

Medicaid Hospital Payment Policy to Improve Value Through Directed Payments: A Proposed Strategy

3M Clinical and Economic Research

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Notes

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Nothing in this document should be considered as legal advice.

All information about specific states is from publicly available sources.

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For Further Information

For each state, 3M Health Information Systems has assigned a program manager to provide information and assistance to Medicaid and other state agencies regarding the 3M patient classification methodologies. For further information, contact Matt Ferrara at mferrara2@mmm.com or 727-452-4529.

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Glossary

In this paper, we define Medicaid supplemental payments in line with the Medicaid and CHIP Payment and Access Commission.¹ Definitions by other organizations may vary.

APC	Medicare Ambulatory Payment Classification (for hospital outpatient care)
APM	Alternative payment model
APR DRG	3M™ All Patient Refined Diagnosis Related Group (for hospital inpatient care)
Base payments	Payment to a hospital for a specific inpatient stay or outpatient visit
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CPE	Certified Public Expenditures
DRG	Diagnosis Related Groups, used here to encompass APR DRGs and MS-DRGs
DSH	Disproportionate Share Hospital, a Medicaid supplemental payment program
DSRIP	Delivery System Reform Initiative Program, a Medicaid supplemental payment program
EAPG	3M™ Enhanced Ambulatory Patient Group (for hospital outpatient care)
FFS	Fee-for-service
FY	Fiscal year, usually the federal fiscal year but can vary with context
GAO	Government Accountability Office, a congressional agency
GME	Graduate Medical Education, a Medicaid supplemental payment program
MCO	Managed care organization
MACPAC	Medicaid and CHIP Payment and Access Commission, a Congressional agency
MS-DRG	Medicare Severity Diagnosis Related Group (for hospital inpatient care)
PPA	3M™ Potentially Preventable Admissions, a measure of population health
PPC	3M™ Potentially Preventable Complications, a measure of hospital outcomes
PPE	3M™ Potentially Preventable Events, comprising PPAs, PPCs, PPRs, PPVs, PPSs
PPR	3M™ Potentially Preventable Readmissions, a measure of both hospital outcomes and population health
PPR ED	3M™ Potentially Preventable Revisits to the Emergency Department, a component of the 3M PPR methodology
PPS	3M™ Potentially Preventable Services, a measure of efficient health care utilization
PPV	3M™ Potentially Preventable Emergency Department Visits, a measure of population health
Supplemental payments	Payment to a hospital not tied to specific services
UCC	Uncompensated Care, a Medicaid supplemental payment program
UPL	Upper Payment Limit, a Medicaid supplemental payment program

1. Summary

This paper proposes a strategy for Medicaid agencies to simultaneously maintain the flow of federal funding to states and hospitals, improve patient outcomes, increase transparency, reward efficiency, and promote access to care.

As background, in fiscal year 2019 the states made \$46 billion in “supplemental payments” to hospitals, that is, payments not tied to specific inpatient stays or outpatient visits. About half of the state share was funded by hospitals themselves through provider tax and intergovernmental transfer (IGT) programs.² Because the federal government funds about 60 percent of Medicaid supplemental payments, provider taxes and IGTs can be used to “draw down” federal funding for higher provider payments. A 2016 regulation blocked states from making supplemental payments through managed care organizations (MCOs), which now serve 69 percent of all Medicaid enrollees.³ However, the regulation did allow states to “direct” payments through MCOs to hospitals when based on utilization and tied to quality.

For more than 30 years, supplemental payment programs have been highly contentious between the state and federal governments and will very likely continue to be. For states, the continuing challenge is to design directed payment programs that comply with federal law and minimize hospital opposition while promoting access, efficiency, and quality.

We recommend that state “directed payment” programs incorporate clinical grouping methods for transparency; encourage MCOs to use prospective payment methods, with flexibility; use prospective payment methods for state-directed fee schedules; and tie directed payments to improved patient outcomes.

From 3M’s experience in patient classification and payment, we offer four recommendations.

- **Use common grouping methods for transparency, even if not for payment.** Medicaid is currently delivered through 51 state fee-for-service programs and 282 Medicaid managed care organizations. The inevitable result is confusion about who is being paid for what, and whether directed payments comply with state and federal law and policy. Even if payment methods differ, it is feasible and helpful to group all hospital claims data through clinical algorithms such as 3M APR DRGs and 3M EAPGs.
- **Encourage common payment methods, with flexibility.** A beneficial second step would be to encourage MCOs to use a single payment method, while allowing MCOs limited flexibility to adjust payment rates for particular services or hospitals. Benefits include increased transparency, more consistent incentives and lower administrative cost.
- **Use prospective payment methods for state directed fee schedules.** Applying directed fee schedule increases within prospective payment methods gives a state three levers to direct funds (the overall base rate, service adjusters, peer group adjusters). Meanwhile, 3M handles the technically difficult task of updating the clinical algorithm every year.
- **Tie directed payments to improved patient outcomes.** We recommend 10 criteria (section 3.4) to be used in implementing pay-for-outcomes programs. Focusing on potentially preventable inpatient complications, readmissions and revisits to the emergency department after inpatient discharge would both reduce costs and improve patient outcomes.

2. Background: Medicaid Hospital Payment Methods

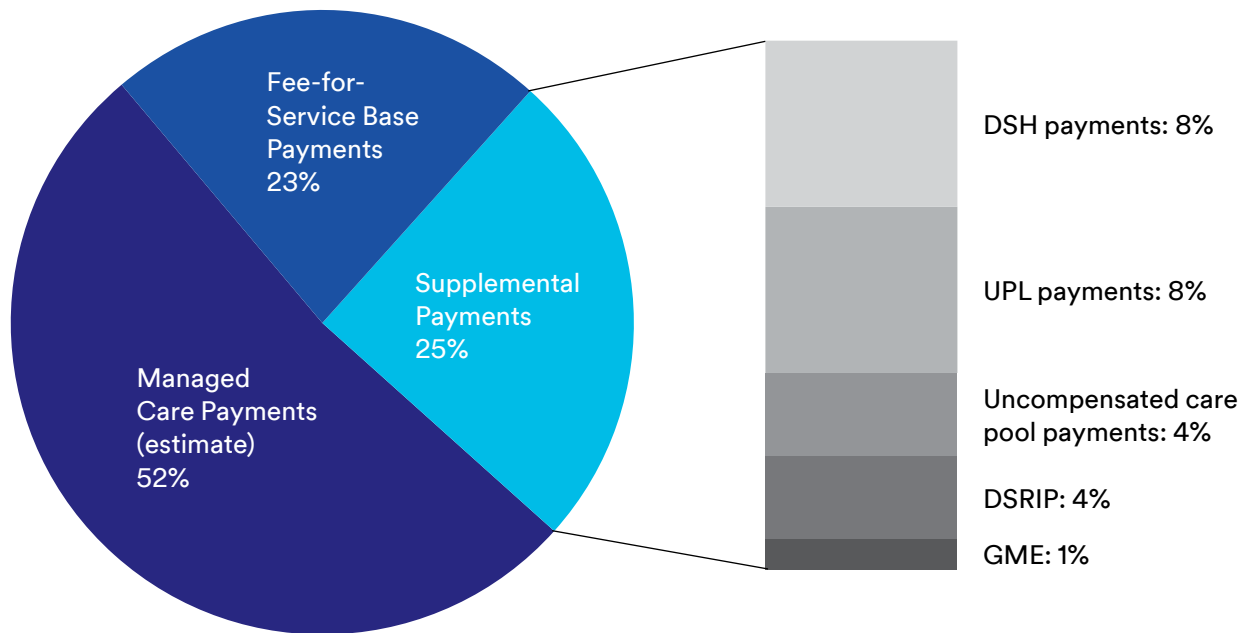
2.1 \$207 Billion in Total Payments

Of more than \$200 billion in annual Medicaid payments for hospital care, base payments for specific services account for about three-quarters and supplemental payments for about one-quarter. In 2019, Medicaid spent an estimated \$207 billion on hospital care.⁴ This vast sum benefited millions of patients and thousands of hospitals. In almost all cases, Medicaid pays for care received by people who otherwise wouldn't have coverage and provided by hospitals that otherwise wouldn't be paid. The \$207 billion represented about 34 percent of total Medicaid spending and 17 percent of payments to hospitals from all payers.

Approximately half of the \$207 billion comprised “base payments” by managed care organizations (MCOs), that is, payments for specific services received by MCO enrollees (Exhibit 2.1.1). Approximately one-quarter of the \$207 billion comprised base payments by state agencies for fee-for-service (FFS) enrollees. The remaining \$46 billion was “supplemental payments,” which are typically made by the state agency as a lump sum, that is, not tied directly to specific inpatient and outpatient services.⁵ Supplemental payments are much more important in Medicaid than in Medicare, and essentially unheard of in commercial insurance.

Of more than \$200 billion in annual Medicaid payments for hospital care, base payments for specific services account for about three-quarters and supplemental payments for about one-quarter.

Exhibit 2.1.1: Estimated Medicaid Payments for Hospital Care, 2019



Source: MACPAC 2021b

2.1 Inpatient Base Payments are Largely by DRG; Outpatient Payment Methods Vary

In the fee-for-service (FFS) sector, base payments were split roughly 75 percent inpatient care and 25 percent outpatient care.⁶ For inpatient care, 42 states pay by diagnosis related group (DRG), almost all either 3M All Patient Refined DRGs (APR DRGs) or Medicare Severity DRGs (MS-DRGs). See Exhibit 2.2.1.⁷

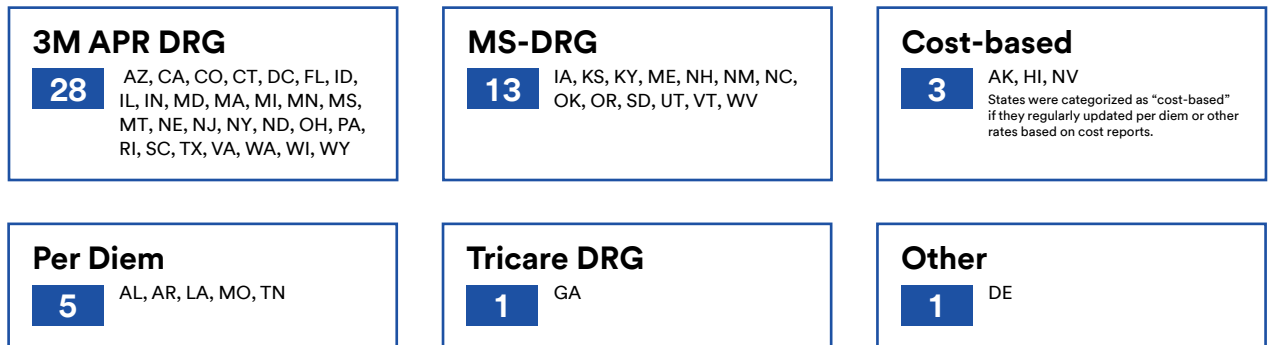
For outpatient care, methods are more diverse. Twenty four states still use cost reimbursement or fee schedule methods that have typically been in place for decades. Twenty seven states use more modern approaches, either Ambulatory Payment Classifications (APCs)⁸ or 3M Enhanced Ambulatory Patient Groups (EAPGs). See Exhibit 2.2.2.

In the managed care sector, reliable and comprehensive data are unavailable. In general, the 282 Medicaid MCOs nationwide⁹ usually have considerable flexibility over payment methods and levels. Some states, however, either require or encourage their MCOs to follow their FFS payment methods. Available Medicaid information,¹⁰ buttressed by evidence from Medicare managed care,¹¹

suggests that Medicaid MCOs often follow FFS in both payment methods and payment levels. This appears to be true even when the MCO parent company has both Medicaid and commercial contracts with the same hospitals.

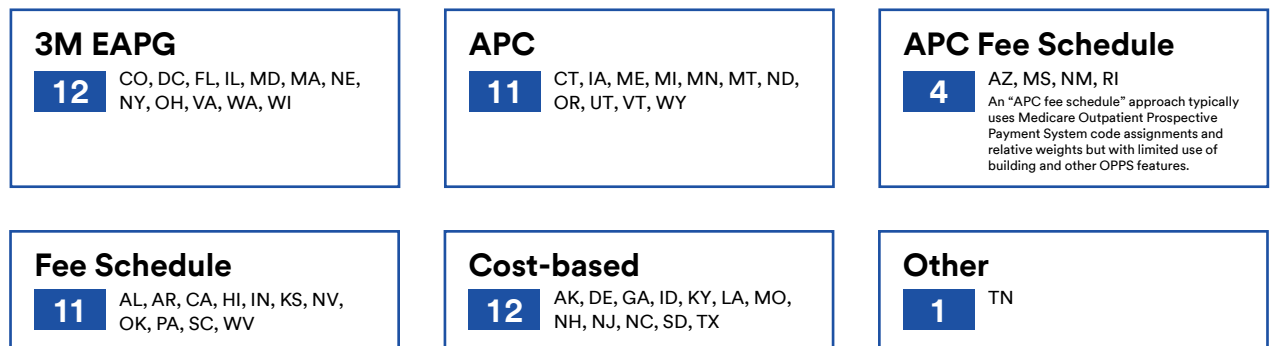
For inpatient care, almost all Medicaid programs use 3M APR DRGs or Medicare DRGs for base payments. For outpatient care, the leading methods are 3M EAPGs and Medicare APCs. Relatively little is known about MCO payment methods and levels.

Exhibit 2.2.1: How States Pay for Hospital Inpatient Care (Fee-for-Service)



Source: Medicaid and CHIP Payment and Access Commission (2018) with updates by 3M Health Information Systems (2021).

Exhibit 2.2.2: How States Pay for Hospital Outpatient Care (Fee-for-Service)



Source: Medicaid and CHIP Payment and Access Commission (2016) with updates by 3M Health Information Systems (2021).

2.3 Supplemental Payments are an Area of Contention

As shown in Exhibit 2.1.1, supplemental payments come in various forms: disproportionate share hospital (DSH), \$15 billion in FY 2019; upper payment limit (UPL), \$14 billion; uncompensated care (UCC), \$8 billion; delivery system reform initiative program (DSRIP), \$6 billion; and graduate medical education, \$3 billion.¹²

Supplemental payments are a major source of financing not only for the hospitals that receive these payments but also for the states that make these payments. That is because the federal government paid approximately \$27 billion or 60 percent¹³ of the \$46 billion in 2019 supplemental payments to hospitals. About half (52 percent) of the other 40 percent – the “state share” – did not come from state general funds but rather from taxes levied on hospitals or transfers from lower-level governments responsible for public hospitals (IGTs).¹⁴ The hospital industry and lower-level governments have been willing to pay these taxes and transfers because they expect to see higher payments in response.

For example, in a state where the federal matching percentage is 60 percent, a hospital tax that generates \$100 million can be used to “draw down” federal funding of \$150 million to generate supplemental payments back to the hospital industry of as much as \$250 million.¹⁵

States are making increasing use of these programs. According to the Government Accountability Office, provider taxes and IGTs from all sources (not just hospitals) rose from \$31 billion in 2008 to \$63 billion in 2018, or from 21 to 28 percent of the state share of Medicaid spending for all services.¹⁶

However, what is good for the hospital industry may not be good for individual hospitals that pay more in taxes or transfers than they receive in supplemental payments. In the late 1980s, before a series of federal statutes and regulations, a state could guarantee each hospital it would receive more than it paid.¹⁷ Such “hold harmless” arrangements are now specifically prohibited by federal law.¹⁸ Federal agencies – both Administration and Congressional, regardless of the party in power – continue to scrutinize supplemental payment programs for possible abuses, especially arrangements that may hold individual providers harmless for taxes and IGTs.¹⁹

Continuing growth in managed care has complicated matters. As shown in Exhibit 2.1.1, Medicaid MCO base payments are roughly twice as high as Medicaid FFS base payments. In general, states previously were prohibited from making supplemental payments for services received through managed care organizations.²⁰ Some states, however, received waivers under Section 1115 of the Social Security Act to continue making supplemental payments when they expanded managed care. Under these waivers, states could require MCOs to “pass through” supplemental payments to hospitals.

In 2016, the Medicaid managed care rule, which was in development for years, changed the game.²¹ All pass-through payments are no longer permitted, and existing arrangements must be phased out by July 1, 2027, at a rate of at least 10 percent a year.²² Moreover, CMS has indicated it views DSRIP funding (\$6 billion in FY 2019) as a one-time investment and does not plan to renew DSRIP demonstrations.²³

Supplemental payments will continue to be contentious, so states must design these programs carefully to comply with federal law while maintaining the support (or at least the lack of opposition) of hospitals for taxes and intergovernmental transfers.

For all states, a new option opened: directed payments, under which states could direct MCOs to make supplemental payments to hospitals. Directed payments must be based on the utilization and delivery of services, must direct expenditures equally for a class of providers and must be expected to advance at least one goal or objective in the state's managed care quality strategy.²⁴ In general, there are two types of directed payment programs.²⁵

- **Fee schedule requirements.**

An example is a minimum or maximum fee schedule for network providers that provide a particular service. Another example is a state requirement that MCOs provide a uniform dollar or percentage increase for network providers that provide a particular service.

- **Value-based payments, delivery system reform.**

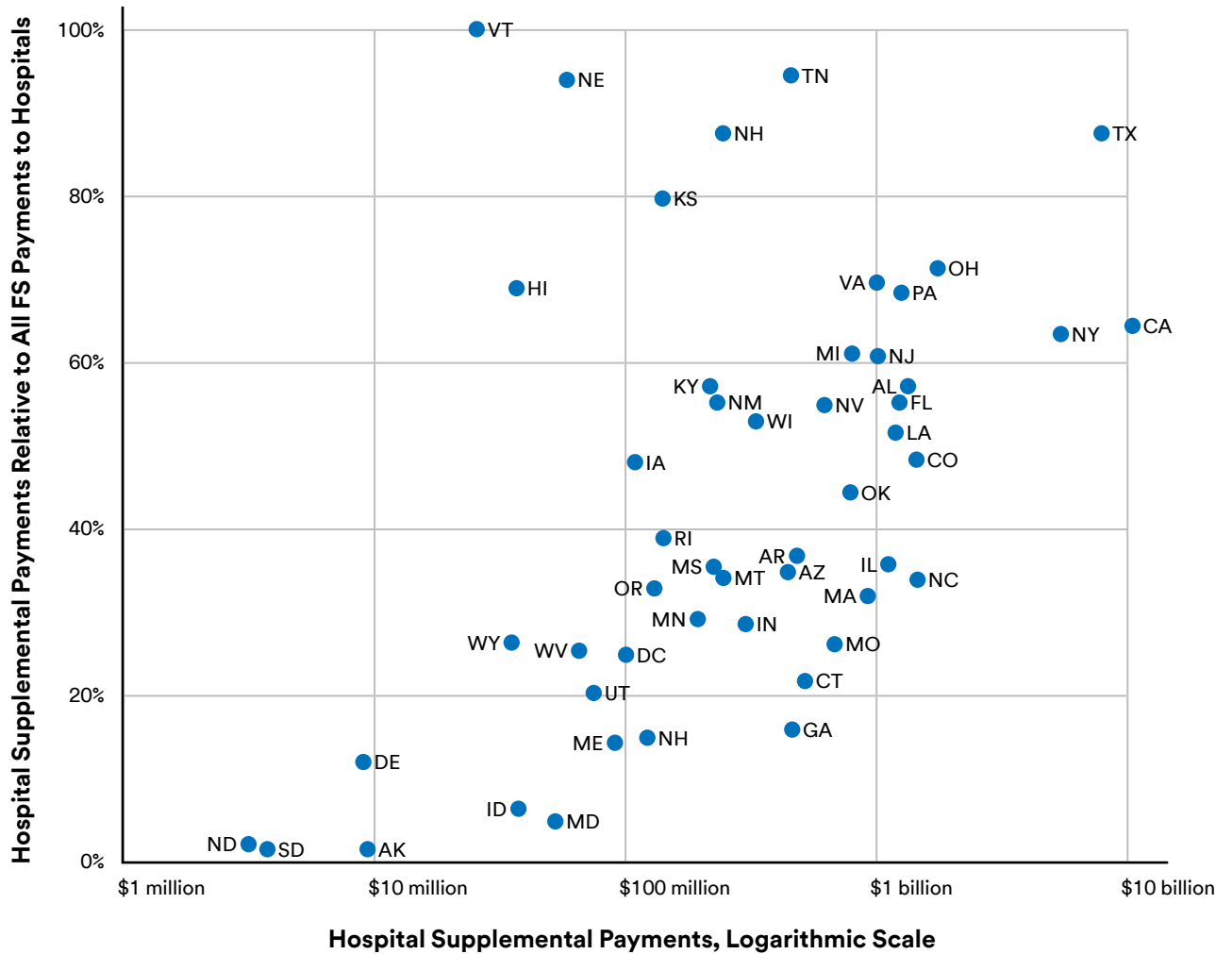
Examples include alternative payment models, pay for performance arrangements, bundled payments or other service payment models intended to recognize value or outcomes over volume of services. The state may also require the MCO to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

At this time, it seems highly likely that directed payment programs will continue to receive federal scrutiny and skepticism. The challenge for states, therefore, is to maintain the flow of federal funding while maintaining support from hospitals to pay taxes and intergovernmental transfers. States can, of course, legislate taxes and transfers against the wishes of those paying the bill. It's just much more difficult when hospitals actively oppose the taxes and transfers.

Exhibit 2.3.1 shows the states with the most at stake. In FY 2019, 13 states paid hospitals at least \$1 billion in supplemental payments; in California, Texas, and New York, the totals were \$10.4 billion, \$7.9 billion, and \$5.4 billion, respectively. Because of the restrictions on payments through MCOs, states also have limited room to maneuver when supplemental payments are high relative to FFS hospital payments. In 24 states, supplemental payments represented at least 40 percent of total FFS hospital payments in FY 2019. Tennessee, Texas, Kansas and New Hampshire, for example, each had supplemental payments that exceeded 80 percent of FFS payments.

This document proposes a strategy to strike the balance between compliance with federal law and state flexibility in directing payments through MCOs to hospitals. At the same time, the proposed strategy aims to increase transparency, reward efficiency and improve quality outcomes in hospital care.

Exhibit 2.3.1: Medicaid Hospital Supplemental Payments in Total and Relative to Total FFS Hospital Payments



Notes:

1. Source is 3M, based on Medicaid and CHIP Payment and Access Commission. MACStats: Medicaid and CHIP Data Book. Washington, DC: MACPAC, December 2020, Exhibit 24.
2. Per MACPAC, supplemental payments include disproportionate share hospital (DSH), upper payment limit (UPL), uncompensated care pool (UCC), delivery system reform incentive payment (DSRIP), and graduate medical education (GME). See also Exhibit 2.1.1 in this paper.
3. Because the majority of DSRIP payments go to hospitals, MACPAC reports these payments as payments to hospitals.
4. Washington State is not shown in this exhibit because prior-period adjustments meant that reported FY 2019 supplemental payments were negative.

3. A Proposed Strategy for Decades to Come

3.1 Using Common Grouping Methods for Transparency, Even if Not for Payment

Confusion has been one obvious result of simultaneous growth in supplemental payments and managed care. Nationwide, Medicaid services are delivered through 51 fee-for-service (FFS) programs and 282 Medicaid managed care organizations (MCOs).²⁶ In a typical state, no one knows how much Medicaid money is being paid to hospitals, by what methods, for what services. Standard reports such as the CMS-64 show payments to MCOs in aggregate, with no breakdown of how the MCOs divide payments across provider types. Similarly, detailed information on supplemental payments is rarely, if ever, available.

As supplemental payments become increasingly tied to utilization and quality – as opposed to lump-sum payments based on, for example, comparing aggregate payments to aggregate hospital costs – it will become more challenging to simply keep straight who is being paid for what. At the same time, states have an obligation to demonstrate that payments are consistent with economy, efficiency, and access to quality care.²⁷ States, like other players in health care, are also espousing increased commitment to transparency.

Even if multiple FFS and MCO methods are used to pay hospitals in a state, we recommend that all hospital claims be run through a clinical classification algorithm in order to understand, manage, and oversee directed payment programs.

We recommend that, at minimum, Medicaid agencies compile summaries of inpatient and outpatient utilization and payment across the fee-for-service and managed care sectors using a common clinical grouping methodology. Without common service definitions and appropriate risk adjustment, it is impossible to fairly compare utilization and payment across Medicaid MCOs and across hospitals. These summaries may be for internal state government use or, preferably, published for the information of the public. Because of standardized claim formats (i.e., UB-04 and X12N 837I) and requirements that MCO submit encounter data, the data already exist. What's missing is the decision to transform the data into information and insight.

The most common methodologies in use by Medicaid today are 3M APR DRGs and Medicare Severity DRGs (MS-DRGs) for inpatient care and 3M EAPGs and Medicare APCs for outpatient care. MS-DRGs and Medicare APCs, however, were designed and intended for the Medicare population, and are only weakly suitable for the newborn, pediatric and obstetric populations that are so important to the Medicaid program. 3M APR DRGs and 3M EAPGs, by contrast, were designed for all populations, with particular attention to conditions and populations rarely seen in Medicare.

Exhibit 3.1.1 shows an example of a state applying a common clinical grouper to diverse datasets, in this case 3M APR DRGs applied to inpatient stays from all payers in Indiana. Similarly, the Agency for Healthcare Research and Quality has long applied 3M APR DRGs and MS-DRGs to create the widely used National Inpatient Sample (NIS). Once the data are grouped, it is straightforward to incorporate relative weights to enable risk adjustment.

As the Indiana and NIS examples show, use of a common grouper does not require that all payers use the same payment method. Indeed, a key benefit of grouping is enabling apples-vs-apples comparisons across hospitals and payers. While the NIS and Indiana databases do not include payment amounts received by hospitals, some state All Payer Claims Databases are moving in this direction. A single risk adjustment process can be used to risk adjust financial fields such as hospital charges, hospital cost and payment.

Exhibit 3.1.1: Example of Applying a Common Clinical Grouper to All Payer Data (Top 10 Indiana Discharges by Total Charges)

3M All Patient Refined DRG	Inpatient Stays	Days	Billed Charges	Average Charge	Average Days
720-4 Septicemia & Disseminated Infections	16,712	136,275	\$1,328,049,057	\$79,467	8.2
720-3 Septicemia & Disseminated Infections	15,874	82,581	\$629,082,779	\$39,630	5.2
710-4 Infectious & Parasitic Diseases Including HIV w O.R. Procedure	2,601	39,176	\$535,371,404	\$205,833	15.1
304-1 Dorsal & Lumbar Fusion Proc Except for Curvature of Back	3,370	8,409	\$517,330,256	\$153,510	2.5
302-1 Knee Joint Replacement	7,636	12,710	\$514,186,957	\$67,337	1.7
301-2 Hip Joint Replacement	6,576	16,141	\$511,762,652	\$77,823	2.5
302-2 Knee Joint Replacement	6,751	14,459	\$499,633,782	\$74,009	2.1
304-2 Dorsal & Lumbar Fusion Proc Except for Curvature of Back	2,979	10,265	\$490,891,336	\$164,784	3.4
301-1 Hip Joint Replacement	6,246	14,292	\$440,609,140	\$70,543	2.3
004-4 Tracheostomy w MV 96+ Hours with Extensive Procedure	2,601	39,176	\$535,371,404	\$205,833	36.0

Source: 3M summary of Indiana Department of Health all-payer data publicly available at www.in.gov/isdh/20624.htm.

3.2 Encourage Common Payment Methods, with Flexibility

A beneficial second step would be for a Medicaid agency to encourage its MCOs to use a common payment method, with flexibility. Federal law gives states wide latitude in determining payment methods for both the FFS and MCO sectors. Some states extend similar flexibility to their MCOs while others already either require or encourage MCOs to use the state FFS methodology. In these states, MCOs may have flexibility to adjust the base rate within limits, or possibly apply service or peer group adjusters.

MCOs, in fact, may welcome a requirement to follow FFS, because MCOs must negotiate voluntary contracts with hospitals that often have considerable bargaining power, especially with increasing hospital consolidation across the U.S.²⁹

As shown in Box 3.2.1, prospective payment methods enable flexibility while providing transparency. In practice, a very difficult task for any payer is to maintain the payment method so that it pays more for sicker patients while keeping up to date with numerous changes in hospital care and coding. In a prospective payment method, the clinical grouping logic is updated annually by 3M for APR DRGs and EAPGs and by CMS for MS-DRGs and APCs.³⁰ That is, the payer doesn't need to undertake the most technically difficult task. This leaves the Medicaid agency or MCO with three significant payment levers: the overall base rate, service adjusters (e.g., pediatrics), and peer group adjusters (e.g., hospitals with high Medicaid utilization). Importantly, federal law allows states latitude to define peer groups for payment purposes.

A significant additional benefit is that coordinated payment incentives allow Medicaid payers (FFS and MCO) to combine their impact on payment to ensure access to care, especially for services such as neonatology, pediatrics, obstetrics, and HIV where Medicaid pays for approximately 50 percent of all stays nationwide.³¹ A concerted approach across FFS and the MCOs would encourage quality improvement more than a patchwork of disjointed quality programs.³²

A beneficial second step would be to encourage all MCOs to use the same inpatient and outpatient payment methods, possibly with limited flexibility to adjust rates, service adjusters or peer group adjusters.

Box 3.2.1: Prospective Payment Methods in Health Care

Prospective payment may be defined as bundled payment based on the clinical condition of the patient, without regard to provider charges or cost for specific services provided. Diagnosis Related Groups (DRGs) are the exemplar, widely used across the U.S. and around the world.³³ In a DRG-based payment method, the unit of payment is the inpatient hospital stay. The same approach can be applied to other units of payment, such as the outpatient hospital visit, a day of nursing facility care, etc.

The essential structure of prospective payment is shown in the chart below, using 3M APR DRG 139-3, Other Pneumonia, severity 3, as an example.

- **Grouping.** The core of a prospective payment method is a clinical algorithm that measures patient severity (also known as acuity). Incorporating patient severity means that providers are paid more for sicker patients, thereby promoting access to care across the continuum of care. States adopt 3M or Medicare algorithms – often called groupers – because the annual maintenance of a clinically credible patient classification methodology is expensive and difficult. Exhibits 2.2.1 and 2.2.2 show current fee-for-service payment methods in each state.
- **Relative weight.** For each severity group (inpatient or outpatient) the developer calculates relative weights based on databases of millions of claims nationwide. The relative weight measures the average hospital cost of that severity group relative to the average cost of all severity groups. In the example, APR DRG 139-3 has a relative weight of 0.8655 using version 38. That is, the hospital cost for patients in this severity group is typically 86.55 percent of the cost of the average inpatient stay overall.
- **Service adjuster.** While relative weights are a calculation, service adjusters are a choice, typically driven by a state's policy priorities. Various states apply service adjusters to boost payment for neonates, pediatrics, obstetrics, mental health or other services. The policy rationale is that Medicaid represents a large proportion of a hospital's business for some service lines, so increased payment rates encourage access.³⁴ To ensure budget neutrality, a boost for one service line means lower rates for other service lines. In the example below, the service adjuster for pneumonia is 1.00, that is, no service adjuster.
- **Base rate.** The base rate – also known as the conversion factor, standard payment amount or base price – converts the other components of the payment formula into dollars. It is typically set through iterative financial simulations that also include the budget target, expected utilization, expected case mix and policy choices such as service and peer group adjusters. In the example, the base rate is \$10,000.
- **Peer group adjuster.** States often choose to vary the base rate by hospital peer group. Options include wage areas, rural, teaching, border, children's, government owned or high disproportionate share. Conceptually, peer group adjusters are a multiple of an overall base rate. In practice, states often simply show different base rates for different peer groups.
- **Base payment.** For a given severity group, the base payment equals the relative weight times the service adjuster times the base rate times the peer group adjuster, or \$8,655 for pneumonia, severity 3.

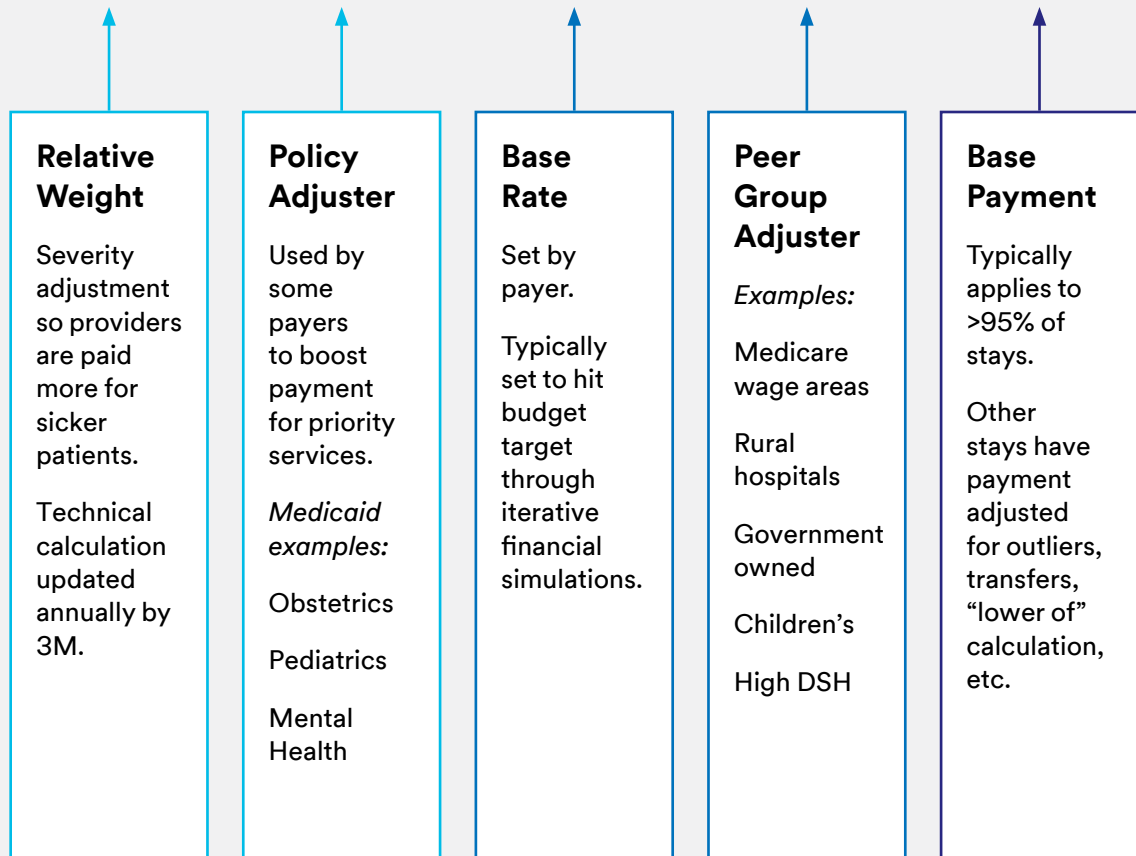
The essential structure typically applies to more than 95 percent of inpatient stays or outpatient visits. In the remaining encounters, adjustments are made for special situations such as outliers, service carveouts, inpatient transfers, partial eligibility and calculated payment exceeding the billed charge.

On balance, prospective payment has been a success because it is a rational, transparent structure that simultaneously generates strong incentives for efficiency and access. It also is a flexible structure that is typically in place for decades, with annual adjustments in grouping, relative weights, service adjusters, the base rate, peer group adjusters and payment method rules.

Typical Components of a Prospective Payment Method

Example: APR DRG 139-3 Other Pneumonia, Severity 3

$$(0.8655 \times 1.00) \times (\$10,000 \times 1.00) = \$8,655$$



This example is based on 3M APR DRG v38 for inpatient hospital care.

The same structure applies to other grouping methodologies (such as Medicare DRG, 3M EAPG, and Medicare APCs) and other provider types (such as outpatient, nursing facilities, and physicians.)

3.3 Use Prospective Payment Methods for State Directed Fee Schedules

State directed fee schedules are the first broad category of permissible directed payment arrangements. States may require MCOs to adopt specific fee schedules for particular services, adopt minimum or maximum fee schedules or provide uniform percentage or dollar increases.³⁵ These contract arrangements must be available on the same terms to all providers within a class (i.e., what we call a peer group). Importantly, federal law allows flexibility for states to define service types and provider peer groups, so long as providers within a class are treated similarly.³⁶

As of June 2019, CMS had approved 55 directed payment arrangements applicable to hospitals.³⁷ Of these, 40 were directed fee schedules, 22 of these arrangements included uniform dollar or percentage increases, 14 included minimum fees and 6 included maximum fees.

In implementing directed fee schedules, we recommend that states use prospective payment methods, either for analytical purposes (Section 3.1 above) or preferably as part of common payment methods (Section 3.2). Prospective payment methods offer “automatic” adjustment for shifts in hospital volume and case mix while giving states three levers to direct payments in line with policy goals.

Prospective payment methods offer “automatic” adjustment for shifts in hospital volume and case mix while giving states three levers to direct payments in line with policy goals. Those levers are the overall base rate, service adjusters, and peer group adjusters.

Consider a state where Medicaid MCO base payments for inpatient hospital services currently total \$500 million. The state wishes to convert \$50 million in current supplemental payments to state-directed fee schedule payments. The effect would be to increase MCO hospital payments to \$550 million. Using inpatient care as an example, the state has three policy levers available:

- **Overall base rate.** Direct the MCOs to increase their DRG base rates for every hospital by 10 percent (i.e., \$50M/\$500M).
- **Service category adjusters.** Direct the MCOs to increase payment for one or more service categories. For example, if 20 percent of payment had been for pediatric and obstetric services, the state could direct the MCOs to apply a 50 percent service adjuster (\$50M/\$100M) for pediatric and obstetric services. Note that the higher rates would apply to any hospital that provided the services, thereby incentivizing increased access.³⁸
- **Provider peer group adjusters.** In this option, the state would direct MCOs to increase rates for particular peer groups. For example, if \$200 million had been paid to hospitals defined as having high Medicaid utilization, then the state could direct the MCOs to apply a 25 percent peer group adjuster (\$50M/\$200M) to high Medicaid hospitals. Note that safety net hospitals are often both owned by local governments and serve a high percentage of Medicaid and uninsured patients.³⁹ Higher base rates tied to utilization are very defensible public policy while also encouraging local governments to support intergovernmental transfers to the state. However, states cannot require hospitals to participate in IGT arrangements as a condition for participation in an MCO fee schedule arrangement.⁴⁰

These strategies, with an explicit policy justification and payment directly tied to utilization, would seem very likely to withstand federal scrutiny.

Although it may be theoretically possible to apply these types of adjustments when different MCOs use different payment methods (such as percentage of charges, per diem, or individual fee schedules), in practice it becomes almost impossible to understand the flow of funds and what it buys, especially as hospital care and payment levels evolve over a period of years. With a prospective payment method, on the other hand, states can make adjustments within an overall structure that can be stable for years.

3.4 Tie Directed Payments to Improved Patient Outcomes

As of 2019, the other 15 directed payment arrangements approved by CMS were for value-based payments, of which 9 included pay-for-performance incentives, 3 included population-based payments and 4 included other incentives.⁴¹ In recent years, more and more states have emphasized these value-based arrangements, which align with the spirit, and sometimes the specific definitions, of alternative payment models (APMs) that have been strongly encouraged by CMS.⁴²

In addition to aligning with CMS priorities, redirecting supplemental payments toward value-based purchasing holds the promise of both improving patient health and saving money. Exhibit 3.4.1 shows six documented examples of reductions in hospital utilization that represented better patient outcomes (fewer potentially preventable admissions, complications and readmissions), lower cost to the hospital and lower payments by providers.

The use of directed payments for value-based payments carries two other significant advantages. First, higher quality would result in higher payment, in contrast to other quality initiatives that carry only penalties. Second, a concerted initiative across Medicaid MCOs can have significant impact, especially if incentives for quality are aligned with Medicare or commercial payers.

In general, we recommend that states and other payers focus on a small set of strong measures with all the following attributes.⁴³

- **Substantial savings** possible in hospital cost and Medicaid funding
- **Outcomes-based**, rather than process-based
- **Comprehensive**, rather than limited to isolated quality problems
- **Actionable**, that is, hospitals can reasonably take action to improve value
- **Risk-adjusted**, using clinically credible risk categories
- **Proportional**, so that financial bonuses or penalties for hospitals are aligned with improvements in value
- **No additional administrative burden**; for example, by using currently available data
- **Scalable**, so that value measures apply across entire patient populations
- **Proven success**, to the extent possible, measures should have a track record of success
- **Transparent**, that is, the details and calculations should be open to review and comment

Among other options, measures that target excess hospital utilization meet all these criteria. Over the past two decades, multiple states have adopted 3M™ Potentially Preventable Event (PPE) methodologies for purposes of analysis, public reporting, and/or payment adjustment.⁴⁴ Each 3M PPE methodology targets deficiencies in quality that result in more care being provided at

Directed payments for value-based programs have the potential to increase hospital revenue, decrease hospital cost, and improve patient outcomes. Examples include programs to reduce potentially preventable inpatient complications, readmissions, and returns to the emergency department after an inpatient stay.

greater cost. Measuring performance, providing actionable data back to hospitals and incentivizing improvement is entirely consistent with state strategies of minimizing wasteful spending. We also note that the 3M PPE methodologies align with CMS encouragement to states to use “existing, validated, and outcomes-based performance measures.”⁴⁵

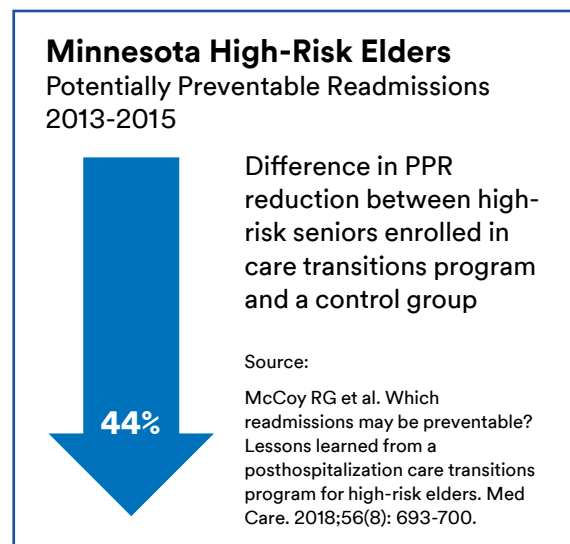
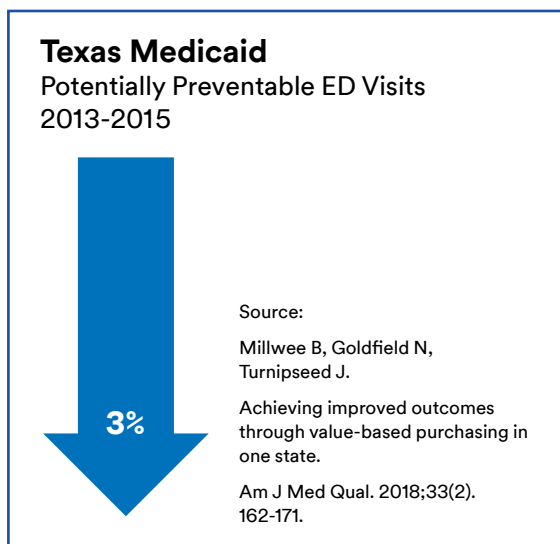
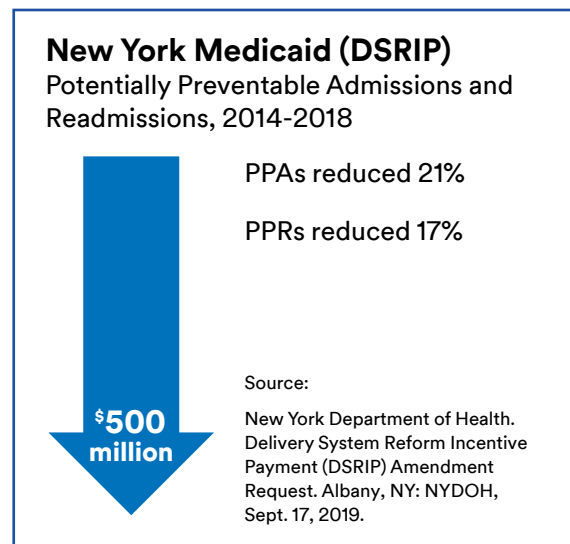
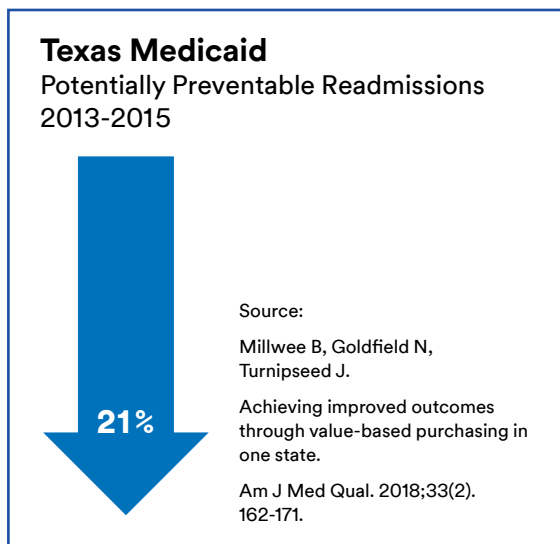
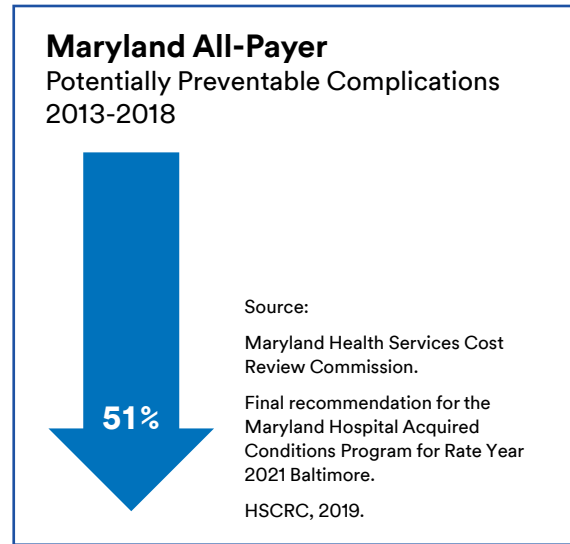
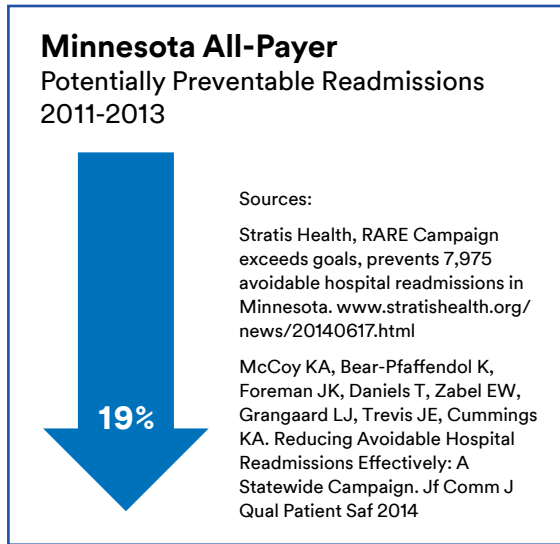
The 3M PPE methodologies most applicable to hospital care are as follows.

- **3M™ Potentially Preventable Readmissions (PPRs).** Approximately 5-10 percent of Medicaid hospital admissions are followed by at least one potentially preventable readmission, according to analyses in several states that used 3M PPRs.⁴⁶ In guidance to states, CMS specifically uses “potentially preventable readmissions” as an example of a mechanism for directed payments.⁴⁷ 3M PPRs include readmissions with a clinical connection to the previous discharge, cover the full range of patient conditions and are risk-adjusted using the 3M APR DRG of the initial admission.
- **3M™ Potentially Preventable Revisits the Emergency Department (PPR EDs).** In understanding readmissions at the national level, the missing part of the picture has been those situations when discharged patients are seen in the emergency department for pain control, infection or other reasons potentially related to the discharge but are not readmitted. In 2019, 3M enhanced the PPR software to include “treat-and-release” ED visits, or PPR EDs. In a Mississippi Medicaid analysis, PPR EDs were more frequent than PPRs, even if not as significant clinically or financially.⁴⁸ As with PPRs, hospital PPR ED performance is risk-adjusted by 3M APR DRGs.
- **3M™ Potentially Preventable Complications (PPCs).** Approximately nine percent of hospital cost reflects potentially preventable complications that occur during an inpatient stay, according to 3M analyses of all-payer California and Maryland data.⁴⁹ The 3M PPC methodology uses the 3M APR DRG calculated at time of admission as the risk adjuster in comparing actual PPC incidence with what would be expected for a hospital of the same case mix.
- **Outpatient hospital outcomes measures.** With the nationwide shift from inpatient to outpatient care – including procedures that even recently were rarely done in an outpatient setting – measures of outpatient safety and efficiency have become ever more important. In a 2019 report, 3M researchers analyzed a Medicare database of 10 million inpatient stays and 14 million emergency department visits to identify complications of outpatient surgeries that resulted in potentially preventable hospital admissions and/or ED visits.⁵⁰ All results were risk-adjusted.

For some hospital providers — such as an integrated delivery system that takes responsibility for the health of a defined population — the 3M population health outcome measures may also be appropriate. These measures include 3M™ Potentially Preventable Admissions, 3M™ Potentially Preventable ED Visits and 3M™ Potentially Preventable Services. States implementing episode-based APMs may also find useful the 3M™ Patient-focused Episodes methodology, which is well integrated with 3M APR DRGs and 3M EAPGs.

Exhibit 3.4.1 shows that meaningful reductions in potentially preventable events are possible, benefiting patients through better health outcomes, payers through lower payments, and hospitals through lower cost of care.⁵¹ We do not claim that merely measuring PPEs leads to improved performance. In fact, the improvements shown in Exhibit 3.4.1 required concerted effort by providers, payers and other organizations. They also occurred in an environment where providers and payers in general have been paying greater attention to quality of care. However, it is hard to imagine making meaningful improvements without robust measurement methods that generate credible and actionable data on a timely basis. 3M provides those measurement methods through the 3M Potentially Preventable Event methodologies.

Exhibit 3.4.1: Examples of State Use of 3M Potentially Preventable Event Methodologies



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- ² In this report, we use “provider taxes” to also encompass provider donations and “intergovernmental transfers” to also encompass certified public expenditures.
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- ⁶ 3M tabulations from the CMS-64 report for federal fiscal year 2019.
- ⁷ For purposes of this analysis, “states” includes the 50 states and the District of Columbia.
- ⁸ Strictly speaking, the Medicare Outpatient Prospective Payment System (OPPS) comprises APCs as well as separate fee schedules for lab services, therapies, etc. “APCs” is commonly used shorthand for the OPPS.
- ⁹ Kaiser Family Foundation, Medicaid Managed Care Tracker. <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>. Accessed August 3, 2021. Hereafter: KFF, Medicaid Managed Care Tracker. The MCO count is as of March 2021.
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- ¹³ 60% is based on 3M analysis of CMS-64 state-by-state supplemental payments to hospitals in 2019. Although the CMS-64 data are not completely aligned with the MACPAC 2021b definition, 60% is a reasonable approximation.
- ¹⁴ Using unpublished GAO data for FY 2018, MACPAC estimated that 65% of the state share of disproportionate share hospital payments came from provider taxes (25%) and IGTs (40%). For non-DSH supplemental payments, the figures were 21% from provider taxes and 25% from IGTs. See MACPAC 2021b. See also Medicaid and CHIP Payment and Access Commission. Health Care-Related Taxes in Medicaid. Issue brief. Washington, DC: MACPAC, May 2021. Hereafter: MACPAC 2021a.
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- ¹⁶ Government Accountability Office. Medicaid: CMS Needs More Information on States’ Financing and Payment Arrangements to Improve Oversight. GAO 21-98. Washington, DC: GAO, December 2020.
- ¹⁷ Morgan D. Small Provision Turns into a Golden Goose; States Used Subsidy to Balance Budgets. *Washington Post*, Jan. 31, 1994.
- ¹⁸ 42 CFR § 433.68(f).
- ¹⁹ See multiple reports and policy documents from the Centers for Medicare and Medicaid Services, Government Accountability Office, MACPAC, and Department of Health and Human Services Office of Inspector General.
- ²⁰ Medicaid and CHIP Payment and Access Commission. Directed Payments in Medicaid Managed Care. Issue brief. Washington, DC: MACPAC, August 2020. Hereafter: MACPAC 2020a.
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- ²² 42 CFR § 438.6(d)(3).
- ²³ MACPAC 2021b p. 6.
- ²⁴ Other requirements also apply. See 42 CFR § 438.6(c) and the State Directed Payments webpage at <https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html>.
- ²⁵ Centers for Medicare and Medicaid Services. 42 C.F.R. § 438.6(c) Preprint (January 2021). State Directed Payment 42 CFR 438.6(c) Proposal Preprint (medicaid.gov). Hereafter: CMS 2021 Preprint.

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- ²⁷ Social Security Act § 1902(a)(30)(A).
- ²⁸ Per CMS: “We advise those non-Medicare systems that need a more up-to-date system to choose from other systems that are currently in use in this country, or to develop their own modifications. As previously stated, we do not have the data or the expertise to develop more extensive newborn and pediatric DRGs. Our mission in maintaining the Medicare DRGs is to serve the Medicare population.” Centers for Medicare and Medicaid Services. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates. Final rule. 69 FR 48939 (August 11, 2004).
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- ³⁵ 42 CFR § 438.6(c)(1)(iii).
- ³⁶ 42 CFR § 438.6(c)(2). See also CMS Preprint 2021, pp. 6-9.
- ³⁷ MACPAC 2020a.
- ³⁸ If a payer chooses to apply service adjusters to relative weights, 3M recommends that these adjusters apply to broad categories such as neonates, pediatrics, obstetrics, or mental health. These broad categories align with hospital decisions by service line that affect capacity and therefore access for Medicaid patients. Singling out individual services at the DRG level would undermine the scientific basis for DRG relative weights, which are calculations based on analysis of hospital costs across millions of inpatient stays nationwide. See 3M Health Information Systems. Recommendations for Updating Payment Methods Based on 3M APR DRGs and 3M EAPGs. Murray, UT: 3M HIS, 2020. www.3m.com/his/methodologies.
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- ⁴⁴ For more information on the 3M Potentially Preventable Event methodologies, follow the links in the methodologies table at www.3m.com/his/methodologies to the specific webpages for PPRs, PPCs, PPAs, PPVs and PPSs.
- ⁴⁵ CMS 2021 Preprint, p. 4.
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- ⁴⁸ Mississippi 2019, p. 9.

⁴⁹ Fuller RL, McCullough EC, Bao MZ, Averill RF. Estimating the costs of potentially preventable hospital acquired conditions. *Health Care Financ Rev.* 2009;30(4):17-32.

⁵⁰ Averill 2019.

⁵¹ Although it is commonly said that poor care benefits hospitals through higher revenue, this ignores a hospital's financial interest in its own reputation and in any case depends on the payment method. For PPRs and PPR EDs, it is true that readmissions and revisits to the ED generate additional revenue, assuming the patient has insurance. For PPCs, however, hospitals paid by DRG only increase profit margins if the increase in DRG payment exceeds the incremental cost of the PPC. In one Medicaid analysis, only 32% of stays with a PPC would have been assigned to a higher-paying APR DRG if there had been no PPC. Texas Health and Human Services Commission. *Potentially Preventable Complications in the Texas Medicaid Population SFY 2012.* Austin, TX: HHSC, 2013, p. 24.



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