MACPAC

Update on MACPAC Work on Hospital Payment Policy

Medicaid and CHIP Payment and Access Commission

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Overview

- Background
  - MACPAC structure and role
  - Medicaid hospital payment context
- Recent analyses
  - Disproportionate share hospital (DSH) allotments
  - Upper payment limit (UPL) supplemental payments
  - Managed care directed payments
- Opportunities for input and feedback

MACPAC: Structure and Role

- Non-partisan (as opposed to bipartisan)
- Provide evidence based analyses and advice to Congress and HHS on Medicaid and CHIP policy issues
  - Report annually on March 15 and June 15
  - Provides technical assistance to Congress
  - Serves as information resource to the broader health policy community
- 17 commissioners appointed by GAO
  - Meet 6 times per year in public
  - Permanent staff of about 30 based in DC

Medicaid Hospital Payment Context

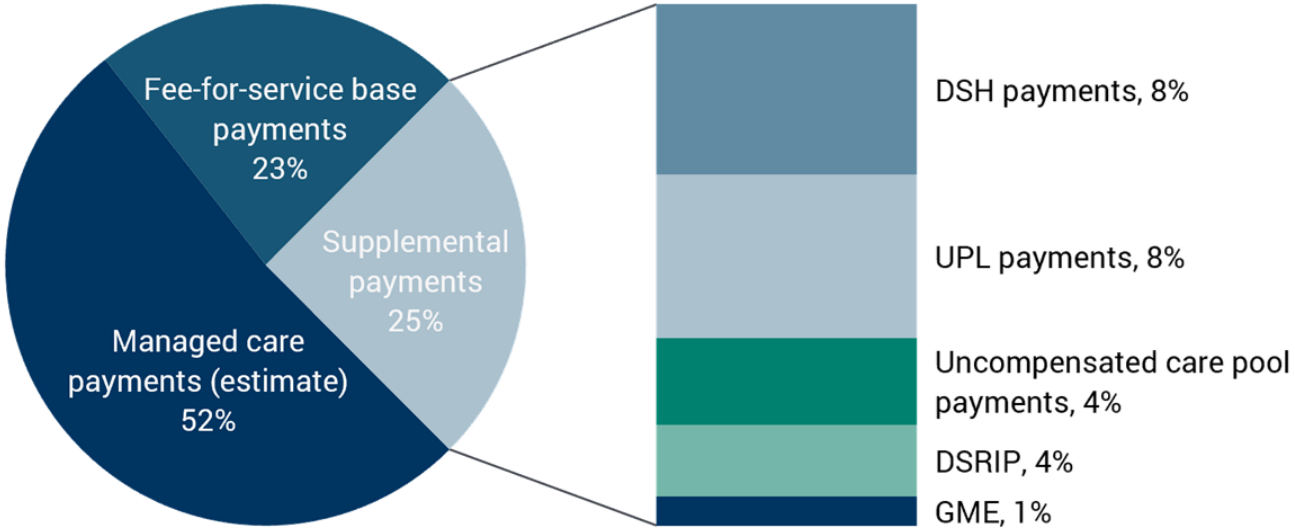
Hospital Payment Work Plan

- MACPAC's analysis of Medicaid hospital payment policy broadly considers all types of Medicaid payments to hospitals, including:
  - Base payments (fee for service and managed care)
  - Disproportionate share hospital (DSH) payments
  - Upper payment limit (UPL) supplemental payments
  - Managed care directed payments
- We are looking at how different policies work on their own and interactions
  - Are policies consistent with efficiency, economy, quality, and access?
  - Are payments appropriately targeted based on measures of need?

General Findings

- Supplemental payments account for a large share of Medicaid payments to hospitals, but there is considerable state variation
- Payment address varied goals, including:
  - offsetting low base payment rates
  - paying for unpaid cost of care for the uninsured
  - supporting hospital financial viability
- Most states finance the non-federal share of supplemental payments with provider taxes or intergovernmental transfers (IGTs)
  - Financing methods appear to affect how they are targeted
  - Provider contributions to the non-federal share also reduce net payments to providers

Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2019



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.
Source: MACPAC, 2021, analysis of CMS-64 net expenditure data.

Fee-for-Service (FFS) Base Payments

- Under federal law, payment rates and methods must be consistent with economy, efficiency, quality, and access
  - Rates cannot exceed the UPL
  - CMS reviews rates and methods as part of its approval of Medicaid state plan amendments
- FFS base payments vary widely by state
  - 2011 Medicaid inpatient base rates ranged from 49 to 169 percent of national average
  - Base payment rates are often below hospital costs

Managed Care Payments

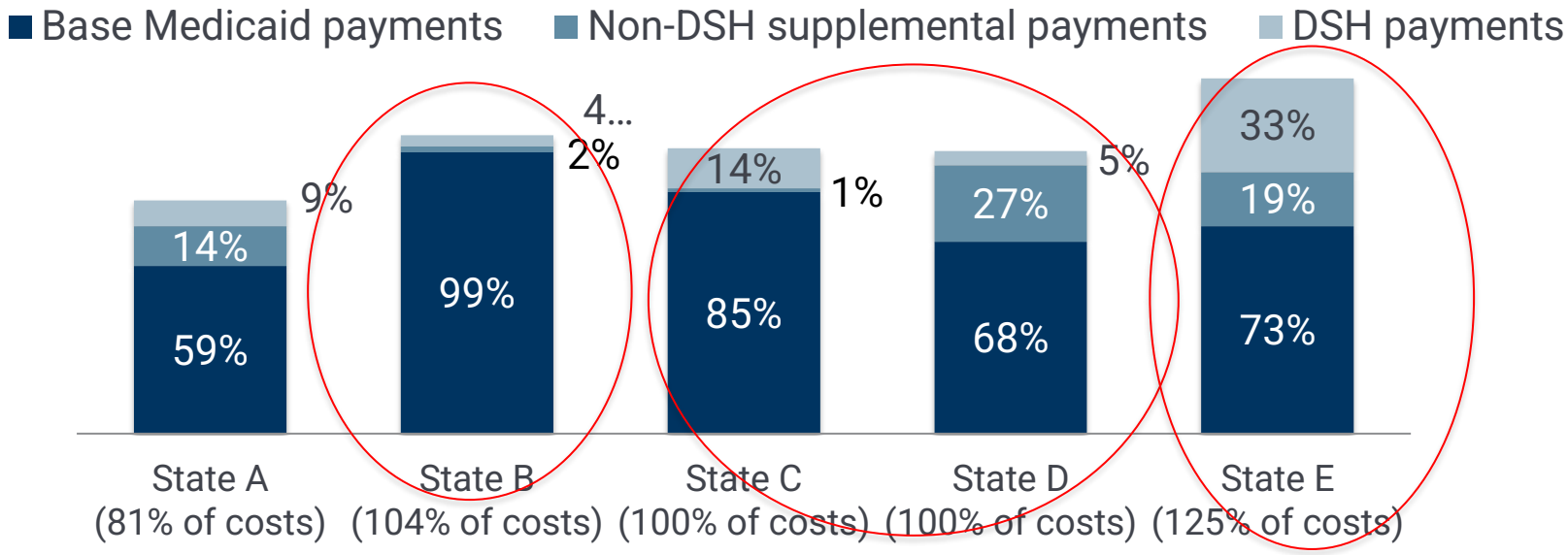
- Managed care capitation rates are required to be actuarially sound
  - Capitation rates are often initially developed based on assumptions about FFS base payment rates and utilization
  - Managed care organizations can negotiate their own payment rates with providers
- States are generally prohibited from making supplemental payments in managed care
  - CMS has granted some exceptions through Section 1115 demonstrations and new directed payment authorities

Supplemental Payments, FY 2019

Type of supplemental payment	Total spending (billions)	Number of states reporting spending	Intent of payment implied from federal rules		
			Medicaid-enrolled patients	Uninsured individuals	Other purposes
DSH	$14.9	50	✓	✓	
UPL	$14.3	32	✓		
Uncompensated care pools	$7.6	8	✓	✓	
DSRIP	$6.3	10			✓
GME	$2.5	30			✓

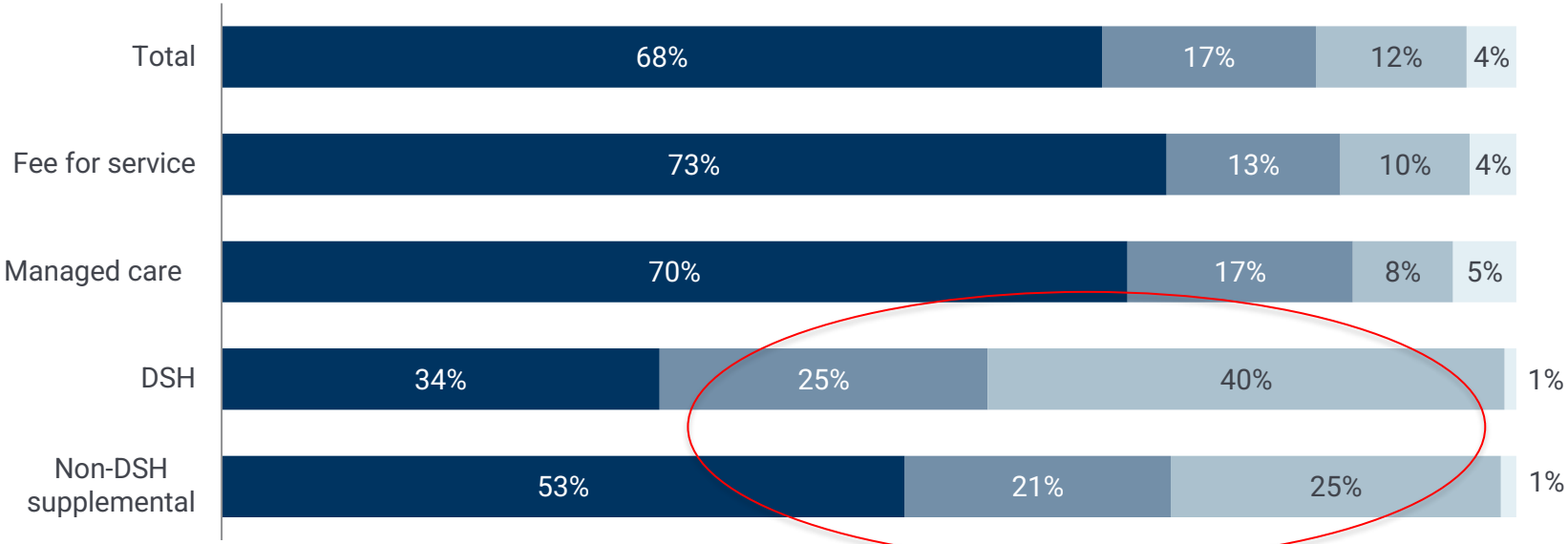
Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. DSRIP is delivery system reform incentive payment. Analysis excludes managed care payments and DSH payments to mental health facilities. Number of states reporting spending includes the District of Columbia.
Source: MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of August 05, 2020 and CMS-64 Schedule C waiver report data as of September 24, 2020.

Supplemental Payments, FY 2014



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Non-DSH hospitals and institutions for mental diseases were excluded from this analysis. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not add due to rounding.
Source: MACPAC, 2018, analysis of 2014 as-filed Medicaid DSH audits.

Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2018



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Non-DSH hospitals and institutions for mental diseases were excluded from this analysis. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not add due to rounding.
Source: GAO 2020

MACPAC Transparency Recommendations

- To enable better analyses of Medicaid hospital payments, the Commission recommended in 2016 that the Secretary of the Department of Health and Human Services collect and report:
  - hospital-specific data on all types of Medicaid payments
  - data on the sources of non-federal share necessary to calculate net payments at the provider level
- The Consolidated Appropriations Act, 2021 requires provider-level reporting of UPL and Section 1115 supplemental payments
- Data on directed payments and sources of non-federal share are still not available

DSH Allotments and Payments

Annual DSH Report to Congress

- MACPAC is statutorily required to annually report on DSH allotments
- We have found that DSH allotments have no meaningful relationship with potential indicators of need that Congress asked us to consider:
  - Number of uninsured
  - State level of uncompensated care costs
  - The number of hospitals that provide essential community services
- In the Commission's view, DSH payments should be targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and have high levels of uncompensated care
- The Commission has not taken a position on whether DSH allotment reductions should take effect

DSH Allotment Policy Goals

- In 2019 the Commission examined ways to restructure DSH allotment reductions if Congress chose to proceed with current law
- We limited our analyses to changes that would be budget neutral
- Recommendations had three goals:
  - improve the relationship between DSH allotments and measures related to hospital uncompensated care costs
  - apply reductions to states independent of their policy choices
  - phase in changes in an orderly way

MACPAC Allotment Recommendations

- Extending the schedule of reductions to phase in reductions more gradually without increasing federal spending
- Applying reductions to states with unspent DSH allotments first to minimize effects of hospitals currently receiving DSH payments
  - In fiscal year 2016, $1.2 billion in federal DSH allotments were unspent
- Revising the DSH allotment reduction methodology to gradually improve the relationship between DSH allotments and the number of non-elderly low-income individuals in a state
  - This measure is associated with uncompensated care costs and is not affect by state decisions about whether to expand Medicaid
  - CMS's current methodology does not improve the relationship between allotments and measures of need for DSH payments

Medicaid Shortfall

- DSH payments to hospitals cannot exceed a hospital's unpaid cost of care for the uninsured and Medicaid shortfall
- Medicaid shortfall is the difference between:
  - the cost of providing care to Medicaid-eligible patients, and
  - payments received for those services
- Court rulings in 2017-2019 changed how shortfall is calculated for Medicaid-eligible patients with third-party coverage, which prompted the Commission to examine this issue
  - The DC district court ruled that third-party payments (e.g., private insurance or Medicare) could not be included in calculations of shortfall
  - This decision was later overturned by the U.S. Court of Appeals for the DC Circuit

MACPAC Shortfall Recommendation

- MACPAC examined approaches to advance the following goals:
  - making more DSH funds available to hospitals that serve a high share of Medicaid and uninsured patients,
  - not creating a disincentive for hospitals to serve Medicaid-eligible patients with third-party coverage
  - promoting administrative simplicity
- In June 2019, MACPAC recommended that the DSH definition of Medicaid shortfall exclude costs and payments for patients for whom Medicaid is not the primary payer

Status of Medicaid Shortfall

- The Consolidated Appropriations Act, 2021 implemented MACPAC's recommendation for most hospitals, effective October 1, 2021
- The legislation also provided exception for hospitals that are in 97th percentile with regards to the number or share of Medicare Supplemental Security Income (SSI) patient days to total inpatient days
  - Hospitals that meet this exception would be able to include costs and payments for Medicaid-eligible patients with third-party coverage
  - CMS is still in the process of setting up a data system that will support this exemption

Future DSH Work

- MACPAC will monitor the effects of the COVID-19 pandemic on hospitals
- During the public health emergency (PHE), Congress changed how DSH allotments are calculated
  - Previously, the limit was set based on the federal share, and so increases in the federal matching rate reduced total DSH funding available
  - During the PHE, Congress set the limit based on state and federal funds combined
- Plan to examine the effects of these different methods for setting DSH allotments to inform policy when PHE ends
  - Different state effects depending on how DSH is financed
  - Implications for future countercyclical financing

UPL Payments

Upper Payment Limits

- States are required to demonstrate that FFS base and supplemental payments are below a reasonable estimate of what Medicare would pay
- MACPAC's review of state UPL demonstrations found large discrepancies in spending
  - 17 states appeared to exceed the UPL by $2.2 billion in the aggregate in 2016
  - State and CMS officials could not fully explain these discrepancies

MACPAC UPL Recommendations

- MACPAC made two UPL recommendations in 2019
  - HHS should make hospital UPL payments and their methodology publicly available
  - HHS should establish process controls to ensure UPL demonstration data are accurate and complete and that calculated limits should be used in the review of claimed expenditures
- Consolidated Appropriations Act, 2021 requires states to report provider-level UPL payment data beginning in FY 2022

Future UPL Work

- MACPAC plans to examine hospital-level supplemental payment data when available
  - How are UPL supplemental payments targeted?
  - How do UPL supplemental payments relate to DSH payments?
  - What are total base and supplemental FFS payments to hospitals?
- We are also monitoring UPL payments to hospital-based physicians and other provider types

Managed Care Directed Payments

Managed Care Directed Payments

- The 2016 managed care rule created a new option for states to direct managed care payments to providers
- MACPAC's recent review found that the use of and spending on directed payments has grown significantly in recent years
  - 65 arrangements in August 2018; more than 200 in December 2020
  - For the half of approved arrangements with spending information, projected spending totaled $25.7 billion in 2020
  - Projected spending is larger than DSH and UPL supplemental payments
  - There is no upper payment limit on directed payment spending

Directed Payment Goals

- We spoke with state officials, CMS, providers, actuaries, and health plans about their experiences with directed payments
- Findings:
  - Some directed payment arrangements are similar to supplemental payments in FFS and do not have a clear link to quality or access goals
  - Because the goals of these payments are unclear, it is difficult to assess whether they are meeting their objectives
  - It is also unclear how directed payments intended to promote access should relate to existing managed care access standards, such as network adequacy

Directed Payments to Hospitals

- Most of the largest directed payment arrangements are targeted to hospitals and financed by hospitals
- Many states have also begun making directed payments to hospital-based physicians
- Some states have used directed payments as a tool to further increase payments to providers after maximizing other types of supplemental payments
  - Several states make payments for inpatient and outpatient services that are well above Medicare payment rates
  - In some cases, states use the average commercial rate as a benchmark

MACPAC Directed Payments Recommendations

- MACPAC's June 2022 report includes several recommendations to improve transparency and oversight of directed payments related to:
  - Transparency of existing directed payment information
  - New, provider-level data on directed payment spending
  - Clarifying directed payment goals and their relationship to network adequacy requirements
  - Guidance for directed payment evaluations
  - Coordinating reviews of directed payments and managed care rates

Future Work

- The June 2022 report concludes with a discussion of potential policy approaches to establish an upper limit on directed payment spending
- Potential limits
  - External benchmark (e.g., UPL, which is based on Medicare)
  - Historic spending (e.g., DSH allotments)
- More data on directed payment spending are needed to examine these approaches

Sharing Information with MACPAC

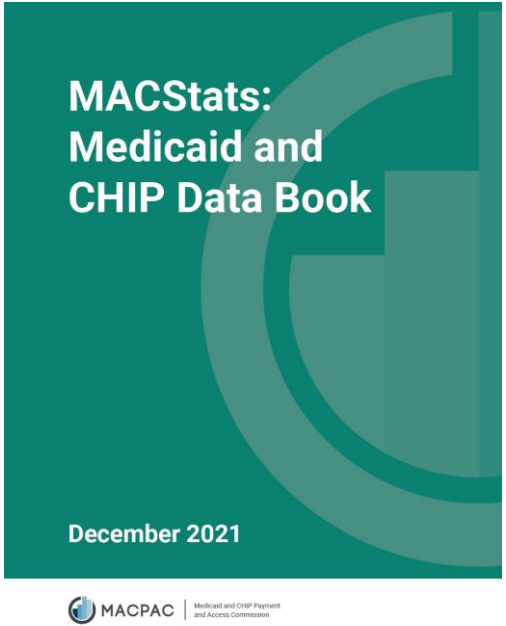
Providing Feedback

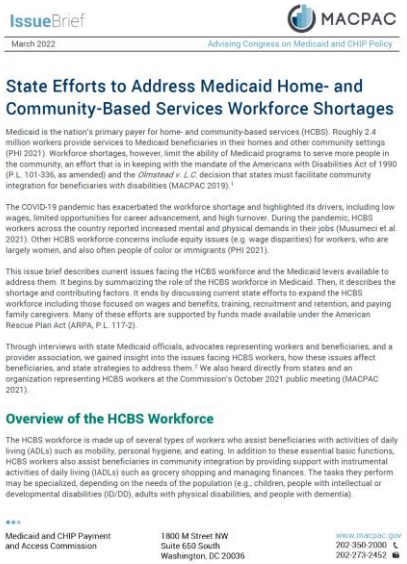
- Attend meetings virtually (go to www.macpac.gov/join-our-mailing-list/ to get notices)
- Access meeting presentations and transcripts online (www.macpac.gov)
- Provide public comment on specific issues at meetings or in writing (macpac@macpac.gov)
- Share data, experiences, concerns
- Request meetings with staff

Additional Resources

- Homepage for MACPAC work on provider payment
  - https://www.macpac.gov/topics/provider-payment/
- Medicaid base and supplemental payments to hospitals (March 2021)
  - https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/
- March 2019 report to Congress
  - https://www.macpac.gov/publication/march-2019-report-to-congress-on-medicaid-and-chip/
- June 2019 report to Congress
  - https://www.macpac.gov/publication/june-2019-report-to-congress-on-medicaid-and-chip/
- March 2022 report to Congress
  - https://www.macpac.gov/publication/march-2022-report-to-congress-on-medicaid-and-chip/
- June 2022 report with more on directed payments will be published June 15

Publications




IssueBrief
MACPAC
March 2022
Advising Congress on Medicaid and CHIP Policy

State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages

Medicaid is the nation's primary payer for home- and community-based services (HCBS). Roughly 2.4 million workers provide services to Medicaid beneficiaries in their homes and other community settings (PHI 2021). Workforce shortages, however, limit the ability of Medicaid programs to serve more people in the community, an effort that is in keeping with the mandate of the Americans with Disabilities Act of 1990 (P.L. 101-336, as amended) and the *Olmstead v. L.C.* decision that states must facilitate community integration for beneficiaries with disabilities (MACPAC 2019).[1]

The COVID-19 pandemic has exacerbated the workforce shortage and highlighted its drivers, including low wages, limited opportunities for career advancement, and high turnover. During the pandemic, HCBS workers across the country reported increased mental and physical demands in their jobs (Musumeci et al. 2021). Other HCBS workforce concerns include equity issues (e.g. wage disparities) for workers, who are largely women, and also often people of color or immigrants (PHI 2021).

This issue brief describes current issues facing the HCBS workforce and the Medicaid levers available to address them. It begins by summarizing the role of the HCBS workforce in Medicaid. Then, it describes the shortage and contributing factors. It ends by discussing current state efforts to expand the HCBS workforce including those focused on wages and benefits, training, recruitment and retention, and paying family caregivers. Many of these efforts are supported by funds made available under the American Rescue Plan Act (ARPA, P.L. 117-2).

Through interviews with state Medicaid officials, advocates representing workers and beneficiaries, and a provider association, we gained insight into the issues facing HCBS workers, how these issues affect beneficiaries, and state strategies to address them.[2] We also heard directly from states and an organization representing HCBS workers at the Commission's October 2021 public meeting (MACPAC 2021).

Overview of the HCBS Workforce

The HCBS workforce is made up of several types of workers who assist beneficiaries with activities of daily living (ADLs) such as mobility, personal hygiene, and eating. In addition to these essential basic functions, HCBS workers also assist beneficiaries in community integration by providing support with instrumental activities of daily living (IADLs) such as grocery shopping and managing finances. The tasks they perform may be specialized, depending on the needs of the population (e.g., children, people with intellectual or developmental disabilities (ID/DD), adults with physical disabilities, and people with dementia).

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