality strategy. Directed payments cannot be contingent on the provider's willingness to provide IGT financing.

The May 2016 regulations also said that state-directed managed care payments that do not comply with the new criteria, referred to as pass-through payments, are not permissible and must be phased out over a ten-year period ending in FY 2027.

Federal policy on directed payments is evolving. At the time of the August 2018 interview, CMS officials reported that they had received directed payment proposals from 28 states and had approved 85 proposals (including multiple proposals in some states). However, state proposals are approved for only one year at a time, and in the future each state will be expected to more closely align the payments to the state's quality goals.

Findings

Managed care supplemental payments exist in four of the five study states, and the fifth state is developing a payment that is expected to be in place in FY 2019 (Table 11).

Table 11. Nature and Financing of Managed Care Supplemental Payments in Study States

State	FY 2016 share of Medicaid hospital payments	Description of payments	Type of directed payment	Source of state share
Arizona	0.6%	Differential Adjusted Payment. Was 0.5% of base payments, increased to 3.5% maximum in FY 2019	Quality incentive	State general funds
Louisiana	18.7%	Full Medicaid Pricing, a replacement for UPL payments instituted when managed care was implemented. The state provides funds globally and directs MCOs to make payments consistent with allocations derived by hospital coalitions.	Not applicable	Primarily IGT
Michigan ¹	27.0%	Hospital Rate Adjustment for acute care, a uniform percentage add-on to managed care base payments implemented in FY 2018, replacing a payment that the state considered a pass-through	Percentage increase	Hospital assessment
Mississippi	31.4%	Mississippi Hospital Access Program, a replacement for a UPL payment that was implemented when inpatient services transitioned to managed care in FY 2016. The payment is considered a passthrough and is being replaced over a multi-year period with base payment increases and quality-based payments.	Uniform dollar adjustment, and quality incentive is planned	Hospital assessment
Virginia	0.0%	The state anticipates implementing a new payment, like the model used in Michigan, in FY 2019	Percentage increase	Hospital assessment

Notes: UPL is upper payment limit. IGT is intergovernmental transfer. MCO is managed care organization. FY is fiscal year.

¹ Michigan also has a much smaller managed care supplemental payment for inpatient psychiatric hospitalization. The current payment is considered a passthrough and the state is planning to replace the current payment in FY 2019 with a per patient day add-on, analogous to the change made in FY 2018 for acute care hospital services.

Source: HMA review of state policies and data provided by the states.

Two of the study states, Michigan and Mississippi, are using directed payments to replace passthrough payments. Both states sought to prevent hospital payment reductions that would occur due to the 10-year phase-out of passthrough payments by implementing a uniform increase using current utilization. There are two important differences in these states' approach. First, Michigan expected an increase the overall amount of payment while Mississippi expects payments to remain the same. Second, Michigan adopted the change at one time, while Mississippi is phasing-in the changes over several years.

Process for Making Changes to Hospital Payment Policies

Medicaid hospital payment policy is complex. While annual updates to rates, weights, and policy adjusters are common, more significant methodology reforms usually entail a time consuming, intensive process that actively engages hospital stakeholders.

States are motivated to pursue major changes to modernize payment systems and target hospital spending in ways that reward efficiency and economy, assure needed access for Medicaid beneficiaries, and address budgetary constraints. As discussed earlier, the study states generally require hospital payment policy changes to be budget neutral – meaning aggregate state payments are unchanged before and after the policy change. Impacts on individual hospitals, however, are usually not budget

neutral. As a result, budget neutral methodology changes can be expected to generate “winners and losers” among individual hospitals – some hospitals’ payments increase while others decrease when converting to the new system.

Tensions naturally arise across the hospital industry when the system changes create positive and negative impacts to individual hospitals. To address industry concerns and technical challenges, some of the study states engaged in lengthy processes including extensive modeling of outcomes and multiple opportunities for stakeholder education and feedback. In several instances, developing and implementing policy changes took two to three years. For example, Louisiana’s implementation of its inpatient and DSH payment changes began in late 2016 and will be completed in January 2019. The first nine months focused on why changes were needed and getting agreement that the current system is not sustainable. An eight-month payment method design phase followed. Detailed implementation (such as changing contracts, policies, and information systems) started in March 2018 and is ongoing.

In some instances, the timeline for developing and implementing change is accelerated by legislative mandate. In Virginia, the new hospital assessments and associated payment increases were enacted by the legislature in May 2018 and must be ready for an October 2018 start date.

During the development and implementation process, hospitals are frequently involved, either individually or collectively through an association. Managed care plans are much less likely to be involved in hospital payment policy changes but plans in at least two states expect to be more engaged as the shift to quality and alternative payment methodologies accelerates. States and stakeholders almost always involve consultants for modeling and analytical support.

States sometimes engage CMS for technical assistance during the process, too. In one state, asking CMS for early involvement was considered instrumental to developing an approvable model of payment. However, most states did not formally involve CMS in the development stages of the project. CMS involvement is always required when states submit state plan amendments and directed payment applications to effectuate the proposed policy changes.

Future Policy Changes

When asked what changes were anticipated, four of the five study states noted that they are likely to focus on incentivizing quality and value. In these states, the Medicaid agency is taking the lead on developing statewide programs to incentivize quality improvement and reduce total cost of care.

Hospitals and MCOs expressed support for these efforts and prefer a statewide approach rather than leaving the decisions up to each plan to develop and implement its own value-based hospital payments. One stakeholder expressed an interest in increasing the focus on managing the utilization of high-cost enrollees such as the disabled. Although it is easier for states to reduce costs by cutting payment rates, stakeholders noted that it was preferable to reduce costs by improving access to care in the most appropriate settings. However, given their concerns about low payment levels, hospital representatives noted that they will continue to have concerns about value-based payment models that place existing Medicaid payments at risk.

States with directed payment programs under managed care were uncertain about how these programs may change when CMS reviews requests to continue programs after each one-year approval period. However, some interviewees expected CMS to intensify the focus on quality and value as their directed

payment programs mature and they are exploring ways to better align directed payments with their value-based payment efforts.

CONCLUSIONS

A discussion of several key research findings that respond to MACPAC's initial policy questions are presented below.

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?

Supplemental payments comprise a significant portion of hospital payments in many states, although there is a great deal of variability from state to state. In the five-state sample, supplemental payments range from 18 percent of total hospital payments to 61 percent.

State budget pressures have negatively affected hospital base payments for at least a decade and even longer in some states. Many states reduced hospital payment rates during the 2007-2011 recession, and all five states surveyed for this report have kept rates frozen with no adjustment for inflation in most, if not all recent years. Consequently, base payments are much lower today relative to other payers and relative to cost.

The response to the declining value of base payments in many states has been to increase supplemental payments and generate the non-federal match with provider assessments or IGTs. For this strategy to be successful, the state legislature and administration must be favorably disposed to increasing hospital payments and hospitals must be willing participants.

States have chosen to implement supplemental payments instead of base rate increases in part because hospitals view supplemental payments as more certain and predictable. Supplemental payments are usually known in advance and there is no risk of unexpected variation or risk of diverting the funds for other purposes. Hospitals view the supplemental payment they receive and the assessment or IGT that they pay as two parts of the same transaction and they prefer that this transaction is separate from base payments to measure the extent to which their assessments or IGT payments are recouped through the supplemental payment. Supplemental payments may also be preferred by states that want to target payments to a type of hospital (such as rural hospital payment pools in three of the five study states).

The specific types of supplemental payments that states make are influenced by a variety of factors. States with larger DSH allotments make more DSH payments and states with higher managed care penetration make less UPL payments. The 2016 Medicaid managed care rule requires states to phase out the use of pass-through payments through the MCOs, but it provides a new pathway for states to make directed payments to hospitals instead.

Why do states target payments to types of hospitals or services, and how do they determine which hospitals or services to target?

This research identified examples of state targeting policies that are intended to prioritize services considered most critical to the Medicaid population, and other state targeting policies that appear to be based on the methods that states use to finance the non-federal share of Medicaid payments.

Base payments in three study states were increased to provide higher rates or DRG weights to hospitals with a high-percentage of Medicaid patients, and services that are critical in the Medicaid population, such as neonatal care, obstetrics, pediatrics, and behavioral health. Also, rural hospitals were frequently

prioritized in hospital payment models, in recognition of their vulnerability and the concerns states have about access to services in remote areas.

In contrast, supplemental payments were more likely to be distributed based on the methods that states used to finance the payments. In general, supplemental payments financed with broad-based provider assessments are distributed broadly to many providers in the state, and supplemental payments financed with IGTs and CPEs are often targeted to publicly owned providers. Examples were also noted of supplemental payments targeted to state-owned institutions that reduced the state general funds that the state would otherwise need to provide to support these facilities.

How do FFS payment policies affect managed care payments to hospitals?

For hospital base payments, FFS policies have an enormous impact on managed care payments to hospitals. In fact, in the five-state sample, a substantial majority of managed care payments to hospitals are made using FFS methods and rates. There are some limited instances in each state where hospital receive more than FFS, and an even fewer number of instances where hospitals receive less than FFS.

Several reasons for the high usage of FFS methods and rates in MCO payments were noted.

- States develop capitation rates using either FFS payment data, or actual historical payment that generally mirrors FFS. Accordingly, capitation rates are generally insufficient to support hospital payment rates that exceed FFS rates.
- FFS base payments have been reduced or inflationary increases have been withheld in most recent years. FFS rates therefore generally lag well below cost. Hospitals are not willing to further discount a payment that is already considered to be too low.
- When states set FFS rates and weights, they typically include managed care encounters in the data they use for rate-setting purposes, establishing an unwritten expectation that plans will use the rates and methods developed by the state.
- Lastly, there is a significant administrative burden on hospitals to maintain unique billing practices for each health plan they contract with, and a burden on plans to maintain unique payment terms with each hospital under contract. Accordingly, work is streamlined for all parties when nearly all plans use the same rates and methods for nearly all hospitals.

Because base payment methods and rates are similar in FFS and managed care, the difference between base payment rates and the amount that Medicare would have paid is proportionately similar in managed care and FFS. Although states are not permitted to make UPL payments to hospitals for services provided in managed care, states may develop directed payments to achieve the same goal of offsetting the Medicaid shortfall in managed care payments to hospitals.

What are the drivers and what are the barriers to changing hospital payment methods?

Preserving funding for hospitals is a key driver for changes to supplemental payments. UPL and related payments emerged to offset the effects of state budget cuts and freezes to base payment rates. Supplemental payments under managed care emerged out of efforts to preserve UPL when states transitioned enrollee populations to managed care.

Preservation of funding is also an important consideration in conversions to new base payment methods, such as adopting APRDRGs and EAPGs. States make considerable effort to ensure budget neutrality (total payments after the conversion approximate total payments before the conversion) and to minimize increases and decreases for individual hospitals.

Other drivers of payment change include:

- Adopting more sophisticated models. DRGs and outpatient prospective payments are a more accurate method of paying for services than per diems or percentage of charges, align with methods used by other payers and provide additional control over utilization.
- More equitable and rational payment. DRGs and outpatient prospective payments reduce the disparities in payment from one hospital to another that were present in many legacy models.
- Promoting access for certain types of hospitals. For example, state legislatures and others may target rural hospitals for additional payments because of concerns over their financial viability.

Several barriers to payment policy change are also present:

State budget are constrained, and frequently changes must be financed with provider assessments and IGTs. Legislatures, however, may be reluctant to support additional provider financing when the outcome may be perceived as a tax increase and hospitals are naturally resistant to self-funding their own revenue. Medicaid agencies may be pressured to make decisions about payment amounts and targeting of payments that are based on financing and may run counter to other objectives of the payment reform initiative.

Often changes in policy must be implemented in a budget neutral manner, resulting in some hospitals gaining and some hospitals losing. In these instances, the change effort may be focused on mitigating the redistributive impact of the policy changes rather than improving efficiency, economy, quality and access.

When a Medicaid program is predominantly managed care, federal Medicaid managed care regulations limit the ability of states to enact policy changes that direct managed care hospital payments.

Finally, making payment changes and reforms is inherently difficult. A major modification to an inpatient or outpatient method may take years to design and implement. Part of the challenge arises from the factors noted above. Many decisions need to be made that have varying impacts on hospitals and sometimes the impact is negative. There may also be many other stakeholders in addition to hospitals whose input is needed. Further, major changes require a significant amount of resources including extensive staff time, contractor costs, and information technology changes.

How are states planning to change hospital payment policies in the future?

States and key stakeholders interviewed expect to see an increase in the prevalence and impact of value-based payments. Currently, value-based payments are used sparingly in the five study states. Three primary reasons were noted.

1. Many states have not made hospital value-based payment a priority in the past.
2. Hospitals are reluctant to put any of their Medicaid base payment at risk, because they believe base payments are too low, and MCOs are reluctant to use part of their capitation for upside incentives to hospitals because they generally do not believe there is enough room in the capitation rates to do so.
3. There may be lack of agreement on measures to use and there are administrative challenges to implementing new payment models.

All Medicaid agencies interviewed expressed an interest in increasing value-based payments and are in various stages of developing and implementing plans to achieve this goal. Under federal regulations directed payments under managed care are required to be tied to one or more goals in the state's quality strategy. Two of the study states have directed payments that are based on utilization only, and a third state is developing a directed payment that will be based on utilization. CMS anticipates that over time, these directed payments will be more closely tied to quality improvement.

The barriers that exist today, however, must be overcome before meaningful increases in value-based payment can realistically occur.

APPENDIX A: STAKEHOLDER INTERVIEWS

State Medicaid Agencies

Arizona Health Care Cost Containment System

Louisiana Department of Health and Hospitals

Michigan Department of Health and Human Services, Medical Services Administration

Mississippi Department of Human Services, Division of Medicaid

Virginia Department of Medical Assistance Services

Hospital Associations

Arizona Hospital and Healthcare Association

Louisiana Hospital Association

Michigan Health & Hospital Association

Mississippi Hospital Association

Virginia Hospital and Healthcare Association

Managed Care Organizations

University Family Care (Arizona)

Amerihealth Caritas Louisiana

UnitedHealthcare Community Plan (Michigan)

UnitedHealthcare Community Plan (Mississippi)

Optima Family Care (Virginia)

Additional Experts

The Centers for Medicare & Medicaid Services

Mercer Government Human Services Consulting

Navigant Consulting

APPENDIX B: STATE PROFILES

Arizona

Arizona’s Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), operates an \$11.1 billion Medicaid program under an integrated managed care model through a Section 1115 demonstration.ⁱ In FY 2016, AHCCCS covered 1.9 million individuals including more than 0.4 million adults under ACA Medicaid expansion.ⁱⁱ There are over 110 hospitals in the state including nearly 80 acute care hospitals. Ownership composition of acute care hospitals is as follows: 53 percent are non-profit, 13 percent are government-owned (including Public Health Service Indian hospitals), and 34 percent are investor-owned. Rural hospitals provide only 3 percent of adjusted patient days, compared to 17 percent nationally.ⁱⁱⁱ

In the past three years the state has made two significant changes to hospital payment policy: Adopting All-Patients Refined Diagnosis-Related Groups (APRDRG) and statewide rates for inpatient reimbursement (FY 2015) and revising the size and distribution of the safety net care pool (2015). The state has various quality incentives that have been in place several years, including a program called Differential Adjusted Payments (DAP) that will be increased significantly in FY 2019, and a new managed care directed payment (Targeted Investment program, or TIP) implemented in FY 2018.

Summary of Payments to Hospitals

In FY 2016, AHCCCS paid approximately \$3.2 billion to hospitals (Table 1). Base payments were 82 percent of the total, and most base payments are from managed care. Supplemental and directed managed care payments comprised 18 percent of total Medicaid payments to hospitals.

A hospital assessment (approximately \$250 million in FY 2016^{iv}) finances a large portion of the nonfederal share of hospital and nonhospital services to persons covered under Medicaid expansion, and the cost of other low-income childless adult services. Intergovernmental transfers (IGTs) are used to finance most of the state share of supplemental and directed payments. The state also uses a certified public expenditure (CPE) from the state hospital and the Maricopa Integrated Health Systems (MIHS) for a portion of Disproportionate Share Hospital (DSH) payments.

TABLE 1. Arizona Medicaid Payments to Hospitals, FY 2016

FY 2016 hospital payments	Type of payment	Total (millions)	Share of total
Base payments	Fee-for-service base payments	\$609	18.6%
	Managed care base payments	\$2,069	63.3%
	Subtotal base payments	\$2,678	81.9%
Supplemental payments	Disproportionate share hospital	\$159	4.9%
	Upper payment limit/other	\$152	4.7%
	Graduate medical education	\$266	8.1%
	Directed payments in managed care	\$12	0.4%
	Subtotal supplemental	\$589	18.1%
Grand Total		\$3,267	100.0%

Sources: Fee-for-service base payments and supplemental payments other than directed payments are from a report prepared by MACPAC, derived from FY 2016 CMS-64 64 Financial Management Report net expenditure data. Managed care base and directed payments are estimated by HMA from FY 2016 data published by the state.

Fee-for-Service Payment Methodologies

Approximately 7 percent of Medicaid enrollees received care through the fee-for-service (FFS) delivery system in FY 2016.^v The largest amount of FFS hospital payments covers services to managed care enrollees from the effective date of Medicaid coverage to the effective date of managed care coverage. For one significant group, American Indians, managed care is optional.

The state uses APRDRGs to pay inpatient fee for service base payments and a procedure-based fee schedule for outpatient services (Table 2). The inpatient payment model includes additional payment for most newborn, pediatric and obstetric cases as well as an adjustment to recognize geographic labor cost differences. In the outpatient payment model, critical access hospitals and other types of hospitals receive enhanced payment.

TABLE 2. Summary of Methods for Arizona Medicaid FFS Base Payments to Hospitals

	Inpatient	Outpatient
Groups	DRG-based payment per discharge, using All-Patients Refined Diagnosis-Related Groups (APRDRG) system.	A fee schedule is maintained for hospital outpatient services, based generally on billed procedure codes.
Weights	APRDRG weights are vendor-supplied national weights. One provider policy adjustor is used: a 5.5% hold-harmless adjustment for high-volume providers projected to incur a loss. Several services receive DRG weight adjustments as follows: normal newborn (55%), neonate (10%), obstetric (55%), psych/rehab (65%), and other pediatric cases (25%).	Several provider policy adjustments are in place, which increase the fee schedule as follows: critical access hospitals (100%), university-affiliated hospital (41%), governmental hospitals (73%), children’s hospitals (78%), other hospitals with over 100 beds (31%), and other hospitals with 100 or fewer beds (37%). The fee schedule is generally used for out of state services.
Rates	A statewide rate adjusted for area wage index differences is used for most hospitals. A second (lower) base rate is used for certain others, primarily specialty hospitals.	Most rates are fixed amounts at the procedure code level. Several rates are paid a percentage of charges using statewide cost/charge ratios (urban and rural ratios differ). ER visits and surgical procedures include packaging of services similar to Medicare.
Rules	Outlier payments are made for high cost cases. Payment reductions for hospital acquired complications and potentially preventable admissions are in place.	No significant incentives, penalties or special payments for unusual circumstances are in place.

Sources: Presentation materials from AHCCCS’ website, and MACPAC review of inpatient fee-for-service payment methods as of March 2018 and outpatient fee-for-service payment methods as of November 2015.

Recent changes: A rebasing of the inpatient base rates occurred in 2018 but did not involve extensive policy changes.

Managed Care

Arizona’s mandatory managed care model covers all Medicaid enrollees including dual eligible and long-term care members. There are currently 15 MCOs operating statewide to provide acute (general medical care), behavioral health, and long-term healthcare services to Medicaid members, who may choose their MCO upon enrollment in Medicaid.

MCOs are required to use FFS rates and methods for payments to out of network hospitals, and it is believed that most provider-MCO contracts are based on the FFS rates and methods, even though the state-MCO contract does not require it.

AHCCCS prioritizes quality incentives and has implemented several value-based purchasing (VBP) models. Most of the incentives and disincentives are focused on physicians. Two VBP programs result in additional payments to hospitals:

- DAP is paid using a percentage add-on to managed care and FFS inpatient and outpatient claims for hospitals meeting the qualification criteria. Participation in the state's health information exchange (HIE) can earn the hospital a 0.5% add-on in FY 2018. In FY 2019, the add-on for health information exchange (HIE) participation increases to 3.0% of base payments, and an additional 0.5% is available for obtaining certification as a pediatric emergency care provider.
- To encourage and facilitate physical and behavioral health integration, Arizona created the Targeted Investments Program (TIP), which gives eligible hospitals additional payments, through the managed care plans, for care coordination for adults discharged with a primary behavioral health diagnosis and or Serious Mental Illness (SMI) designation. There are approximately 25 participating hospitals and three percent (3%) of the total program funds are allocated to hospitals. Most TIP funds will be paid to primary care and behavioral health providers.

Supplemental Payments in FFS

DSH payments: Nearly 90 percent of DSH payments (\$142 million in FY 2016) are allocated to two public hospitals, and these DSH payments are financed by CPEs. Most of the remaining DSH funding is allocated to a small number of DSH hospitals that have agreements in place with non-state political subdivisions to make IGTs for the state share. Less than 1 percent of DSH funding in FY 2016 was paid to other private hospitals meeting eligibility criteria.

Upper payment limit (UPL) and other supplemental payments: Arizona has four other supplemental hospital payments:

- The Safety Net Care Pool (SNCP), established in FY 2012, gave political subdivisions of the state the ability to directly support hospital systems in their communities. The funding pool used intergovernmental transfers (IGTs) to draw down federal matching dollars that AHCCCS distributed to participating hospitals to help defray the costs of uncompensated care. Funding through the Safety Net Care Pool (SNCP) was open to all Arizona hospitals through 12/31/13. Phoenix Children's Hospital received an extension for the program through 12/31/17 and the funding has now expired. \$117 million was paid in FY 2016.
- Critical Access Hospitals (CAHs) receive semi-annual CAH payments. \$10.5M has been paid annually for several years and the amount increases to \$16.5 M beginning in FY 2019.
- The Rural Hospital Inpatient Fund was established in 2005 to supplement rural hospital inpatient payments (included CAHs). \$12.2M has been paid annually for several years.
- Trauma and Emergency Department Payments: Hospitals with Level 1 trauma centers and hospitals with emergency rooms receive a supplemental payment funded by tribal gaming revenue. Payments vary with the amount of revenue collected. In FY 2016 trauma hospitals and hospitals with emergency rooms received \$20.9 million and \$2.2 million, respectively.

Graduate medical education (GME) payments: GME funds are distributed to hospitals that provide training and education for medical school graduates. GME funds cover direct medical education expenses (DME) and indirect medical education (IME) expenses. The state share is financed by IGTs.

Louisiana

In fiscal year (FY) 2016 the Louisiana Medicaid Program spent \$8.6 billionⁱ and covered 1.6 million individuals, including nearly 0.2 million under ACA Medicaid expansion which was implemented during FY 2016.ⁱⁱ The number of expansion enrollees increased to over 461,000 in January of 2018. There are over 210 hospitals in the state, of which 140 are acute care. 30 percent of acute care hospitals are non-profit, 35 percent are government-owned, and 36 percent are investor-owned. Rural hospitals provide 12 percent of adjusted patient days, compared to 17 percent nationally.ⁱⁱⁱ

Louisiana Medicaid is preparing for significant changes to its hospital payment policy that are planned for 2019: adopting all-patients refined diagnostic-related groups (APR DRGs) and statewide rates for inpatient reimbursement, redefining teaching hospital peer groups, and shifting 21 percent of hospital supplemental payments to base payments.

Summary of Payments to Hospitals

Louisiana Medicaid paid approximately \$3.1 billion for hospital services in FY 2016 (Table 3). Base payments were 39 percent of the total and most base payments were from managed care. Supplemental fee-for-service (FFS) and managed care payments were 61 percent of total hospital payments.

A hospital assessment, based on net patient revenue, was added in FY 2017 to finance the state share of hospital payments for the expansion population and to finance some targeted hospital rate increases. In FY2017 the assessment was \$29 million, and it has increased significantly in subsequent years.^{vi} Intergovernmental transfers (IGTs) and certified public expenditures (CPEs) financed nearly half of the state share of supplemental payments in FY 2016.

TABLE 3. Louisiana Medicaid Payments to Hospitals, FY 2016

FY 2016 hospital payments	Type of payment	Total (millions)	Share of total
Base payments	Fee-for-service base payments	\$199	6.5%
	Managed care base payments	\$993	32.4%
	Subtotal base payments	\$1,192	38.8%
Supplemental payments	Disproportionate share hospital	\$1,193	38.9%
	Upper payment limit/other	\$89	2.9%
	Graduate medical education	\$20	0.7%
	Supplemental payments in managed care	\$574	18.7%
	Subtotal supplemental	\$1,877	61.2%
Grand Total		\$3,069	100.0%

Sources: Fee-for-service and supplemental payments are from a report prepared by MACPAC, derived from FY 2016 CMS-64 Financial Management Report net expenditure data. Managed care base payments are derived from a 2018 presentation from the Medicaid agency. Supplemental managed care payments are from a report published on the state's website.

Fee-for-Service Payment Methodologies

Approximately 8 percent of Medicaid enrollees received care through the fee-for-service (FFS) delivery system in FY 2016.^v The largest amount of FFS hospital payments covers services provided to managed care enrollees between the effective date of Medicaid coverage to the effective date of managed care coverage. Also, some

groups are excluded from mandatory managed care enrollment including persons dually eligible for Medicare and Medicaid, and the intellectually or developmentally disabled.

Through 2018 the state is using hospital-specific per diem rates to pay for inpatient hospital services in FFS. The per diem rates were established from cost reports from the 1990s. The state is planning to adopt APRDRG-based reimbursement for inpatient services effective January 1, 2019. Under the planned conversion, 21 percent of supplemental payments will be shifted to base payments. Adjustments will be made to increase payment for teaching hospitals, rural hospitals and high Medicaid volume hospitals. Outpatient hospital services are reimbursed using a combination of percentage of charges and fee schedules (Table 4).

TABLE 4. Summary of Methods for Louisiana Medicaid FFS Base Payments to Hospitals

	Inpatient (beginning 1/1/19)	Outpatient
Groups	DRG-based payment per discharge, using All-Patients Refined Diagnosis-Related Groups (APRDRG) system.	Billed tests and procedures.
Weights	State specific weights developed based on historic Medicaid utilization in Louisiana. Psychiatric and rehabilitation care to be paid using weighted per diems.	Fee schedule or percentage of charges for most services using hospital-specific cost to charge ratios, adjusted to 66% of cost. Ambulatory surgical center (ASC) groupings are also utilized.
Rates	Urban: Statewide base rates will be set at an estimated 87%of cost for three peer groups (major teaching, other teaching and non-teaching). Increases for hospitals with high Medicaid volume will be added. Hospital-specific add-ons for direct graduate medical education cost and capital cost will be included. Rural: A statewide base rate equal to 105 percent of the median cost will be used.	Higher reimbursement (generally at cost) is provided for rural and state-owned hospitals.
Rules	Outlier payments are made for high cost cases. No incentives or penalties.	None

Source: Inpatient information was derived by HMA from state presentation materials; outpatient information is from MACPAC review of outpatient fee-for-service payment methods as of November 2015.

Managed Care

Currently, Louisiana contracts with five managed care organizations (MCOs) to cover physical and specialized behavioral health services for nearly 1.5 million enrollees. The MCO have a broad range of covered lives with the largest covering approximately 32 percent of enrollees and the smallest covering 8 percent of enrollees. All plans are part of national organizations, including one with a Blue Cross / Blue Shield affiliation. Behavioral health services initially were carved-out, but behavioral health services are currently integrated with the five MCOs. Managed care is mandatory for the most significant eligibility groups, except the aged and developmentally disabled.

Most hospital services are provided in-network and the Medicaid fee schedule serves as a mandatory rate floor for managed care payments to hospitals. State officials and other stakeholders report that most managed care payments are made using FFS rates and methods. The state plans to require MCOs to utilize the new DRG model being implemented for FFS as the minimum fee schedule.

The state has an additional managed care payment called Full Medicaid Pricing (FMP). The FMP was established during the transition to managed care and is designed to increase capitation rates to offset the loss of upper payment limit (UPL) payments in FFS. The MCOs must use the increased hospital funds received above the base rate (subject to risk adjustment) to pay for inpatient and outpatient hospital services. The FMP amount is calculated during the rate development process, and the FMP payment is paid to hospitals using allocations developed by the hospital industry. The state share of the FMP is funded primarily by IGTs and a smaller portion from CPEs from public rural hospitals.

Historically there has not been a prevalent use of value-based payments or quality incentives for hospital payment in managed care, but the state is encouraging MCOs to expand the use of value-based payments.

Supplemental Payments in FFS

Disproportionate Share Hospital (DSH) payments: At nearly \$1.2 billion, the Louisiana Medicaid DSH program is the largest in the country as a percentage of total hospital payments. Historically, most of the funds were designated for state-owned hospitals. Over the past decade the state has closed or transitioned many state-owned facilities to public private partnerships, and a significant portion of the DSH payments shifted to private hospitals.

As part of the implementation of APRDRGs, the state plans to shift an estimated \$379 million of DSH payments into base rates in 2019. A significant portion of the state share of DSH is financed by IGTs.

Upper payment limit (UPL) and other supplemental payments: When the state adopted managed care, most of the UPL payments were eliminated. Remaining UPL payments are primarily for hospitals with low-income care agreements with local governments (approximately 50 hospitals in FY 2016). The state share is largely financed by IGTs.

Graduate medical education (GME) payments: Most GME payments are from add-ons to the per diem rates based on peer groups, and cost-based settlement for outpatient cost. After DRGs are implemented, add-ons will be changed to per-case amounts. The state calculates and pays hospitals the GME add-on directly for FFS and managed care claims and makes the outpatient cost settlements. The state share is from state general funds.

Michigan

In fiscal year (FY) 2016, Michigan Medicaid spent \$16.9 billionⁱ and covered 2.3 million individuals, including more than 0.6 million adults under ACA Medicaid expansion, primarily through managed care.ⁱⁱ There are over 160 hospitals in the state of which 130 are acute care hospitals. Ownership composition of acute care hospitals is as follows: 83 percent are non-profit, 10 percent are government-owned, and 8 percent are investor-owned. Rural hospitals provide 21 percent of adjusted patient days, compared to 17 percent nationally.ⁱⁱⁱ

In the past three years the state has made three significant changes to hospital payment policy: Changing disproportionate share hospital (DSH) payment policy following expansion (FY 2015), adopting all patients refined diagnostic-related groups (APRDRGs) and statewide rates for inpatient reimbursement (FY 2016), and replacing a managed care pass-through payment with a directed rate adjustment (FY 2018).

Summary of Payments to Hospitals

In FY 2016, Michigan's Medicaid program paid approximately \$5.3 billion to hospitals (Table 5). Base payments were 51 percent of the total, and most base payments are from managed care. Supplemental fee-for-service (FFS) and managed care payments comprised 49 percent of total Medicaid payments to hospitals.

A hospital assessment based on non-Medicare net patient revenue finances most of the state share of supplemental and directed payments and provides the state with a significant amount of additional funding for its Medicaid program (over \$300 million in FY 2016).^{vi} The state also uses a certified public expenditure for a portion of DSH payments. Since FY 2014, intergovernmental transfers have not played a significant role in financing hospital payments.

TABLE 5. Michigan Medicaid Payments to Hospitals, FY 2016

FY 2016 hospital payments	Type of payment	Total (millions)	Share of total
Base payments	Fee-for-service base payments	\$539	10.0%
	Managed care base payments	\$2,184	40.3%
	Subtotal base payments	\$2,723	50.3%
Supplemental payments	Disproportionate share hospital	\$366	6.8%
	Upper payment limit/other	\$699	12.9%
	Graduate medical education	\$163	3.0%
	Supplemental payments in managed care	\$1,462	27.0%
	Subtotal supplemental	\$2,690	49.7%
Grand total		\$5,413	100.0%

Sources: Fee-for-service base payments are from a report prepared by MACPAC, derived from FY 2016 CMS-64 Financial Management Report net expenditure data. Managed care base payments and supplemental payments are derived by HMA from data supplied by the state.

Fee-for-Service Payment Methodologies

Approximately 25 percent of Medicaid enrollees received care through the FFS delivery system in FY 2016.^v The largest amount of FFS hospital payments is for enrollees who eventually enroll in managed care, but services are provided after the effective date of Medicaid coverage and prior to the effective date of managed care coverage. Also, several groups are excluded from mandatory managed care enrollment, including persons dually eligible for Medicare and Medicaid, enrollees with commercial insurance, persons in nursing and psychiatric facilities, enrollees in spend-down status, and persons in home and community-based services waivers.

The state uses APRDRGs to pay inpatient FFS base payments and a Medicare-based reimbursement method for outpatient services that is reduced by about 49 percent to maintain payments at a targeted level (Table 6). The inpatient model includes additional payment to hospitals with neonatal intensive care unit (NICU) beds and an adjustment to recognize geographic labor cost differences. No other policy adjustments or value-based payments are made.

TABLE 6. Summary of Methods for Michigan Medicaid FFS Base Payments to Hospitals

	Inpatient	Outpatient
Groups	DRG-based payment per discharge, using All-Patients Refined Diagnosis-Related Groups (APRDRG) system.	Medicare payments and methods are used for all services. The Outpatient Prospective Payment System (OPPS) is used for most services, and fee schedules are used for lab, physical therapy, and other non-OPPS services.
Weights	APRDRG weights are generally based on state-specific experience. Two sets of relative weights are used for Neonatal DRGs, a higher weight for hospitals with a NICU and a lower weight for all others.	No modifications are made to Medicare OPPS weights.
Rates	A single statewide rate is used for critical access hospitals; a statewide rate adjusted for area wage index differences is used for all other hospitals. No other adjustments are made.	Medicare payments are multiplied by a budget neutrality factor, to maintain outpatient payments at a targeted level. In SFY2018 the factor is 50.9%. Unlike Medicare, no area wage index is used.
Rules	Outlier payments are made for high cost cases. No incentives or penalties.	Outlier payments are made for high cost encounters. No incentives or penalties.

Source: MACPAC review of inpatient fee-for-service payment methods as of March 2018 and outpatient fee-for-service payment methods as of November 2015.

Recent changes: On October 1, 2015, Michigan converted from Medicare Severity Diagnosis Related Groups (MS-DRG) and hospital-specific cost-based rates, to the APRDRG inpatient model with statewide base rates described in the table above. Under the previous model, the program used hospital-specific rates with limits.

Managed Care

Michigan contracts with 11 managed care organizations (MCOs) to cover physical health services for nearly 1.8 million enrollees. Six of the MCOs have 90 percent of the enrollment. Four of the plans are part of national organizations, one is owned by the largest private insurer in the state, and the remainder are provider-owned. Behavioral health services are carved-out and managed by 10 Prepaid Inpatient Health Plans (PIHPs) and several community agencies. Managed care is mandatory for most eligibility groups, except the aged.

MCOs are required to use FFS rates and methods for payments to hospitals not under contract, and it is believed that most provider-MCO contracts also provide for FFS rates and methods, even though the state-MCO contract does not require it. There is not extensive use of value-based payments or quality incentives for hospitals. The MCO contract requires plans to develop and implement value-based provisions in the future.

Supplemental payments in managed care: Before FY 2018 Michigan distributed additional payments to hospitals through a managed care pass-through payment referred to as the Hospital Rate Adjustment (HRA) program. The HRA was a discrete component of MCO capitation. Each month, HRA capitation was allocated to hospitals using historic managed care base payments from two-years prior.

Beginning in FY 2018, the state replaced HRA with a directed add-on payment. Under the new model, hospitals receive a percentage add-on payment for inpatient and outpatient encounters on a quarterly basis, which is calculated using base payment data from the most recent quarter.

Michigan also makes pass-through payments for inpatient psychiatric services, totaling \$45 million per year. The state is planning to replace the psychiatric payment in 2019 with a fixed per-diem add-on directed payment.

The state directs up to \$100 million of the Graduate Medical Education (GME) payment (see below) to be paid through managed care.

The state share of the directed add-on payments and the psychiatric services pool is funded by the hospital assessment.

Supplemental Payments in FFS

DSH payments: There are several components to the Michigan DSH program, which have different distributions and financing sources:

- A \$45 million inpatient DSH pool is allocated to hospitals with at least 20 percent of their inpatient days for indigent care. The state share is funded by state general fund revenues.
- A \$145 million outpatient DSH pool is allocated to all DSH-eligible hospitals based on their amount of outpatient uncompensated care. The state share is funded by the hospital assessment.
- Governmental provider DSH payments, totaling \$67 million in FY 2016, is allocated to non-state public hospitals with payment equal to their remaining DSH limit. The state share is funded by a certified public expenditure.
- Institutions for mental diseases (IMDs) also receive a significant portion of DSH. The state share is funded by state general fund revenues.
- Finally, any unused federal DSH allotment along with a state match, funded by an additional hospital assessment, is distributed to hospitals with remaining uncompensated care after the DSH audit for the respective year is completed.

(Note: The remaining allotment payments are not included in Table 1.)

In FY 2015, the state eliminated additional DSH payments to hospitals in counties that provided county-funded health care coverage for low-income adults because the ACA expansion eliminated the need for these county programs. Most of the DSH funding previously used for this county indigent care support was added to outpatient DSH beginning in FY 2015.

Upper payment limit (UPL) and other supplemental payments: The state makes UPL payments for both traditional Medicaid populations and the Medicaid expansion population. The state determines the aggregate payments using annual calculations of the UPL gap (the difference between FFS payments and what Medicare would pay for the same services). Pools are distributed to all hospitals in proportion to two-year lagged FFS base payments made to the hospitals. The state share is funded by the hospital assessment.

Beginning in 2011, Michigan added two new supplemental payments to help support rural hospitals. The portion paid through managed care (approximately \$35 million in FY 2016) was determined to be a pass-through payment and was terminated in FY 2018; however, the state continues to pay the state share to rural hospitals in the form of a non-matched grant. The FFS portion continues (approximately \$10 million in FY 2016).

Graduate medical education (GME) payments: Since 1997, Michigan has had a GME pool to provide additional reimbursement for teaching hospitals' direct and indirect medical education. The pool has not been increased since its inception; and has been reduced in some years for budgetary reasons. Distribution to teaching hospitals is based on complex formulae involving resident full-time equivalents, Medicaid volume and case mix. The state share is funded by state general fund revenues.

Mississippi

In fiscal year (FY) 2016, Mississippi Medicaid spent \$5.4 billionⁱ and covered 0.7 million individuals, primarily through managed care.ⁱⁱ Mississippi has not expanded coverage to low-income adults under the Affordable Care Act (ACA). There are over 110 hospitals in the state of which over 90 are acute care hospitals. Ownership composition of acute care hospitals is as follows: 31 percent are non-profit, 45 percent are government-owned, and 24 percent are investor-owned. Rural hospitals provide 63 percent of adjusted patient days, compared to 17 percent nationally.ⁱⁱⁱ

Mississippi implemented its managed care program, MississippiCAN, on January 1, 2011, but did not include inpatient hospital services in managed care until December 1, 2015. As part of the transition of inpatient hospital services to managed care, hospital upper payment limit (UPL) supplemental payments transitioned to managed care pass-through payments to hospitals, referred to as Mississippi Hospital Access Payments (MHAP). To comply with the requirements of the May 2016 Medicaid managed care rule to phase-down pass-through payments, Mississippi replaced a portion of MHAP in FY 2018 with new directed payments based on a fee schedule adjustment. The state plans to completely transition MHAP to a mix of directed fee schedule adjustments and quality incentive payments by FY 2027.

Summary of Payments to Hospitals

Mississippi Medicaid spent approximately \$2.1 billion on hospital services in FY 2016. Over 55 percent was spent on FFS and managed care base payments, including add-ons for medical education. Disproportionate share hospital (DSH) and managed care pass-through payments made up the remaining 45 percent of hospital spending. In future years, the pass-through payments will transition to directed payments allowable under the Medicaid managed care rule, but the total spending amount is forecasted to remain constant at \$533 million.

Mississippi Medicaid spent approximately \$2.1 billion on hospital services in FY 2016. Over 55% was spent on FFS and managed care base payments, including add-ons for medical education. DSH and managed care pass-through payments made up the remaining 45% of spending.

All Mississippi hospitals are subject to a provider tax which finances the state share all supplemental payments and supplies an additional \$104 million in state funding for the general Medicaid program.^{vii}

TABLE 7. Mississippi Medicaid Payments to Hospitals, FY 2016

FY 2016 hospital payments	Type of payment	Total (millions)	Share of total
Base payments	Fee-for-service base payments	\$259	15.3%
	Managed care base payments	\$684	40.2%
	Subtotal base payments	\$943	55.5%
Supplemental payments	Disproportionate share hospital	\$223	13.1%
	Upper payment limit/other	\$0	0.0%
	Graduate medical education	\$0	0.0%
	Supplemental payments in managed care	\$533	31.4%
	Subtotal supplemental	\$756	44.5%
Grand total		\$1,699	100.0%

Sources: Fee-for-service and managed care base payments are from a report published by the state. Because of the midyear shift of inpatient services to managed care, FY 2017 inpatient amounts are used in the above table (approximately the same total as FY 2016). Disproportionate Share Hospital payments are from FY 2016 CMS-64 Financial Management Report net expenditure data. The managed care supplemental payment was provided by state officials.

(Note – the managed care supplemental payments replaced a UPL payment on December 1, 2015. A portion of the amount shown as supplemental payments in managed care in the above table was a UPL payment in FY 2016; the entire amount is shown as supplemental payments in managed care to be consistent with all subsequent years.)

Fee-for-Service Payment Methodologies

Approximately 30 percent of Medicaid beneficiaries received care through the fee-for-service (FFS) delivery system in FY 2016.^v These include Medicaid beneficiaries in any home and community-based waiver program, enrollees dually eligible for Medicaid and Medicare, and those residing in institutions. Medicaid enrollees that qualify under supplemental security income, children with disabilities living at home, and foster care children are not required to enroll in managed care.

In FFS, Mississippi Medicaid pays for inpatient hospital services using all patients refined diagnostic-related groups (APRDRGs) and pays for outpatient hospital services using an outpatient prospective payment system (OPPS) like Medicare, including ambulatory patient classifications (APC) bundling (Table 8). Adjustors are applied to inpatient payments to recognize specific services and add-ons are included for hospitals eligible for medical education payments. OPPS reimbursement is determined consistent with APC weights, Medicare pricing, and the Medicare fee schedule. By state law, outpatient reimbursement is discounted by 5 percent for all services.

TABLE 8. Summary of Methods for Mississippi Medicaid FFS Base Payments to Hospitals

	Inpatient	Outpatient
Groups	DRG-based payment per discharge, using All-Patients Refined Diagnosis-Related Groups (APRDRG) system.	Outpatient Prospective Payment System (OPPS) similar, but not identical, to the Medicare OPPS, including APC bundling. Differences include the application of a charge cap and the range of services covered.
Weights	State-specific relative value weights are used, with obstetric/newborn, neonate, rehab, mental health, and transplant weight increases.	Medicaid uses the same relative weights as Medicare adjusted annually.
Rates	A single base payment is used for all hospitals. Beginning FY 2019, a pediatric or adult Medicaid Care Category adjustor is assigned to each claim.	Reimbursement for services or procedures is determined by 95% of the APC rate. If no APC weight is assigned, reimbursement is 95% of the Medicare payment rate if available or if not, the Medicaid fee.
Rules	Outlier payments are made for high cost cases. For hospitals that qualify for graduate medical education (GME) payments, a per stay amount is added on. No incentives or penalties.	No outpatient outlier payments are made. Date bundling is allowed for physical, occupational, and speech therapies; chemotherapy services; observation; emergency room; and recovery room. No incentives or penalties.

Sources: MACPAC review of inpatient fee-for-service payment methods as of March 2018 and outpatient fee-for-service payment methods as of November 2015.

Recent and planned changes: Mississippi implemented APRDRGs and OPPS in 2012; the implementation of OPPS Phase 2, which included procedure bundling, was delayed until FY 2016. Mississippi plans to establish pediatric and adult Medicaid Care Category adjustors in FY 2019. In 2018, legislation passed allowing rural hospitals to opt-out of DRG/OPPS payments and be reimbursed at 101 percent of cost. This change is expected to be implemented in 2019.

Managed Care

Approximately 70 percent of Medicaid beneficiaries are enrolled in Mississippi's managed care program, MississippiCAN. Effectively July 1, 2018, MississippiCAN coverage is provided by three coordinated care organizations (CCOs): Magnolia Health (Centene), UnitedHealthcare of Mississippi, and Molina Healthcare of Mississippi. All three health plans are affiliated with national organizations. Managed care is mandatory for most eligibility groups and optional for the enrollees with supplemental security income (SSI), disabled children living at home, and foster care children.

State law requires managed care plans to pay at a rate no less than fee-for-service Medicaid reimbursement. However, the state Medicaid agency reserves the right to approve use of alternative payment models. Participation in the provider network of any health plan cannot be conditioned on the provider's agreement to accept an alternative payment model.

Supplemental payments:

- In December 2015, when inpatient services transitioned from FFS to managed care, the state's hospital tax-funded UPL payments transitioned into MHAP pass-through payments made by the CCOs. The pass-through payments totaled \$533.1 million. Under the 2016 managed care rule, these transitioned payments must be phased out by the end of FY 2027.
- To comply with the managed care rule, Mississippi received approval to begin making directed payments in FY 2018. Specifically, \$110.9 million will be paid through directed fee schedule adjustments in FY 2018. Under the new directed payments model, there is a per-discharge add-on for inpatient hospital services and a percentage increase for outpatient hospital services. The adjustments are higher for critical access hospitals and lower for non-critical access hospitals.
- From 2019-2027 the state will continue to transition the MHAP payments to fee schedule adjustment and quality incentive payments.
- Until 2027 there will be three payment types (MHAP, fee schedule adjustments and quality payments) and the sum in each year is expected to equal \$533.1 million. The state anticipates that the directed fee schedule adjustments will be limited to \$153.1 million, and remaining reductions to the pass-through payments beyond that amount will be paid as quality incentive payments. The quality component is being discussed and is expected to begin in 2020.
- The state share of the managed care supplemental payments is financed entirely through the hospital tax.

Supplemental Payments in FFS

Disproportionate Share Hospital (DSH) payments: Mississippi spent \$223 million on DSH payments in FY 2016. All hospitals meeting the federal requirements for receiving DSH payments are included in Mississippi's DSH distribution methodology. Payments are allocated across hospitals based on net uncompensated care costs for uninsured individuals, with the exception that the state-owned teaching hospital receives twice as much funding relative to its share of net uninsured costs. DSH payments are entirely financed through the hospital tax.

Prior to December 2015, Mississippi made \$533.1 million in inpatient UPL payments to hospitals. In December 2015, that full amount was transitioned to MHAP payments that pass through the CCOs.

Graduate medical education (GME) payments: Mississippi does not make supplemental GME payments. Instead, GME add-ons are built into the APRDRG reimbursement methodology.

Virginia

In fiscal year (FY) 2016, Virginia Medicaid spent \$8.6 billionⁱ and covered 1.0 million individuals, primarily through managed care.ⁱⁱ Virginia's legislature recently approved ACA Medicaid expansion, which is planned to begin in 2019. There are over 120 hospitals in the state of which nearly 90 are acute care hospitals. Ownership composition of acute care hospitals is as follows: 68 percent are non-profit, 9 percent are government-owned, and 23 percent are investor-owned. Rural hospitals provide 14 percent of adjusted patient days, compared to 17 percent nationally.ⁱⁱⁱ

In the past four years the state has made two significant changes to hospital payment policy: adopting enhanced ambulatory payment group (EAPG) reimbursement for outpatient services in 2014, with a 3.5-year transition, and changing from all-patients diagnostic related groups (APDRGs) to all-patients refined diagnosis-related groups (APRDRG) on October 1, 2014.

Additional changes are being planned for FY 2019: the state is developing a new upper payment limit (UPL) payment applicable to fee for service (FFS) and a new managed care directed payment, to be financed by a new hospital assessment.

Summary of Payments to Hospitals

In FY 2016, Virginia's Medicaid program paid approximately \$2.0 billion for hospital services (Table 9). Base payments were 78 percent of total payments and most of these payments were made under managed care. Supplemental payments comprised 22 percent of total Medicaid hospital payments. The state does not currently have a hospital assessment or tax. The state uses intergovernmental transfers (IGTs) for its current UPL payments and certified public expenditures (CPEs) for a small part of the state share for GME payments to state hospitals.

TABLE 9. Virginia Medicaid Payments to Hospitals, FY 2016

FY 2016 hospital payments	Type of payment	Total (millions)	Share of total
Base payments	Fee-for-service base payments	\$502	25.5%
	Managed care base payments	\$1,028	52.2%
	Subtotal base payments	\$1,530	77.7%
Supplemental payments	Disproportionate share hospital	\$172	8.8%
	Upper payment limit/other	\$2	0.1%
	Graduate medical education	\$265	13.4%
	Supplemental payments in managed care	\$0	0.0%
	Subtotal supplemental	\$439	22.3%
Grand total		\$1,969	100.0%

Sources: Fee-for-service and supplemental payments are from a report prepared by MACPAC, derived from FY 2016 CMS-64 Financial Management Report net expenditure data. Managed care payments are estimated by MACPAC based on CMS-64 data.

Fee-for-Service Payment Methodologies

Approximately 24 percent of Medicaid enrollees received care through the FFS delivery system in FY 2016.^v The largest amount of FFS hospital payments covers services provided to managed care enrollees from the effective date of Medicaid coverage to the effective date of managed care coverage. Also, in FY16, several groups were excluded from mandatory managed care enrollment, including persons dually eligible for Medicare and Medicaid,

enrollees with commercial insurance, most persons receiving LTSS services and persons in programs of all-inclusive care for the elderly (PACE).

The state uses All-Patients Refined Diagnosis-Related Groups (APRDRGs) to pay inpatient FFS base payments and uses Enhanced Ambulatory Payment Groups (EAPGs) for outpatient services (Table 10). An adjustment to recognize geographic labor cost differences is included in the inpatient and outpatient models. Reimbursement is reduced for inpatient preventable complications. No other policy adjustments or value-based payments are made.

TABLE 10. Summary of Methods for Virginia Medicaid FFS Base Payments to Hospitals

	Inpatient	Outpatient
Groups	DRG-based payment per discharge, using All-Patients Refined Diagnosis-Related Groups (APRDRG) system. Cost based reimbursement for capital. Per diem reimbursement for psychiatric and rehab services.	Procedure-based payment for outpatient claims, using the Enhanced Ambulatory Payment Groups (EAPG) system.
Weights	APRDRG weights are generally based on state-specific experience. No policy adjustments are made for target services.	EAPG weights are based on national weights supplied by the vendor. No policy adjustments are made for target services.
Rates	A single statewide rate adjusted for area wage index differences is used for all hospitals. For wage index purposes, rural hospitals receive the greater of the rural index or the index from the closest urban area. No other adjustments are made.	A single statewide rate adjusted for area wage index differences is used for all hospitals. For wage index purposes, rural hospitals receive the greater of the rural index or the index from the closest urban area. A separate (higher) base rate is used for the two state university hospitals; a 5% increase is made for the children’s hospital; all other hospitals have the same base rate.
Rules	Outlier payments are made for high cost cases. No reimbursement is made for provider-preventable conditions. No other incentives or penalties.	No incentives or penalties.

Sources: HMA review of State Administrative Code, and MACPAC review of inpatient fee-for-service payment methods as of March 2018 and outpatient fee-for-service payment methods as of November 2015.

Recent changes: On January 1, 2014, Virginia converted from a cost-based fee schedule to EAPG for outpatient. On October 1, 2014 the state converted from APDRG weights to APRDRG weights for inpatient services.

Managed Care

As of July 1, 2017, Virginia’s managed care program covered approximately 750,000 enrollees. The state recently completed a procurement of a new MLTSS program that began August 1, 2017 covering dual eligibles and individuals with LTSS and a re-procurement of its family and children’s managed care program and beginning August 1, 2018, which added enrollees with commercial insurance. The state will have contracts with six managed care organizations (MCOs). Four of the plans are part of national organizations and two are local non-profit organizations. Managed care is now mandatory for most eligibility groups.

MCOs are required to use FFS rates and methods for payments to non-contracted hospitals, and it is believed that most provider-MCO contracts also provide for FFS rates (or in some cases modest increases above FFS rates) and FFS methods, even though the state does not require it. There is not extensive use of value-based payment

provisions or quality incentives for hospital payments in managed care. However, the MCO contract requires plans to develop and implement value-based provisions in the future.

The state does not currently make any directed payments under managed care, but the state is in the process of adding a new directed payment program for FY 2019. The managed care allocation of GME payments is paid by the state directly to hospitals.

Supplemental Payments

Disproportionate share hospital (DSH) payments: There are three components to the Virginia DSH program:

- Two public university-based hospitals are allocated a DSH payment equal to their hospital-specific DSH limit, up the available DSH allotment. The state's one children's hospital also receives a significant amount of DSH payments. These hospitals receive most of the DSH payments in Virginia.
- A \$24 million payment allocated to hospitals with at least 14 percent Medicaid inpatient utilization. Available funds are converted to a per diem amount (funds divided by eligible patient days) and each hospital receives DSH payments based on its eligible patient days times the per diem rate. Eligible patient days are generally based on the number of Medicaid patient days exceeding the 14 percent Medicaid inpatient utilization rate threshold. Out-of-state hospitals are also eligible DSH, but it is reduced for hospitals with small Virginia Medicaid utilization.
- Institutes for Mental Disease (IMDs) also receive a portion of DSH payments.

Upper payment limit (UPL) and other supplemental payments: The state currently makes relatively small UPL payments (\$2.0 million in FY 2016) to private hospitals in which a public university-based hospital has an ownership interest. Two large private hospitals affiliated to public medical schools are eligible for supplemental payments in FY18. UPL payments are funded by IGTs. As described below, the state is in the process of adding new UPL payments for private acute care hospitals for FY 2019.

GME payments:

- Direct medical education payments for GME and other health professions education are made to teaching hospitals. GME is paid using a hospital specific per-resident amount x number of FTE residents, except for two public university-based hospitals, which receive 100% of allowable costs. Other health professions education is reimbursed at cost.
- Indirect medical education (IME) payments are paid to teaching hospitals using a formula that considers full-time equivalent residents and available beds (similar to the Medicare formula). Out-of-state hospitals with significant Virginia Medicaid utilization are also eligible for IME. Two public university-based hospitals and the one children's hospital receive additional IME, using a formula intended to result in total inpatient reimbursement equal to cost.

The state share of DSH and GME is funded primarily by state general funds. The state share of IME payments is funded partly by a CPE from the university-based hospitals and the majority from general revenue.

Future Changes

In late May, the state approved Medicaid expansion for low-income adults effective January 2019. The state will expand coverage through a state plan amendment while at the same time seeking a Section 1115 demonstration waiver to impose work requirements on the Medicaid expansion population.

The legislation that approved the Medicaid expansion also made several significant changes in hospital payment policy:

- A new UPL payment will be established to pay the difference between what Medicaid pays and what Medicare would pay for FFS inpatient and outpatient hospital services. The new payment is expected to

be a quarterly percentage add-on based on the most recent quarter's FFS base payments. The increase applies to the existing program on 10/1/18 and expansion on 1/1/19.

- A new directed payment will be created to pay the difference between what Medicaid managed care plans pay and what Medicare would pay for hospital services delivered in managed care. The payment is expected to be a quarterly percentage add-on based on the most recent quarter's managed care base payments. The timing is the same as the FFS increase and it applies to the same populations (existing Medicaid enrollees and expansion enrollees).
- The supplemental payments to private hospitals affiliated with public university-based hospitals and private hospitals affiliated with public medical schools will be eliminated.
- A new hospital assessment will be implemented, based on net revenue, to finance the state share of the new UPL and directed payments described above and finance the state share of the cost of Medicaid expansion.

Because of Medicaid expansion, the state expects significant DSH savings from the reduction of uncompensated care costs at university-based hospitals.

ⁱ Henry J. Kaiser Family Foundation (KFF). Total Medicaid spending FY 2016. <https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/>

ⁱⁱ Henry J. Kaiser Family Foundation (KFF). Medicaid expansion enrollment FY 2016. <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/>

ⁱⁱⁱ HMA analysis of the American Hospital Association annual hospital survey database, 2016 information

^{iv} AHCCCS website, SFY 2016 Assessment Model

^v Henry J. Kaiser Family Foundation (KFF). Share of Medicaid Population Covered under Different Delivery Systems FY 2017. <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/>

^{vi} Assessment information derived by HMA from analysis of state data

^{vii} Assessment information was provided by state officials