THIRD WAY

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How to Increase Transparency of Medicaid's Hospital Payments

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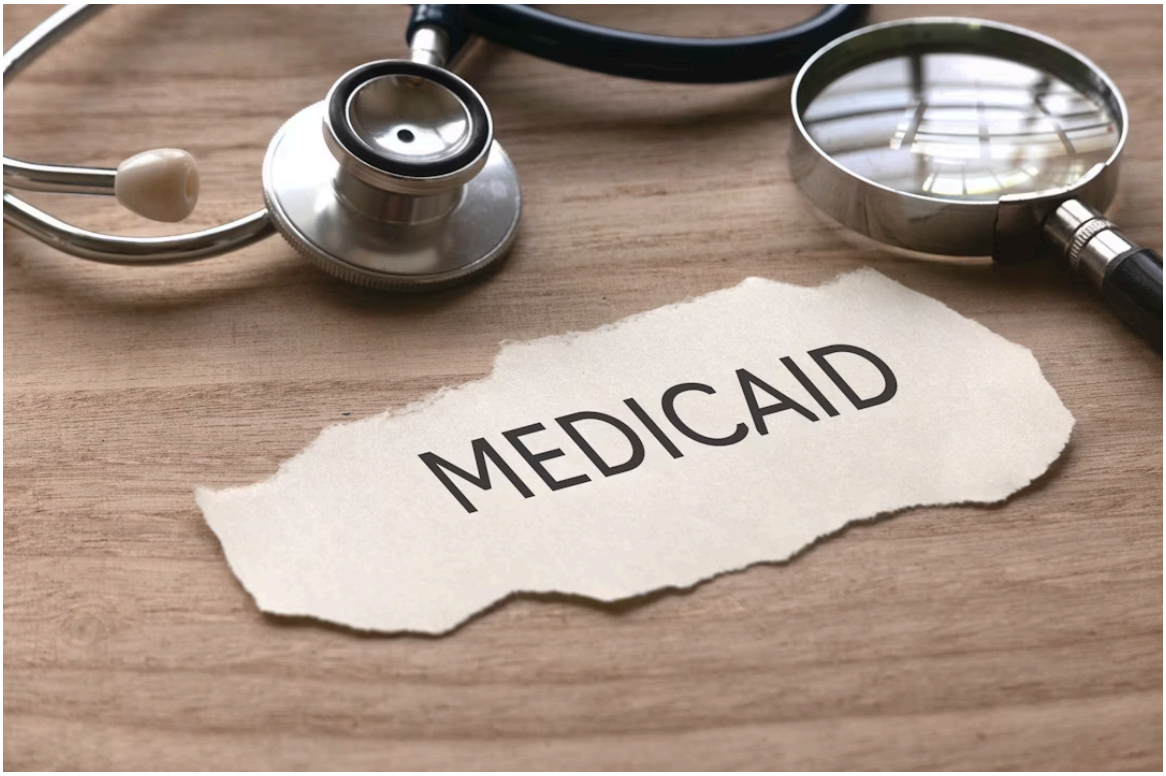


After Republicans gutted Medicaid by $1 trillion in their budget bill, it's more important than ever to protect what's left of the program and make sure it works for the states and families who depend on it.

The amount of money that Medicaid pays to hospitals has risen sharply over the past five years. Between 2019 and 2022 alone, Medicaid's hospital

payments grew by 27%, and this trend is expected to continue. But there's a significant issue with this payment growth: the federal government often doesn't know where increased funding goes, with limited visibility into whether the funding is going to hospitals that need it most.
It is critical to improve Medicaid's efficiency and effectiveness in order to help states adjust to recent changes and safeguard the program from future funding threats. In this memo, we provide an overview of hospital costs in the Medicaid program and a framework to improve transparency.

Current Situation

Medicaid provides health coverage to over 72 million low-income Americans, including children, pregnant women, seniors, and people with disabilities. It operates as 50 different state-administered programs with distinct financing structures—including complex supplemental payments. As a result of this complexity, there is limited visibility into how much hospitals are actually paid, how those payments are financed, and who benefits.

Medicaid costs the federal government approximately $600 billion annually and is also the largest line item in most state budgets. This essential program is already expected to grow by 5.5% per year over the next decade. A key driver of this growth comes from increased payments to health care providers, particularly hospitals. Roughly 33% of all Medicaid spending goes to hospitals.

Medicaid pays hospitals in seven separate ways, two through what's called base payments and five through supplemental payments:

Base Payments

1. **Base fee-for-service payments** go directly from state Medicaid

programs to providers for each service delivered.

2. **Base managed care payments** are capitated, per-enrollee payments that states make to Medicaid managed-care plans to cover the full range of covered services for beneficiaries, incentivizing cost control through negotiation with providers and care coordination within a fixed monthly rate.

Supplemental Payments

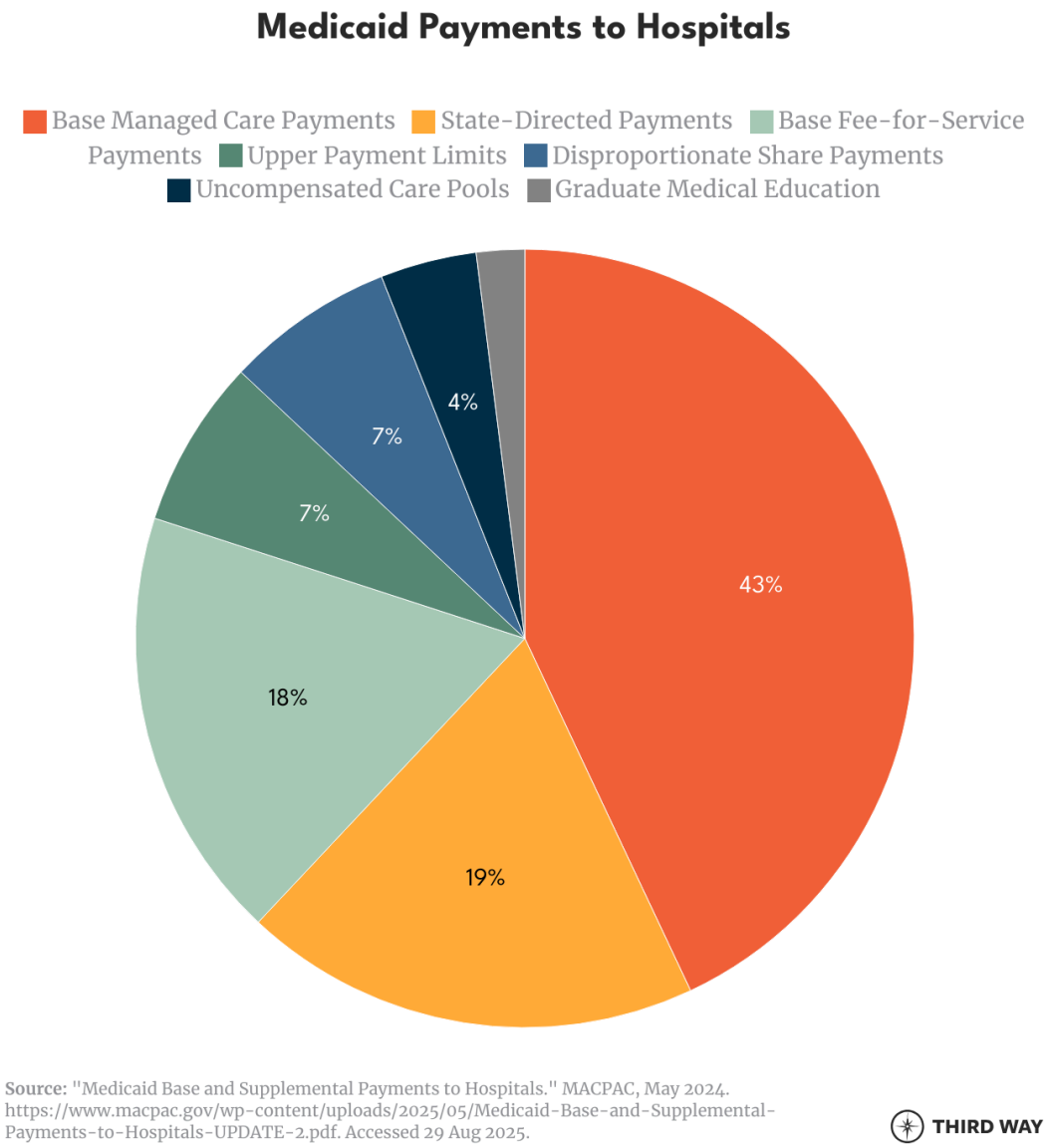
1. **State-directed payments** are made by the state to Medicaid managed care plans as a way to support specific provider types—most commonly hospitals—with the payments flowing through the plans, and often tied to supplemental funding arrangements or directed quality or access goals.

2. **Upper payment limits** are targeted payments that go to providers in the fee-for-service system to make up the difference between Medicaid payments and Medicare rates.

3. **Disproportionate share hospital** payments go to hospitals that serve a large number of Medicaid and uninsured patients.

4. **Uncompensated Care Pool** payments help cover the cost of caring for uninsured and underinsured patients.

5. **Graduate medical education** payments go to teaching hospitals to support the training of medical residents.



While the federal government receives information from the states on *how much* money is being paid through these various financing mechanisms, this information does not include provider-level data *showing* which hospitals are benefiting and by how much.

Historically, Medicaid has been known to underpay hospitals and other providers, exacerbating the gap between wealthier hospital chains and those primarily serving low-income and rural communities that heavily rely on Medicaid. But a sharp increase in supplemental payments is causing hospital payments to surpass Medicare levels and even reach commercial

prices on average, a drastic overcorrection. Between 2019 and 2022, total payments to hospitals grew by 27% (from $207 billion to $263 billion). Within that, supplemental payments *doubled*, from $52 billion to $105 billion. Despite these increases, the disparity between wealthier hospital chains and safety-net/rural hospitals remains persistent and continues to widen.

Under the current system, it's unclear who the increase in hospital funding is benefitting. For example, of the $105 billion in supplemental hospital payments in 2022, $3.9 billion went to a single for-profit hospital system: HCA Healthcare, the wealthiest hospital system in the country.

In particular, state-directed supplemental payments have significantly increased over the past several years. Between 2020 and 2023, state-directed payments increased from $26 billion to $69 billion annually, a 265% increase. Last year, the federal government enacted a rule that will allow state-directed payments to grow substantially more—up to what commercial health plans pay for the same services. As a result, state-directed payments were projected to grow between $50 and $220 billion over the next 10 years. But Congressional Republicans capped state-directed payments at Medicare rates in expansion states and 110% of Medicare rates in non-expansion states.

Because the federal government is responsible for matching more than half of Medicaid spending, the federal government will eventually be responsible for most of this increased spending. That's why federal oversight is needed to ensure funding to hospitals is boosting financial stability for hospitals facing financial struggles, not merely boosting revenues for already-wealthy hospital chains.

Increasing Transparency

As a result of the rising costs in Medicaid, both the Government Accountability Office and the Medicaid and CHIP Payment and Access Commission (MACPAC) recently called for improvements to transparency and oversight of hospital payments. MACPAC proposed practical reforms to improve transparency and accountability in Medicaid and financing. These steps are designed to address persistent gaps in data and oversight that hinder federal and state policymakers from evaluating whether Medicaid funds are being used appropriately and are well targeted to hospitals that need it most.

One of MACPAC's central recommendations is for the Centers for Medicare & Medicaid Services (CMS) to establish a **standardized, comprehensive hospital payment report**. This would require states to submit data on **all Medicaid payments to hospitals**—including base payments, supplemental payments under fee-for-service, and state-directed payments made through managed care. By consolidating this information into a uniform national reporting structure, CMS would have a clearer picture of how taxpayer dollars are distributed across different types of hospitals and services.

This proposed reporting system would include key data elements such as:

- **Payment amounts** by hospital and payment type (e.g. base, supplemental, state-directed);
- **Funding sources**, including non-federal share contributions from state provider taxes and intergovernmental transfers;

- **Hospital characteristics**, such as ownership status (public, non-profit, for-profit), Medicaid patient mix, and safety-net designations; and

- **Comparisons to Medicare and commercial payment levels**, to better assess alignment with market rates.

With these reforms, policymakers would have the tools to answer foundational questions: Are Medicaid hospital payments equitable across different types of hospitals? Are they efficient and aligned with access and quality goals? And are state financing mechanisms creating perverse incentives or exacerbating disparities?

Conclusion

It is critical for Medicaid provider payments to be transparent in order to ensure that Medicaid payments are targeted towards hospitals that need it most. As payment growth accelerates, so does the risk that Medicaid funding will reinforce existing disparities rather than remedy them.

Implementing commonsense transparency reforms would strengthen oversight, protect taxpayer resources, and, most importantly, ensure that hospitals serving low-income communities are not left behind. It would also reinforce the case for protecting and strengthening Medicaid in the face of political opposition—making the program more sustainable, defensible, and equitable for the future.

TOPICS

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