

Healthcare Systems and Services Practice

# Ensuring financial sustainability while serving a growing Medicaid population

High-performing health systems have succeeded in “breaking even” in Medicare, but many continue to struggle to achieve similar results in Medicaid. A concerted effort to improve revenue can strengthen a system’s financial sustainability.

*by Bede Broome, MD; Connie Cibrone; Michael Elliott; and Li Han*



**Many high-performing health systems have succeeded in “breaking even”** in the Medicare segment of their business, but their hospitals continue to struggle financially with both fee-for-service (FFS) and managed Medicaid. Furthermore, an increasing number of states are working with Medicaid managed care organizations (MCOs), and we anticipate that these MCOs will experience ongoing, if not increasing, pressures to maintain or lower hospital reimbursement rates. Given the other challenges health systems currently face—including overall cost pressures, slow growth in reimbursement rates, and decreased commercial volume—absorbing losses in the Medicaid segment is becoming increasingly untenable for many of them. These systems need to pivot quickly to improve their hospitals’ financial performance in Medicaid—the era of “breaking even” only on Medicare is over if they want to ensure their financial sustainability.

Because Medicaid’s reimbursement structures differ from Medicare’s, the traditional methods health systems have been using to ensure financial success in Medicare may not be sufficient in the Medicaid line of business. Both Medicaid’s base payments and the percentage of total Medicaid costs those payments cover vary tremendously by state (Exhibit 1).<sup>1</sup> In addition,

many health systems receive disproportional share hospital or other supplemental payments from the federal and/or state governments; however, the availability and size of the supplemental payments also vary by state. Additional complexity arises from the fact that, in some cases, the lag time between when services are provided and when some of the supplemental payments are received can be as long as three years.

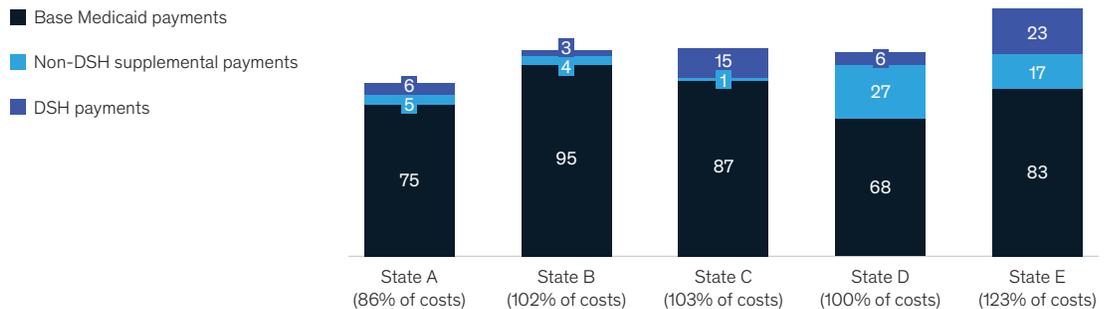
The complexity of Medicaid reimbursement—the different base rates, payment structures, and sources of supplemental reimbursement—has made it difficult for many health systems to improve their financial performance in that line of business. It can be done, especially by systems that already serve a high volume of Medicaid patients. However, most systems will need innovative solutions if they want to do so without jeopardizing quality of care. We have found that one approach, in particular, can help many health systems—combining stringent cost containment efforts with a strengthened approach for claiming the supplemental reimbursements they are entitled to receive. This combined strategy is the focus of this article.

Time is of the essence, however, given the lag time until supplemental payments may be re-

<sup>1</sup> MACPAC, Medicaid base and supplemental payments to hospitals, Issue brief, June 2018, macpac.gov.

Exhibit 1

### Medicaid payments to DSH hospitals as a percentage of Medicaid costs for selected states, SPRY 2013



Note: In this exhibit “base Medicaid payments” include both fee-for-service and managed care payments. DSH, disproportionate share hospital; SPRY, state plan rate year.

Source: MACPAC, Medicaid base and supplemental payments to hospitals. Issue brief. June 2018

Exhibit 2

## Strong expense, revenue cycle, and operational management can help health systems improve financial performance in Medicaid

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|                                           |                                                                                                                                                                             |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Labor and organizational structure</b> | <ul style="list-style-type: none"><li>• Spans and layers</li><li>• Productivity</li></ul>                                                                                   |
| <b>External spend</b>                     | <ul style="list-style-type: none"><li>• Supplies</li><li>• Pharmaceuticals</li><li>• Purchased services</li></ul>                                                           |
| <b>Revenue cycle management</b>           | <ul style="list-style-type: none"><li>• Payer yield and collections</li><li>• Uncompensated care</li><li>• Coding and documentation</li></ul>                               |
| <b>Managed care and pricing</b>           | <ul style="list-style-type: none"><li>• Strategic pricing</li><li>• Contracting terms and conditions</li><li>• Value-based contracting models (e.g., capitation)</li></ul>  |
| <b>Clinical operations</b>                | <ul style="list-style-type: none"><li>• Length of stay</li><li>• Emergency room throughput and access</li><li>• Operating room, outpatient, and clinic efficiency</li></ul> |

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ceived. Health systems that want to improve their financial performance in Medicaid should start making changes now to account for that delay.

Note: Some healthcare systems may want to launch—or have launched—broader strategies to address the full continuum of care, which would allow them to fully benefit from a capitated payment model. Those systems that succeed with this approach are likely to find themselves under less financial pressure from Medicaid reimbursement. Nevertheless, even those systems would benefit from the steps outlined in this article.

### Traditional cost containment strategies

There is no doubt that a sustained push to balance costs and revenues using the methods health systems have traditionally relied on to break even in Medicare—disciplined expense management, stronger revenue cycle management, and improved operations—is crucial for success in Medicaid (Exhibit 2). But, even if these steps are pursued aggressively, they may not be enough in Medicaid.

### Disciplined expense management

In our experience, best practice for an average health system with a typical payer mix would be to spend just under half of its net revenues on labor, no more than 20 percent on supplies and drugs, and perhaps 15 percent to 25 percent on all other costs.<sup>2</sup> (The exact percentages will depend on a system's geographic footprint and the extent to which it has outsourced certain functions.) Depending on how heavily a health system pulls various levers, it might achieve savings of 5 percent to 10 percent—and sometimes more—over one to five years if it adopts a very disciplined approach to expense management.

**Workforce.** Initial levers that can be used to reduce workforce spend include setting department-level targets for productivity<sup>3</sup> and premium spend (e.g., overtime and contract labor), actively managing staff scheduling and flexing, and when necessary, right-sizing through a reduction in force. In addition, strict, ongoing tracking and adherence processes for performance against best-practice targets should be instituted, and steps should be taken to ensure that all caregivers are practicing at the top of their license.

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<sup>2</sup> For-profit provider quarterly earnings data, January 2017.

<sup>3</sup> See Sahni N et al. *The productivity imperative for healthcare delivery in the United States*, February 2019, McKinsey.com.

**External spend.** Reducing external spend also requires a very lean approach, including a highly standardized pharmacy formulary, narrow set of approved commodity supplies, and approval requirements for select high-cost, long-term-use drugs. In addition, restrictions should be placed on physician-preference items when evidence demonstrates that more cost-effective options with equal or better efficacy exist.

**Outsourcing.** For health systems with mostly in-house operations, outsourcing can achieve significant savings. Among the functions that can be outsourced are food purchasing and cafeteria services, IT services, supply chain management, and revenue cycle management. Although outsourcing may entail dramatic changes in existing processes and operations, it can have a proportionally large impact on costs.

#### **Stronger revenue cycle management**

Health systems should also focus closely on revenue cycle management in all lines of business. Two levers are especially important:

**Addressing denials with payers to ensure full, accurate payment.** Health systems today need to navigate the complex and varying medical policies and requirements different payers use if they are to receive appropriate payment commensurate with the care provided. For health systems that want to ensure full revenue capture, effective mid-cycle management—including appropriate coding, billing, and documentation—is essential. As part of the process of improving operations and performance, these systems must stress the importance of proper clinical documentation to ensure appropriate and timely payment. When denials or other issues arise, they should be addressed rapidly. Other revenue levers that can be used include bad debt reduction (for example, through coverage discovery) and accurate documentation to support coding and billing.

**Effectively negotiating with MCOs.** Given the large shift from FFS Medicaid to managed care, a nuanced pricing and negotiation strategy with MCOs can help a health system achieve an appropriate, market-competitive payment schedule. In addition to traditional service-pricing levers, other

areas that should be explored include terms and conditions (especially in reducing administrative costs), pay-for-performance/pay-for-quality programs, and capitated arrangements.

A comprehensive approach that combines revenue cycle management and MCO contracting may increase Medicaid revenues by 5 percent or more. As we discuss below, however, approaches that go beyond these steps are often needed to significantly increase Medicaid revenues.

#### **Improved operations**

Despite the differences in Medicare and Medicaid reimbursement, both programs often base reimbursement on some type of bundled payment, such as case rates or diagnosis-related groups (DRGs).<sup>4</sup> Increasingly, MCOs are moving in the same direction. In this environment, additional operational improvements (e.g., reducing length of stay, increasing emergency department access and throughput, and optimizing operating room capacity) can help further reduce costs and may allow for volume growth. However, the full impact of these measures depends on whether the health system can fill the freed-up capacity or has strict cost-management measures in place. Additional savings here can yield a further 1 percent to 2 percent reduction in the total cost of care. In addition, volume growth can contribute to a significant uptick in revenue and profitability. Despite the difficulty in “breaking even” on Medicaid overall, Medicaid patients are still typically contribution positive—because reimbursement for their care exceeds variable costs, every incremental case helps the overall financial performance of the hospital.

#### **Strengthened approach to supplemental payments**

The steps outlined above, if implemented aggressively, should yield 10 percent to 15 percent in a combination of expense savings and revenue impact. Even if some of the steps are implemented with only Medicaid as a focus point, they are likely to produce a halo effect across the system—stronger labor standards and payer-contracting strategies, as well as better supply choices and revenue cycle management, are usually transferable to other lines of business. Similarly, improve-

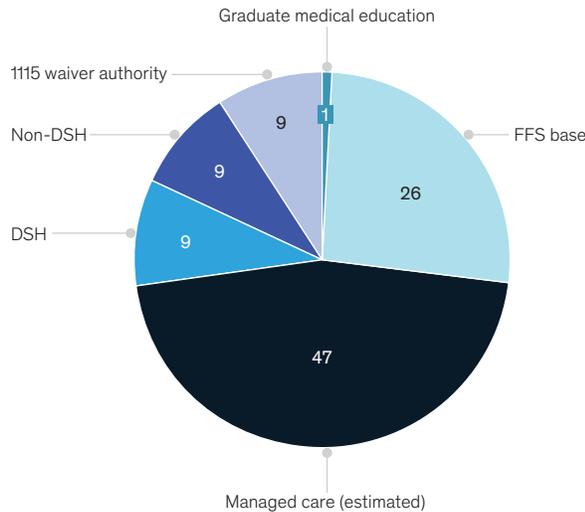
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<sup>4</sup> Some exceptions apply, such as behavioral health cases, which are often reimbursed on a per-diem basis.

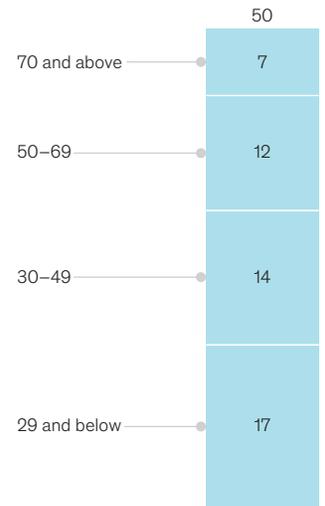
Exhibit 3

## Supplemental payments are a significant portion of total Medicaid reimbursement

Sources of Medicaid payments to hospitals, % (FY 2016, nationwide)<sup>1</sup>



Count of states by share of supplemental Medicaid payments as a percentage of total reimbursement



DSH, disproportionate share hospital; FFS, fee-for-service.  
<sup>1</sup> Figures may not sum to 100%, because of rounding.

Source: MACPAC. Medicaid base and supplemental payments to hospitals. Issue brief, June 2018; *MACStats: Medicaid and CHIP Data Book*, December 2018.

ments in length of stay, throughput, and access often involve operational changes that lead to better performance throughout the hospital. Such efforts would not only improve the financial viability of Medicaid patients, but also help ensure profitability across the entire system. But, are savings of 10 percent to 15 percent always sufficient in the Medicaid line of business? If not, what can be done to cover the gap?

Answering these questions requires that a health system know how much total Medicaid reimbursement it is receiving and how wide the current gap is between revenues and costs. These questions are especially important—and should be a focus area—for systems that are not receiving reimbursements beyond base-rate payments from Medicaid. However, given the various streams through which Medicaid payments are made and the timing of when some payments are received, answering the questions is not as easy as it might seem.

### The gap between base payments and costs

As discussed, Medicaid base-rate payments vary significantly among the states, depending on funding availability. Although some states still reimburse for inpatient care on a per-diem basis, many have moved, or are in the process of moving, toward using approaches based on DRGs. Based on data from the Medicaid and CHIP Payment and Access Commission (MACPAC), we estimate that many hospitals will need to meet an average gap of about 20 percent to break even if they receive base-rate payments alone, and even stronger performance to achieve a positive margin.

A sizable portion of the gap can be closed if health systems strengthen their approach to claiming the supplemental payments they are entitled to receive. MACPAC data indicate that about 27 percent of Medicaid payments to hospitals in fiscal year 2016 (which totaled almost \$190 billion) came from supplemental sources (Exhibit 3),<sup>5</sup>

<sup>5</sup> MACPAC, Medicaid base and supplemental payments to hospitals, Issue brief, June 2018, [macpac.gov](http://macpac.gov); *MACPAC Stats: Medicaid and CHIP Data Book*, December 2018, [macpac.gov](http://macpac.gov).

Exhibit 4

## Medicaid supplementary payment programs include an initial qualification requirement and an ongoing payment determination structure

|                             | Qualification for payment                                                                                                                 | Payment structure                                                                                                              |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <b>Medicaid DSH</b>         | Based on Medicaid utilization rate or low-income utilization rate, both of which include a component of Medicaid revenue or Medicaid days | Once qualified, payment is based on Medicaid and managed Medicaid patient days                                                 |
| <b>Medicare DSH</b>         | Based on DPP, which includes input from total Medicaid days in addition to Medicare days                                                  | Similar to the qualification metric; payment is also based on DPP, which is dependent, in part, on Medicaid days               |
| <b>Non-DSH supplemental</b> | Qualification for payment varies by state; many states opt to exclude requirements for any specific threshold to be met                   | Various payment structures, depending on the state program; many look at Medicaid and managed Medicaid patient days or revenue |

DPP, disproportionate patient percentage; DSH, disproportionate share hospital.

### DSH and non-DSH supplemental payments

The supplemental payments used to help reimburse for care delivered to Medicaid patients come primarily from three sources: the Medicare disproportionate share hospital (DSH) program, the Medicaid DSH program, and various state-based non-DSH programs, or a mix of the three (Exhibit 4).<sup>6</sup> Total nationwide state non-DSH supplemental payments are estimated to have reached \$18 billion in fiscal year 2016 (about 9 percent of total Medicaid payments), a sum that surpassed the \$16.5 billion paid that year through the Medicaid DSH program.<sup>7</sup> In addition, states are allowed to apply for Section 1115 Medicaid demonstration waivers to use a portion of their base payments to test innovative approaches to Medicaid reimbursement.

**DSH payments.** Both the Medicare and Medicaid programs offer DSH payments to qualifying hospitals. A hospital may qualify for one or both sources based on the percentage of inpatient days attributed to patients either A) covered by Medicare Part A and Supplemental Security Income or B)

eligible for Medicaid but not covered by Medicare Part A.<sup>8</sup> (Medicaid DSH payments are meant to reimburse health systems for services delivered to uninsured patients as well as Medicaid beneficiaries.) Although Medicare DSH payments are made directly to hospitals by the Centers for Medicare & Medicaid Services, Medicaid DSH payments are distributed by each state individually. Because the rules for DSH payments differ between FFS and managed Medicaid, the increasing shift to managed care is altering DSH allocations for that program.

**Non-DSH payments.** Most states also offer additional, non-DSH payments under different structures.<sup>9,10</sup> Some states also offer other types of MCO-based supplemental Medicaid payments (funding levels vary by state).<sup>11</sup> However, the availability and size of supplemental payments is highly dependent on state laws. In some states, Medicaid supplemental programs are based on qualification criteria similar to those used by the federal DSH program; in other states, funds may be distributed based simply on Medicaid and managed Medicaid patients served, often by

<sup>6</sup> The reductions in DSH allotments stipulated in the Affordable Care Act have been repeatedly delayed by Congressional action. Whether the cuts scheduled for 2020 will go into effect remains unclear.

<sup>7</sup> MACPAC, Medicaid base and supplemental payments to hospitals, Issue brief, June 2018, macpac.gov.

<sup>8</sup> For more details about the qualifications for becoming a disproportionate share hospital, see Centers for Medicare & Medicaid Services, Disproportionate share hospital (DSH), April 23, 2019, cms.gov.

<sup>9</sup> Centers for Medicare & Medicaid Services, Medicare disproportionate share hospital, September 2017, cms.gov.

<sup>10</sup> Office of Statewide Health Planning and Development, Description of disproportionate share hospitals eligible formulas, November 2017, oshpd.ca.gov.

<sup>11</sup> Note: MCO-based supplemental payments are difficult to track.

relevant patient days. The state funds are given to qualifying hospitals either directly or indirectly (via Medicaid MCOs) as additional payments.

In short, DSH and state non-DSH supplemental payments vary greatly in terms of funding availability, eligibility criteria, and how (and when) the money is paid—which helps explain why many health systems have difficulty determining how much Medicaid reimbursement they are receiving. Nevertheless, the MACPAC data suggest that if a hospital qualifies for DSH funds *and* is in a state that provides an average level of non-DSH supplemental payments, the total Medicaid payments could cover up to 107 percent of costs. In our experience, however, many hospitals either are in states that do not provide an average (or higher) level of non-DSH supplemental funding or have not increased their volume of Medicaid patients sufficiently to qualify for the payments.

### **Calculating a hospital's performance**

When a health system is trying to determine whether its hospitals can improve their financial performance in Medicaid through both traditional methods and increased supplemental revenue, the first factor to consider is where the hospitals are situated—location strongly influences the level of available federal and state supplemental payments, as well as the qualifications for payment and how the ongoing payments work (these are dependent on state-established rules for how the funding should be distributed). For each hospital, the health system should calculate two things:

- The average number of Medicaid and uninsured patients it treats annually
- The individual contributions of both supplemental payments and Medicaid base (FFS or MCO) reimbursement to covering the cost of care for those patients

### Sidebar

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## **Potential pitfalls when attempting to increase Medicaid payments**

Although increasing the volume of Medicaid patients can help hospitals maximize appropriate reimbursement for the care delivered to those patients, the effort is not without risk. Several factors must be kept in mind whenever a hospital is contemplating this strategy.

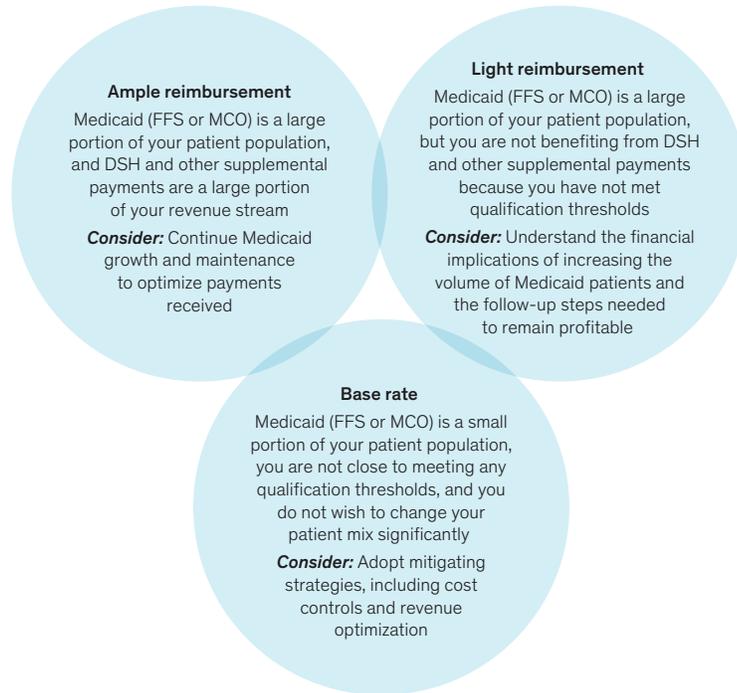
For example, there can be up to a three-year lag in receiving state supplemental payments (for example, 2017 Medicaid days would be used to determine 2020 supplemental payments.) There is also a two-year lag for Medicare and Medicaid DSH funds. (Payments are predetermined for the current and next fiscal year.) Thus, any efforts to increase the Medicaid FFS or managed care volume must be planned to ensure that the jump from the current Medicaid mix to the qualification threshold can, ideally, be completed in a single year.

Furthermore, if the increase in Medicaid volume required to meet the qualifications for DSH/

non-DSH supplemental payments is large, the move could prove financially detrimental if a hospital has significant Medicare and/or commercial volume and the Medicaid increase comes at the expense of those patients. Most hospitals today have spare capacity; however, if a hospital at or close to full capacity substantially increases its Medicaid volume yet is not able to meet the necessary thresholds to qualify for DSH payments, the shift in payer mix could put it at a disadvantage.

Given the complexity of the qualification criteria and subsequent payment structure, the delayed payment timeline, and the need to consider the non-Medicaid patient segments, thorough due diligence should be conducted before a health system or hospital decides to pursue either an increased share of incremental Medicaid volume within existing operational structures or transformative innovative solutions that could potentially have adverse downstream financial implications.

## How health systems can close the Medicaid reimbursement gap



DSH, disproportionate share hospital; FFS, fee-for-service; MCO, managed care organization.

Given the lag times until some types of payment are made, the calculations should be based on multiple years of data.

If a hospital with adequate operational/expense management qualifies for DSH funds and the state provides generous supplemental payments, then it may already be breaking even on Medicaid (or even see that its Medicaid reimbursement exceeds its Medicare payments). However, if the hospital has access to only the base rate—or the base rate plus either DSH funds or some non-DSH supplementary payments—then a shortfall is likely; the extent of the shortfall depends on the state but, on average, could be around 10 percent or 15 percent. Very aggressive management of operational performance and expenses (as discussed above) could help narrow that gap to between 5 percent and 10 percent. To further narrow the gap, even more innovative solutions must be considered.

### Increasing Medicaid volume

For hospitals that are close to qualifying for Medicare and Medicaid DSH funds (and, in some cases,

state supplemental payment programs), a modest increase in Medicaid patient volume to meet the qualification thresholds could be beneficial—and better support the needs of the community. As noted earlier, Medicaid patients can be contribution positive even if a hospital is not yet “breaking even” on the program overall. Furthermore, because eligibility is often determined on a threshold basis, just a small change in the number of Medicaid patients served can alter a hospital's eligibility status. The volume increase can be achieved in a variety of ways, including geographically segmented marketing and advertising, a focus on growth in specific service lines (e.g., obstetrics), or targeted patient capture through emergency department and hospital outpatient visits. A longer-term solution might be clinic-based scheduling modifications that increase the number of Medicaid patients.

Another potential solution would be to develop one or more end-to-end tailored programs. Such programs could include but are not limited to:

- Value-based payment programs and provider-led health plans

Exhibit 6

## Approaches hospitals can consider based on their Medicaid reimbursement level

|                                    | Patient access                                                                                                                              | Targeted strategy                                                                                                                                                                           |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The “ample reimbursement” hospital | <ul style="list-style-type: none"> <li>• Innovative end-to-end programs</li> <li>• Targeted physician recruitment</li> </ul>                | <ul style="list-style-type: none"> <li>• Explore partnerships to sustain long-term pipeline for Medicaid population</li> </ul>                                                              |
| The “light reimbursement” hospital | <ul style="list-style-type: none"> <li>• Targeted service line growth</li> <li>• Targeted branding and marketing</li> </ul>                 | <ul style="list-style-type: none"> <li>• Joint ventures and partnership to draw in target volume</li> <li>• Targeted patient attachment strategies (e.g., in the emergency room)</li> </ul> |
| The “base rate” hospital           | <ul style="list-style-type: none"> <li>• Site-of-care analysis</li> <li>• Transfer protocols to ensure appropriate level of care</li> </ul> | <ul style="list-style-type: none"> <li>• Care delivery and post-acute partnerships (e.g., with a federally qualified health center)</li> </ul>                                              |

- Improved care delivery in line with episode-based payment models (e.g., an end-to-end pregnancy support program)
- Nonacute care delivery, including urgent care centers, as a way to build loyalty to the hospital

All strategies to increase the volume of Medicaid patients must be refined and tailored to each hospital to achieve the desired increase while minimizing potential risks. (For a discussion of these risks, see the sidebar on p. 6.) Because the thresholds often vary by state and include graduated or scaled payment structures, health systems cannot use a one-size-fits-all approach.

Even once the required thresholds have been met, it may make sense to further increase the volume of Medicaid patients to augment the supplemental payments received (Exhibit 5). Even in states where non-DSH supplemental payments are minimal, carefully managed hospitals that can qualify for and maximize appropriate DSH payments have been shown to obtain total Medicaid payments covering an average of 96 percent of costs.<sup>12</sup> If

additional state supplemental funding is available and obtained, then DSH-qualified hospitals may be able to reach or exceed the break-even point.

In addition to increasing Medicaid patient volume on an incremental basis with existing operational structures, other innovative solutions are available. The ideal strategy for a hospital depends on how close it comes to meeting or exceeding the Medicaid thresholds (Exhibit 6). To ensure success, the health system (and hospital) should explore a complement of different initiatives, including partnerships and joint ventures, targeted physician recruiting, and improved overall care delivery.

The range of options health systems have to improve the economics of delivering care to Medicaid beneficiaries are abundant. At many health systems, there are typically broader problems—with access, cost management, payer mix, and revenue optimization—that are putting margin pressure on the organization, pressure that is felt especially acutely in the Medicaid line of business.

<sup>12</sup> MACPAC, Improving data as the first step to a more targeted disproportionate share hospital policy, March 2016, macpac.gov.

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