MACPAC

Advising Congress on
Medicaid and CHIP Policy

Statement of
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Medicaid and CHIP
Payment and Access Commission

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House Committee on Energy and Commerce

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Summary

In our testimony today, we focus on reporting of provider-level data on supplemental payments and contributions to the non-federal share, the subject of two of bills being considered by the Subcommittee: H.R. 2151 and H.R. 1362. The Commission shares the objective of transparency reflected in the bills before the Subcommittee today.

There are several compelling reasons that such data should be reported at the provider level. First, such data are necessary for assessing whether state payment methods and rates are consistent with federal statute. While states have considerable flexibility in setting rates and methods, Section 1902 (a)(30)(A) of the Social Security Act requires that Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization. But information on the base Medicaid payments that providers receive – that is the per case or per diem payment associated with delivery of specific services to specific Medicaid beneficiaries – provides only a partial picture of how much Medicaid is paying a given provider.
To assess payment fully, policymakers need to know the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures.

Second, Medicaid spending for supplemental payments is substantial. In fiscal year 2014, states reported making $24.2 billion in non-disproportionate share hospital (DSH) supplemental payments, more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states. The amount of funds raised through providers and local government contributions is also significant and increasing. As such, the federal government has a reasonable expectation of having complete payment and financing data that permit it to understand and oversee states' use of Medicaid funds.

In light of these concerns, MACPAC recommended, in its March 2014 report to Congress, that the Secretary of the U.S. Department of Health and Human Services (HHS) collect and report data on non-DSH supplemental payments at the provider level. And just last week, in deliberations on a congressionally mandated report on DSH payments that will be transmitted to Congress on February 1, the Commission voted unanimously on a recommendation focused on reporting of data for both payments and the non-federal share. Specifically, MACPAC recommends that the Secretary of HHS collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Commission recommends that the Secretary collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

Efforts to fully understand provider payment levels is more relevant now than at any time in the program's history. Use of supplemental payments is growing, particularly to hospitals through Section 1115 expenditure authority. In addition, interest in payment reforms that incentivize greater value in the delivery of health services is also growing. Even so, lack of solid data on net payments makes it extremely difficult to assess the effectiveness of these efforts.

Statement of Anne L. Schwartz, Ph.D., Executive Director

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Green, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of MACPAC, the Medicaid and CHIP Payment and Access Commission. As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS) and the states on issues affecting these programs. Its members, led by Chair Diane Rowland and Vice Chair Marsha Gold, are appointed by the U.S. Government Accountability Office (GAO). The insights I will share this morning reflect the consensus views of the Commission itself, anchored in a body of analytic work conducted over the past five years. We appreciate the opportunity to share MACPAC's views with the Subcommittee.

My testimony today will focus on reporting of provider-level data on supplemental payments and contributions to the non-federal share, the subject of two of bills being considered by the Subcommittee: H.R. 2151 which seeks to improve oversight and accountability in Medicaid non-disproportionate share hospital (DSH) supplemental payments, and H.R. 1362 which requires states to report the sources and amounts used by states to finance the non-federal share of Medicaid.

Over the past five years, the Commission, using data reported to the Centers for Medicare & Medicaid Services (CMS) as well as those collected from individual states, has devoted considerable analytic resources to these two

related topics and has made recommendations concerning both. The Commission shares the objective of transparency reflected in the bills before the Subcommittee today.

Specifically, in its March 2014 report to Congress, MACPAC recommended that the Secretary collect and report data on non-DSH supplemental payments at the institutional level. And just last week, in deliberations on a congressionally mandated report on DSH payments that will be transmitted to Congress on February 1, the Commission voted unanimously on a recommendation focused on reporting of data for both payments and the non-federal share. Specifically, MACPAC recommends that the Secretary of HHS collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Commission recommends that the Secretary collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

Below we describe the Commission's rationale for these recommendations and also comment on different approaches to collecting needed data. In addition we provide some brief comments on the proposed Quality Care for Moms and Babies Act.

Rationale for Recommendations

In the Commission's view, there are several compelling reasons that data on supplemental payments and contributions to the non-federal share of Medicaid spending should be reported at the provider level. First, such data are necessary for assessing whether state payment methods and rates are consistent with federal statute. While states have considerable flexibility in setting rates and methods, Section 1902 (a)(30)(A) of the Social

Security Act requires that Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization. But information on the base Medicaid payments that hospitals receive – that is the per case or per diem payment associated with delivery of specific services to specific Medicaid beneficiaries – provides only a partial picture of how much Medicaid is paying a given provider. To assess payment fully, policymakers need to know the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures.

Because data on supplemental payments and provider contributions to the non-federal Medicaid share (whether in the form of health care related taxes or other mechanisms such as intergovernmental transfers) are not reported to the federal government at the provider level, it is not possible to fully analyze the relationship of payment to program objectives. Moreover, given the variety of methods and payment levels used across states, there is value in assessing payment through a consistent lens.

Other health care payers, including Medicare, commonly conduct assessments of payment adequacy and compare payment levels across providers and geographic areas. The level of payment, or payment rate, can be considered the most basic measure of economy and is essential to an assessment of payment efficiency, a measure of value that compares what is spent (economy) to what is obtained (quality, access, utilization). Typically, an analysis of whether a health care payment is economical includes comparison to the cost to provide a given service and comparison to what other payers (for example, other states, Medicare, commercial insurance) pay for a comparable service in a given geographic area. In Medicaid, however, federal policymakers and program administrators do not have the complete data to make such assessments and therefore to ensure that payments are consistent with delivery of quality, necessary care to beneficiaries.

Second, Medicaid spending for supplemental payments is substantial. In fiscal year 2014, states reported making $24.2 billion in non-DSH supplemental payments. Such payments account for more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states. The amount of funds raised through providers and local government contributions is also significant and increasing. GAO reported that in 2012, about two-thirds of DSH payments, and three quarters of non-DSH supplemental payments, were financed by non-state sources of funding. Eight states used non-state funds to finance more than 90 percent of their DSH payments. Because providers often supply the non-federal share of Medicaid payments, the net payment that they receive may be less than payment data indicate. As such, the federal government has a reasonable expectation of having complete payment and financing data that permit it to understand and oversee states' use of Medicaid funds.

The task of ensuring that payments are set to incentivize value is more relevant now than at any time in the program's history. Use of supplemental payments is growing, particularly to hospitals through Section 1115 expenditure authority. In 2014, 44 percent of the $24.2 billion in non-DSH supplemental payments was made through Section 1115 expenditure authority, including delivery system reform incentive program (DSRIP) payments and uncompensated care pools. Although DSRIP payments are not made for Medicaid services directly, they do represent large payments to hospitals that should be considered in analyses of Medicaid payments.

In addition, interest in payment reforms that incentivize greater value in the delivery of health services is also growing. Even so, lack of solid data on net payments makes it extremely difficult to assess the effectiveness of these efforts.

Data Collection Issues

The bills before the Subcommittee today map out specific strategies for data collection. H.R. 2151 requires both annual reporting of non-DSH supplemental payments and an annual independent certified audit of such payments. H.R. 1362 requires that states submit an annual report on the sources and amounts associated with the non-federal share of Medicaid spending. In its recommendations, MACPAC has not spelled out the mode of data collection, rather calling on the Secretary of HHS to develop the appropriate methods. In doing so, the Secretary must balance the interest in collecting specific information from all states in a timely manner against the burden this task would create for state and federal program administrators as well as providers serving Medicaid beneficiaries. In the Commission's view, it makes sense to build upon existing data collection efforts to the extent possible. Below we describe different approaches to data collection and their strengths and limitations.

Currently, most provider-level payment data are reported through the Medicaid Statistical Information System (MSIS). While MSIS appears to be capable of receiving and reporting supplemental payment data, our analysis finds that most states do not currently report them. The specifications for the next iteration of MSIS (known as the Transformed Medicaid Statistical Information System or T-MSIS) also include fields for the collection of supplemental payments, although it is not clear whether or to what extent these elements will be required.

CMS currently collects some supplemental payment data as part of its oversight activities. Beginning in 2014, CMS began requiring states to submit annual non-DSH supplemental data for certain providers. These data are being collected by CMS regional offices and are meant to allow the agency to assure compliance with federal statute and upper payment limit (UPL) regulations, and may provide an improved understanding of total Medicaid

payments at the provider level. A solicitation for contractor support issued by CMS in 2014 indicated the agency's interest in compiling a database of DSH and non-DSH supplemental payment data, analyzing payments at state and provider-specific levels, and assessing the utility of data from the T-MSIS for oversight and analysis of DSH payments and state UPL submissions. However, data now being collected are not required to be submitted in a standardized format, nor are they publicly available.

CMS also collects non-DSH supplemental payment data through its DSH audit reports, but these data only include about half of U.S. hospitals. While audit requirements could be expanded to include all hospitals that receive Medicaid payments, the burden on states and hospitals of conducting such audits should be carefully weighed against other alternatives. In addition, reliance on audits alone raises concerns about timeliness, particularly given that the most current DSH audit data are five years old. Given the rapid evolution of the health care system and frequent changes in state Medicaid payment policy, submission of complete payment data on a more timely basis is desirable.

With regard to the non-federal share of Medicaid spending, MACPAC is unaware of any consistent and complete source of data on the sources and amounts of such payments. In response to the GAO, CMS has expressed concerns about the feasibility and desirability of collecting facility-level data on the non-federal share and whether such data could be collected through T-MSIS. CMS does require states to answer a series of questions related to non-federal financing as part of the previously mentioned annual UPL demonstrations. States are asked to provide, for any payment funded by via intergovernmental transfers or certified public expenditures, a complete list of the names of entities transferring or certifying funds and the amounts. Most of the questions, however, require general, rather than provider-specific, responses.

Regardless of the method of data collection, the ability to link different sources of data for the same providers is useful, especially for analyses of payments such as DSH that support services to Medicaid enrollees as well as individuals without insurance. CMS recently required that Medicaid DSH audit data include Medicare provider identification numbers which help link these data to Medicare cost reports. We are also interested in the ability to link Medicaid data to other sources, such as the community benefit report provided to the Internal Revenue Service. Thus, we urge that any data collection efforts that result from the bills also allow policymakers to link to other relevant data.

Improving Quality of Care for Mothers and Infants

The Commission supports efforts to improve the quality of care for children and adults in Medicaid and CHIP and has shared its support for data improvements and the development of core measures in its comments on HHS reports to Congress. Broader use of nationally recognized, evidence-based measures is important to help identify those program characteristics and policies that have the greatest impact on quality of care received by Medicaid and CHIP enrollees. In addition, quality measurement is a necessary component of payment and delivery reforms intended to improve the efficiency of Medicaid payments. Development and broader use of core measures is desirable because the proliferation of different measures can make it difficult to compare quality outcomes and adds administrative complexity for providers.

With Medicaid now covering almost half of all births in the United States, the program plays a key role in reducing preterm births and improving care and outcomes for mothers and their children. State Medicaid programs are working with federal and private sector partners to reduce non-medically indicated inductions and elective cesarean sections before 39 weeks of gestation, which are associated with adverse outcomes. In addition, state-

based perinatal health quality collaboratives are providing feedback to providers, implementing new policies to limit the circumstances under which elective deliveries care take place, and changing delivery scheduling processes. Such efforts have been effective in significantly reducing early elective deliveries and changing rates of admission to neonatal intensive care units.

The legislation before the Subcommittee would add measures focused on maternal and infant health to the existing set of core quality measures, and provide resources to develop and expand collaborative activities such as those described above. MACPAC supports expanding use of core measures in state quality improvement efforts and in particular, those measures that can be calculated by states using existing data. In addition, the Commission has previously noted that needed investments in quality measurement are small compared to total Medicaid spending, but are important for ensuring that taxpayers' investments in the program result in the delivery of high quality care to beneficiaries.

Conclusion

MACPAC shares this Subcommittee's interest in ensuring that taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing and reducing fraud, waste, and abuse. Making provider-level data on supplemental payments and contributions to the non-federal share of Medicaid funds would provide greater transparency and facilitate Medicaid payment analysis, including assessments of Medicaid payment efficiency and analysis of the relationship between payment and desired outcomes.