



**Healthy
Louisiana**

THE CASE FOR HOSPITAL PAYMENT TRANSFORMATION

November 30, 2016

LOUISIANA RANKS LAST IN OVERALL HEALTH

- 50th in **health behavior** (e.g., physical inactivity, obesity, % of adult population that smokes)
- 50th in **community and environmental factors** (e.g., children in poverty, infectious disease)
- 50th in **clinical care** (e.g., % of live births that are low birthweight, preventable hospitalizations)
- 50th in **outcomes** (e.g., infant mortality, premature death, cardiovascular deaths)

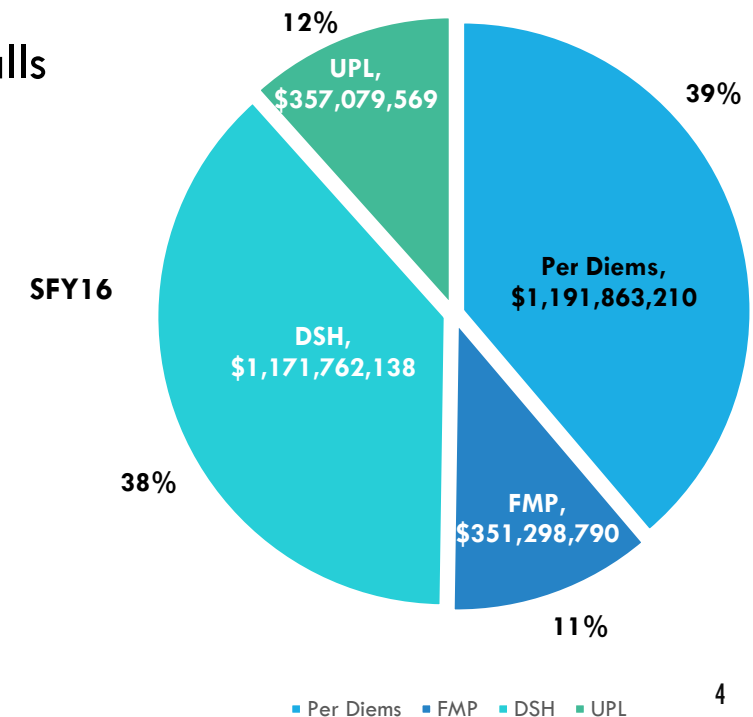
Source: “America’s Health Rankings 2015 Annual Report,” United Health Foundation, American Public Health Association (APHA)

HOW MEDICAID PAYS FOR HEALTH CARE IS PART OF THE PROBLEM

- We pay for volume, not value
- We focus on disease, not health
- We pay on a Fee for Service basis, even in managed care
- Doctors paid per procedure at 60-70% of Medicare rates
- Hospitals paid per diems and supplemental payments

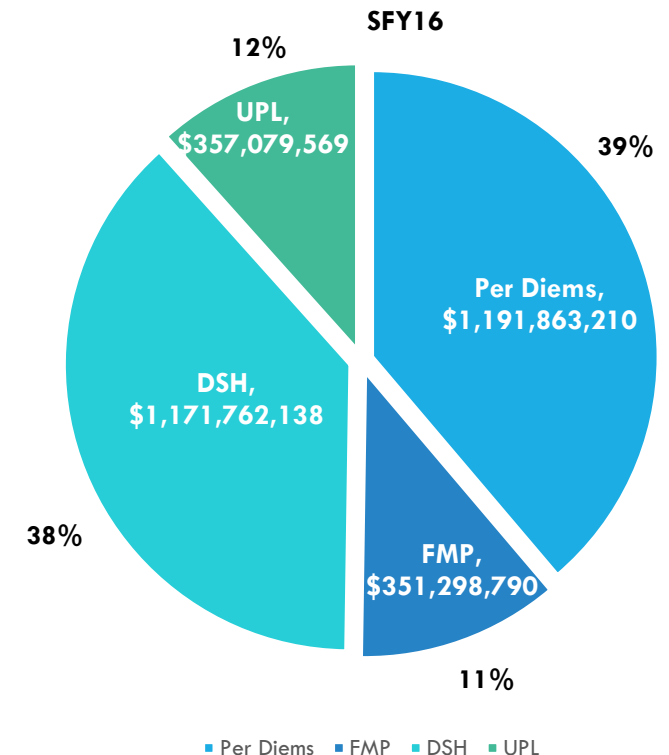
HOSPITAL BASE PAYMENTS

- **39% of total hospital payments are made in “base rate” per diems**
 - Daily rates reward longer stays, provide no financial incentive to avoid unnecessary days
 - No transparency into actual clinical activities (inputs) or health outcomes (outputs)
 - Based on 1990s cost reports
 - Successively cut (26% since 2008) in response to SGF shortfalls
 - Vary widely across hospitals
 - Universally below cost



HOSPITAL SUPPLEMENTAL PAYMENTS

- 61% of total hospital payments are made in supplemental payments
 - Not tied to patients or services
 - 3 types of supplemental payments
 - Disproportionate Share Hospital (DSH)
 - Upper Payment Limit (UPL)
 - Full Medicaid Payment (FMP)
 - All designed to bridge gap between “base” (per diem) payments and cost
 - Vary widely across hospitals
 - Often depend on non-SGF sources to draw down federal matching dollars
 - Inter-Governmental Transfers (IGT)

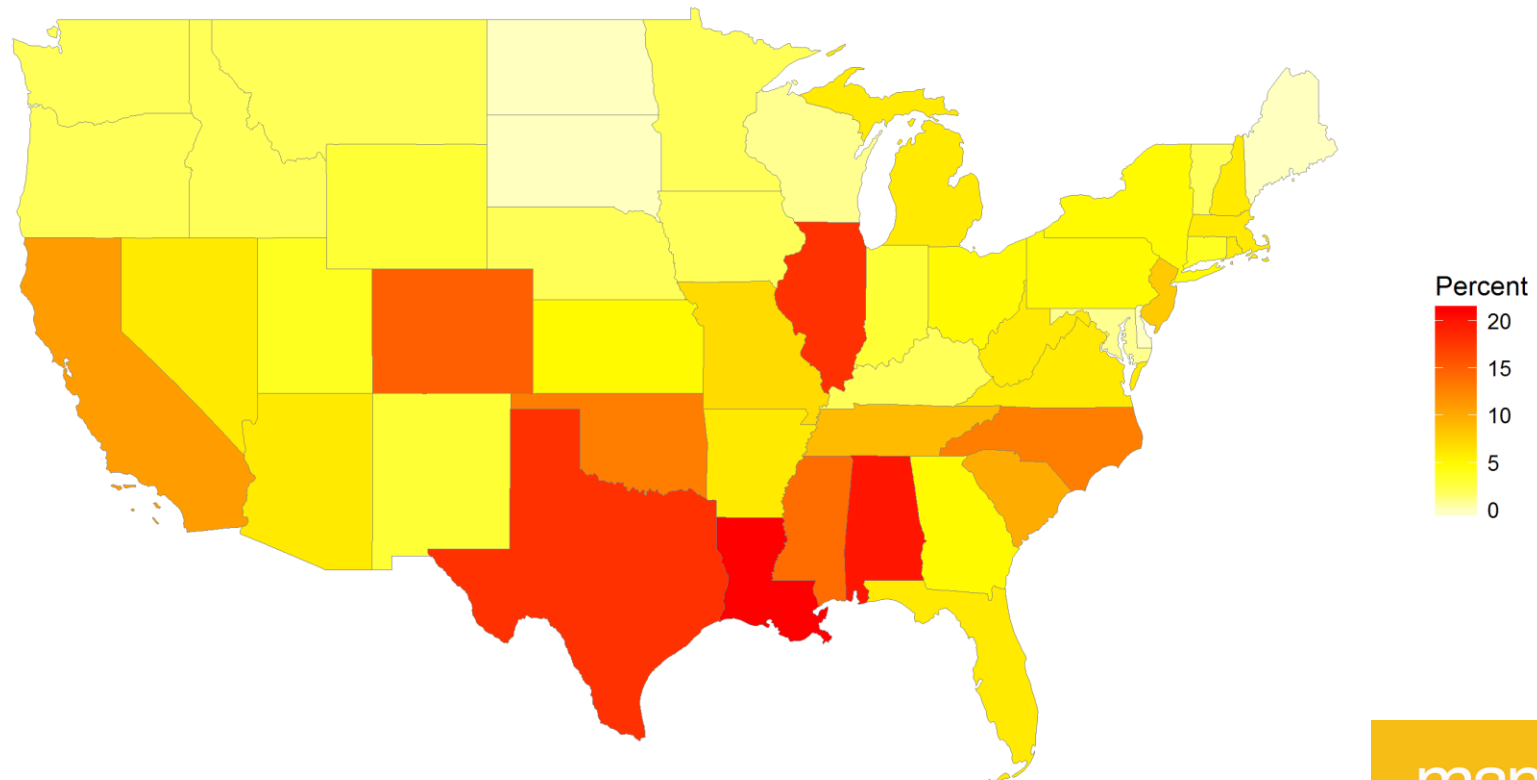


Supplemental Payments Make Up the Lions' Share of Payments to Hospitals

KEY FINDING

- In 2014, more than 1 out of every 5 Medicaid dollars in Louisiana was spent on supplemental payments to hospitals—the **most in the country**
- More than half of total Medicaid dollars that flow to hospitals are in the form of supplemental payments

Hospital Supplemental Payments by State, Percent of Medicaid Funding FY 2014



DISPROPORTIONATE SHARE HOSPITAL (DSH)

- For hospitals that serve a large number of Medicaid and low-income uninsured patients
- Capped at the State's allotment of federal financial participation
 - Louisiana's federal DSH allotment is \$743M
- Louisiana has the highest DSH allotment per capita in the nation
 - At \$161.52 per Louisiana resident in FY15, it is 4.4 times the national average
- Louisiana's aggregate allotment is surpassed only by the far more populous states of New York, California and Texas
- LDH has \$959M in DSH payments budgeted for FY17

UPPER PAYMENT LIMIT (UPL)

- Accounts for the difference between total base payments and the maximum payment level allowed for the services under federal law
- Capped at the difference between the UPL for services provided by a *class* of institutions and the *aggregate* amount Medicaid paid for those services *under Fee for Service*.
- The aggregate amount is *allocated among eligible institutions based on state-defined criteria*
- A major source of revenue for providers in many states
- LDH has \$66M in UPL payments budgeted for FY17

FULL MEDICAID PAYMENT (FMP)

- As managed care has replaced fee-for-service in the Medicaid market, states have sought to replicate fee-for-service supplemental UPL payment programs in managed care
- “Pass-through payments” are the primary mechanism currently used to retain UPL supplemental payment funding in managed care
- Within Louisiana’s Healthy Louisiana program, “Full Medicaid Payment” is the UPL equivalent for services provided to managed care enrollees and is incorporated into health plan capitation rates
- *Unlike UPL supplemental payments which may be allocated among eligible institutions based on state-defined criteria, the State cannot direct Full Medicaid Payments to specific institutions*
- LDH has \$828M in FMP payments budgeted for FY17

SUPPLEMENTAL PAYMENTS AT RISK BEFORE ELECTION

- DSH reductions mandated by Affordable Care Act
 - Begin in FFY2018, continue until 2025, and targeted to high-DSH states (LA)
 - [LDH has \\$959 million in DSH payments budgeted for FY17](#)
- Managed care pass through payments must be phased out per new Managed Care rule
 - 10 year timeline ending in 2027, with exceptions for payments tied to value
 - [LDH has \\$828 million in Full Medicaid Payments budgeted for FY17](#)
- LINCCA disallowed in Texas
 - Federal regulations prohibit use of “expense alleviation” models financed by Inter-Governmental Transfers
 - Louisiana model based on “Texas two step”
 - [LDH has \\$332M in LINCCA payments budgeted for FY17](#)
 - [\\$63M for LDH LINCCA](#)
 - [\\$269M total for other LINCCA \(plus a \\$144M request pending\)](#)

SUPPLEMENTAL PAYMENTS AT RISK AFTER ELECTION

- Even if the Trump administration:
 - Maintains state DSH allotments
 - Scraps the managed care rule's prohibition on pass through payments
 - Limits LINCCA disallowance to Texas
 - Ends Medicaid expansion...
- Louisiana's need for a stable funding mechanisms - to maintain access to essential inpatient and outpatient services for all Louisianans - continues independent of the election outcome
- As early as FY18, LDH will no longer be able to grow supplemental payments enough to fund hospital program growth – *giving us CY17 to develop a sustainable alternative*
 - UPL will be minimal
 - FMP not enough to sustain rural hospitals and PPP cost growth
 - DSH will be a moving target as Medicaid and uninsured utilization shifts and hospitals see net decreases in UCC (even as Medicaid shortfall increases)
- Total cost of care efforts will be even more pressing as the block grant debate takes shape
 - Value-based payment efforts bipartisan and expected to continue unabated, if not increase along with calls for increased transparency, accountability, quality, value

HOSPITAL PERSPECTIVES

- What are the challenges posed to your hospital by the current Medicaid hospital payment system?
- How do you see the problem?
- How would you approach arriving at a solution of common interest?

STAKEHOLDER INPUT CRITICAL TO MOVING FORWARD

- Develop a common understanding of the current payment system
- Produce baseline report containing information on:
 - Volume trends by APR-DRG (inpatient), EAPG (outpatient)
 - Hospital cost coverage trends using current reimbursement rates
 - Compare inpatient, outpatient payments to Medicare
- Lay a foundation for detailed design work to transition to a more sustainable payment system over multiple years
 - More equitable, adequate base rates
 - Base rates that increase transparency and value
 - Supplemental payments limited to those areas that base rates alone cannot adequately support

PROCESS & TIMELINE

- December 2016 – February 2017 baseline study
 - Medicaid data provided by LDH
 - Uninsured data to be requested from hospitals in December 2016
 - Stakeholder work group to be developed in December 2016
 - Series of 3 work group meetings to review findings in January and February 2017
- Final report to serve as launch point for subsequent base rate development work in CY17
- End goal: Implementation of a sustainable and equitable payment system that provides access to quality care beginning in CY18

IMMEDIATE NEXT STEPS

- Finalize uninsured data request
 - Conference call to address technical details at 3:30p CT on 12/1/16
 - Dial in: 888-873-3658, Access Code: 6377683
- Identify hospital work group members
- Finalize work group meeting schedule
- Notify work group members of meeting days/times

QUESTIONS? COMMENTS?

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