MACPAC

Update on MACPAC Work on Hospital Payment Policy

Medicaid and CHIP Payment and Access Commission

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Overview

- Background
  - MACPAC
  - Medicaid hospital payment work plan
- Recent recommendations
  - Disproportionate share hospital (DSH) allotments
  - DSH definition of Medicaid shortfall
  - Upper payment limit (UPL) supplemental payments
- Opportunities to provide feedback and input

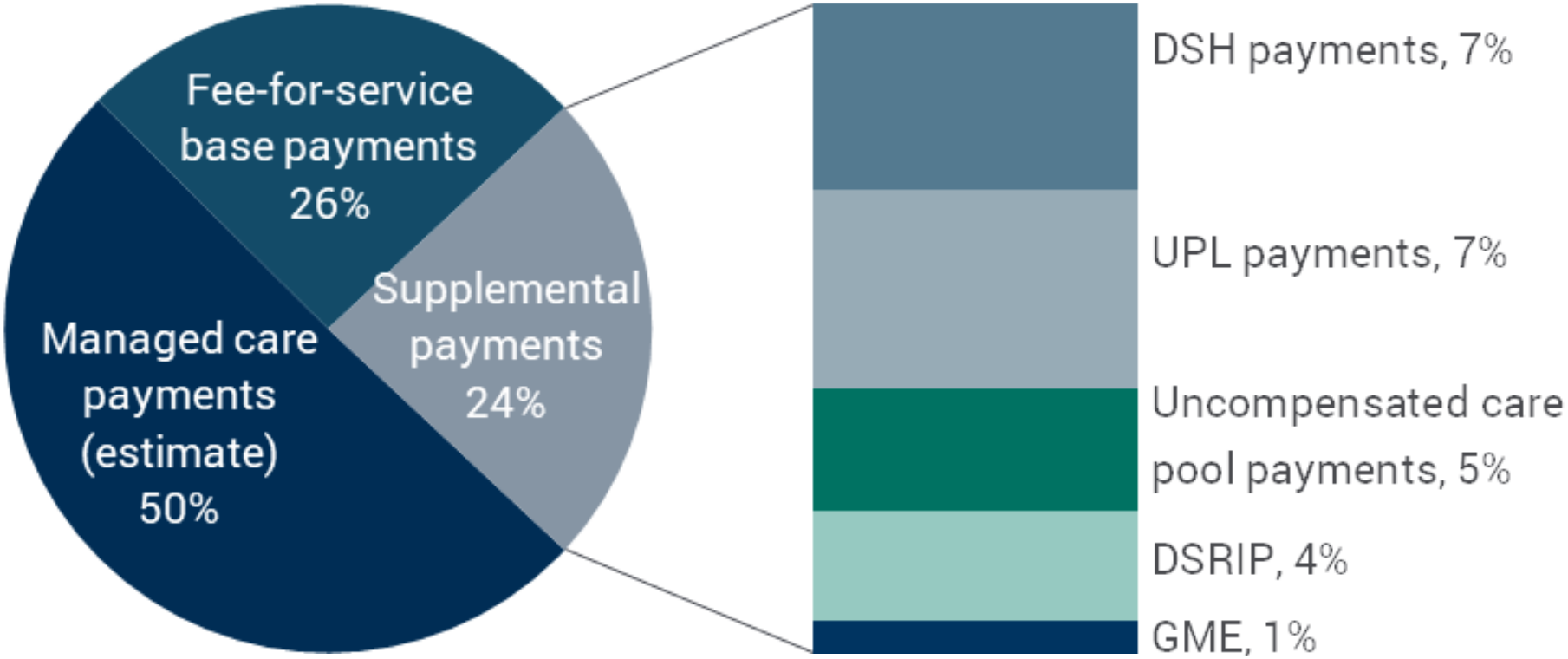
MACPAC: Structure and Role

- Non-partisan (as opposed to bipartisan)
- Provide analyses and advice to Congress and HHS on Medicaid and CHIP policy issues
  - Report annually on March 15 and June 15
  - Provide technical assistance to Congress
  - Serve as an information resource to the broader health policy community
- 17 commissioners appointed by GAO
  - Meet 6–8 times per year in public
  - Permanent staff of 30 based in DC

Work on Hospital Payment

- MACPAC has been undertaking an analysis of Medicaid hospital payment policy that broadly considers all types of Medicaid payments to hospitals, including:
  - base payments (fee-for-service and managed care)
  - DSH
  - UPL supplemental payments
- Consider how different payment policies work on their own and interactions
- Are policies consistent with efficiency, economy, quality, and access?

Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2017



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. Totals do not sum due to rounding.
Source: MACPAC, 2019, analysis of CMS-64 net expenditure data.

DSH Allotments

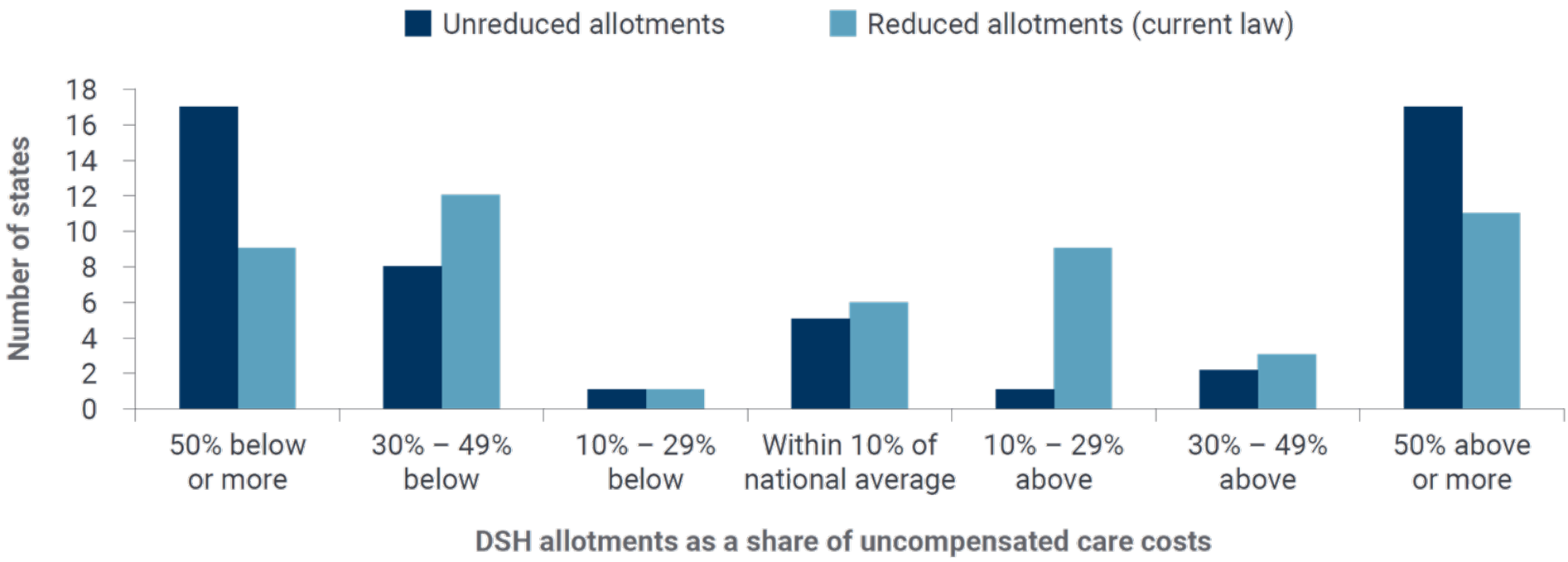
Background

- Medicaid DSH payments are limited by annual federal allotments
  - Allotments vary widely by state based on state DSH spending in 1992
  - The ACA included reductions to DSH allotments under the assumption that increased coverage would reduce hospital uncompensated care costs
- Current reduction amounts
  - $4 billion in fiscal year (FY) 2020
  - $8 billion per year in FYs 2021–2025
  - No reduction in FY 2026 and subsequent years

CMS Reduction Methodology

- The statute currently requires CMS to apply reductions based on several factors
  - Larger reductions to states with low uninsured rates
  - Larger reductions to states that do not target DSH payments to hospitals with a high volume of Medicaid patients or high levels of uncompensated care
- MACPAC provided technical comments on CMS's proposed methodology in August 2017
- This methodology preserves much of the existing variation in DSH allotments and is unlikely to improve the targeting of DSH payments

DSH Allotments as a Share of Hospital Uncompensated Care Costs Relative to the National Average, FY 2023



Notes: DSH is disproportionate share hospital. FY is fiscal year. DSH allotments as a share of hospital uncompensated care in the state were calculated using 2016 Medicare cost reports, which define uncompensated care as charity care and bad debt. The number of states includes the District of Columbia. In FY 2023, federal unreduced allotments are projected to equal 40 percent of 2016 hospital uncompensated care costs, and reduced allotments are projected to equal 17 percent of 2016 hospital uncompensated care costs.
Source: MACPAC, 2019, analysis of the CMS Medicaid Budget Expenditure System and Medicare cost reports.

DSH Allotment Policy Goals

- We limited our analyses to changes that would be budget neutral for the federal government
- MACPAC examined approaches to change the structure of DSH allotment reductions to advance the following goals:
  - improving relationship between DSH allotments to states and measures related to hospital uncompensated care costs
  - applying reductions to states independent of state policy choices
  - phasing in changes in an orderly way

MACPAC DSH Recommendations: March 2019 Report

- Three components:
  - Reduce unspent funds first
  - Change schedule of reductions (longer period of time)
  - Improve the relationship between DSH allotments and measures related to hospital uncompensated care costs

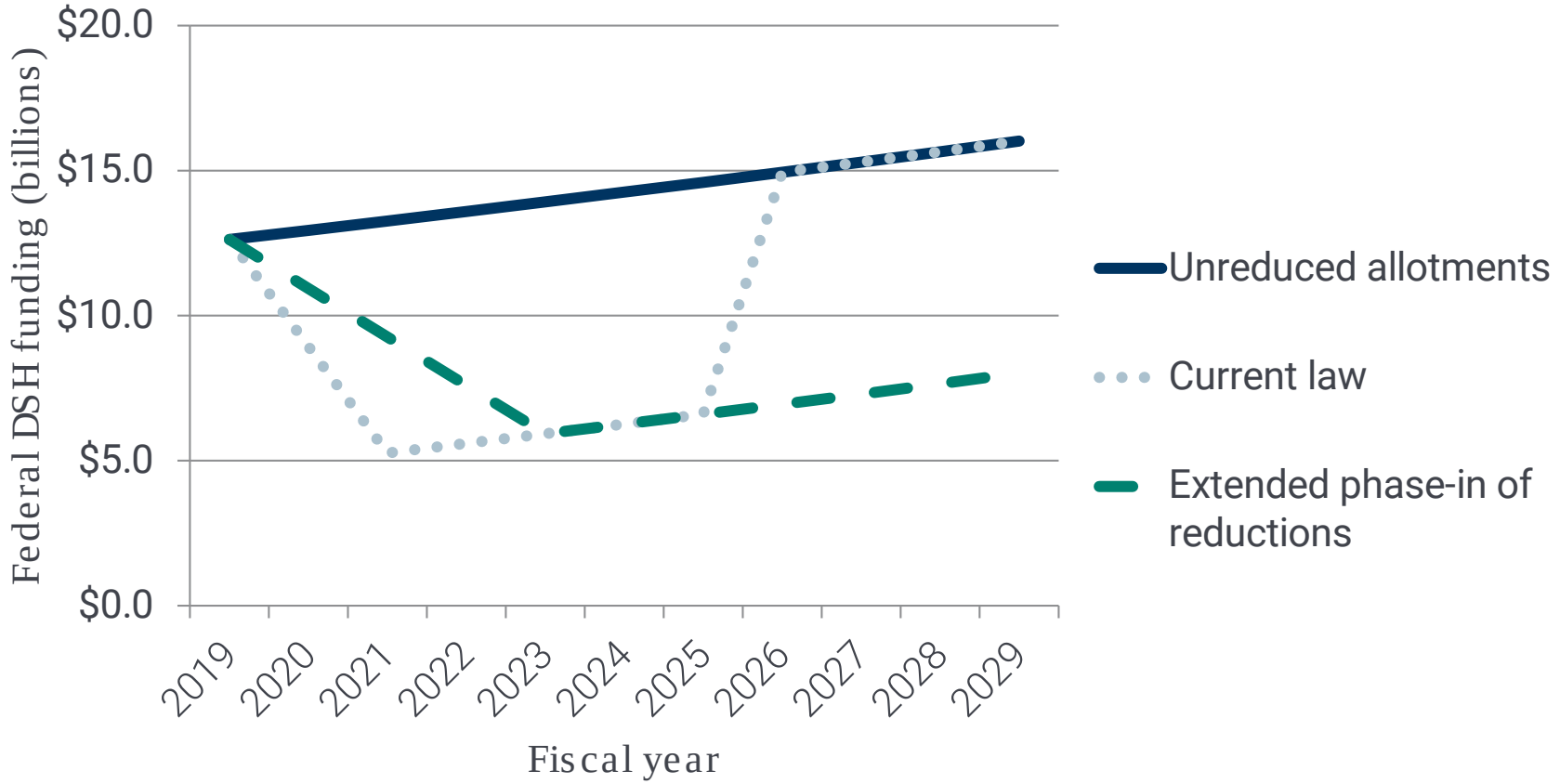
Recommendation 1

- If Congress chooses to proceed with DSH allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending

Recommendation 1: Rationale

- Mitigate disruption for DSH hospitals
- Time for states to adjust other Medicaid hospital payment policies if they so choose

Federal DSH Funding Under Various Policy Options, FYs 2019 – 2028



Notes: DSH is disproportionate share hospital. FY is fiscal year.
Source: MACPAC, 2019, analysis of the CMS Medicaid Budget Expenditure System and Congressional Budget Office (CBO), 2019, An update to the economic outlook: 2018 to 2028.

Recommendation 2

- In order to minimize the effects of DSH allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states

Recommendation 2: Rationale

- Minimizes amount of reductions to DSH funds that are currently paid to providers
  - In FY 2016, $1.2 billion in federal DSH allotments were unspent
  - The amount of unspent funds has been relatively consistent over the past several years
- Design considerations
  - Method for projecting unspent funds
  - Whether and how to account for funds that continue to be unspent after reductions take effect
  - Clarifying that reductions to unspent DSH funds do not affect DSH payments

Recommendation 3

- In order to reduce the wide variation in state DSH allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly, low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas

Recommendation 3: Rationale

- The number of low-income individuals in a state relates to hospital uncompensated care costs and is independent of state coverage choices
- Other measures the Commission considered did not have reliable data sources or were highly affected by state coverage choices
- Geographic variations in hospital costs affect uncompensated care costs
- Phasing in changes gradually provides states and hospitals time to respond before the full amount of reductions takes effect

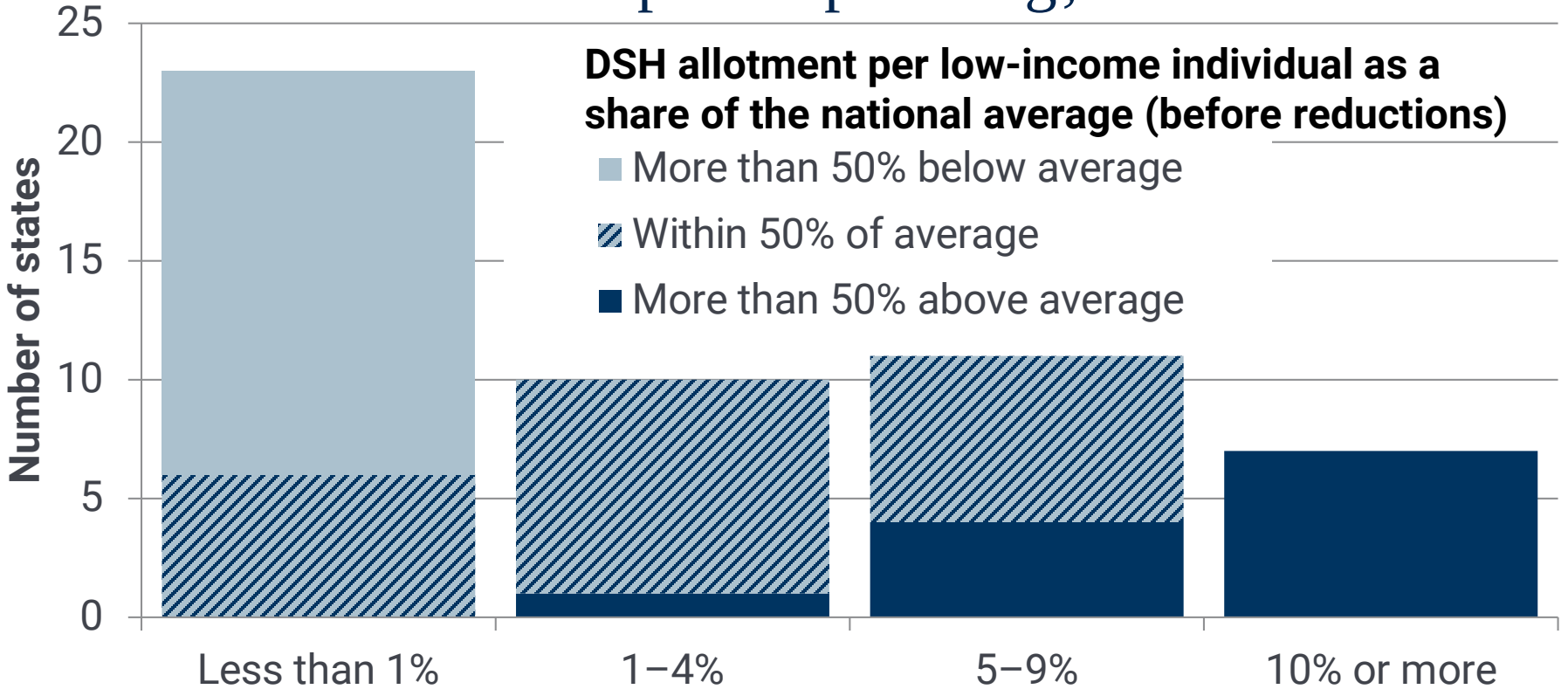
Recommendation 3: Design

- To estimate the effects of this recommendation, we made several assumptions about how rebasing might be applied
  - Reductions to states with allotments above the rebased amount are larger than increases to states with allotments below the rebased amount
  - Maximum reduction amount of 30 percent a year
- Congress could direct CMS to define many details of the methodology through rulemaking

Implications

- Federal government
  - Modest federal budget savings over the FY 2019–2029 budget period
- States
  - Larger reductions for states with unspent funds and high DSH allotments per low-income individual, compared to current law
- Providers and enrollees
  - Effects vary by state and how states respond to allotment reductions

Reduction in State DSH Spending as a Share of Total Medicaid Hospital Spending, FY 2023



Notes: DSH is disproportionate share hospital. Low-income individual defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Reductions in DSH spending exclude reductions to unspent DSH funds. Total hospital spending includes fee-for-service base payments, supplemental payments, and an estimate of managed care payments to hospitals. The number of states includes the District of Columbia.

Source: MACPAC, 2019, analysis of the CMS Medicaid Budget Expenditure System, 2016 American Community Survey, CMS FY 2019 inpatient prospective payment system final rule, and CMS national health expenditure data

DSH Definition of Medicaid Shortfall

Background

- DSH payments to an individual hospital cannot exceed a hospital's uncompensated care costs for Medicaid and uninsured patients
- Medicaid shortfall is the difference between
  - the cost of providing care to Medicaid-eligible patients, and
  - payments received for those services
- Recent court rulings have changed how Medicaid shortfall is calculated for Medicaid-eligible patients with third-party coverage

History of DSH Definition of Medicaid Shortfall

- 1993: Hospital-specific limit established
- 2003: States required to audit hospital costs
- 2008: CMS finalizes DSH audit rule
- 2010: CMS issues sub-regulatory guidance clarifying that third-party payments should be counted in the shortfall calculation
- 2017: Court rulings invalidating CMS's guidance
- 2017: Final rule codifying CMS's 2010 policy
- 2018: District court invalidates the CMS 2017 rule
- 2019: Appellate court upholds the 2017 rule

Components of Medicaid Shortfall Under Different Accounting Methods

Method of calculating Medicaid shortfall	Medicaid patients with third-party coverage			Medicaid-only patients	
	Medicaid payments	Third-party payments	Costs	Medicaid payments	Costs
Count all payments and costs (CMS 2010 policy)	X	X	X	X	X
Do not count third-party payments, but count third-party costs (District court ruling)	X		X	X	X
Do not count payments or costs for patients with third-party coverage (MACPAC recommendation)				X	X

Notes: CMS 2010 policy is the policy described in CMS's 2010 sub-regulatory guidance on counting third-party payments in the calculation of Medicaid shortfall. District court ruling is the policy described in Children's Hospital Association of Texas v. Azar, No. 17-844 (D.DC 2018 March 2, 2019), appeal docketed, No. 18-5135 (D.C. Cir. May 9, 2019).

State and Hospital Effects of the District Court Ruling

- No change to state DSH allotments
- Substantial increase in the amount of Medicaid shortfall reported for Medicaid-eligible patients with third-party coverage
  - Increased uncompensated care costs increase the amount of DSH funds that each hospital can receive
  - Different effects on the amount of shortfall reported for Medicare and privately insured patients
- Potential redistribution of DSH payments in states that base DSH payments on hospital uncompensated care costs (24 states)

Policy Goals

- Because the district court ruling was under appeal, MACPAC focused its work on what the preferred policy should be
- 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

MACPAC DSH Recommendation: June 2019 Report

- To avoid Medicaid making DSH payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer

Implications

- Federal spending
  - The Congressional Budget Office estimates that this policy will have an insignificant effect on federal spending
- States
  - No change to state DSH allotments
- Providers
  - Will avoid the large redistribution in DSH spending expected from the district court ruling
  - Compared to CMS's 2010 policy, hospitals with neonatal intensive care units should be eligible for more DSH funding
- Enrollees
  - Effects on enrollees depend on how states and hospitals respond

Appellate Court Ruling

- On August 13, the DC Court of Appeals reversed the district court decision in *Children's Hospital Association of Texas v. Azar*
- CMS's 2017 final rule will now be enforceable in most states for DSH payments made as of June 2, 2017
- The Children's Hospital Association of Texas and other litigants could further appeal this decision
- Other challenges to the CMS 2017 rule are still pending in the 5th and 8th Circuit Court of Appeals

UPL Supplemental Payments

Upper Payment Limits

- The UPL is an upper limit on aggregate FFS payments for a class of providers
  - The UPL is based on a reasonable estimate of what Medicare would have paid for the same services
  - If base payments are below the UPL, states can make UPL supplemental payments to make up the difference
- States make UPL payments to hospitals, nursing facilities, physicians, and other providers

Demonstrating UPL Compliance

- In 2013, CMS issued guidance requiring states to demonstrate compliance with UPL requirements annually
- States submit hospital-specific data to CMS in a standard format
  - Medicaid FFS base and supplemental payments
  - Estimates of what would have been paid according to Medicare payment principles
- MACPAC reviewed hospital-specific UPL data for state fiscal year 2016 and compared state-reported data with actual spending

MACPAC Findings

- In 17 states, actual amount of UPL payments exceeded the state-calculated UPL by $2.2 billion in the aggregate
- CMS does not have a process to certify that UPL demonstration data are accurate and complete
- Many states use methods of calculating the UPL that appear to result in limits that are higher than what Medicare would have paid

MACPAC UPL Recommendations: March 2019 Report

- Two components:
  - Improving process controls
  - Improving transparency

Recommendation 1

- The Secretary of the U.S. Department of Health and Human Services should establish process controls to ensure that annual hospital upper payment limit demonstration data are accurate and complete and that the limits calculated with these data are used in the review of claimed expenditures

Recommendation 1: Rationale

- The UPL is intended to provide an upper limit on Medicaid payments to providers
- Existing information is not reliable
- CMS could implement a range of process controls to better enforce UPL compliance

Recommendation 1: Implications

- Federal government
  - If CMS determines that overpayments were made, it could recoup federal funds
  - CBO does not assume federal budget savings for proposals that enforce existing policy
- States
  - May affect state administrative effort
- Providers
  - If CMS determines that overpayments were made, it could result in reduced funding for some providers
- Enrollees
  - Effects depend on how providers respond

Recommendation 2

- To help inform development of payment methods that promote efficiency and economy, the Secretary of the U.S. Department of Health and Human Services should make hospital upper payment limit demonstration data and methods publicly available in a standard format that enables analysis

Recommendation 2: Rationale

- UPL payments were the largest type of hospital supplemental payment reported in fiscal year 2017, but we do not have data on how the $13.1 billion in hospital UPL payments was spent
- CMS already publicly reports hospital-specific data on DSH payments
- This recommendation builds on MACPAC's prior recommendations
  - UPL demonstrations are an existing data source that can be reported without creating a new system
  - Data can support analyses of changes in payment policy

Recommendation 2: Implications

- Federal government
  - No change in federal spending expected
  - Increased federal administrative effort
- States
  - Limited effect because states already provide this information to CMS
- Providers and enrollees
  - No direct effect

Sharing Information with MACPAC

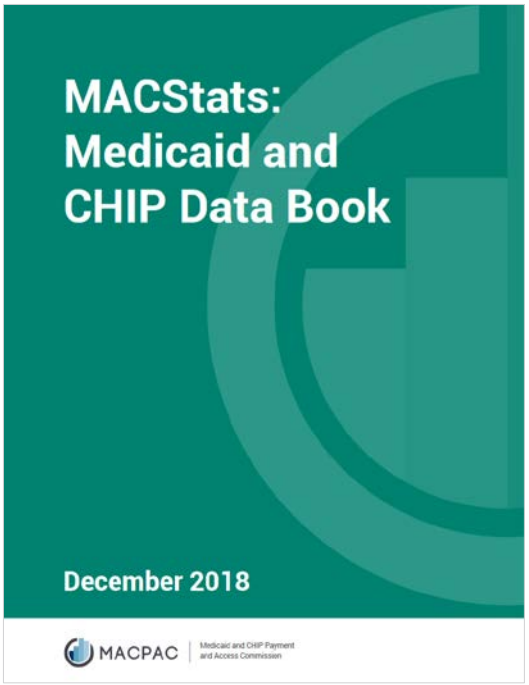
Providing Feedback, Input

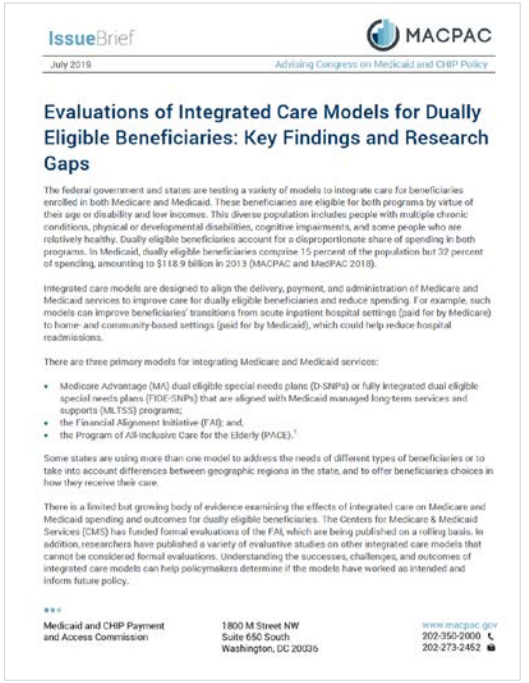
- Attend meetings
- Access meeting presentations and transcripts online (www.macpac.gov)
- Provide public comment on specific issues in person at meetings or in writing (macpac@macpac.gov)
- Share data, experiences, concerns
- Request in-person meeting with MACPAC staff

Additional Resources

- Homepage for MACPAC work on provider payment
  - https://www.macpac.gov/topics/provider-payment/
- Medicaid base and supplemental payments to hospitals (March 2019)
  - 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/

Publications




IssueBrief

MACPAC

July 2019

Advising Congress on Medicaid and CHIP Policy

Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps

The federal government and states are testing a variety of models to integrate care for beneficiaries enrolled in both Medicare and Medicaid. These beneficiaries are eligible for both programs by virtue of their age or disability and low incomes. This diverse population includes people with multiple chronic conditions, physical or developmental disabilities, cognitive impairments, and some people who are relatively healthy. Dually eligible beneficiaries account for a disproportionate share of spending in both programs. In Medicaid, dually eligible beneficiaries comprise 15 percent of the population but 32 percent of spending, amounting to $118.9 billion in 2013 (MACPAC and MedPAC 2018).

Integrated care models are designed to align the delivery, payment, and administration of Medicare and Medicaid services to improve care for dually eligible beneficiaries and reduce spending. For example, such models can improve beneficiaries' transitions from acute inpatient hospital settings (paid for by Medicare) to home- and community-based settings (paid for by Medicaid), which could help reduce hospital readmissions.

There are three primary models for integrating Medicare and Medicaid services:

- Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) or fully integrated dual eligible special needs plans (FIDE-SNPs) that are aligned with Medicaid managed long-term services and supports (MLTSS) programs;
- the Financial Alignment Initiative (FAI); and,
- the Program of All-Inclusive Care for the Elderly (PACE).[1]

Some states are using more than one model to address the needs of different types of beneficiaries or to take into account differences between geographic regions in the state, and to offer beneficiaries choices in how they receive their care.

There is a limited but growing body of evidence examining the effects of integrated care on Medicare and Medicaid spending and outcomes for dually eligible beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has funded formal evaluations of the FAI, which are being published on a rolling basis. In addition, researchers have published a variety of evaluative studies on other integrated care models that cannot be considered formal evaluations. Understanding the successes, challenges, and outcomes of integrated care models can help policymakers determine if the models have worked as intended and inform future policy.

Medicaid and CHIP Payment and Access Commission

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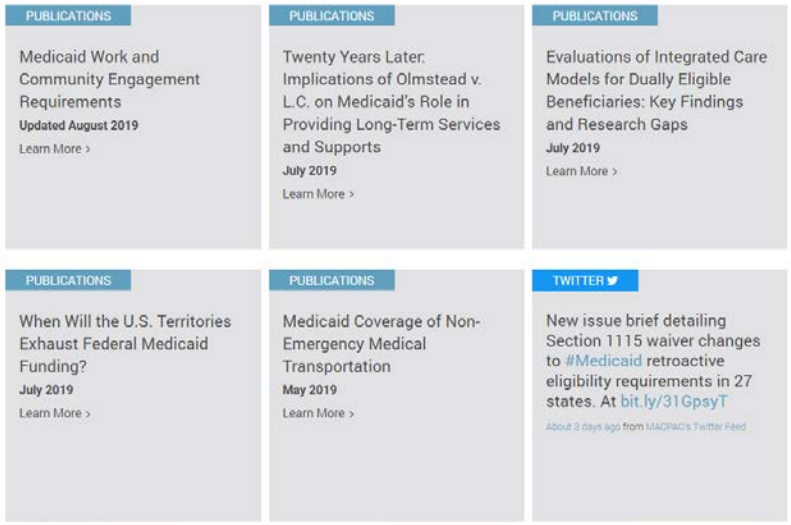

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