Healthy Louisiana

RESPONSE TO HCR 86 OF THE 2017 REGULAR LEGISLATIVE SESSION

March 2018

CONTENTS

Healthy Louisiana

CONTENTS

Healthy Louisiana

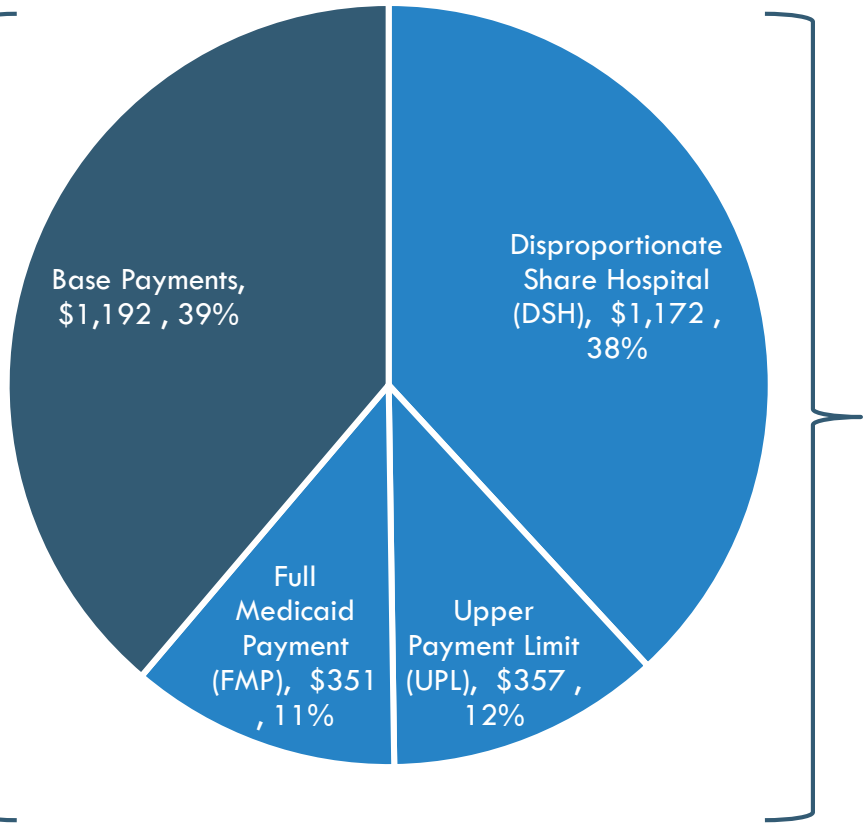
TODAY, MEDICAID HOSPITAL PAYMENTS ARE CHARACTERIZED BY AN OUTDATED BASE PAYMENT STRUCTURE AND HEAVY RELIANCE ON SUPPLEMENTAL PAYMENTS

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- Outdated methodology based on 1990s cost reports; well below current costs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%*

Source: Hospital Payment Modernization Project Analysis. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/nov/1916_mann_integrating_medicaid_suppl_payments.pdf
*Note: Includes DSH, UPL, and Waiver 1115 supplemental payments.

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

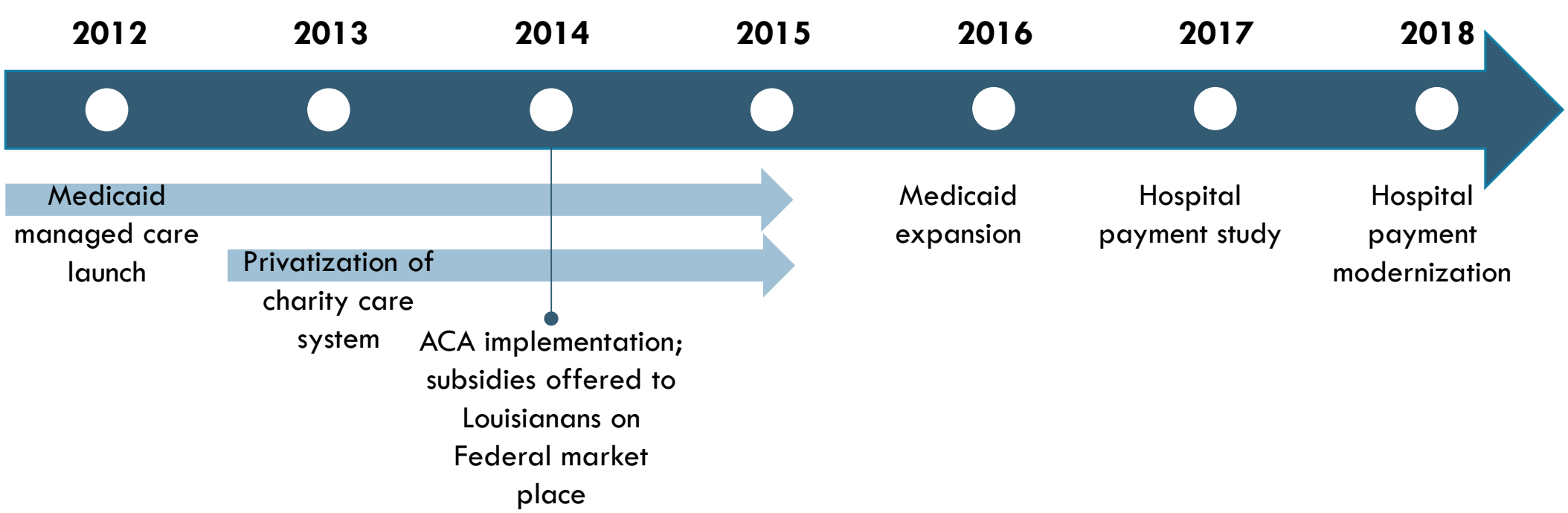
The following principles have guided the development of a modernized hospital payment model.

- 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.

CY16 Performance	HEDIS Measure Domain		
	Effectiveness of Care	**Access/Availability of Care**	**Utilization and Relative Resource Use**
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

Source: Louisiana Department of Health CY16 MCO Performance

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.

UNINSURED RATE HAS DECLINED FROM 16.6% IN 2013 TO A HISTORICAL LOW OF 10.3% DUE TO EXPANSION.

MEDICAID EXPANSION DASHBOARD

LIVES IMPACTED	OUTCOME
464,154	**Health Insurance** Adults enrolled in Medicaid Expansion as of February 12, 2018
75% 172,756	**Doctor Visits** Percentage of adults who had a doctor's office visit during the year*,** Adults who visited a doctor and received new patient or preventive healthcare services*
33,175 317	**Breast Cancer** Women who've gotten screening or diagnostic breast imaging* Women diagnosed with breast cancer as a result of this imaging*
19,903 6,310 274	**Colon Cancer** Adults who received colon cancer screening* Adults with colon polyps removed: colon cancer averted* Adults diagnosed with colon cancer as a result of this screening*

LIVES IMPACTED	OUTCOME
6,267	**Newly Diagnosed Diabetes** Adults newly diagnosed and now treated for Diabetes*
16,049	**Newly Diagnosed Hypertension** Adults newly diagnosed and now treated for Hypertension*
45,608 9,382	**Mental Health** Adults receiving specialized outpatient mental health services* Adults receiving inpatient mental health services at a psychiatric facility*
7,999 8,915	**Substance Use** Adults receiving specialized substance use outpatient services* Adults receiving specialized substance use residential services*

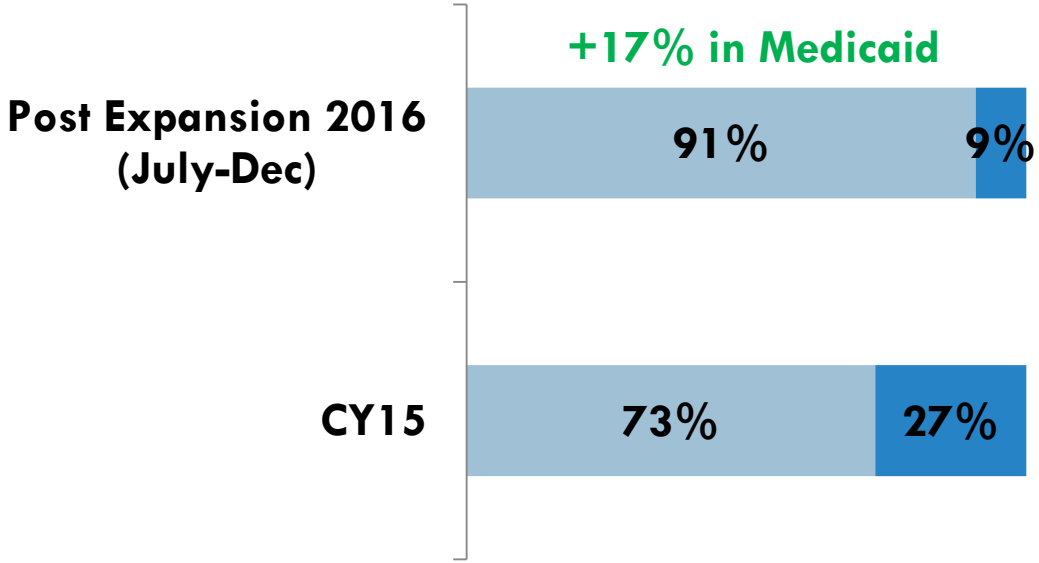
Source: http://www.ldh.la.gov/HealthyLaDashboard/

*Notes: Enrollment data as of 2/12/2018 and other statistics as of 2/5/2018.

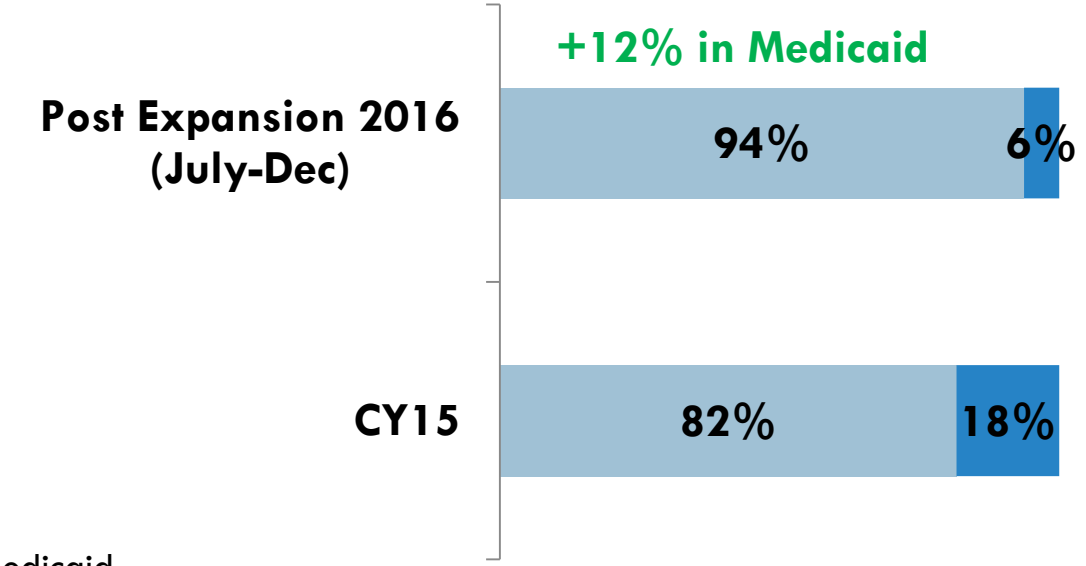
AS A RESULT OF MEDICAID EXPANSION, MEDICAID HOSPITAL CLAIMS HAVE INCREASED WHILE UNINSURED CLAIMS HAVE DECREASED

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%.

Proportion of Inpatient Discharges By Medicaid and Uninsured Patients (CY15 and CY16 Post Expansion)



Proportion of Outpatient Claims By Medicaid and Uninsured Patients (CY15 and CY16 Post Expansion)



Medicaid
Uninsured

Source: Hospital Payment Modernization Project Analysis.

CONTENTS

Healthy Louisiana

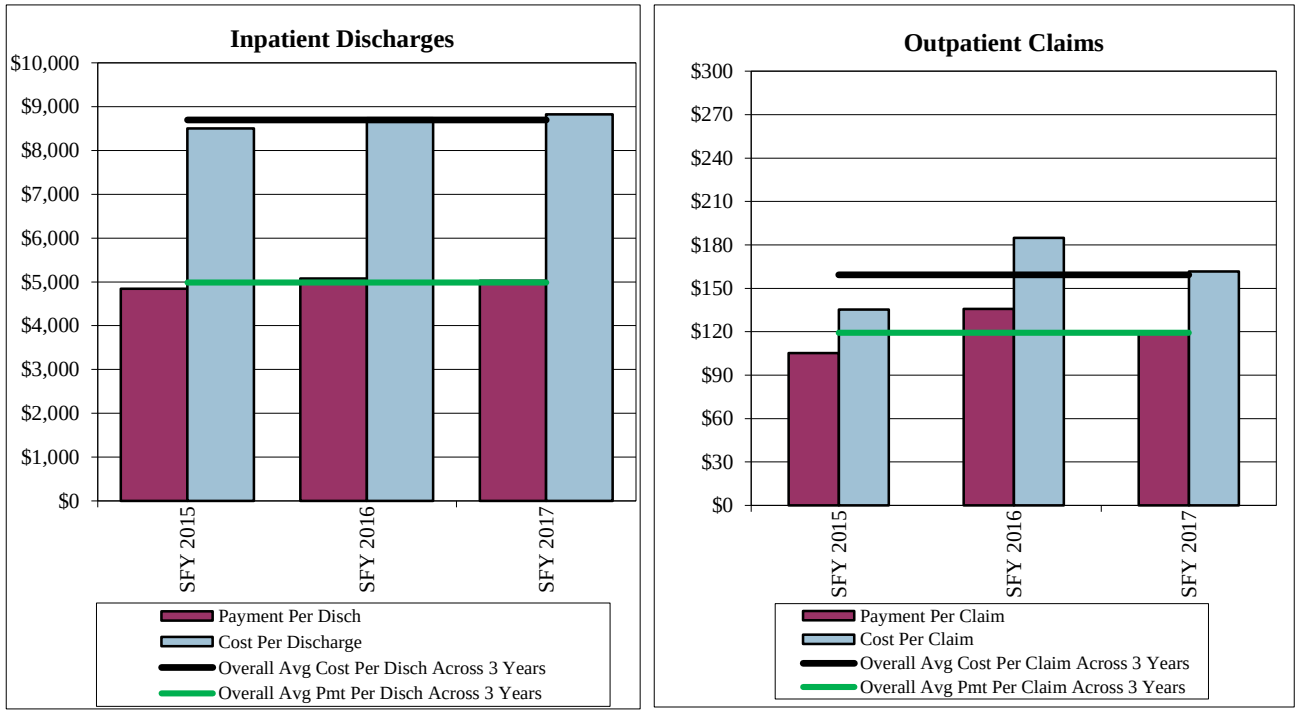
HOSPITAL BASE PAYMENTS COVER ONLY 63% OF HOSPITAL COSTS

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 <u>inpatient</u> services only, the 3-year average was 57%.
4. For <u>outpatient</u> services only, the 3-year average was 75%.

Trends in Medicaid Payment Per Case and Cost Per Case (SFY15-17)

Medicaid Claims Only and Excludes Supplemental Payments



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 MEDICAID HOSPITAL PAYMENTS TO A NEW SYSTEM OF DIAGNOSIS-RELATED GROUPS MODERNIZES HOW HOSPITALS ARE PAID

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

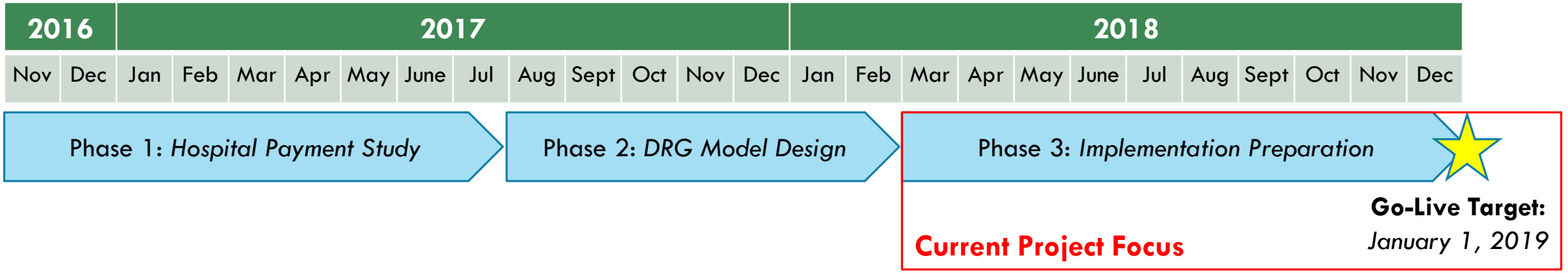
Source: Hospital Payment Modernization Project Analysis. https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/.

CONTENTS

Healthy Louisiana

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.



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

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

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)

CONTENTS

Healthy Louisiana

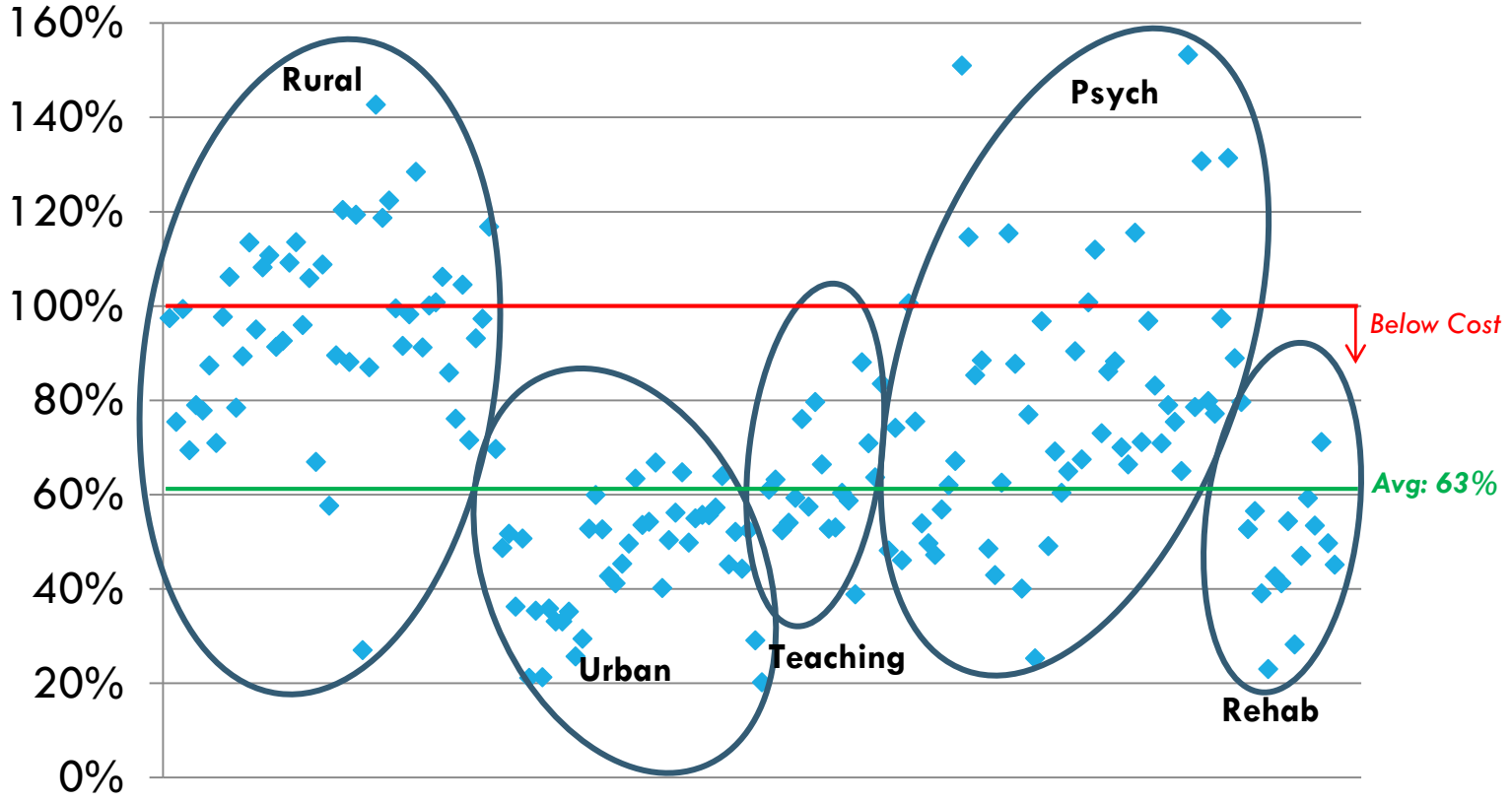
COST COVERAGE VARIES WIDELY ACROSS HOSPITALS WITH MOST HOSPITALS LOSING MONEY ON MEDICAID BASE PAYMENTS

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.

Cost Coverage By Hospital Medicaid IP & OP, SFY17

Medicaid Claims Only and Excludes Supplemental Payments



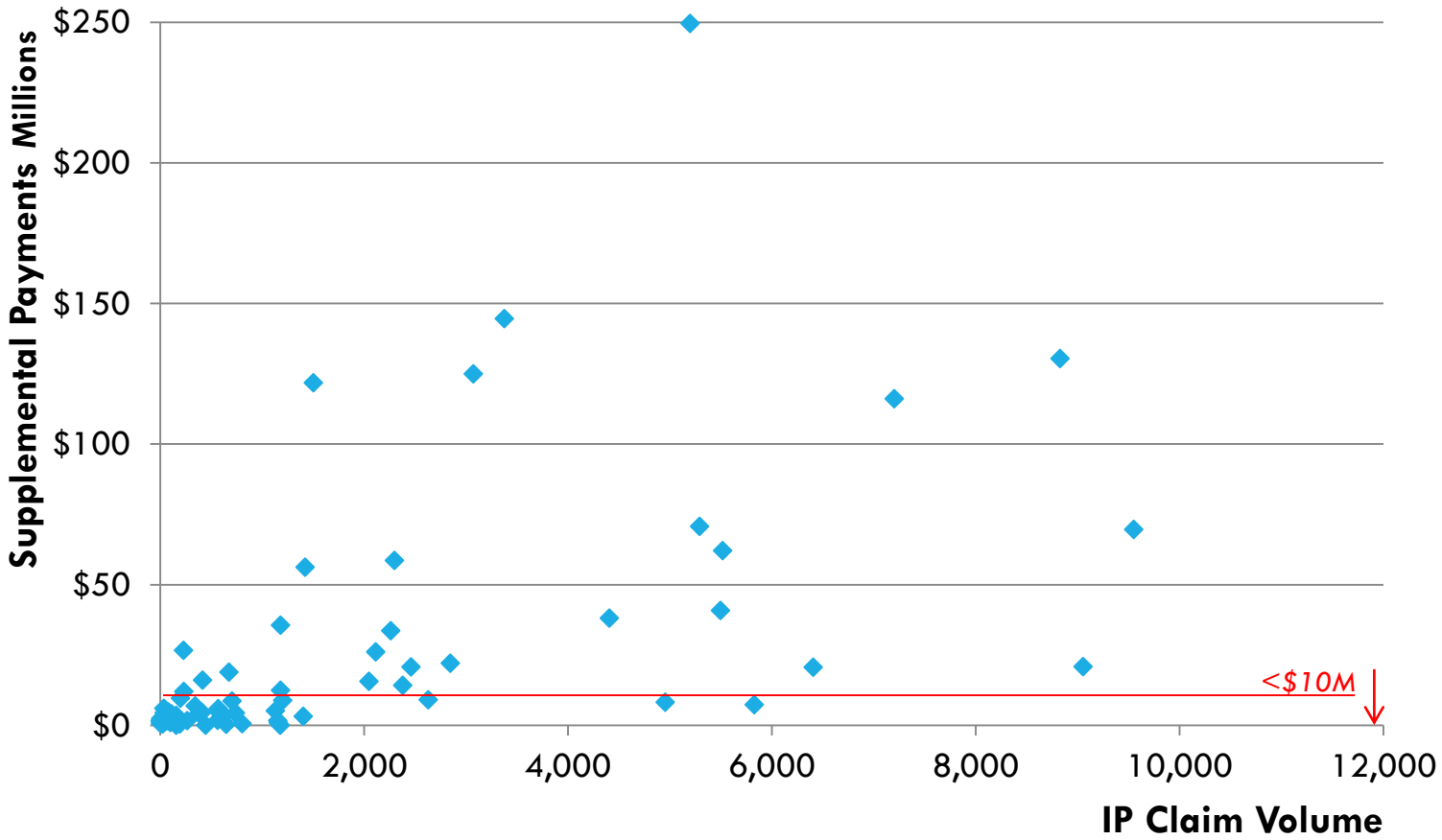
Source: Hospital Payment Modernization Project Analysis. Includes 176 hospitals from all peer groups.

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.

Distribution of Supplemental Payments Against Medicaid IP Claims, FY17

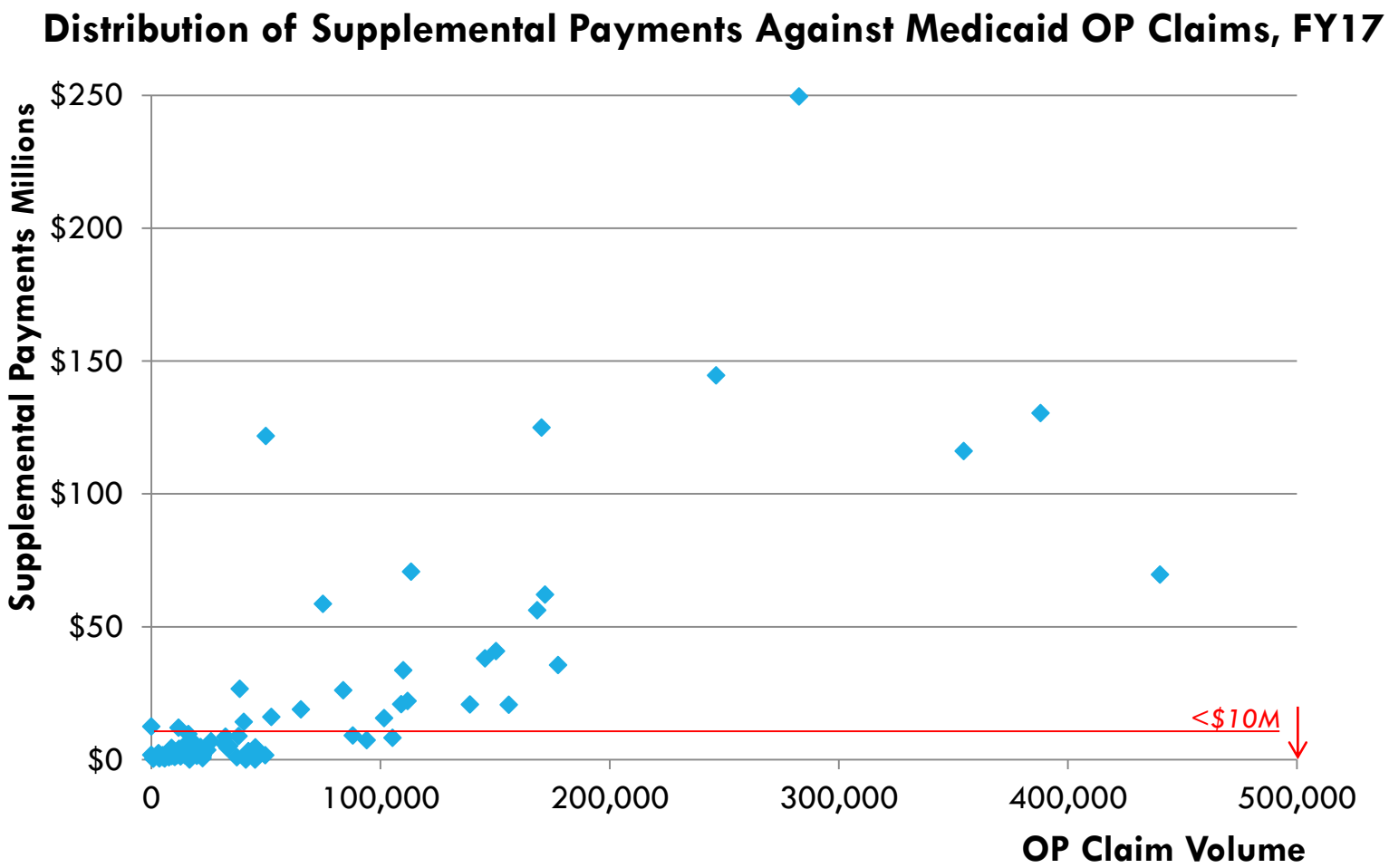


Source: Hospital Payment Modernization Project Analysis.
Notes: Uses FY17 IP Claims and supplemental payments. Graph only shows data for the 88 hospitals with supplemental payments.

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.

CONTENTS

Healthy Louisiana

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.

WITH MEDICAID COVERAGE EXPANSION AND IMPLEMENTATION OF MANAGED CARE

ACCESS AND BENEFICIARY CHOICE IMPROVE , CHANGING UTILIZATION PATTERNS

CREATES AN IMPERATIVE TO REALIGN THE HOSPITAL PAYMENTS WITH UTILIZATION

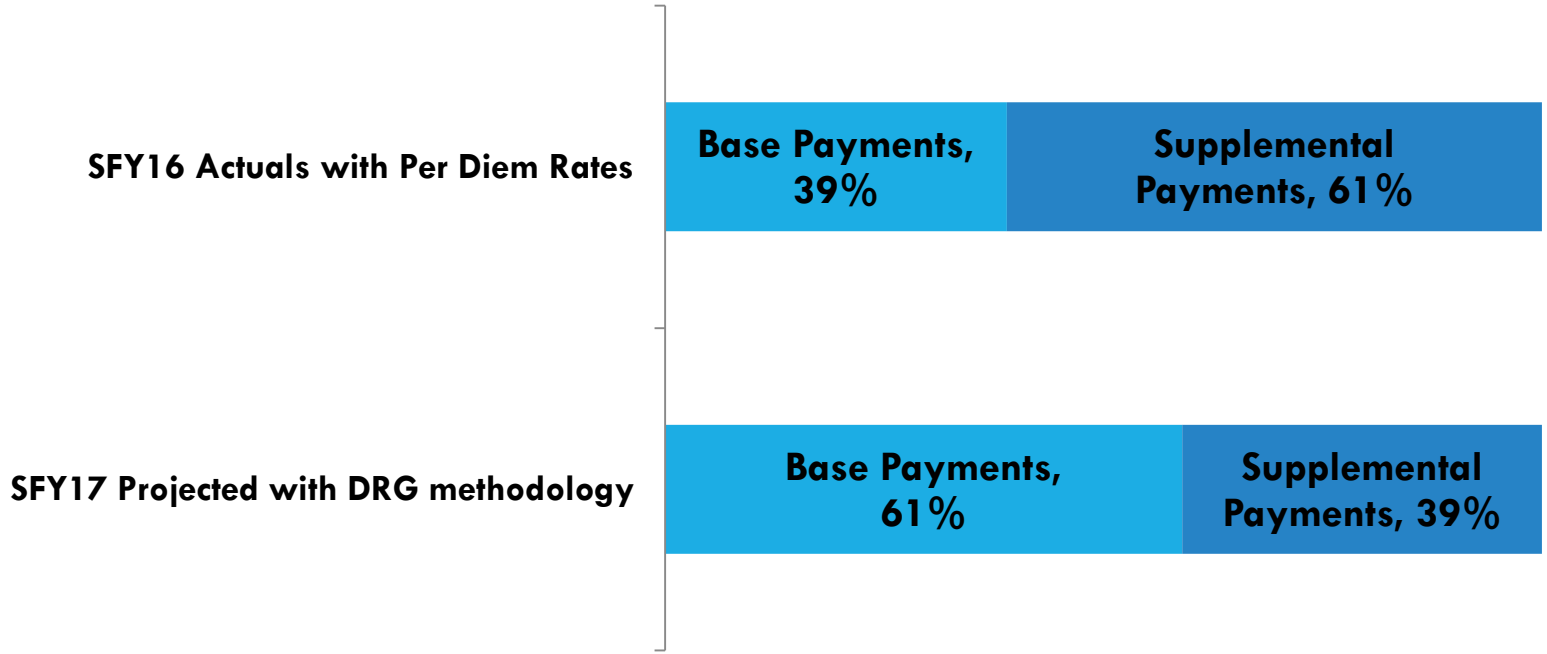
WITH DRG-BASED HOSPITAL PAYMENT METHODOLOGY, PAYMENTS FOLLOW THE PATIENT

THE DRG PAYMENT METHODOLOGY ALIGNS WITH PAYMENT PRINCIPLES

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

THE DRG METHODOLOGY LINKS PAYMENTS TO SERVICES WITH 61% OF PROJECTED HOSPITAL PAYMENTS MADE AS BASE PAYMENTS

Proportion of Medicaid Payments From Base Payments vs. Supplemental Payments, *SFY16 Actuals with Per Diems and SFY17 Projected with DRGs*



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.

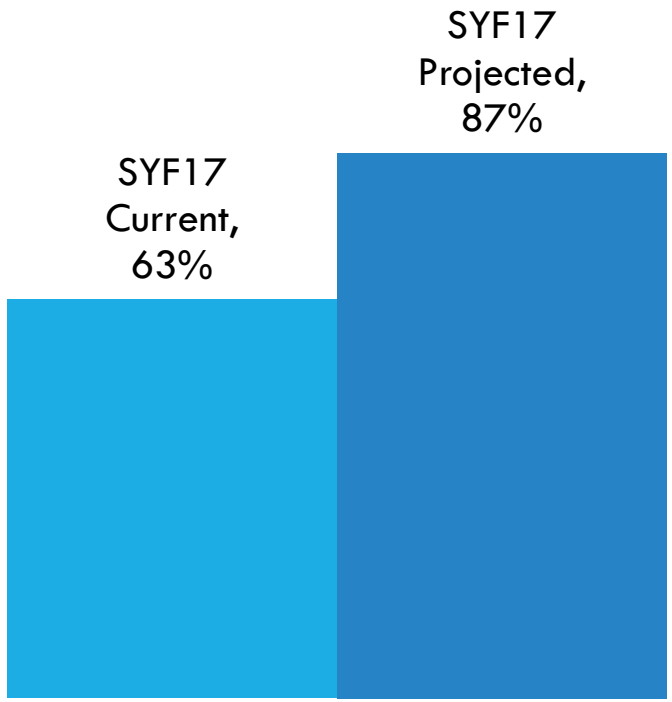
IN THE NEW DRG METHODOLOGY, HOSPITAL BASE PAYMENTS COVER 87% OF INPATIENT HOSPITAL COSTS

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

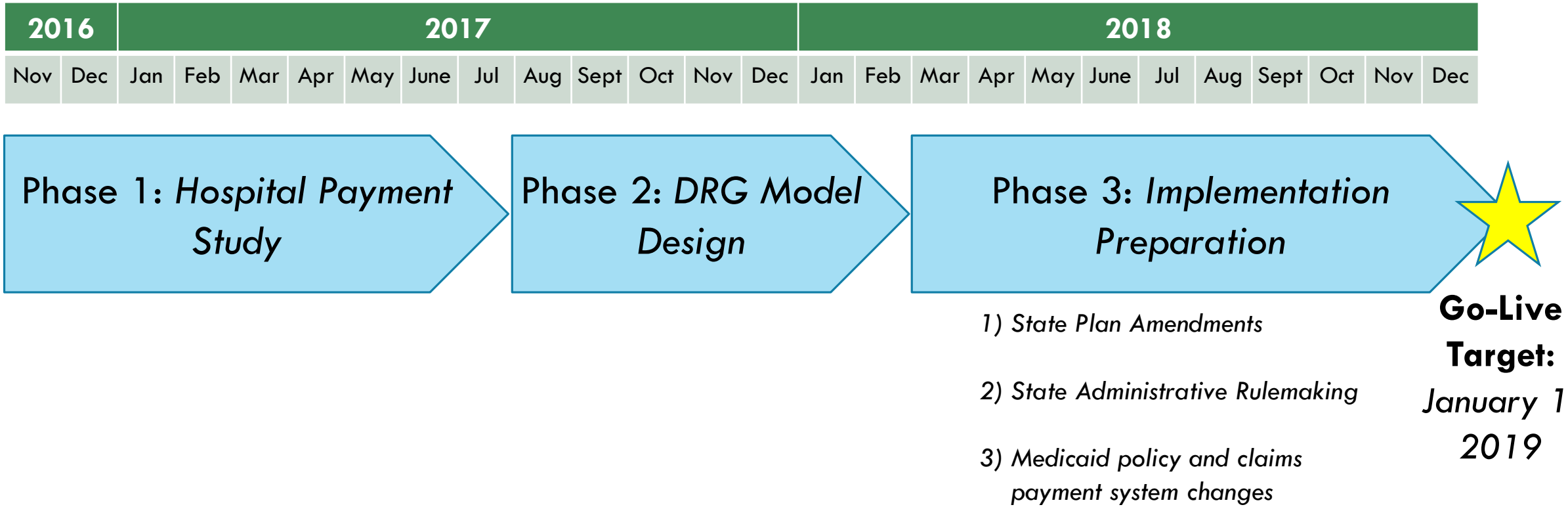


Source: Hospital Payment Modernization Project Analysis.
Notes: Excludes supplemental payments and cost settlements. Decision was made to not change the Outpatient cost coverage at this time.

CONTENTS

Healthy Louisiana

THE DEPARTMENT OF HEALTH'S FOCUS IS TO FINALIZE THE DRG MODEL DESIGN AND PREPARE FOR IMPLEMENTATION TARGETED FOR 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.

APPENDIX

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)

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

THE DRG PAYMENT METHODOLOGY DESIGN CONSIDERATIONS (2 OF 2)

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