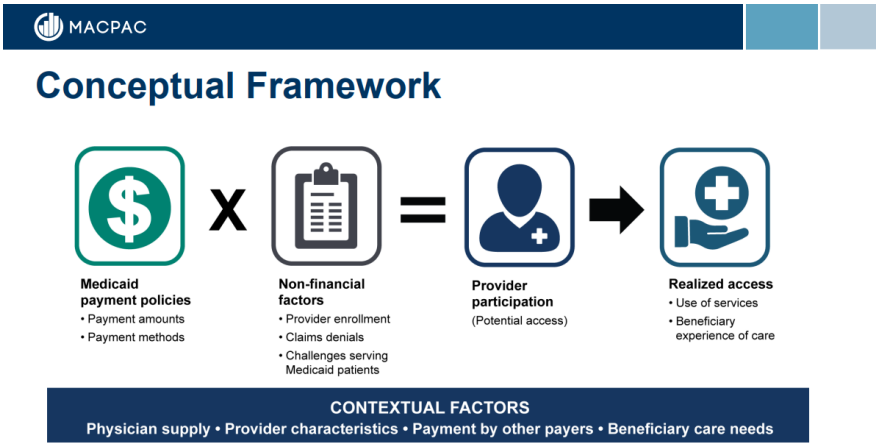
MACPAC Session on Updates to Hospital Supplemental Payment Analysis
April 2024
Presentation Slide Deck: Update on Hospital Supplemental Payment Analysis

Background:
In recent years, both CMS and MACPAC have explored the importance of – and barriers to – access to physician services for Medicaid beneficiaries. MACPAC's prior analyses found variation in Medicaid acceptance rates among different types of providers and noted states' flexibility in setting Medicaid payment rates. Building off of content shared during the September 2023 and January 2024 meetings, MACPAC reiterated their recommended conceptual framework:



During the April 2024 meeting, MACPAC reviewed updates to their analysis on various Medicaid supplemental payments:

- In FY 2022, supplemental payments (which includes UPL payments, DSH and state directed payment programs) to state Medicaid programs comprised 20% of all payments made
- When looking at the variety and composition of 2022 supplemental payments made, state directed payment programs paid the largest amount to Medicaid programs ($47.8B), while DSRIP paid the smallest amount ($0.2B)
- State participation in supplemental payments varied in 2022, as in other years. Some states had lower state directed payment program activity but higher participation in other non-DSH payment programs, while other states relied more heavily on state directed payments to supplement other Medicaid programs. Using five states (Florida, New Hampshire, New Mexico, North Dakota, and Virginia) as illustrative examples during the April 2024 meeting, MACPAC highlighted the variety and use of supplemental payments for state Medicaid programs. MACPAC presented these state examples based on publicly available data from FY 2022 that was also vetted by CMS staff in 2023.

Use and Distribution of Medicaid Hospital Supplemental Payments in Selected States, FY 2022

State	Supplemental payments as a share of Medicaid benefit spending				Share of hospitals receiving DSH or non-DSH supplemental payments
	DSH (2019)	Non-DSH	Directed payments	Total	
North Dakota	0%	0%	—	0%	71%
New Mexico	0%	3%	5%	8%	64%
Florida	1%	6%	8%	14%	73%
Virginia	0%	15%	16%	32%	69%
New Hampshire	8%	1%	1%	11%	93%

Notes: FY is fiscal year. DSH is disproportionate share hospital. Non-DSH supplemental payments include upper payment limit supplemental payments, graduate medical education payments, and supplemental payments authorized through Section 1115 demonstrations. Directed payment spending is estimated based on annual spending projected in the most recently approved preprint as of February 1, 2023. Percentages do not add due to rounding.
— Dash indicates zero. 0% is a non-zero amount that rounds to zero.
Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023, directed payment preprint data as of February 1, 2023, Medicare cost reports, and non-DSH supplemental payment data.

As MACPAC reviews additional supplemental payment program data and refines the conceptual framework, MACPAC has charged its Commissioners to consider:

- Should states have unlimited flexibility to target supplemental payments to hospitals they identify (e.g. safety net hospitals, teaching hospitals, rural hospitals) or should targeting be tied to specific measures of use or need?
- ***Should there be limits on supplemental payments (e.g., Medicare, cost), and if so, should there be variation in the limits set for different types of supplemental payments?***
- How should policymakers evaluate the efficiency of hospital supplemental payments? How can we measure, quantify, and assess the outcomes that these payments produce?

MACPAC will continue to define and refine the conceptual framework for reviewing supplemental payments through 2024 and will present additional findings during future MACPAC meetings.

Highlights from Commissioner's Feedback on Conceptual Framework

- Comparisons of available supplemental payment programs should include data on year-to-year changes as well as ***data on the impact of these programs on Medicaid***
- The conceptual framework should include historical data about *how*, *when* and *why* specific supplemental payment programs were started
- The conceptual framework should include a working glossary or list of terms to help MACPAC members – and researchers – understand the nuances and necessity of the proposed framework
- Differentiate between specialty and general practice providers, and access to physicians vs. other providers (e.g., nurse practitioners)
- Distinguish between facility types (e.g., academic medical center vs. FQHC), provider location (mainly, urban vs. rural), and what Medicaid beneficiaries can access in a reasonable timeframe.

Next Steps

MACPAC plans to publish an issue brief summarizing findings from literature review and themes from expert roundtable discussion within the next year. We will continue to watch for more presentations from MACPAC on provider access, and whether any related recommendations will be included in the June 2024 report to Congress.