September 20, 2024

Themes from Hospital Payment Index Technical Expert Panel

Asher Wang and Chris Park

Medicaid and CHIP Payment and Access Commission

@macpacgov

www.macpac.gov

Overview

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  - Medicaid hospital payment
  - Prior Medicaid hospital payment index
- Themes from Technical Expert Panel (TEP)
- Uses for payment index
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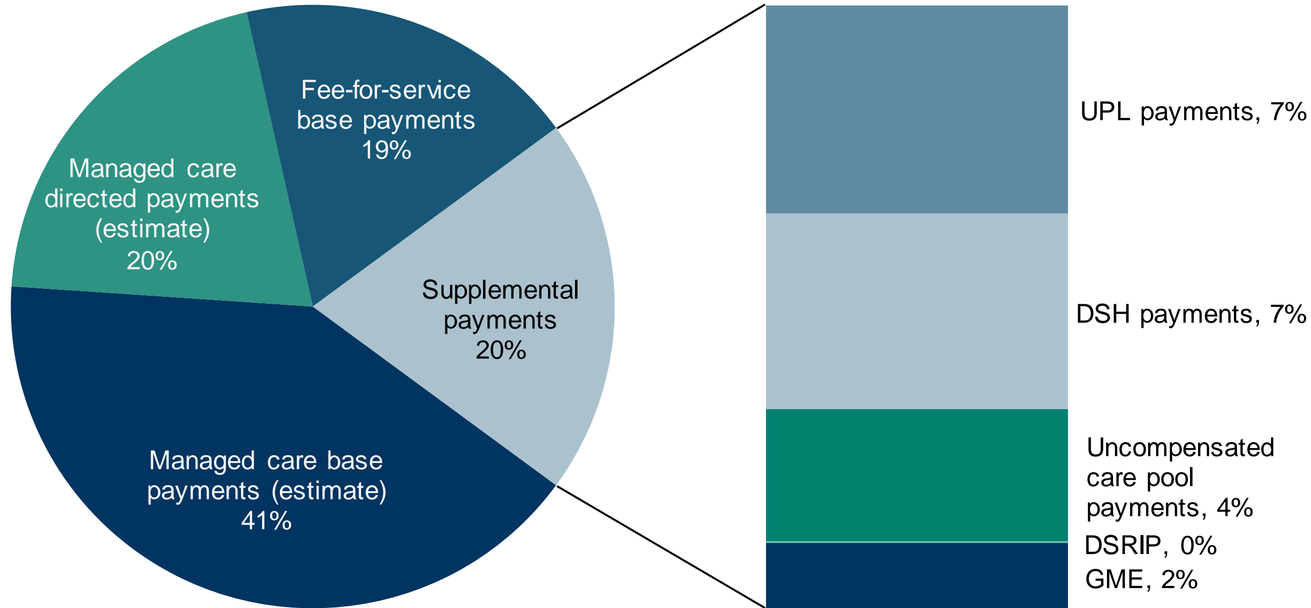
Background

Medicaid Hospital Payments

- **Base payments** are tied to specific services provided to Medicaid enrollees
  - – Medicaid fee-for-service (FFS) base payments to hospitals are on average less than the cost of providing services and less than Medicare base payment rates
- **Supplemental payments** are typically fixed, lump sum payments that can help offset low base payments and advance other goals
  - – Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), and uncompensated care pool payments are used to reduce Medicaid shortfall
    - DSH and uncompensated care pools can also pay for the cost of care for uninsured individuals
  - – Managed care state directed payments are used by many states to make large uniform rate increases, similar to lump sum FFS supplemental payments

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



Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. DSRIP spending is a non-zero amount that rounds to 0%.

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

State Financing Methods Influence Net Medicaid Payments to Hospitals

- The Medicaid statute permits states to finance the non-federal share of Medicaid spending from a variety of sources, including:
  - State general funds
  - Health care-related taxes (often referred to as provider taxes)
  - Intergovernmental transfers (IGTs)
  - Certified public expenditures (CPEs)
- Supplemental payments are often targeted to providers who finance the non-federal share of these Medicaid payments
  - In state fiscal year (SFY) 2018, provider contributions and local governments funded 65 percent of DSH payments and 46 percent of non-DSH supplemental payments
  - Provider contributions to the non-federal share of Medicaid spending reduce the net payments that providers receive

Prior Medicaid Hospital Payment Index

- In 2017, MACPAC constructed a state-level payment index for FFS inpatient hospital payments to compare:
  - Medicaid payments across states
  - Medicaid payments to Medicare
- Payment index used 2010 Medicaid Analytic Extract (MAX) claims data and adjusted for wage level and case mix variations
- The study found that:
  - Medicaid inpatient hospital base payments varied widely across states, ranging from 49 percent to 169 percent of the national average
  - Medicaid payment is comparable or higher than Medicare after accounting for supplemental payments and provider financing

Themes from Technical Expert Panel

Technical Expert Panel (TEP)

- Partnered with the American Institutes for Research (AIR) to facilitate a hospital payment index TEP
- The TEP discussed ways to update the prior payment index and incorporate data on outpatient hospital services and managed care
  - Included participants from federal and state government, hospitals, consultants, and researchers with expertise in Medicaid and Medicare payment policies
- Topics
  - Availability and reliability of current data sources
  - Methods for calculating the hospital payment index
  - Benchmarks for Medicaid payment comparison
  - Methods to account for supplemental payments and provider financing
  - Potential uses and policy implications

T-MSIS Data Validation

- T-MSIS Analytic File (TAF) is the primary source for Medicaid hospital base payments at the provider and beneficiary level
- Distribution of stays and visits were within reasonable ranges and spending was comparable to other benchmarks
- Inpatient hospital claims were largely complete, but about one-third of outpatient hospital claims were missing key information (e.g., procedure codes) required to classify services for a case mix adjustment
- While supplemental payment claims can be submitted in T-MSIS, these data were incomplete

Additional Data Sources

- **CMS-64** – State-level summary of expenditures are accurate and timely, but information is not available at the provider or beneficiary level
- **DSH audits** – Contains provider-level data on DSH payments, but it is not timely (most recently available is from 2019)
- **Supplemental payment validation (SPV) data** – New data set contains provider-level data on non-DSH supplemental payments and allows for better allocation of payments across providers
- **Directed payment preprints** – States report projected expenditures in preprints, but these estimates may differ from actual directed payment spending and may only be available at a provider class level
- **Hospital cost reports** – Hospital-level data that can be used to estimate Medicaid costs and assign facility characteristics, but may not include information for all hospitals (e.g., children's hospitals)

Proposed Methods to Calculate Index

- While an overall hospital payment index would be useful, participants suggested breaking down components of the payment index based on service type (inpatient vs outpatient) and delivery system (FFS and managed care)
  - Would allow for different methods to account for varying levels of data quality
- Missing procedure codes in outpatient data make it difficult to classify services and adjust for case mix
  - Data concerns may be addressed by focusing on selected states with high-level quality or using a different metric such as payment-to-cost ratios
  - Outpatient hospital payment index should still be attempted even with these limitations

Adjustments for Outliers, Wage, and Case Mix

- Participants discussed various methods of excluding outliers while keeping legitimate high-cost cases (e.g., transplants, neonatal intensive care unit stays) in the dataset
  - Suggested identifying outliers based on average daily cost rather than trimming the top percentage of total dollars
- Some participants identified refinements to the prior index methodology to adjust for variations in wage levels and case mix
  - The pre-reclassification, pre-floor Medicare wage index may reflect state differences more accurately than final wage index used in prior methodology
  - Using All Patient Refined Diagnosis Related Grouper (APR DRG) weights could be simpler than the regression analysis used in prior methodology

Accounting for Directed Payments

- Including managed care payments introduces new challenges due to directed payments
- Preprints report estimated spending on directed payments but are not reconciled to actual amounts
  - May be at the provider class level (e.g., public hospitals) but not at individual provider level
  - Fee schedules set at state plan rates do not require preprint
- Directed payments may be paid through base rate adjustments or through lump sum payments
  - Base rate adjustments may be included in the payment on T-MSIS claims
  - Lump sum amounts would need to be added from preprint estimates

Supplemental Payments and Provider Financing

- Participants supported using the new SPV data to allocate supplemental payments at the provider level rather than assuming an average spread across all providers
  - The prior index demonstrated that method used to account for supplemental payments can affect total calculations of hospital payments
  - States may allocate supplemental payments to specific types of hospitals and services (e.g., public hospitals, labor and delivery services)
- Lack of financing data at the provider level to calculate Medicaid net payments to specific providers
  - Directed payment preprints contain some information on state financing sources but not necessarily the amount contributed by providers
  - 2020 Government Accountability Office report surveyed states on the use of financing methods at a high level and remains the best source of information
- Some participants cautioned that not all hospital financing of the non-federal share is used to fund hospital payments and it will be important to consider whether to net out amounts that that do not finance payments back to those providers

Benchmarks for Medicaid Payment Comparisons

- 2017 index benchmarked against Medicare FFS data for 18 high-volume Medicare Severity Diagnosis Related Groups (MS-DRGs)
  - Participants were interested in additional services that are mainly covered by Medicaid, such as labor, delivery, pediatric, and behavioral health services, but Medicare may not be the most appropriate benchmark for these services
- Hospitals with a low volume of Medicare services (e.g., children's hospitals) may need to be considered separately
- Additional breakouts by facility characteristics (e.g., urban vs rural) would be helpful comparisons for stakeholders
- Comparing payment to costs could be another useful metric to compare Medicaid payments across states
  - States often look at payment-to-cost ratios as a benchmark when setting rates

Payment Index Uses and Policy Implications

- Hospitals are interested in payment rate comparisons across states, including supplemental payments
- Cross-state comparisons and comparisons with Medicare payments can inform state decisions for budgeting purposes
- Increase transparency on Medicaid spending and highlight areas that need more sufficient data
- Tie hospital payments to quality, outcomes, and access
  - Examples include the relationship between payment rates and provider closures or comparison of state outcomes relative to reimbursement levels

Next Steps

- Construct an updated payment index that will compare Medicaid hospital payments across states and to Medicare payment rates
  - Updated payment index will incorporate FFS and managed care payments, and inpatient and outpatient services
- Continue to review UPL narratives and directed payment preprints to inform how states are targeting those payments to certain classes of providers

Areas for Commissioner Discussion

- Any clarifying questions regarding the previous index or TEP findings
- Any comments or considerations for the next phase of work
  - Methodological considerations
  - Specific categories of hospitals you would like the analysis to highlight

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