



**Healthy
Louisiana**

**RESPONSE TO HCR 86 OF
THE 2017 REGULAR
LEGISLATIVE SESSION**

January 9, 2018

CONTENTS

- Hospital Payment Modernization in Context
- Current State and Rationale for Change
- Consultative Process To-Date
- Hospital Payment Modernization Study Findings
- Considerations and Next Steps

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THIS REPORT IS IN RESPONSE TO HCR 86 OF THE 2017 REGULAR LEGISLATIVE SESSION REQUESTING LOUISIANA DEPARTMENT OF HEALTH TO MODERNIZE THE MEDICAID PROGRAM'S HOSPITAL PAYMENT SYSTEM

HCR NO. 86

ENROLLED

2017 Regular Session
HOUSE CONCURRENT RESOLUTION NO. 86
BY REPRESENTATIVES THOMAS, BAGLEY, BILLIOT, CONNICK, HENRY, HOFFMANN, HORTON, MARINO, DUSTIN MILLER, POPE, STAGNI, STOKES, AND TALBOT

A CONCURRENT RESOLUTION

To urge and request the Louisiana Department of Health to finalize plans for implementing hospital payment reform within the Medicaid program and to make a report to the legislature by a certain date concerning the payment reform effort.

WHEREAS, it is imperative as a matter of fiscal and public health policy that Louisiana address the structural problem of over-reliance on supplemental payments in lieu of base rate payments within the Medicaid hospital program; and

WHEREAS, in 2014, over twenty percent of this state's entire Medicaid budget was expended on supplemental payments to hospitals, representing the highest rate of such spending in the nation; and

WHEREAS, supplemental payments such as those made through the Medicaid disproportionate share hospital program, upper payment limit programs, and full Medicaid pricing programs are expended pursuant to special arrangements with individual hospitals or groups of hospitals; and

SUMMARY OF REQUEST

- 1 Finalize Medicaid hospital payment modernization plans in cooperation with hospital participants and submit a report to legislature
- 2 Address the over-reliance on supplemental payments (in lieu of base rate payments) to improve transparency, fairness, and stability in the Medicaid program
- 3 Use supplemental payments to create incentives for quality in care, implementing a 'money follows the patient' system for indigent care, and providing other innovative hospital programs
- 4 Provide full transparency of payments to providers funded through the state of Louisiana

ACTIONS TAKEN

In the past year, the Louisiana Department of Health has engaged a highly consultative *Hospital Payment Modernization Project* with hospital partners

As outlined in HCR 86, hospital payment modernization is a key component of the Department's multi-year journey towards paying for value, rather than volume, for Medicaid services provided

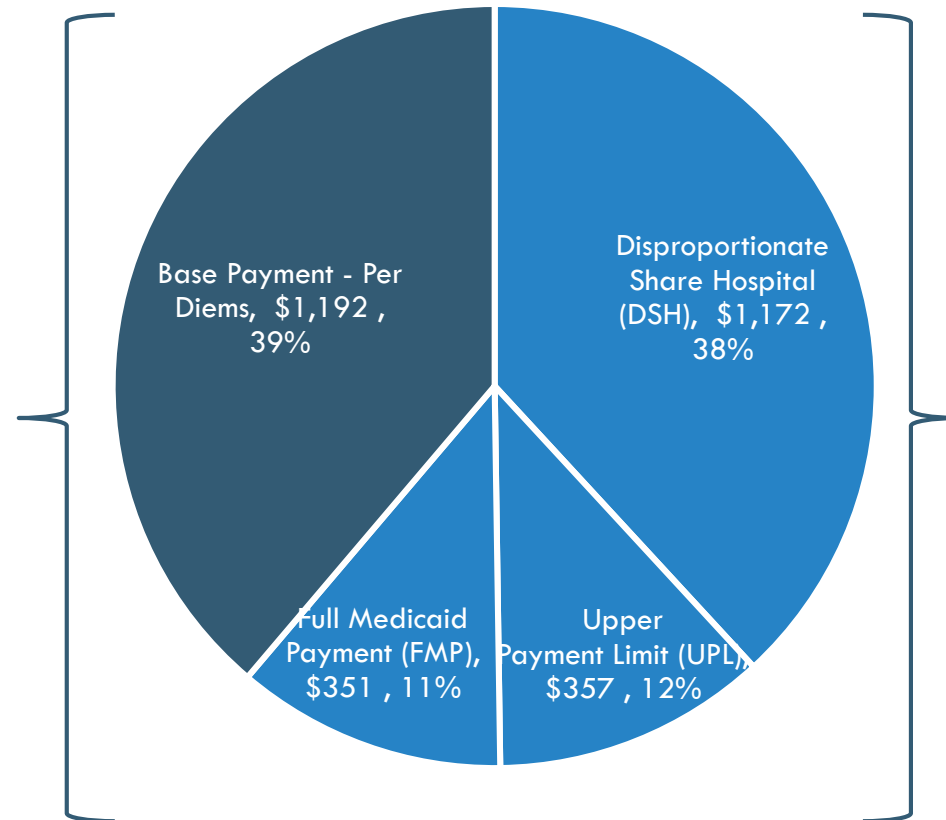
TODAY, MEDICAID HOSPITAL PAYMENTS ARE CHARACTERIZED BY AN OUTDATED BASE PAYMENT STRUCTURE AND HEAVY RELIANCE ON SUPPLEMENTAL PAYMENTS

Base Payments – Per Diems

39% of Medicaid hospital payments totaling \$1.2B spending in SFY16

- Daily rates 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%*

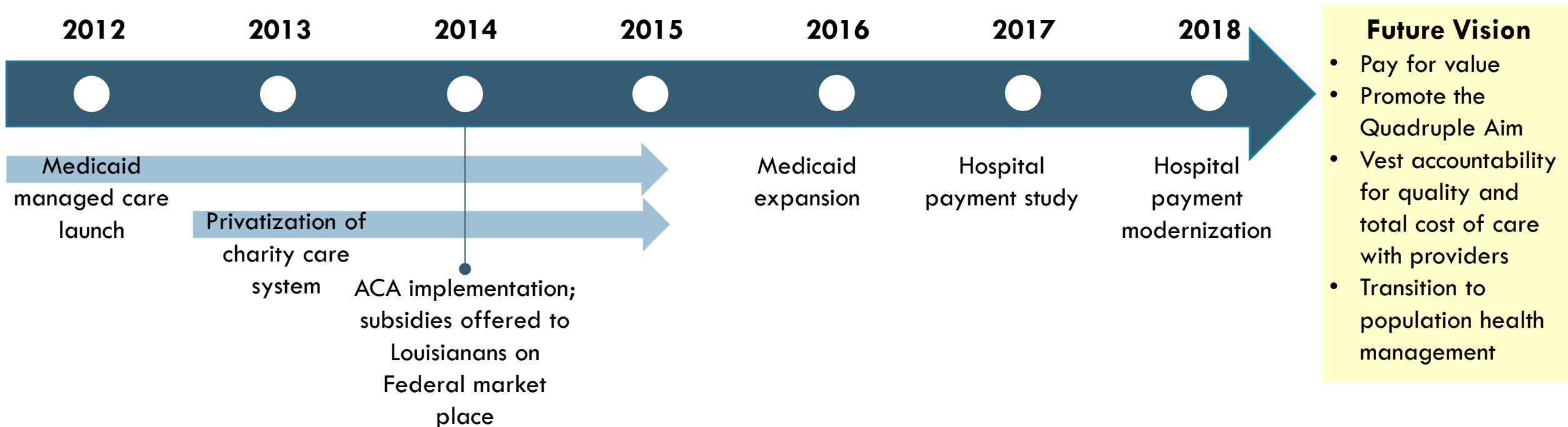
DESIGNING A MODERNIZED HOSPITAL PAYMENT METHODOLOGY SHOULD BE BASED ON PRINCIPLES OF PAYMENT FOLLOWING THE PERSON

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

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.



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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Postpartum Care 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Comprehensive Diabetes Care—HbA1c Testing Childhood Immunization Status—Combo #2 Childhood Immunization Status—Combo #3 	<ul style="list-style-type: none"> Timeliness of Prenatal Care Child and Adolescents' Access to Primary Care Practitioners: <ul style="list-style-type: none"> 25 months-6 years 7-11 years 12-19 years 	<ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> Child and Adolescents' Access to Primary Care Practitioners (CAP) 12-24 months 	<ul style="list-style-type: none"> 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 December 4, 2017, 447,081 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	LIVES IMPACTED	OUTCOME
 447,081	Health Insurance Adults enrolled in Medicaid Expansion as of December 04, 2017	 5,162	Newly Diagnosed Diabetes Adults newly diagnosed and now treated for Diabetes*
 153,822	Preventive Care Adults who received preventive healthcare or new patient services*	 13,077	Newly Diagnosed Hypertension Adults newly diagnosed and now treated for Hypertension*
 28,852 282	Breast Cancer Women who've gotten screening or diagnostic breast imaging* Women diagnosed with breast cancer as a result of this imaging*	 40,434 7,992	Mental Health Adults receiving specialized outpatient mental health services* Adults receiving inpatient mental health services at a psychiatric facility*
 17,717 5,582 248	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*	 7,218 7,873	Substance Use Adults receiving specialized substance use outpatient services* Adults receiving specialized substance use residential services*

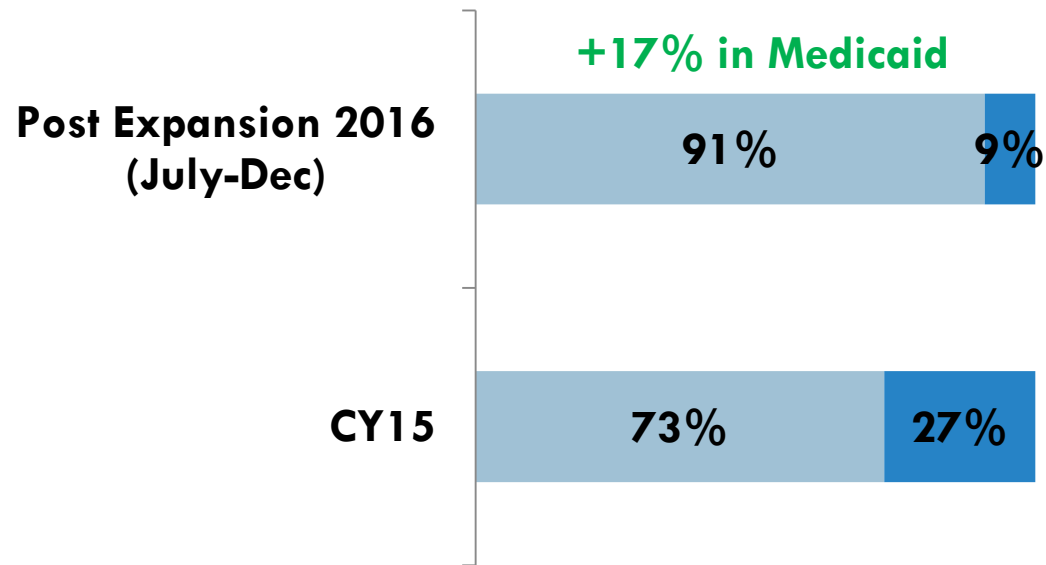
Source: <http://www.lah.gov/healthydashboards/>; <https://www2.census.gov/programs-surveys/demo/tables/p60/260/table6.pdf>

*Notes: Statistic as of December 4, 2017

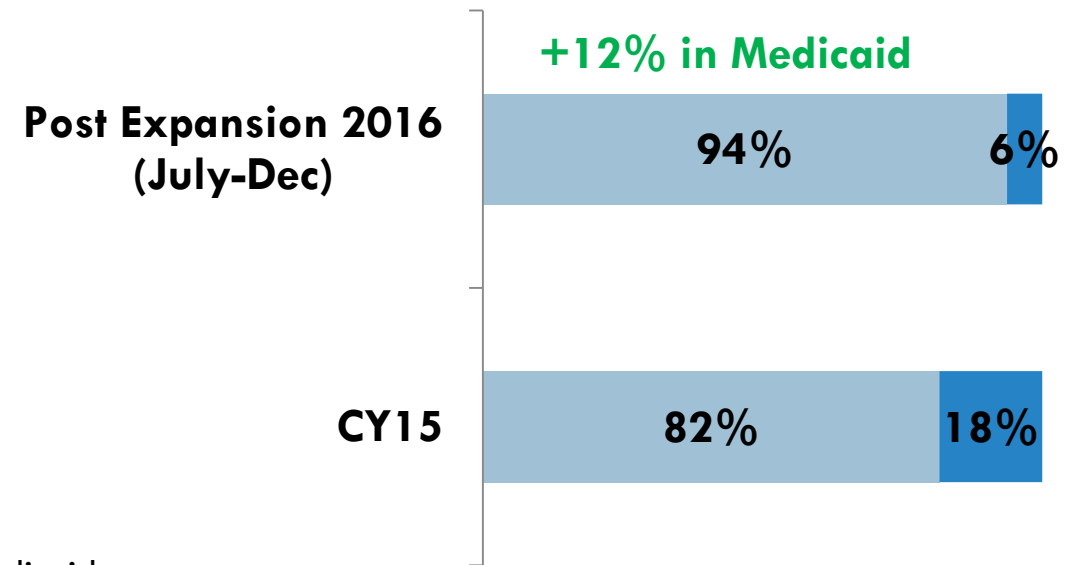
AS A RESULT OF MEDICAID EXPANSION, MEDICAID HOSPITAL CLAIMS HAVE INCREASED WHILE UNINSURED CLAIMS HAVE DECREASED

In CY16 post Medicaid expansion, inpatient service claims paid by Medicaid increased by 17%. 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

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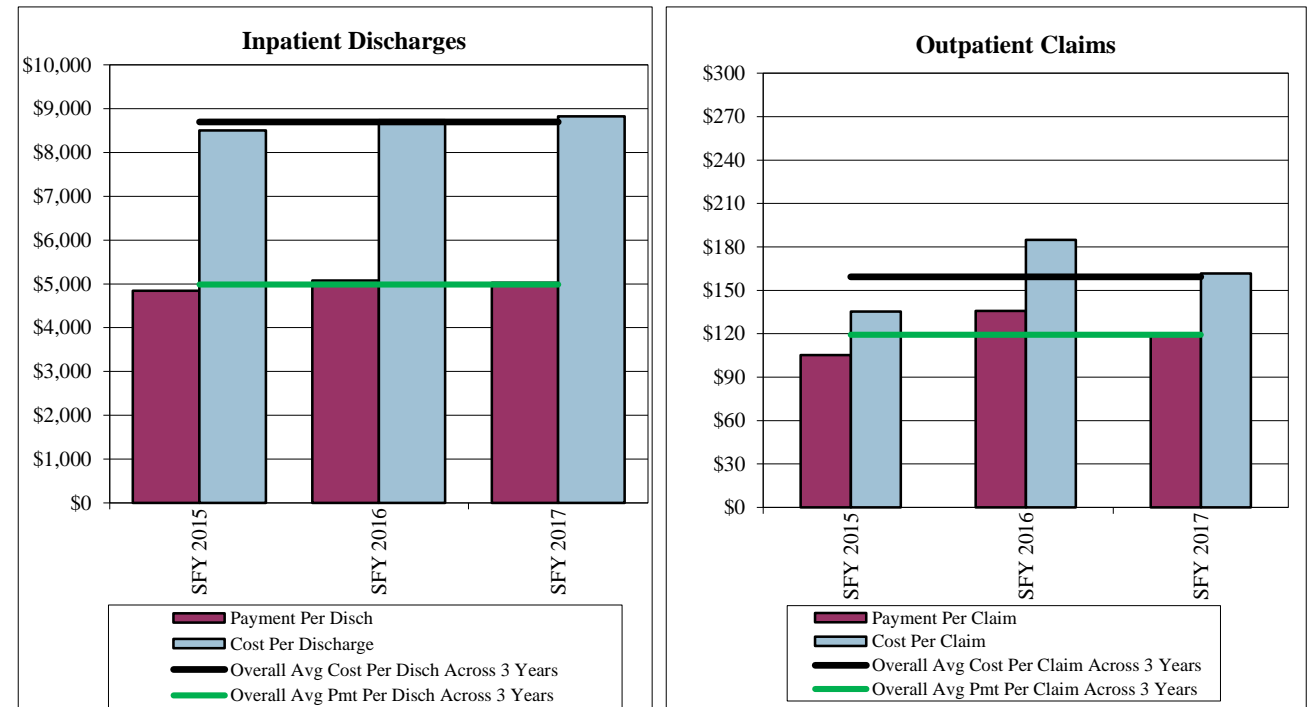
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HOSPITAL PER DIEM BASE PAYMENTS COVER ONLY 63% OF HOSPITAL COSTS

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 inpatient services only, the 3-year average was 57%.
4. For outpatient 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



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, beginning in FY2018; might be delayed, but 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

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

Transitioning 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 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

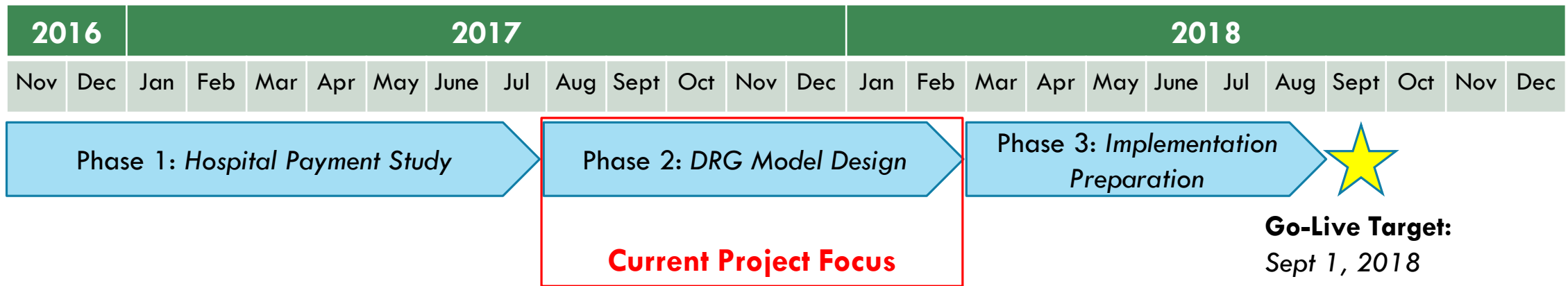
- Shifting some supplemental payments to the new base payment lessens the gap between Medicaid payments and costs
- Decreases reliance on supplemental payments
- Protects hospitals and the state against exposure risk in the changing supplemental payment landscape

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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. Currently, the Department is finalizing the 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 NUMEROUS WORK GROUPS AND INDIVIDUAL CONSULTATIVE 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

Additional One-On-One Consultations

- Woman's Hospital (9/21)
- Franciscan Missionaries of Our Lady Health System (10/25)
- Lake Charles Memorial Health System (10/27)
- North Oaks Health System (10/30)
- River Oaks/Brentwood Hospitals (11/13)
- Ochsner Health System (11/13)
- Lafayette General Health (11/15)
- Rural Hospital Coalition (11/20)
- Christus Health (11/27)
- Willis-Knighton Health System (12/14)
- LCMC Health (10/24, 12/4, 12/21)
- Tulane University School of Medicine (12/21)
- Louisiana State University School of Medicine (12/21)

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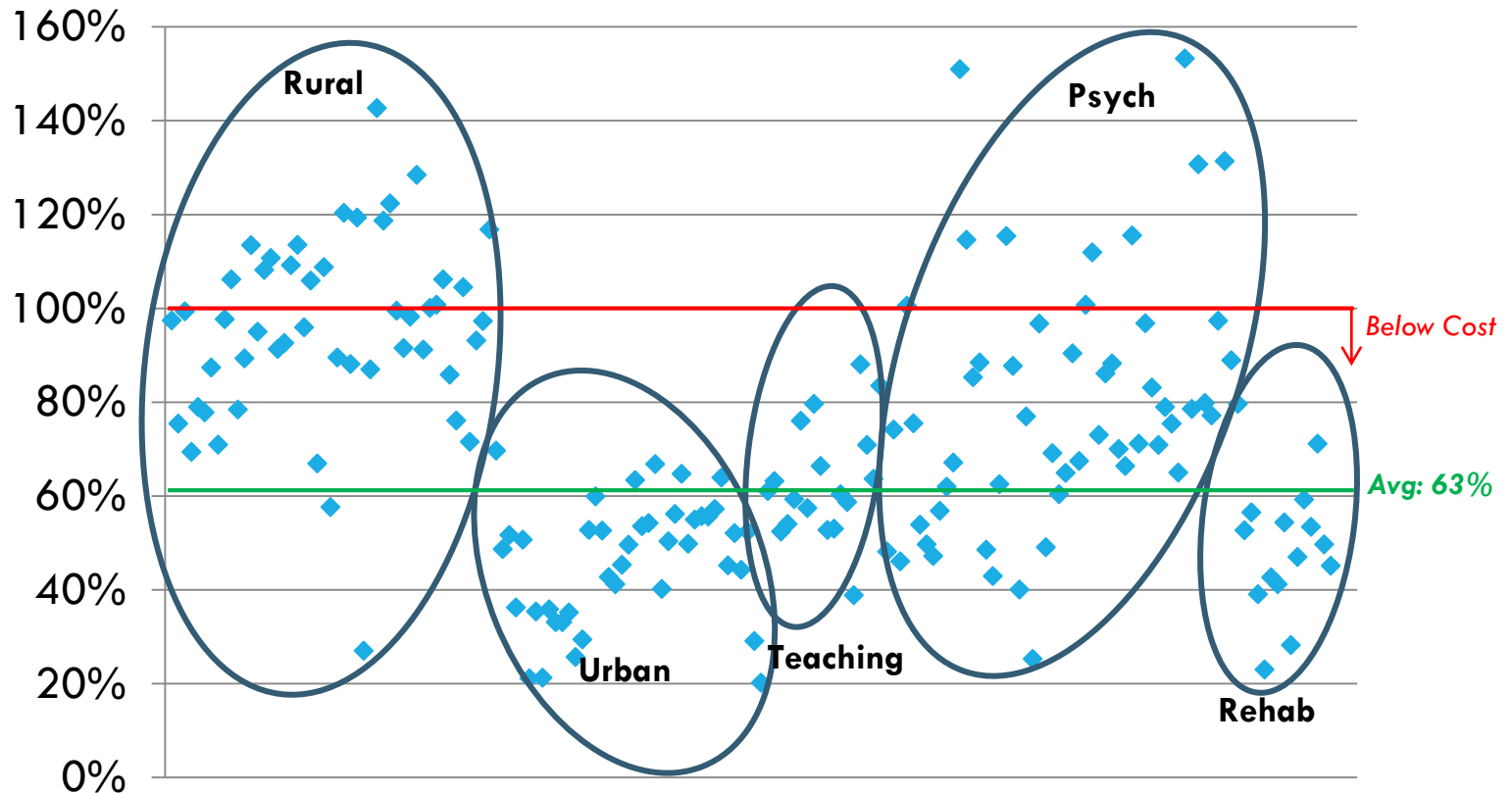
COST COVERAGE VARIES WIDELY ACROSS HOSPITALS WITH MOST HOSPITALS LOSING MONEY ON MEDICAID CLAIMS PAYMENTS

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

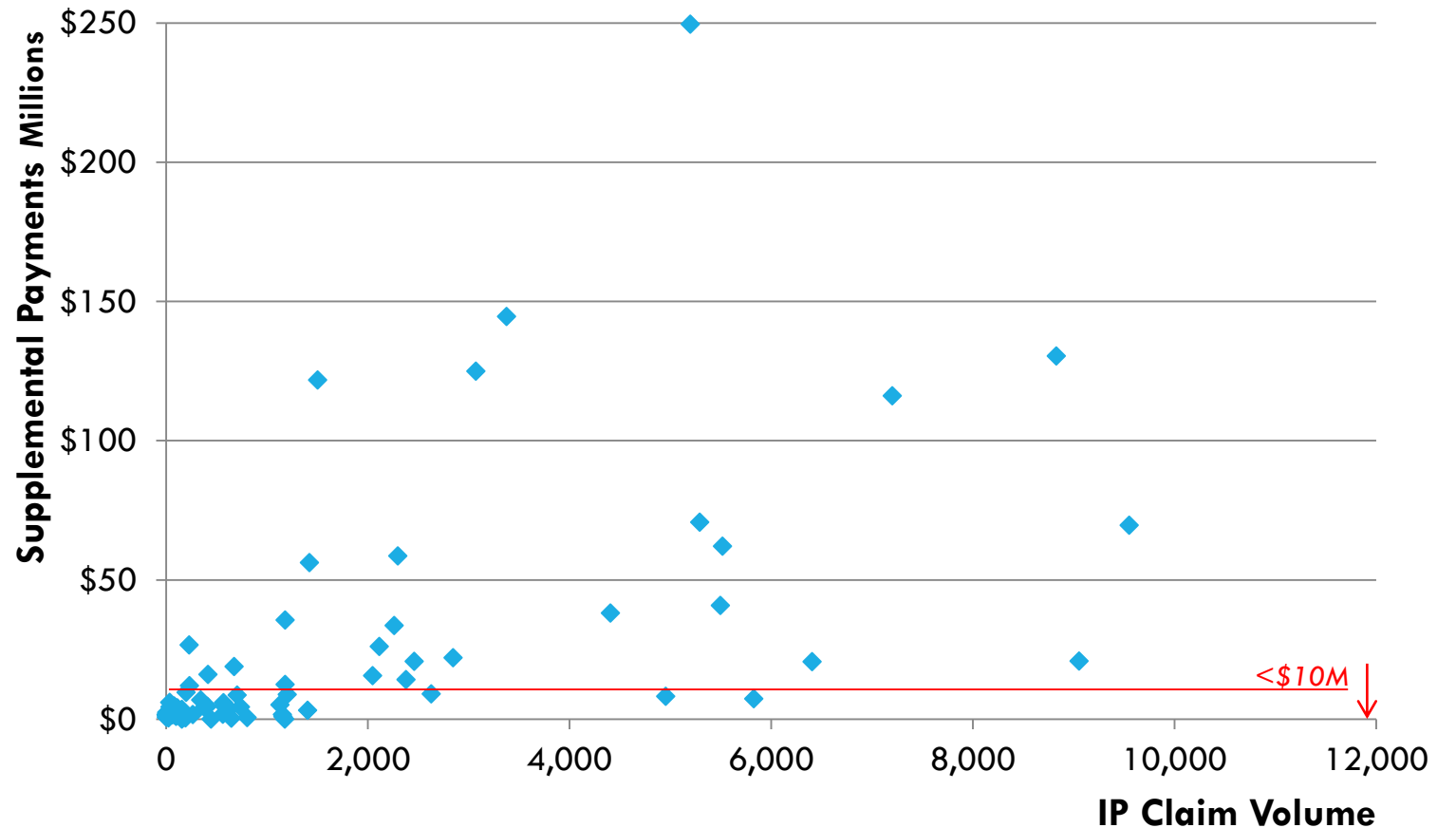


SUPPLEMENTAL PAYMENTS ARE NOT TIED TO INPATIENT SERVICE VOLUME

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 1/2 of the total supplemental payments.

Distribution of Supplemental Payments Against Medicaid IP Claims, FY17

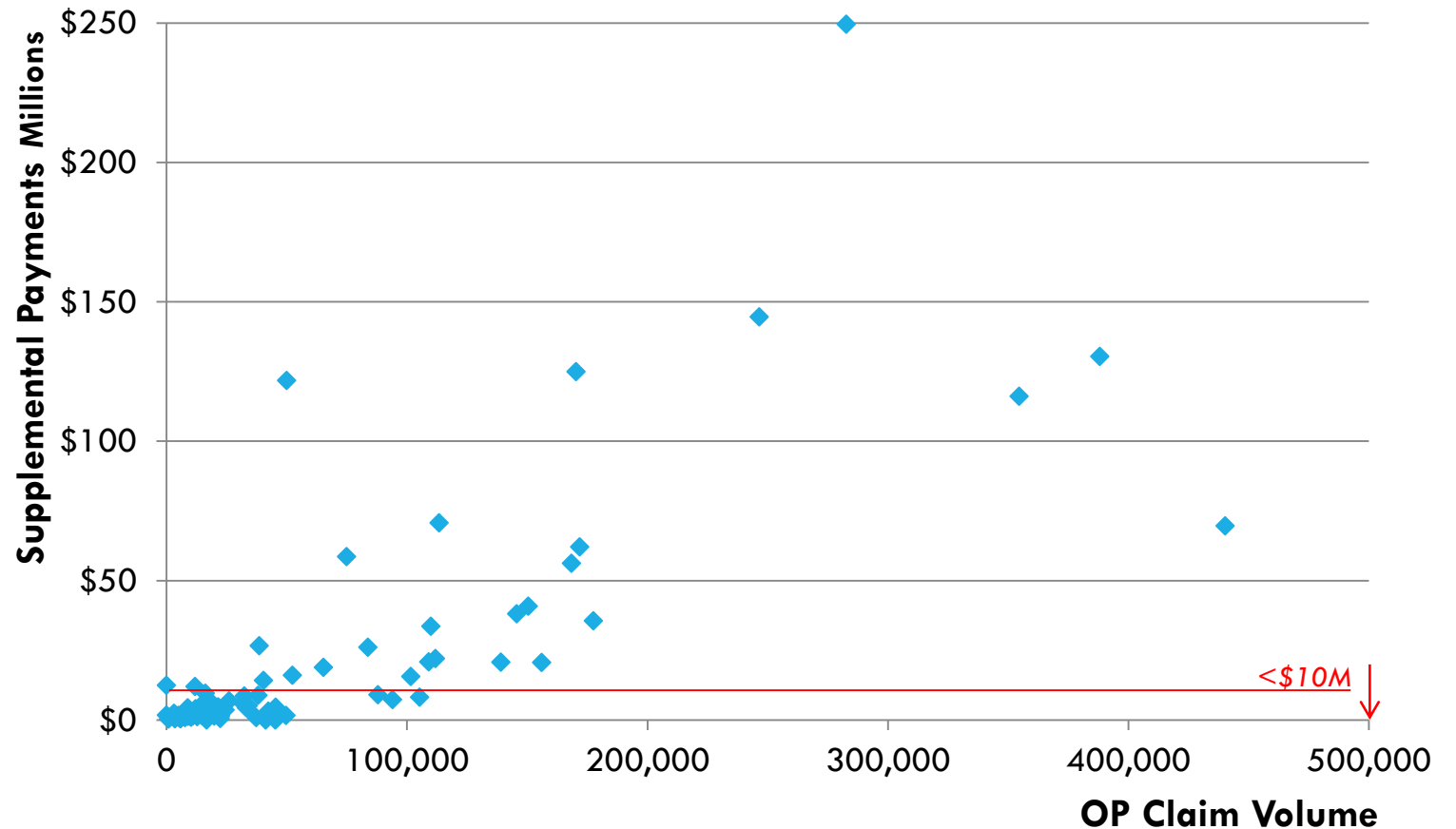


SUPPLEMENTAL PAYMENTS ARE NOT TIED TO OUTPATIENT SERVICE VOLUME

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 1/2 of the total supplemental payments.

Distribution of Supplemental Payments Against Medicaid OP Claims, FY17

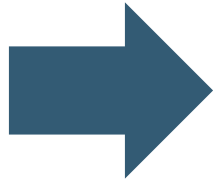


CHANGES IN HOW AND WHERE PEOPLE RECEIVE CARE HAVE CREATED MISALIGNMENT BETWEEN HOSPITAL PAYMENTS AND SERVICES

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**

BUILDING ON ANALYSIS FINDINGS, THE HOSPITAL WORKGROUP HAS FOCUSED ON THE FOLLOWING DESIGN QUESTIONS TO BUILD THE NEW DRG-BASED PAYMENT METHODOLOGY

- What are the components of the new DRG-based payment methodology?
- How do we address:
 - Hospital peer groups
 - Hospitals with high Medicaid volume
 - Medical education
 - Capital costs
 - Rural hospitals
 - Psychiatric hospitals
 - Rehab hospitals
 - Outlier payments
 - Transfers
- What is the appropriate timing and amount to shift from supplemental payments to strengthen the base rates, as well as address disparities and financial impact to hospitals?

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THE DEPARTMENT OF HEALTH'S FOCUS IS TO FINALIZE THE DRG MODEL DESIGN AND PREPARE FOR IMPLEMENTATION; GO-LIVE TARGET IS SEPTEMBER 1, 2018

2016		2017												2018											
Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec



CONCLUSION

- **Multi-year journey:** Hospital payment modernization is the first step in a multi-year journey to ensure that Louisiana's Medicaid program pays for value and 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. These are characterized as “pass-through payments.”