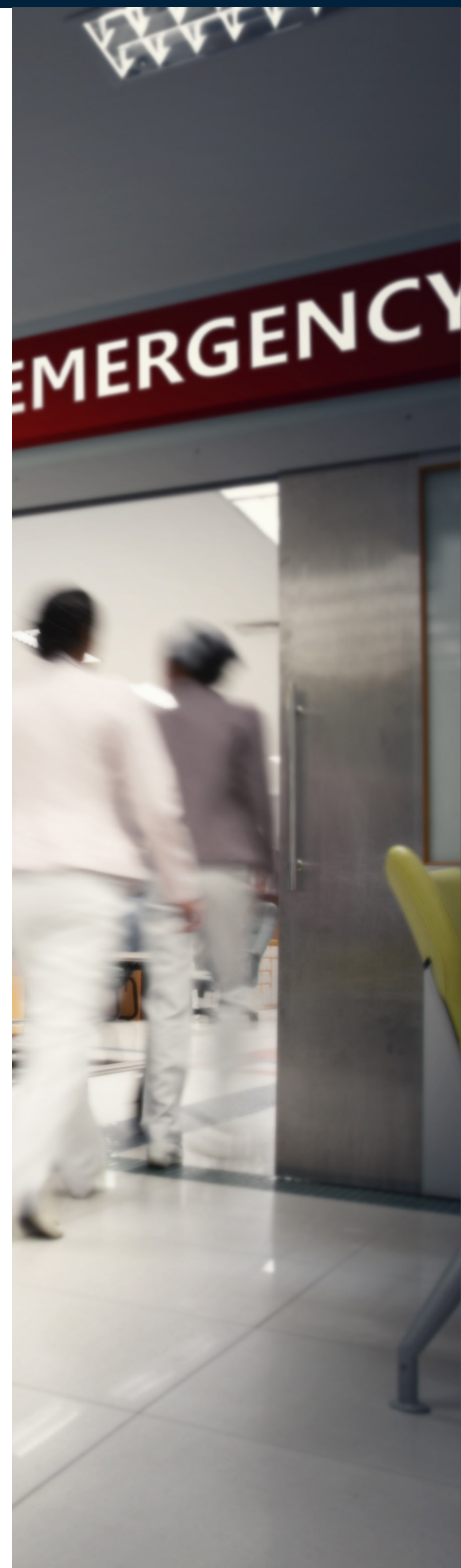
Evaluation report
February 2024

Medicaid Hospital Rates



Office of Performance Evaluations
Idaho Legislature

Promoting confidence and accountability in state government

Office of Performance Evaluations

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Joint Legislative Oversight Committee 2023–2024

The eight-member, equally bipartisan Joint Legislative Oversight Committee (JLOC) selects evaluation topics; OPE staff conduct the evaluations. Reports are released in a public meeting of the committee. The findings, conclusions, and recommendations in OPE reports are not intended to reflect the views of the Oversight Committee or its individual members.

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Representatives

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Senator Melissa Wintrow (D) and Representative David M. Cannon (R) cochair the committee.

From the director

February 6, 2024

Members
Joint Legislative Oversight Committee
Idaho Legislature

The lack of transparency in managed care contracts and great variation in state administration of Medicaid programs makes it difficult to compare Medicaid rates across states. We found that Idaho's hospital payment rates are higher than all four states with comparable payment policies.

Idaho's Medicaid program recently transitioned its payment and quality assurance for inpatient hospital services to a model that better reflects legislative priorities of cost containment and paying for value. The new payment model gives the Legislature tools to control costs, but the Department of Health and Welfare struggles to provide data analysis and reporting to ensure the Legislature has the necessary information to make tough choices. Variation in payment rates across service arrays suggests that any changes to payment policy require nuanced understanding of the tradeoffs involved.

This is the third in a trilogy of our reports with Medicaid payment policy at their core, following Medicaid Rate Setting and Sustainability of the Direct Care Workforce. Despite recent progress in the way Idaho pays hospitals, we continue to be concerned that Medicaid staff have less resources and analytical capacity than the providers and national contractors they must negotiate with and oversee.

Sincerely,

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Formal responses from the Governor and the Department of Health and Welfare are in the back of the report.

Ryan Langrill and Sasha O'Connell conducted this evaluation.

Leslie Baker copyedited the report.

The Medicaid and CHIP Payment and Access Commission offered technical assistance.

The Idaho Hospital Association and Bob Thomas of Robert C. Thomas and Associates provided technical reviews.

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Medicaid hospital rates

For most of its history, the Idaho Medicaid program paid hospitals based on the allowable costs they incurred serving Medicaid participants. In July 2021, Idaho joined most other states by paying for inpatient hospital stays using the diagnosis-related group (DRG) for each stay. The Division of Medicaid within the Department of Health and Welfare plans to transition its payment for outpatient hospital services to a similar payment model in July 2024.

The transition to DRGs allowed us to compare what Idaho pays for a hospital stay to what other Medicaid programs using the same model would pay for the same DRG. In March 2023, the Joint Legislative Oversight Committee asked us to compare Idaho's rates to Medicare and other state Medicaid programs and to answer some related questions. The letter requesting our evaluation is in appendix A. The evaluation scope is in appendix B.

A common refrain about Medicaid programs is "Once you've seen one Medicaid program, you've only seen one Medicaid program." Medicaid programs vary widely from state to state and hospital payment policies are no exception. This complexity has led other states to avoid comparing hospital rates between states. Our methods and their limitations are discussed in appendix C.

Enrollment growth and inflation have driven increased spending on hospital services.

Total Medicaid hospital spending doubled over the last decade.

After adjusting for inflation, per-member spending decreased 10%.

Medicaid is Idaho's largest program, spending almost $4.3 billion in fiscal year 2023. Hospital services made up about a quarter of that spending. Exhibit 1 shows trends in hospital spending over the last decade.

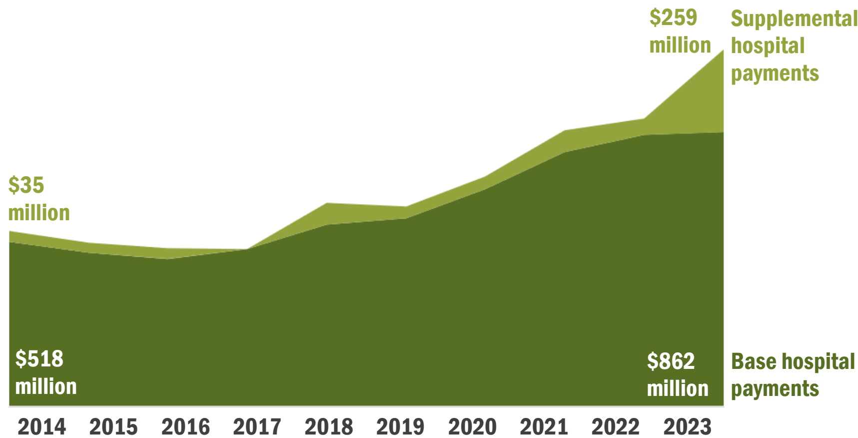
Total Medicaid spending on hospitals has doubled over the last decade. However, this notable increase obscures some important changes that are necessary to understand the trends in hospital payment. About 40 percent of the increase—about $224 million—comes from supplemental payments. These payments are funded from a tax on hospitals and from federal matching funds, not from state general funds.

Base payments to hospitals increased 67 percent—$345 million—over the last decade. However, this growth is driven by serving more Idahoans under Medicaid expansion. This growth was funded by a higher match rate from the federal government, which covers 90 percent of costs. After adjusting for inflation, per-member spending has decreased 10 percent.

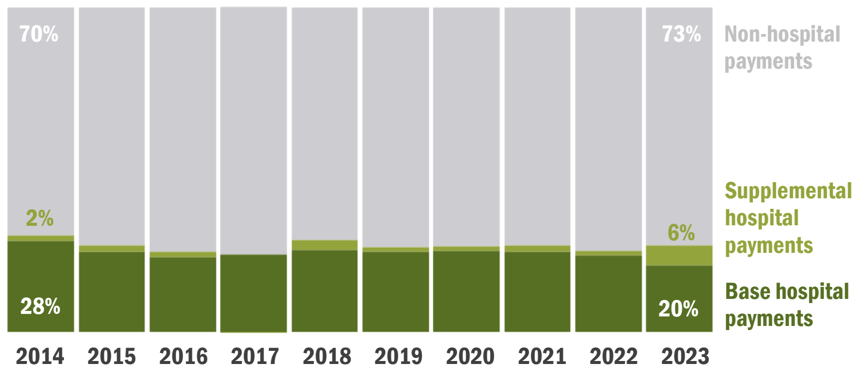
Exhibit 1

Medicaid hospital costs have increased over the last decade due to inflation and higher enrollment.

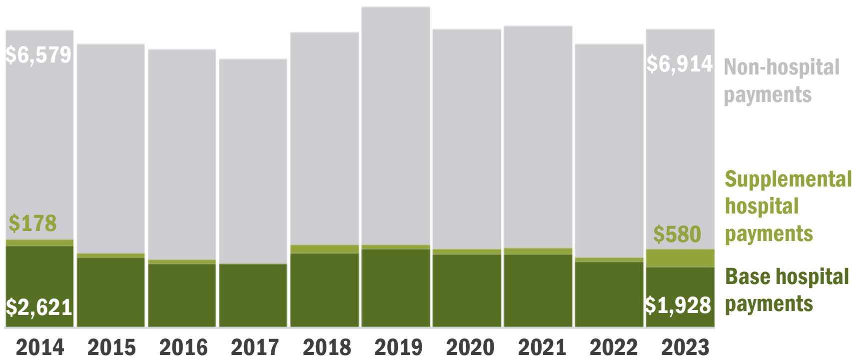
Total Medicaid expenditures on hospitals have increased 103% over the last decade without adjusting for inflation.



Hospitals make up a smaller share of total Medicaid payments than they once did.



After adjusting for inflation, hospital spending per enrollee has decreased 10% over the last decade.



Note: Some totals do not add up to 100% because of rounding.
Source: Office of Performance Evaluations' analysis of agency data. Amounts adjusted to 2023 dollars using the Consumer Price Index reported by the Federal Reserve Bank of Minneapolis.

Medicaid's payment models influence how providers can financially succeed.

14% of hospital expenditures for Idahoans were paid by Medicaid.

Hospitals make many decisions about how to invest resources. Should a hospital encourage doctors to order the tests most likely to give the patient answers or to order a wide range of tests to rule out all possibilities? Should a hospital hire an additional obstetrician or cardiologist? Should a hospital outsource certain diagnostic services or invest in high-cost technology that will save money in the long run?

The right investment from a financial perspective is one that increases revenues relative to costs. The more that providers rely on Medicaid for payment, the more Medicaid policy shapes how services are delivered.

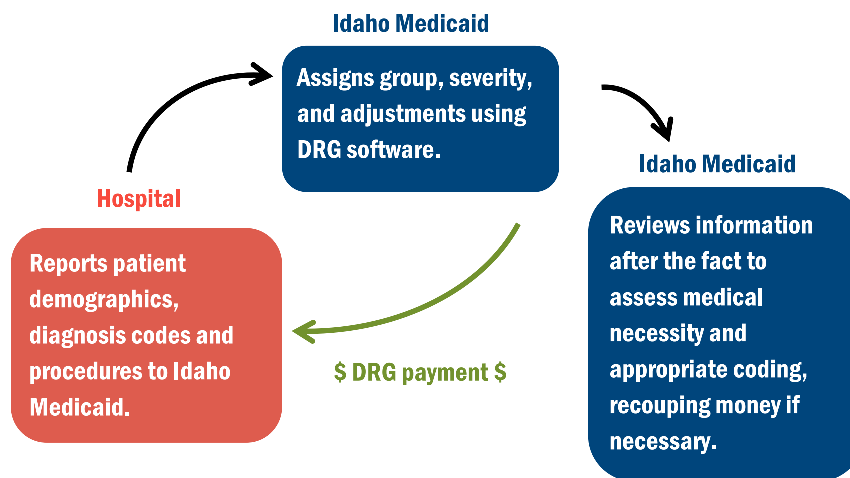
Medicaid is less important to hospitals than it is for direct care, an industry whose relationship with Medicaid we documented in our 2023 report, *Sustainability of Idaho's Direct Care Workforce*. Nevertheless, Medicaid paid for 14 percent of hospital expenditures for Idahoans in 2020, according to the Centers for Medicare and Medicaid Services.

Paying based on allowable costs encouraged hospitals to provide services but did little to reward cost-effective care.

Hospitals provide Medicaid with information about a patient's primary and secondary diagnoses, what procedures the hospital did, and other clinically relevant information about the hospital stay. Hospitals used to receive an interim payment that was later followed by a final settlement. The settlement depended on the allowable costs incurred serving Medicaid patients, as reported to the Centers for Medicare and Medicaid Services. Idaho's new payment model is simpler, though hospitals still need to report information to the Centers for Medicare and Medicaid Services. See exhibit 2.

Exhibit 2

Medicaid's new payment model allows a single payment after discharge, rather than the previous two-step process.



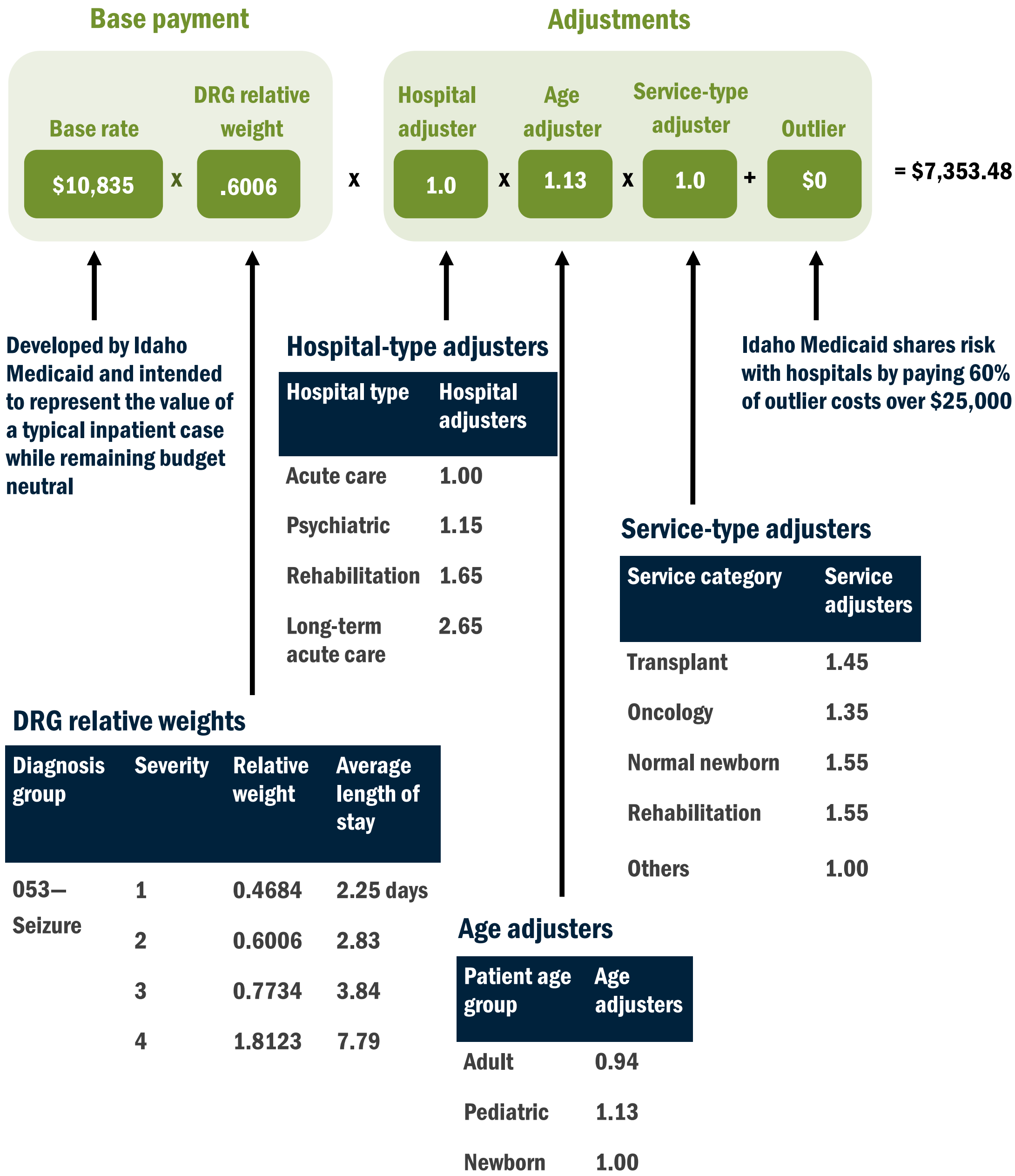
Source: Office of Performance Evaluations' analysis of agency documents.

Rather than reimbursing for allowable costs, Medicaid now uses software licensed from 3M to categorize the hospital stay into one of about 330 DRGs with 4 levels of severity each. The DRG payment model assigns an estimate of the level of resources needed for each hospital stay according to national averages. Exhibit 3 shows this in more detail.

Exhibit 3

Idaho Medicaid's new payment model categorizes hospital stays based on the resources used for similar stays.

Example base hospital payment and adjustments for treating a child's seizure under Idaho's DRG model.



Hospital-type adjusters

Hospital type	Hospital adjusters
Acute care	1.00
Psychiatric	1.15
Rehabilitation	1.65
Long-term acute care	2.65

Service-type adjusters

Service category	Service adjusters
Transplant	1.45
Oncology	1.35
Normal newborn	1.55
Rehabilitation	1.55
Others	1.00

DRG relative weights

Diagnosis group	Severity	Relative weight	Average length of stay
053—Seizure	1	0.4684	2.25 days
	2	0.6006	2.83
	3	0.7734	3.84
	4	1.8123	7.79

Age adjusters

Patient age group	Age adjusters
Adult	0.94
Pediatric	1.13
Newborn	1.00

Source: OPE analysis of Idaho Medicaid's DRG payment model for state fiscal year 2023

Before it transitioned to DRGs, Idaho was one of only 7 states that paid for inpatient hospital services based on recently reported allowable costs. As shown in exhibit 4, cost-based payment offers little incentive for hospitals to invest in cost-saving technologies or business practices. Hospitals earn more revenue when they incur more allowable costs.

Exhibit 4

Idaho's new payment model changed incentives for hospitals and the type of state oversight needed.

Strength of incentives offered under cost-based and DRG payment models.

	Increase activity	Control expenditures	Improve quality	Enhance efficiency		
				Technical	Cost	Allocative
Diagnosis Related Grouping	Moderate	Moderate	Moderate	Strong	Strong	Moderate
Cost-based	Strong	Weak	Strong	Weak	Weak	Weak

Source: Office of Performance Evaluations' analysis and Andrew David Street, Jacqueline O'Reilly, Padraic Ward, & Anne Mason, *DRG-based hospital payment and efficiency: theory, evidence, and challenges*, *in* DIAGNOSIS RELATED GROUPS IN EUROPE: MOVING TOWARD TRANSPARENCY, EFFICIENCY AND QUALITY IN HOSPITALS 93-114, (2011).

Only 7 states still paid hospitals based on their costs when Idaho stopped in 2021.

Adopting the DRG payment model is one step towards cost containment and paying for value.

The DRG model is one step in a series of policies meant to align payment and value.

DRG payment changes the financial incentives for hospitals. Each dollar a hospital saves is a dollar the hospital gets to keep. Under cost-based payment, when hospitals saved money they received less revenue.

The new payment model aligns hospital incentives with legislative priorities for cost containment, as expressed in House Bill 351 passed during the 2020 legislative session. It is one step in a series of policies meant to align payment and value. This series of policies includes

- the plan to pay for outpatient hospital services using a model similar to DRG (known as Ambulatory Payment Classifications) starting in July 2024;
- Healthy Connections Value Care, which introduces a risk-sharing payment model and payment based on quality metrics; and
- tying the state's supplemental payment for nursing facilities to performance on federal quality measures.

The DRG payment model gives the Legislature more budgetary insight.

The Legislature controls what rates Idaho Medicaid can pay. As discussed in our 2022 report *Medicaid Rate Setting*, the Legislature must approve changes to Medicaid's payment rates as a line item in the program's appropriation. Idaho Code § 56-265 (4) states that "All changes to provider payment rates shall be subject to approval of the legislature by appropriation."

Cost-based payment is an exception. Although the Legislature still appropriates money, the amount Medicaid owes is set in statute based on allowable costs. The Legislature can amend the statute to adjust the percentage of costs that will be paid, but there is no 'rate' for the Legislature to approve. When Idaho paid for inpatient hospital services based on cost, changes in hospital spending were mandatory budget adjustments rather than line items. Idaho Medicaid and legislators had little information about factors that drove changes in the budget.

Idaho Medicaid and legislators had little information about factors that drove changes in the budget.

Under the DRG payment model, Medicaid now has access to information that could help distinguish between budgetary changes driven by caseload, case mix complexity, and other factors.

The Legislature should consider asking the department to regularly analyze the drivers of budgetary changes for Medicaid hospital services.

This analysis would support Idaho Medicaid in reaching its goals of efficiency and quality of care. The Legislature could consider asking for information on

- changes in payments by eligibility group;
- annual budget changes attributable to caseload changes, changes in case mix complexity, and other factors; and
- changes in payments by service category, such as obstetrics or transplants.

In our 2022 report *Medicaid Rate Setting*, we discussed how the Legislature is asked to make rate-setting decisions with little information. This policy consideration could be a step towards giving the Legislature greater access to information.

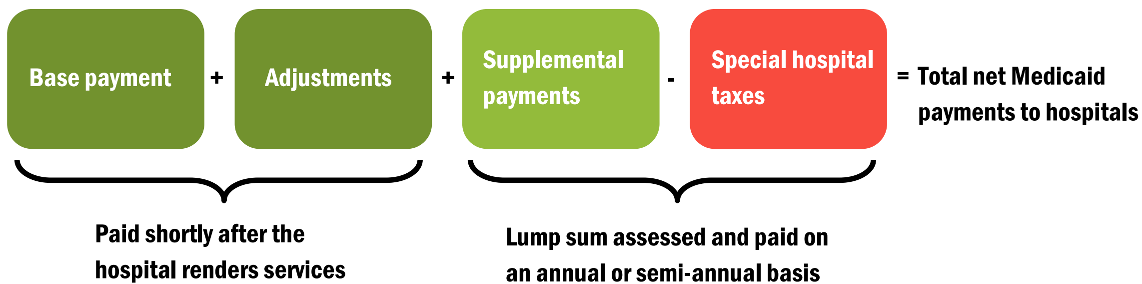
A full picture of hospital rates requires adjusting for supplemental payments and provider taxes.

We were asked to compare what Idaho pays for inpatient hospital services to what other states pay. The business relationship between Medicaid and hospitals is not limited to base payments for services. See exhibit 5.

Exhibit 5

Medicaid pays hospitals through several mechanisms that are unique to each state.

Elements of Medicaid hospital payments.



Source: Office of Performance Evaluations' literature review.

Nearly all state Medicaid programs make supplemental payments to hospitals. These are lump sum payments not connected to any specific service. States can make supplemental payments to cover the difference between Medicaid rates and a reasonable estimate of what Medicare would have paid for similar services, known as the upper payment limit. States can also make payments to support hospitals that provide uncompensated care through disproportionate share hospital payments. Finally, states can also promote quality care, medical education, or other state priorities through other supplemental payments.

Nationwide, Medicaid pays more in supplemental payments than in base payments for services. Although Idaho has recently increased supplemental payments, we still rely less on supplemental payments than other states. In fiscal year 2022, Idaho was 47th in reliance on supplemental payments out of Medicaid programs in the 50 states and DC.

Like most Medicaid spending, supplemental payments are jointly funded by the state and federal government. However, many states impose a tax on hospital services to fund the state's share of the payment. The tax reduces the amount that hospitals receive from supplemental payments but makes them budget neutral from a state general fund perspective.

In 2019, 42 states and DC had hospital taxes. While usually used to cover the state share of supplemental payments, some states use the tax to cover other Medicaid costs such as the state share of Medicaid expansion. In 2022, the Legislature allowed Idaho Medicaid to start using hospital assessments to fund rate increases for home and community services not provided by hospitals. This change ensured the rate increase would not affect the general fund.

Both supplemental payments and provider taxes must be taken into account to accurately compare hospital payment rates among states. We chose to adjust only for those taxes that were directly related to hospital payment.

Special hospital taxes are used by many states to pay for a share of state Medicaid costs.

Idaho paid for inpatient hospital services at a higher rate than our comparison states, though not for every service type.

We chose comparison states that were similar to Idaho in that they had minimal spending tied to managed care and used the same DRG grouper. These criteria eliminated many states. Managed care models do not offer sufficient transparency to enable comparison. We eliminated states that, unlike Idaho, had more than 10 percent of Medicaid participants under comprehensive managed care. Of the remaining 12 states, 3 paid based on cost and 4 paid using Medicare's version of DRGs, which is less comparable to Idaho's. Colorado, Connecticut, Montana, and Wyoming were the states that fit both criteria.

While most inpatient services are paid through DRGs, Idaho continues to pay critical access hospitals based on cost. When possible, we excluded payments that states made to their critical access hospitals. Even after accounting for these differences, states still make several policy decisions that must be addressed when comparing rates. Exhibit 6 shows how we derived the rates for each comparison state.

Exhibit 6

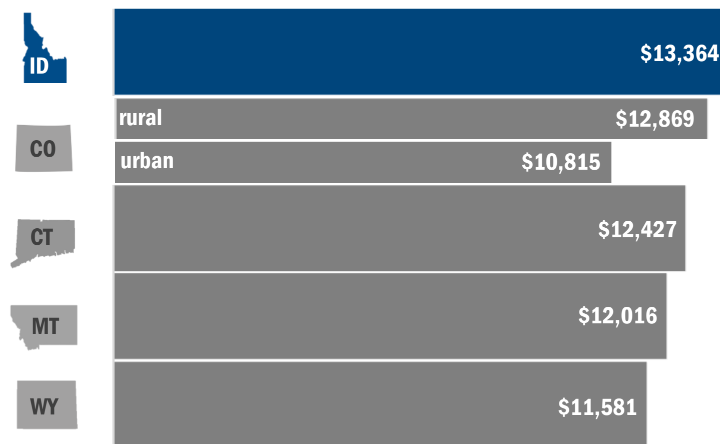
We made several adjustments to account for differing Medicaid policies in our comparison states.

	Base rates used	Additional base payments	Adjustments	Supplemental payments	Special hospital taxes	DRG version
ID	In-state acute care base rate		Age and service weights	Disproportionate Share Hospital Payment, Upper Payment Limit	Calculated from state share of supplemental	
CO	In-state urban and rural hospital averages			Disproportionate Share Hospital Payment, Upper Payment Limit Health Quality Incentive	Calculated from state share of supplemental	8.6% increase to account for DRG grouper version
CT	In-state median hospital rate			Disproportionate Share Hospital Payment, Upper Payment Limit	Calculated from state share of supplemental	
MT	Acute care base rate		Age and service weights	Disproportionate Share Hospital Payment, Upper Payment Limit	Calculated from state share of supplemental	
WY	Non-trauma hospital acute care base rate	Per-discharge capital payment	Age and service weights	Disproportionate Share Hospital Payment, Upper Payment Limit	Calculated from state share of supplemental	8.6% increase to account for DRG grouper version

We estimated that Idaho paid a higher rate for inpatient hospital services than our comparison states did. See exhibit 7. Idaho's overall rates were 4 percent higher than Colorado's rural hospital rates and 24 percent higher than Colorado's urban hospital rates. Idaho's rates were higher than Connecticut's by 8 percent, Montana's by 11 percent, and Wyoming's by 15 percent.

Exhibit 7

Medicaid hospital rates were higher in Idaho than comparison states.



Source: Office of Performance Evaluations' analysis of agency data.

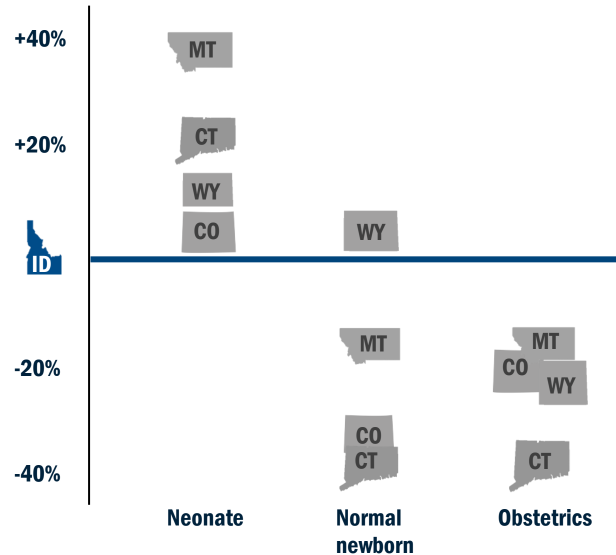
While Idaho's overall rates were higher, examining certain service categories gives a more nuanced picture. Idaho paid 38 percent more for mental health and substance use disorder stays and 32 percent more for rehabilitation stays than the next highest rate. Conversely, Idaho paid 25 percent less for care for sick newborns and 4 percent less for healthy newborns, relative to the highest comparison states. Exhibit 8 shows the rate comparison for pregnancy and newborn services.

Idaho paid 38% more than Colorado's rural rate for mental health and substance use disorder stays.

Idaho paid 25% less than Montana for sick newborn care.

Exhibit 8

Idaho's rates for pregnancy and newborn care vary, and are lower than some comparison states.



Source: Office of Performance Evaluations' analysis of agency data.

How much should Idaho pay?

By our estimates, Idaho pays hospitals a higher rate than our comparison states do. Context is important to interpret this information.

First, the rates in other states may not be sufficient to ensure adequate access and quality of care. In our conversation with Connecticut's Medicaid program, staff shared concerns about hospitals not admitting Medicaid clients despite the clients' need for care or hospitals attempting to "dump" Medicaid clients onto other hospitals. Connecticut is also under a settlement agreement with its hospitals because of hospital rates.

Second, hospitals in other states may be subsidizing lower Medicaid payments with private health insurance. For example, Colorado estimated that in 2021 their Medicaid program paid $800 million less than hospitals spent to serve Medicaid clients. This loss was offset by private insurance paying hospitals an additional $4 billion to serve clients with private insurance.

Finally, we did not account for differences in tax policies affecting hospitals other than those tied directly to hospital services.

Idaho's implementation of the DRG payment model should be monitored for unintended consequences.

DRG payment relies on being able to categorize hospital stays based on complexity and resource needs. In some circumstances, this categorization may poorly fit the clinical reality and other payment models may be more appropriate. For example, the needs of rehabilitation and behavioral health clients may vary more than is captured under DRG's four levels of severity. As a result, DRGs may encourage hospitals to release patients inappropriately early or not accept patients with particularly high needs. Many states exempt services like these from DRG-based payment. Colorado and Connecticut pay for rehabilitation and behavioral health on a per-day basis.

Many states exclude certain hospital services from the DRG model.

Idaho pays for behavioral health and rehabilitation with DRGs but offers hospitals specializing in these services a higher payment rate. Psychiatric hospitals receive 15 percent more for the same hospital stay, rehabilitation hospitals receive 65 percent more, and long-term acute care hospitals receive 165 percent more.[1] How these hospitals are paid is an important policy decision that affects provider incentives. For example, Idaho makes a much larger adjustment for long-term acute care hospitals than Montana, which only pays these hospitals 35 percent more. Long-term acute care hospitals are meant for patients needing extended or specialized care, but their higher rate encourages shorter, simpler stays.

We recommend that the department monitor its choice to use DRGs to pay for certain services.

We recommend that the department monitor whether the hospital-based adjustments for behavioral health, rehabilitation, and long-term acute care have unintended consequences and may better fit a per-day payment model.

1. The rate for Idaho's long-term acute care hospitals is higher in part because they do not receive supplemental payments but do pay special hospital taxes.

DRG payment carries different risks and requires different quality assurance strategies.

As exhibit 9 shows, the DRG payment model carries different risks than the cost-based payment model. Because most of the risks associated with the cost-based payment model involve inappropriate use of resources, Idaho designed its quality assurance process to ensure that hospitals were only using resources when necessary. Under cost-based payment, Idaho had two primary quality assurance practices: requiring prior authorization for non-emergency services and conducting concurrent-stay reviews every three days to ensure the stay was still necessary. Most of the authorization was done by one of Idaho's contractors, Telligen.

Exhibit 9

Idaho's new payment model changed both the incentives for hospitals and the type of oversight needed by the state.

Advantages, disadvantages, and the role of state oversight under cost-based and DRG payment.

	Advantages	Disadvantages	State oversight
DRG	State carries less financial risk as it has more control in setting rates and can ensure expenses are more predictable Encourages hospitals to use resources more efficiently, based on the average costs of services nationally More transparent by making rates publicly available Potential for the state to compare hospital performance	Hospitals carry more financial risk Requires adjustments to account for variation in hospital input prices (urban versus rural, wage differences etc.) and cases with extraordinarily high costs ('outliers') Higher risk of hospitals inaccurately categorizing claims ('upcoding') Higher risk of early discharge and subsequent rehospitalization Higher risk of adverse selection ('cherry-picking' lower-needs patients)	Requires more oversight to determine whether a sufficient amount and sufficient quality of services were provided Requires more oversight of hospital service coding
Cost-based	Hospitals carry less financial risk Encourages hospitals to provide more services Encourages hospitals to adopt innovative practices regardless of cost.	State carries more financial risk as it has less control in setting rates and expenses are less predictable for state budgets Less incentive for hospitals to increase efficiency in the short term	Requires more oversight to determine whether services provided are truly needed

Source: Office of Performance Evaluations' analysis of academic literature, federal reports, and interviews.

Under the DRG payment model, the state pays the same amount regardless of the costs the hospital incurs.[2] While this encourages efficient treatment, it may also encourage reducing costs at the expense of patient care. The state's quality assurance process should focus on ensuring that care is delivered according to medical standards, rather than on preventing unnecessary care. Ensuring that the hospital appropriately coded the services also becomes more important because service codes affect the DRG grouping and severity, which in turn affect the payment rate.

Under the DRG payment model, Idaho Medicaid pays the same amount regardless of costs incurred by the hospital.

2. Most states using DRG payment methods, including Idaho, have policies to pay extra for outlier stays. If a hospital's costs exceed the standard payment by a large amount, Medicaid will make an outlier payment to mitigate the hospital's losses. See exhibit 3.

The department properly adjusted its quality assurance strategies to fit the new payment model.

About one third of all claims are reviewed.

The department planned and implemented three major changes to its quality assurance strategy that align with the risk management needs of the DRG payment model. First, the department transferred oversight of the quality assurance process from the department's contract management staff to clinical staff. Second, the department reduced its reliance on prior authorization. Third, the department started doing post-discharge reviews on a sample of hospital stays rather than concurrent-stay reviews on all stays every three days. The new post-discharge reviews primarily concern DRG coding and medical necessity. The department simultaneously reviews these cases for quality of care as needed. About one third of all claims are reviewed. See exhibit 10.

While the approach to quality assurance was appropriate, the transition had some implementation problems. The department reported that it prioritized a quicker transition to DRGs over making the transition with a fully developed quality assurance process. The department identified two major problems in implementing its new quality assurance approach:

- The state did not conduct any post-discharge reviews for ten months following the transition to DRGs, when hospitals would have most benefitted from oversight and feedback.

- If a review finds that the hospital stay was not medically necessary and denies payment, the department's claims system has no way of preventing the hospital from resubmitting the claim to receive payment. Resubmissions are only caught if they happen to be in the review sample both times.

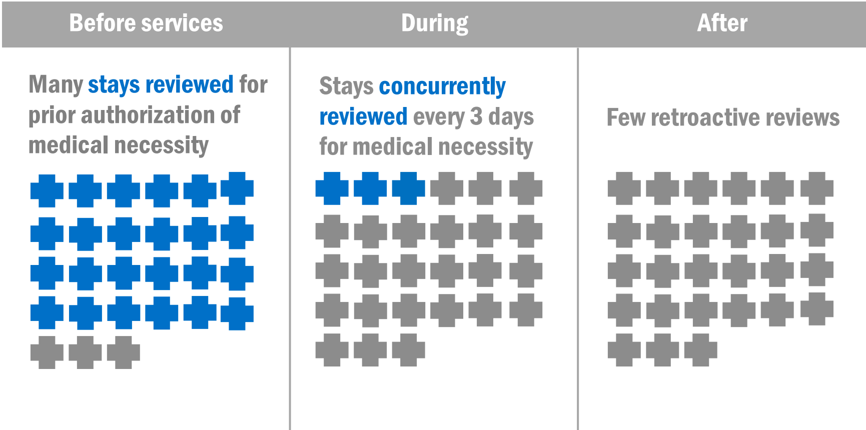
The department intends to address the second of these problems in the procurement of a new Medicaid Management Information System. In the meantime, hospitals that are found to have resubmitted inappropriate claims could face a more serious compliance action.

Exhibit 10

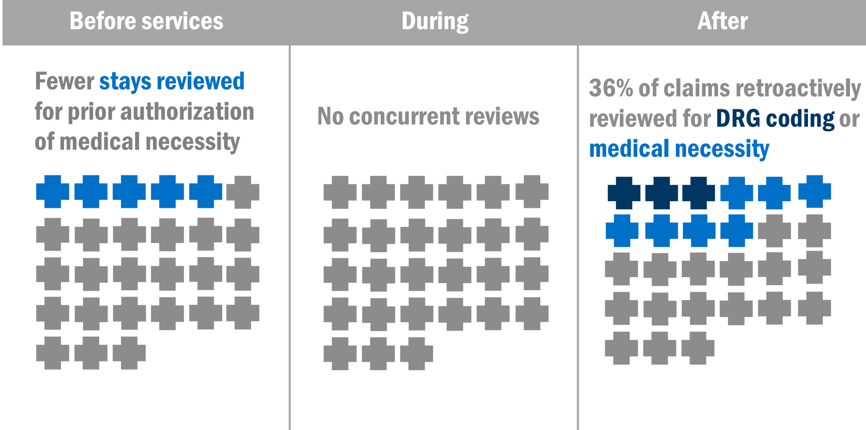
While all claims used to go through a prior authorization process, Idaho Medicaid now reviews only a sample of claims before and after payment.

Quality assurance process under cost-based payment and payment with DRGs.

Cost-based



DRG



Notes: 2,740 claims were received by Idaho Medicaid in an average month of FY 2023.
Source: Office of Performance Evaluations' analysis of agency data.

DRGs allow hospitals to be compared and paid based on outcomes.

Idaho Medicaid does not measure hospital-level quality.

The DRG payment model was initially developed in the late 1970s to "create an effective framework for monitoring the quality of care and the utilization of services in a hospital setting." DRGs allow for hospitals to be compared based on the complexity of their case mix. Hospitals can also be compared based on outcomes for each hospital stay category. Payers such as Medicaid can reward higher quality, either by paying higher rates to hospitals that score better or by giving supplemental payments to hospitals with better measures. These quality payments could be integrated with, or complement, Medicaid's Healthy Connections Value Care program.

Quality metrics can be valuable without being tied to payment policy. Patients can use quality metrics to make decisions about where to receive treatment, which can encourage hospitals to continuously invest in improving their measured quality. Exhibit 11 gives an example of some metrics published by the Centers for Medicare and Medicaid Services.

Exhibit 11

Medicare has dozens of quality measures, some of which Idaho Medicaid could collect and use to inform its payment model.

Examples of hospital quality measures collected by the Centers for Medicare and Medicaid Services for the Medicare population.

Category	Example of Medicare quality measure
Complications and deaths	Rate of complications for hip/knee replacement patients
	Death rate for stroke patients
	Catheter-associated urinary tract infections in intensive care units and select wards
Unplanned hospital visits	Rate of readmission after discharge from hospital
	Ratio of unplanned hospital visits after hospital outpatient surgery
Maternal health	Percentage of mothers whose deliveries were scheduled too early when a scheduled delivery wasn't medically necessary
Psychiatric unit services	Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge

Source: The Centers for Medicare and Medicaid Services' Medicare Care Compare database.

Idaho Medicaid does not currently measure hospital quality in a meaningful way. The department could develop measures of mortality or readmission using information that is already available. The barrier to meaningful measurement is not a lack of data, but a lack of capacity. Department officials reported being unable to query, analyze, and publish more meaningful quality measures with their current staffing levels and responsibilities.

We recommend that the department work with stakeholders to develop hospital-level quality metrics and report those measures to the public.

In our 2022 report, *Medicaid Rate Setting,* we found that limited staff capacity for Medicaid hindered the department's ability to fulfill its responsibilities. The department submitted a 2024 budget request that included 60 additional staff for Medicaid, including 4 positions in the Bureau of Clinical and Quality Management now overseeing the post-discharge review process.

The DRG payment model provides more policy tools for the Legislature.

Although the budget will still be subject to variations in the number of Medicaid enrollees, hospital usage, and case mix complexity, it is possible to have greater predictability and control. DRG payment introduces tools to the Legislature for managing Medicaid hospital spending and improving budget predictability.

DRGs provide a ratio of resources needed for each service, but they do not set the base rate. The Legislature could develop rules for the base rate or hospital spending in the aggregate. Some states follow Medicare's lead by using its base rate. We also found that several states limit growth in the base rate by indexing it to an inflation measure developed specifically for inpatient hospital services by the Centers for Medicare and Medicaid Services.

The Legislature can influence any of the policy adjustments made by Medicaid.

The Legislature could also influence any of the policy adjustments made by Idaho Medicaid. For example, the Legislature could direct additional funding towards specialties where Idaho has particular gaps or to areas of the state where additional hospital capacity is needed. If the department could provide more analysis, the Legislature could be better informed as they make these important decisions.

Request for evaluation

House of Representatives
STATE OF IDAHO
CAPITOL BUILDING
P.O. BOX 83720
BOISE, ID 83720-0038

March 21, 2023

Rep. David M. Cannon, Co-Chair
Sen. Melissa Wintrow, Co-Chair
Joint Legislative Oversight Committee

Dear Co-Chairs,

Starting fiscal year 2022, the Division of Medicaid changed the way it paid for most inpatient hospitalization. Instead of a cost-based reimbursement model, where the division would pay hospitals based on their costs, the division now pays hospitals using a diagnosis-related grouping (DRG) method. Instead of paying for each separate element of a patient's stay, the division makes a single payment based on the DRG of the patient's stay. This method standardizes payment among hospitals.

DRG payment is common among Medicare and state Medicaid programs. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), as of November 2018, 37 states used DRGs.

This standardized categorization and payment method opens up the possibility for meaningful comparisons of Idaho's Medicaid hospital utilization and spending to Medicare and other state Medicaid programs.

We ask the Joint Legislative Oversight Committee to direct the Office of Performance Evaluations to evaluate the following aspects of Idaho's Medicaid hospital payment.

1. How do Idaho's hospital payment rates compare to Medicare and other state Medicaid programs, particularly when adjusting for supplemental payments to hospitals?
2. How does Idaho differ from other states' programs that incorporate DRGs into their payment models? This information could identify opportunities for an improved service array and reduced costs, for example if Idaho has more, preventable, low-severity hospitalizations.
3. The Department of Health and Welfare claimed that the DRG payment method would lower costs. Is this true so far? And if so, where have savings come from?
4. How much is Idaho's aggregate Medicaid spending on outpatient hospital services compared to Medicare and other state Medicaid programs?
5. What is the status of the Division of Medicaid's plans to transition outpatient hospital payment to a system similar to DRG payment? Has the state saved any money?

Thank you for your consideration.

Sincerely,

Rep. Mike Moyle
Speaker of the House

Rep. Ilana Rubel
House Minority Leader

Rep. David Cannon

Rep. Douglas Pickett

mm:jh

cc: Mr. Rakesh Mohan, Office of Performance Evaluations

Evaluation scope

The report will address the following objectives:

1. Describe Idaho's current hospital payment policy and describe options the state has with DRG payment to improve budget predictability, quality of care, and efficiency.

2. Compare Idaho's hospital payment rates on a per-discharge basis to payments made by Medicare and by other state Medicaid programs with comparable payment policies. (These rates will be adjusted for supplemental payments and hospital taxes to ensure fair comparisons. A comparison of aggregate spending on outpatient hospital services will also be included.)

3. Describe Idaho Medicaid's management of the recent change in inpatient payment policy and offer recommendations for the upcoming change in outpatient payment policy.

4. Assess Idaho Medicaid's strategies to mitigate the risks to efficient and high-quality patient care involved in its hospital payment policies.

C Methods

This section will discuss our approach to developing and accomplishing the objectives described in the scope.

To develop our scope objectives, we conducted interviews with the requestors of the study, the chairs of the Health and Welfare Committees and the Medicaid Managed Care Task Force, the Department of Health and Welfare, relevant stakeholders, and subject matter experts. We also conducted a literature review, collecting background information and studies comparing hospital rates among states, particularly from the Medicaid and CHIP Payment and Access Commission (MACPAC).

Throughout these interviews and our literature review, we found a reluctance to compare hospital rates across states. In some circumstances analysts do not even attempt to make comparisons owing to the myriad differences in payment policy among states.

Describing Idaho's hospital payment policy and budgeting options

Idaho's hospital payment policies are outlined in statute, rule, and in various communications between the Department of Health and Welfare and stakeholders for the Centers for Medicare and Medicaid Services (CMS).

The key documents are:

Statute and legislation

§ 56-265 Idaho Code – Provider Payment
Title 56, Chapter 14 Idaho Code – Idaho Hospital Assessment Act
House Bill 656, 2010 – Amended the Idaho Hospital Assessment Act to increase general fund revenue for two years through the hospital assessment.
House Bill 351, 2020 – Amended § 56-265 to direct the

Department to reduce Medicaid payments for hospital services and work with hospitals to establish value-based payment methods for hospital services.
Senate Bill 1350, 2022 – Amended the Idaho Hospital Assessment Act to increase upper payment limit payments to hospitals and to allow the revenue collected by the hospital assessment to be used for purposes other than funding the state share of supplemental payments.

Rules

IDAPA 16.03.09 Basic Medicaid Plan Benefits, Sections 400-449 Hospital Services
IDAPA 16.03.10 Enhanced Medicaid Plan Benefits, Sections 090-099 Enhanced Hospital Services; 100-199, Enhanced Inpatient Behavioral Health Services

Medicaid communications

Idaho Medicaid Provider Handbook – Hospitals
Medicaid Information Release MA21-07 – Change in Hospital Reimbursement Methodology
Medicaid Information Release MA21-28 – Change in Outpatient Hospital Reimbursement Methodology – APC
Medicaid Information Release MA22-16 – Outpatient Hospital Reimbursement Procedure Code Pricing
State Plan Amendment ID-21-0011 – Amendment revising payment method for acute care hospitals to APR-DRG
State Plan Amendment ID-21-0003 – Amendment to supplemental payment methodologies to hospitals for inpatient and outpatient services.

In addition to Idaho-specific documentation, we reviewed legislative publications and budget documents, where available, for Colorado, Connecticut, Mississippi, Montana, Wisconsin, and Wyoming. We also corresponded with these states about their rate setting policies.

Comparing Idaho's inpatient hospital payment rates to payments made by other Medicaid programs

We first decided on the criteria that would make other states' programs good comparisons to Idaho's. Medicaid programs differ in how they pay hospitals. This is best demonstrated in

MACPAC's documents *Medicaid Inpatient Hospital Services Payment Policy* and their *State Medicaid Payment Policies for Inpatient Hospital Services* compendium.

Differences among Medicaid payment policies

Based on MACPAC's work, we identified the following variables that influenced the selection of comparison states and our rate comparison model.

Managed care penetration

Under managed care, states contract with private health plans to administer Medicaid benefits. Medicaid participants often have a choice of managed care plan, with some plans only available in particular regions of a state. Each managed care plan can negotiate rates with individual hospitals and these rates are usually not made public.

States with high managed care penetration may still develop rates for Medicaid participants who are not on managed care. Rather than general-purpose rates, these rates may be for specific populations or areas of the state that are not representative of the total Medicaid population.

Only about 0.5 percent of Idaho's Medicaid hospital spending is through managed care, so our ideal comparison states have low managed care penetration.

Base payment policy

States typically pay for inpatient hospital services in three ways: a per-day rate that constitutes final payment, a per-day interim payment (often with a process to settle payments annually based on hospital costs), and a diagnosis-related grouping (DRG) system where hospitals receive payment for each hospital stay based on the stay's complexity.

States using a DRG payment model use one of four groupers. The groupers use information provided by the hospital about the patient and their stay to group the stay into a category and level of severity, each of which has an estimated resource value that is used as a basis for payment.

The two major groupers, both developed by 3M, are the All-Patient Revised or APR-DRG and the Medicare Severity or MS-DRG. The APR-DRG model is developed using national data

across all populations, while the MS-DRG model is developed using data from Medicare patients. The two are not directly comparable; MS-DRG has fewer diagnosis groups and levels of severity, particularly for services not used by the Medicare population.

Idaho adopted the APR-DRG payment model, making other states that use that model ideal for comparison.

The grouper is updated each year by 3M and states have adopted different versions of the updates. The updates reflect changes in resource needs for various procedures based on changes in technology or practice, adding new categories for new procedures or diagnoses, or eliminating categories. The most current grouper is version 41. Idaho uses version 39; version 33 is still in use in some states.

Services included in base payments

One significant difference among states is whether the base payment to hospitals includes payment for professional services. Idaho and our comparison states usually make a single payment to hospitals that is inclusive of professional services. Other states—and Medicare—make separate payments to the hospital and to professional services at the hospital.

Adjustments for comparison

For a more detailed discussion of the adjustments made for comparison, we have published the workbook created for comparison. This workbook includes more detail than what is discussed here.

In building the comparison, we worked with the Medicaid programs in each of our comparison states to ensure that we did not miss any important differences in their hospital payment methods that would affect how comparable they are.

The components of the comparison are:

Base rates
Supplemental payments
Provider taxes
Case mix
Adjustments for non-comparable services

Limitations

Our comparison does not account for every difference between state payment methods. The following are some limitations of our comparison.

We made no adjustments for differences in the economic situations across various states. Labor costs, state or local tax differences, and non-Medicaid revenue sources likely drive differences in hospital rates, but we did not account for these differences.

States vary in how they pay hospitals when a patient is transferred to another hospital or to another level of care. We did not account for how differences in these adjustments affect hospital revenue, instead treating each hospital stay as a full stay.

States vary in the method and amount they pay for high-cost outlier hospital stays. We did not account for differences in outlier payment policy.

Some states include outpatient services related to an inpatient stay as part of the payment for the inpatient stay, while some states make separate payments for the inpatient and outpatient services. We did not account for differences in whether related outpatient services were included in the scope of inpatient payments.

We used a single base rate for each state, (except Colorado, where we include both urban and rural base rates). Many states, including Idaho, have different base rates for different hospitals. We included several base rates per state in the workbook, but we selected a single base rate to represent the state.

Base rates

The base rates we use in our comparison are included in most states' DRG calculators. For Idaho, we used the in-state acute care rate. We used that rate, when available, for other states. When states have hospital-specific rates, we took the median rate for non-critical access hospitals. The workbook includes options for other base rates.

Supplemental payments

In addition to base payments for services, states make lump-sum payments to hospitals to expand access to care, to promote quality, or for other policy goals. These supplemental payments

are a large portion of what some Medicaid programs pay hospitals. Nationwide in fiscal year 2021, according to MACPAC, supplemental payments made up just over half of what Medicaid paid hospitals.

We calculated an adjustment for supplemental payments using each state's Upper Payment Limit (UPL) demonstration workbook, which states must submit to the Centers for Medicare and Medicaid Services. States submit separate workbooks for inpatient and outpatient hospital services.

States make disproportionate share hospital (DSH) payments to hospitals based on the hospital's volume of uninsured and Medicaid clients and the amount of uncompensated care. We included the DSH payment in the Medicaid hospital rate, even though the payment includes some non-Medicaid factors. The amount of the DSH payment was allocated between inpatient and outpatient based on the proportion of other supplemental payments.

Total supplemental payments were divided by total base payments to derive how much to adjust each state's base rate for supplemental payments. Separate estimates are provided for all hospitals and for only non-critical access hospitals.

Provider taxes

While we did not account for differences in taxes more broadly, we did account for taxes that are directly related to Medicaid hospital payments.

Both Idaho and our comparison states use hospital taxes to pay for the state's share of supplemental payments. For example, for every $1,000,000 in supplemental payments Wyoming made, it levied a $500,000 tax on hospitals to pay the state's share. The net revenue to hospitals would be $500,000, although taxes and revenues are not evenly distributed among hospitals.

Some states use hospital taxes for other purposes. For example, Colorado funds the state share of Medicaid expansion costs using hospital taxes. Idaho recently increased hospital taxes to fund rate increases in home and community based services.

We adjusted only for hospital taxes levied to cover the state share of supplemental payments. We calculated this amount using state match rates and data on Medicaid expansion enrollment, which the federal government funds at a higher rate.

Case mix

Each state has about 1,200 unique rates, one for each diagnosis group and severity level. We calculated the rate for each of these, adjusting for supplemental payments and taxes, which is included in the workbook.

However, not each of these rates is equally important. Idaho had several DRG-severity combinations with no hospital stays in state fiscal year 2023.

We used Idaho's case mix—the number of hospital stays for each DRG-severity combination—to weight the rates for each state. The Division of Medicaid provided us discharge-level data for state fiscal year 2023, which allowed us to account for the separate rates many states have for adult and pediatric stays.

Adjustments for non-comparable services

Colorado and Wyoming used older versions of the APR-DRG grouper that do not include all of the DRGs that Idaho paid. For each category of service, we calculated the portion of Idaho's spending that was missing from these states which we used to adjust our estimates for Colorado and Wyoming.

What about Medicare?

Medicare pays hospitals in a variety of ways, including using a DRG payment model. However, Medicare's DRG model is not comparable to Idaho's.

Medicare's payment model is developed using Medicare claims data. This data is limited to the Medicare population, which differs dramatically from the Medicaid population. Most Medicare enrollees are over 65 while most Medicaid enrollees in Idaho are under 18. The resource needs may vary between these populations.

Based on its population, Medicare's payment model includes few categories of care for pregnancy, childbirth, and newborn care. For example, Medicare's model has 7 categories for hospital stays for newborns. Idaho's model has 28 categories. Pediatric care and pregnancy-related care made up 45 percent of Idaho's DRG payments in 2023.

Medicare has also expanded its use of value-based purchasing. 53 percent of Medicare beneficiaries are enrolled in Medicare managed care. Another 23 percent are enrolled with accountable care organizations, which are similar to managed care but are provider led, similar to Idaho Medicaid's value care organizations. We selected comparison states with minimal Medicaid managed care enrollment because managed care payments are not transparent. Medicare also expanded its use of bundled payments, where Medicare makes a single payment for a combination of outpatient and inpatient services. These policies make it difficult to isolate Medicare payment for a specific hospital stay.

Finally, Medicare makes separate payments for hospital services and for professional services provided at a hospital. In Idaho and the four comparison states, professional services are typically involved in the payment to the hospital.

The difference in populations and the difficulty isolating payments led us not to compare Idaho's rates to Medicare.

MACPAC compared state Medicaid rates with Medicare using data from 2010, when Medicare had simpler payment models, and only for selected high-volume procedures. MACPAC found that Medicaid programs nationwide paid about 106 percent of what Medicare paid, after accounting for supplemental payments and provider taxes.

Responses to the evaluation

Brad Little,
Governor of Idaho

> [T]hank you for work on this important issue and I stand ready to work with IDHW and hospitals to address future rates and rate methodologies.

Dean Cameron,
Interim Director
Idaho Department of Health and Welfare

> This report has highlighted well the advancements Medicaid has made; the risk those advancements create; and thoughtful considerations for improved monitoring over time. We look forward to continued collaboration with the legislature around this work and how to best respond to the needs of Idaho's Medicaid providers, participants, and state taxpayers.

BRAD LITTLE
GOVERNOR

February 6, 2024

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702
Via Email: rmohan@ope.idaho.gov

Dear Director Mohan:

Thank you for your office's work related to Idaho Medicaid's hospital rates.

The Idaho Department of Health and Welfare (IDHW) is tasked with a difficult job to balance appropriate provider reimbursement rates while managing Medicaid costs. These are not easy tasks, but I am pleased with the work IDHW has done to implement new rate methodologies. The IDHW team and I are committed to continuing this work and meeting the needs of providers and Medicaid clients while responsibly serving Idaho taxpayers.

Again, thank you for work on this important issue and I stand ready to work with IDHW and hospitals to address future rates and rate methodologies.

Sincerely,

Brad Little
Governor of Idaho

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 24, 2024

Office of Performance Evaluations
Attn: Rakesh Mohan
954 W. Jefferson St. Suite 202
Boise, Idaho 83702

Dear Director Mohan,

I want to thank you and your staff for the time and effort spent on your office's report of the Medicaid Hospital Rates. As acknowledged in the report, Medicaid has recently made significant changes to provide improved oversight and cost control while also making required updates to hospital supplemental payments by utilizing standard, national approaches. Idaho Medicaid's hospital reimbursement methodology is still undergoing changes in these early years of implementation and will continue to advance as changes are made to the reimbursement model itself; changes to the Idaho Medicaid behavioral health system; and quality programs across the Medicaid network.

Your review and report summarize well the changes and opportunities Medicaid must advance over the next few years.

- We agree that the legislatively directed shift in hospital reimbursement from a cost-based model to one that offers greater budget predictability was an important change for Idaho Medicaid to better control expenditures and improve opportunities to monitor quality over time. The updated reimbursement methodology will continue to provide a strong cost containment approach for base reimbursement to hospitals. Further, the legislature should anticipate changes that will enhance the model and cost containment within the program; this includes changes such as the removal of transitional policy adjustors in SFY 2025 to support the final transition to a true Diagnosis Related Grouping reimbursement approach.

- As noted in the report, hospital expenditures have increased over the last decade primarily due to inflation and an increase in Medicaid enrollment, including Medicaid expansion in January

2020. It should be noted that a significant portion of the increase has also been tied to a substantial increase in the Upper Payment Limit supplemental payment, which is a pure federal funds increase.

- We also agree that the new approach to hospital reimbursement will allow for more quantifiable and transparent rate requests in the upcoming years and improved budget predictability. Data analytics, network adequacy monitoring, and enhanced stakeholder relations are and have been a continued priorities for Medicaid and these advancements in reimbursement further support Medicaid's ability to administer an efficient program. We welcome any requests from state policymakers to better provide data and information that supports and informs decisions around reimbursement and expenditures within the program.

- This report outlines well the rates on a per-discharge basis to payments made by Medicare and by other states. To monitor and benchmark our rates, Medicaid is working towards a deliverable that will review and compare Idaho's reimbursement on a national level by hospital. Medicaid is confident that this report will provide a measurable review of our network's health ongoing; this report is projected to be completed by late February 2024.

- Idaho Medicaid agrees that the new hospital reimbursement methodology will need to be closely monitored for unintended consequences, program integrity, and impact to quality and access to care. While this is a standard hospital reimbursement methodology used across many state Medicaid programs, it does not discount the need for robust oversight. Medicaid's staffing request presented for SFY25 includes positions to support and evolve this oversight and quality measure development work to ensure an efficient program and provider accountability.

The Division of Medicaid has worked over the past three years to implement enhancements to hospital reimbursement and the rate methodology. The Division is proud of the progress made with the resources available at this time. The Division is staffed with incredibly competent, dedicated, and innovative individuals who have completed this work and will continue to refine the approach to hospital reimbursement to improve the program. The approach taken in compliance with H351 (2020) has mitigated the state's financial risk and has provided greater ability to control rates and monitor hospital expenditures within the Medicaid program. This report has highlighted well the advancements Medicaid has made; the risk those advancements create; and thoughtful considerations for improved monitoring over time. We look forward to continued collaboration with the legislature around this work and how to best respond to the needs of Idaho's Medicaid providers, participants, and state taxpayers.

Sincerely,

Dean Cameron
Interim Director

Office of Performance Evaluations
ope
Idaho Legislature