CONTENTS

- Hospital Payment Modernization in Context
- Current State and Rationale for Change
- Consultative Process
- Hospital Payment Modernization Study Findings
- Hospital Payment Recommendations
- Considerations and Next Steps
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TODAY, MEDICAID HOSPITAL PAYMENTS ARE CHARACTERIZED BY AN OUTDATED BASE PAYMENT STRUCTURE AND HEAVY RELIANCE ON SUPPLEMENTAL PAYMENTS

Base Payments

39% of Medicaid hospital payments totaling $1.2B spending in SFY16
- Inpatient daily rates (per diems) that incentivize long lengths of stay
- Outdated methodology based on 1990s cost reports; well below current costs
- Highly variable across hospitals
- Unit of payment (day) not reflective of service acuity or resource intensity

SFY16 Medicaid Hospital Payments, $M

Supplemental Payments

61% of Medicaid hospital payments totaling $1.9B spending in SFY16
- Intended to bridge the gap between base payments and costs for Medicaid and uninsured patients
- 21 types of supplemental payments
- Not tied to patients or services
- Complex system that is neither transparent nor equitable across hospitals
- 20%+ of the State’s total Medicaid spending, highest in the country and twice the national average of 10%*

Base Payments, $1,192, 39%
Disproportionate Share Hospital (DSH), $1,172, 38%
Full Medicaid Payment (FMP), $351, 11%
Upper Payment Limit (UPL), $357, 12%

*Note: Includes DSH, UPL, and Waiver 1115 supplemental payments.

MODERNIZED HOSPITAL PAYMENT METHODOLOGY SHOULD BE BASED ON GUIDING PRINCIPLE OF MONEY FOLLOWS THE PERSON

The following principles have guided the development of a modernized hospital payment model.

- Money follows the person
- Reflects current policies, access trends, and costs
- Tied to value and clinical outcomes
- Adequately covers cost of care
- Equitable across hospitals
- Transparent and data-driven
- Sustainable mix of base and supplemental payments
- Promotes access to care for Medicaid beneficiaries

Source: Hospital Payment Modernization Project Analysis.
HOSPITAL PAYMENT MODERNIZATION IS PART OF THE BROADER COVERAGE AND DELIVERY SYSTEM REFORMS IN LOUISIANA SINCE 2012

Louisiana has made significant strides in how Medicaid and uninsured populations access care. Building on this strong foundation, the Medicaid program continues on its journey to pay for value and outcomes, as opposed to volume.

Future Vision
- Pay for value
- Promote the Triple Aim of better health, better care, and lower cost
- Vest accountability for quality and total cost of care with providers
- Transition to population health management

Source: Louisiana Department of Health.
MEDICAID MANAGED CARE HAS CHANGED THE PATTERN OF ACCESS TO CARE AND IMPROVED QUALITY OF CARE FOR MEDICAID BENEFICIARIES

Of the 22 HEDIS measures that Healthy Louisiana MCOs track, 11 measures met or exceeded benchmarks in 2016.

<table>
<thead>
<tr>
<th>CY16 Performance</th>
<th>HEDIS Measure Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of Care</strong></td>
<td><strong>Access/Availability of Care</strong></td>
</tr>
</tbody>
</table>
| 11 measures met or exceeded the NCQA Quality Compass South Central 50th percentile benchmark | • Chlamydia Screening in Women  
• Immunization Status for Adolescents  
• Human Papillomavirus Vaccine for Female Adolescents  
• Breast Cancer Screening  
• Cervical Cancer Screening  
• Antidepressant Medication Management—Acute  
• Antidepressant Medication Management—Continuation  
• Adherence to Antipsychotic Medications for Individuals with Schizophrenia | • Postpartum Care | • Ambulatory Care (AMB)—Outpatient Visits/1000 Member Months  
• Well-Child Visits in the First 15 Months of Life—6+ Visits |
| 9 measures were below benchmark, but had substantial improvement from the 2011 fee-for-service baseline | • Comprehensive Diabetes Care—HbA1c Testing  
• Childhood Immunization Status—Combo #2  
• Childhood Immunization Status—Combo #3 | • Timeliness of Prenatal Care  
• Child and Adolescents’ Access to Primary Care Practitioners:  
  • 25 months-6 years  
  • 7-11 years  
  • 12-19 years | • Adolescent Well-Care Visits  
• Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life |
| 2 measures were below benchmark and at/below baseline | • Child and Adolescents’ Access to Primary Care Practitioners (CAP) 12-24 months | • Ambulatory Care—ED Visits/1000 Member Months |
MEDICAID EXPANSION HAS RESULTED IN DRAMATIC IMPROVEMENT IN HEALTH INSURANCE COVERAGE AND ACCESS TO HEALTH CARE

As of February 12, 2018, 464,154 Louisianans had gained health insurance coverage through Medicaid expansion. According to the latest data, the uninsured rate has declined from 16.6% in 2013 to a historical low of 10.3% due to expansion. The Medicaid Expansion Dashboard shows the following outcomes:

### Lives Impacted

**Health Insurance**
- Total: 464,154
- 75% Enrollment
- 172,756

**Doctor Visits**
- Percentage of adults who had a doctor's office visit during the year:
  - 75%
  - 172,756

**Breast Cancer**
- Women who've gotten screening or diagnostic breast imaging:
  - 33,175
  - 317

**Colon Cancer**
- Adults who received colon cancer screening:
  - 19,903
  - 6,310
  - 274

### Outcome

#### Newly Diagnosed Diabetes
- 6,267 Adults newly diagnosed and now treated for diabetes.

#### Newly Diagnosed Hypertension
- 16,049 Adults newly diagnosed and now treated for hypertension.

#### Mental Health
- 45,606 Adults receiving specialized outpatient mental health services.
- 9,382 Adults receiving inpatient mental health services at a psychiatric facility.

#### Substance Use
- 7,999 Adults receiving specialized substance use outpatient services.
- 8,915 Adults receiving specialized substance use residential services.

Source: [http://www.ldh.la.gov/HealthyLaDashboard/](http://www.ldh.la.gov/HealthyLaDashboard/)

*Notes: Enrollment data as of 2/12/2018 and other statistics as of 2/5/2018.*
**AS A RESULT OF MEDICAID EXPANSION, MEDICAID HOSPITAL CLAIMS HAVE INCREASED WHILE UNINSURED CLAIMS HAVE DECREASED**

In CY16 post Medicaid expansion, inpatient service claims paid by Medicaid increased by 17% among high volume hospitals in the State. Outpatient Medicaid payments increased by 12%.

<table>
<thead>
<tr>
<th></th>
<th>Proportion of Inpatient Discharges By Medicaid and Uninsured Patients (CY15 and CY16 Post Expansion)</th>
<th>Proportion of Outpatient Claims By Medicaid and Uninsured Patients (CY15 and CY16 Post Expansion)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post Expansion 2016</strong></td>
<td><strong>91%</strong></td>
<td><strong>9%</strong></td>
</tr>
<tr>
<td><strong>(July-Dec)</strong></td>
<td>+17% in Medicaid</td>
<td>+12% in Medicaid</td>
</tr>
<tr>
<td><strong>CY15</strong></td>
<td>73%</td>
<td>27%</td>
</tr>
</tbody>
</table>

| Source: Hospital Payment Modernization Project Analysis. |
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  - Hospital Payment Recommendations
  - Considerations and Next Steps
Key Findings:
1. This analysis shows the extent to which current Medicaid base payments cover costs for inpatient and outpatient care.
2. Over three years, base payments accounted for only 63% of costs (outpatient and inpatient).
3. For inpatient services only, the 3-year average was 57%.
4. For outpatient services only, the 3-year average was 75%.

Source: Hospital Payment Modernization Project Analysis.
Notes: Excludes supplemental payments and cost settlements.
HOSPITAL PAYMENT SYSTEM IS FINANCIALLY UNSUSTAINABLE AND DOES NOT PROPERLY ACCOUNT FOR RISKS IN THE CHANGING LANDSCAPE

Supplemental payments are limited and already maximized by the Louisiana Department of Health. Failure to reduce reliance on supplemental payments puts member services and access to care at risk.

- Disproportionate Share Hospital” (DSH) reductions are mandated by Affordable Care Act; annual delays deepen out-year reductions
- Other types of supplemental payments are subject to a limit calculated based on fee-for-service Medicaid payments; managed care constrains Louisiana’s ability to grow these payments
- Supplemental payments considered to be “pass-through payments” under new federal rules must be phased out and ended completely by 2027
- There is increased federal scrutiny and limits on non-federal share sources of funds (e.g. provider donations, Intergovernmental Transfers)

Responsible course is to transition into more sustainable payment models

Source: Hospital Payment Modernization Project Analysis.
Transitioning from inpatient per diems to Diagnosis-Related Groups (DRGs) and shifting some supplemental payments towards base payments builds a hospital payment system that is modern, efficient, transparent, and sustainable.

1 **MODERN INDUSTRY STANDARD**
   - DRGs are the prevailing Medicaid payment methodology for inpatient stays with 36 states using DRGs (69%)
   - Industry standard for Medicare and commercial payers

2 **EFFICIENT**
   - DRG-based methods de-incentivize unnecessarily long hospital stays and tie payments to clinical complexity

3 **TRANSPARENT**
   - Strengthens the link between payments to people and care delivery
   - Equitable across hospitals with updated peer groupings
   - Data-driven, collectively developed solution

4 **SUSTAINABLE**
   - Shifting some supplemental payments to the new base payment lessens the gap between Medicaid payments and costs
   - Decreases reliance on supplemental payments
   - Protects hospitals and the state against exposure risk in the changing supplemental payment landscape

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Consultative Process

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Since November 2016, Louisiana Department of Health has facilitated a transparent, inclusive and consultative process with hospitals.

We have employed a data-driven analytical process to develop the hospital payment modernization proposal, including DRG design and financial modeling.

<table>
<thead>
<tr>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
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<tbody>
<tr>
<td>Nov</td>
<td>Dec</td>
<td>Jan</td>
</tr>
<tr>
<td>Nov</td>
<td>Dec</td>
<td>Jan</td>
</tr>
</tbody>
</table>

**Phase 1: Hospital Payment Study**

**Phase 2: DRG Model Design**

**Phase 3: Implementation Preparation**

**Go-Live Target:** January 1, 2019

**Current Project Focus**

**Hospital Project Participants**

- Louisiana Hospital Association
- Acadia Healthcare Company
- Brentwood Hospital
- Christus Health
- Franciscan Missionaries of Our Lady Health
- HealthSouth Corporation
- HCA MidAmerica Division
- Lafayette General Health
- Lake Charles Memorial Health System
- LCMC Health
- Louisiana Association of Behavioral Health
- North Oaks Health System
- Ochsner Health System
- Promise Hospital of Baton Rouge
- Regional Health System of Acadiana
- River Oaks Hospital
- Rural Hospital Coalition
- St. James Parish Hospital
- University Health Shreveport and Monroe
- Willis-Knighton Health System
- Woman’s Hospital
LDH conducted many meetings with hospital CEOs, CFOS, and medical schools to design the hospital payment modernization proposal.

### Work Group Meeting Timeline, Participants, and Topics

<table>
<thead>
<tr>
<th>DATE</th>
<th>PARTICIPANTS</th>
<th>TOPICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/30/16</td>
<td>CEOs</td>
<td>The Case for Hospital Payment Transformation</td>
</tr>
<tr>
<td>02/06/17</td>
<td>CFOs</td>
<td>Hospital Payment Study Baseline Review (Medicaid Data)</td>
</tr>
<tr>
<td>03/22/17</td>
<td>CFOs</td>
<td>Hospital Payment Study Baseline Review (Medicaid, Uninsured Data)</td>
</tr>
<tr>
<td>04/06/17</td>
<td>CEOs</td>
<td>Hospital Payment Study Results and Next Steps (Expansion Impact Analysis, Refined Cost Coverage Data, Hospital DRG Workgroup)</td>
</tr>
<tr>
<td>05/24/17</td>
<td>CEOs</td>
<td>Guiding Principles for Hospital Payment Modernization; Updated Pre-Expansion Cost Coverage Analysis; Expansion Impact Analysis</td>
</tr>
<tr>
<td>06/19/17</td>
<td>CFOs</td>
<td>Recap of May 24 CEO Meeting; Next Steps for DRG Modeling Project</td>
</tr>
<tr>
<td>08/30/17</td>
<td>CFOs</td>
<td>DRG design meeting #1: Introduction to DRG Modeling Project, Review Hospital Claims and Costs Data, Review Updated Cost Coverage Data</td>
</tr>
<tr>
<td>09/11/17</td>
<td>CFOs</td>
<td>DRG design meeting #2: Policy Considerations for Hospital Peer Groups, High-Cost Outlier Reimbursement, Capital Cost Reimbursement</td>
</tr>
<tr>
<td>10/10/17</td>
<td>CFOs</td>
<td>DRG design meeting #3: Data validation updates, deep dive on psychiatric/rehabilitation data, GME costing/financial modeling next steps</td>
</tr>
<tr>
<td>11/13/17</td>
<td>CEOs &amp; CFOs</td>
<td>Financial modeling meeting #1: Base rates only</td>
</tr>
<tr>
<td>11/20/17</td>
<td>GME Reps</td>
<td>First meeting of the GME Workgroup to introduce hospital payment GME initiative, solicit perspectives on status quo, and discuss guiding principles for state decision making on Medicaid GME payment policy</td>
</tr>
<tr>
<td>12/14/17</td>
<td>CEOs, CFOs &amp; GME Reps</td>
<td>Updated fiscal models with consideration of GME, teaching peer groups, high-volume Medicaid multipliers, capital costs, and risk corridors</td>
</tr>
<tr>
<td>1/26/18</td>
<td>CEOs &amp; CFOs</td>
<td>Presentation of final proposed fiscal model and supplemental payments redistribution</td>
</tr>
<tr>
<td>2/8/18</td>
<td>CEOs &amp; CFOs</td>
<td>Presentation of updated fiscal model with changes to capital cost add-on, rural hospitals per diem rates, and outlier payments</td>
</tr>
</tbody>
</table>

### Additional One-On-One Consultations

- Woman’s Hospital (9/21)
- Franciscan Missionaries of Our Lady Health System (10/25 & 1/22)
- Lake Charles Memorial Health System (10/27)
- North Oaks Health System (10/30 & 1/25)
- River Oaks/Brentwood Hospitals (11/13)
- Ochsner Health System (11/13)
- Lafayette General Health (11/15)
- Rural Hospital Coalition (11/20 & 1/12)
- Christus Health (11/27 & 1/30)
- Willis-Knighton Health System (12/14 & 1/24)
- LCMC Health (10/24, 12/4, 12/21 & 1/31)
- Tulane University School of Medicine (12/21)
- Louisiana State University School of Medicine (12/21)
- HCA MidAmerica Division (1/25)
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COST COVERAGE VARIES WIDELY ACROSS HOSPITALS WITH MOST HOSPITALS LOSING MONEY ON MEDICAID BASE PAYMENTS

Key Findings:
1. There is wide disparity in the extent to which Medicaid payments align with hospital costs (each point below the red line represents hospitals for which Medicaid costs exceed base payments).
2. The disparity is particularly pronounced amongst rural and psych hospitals, while the urban and teaching hospitals cluster more tightly around the average, but well below costs.

Source: Hospital Payment Modernization Project Analysis. Includes 176 hospitals from all peer groups.
**SUPPLEMENTAL PAYMENTS ARE NOT TIED TO INPATIENT SERVICE VOLUME**

**Key Findings:**
1. There is little relationship between a hospital’s inpatient (IP) Medicaid volume and the amount of supplemental payments received.
2. Each point on the graph represents a single hospital’s data on FY17 IP claims (x-axis) and FY17 supplemental payments (y-axis).
3. The 17 hospitals that receive 80% of supplemental payments generate 42% of Medicaid IP volume.
4. 6 of the 17 hospitals account for ½ of the total supplemental payments.

Source: Hospital Payment Modernization Project Analysis.
Notes: Uses FY17 IP Claims and supplemental payments. Graph only shows data for the 88 hospitals with supplemental payments.
SUPPLEMENTAL PAYMENTS ARE NOT TIED TO OUTPATIENT SERVICE VOLUME

Key Findings:
1. There is also little relationship between a hospital’s outpatient (OP) Medicaid volume and the amount of supplemental payments received.
2. Each point on the graph represents a single hospital’s data on FY17 OP claims (x-axis) and FY17 supplemental payments (y-axis).
3. The 17 hospitals that receive 80% of supplemental payments generate 53% of Medicaid OP volume.
4. 6 of the 17 hospitals account for ½ of the total supplemental payments.

Source: Hospital Payment Modernization Project Analysis.
Notes: Uses FY17 IP Claims and supplemental payments. Graph only shows data for the 88 hospitals with supplemental payments.
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CHANGES IN HOW AND WHERE PEOPLE RECEIVE CARE HAVE CREATED MISALIGNMENT BETWEEN HOSPITAL PAYMENTS AND SERVICES

As expanded Medicaid coverage and managed care improves access, Louisiana has an opportunity to deploy state resources more efficiently and equitably through a modernized hospital payment system.
### The DRG Payment Methodology Aligns with Payment Principles

<table>
<thead>
<tr>
<th>Payment principles drive methodology</th>
<th>DRG payment methodology aligns with principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money follows the person</td>
<td>✓ Directs resources to high Medicaid volume hospitals</td>
</tr>
<tr>
<td>Reflects current policies, access trends, and costs</td>
<td>✓ Uses current costs and claims data to set payment rates (FY15-17 data used)</td>
</tr>
<tr>
<td>Tie to value and clinical outcomes</td>
<td>✓ Adjusts DRGs for clinical services and acuity</td>
</tr>
<tr>
<td>Adequately covers cost of care</td>
<td>✓ Reduces variation in cost coverage among hospitals (Cost coverage corridor of 70-110% for inpatient services)</td>
</tr>
<tr>
<td>Equitable across hospitals</td>
<td>✓ Simplifies peer groups and reduces cost coverage disparity across/within groups</td>
</tr>
<tr>
<td>Transparent and data-driven</td>
<td>✓ Has followed an inclusive process with extensive data validation, analysis and financial modeling</td>
</tr>
<tr>
<td>Sustainable mix of base and supplemental payments</td>
<td>✓ Rebalances mix of base and supplemental payments to mitigate risks associated with supplemental payments</td>
</tr>
<tr>
<td>Promotes access to care for Medicaid beneficiaries</td>
<td>✓ Protects rural hospitals and directs resources to teaching hospitals</td>
</tr>
</tbody>
</table>
THE DRG METHODOLOGY LINKS PAYMENTS TO SERVICES WITH 61% OF PROJECTED HOSPITAL PAYMENTS MADE AS BASE PAYMENTS

<table>
<thead>
<tr>
<th>SFY16 Actuals with Per Diem Rates</th>
<th>SFY17 Projected with DRG methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Payments, 39%</strong></td>
<td><strong>Base Payments, 61%</strong></td>
</tr>
<tr>
<td><strong>Supplemental Payments, 61%</strong></td>
<td><strong>Supplemental Payments, 39%</strong></td>
</tr>
</tbody>
</table>

**SFY17 Projection Results**

- **Base Payments – Per Diems:** 61% of Medicaid hospital payments totaling $2.17B of projected spending
- **Supplemental Payments:** 39% of Medicaid hospital payments totaling $1.37B of projected spending
- **21% of supplemental payments ($379M)** redirected to base payments, which links payments to services provided and improves financial sustainability

Source: Hospital Payment Modernization Project Analysis.

*Note: Includes DSH, UPL, and Waiver 1115 supplemental payments. SFY17 projections show the results of the DRG payment methodology.*
IN THE NEW DRG METHODOLOGY, HOSPITAL BASE PAYMENTS COVER 87% OF INPATIENT HOSPITAL COSTS

Key Findings:
1. This analysis shows the extent to which current Medicaid base payments cover costs for inpatient care.

2. The new DRG methodology projects base payments to account for 87% of the cost of inpatient hospital stays, which is a 38% improvement from the current 63%.

Medicaid Current and Projected Inpatient Cost Coverage
(SFY17 current methodology and projected with DRG methodology)
Medicaid IP Claims Only and Excludes Supplemental Payments

Source: Hospital Payment Modernization Project Analysis.
Notes: Excludes supplemental payments and cost settlements. Decision was made to not change the Outpatient cost coverage at this time.
Hospital Payment Modernization in Context
Current State and Rationale for Change
Consultative Process To-Date
Hospital Payment Modernization Study Findings
Hospital Payment Recommendations

Considerations and Next Steps
THE DEPARTMENT OF HEALTH’S FOCUS IS TO FINALIZE THE DRG MODEL DESIGN AND PREPARE FOR IMPLEMENTATION TARGETED FOR JANUARY 1, 2019

<table>
<thead>
<tr>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>Dec</td>
<td>Jan</td>
</tr>
</tbody>
</table>

Phase 1: Hospital Payment Study

Phase 2: DRG Model Design

Phase 3: Implementation Preparation

1) State Plan Amendments
2) State Administrative Rulemaking
3) Medicaid policy and claims payment system changes

Go-Live Target: January 1, 2019
CONCLUSION

- **Multi-year journey:** Hospital payment modernization is the first step in a multi-year journey to ensure that Louisiana’s Medicaid hospital payments are transparent and equitable and designed to achieve value and better health outcomes.

- **Modernized:** Shifting to the DRG methodology for base payments creates a modernized hospital payment system consistent with industry standards.

- **Sustainable:** Shifting payment mix from supplemental to base payments mitigates the risks associated with reliance supplemental payments and ensures sustainability of the hospital system.
GLOSSARY OF TERMS

- **DSH**: Disproportionate share hospital payments are a type of supplemental payment to stabilize funding for safety-net hospitals that serve large numbers of uninsured and Medicaid patients. They are capped at the State’s allotment of federal financial participation.

- **UPL**: Upper limit payments are a supplemental payment to compensate providers for low Medicaid payments. They account for the difference between total base payments and the maximum payment level allowed for the services under federal law (often based on Medicare rates).

- **FMP**: Full Medicaid Payment is the UPL equivalent for services provided to managed care enrollees and is incorporated into health plan capitation rates.
## THE DRG PAYMENT METHODOLOGY DESIGN CONSIDERATIONS (1 OF 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>Design Consideration</th>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Categories</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital peer groups</td>
<td></td>
<td>13 peer groups</td>
<td>8 peer groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Major Teaching</td>
<td>1. Teaching 1 (Must have at least 100 interns/residents, includes Children's)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Children's</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Minor Teaching</td>
<td>2. Teaching 2 (Must have at least 10 interns/residents)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Non Teaching &lt;58 beds</td>
<td>3. Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Non Teaching 58-138 beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Non Teaching &gt; 138 beds</td>
<td></td>
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<td></td>
<td></td>
<td>7. Rural</td>
<td>4. Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Urban Distinct Psych Unit</td>
<td>5. All Psychiatric, any peer group including Teaching, Urban, and Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Rural Distinct Psych Unit</td>
<td></td>
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<td></td>
<td></td>
<td>10. Free Standing Psych</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Free Standing Rehab</td>
<td>6. All Rehab, any peer group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Long Term Acute Hospitals</td>
<td>7. No change, not in DRG system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. State Owned Hospitals</td>
<td>8. No change, not in DRG system</td>
</tr>
<tr>
<td>Hospitals with high Medicaid volume</td>
<td>No explicit preferred treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural hospitals</td>
<td>110% of median per diem rate and 105% cost coverage</td>
<td></td>
<td>DRG methodology with 105% cost coverage</td>
</tr>
</tbody>
</table>

- Hospitals with 20-40% of volume in Medicaid gets a 10% bump in payment and hospitals with 40%+ Medicaid volume or 5% of total Medicaid volume statewide among acute care hospitals gets a 20% bump.

- Rural hospitals receive 110% of median per diem rate and 105% cost coverage.

- Hospitals with high Medicaid volume have no explicit preferred treatment.
### The DRG Payment Methodology Design Considerations (2 of 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>Design Consideration</th>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Components of Base Payments</td>
<td>Medical education Component of the per diem rate (Hospital specific)</td>
<td>Hospital specific add-on, paid by LDH, outside of MCO capitation rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Capital costs Component of the per diem rate (Hospital specific)</td>
<td>Hospital specific add-on (high/low by peer group)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outlier payments $10M pool</td>
<td>$100M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatric hospitals Per diem not adjusted for acuity</td>
<td>Per diem adjusted for acuity and length of stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical rehab cases Per diem not adjusted for acuity</td>
<td>Per diem adjusted for acuity and length of stay</td>
<td></td>
</tr>
<tr>
<td>Adjustments</td>
<td>Cost coverage corridors None</td>
<td>Minimum cost coverage in IP base payments of 70% with an acute care cap of 110%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplemental payments Based on historical agreements not tied to services provided</td>
<td>Shift 21% of supplemental payments to base payments ($379M)</td>
<td></td>
</tr>
</tbody>
</table>