MEDICAID STATE DIRECTED PAYMENTS: CLOSING THE PAYMENT EQUITY GAP FOR ESSENTIAL HOSPITALS

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The Medicaid program is intended to give the nation's most financially disadvantaged people health care access on par with that available to those of greater means. To achieve this goal, statute requires that Medicaid payment rates be sufficient to ensure access.[1] However, structural barriers to financing Medicaid payments often have limited the ability of states to value care for Medicaid patients at the same rate as that for patients covered by other payers.

In fee-for-service (FFS) payment systems, states can make supplemental payments to providers to directly offset low payment rates. But in Medicaid managed care, states have historically lacked control over how managed care organizations (MCOs) pay providers. Because most Medicaid beneficiaries now are enrolled in managed care, low managed care payment rates are an increasing threat to the financial stability of safety net providers—including essential hospitals, which are committed to serving all people, regardless of income or insurance status.

Medicaid state directed payments (SDPs) are a new option to overcome these challenges by permitting states to direct MCOs to pay providers according to specific rates or methods. This brief examines how states are using this new authority to begin closing the payment equity gap for essential hospitals and improve access to care for Medicaid beneficiaries.

BACKGROUND

In the 2016 Medicaid managed care rule, the Centers for Medicare & Medicaid Services (CMS) permitted states to establish several different types of SDPs, each of which is subject to its own rules and regulations. The three categories used in CMS' standard application form (referred to as a preprint) are:

- Minimum fee schedules
- Uniform rate increases
- Value-based payments

Most minimum fee schedules require MCOs to pay no less than the Medicaid FFS payment rate. Because CMS already has approved those rates as part of the Medicaid state plan, the agency no longer requires prior approval for minimum fee schedules based on state plan approved rates or those that are less than what Medicare would have paid.

Uniform rate increases require MCOs to increase payments to providers by a predetermined amount to help close the gap between Medicaid rates and the average commercial rate (ACR). Because this gap is so large, these SDPs often are the largest and most important for maintaining the financial viability of hospitals that provide safety net care. CMS closely monitors these SDPs before and after approval, including requiring states to evaluate how these SDPs advance the state's access and quality goals.

Value-based payment (VBP) SDPs require MCOs to implement state-defined pay-for-performance incentives, shared savings arrangements, or other alternative payment models. These arrangements are less common because it often is difficult for essential hospitals to take on risk when payment rates are not sufficient. However, when VBP arrangements are used together with

rate increases, they can help reward essential hospitals for their efforts to continually improve care for their patients.

Like other Medicaid payments, states are permitted to finance SDPs with a variety of permissible sources, including state general funds, intergovernmental transfers (IGTs) from local governments, and health care–related taxes. These financing options have been a part of the Medicaid program since its inception and reflect the way state and local governments share responsibility for supporting safety net providers. Provider contributions to the nonfederal share of Medicaid payments also have played an important role in helping states stretch scarce resources to expand Medicaid coverage and access to covered benefits.

Although essential hospitals would prefer increased state general funding to help close Medicaid payment equity gaps, state budget realities often require SDPs to be financed with IGTs or provider taxes. These contributions represent an added cost to providers, reducing the net payments they receive. As a result, even when states make SDPs up to the ACR, the net payments providers receive after accounting for the costs of taxes and IGTs often is much lower than this payment equity benchmark.[2]

USE OF SDPS AT ESSENTIAL HOSPITALS

Some states have started using SDPs to help close payment equity gaps at essential hospitals. So far, their experience has shown that when essential hospitals are paid by Medicaid at the same rates as other payers, they can expand access to high-quality care in their communities.

Ohio

In 2017, Ohio Medicaid worked with a coalition of public safety net hospitals and academic medical centers—The MetroHealth System, in Cleveland; The Ohio State University (OSU) Wexner Medical Center, in Columbus; UC Health, in Cincinnati; and University of Toledo—and their affiliated multispecialty physician practices to design the Care Innovation and Community Improvement Program (CICIP) SDPs. CICIP aimed to increase payments for physicians affiliated with academic medical centers to the ACR. Not only does this program offset low payment rates to preserve access to care, it also ties about 10 percent of SDPs to quality goals for substance use, behavioral health, infant mortality, opioid prescribing and pain management, and reductions in avoidable emergency department (ED) use.

The CICIP institutions receive their SDPs in two ways:

- 90 percent in monthly payments
- Up to 10 percent through a quality performance incentive for the eight CICIP performance measures

CICIP's quality improvement targets encourage all participating hospitals to work collaboratively to achieve joint goals. This coordinated effort on state-defined goals established by the SDPs ultimately is more efficient and effective than leaving decisions on quality measures and targets up to MCOs, which can lead to misaligned measures and duplicative reporting.

As an example of how CICIP has helped transform care quality for Medicaid patients in Ohio, OSU Wexner Medical Center, a member of America's Essential Hospitals, has used CICIP to invest in 38 different projects to transform care. An independent evaluation by the state found OSU's expanded access to behavioral health care reduced psychiatric ED visits by 67 percent, and its initiative to expand prenatal care for women with a history of preterm birth in the Near East Side neighborhood of Columbus helped reduce the preterm birth rate by 35 percent.[3]

Overall, after the state increased Medicaid physician payments to commercial rates, OSU's performance for Medicaid patients in Ohio on the two CICIP behavioral health measures and reducing ED utilization measure, as well as those for each of the other three CICIP medical centers, now exceeds national quality benchmarks for both Medicaid and privately insured patients.

Kentucky

In 2019, Kentucky was among the first states to design an SDP program that elevates all Medicaid hospital payments (inpatient, outpatient, and physician services) to the ACR for state-affiliated academic medical centers on the forefront of addressing

health care workforce and health equity issues. The state's SDP program is focused on transforming care to confront Kentucky's toughest health challenges, including cancer, heart disease, diabetes, obesity, behavioral health, and substance use disorders. Although most of the SDPs are a uniform rate increase, up to 20 percent are based on reaching quality milestones.

University of Kentucky (UK) HealthCare, a member of America's Essential Hospitals, used funding from SDPs to transform its health system from top to bottom. UK HealthCare reorganized its data and analytics infrastructure to provide the data tools and reporting for continuous feedback on performance at the organizational, unit, and clinician levels. The system's quality improvement leaders also created a population health team to work alongside clinical teams in engaging patients in their care and to address social determinants of health. Improvement coaches work with clinical teams on setting goals for improvement, identifying root causes, and performing tests to close gaps in performance. As a result of these efforts, UK HealthCare achieved double-digit improvements in 12 quality measures in just four years. America's Essential Hospitals recognized UK HealthCare with a Gage Award in 2023 for quality excellence and innovation.

In 2021, UK HealthCare and the state of Kentucky worked together to help maintain access to care in rural northeastern Kentucky. King's Daughters Hospital, in Ashland, Ky., faced significant financial challenges when another hospital in the region closed, causing a sudden influx of new patients and increased costs that King's Daughters could not offset with payments from Medicaid, Medicare, and other payers. However, because of the financial stability UK HealthCare gained from its SDP-supported initiatives, the system was able to work with King's Daughters in a joint venture to develop a new partnership to expand specialty health services throughout this region.[4]

California

California has used SDPs to sustain and grow longstanding revenue streams by tying some to quality improvement efforts for public hospital systems. The state's Enhanced Payment Program (EPP) and Quality Incentive Pool (QIP) continue quality improvement initiatives started in 2010 under California's Section 1115 demonstration waiver.[5] Early waiver investments helped public hospitals develop the capacity to report on new quality measures, and now the QIP includes 57 measures for a variety of state and local priorities, including racial and ethnic disparities in diabetes care and other health equity measures.

Since 2016, CMS has encouraged most states that previously made additional payments to providers through Section 1115 demonstrations to transition these payments to SDPs. Compared with Section 1115 demonstrations, which must be renegotiated with CMS every five years and are subject to limits based on historic spending, the state option for SDPs in federal regulations is easier for states to use and better suited for closing longstanding payment equity gaps.

EPP and QIP are part of a patchwork of payments to California's 21 designated public hospitals, which provide care to 3.7 million people a year in inpatient, outpatient, and primary care settings. However, even with these SDPs and other additional payment programs, payments to these hospitals are still well below the ACR benchmark. Moreover, because public hospitals finance the nonfederal share of these payments through IGTs, the net payments these hospitals receive are only a portion of the gross payment amount approved in the state's SDP program. California has stated its intention to seek higher SDPs for public hospital systems; if those increases are not approved, the state's public health care systems will experience an estimated shortfall of $3 billion to $4 billion in 2027.[6]

Georgia

In 2021, Georgia created the Advancing Innovation to Deliver Equity (GA-AIDE), an SDP program to help close Medicaid payment equity gaps for two public hospitals in the state. Historically, these hospitals received Medicaid disproportionate share hospital (DSH) funding to cover the costs of care for Medicaid and uninsured patients. However, because the SDPs helped cover their costs of care for Medicaid patients, the state was able to redistribute more than $100 million in Medicaid

DSH funding to help support rural hospitals at risk of closing.[7]

GA-AIDE is critical to helping Georgia's single largest provider of Medicaid services, Grady Health System, in Atlanta, maintain access to care. Although most of the SDPs are of the uniform rate increase type to close payment equity gaps in existing care for Medicaid patients, Grady also has invested GA-AIDE funding in more than 20 delivery system improvements to transform the care it provides and increase access to care.

For example, Grady is tackling many of the root causes of maternal mortality, a challenge that disproportionately affects people of color. With funding from GA-AIDE, Grady was able to expand home visits for pregnant patients with hypertension, preeclampsia, or eclampsia. Thousands of patients have benefited from this intervention, and early evaluation results showed significant declines in blood pressure for patients within just six weeks of follow-up.

Grady also was able to expand access to critical cancer screenings in the community with a new Mobile Screening Service supported by GA-AIDE funds. The 40-foot mobile unit offers screening mammography and cervical cancer screening to patients at Grady's neighborhood health centers and at community events locally. This additional capacity and improved access closer to home was instrumental in achieving target breast cancer and cervical cancer screening rates, with more than 3,000 patients served in the first nine months of operation. Many of these patients received screenings for the first time.

BUILDING ON SUCCESS

So far, the experience of states that use SDPs to close payment equity gaps shows that when Medicaid pays essential hospitals at the same rates as other payers, these vital safety net providers can expand access to high-quality care in their communities. Indeed, essential hospitals lead the way in demonstrating the potential of SDPs to improve care quality and access.

Many states now are looking to replicate the success of these models by using SDPs to close the payment equity gap between Medicaid rates and the ACR for their essential hospitals. In 2024, CMS finalized updated regulations to improve the transparency and evaluation of SDPs, which should provide additional data in years to come about the important role SDPs play in enabling essential hospitals to continue to meet the needs of the communities they serve.

Endnotes

1. Section 1902(a)(30)(A), Social Security Act

2. Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP. June 2024. https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing-1.pdf. Accessed Aug. 13, 2024.

3. IPRO. Care Innovation and Community Improvement Program Evaluation Report Calendar Year 2023. March 2024.

4. UK HealthCare. UK HealthCare, King's Daughters Celebrate New Partnership. July 28, 2021. https://ukhealthcare.uky.edu/wellness-community/blog/uk-healthcare-kings-daughters-celebrate-new-partnership. Accessed Aug. 13, 2024.

5. In 2010, California was the first state to get approval for a Delivery System Reform Incentive Payment program. In 2016, the state renewed the program under a new name, the Public Hospital Redesign Incentives in Medi - Cal, and CMS required the state to start transitioning these payments to SDPs.

6. California Association of Public Hospitals. Sustainable Financing: A Looming Financial Crisis. https://caph.org/priorities/sustainable-financing/. Accessed Aug. 27, 2024.

7. Georgia Department of Community Health. Medicaid Payment Program Aimed at Improving Health Outcomes through Increased Payments to Eligible Hospitals Receives Final Approval. July 27, 2022. https://dch.georgia.gov/announcement/2022-07-27/ga-aide-press-release. Accessed Aug. 13, 2024.