

October 29, 2026

Hospital Cost Drivers

Literature review findings

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Medicaid and CHIP Payment and Access Commission

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Overview

- Project overview
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- Drivers of hospital cost and spending
 - Labor, supplies, and administration
 - Utilization, acuity, and sites of care
 - Technology, specialty drugs, and therapies
 - Market concentration, ownership, and federal and state policy
- Next steps





Project Overview

Project Overview

- Inpatient and outpatient hospital spending account for a significant portion of healthcare spending, driven in part by rising hospital costs
- MACPAC staff are conducting a research project to identify hospital cost drivers and how they impact Medicaid hospital payment policy
- Research methods
 - Literature review
 - Fee-for-service (FFS) inpatient and outpatient hospital payment policy compendium
 - Stakeholder interviews
- Descriptive chapter in March 2027 with work continuing into the 2027/28 meeting cycle

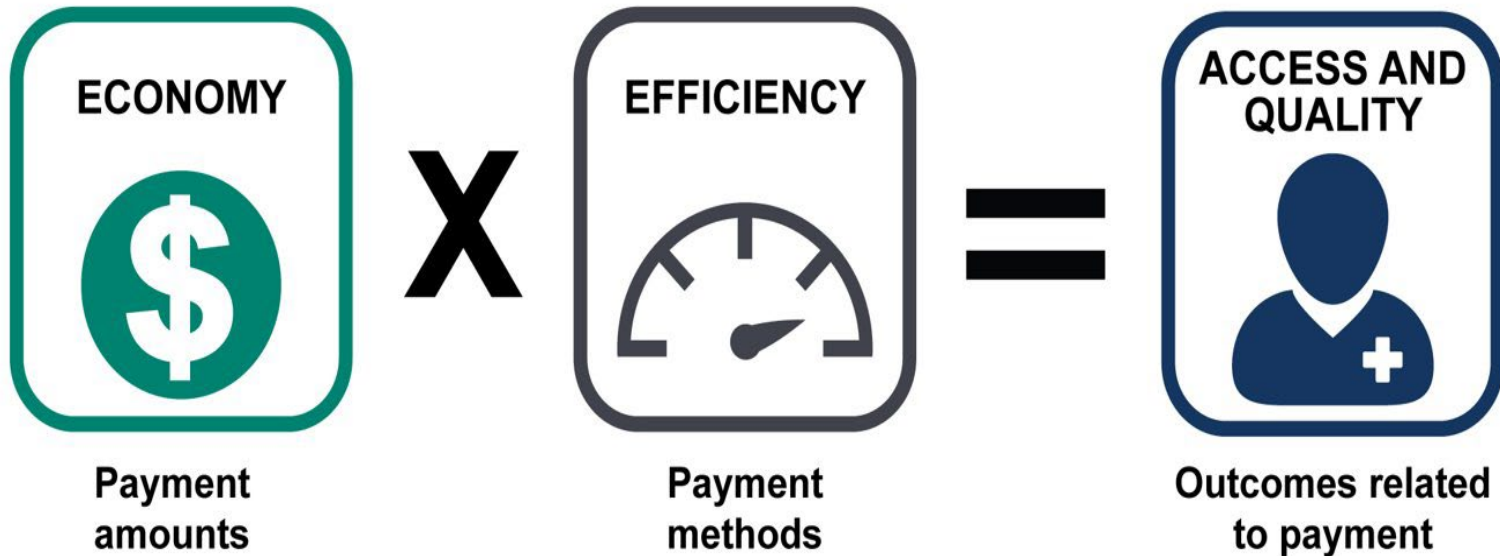
The background features a dark blue field with several overlapping, semi-transparent light blue geometric shapes. These shapes include a large circle on the left, a vertical rectangle in the center, and a horizontal rectangle to the right of the center. The word "Background" is written in white, bold, sans-serif font, positioned in the upper-left quadrant of the image.

Background

FFS Hospital Payment Methodologies

- Medicaid programs are required to cover hospital services, including non-practitioner labor, capital, medical supplies, and other operating costs
- States have flexibility to determine payments for inpatient and outpatient hospital services
 - Generally, states use a combination of base rate, adjustments, and supplemental payments
- Under managed care, the plans negotiate payment rates with providers

Provider Payment Framework



Base Payment Rates

Inpatient	Outpatient
<p>Prospective payment: fixed payment for services requiring similar resource intensity, typically based on diagnosis related groups (DRG)</p> <ul style="list-style-type: none">• Medicare Severity (MS) DRG• All Patient Refined (APR) DRG	<p>Prospective payment: bundled payment for services based on clinical and cost similarity</p> <ul style="list-style-type: none">• Ambulatory patient classification (APC)• Enhanced ambulatory patient group (EAPG)
<p>Per diem: base rate paid for each day of admission</p>	<p>Fee schedule: each service offered has its own base rate</p>
<p>Cost-based reimbursement: payments are based on individual hospitals' costs</p>	<p>Cost-based reimbursement: payments are based on individual hospitals' costs</p>

Payment Adjustments and Supplemental Payments

- States may apply payment adjustments to base payment rates to account for hospital (e.g., type, geography) or service-specific (e.g., outlier) factors
- States can make supplemental payments above their base rates
 - **Disproportionate share hospital (DSH) payments:** statutorily required payments based on uncompensated care cost to hospitals that serve a high share of Medicaid and low-income patients
 - **Non-DSH supplemental payments:** lump-sum payments that cover the difference between FFS base payments and the upper payment limit (UPL), which is the amount that would have been paid under Medicare payment principles
 - **State directed payments (SDPs):** payments made by managed care plans to providers under the direction of states (e.g., minimum fee schedule); subject to new Medicare-based limits
 - **Graduate medical education (GME) payments:** payments that help support teaching hospitals with direct costs of training and education

Costs and Spending

- Hospital costs and hospital spending are two distinct concepts
 - **Cost:** the monetary value of the goods and services a hospital expends to render services
 - **Spending:** the total amount of money paid to hospitals by payers (such as Medicaid) to render services
- Types of hospital cost
 - **Fixed overhead cost:** costs do not change with utilization. Examples include capital depreciation, amortization, rent, or property taxes
 - **Fixed operating cost:** costs incurred delivering services to patients not dependent on utilization. Examples include hospital equipment and salaries
 - **Variable operating cost:** costs incurred delivering services to patients that are dependent on utilization or acuity. Examples include medical supplies and malpractice insurance



Drivers of Hospital Costs and Spending

Labor, Supplies, and Administration

- Labor costs are a significant driver of hospital costs
 - Labor costs increased substantially during the COVID-19 public health emergency due to labor shortages and increased reliance on contract labor
 - In January 2021, hospitals experienced a 30 percent increase in labor expenses per discharge compared to the previous year
 - In Colorado, contract labor costs increased 247 percent between 2019 and 2022
- Fixed and variable operating costs such as medical and surgical supplies are significant contributors to cost growth
- Administrative processes such as prior authorization and revenue cycle management contribute to hospital costs
 - Medicaid beneficiaries require increased administrative time relative Medicare and other government insurance beneficiaries

Utilization, Acuity, and Sites of Care

- Cost impacts
 - Readmissions result in longer stays and higher overall hospitalization costs
 - Medicaid enrollees are more likely to be readmitted and have longer stays following readmission than the general population
- Spending impacts
 - Higher acuity sites of care, such as emergency departments, drive spending
 - Medicaid beneficiaries are more likely to utilize high-acuity sites of care
 - Research shows that some high-acuity care could be delivered in lower-acuity settings and result in reduced readmissions, lengths of stay, and spending
 - Maternity-related services are a significant source of Medicaid hospital spending, covering 41 percent of all births in the U.S. in 2024
- Interaction with rurality
 - Rural hospitals experience a greater number of preventable high-acuity visits, which may drive costs and spending in these settings

Technology, Specialty Drugs and Therapies

- Cost impacts
 - Cell and gene therapies (CGTs) require high-cost infrastructure, specialized training, and significant physician time
 - Medicaid plans are more likely than commercial plans to restrict coverage of CGTs
 - Research on artificial intelligence (AI) is mixed: some studies show increased efficiency and reduced costs, while others show no cost savings or even increased administrative activity
- Spending impacts
 - Specialty pharmaceuticals and biologics can dominate spending in specific Medicaid populations, and can present financing issues for Medicaid
 - Some specialty drugs and therapies may reduce acute care utilization, which could reduce future spending and costs
 - There is limited research on AI's impact on spending, though some existing research indicates that AI may lead to greater billing intensity

Market Concentration, Ownership, and Federal and State Policy

- Market concentration can increase prices, but there is less evidence on its relationship to underlying costs
 - Horizontal mergers increased inpatient and outpatient prices
 - Vertical mergers increased prices for labor and delivery services
- Ownership also impacts prices and can impact costs
 - Hospitals acquired by private equity had lower operational and patient care costs, less staffing, and fewer Medicaid discharges
 - Privately owned hospitals had higher prices and fewer Medicaid patients
- Federal and state policies have had a limited impact on hospital prices
 - Posted prices do not match actual reimbursement, even with federal transparency requirements
 - State spending growth benchmarks did not reduce growth in hospital prices



Next Steps

Next Steps

- Staff will return in January to present findings from the policy compendium
- We ask the Commissioners to provide feedback on the following questions:
 - Are there specific topics, cost drivers, or payment policies staff should focus on during the stakeholder interviews?
 - Are there certain services or hospital provider types staff should pay particular interest to?

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