MACPAC

# Assessing the Role of Base and Supplemental Payments to Hospitals

## Medicaid and CHIP Payment and Access Commission

Robert Nelb

# Overview

- Background
- Base payments
- Supplemental payments
- Illustrative examples
- Policy questions
  - What is  the most appropriate relationship between base and supplemental payments?
  - Should there be more explicit federal parameters on levels of base payments and the use of supplemental payments?
- Next steps

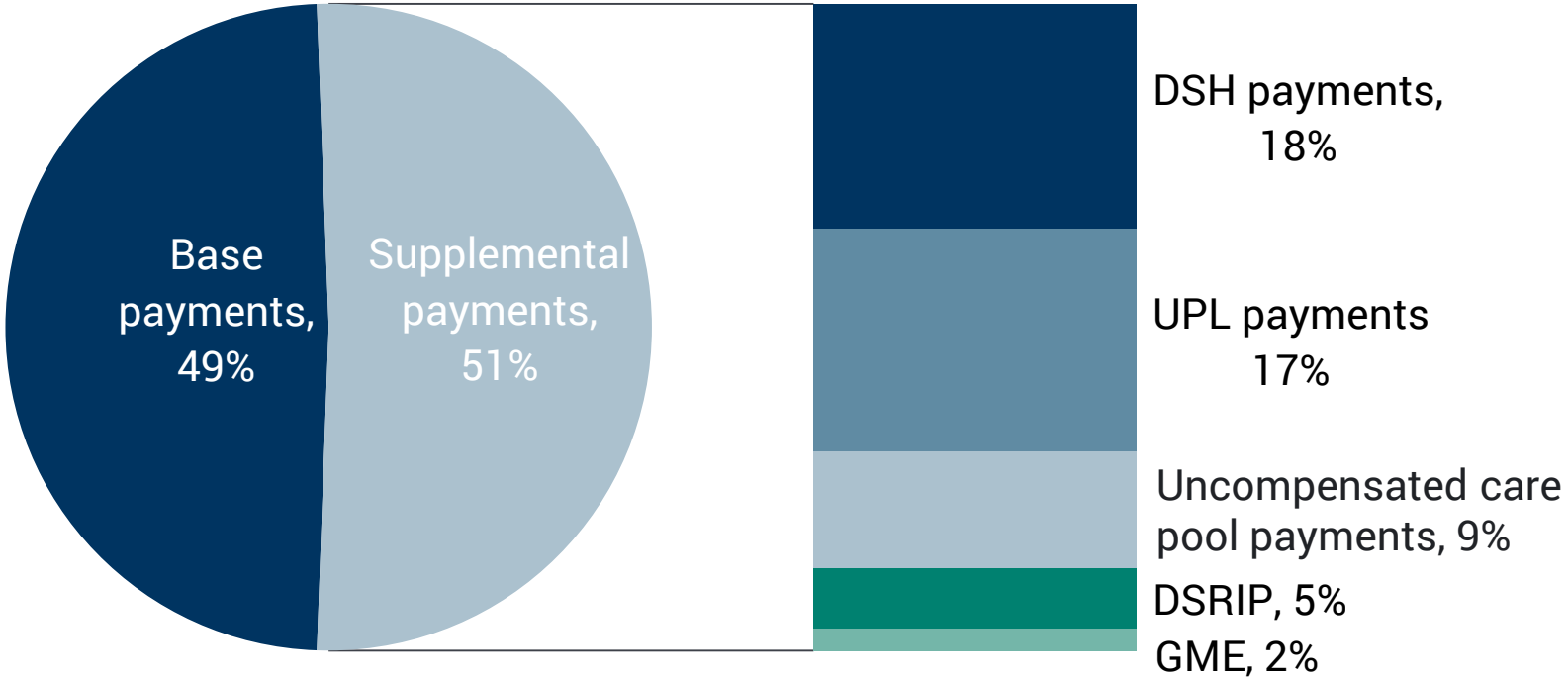
# Hospital Payment Work Plan

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

# Background

- Many states make supplemental payments to offset low Medicaid base payment rates
- Supplemental payments are also used to:
  - Provide access to care for uninsured patients
  - Promote overall hospital financial viability
- Different views about supplemental payments
  - Federal policymakers: concerns about transparency and accountability
  - States: value the flexibility of multiple payment streams
  - Hospitals: concerns about low base payment rates

# Base and Supplemental Payments as a Share of Total Fee-for-Service 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 waivers. Analysis excludes managed care payments, payments to mental health facilities, and electronic health record incentive payments to hospitals. Total does not sum due to rounding.
**Source:** MACPAC, 2018, analysis of CMS-64 net expenditure data.

# Base Payments

# Fee-for-Service Base Payments

- Federal requirements
  - CMS reviews state plan amendments to change FFS rates
  - States are now required to submit access monitoring review plans every three years
- On average, FFS base payments are below costs and below Medicare rates for comparable services
  - 82 percent of costs for disproportionate share hospitals (DSH) in state plan rate year 2013
  - 78 percent of Medicare in 2011 for selected services
- FFS base payments vary considerably across states and also vary within states

# Managed Care Base Payments

- Managed care capitation rates are required to be actuarially sound
- Managed care plans have flexibility to design their payment policies to hospitals
  - Plans must meet network adequacy requirements
  - States can require plans to direct payments to particular providers for rate increases or quality improvement activities
- Managed care payments are similar to fee-for-service in some states, but different in others

# Supplemental Payments

# Spending and Implied Goals of Supplemental Payments to Hospital, FY 2016

| Type of supplemental payment | Total spending (billions) | Number of states | Intent of payment implied from federal rules | | |
|---|---|---|---|---|---|
| | | | Medicaid-enrolled patients | Uninsured individuals | Other purposes |
| DSH | $16.5 | 47 | ✓ | ✓ | |
| UPL | 16.4 | 36 | ✓ | | |
| Uncompensated care pool | 8.5 | 9 | ✓ | ✓ | |
| DSRIP | 4.5 | 8 | | | ✓ |
| GME | 1.6 | 29 | | | ✓ |

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. DSRIP is delivery system reform incentive payment. Analysis excludes managed care payments and payments to mental health facilities. Number of states reporting spending includes the District of Columbia.
**Source:** MACPAC, 2018, analysis of CMS-64 net expenditure data.

# DSH versus UPL limits

## DSH

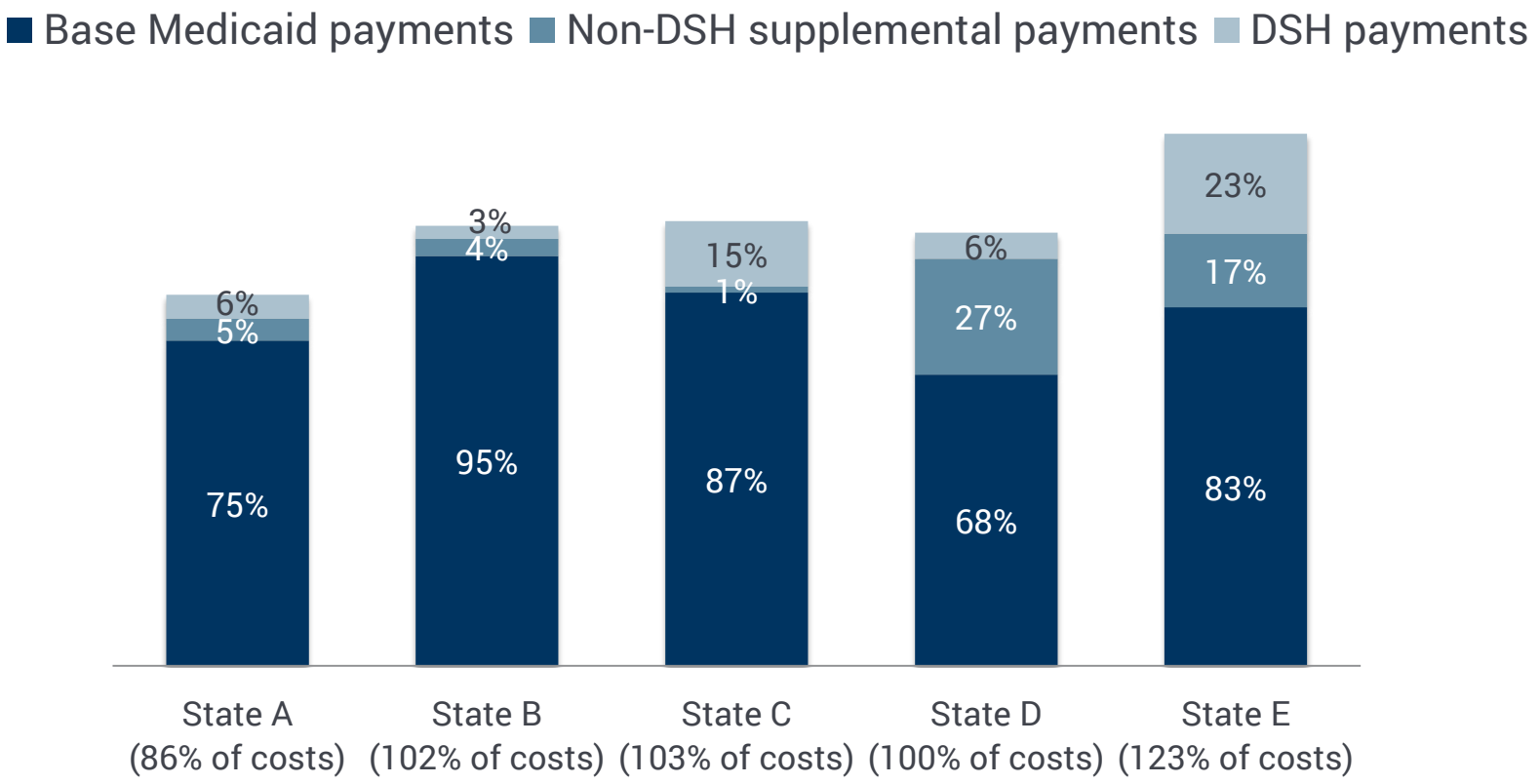
- Hospital-specific
- Cost-based
- Includes Medicaid and uninsured patients (including dually eligible patients)
- 20 percent of DSH hospitals received the maximum allowable amount of DSH payments in 2013

## UPL

- Aggregate
- Cost- or payment-based
- Medicaid services only (excluding dually eligible patients)
- States reported the ability to make $6.5 billion more in UPL payments to hospitals in 2014

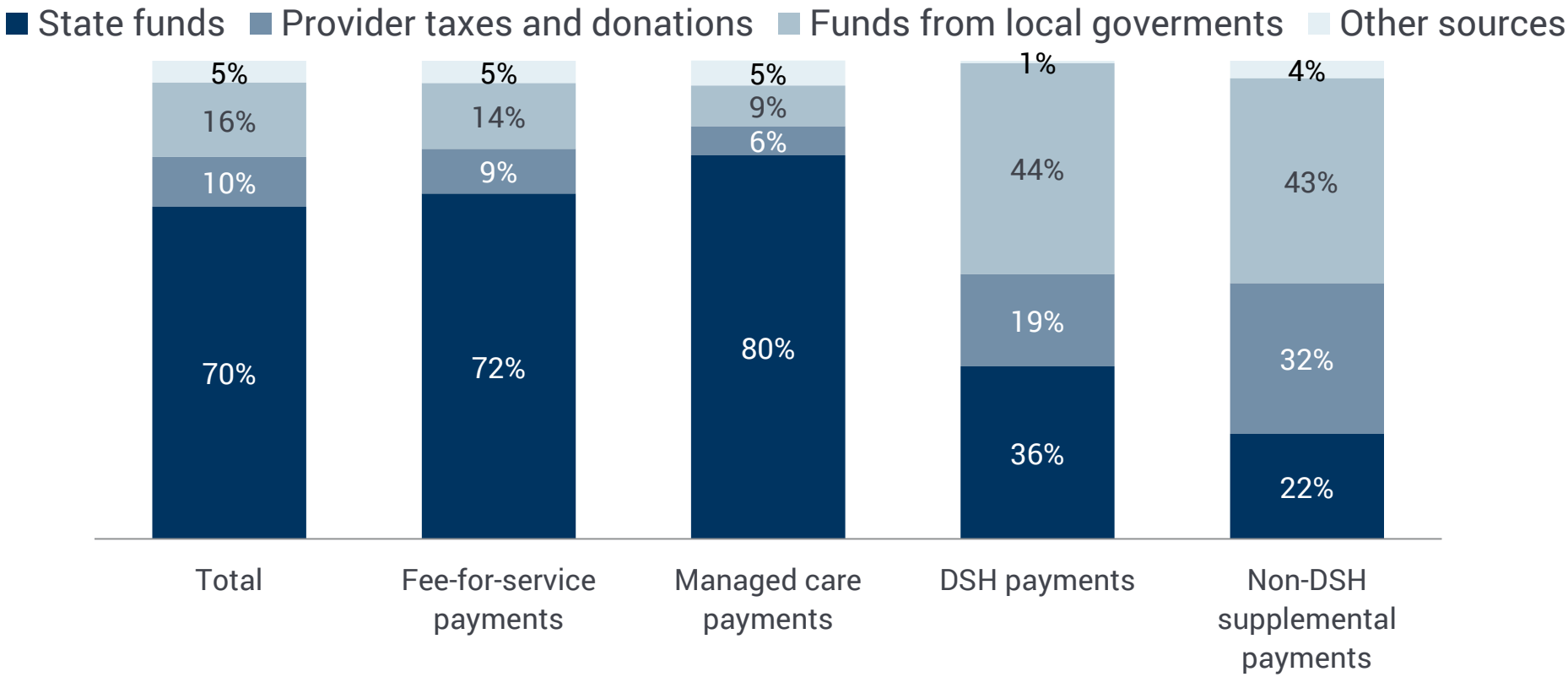
# Illustrative Examples

# Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs, SPRY 2013




**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. Institutions for mental diseases were excluded from this analysis. Base Medicaid payments include fee-for-service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on DSH audits). Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments.
**Source:** MACPAC, 2018, analysis of 2013 as-filed Medicaid DSH audits.

# Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2012




**Notes:** SFY is state fiscal year. DSH is disproportionate share hospital. State funds include state general funds and inter-agency transfers. Funds from local governments include intergovernmental transfers and certified public expenditures. Other sources include funds, such as tobacco settlement funds, that are used to fund the state's non-federal share of Medicaid expenditures and are not considered to fit in the other categories listed. Numbers do not add due to rounding. Data reflects all Medicaid payments, not just Medicaid payments to hospitals.
**Source:** U.S. Government Accountability Office (GAO), 2014, *States' increased reliance on funds from health care providers and local governments warrants improved CMS data collection*, Report no. GAO-14-627, Washington, DC: GAO.

# Policy Questions and Next Steps

# Policy Questions

- What are the implications of allowing states to use supplemental payments to offset low base rates?
- To what extent are different types of supplemental payments interchangeable with each other and with base payments rates?
- To what extent do supplemental payments pay for services provided to Medicaid enrollees versus other goals?
- Should policies affecting base payments and supplemental payments differ in FFS and managed care delivery systems?

# Policy Questions (Continued)

- Should there be more explicit federal parameters for determining base and supplemental payments?
- How would different approaches to payment compare in terms of:
  - Transparency
  - Accountability
  - Sustainability
  - State flexibility
  - Adequacy

# Next Steps

- Commission feedback on these issues will help to guide the other hospital payment analyses we have planned, including:
  - Additional analyses of UPL payment policies
  - Interviews with states and other stakeholders about the development of hospital payment policies

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