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Hospital Medicaid and Uninsured Payments Compared with Costs in the Commonwealth of Pennsylvania

Prepared for the Hospital and Healthsystem Association of Pennsylvania

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Table of Contents

I. Executive Summary 3
II. Introduction 4
III. Background 4
IV. Methodology 5
V. Results 6
Statewide Outlook 6
Hospital Type 7
Indigent Payer Mix 8
VI. Discussion and Conclusion 9
VII. Appendix: Data Fields and Calculations 10

I. EXECUTIVE SUMMARY

On behalf of the Hospital and Healthsystem Association of Pennsylvania (HAP), Health Management Associates, Inc. (HMA), conducted a review of Medicaid and uninsured costs and payments over the course of the past six years. **The results of this analysis show that the Pennsylvania Medicaid program is inadequately reimbursing hospitals for these services and that hospitals consistently experience substantial shortfalls related to providing services to these populations.**

Data were not yet available to fully assess hospital results in the two most recent state fiscal years (FY 2022−23 and FY 2023−24). However, cost increases based on national trends and known changes to hospital supplemental payments and Quality Care Assessment (QCA) amounts were applied to estimate the results for these years. Despite a substantial increase in funding through a state-directed payment program, which was funded using QCA assessment increases, **the shortfall for hospitals that provide services to the Medicaid and uninsured populations is projected to continue to grow.**

Total Medicaid and Uninsured Costs and Revenues (in millions)						
	FY 2018–19	FY 2019–20	FY 2020–21	FY 2021–22	FY 2022–23	FY 2023–24
Costs	$8,057	$8,490	$8,846	$9,814	*$10,101*	*$10,590*
Revenues	$7,060	$7,493	$8,020	$8,376	*$8,433*	*$8,715*
Shortfall	($997)	($997)	($826)	($1,438)	*($1,668)*	*($1,876)*

Translating these amounts to a payment-to-cost ratio (PCR) shows that **hospitals on a statewide basis will receive about 82 cents on the dollar for Medicaid and uninsured services.** These levels may vary by hospital and hospital type, however, and the median hospital level is even lower at 75 cents on the dollar, meaning half of hospitals are at or below that level.

Total Medicaid and Uninsured PCR for Pennsylvania Hospitals						
	FY 2018–19	FY 2019–20	FY 2020–21	FY 2021–22	FY 2022–23	FY 2023–24
Statewide Total	88%	88%	91%	85%	83%	82%
Hospital Median	78%	81%	82%	76%	74%	75%

Though the data show that Medicaid payments have increased annually, they are being outpaced by the level of cost increases. The trajectory of the healthcare industry shows that hospital costs will continue to rise. With approximately one-quarter of the Pennsylvania's population reliant on Medicaid for healthcare coverage, the low rates of Medicaid reimbursement can have major detrimental impacts on a hospital's financial viability. Additional investment will be necessary if the current level of annual shortfalls are to be addressed. Furthermore, healthcare costs will continue to rise. It will be important to ensure that Medicaid reimbursement matches the level of cost growth, so hospitals can continue to operate and provide quality services to these vulnerable populations.

II. INTRODUCTION

The Hospital and Healthsystem Association of Pennsylvania (HAP) contracted with Health Management Associates, Inc. (HMA) to conduct an analysis of hospital Medicaid and uninsured costs and payments. The objective of this report is to determine the Medicaid/uninsured payment-to-cost ratio (PCR) and the overall shortfalls hospitals sustained when providing services to these populations. In performing these calculations, HMA analyzed multiple years of data and examined the results based on several factors, such as hospital classification and share of indigent volume. Results show that Medicaid reimbursement is inadequate to cover the cost of services, and despite some recent changes resulting in increased Medicaid revenue, the shortfalls will likely continue to grow. This level of concern may vary depending on hospital and hospital type.

III. BACKGROUND

Medicaid provides health coverage to eligible low-income individuals and families. It's jointly funded by federal and state governments, though each state administers its own program. As such, many aspects of Medicaid programs can vary by state, including individual eligibility, covered benefits, and reimbursement rates for service providers. Prior to implementation to provisions of the Affordable Care Act (ACA) in 2014, Medicaid eligibility was typically limited to low-income children and adults with disabilities. The ACA gave states the option to expand Medicaid eligibility to non-elderly low-income adults. Pennsylvania exercised this option one year later and expanded Medicaid on January 1, 2015, allowing adults with incomes up to 138 percent of the federal poverty level to qualify for coverage.

Eligibility for Medicaid is typically determined on an annual basis; however, due to federal requirements related to the COVID-19 public health emergency, eligibility redeterminations were paused from 2020 to 2023, causing Medicaid enrollment levels to increase substantially. These redeterminations and resultant disenrollments have resumed, causing enrollment levels to decline from its highest levels of 3.7 million in early 2023, although 3 million Pennsylvanians continue to be enrolled in Medicaid[1].

The cost of care and lack of adequate reimbursement for the Medicaid and uninsured population is a longstanding issue of concern across the country. With funding for Medicaid payments coming from both state and federal sources, it is common for states to pay Medicaid providers low reimbursement rates to contain state costs. In addition, federal regulations allow for certain provider classes to be assessed, and the revenue from those provider assessments can then be used as the state share for Medicaid payments, although these revenues are not limited to this purpose. Most states have hospital provider assessment programs through which they collect from hospitals. A portion of those collections are often designated as the state share for directed or supplemental payments that go back to the hospital industry. There is no guarantee that a hospital

[1] Pennsylvania Department of Human Services. Monthly Data Report. May 2024. Available at: https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/about/documents/2024-05-may-dhs-montly-data-report.pdf.

will receive more in Medicaid supplemental funding than the amount it is assessed, however, because federal regulations prohibit states from designing these programs in such a manner.

The Commonwealth of Pennsylvania first implemented its hospital provider assessment program, known as the Quality Care Assessment (QCA), in state fiscal year (SFY) 2010−11. Though the program has gone through iterative changes throughout the years, it essentially has always served two purposes. The first is to provide funding for the non-federal share of Medicaid payments to hospitals. The second is to provide funding that is retained by the Commonwealth for other state budgetary purposes. Regarding the latter, Pennsylvania hospitals contributed approximately $368 million over the amount needed to fund the non-federal share of QCA-related payments in SFY 2023−24. Though that amount is significant, Pennsylvania hospitals, as an industry, still see substantial net benefits from the overall QCA program.

Pennsylvania has a number of payment programs that are funded through the QCA assessment, including reimbursement through the disproportionate share hospital (DSH) program, which factors in the costs to provide services to people who are uninsured. Some of these initiatives are broadly designed to provide increased reimbursement for any Medicaid stay or visit, whereas others have very specific program requirements that target the funding to hospitals based on certain characteristics. Pennsylvania also has several supplemental payment programs that do not use the QCA as a source of funding. These non-QCA programs tend to be designed to meet the needs of certain hospital types. As a result of these supplemental payment programs, reimbursement levels can vary by hospital.

Pennsylvania recently implemented considerable changes to the QCA-related payments that flow through the Medicaid managed care organizations (MCOs). Along with transitioning from a previous pass-through methodology to a state-directed payment (SDP), which results in payments being based on current year utilization, the total amounts paid through the MCOs also increased in FY 2023−2024 by about $547 million, or 45 percent. However, this hospital Medicaid payment increase came with an increase to the QCA assessment amounts, which lowered the industry net benefit. Though the increased funding is beneficial to hospitals, the process change comes with decreased predictability, as payment amounts are calculated on an interim basis based on quarterly submissions from the MCOs to the Pennsylvania Department of Human Services (DHS), and then reconciled once DHS determines the service year is complete, 18 to 24 months after interim payments were made. The increased SDP payment also came at the same time other supplemental payments related to the COVID-19 pandemic expired. As such, the net year-to-year reimbursement impact was much lower than the gross SDP change.

Notable Reimbursement Changes from FY2022−23 to FY2023−24
MCO directed payments increase by $547 million
COVID-19 relief payments decrease by $237 million
QCA assessment costs increase by $243 million
Net increase to hospitals of $66 million

IV. METHODOLOGY

The main source for inpatient and outpatient cost and payment data came from medical assistance (MA) cost reports. HMA analyzed cost report data from four different years—each year from SFY 2018−19 through SFY

2021−22. Additional data related to each hospital's QCA cost were derived from annual DHS budget documentation. Though QCA assessment amounts are included as a hospital expense in the cost reports, the initial Medicaid/uninsured cost-to-charge ratio would only pick up these costs based on the share of Medicaid/uninsured charges compared with the whole hospital charges. Because the QCA assessment is used to fund the non-federal share of Medicaid payments, calculation adjustments were made to include the full QCA assessment amounts as a cost attributable to the Medicaid and uninsured populations.

Due to substantial changes occurring in the QCA assessment amounts and MCO payment amounts through the new SDP, estimates have been provided for FY 2022−23 and FY 2023−24. Because cost report data are not yet available for these timeframes, hospital costs were estimated using the base data from FY 2021−22 and cost trends derived from the Centers for Medicare & Medicaid Services Market Basket Index. Revenues also used FY 2021−22 as the basis but adjusted supplemental and MCO payment amounts based on both known changes (removal of COVID supplemental and COVID DSH pools) and the most recent estimates of SDP amounts. The statewide results below include estimates for these future years, while analysis based on different hospital characteristics focuses on FY 2021−22 due to this year being the most recent available with full cost report information.

A full description of the data fields used and the calculations performed can be found in Appendix A.

V. RESULTS

Statewide Outlook

As Tables 1 and 2 indicate, costs for providing hospital services to the Medicaid and uninsured populations consistently far exceed the revenues hospitals receive for these patients. Though both costs and revenues increased in each of the four years of available cost reports, the significant increase in costs for FY 2021−22, fueled by the aftershocks of the pandemic, far outpaced the revenue gains in that same year. Though data are not yet available to fully understand the outcomes of FY 2022−23 and FY 2023−24 (so these results may change when those cost reports are available), it is well documented that hospital costs were expected to rise during that time.

Medicaid revenues were also expected to experience some increases during this period, though not to the same levels. A higher federal matching rate in place during the COVID-19 pandemic allowed for three years of higher supplemental payments without increases to the assessment. In FY 2023−24, HAP successfully advocated for a new methodology based on average commercial rates, and CMS approval was received to increase Pennsylvania's hospital SDP program by about $547 million. Though this increase was significant, it also came with about $243 million in additional assessment costs and coincided with the end of the enhanced COVID-19 supplemental payments. Consequently, **costs are still outpacing revenue gains, and the payment shortfall is growing.**

Table 1. Total Medicaid and Uninsured Costs and Revenues (in millions)

	FY 2018–19	FY 2019–20	FY 2020–21	FY 2021–22	FY 2022–23	FY 2023–24
Costs	$8,057	$8,490	$8,846	$9,814	*$10,101*	*$10,590*
Revenues	$7,060	$7,493	$8,020	$8,376	*$8,433*	*$8,715*
Shortfall	($997)	($997)	($826)	($1,438)	*($1,668)*	*($1,876)*
Number of Hospitals	217	213	215	215	213	209

Table 2. Total Medicaid and Uninsured PCR for Pennsylvania Hospitals

	FY 2018–19	FY 2019–20	FY 2020–21	FY 2021–22	FY 2022–23	FY 2023–24
Statewide Total	88%	88%	91%	85%	83%	82%
Hospital Median	78%	81%	82%	76%	74%	75%

These PCR values indicate that on a statewide basis, hospitals are projected to receive about 82 cents on the dollar for Medicaid and uninsured services in FY 2023−24. Table 2 shows a gap between statewide total PCR and the hospital median PCR, which means that while the statewide average in FY 2023−24 is projected to be 82 percent, half of the hospitals in Pennsylvania are projected to be at or below 75 percent. The difference between average and median amounts may be attributed to a small number of outliers in the data, including a few larger hospitals that exceed the average value. A number of factors can influence a hospital's calculated PCR values, including the ability to control costs, Medicaid base payment policy, QCA policy, and Medicaid supplemental payment design.

Hospital Type

HMA further explored the results based on hospital characteristics. Though the table below shows a variance in PCR based on these characteristics, the underlying issue of Medicaid payments not covering the costs of care persists for each hospital group.

The largest variance from the statewide average occurs for hospitals classified as rural. A hospital meets the rural designation if it provides inpatient general acute services located in a county of the fourth, fifth, sixth, seventh, or eighth class, as defined by the County Commissioners Association of Pennsylvania.[2] In Pennsylvania, approximately 30% of hospitals meet this rural definition. However, due to the relatively smaller size of most rural hospitals, they only account for about 16% of the statewide share of Medicaid and uninsured costs. As can be seen from the chart below, rural hospitals fare worse than their non-rural counterparts at having their Medicaid and uninsured revenues cover those related costs.

[2] County Commissioners Association of Pennsylvania. Pennsylvania Counties by Class. Available at: https://www.pacounties.org/who-we-are/pennsylvania-county-by-class.

Table 3. FY 2021–2022 PCR by Hospital Type

Hospital Type	Number of Hospitals	PCR	Share of Medicaid Costs
Acute Non-Rural	89	87%	78.8%
Rural	64	74%	15.6%
Long Term Acute or Rehab	33	90%	1.3%
Psychiatric	22	92%	4.0%
Specialty	7	89%	0.4%
Total	**215**	**86%**	**100%**

Indigent Payer Mix

A hospital's payor mix can play an important role in its financial outlook. If a high percentage of a hospital's service volume comes from patients with commercial insurance, it can often use those higher reimbursement levels to offset losses it may incur from lower reimbursement rates from providing care to Medicaid and uninsured populations. For hospitals with a high indigent payer mix, defined here as the percentage of Medicaid and uninsured charges divided by a hospital's total charges, Medicaid reimbursement levels are a crucial factor in determining financial sustainability.

As Table 4 demonstrates, the Medicaid and uninsured PCR for general acute hospitals increases as the level of indigent payor mix increases. As these ratios can be driven by both costs and revenues, it's likely that both play a factor. Hospitals with a high indigent payer mix may have a greater need to control costs. In addition, Pennsylvania Medicaid reimbursement policy can be used to target funds to those hospitals with a higher indigent payor population. This result meets the intent of Medicaid DSH policy, which is to financially support those hospitals serving the most vulnerable Medicaid patients. Though the results improve for hospitals with a higher indigent payer mix, they also fall short of covering the full costs for services.

Table 4. FY 2021–22 General Acute Hospital PCR by Indigent Payer Mix

Indigent Payor Mix	Number of Hospitals	PCR
Less than 10%	14	58%
10% to 15%	32	74%
15% to 20%	49	78%
Greater than 20%	38	91%

VI. DISCUSSION AND CONCLUSION

On a statewide basis, the results of this analysis make it clear that the current Medicaid program in Pennsylvania is unable to cover the costs of the services provided to the Medicaid and uninsured populations. Though the additional COVID supplemental payments in FY 2019−20 through FY 2021−22 and the increased SDP payments beginning in FY 2023−24 helped mitigate the increased costs that hospitals incurred in those particular years, the overall rate of increases to hospital costs in the past six years is far outpacing the increases to Medicaid revenues during that period. Unless the state makes substantial changes, shortfalls for providing services to low-income Pennsylvanians will continue to grow.

The Pennsylvania program addresses hospitals that are more reliant on Medicaid funding or more typically at risk of closure; however, when most of the state's hospitals have less than 80 percent of their indigent care costs covered, there is still cause for concern. To fully address the underlying issue of the substantial Medicaid shortfall that the industry is experiencing, additional investment in hospital reimbursement will be required. As costs continue to rise, it will be important to continue monitoring funding to ensure revenues keep pace at reasonable levels.

VII. APPENDIX: DATA FIELDS AND CALCULATIONS

This appendix describes the data sources and calculation methodology used for the analyses presented in this report.

This report provides detailed information related to the Medicaid and uninsured payment-to-cost ratio (PCR) for hospitals in the Commonwealth of Pennsylvania. The PCR divides the payments by costs to provide an indicator of how well hospitals are reimbursed for providing services to these populations. In these calculations, a value of 100 percent would indicate that payments are equal to costs. Any value under 100 percent indicates that payments were insufficient to cover the costs of services, whereas a value over 100 percent indicates that payments exceeded those expenditures.

The primary source of data used for the calculations in this report came from medical assistance cost reports, which contain data related to total hospital charges and costs, broken out by inpatient and outpatient services, as well as Medicaid-specific data on charges, base payments, and supplemental payments. The accuracy of the calculations and analysis in this report are dependent on the accuracy of the MA cost report data. Though no major concerns were identified during the review, HMA did not audit the values in the MA cost report to determine validity.

Medicaid and Uninsured Costs

To determine Medicaid and uninsured costs, HMA first calculated hospital cost-to-charge ratios (CCRs) for each hospital's inpatient and outpatient services. Total hospital inpatient and outpatient charges are identified on Worksheet S6 of the cost report, and total hospital inpatient and outpatient costs are identified on Worksheet S3. Dividing these values, as shown below, results in the calculated CCRs.

$$\text{Inpatient Cost-to-Charge Ratio} = \frac{\text{Total Inpatient Hospital Costs}}{\text{Total Inpatient Hospital Charges}}$$

$$\text{Outpatient Cost-to-Charge Ratio} = \frac{\text{Total Outpatient Hospital Costs}}{\text{Total Outpatient Hospital Charges}}$$

Medicaid and uninsured charges are provided on Worksheet S7 of the MA cost report. Multiplying these charges by their applicable CCRs results in the calculated costs of providing services to Medicaid and uninsured patients.

Inpatient Medicaid Costs = Inpatient Medicaid Charges * Inpatient Hospital CCR

Inpatient Uninsured Costs = Inpatient Uninsured Charges * Inpatient Hospital CCR

Outpatient Medicaid Costs = Outpatient Medicaid Charges * Outpatient Hospital CCR

Outpatient Uninsured Costs = Outpatient Uninsured Charges * Outpatient Hospital CCR

For the purposes of this report, QCA assessment amounts are considered as costs for Medicaid and uninsured populations because the QCA assessments are used to fund the non-federal share of Medicaid payments, including DSH payments, which can be used to cover the costs of the uninsured population. Though hospitals would include these assessments in their total hospital costs noted above, the Medicaid and uninsured cost calculation using charges and the CCRs would only pick up a portion of the QCA assessment costs based on the share of the hospital's Medicaid and uninsured charges versus total charges. Hence, the calculation below was performed to ensure all QCA assessment costs were included as Medicaid and uninsured costs.

$$\text{Additional QCA Costs} = \text{Total QCA Assessment} * \left(1 - \frac{\text{Medicaid + Uninsured Charges}}{\text{Total Hospital Charges}}\right)$$

Total Medicaid and uninsured costs are then obtained from the sum of these values.

Total Medicaid / Uninsured Costs = Inpatient Medicaid Costs + Inpatient Uninsured Costs + Outpatient Medicaid Costs + Outpatient Uninsured Costs + QCA Costs

Cost report data for FY 2022−23 and FY 2023−24 were unavailable at the time of this report. The CMS Market Basket Index was used to project changes to costs from the FY 2021−22 MA cost report calculations described above. An annual trend was applied to costs, excluding the QCA assessment amount. The QCA assessment was updated to include the known amounts for each respective year, based on the QCA models provided by DHS. This included a significant increase in FY 2023−24. No adjustments were made in these years to account for potential utilization changes.

Medicaid and Uninsured Revenues

Base payments, those payments made initially for billed services, for the Medicaid and uninsured populations are included on Worksheet S7 of the MA cost reports. Pennsylvania also operates several supplemental payment programs, including DSH, graduate medical education, academic medical center, burn center, access to care, critical access hospital, obstetrics/neonatal intensive care unit, tobacco, ocular services, opioid use disorder, and trauma payments. In addition, in FY 2019−20 through FY 2022−23, there were two supplemental payment programs, one through DSH, for COVID relief. Supplemental payments are included on Worksheet S6. Amounts received for state and local government subsidies are also included on Worksheet S6. These values are summed to get the total Medicaid and uninsured payments for the year.

Total Medicaid / Uninsured Payments = Medicaid Hospital Base Payments + Uninsured / Self-Pay Revenue + Supplemental Payments + Cash Subsidies Received from State and Local Government

Adjustments were made to MCO and supplemental payment revenues in FY 2022−23 and FY 2023−24 based on known changes to these programs. This included transitioning MCO Appendix 14 and 17 payments to state-directed payments on January 1, 2023, significant increases to the SDPs in FY 2023−24, and changes to the Covid-19 DSH supplemental payment amounts. The COVID-19 DSH supplemental payment amounts increased in FY 2022−23 compared with FY 2021−22, and then were eliminated in FY

2023−24. Note that, similar to costs, no utilization adjustments were made to Medicaid base payments or uninsured/self-pay for these years.

PCR and Annual Shortfall Calculation

With annual costs and revenues calculated, the resulting PCR is obtained by dividing these values. Similarly, the shortfall is calculated from subtracting the total costs from the total payments.

$$\text{Medicaid / Uninsured PCR} = \frac{\text{Total Medicaid / Uninsured Payments}}{\text{Total Medicaid / Uninsured Costs}}$$

$$\text{Medicaid / Uninsured Shortfall} = \text{Total Medicaid / Uninsured Payments} - \text{Total Medicaid / Uninsured Costs}$$