Louisiana Department of Health Directed Payment Options Analysis

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Section 1: Executive Summary

In response to Senate Concurrent Resolution Number 27, the Louisiana Department of Health (LDH) requested that Milliman, Inc. (Milliman) develop alternative state directed payment methodologies under 42 CFR 438.6(c) (referred to hereafter as "directed payments") for Medicaid managed care inpatient and outpatient hospital services. In developing alternative options, LDH requested that Milliman evaluate the impact on access to hospital services in both rural and urban areas, as well as assess the impact on improving the quality of services provided by Louisiana's hospitals. Potential next steps in the directed payment consideration process and important limitations to this analysis are included in Sections 5 and 6 of this report.

LDH outlined the following seven assumptions to guide our analyses of directed payment options:

1. Directed payment methodologies **must not require any additional State General Fund dollars**, as defined by LDH, over the amount utilized in the prior state fiscal year for hospital reimbursement.
2. Directed payment methodologies should take into account LDH's **priority of maintaining reimbursement levels for Rural Hospitals**, as defined in the Rural Hospital Preservation Act (minimum reimbursement levels), and Louisiana State University's (LSU's) **Public-Private Partners** that are parties to Cooperative Endeavor Agreements.
3. Milliman should examine the current reimbursement level for hospitals, inclusive of base rates and any supplemental payments, and any alternative methodology should **minimize any reductions to those reimbursement levels**.
4. Directed payment methodologies should utilize, at a minimum, the principle of reimbursement **"following" the patient thereby "rewarding" hospitals for treating Medicaid patients and/or increasing access** to services for Medicaid recipients.
5. To the extent allowable by federal regulations, Milliman may suggest **alternative sources of funds** that can be used as state match.
6. Milliman may analyze **value-based purchasing (VBP) principles** where advisable.
7. Directed payment methodologies must meet CMS standardized **measure benchmarking requirements**.

This report provides background on applicable statutory and regulatory considerations, potential alternative directed payment methodologies, estimated fiscal impacts under various funding levels for LDH's consideration, and a review of strategies pursued by other states which may be useful for LDH in developing its preferred directed payment program.

DIRECTED PAYMENT OVERVIEW

Supplemental payment programs, of which directed payments are a subset, constitute a major source of Medicaid revenue for hospitals in many states, including Louisiana.[1] Per a 2018 Medicaid and CHIP Payment and Access Commission (MACPAC) issue brief on Medicaid hospital supplemental payments, $47.2 billion, or 27% of total national Medicaid hospital expenditures, was attributable to supplemental payments.[2] Nationally, the political support needed to implement supplemental payment programs involving local funding sources is highly dependent on a state's ability to financially support the providers that help fund the state share of payments.

To address the issues facing states, CMS introduced permissible alternative approaches for Medicaid supplemental payments under Medicaid managed care, as documented in **42 CFR §438.6(c)**, "Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts." This section of the federal regulation provides specific mechanisms that can be used by states to support innovative efforts to transform care delivery and payment and allows states to contractually require Managed Care Organizations (MCOs) to adopt minimum fee schedules for provider payments, use VBP approaches for provider reimbursement, and participate in delivery system reform

[1] Supplemental payments are payments made to providers above what they are paid for individual services, while directed payments are a type of supplemental payments that are required by a state to occur under MCO contract requirements.
[2] MACPAC, "Medicaid Base and Supplemental Payments to Hospitals" (June 2018).

initiatives. Directed payment arrangements must be based on delivery and utilization of services, direct expenditures equally for a class of providers using a common set of performance measures and advance at least one goal and objective in the state's quality strategy. States must submit a "preprint" application to CMS on an annual basis for federal approval of a directed payment arrangement.

Today, directed payment arrangements are a commonly used approach for states to direct specified payments to providers in Medicaid managed care programs, with the majority of states having at least one approved preprint.[3] In this report we describe approaches utilized by other states under CMS-approved preprints, which helped inform our development of potential directed payment options for LDH's consideration. However, it is important to note that CMS' requirements and approval criteria for directed payment arrangements have evolved over time, including the new November 2020 Medicaid managed care final rule[4] and new January 2021 CMS preprint guidance and requirements.[5] These new requirements, paired with CMS leadership changes, create some uncertainty for how CMS will operationalize and administer its preprint evaluation process going forward. In addition, we expect CMS may consider elements of the arrangement beyond the proposed payment mechanism, potentially also considering state goals and objectives for quality and access to care, duration, managed care plan requirements, and other factors.

The approaches described in this report should be considered as examples of historically permissible frameworks, but not as templates that, if replicated using Louisiana's specific parameters and funding and impact objectives, would ensure CMS approval. Additionally, it is important to note that all directed payment arrangements are currently subject to annual evaluation and approval by CMS, regardless of the expected duration submitted in the preprint. CMS approval of the first year of an expected multi-year arrangement may not imply approval in subsequent years.

MODELED DIRECTED PAYMENT OPTIONS

Our directed payment modeling has focused on directed fee schedule (DFS, CMS' technical term for a permissible type of §438.6(c) directed payment arrangement) "uniform percentage increase" options. Under DFS, MCOs would be directed to pay specified percent increases to claim-based payments (under negotiated rates). These payment increases would be determined by establishing payment pools, where payments would be distributed to the hospitals within each pool based on contract year utilization to be calculated using managed care encounter data.

We developed two different methodologies for establishing fixed payment pools in terms of the number of pools, the hospitals assigned to each pool, and the size of the pools:

- **Methodology 1 (tiered approach):** establishes separate payment pools based on five **hospital tiers** determined based on ranges of numeric point values associated with eight hospital categories. Hospital categories each have their own point weighting and consist of four mutually exclusive "base" provider type categories and four "add-on" key Medicaid service line categories which are **not** mutually exclusive. The selected add-on categories focus on hospital units related to key Medicaid service lines where opportunities to cost shift are limited and maintaining access to care is critical for the Medicaid population and for network adequacy.
- **Methodology 2 (class approach):** establishes separate payment pools based on four mutually exclusive **hospital classes**, each with its own directed payment increase percentage. Hospital class directed payment increase percentages are based on the funding needed to achieve each class's target percentage of payments under Medicare or Commercial reimbursement.

Under both model methodologies, a portion of existing Medicaid disproportionate share hospital (DSH) and fee-for-service (FFS) Upper Payment Limit (UPL) supplemental payments would be retained in order to help mitigate payment impacts. Note LDH proposed to transition all of the current Medicaid managed care hospital "Full Medicaid Pricing" (FMP) payments to a directed payment arrangement.

[3] MACPAC's September 219 presentation: https://www.macpac.gov/publication/use-and-oversight-of-directed-payments-in-medicaid-managed-care/
[4] https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care
[5] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf

Following a review of each methodology and preliminary impact estimates, **LDH proposes methodology 1 (tiered approach)** for implementation purposes. The considerations involved in this selection process are discussed in Section 2 of this report.

Hospital supplemental payments in Louisiana currently total approximately **$1.7 billion** in aggregate from a combination of hospital FMP, UPL, and DSH payments. Funding scenarios from $0 increase up to 95% of commercial reimbursement ($1 billion payment increase) were considered in our review of DFS options. Following the identification of the tiered approach and preliminary funding discussions with LDH, we modeled DFS options under four separate funding level assumptions ranging from a $400 million to approximately $1 billion payment increase relative to existing funding levels. Based on a review of the impact of the DFS by hospital class, **LDH proposes an approximately $900 million increase** relative to existing hospital supplemental payment levels. This is illustrated under scenario 3 in this report and was selected to balance hospital system impacts with the need to finance the non-federal share of DFS payment increases.

It is our understanding that LDH explored different approaches to fund the non-federal share of DFS payment increases, which LDH estimates to be approximately **$126 million** (under its proposed $900 total computable payment increase scenario). Traditionally, the non-federal share of a DFS increase may be sourced from a combination of existing intergovernmental transfers (IGTs)[6], new provider assessments, and state general funds. We understand LDH is proposing hospital assessment increases for the non-federal share of DFS increases, given the lack of available state general funds and its decision to not increase IGTs above current levels (to support a better balance of funding sources).

LDH currently assesses non-rural hospitals at a rate of approximately 1.0% of net patient revenues (based upon net patient revenue base data from calendar year 2015). Federal requirements for permissible health care-related assessments include the “hold harmless” test under 42 CFR § 433.68(f), which limits the size of Louisiana’s aggregate hospital assessments to 6.0% of net patient revenues. Historically, Congress has attempted to reduce the percentage of allowable assessments in its budgets.[7] Note that CMS’ evaluation of hospital assessment changes may involve factors beyond the 6% hold harmless test and P1/P2 test (which demonstrates whether the assessment is generally redistributive and which LDH currently passes), including evaluation of net hospital impacts and other considerations.

For the purposes of this report, net payment impacts (payment increases net of provider contributions) associated with each modeled funding scenario are illustrated at the statewide composite level. Hospital system net payment impacts may vary due to the final funding approach utilized by LDH.

The CMS preprint approval process and new preprint guidance requires states to submit a Medicaid managed care payment benchmarking analysis that estimates the base claim payments and other supplemental payments (including the proposed directed payment) “as a percent of Medicare, or some other standardized measure”.[8] [9] To inform directed payment options and parameters and provide insight on CMS evaluation considerations, we calculated payment benchmarks to compare Medicaid payments (under the current methodology and under each modeled DFS payment increase scenario) to estimated costs (incurred by the hospitals for performing Medicaid managed care services), estimated payments under Medicare FFS rates, and estimated payments under commercial insurance rates. Aggregate state benchmarking results are summarized in Figure 1 below.

[6] IGTs are transfer of funds from another government entity to the state Medicaid agency.
[7] Provider Tax Limits Should Be On the Table for Medicaid Reform, Committee for a Responsible Federal Budget, March 29, 2016, https://www.crfb.org/blogs/provider-tax-limits-should-be-table-medicaid-reform, retrieved February 5, 2021
[8] CMS Appendix C38 Preprint, https://www.medicaid.gov/sites/default/files/2020-02/438-preprint.pdf, retrieved January 7, 2021
[9] CMS SMD Letter # 21-001, January 8, 2021 https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf

Figure 1. Statewide Payment Benchmarking Comparison – Methodology 1

Funding Scenario	Total Hospital Payments (Claim, DSH, UPL, and Supplemental Payments)[10]	Total Medicaid Managed Care Payments (Claim and Supplemental Payments)[11],[12]	Medicaid Managed Care Payments as Percent of Estimated Costs	Medicaid Managed Care Payments as Percent of Estimated Payments Under Medicare	Medicaid Managed Care Payments as Percent of Estimated Payments Under Commercial
Current Methodology	$3.74 billion	$2.73 billion	93.7%	86.7%	55.4%
Scenario 1: +$400M	$4.14 billion	$3.79 billion	130.0%	120.2%	76.8%
Scenario 2: +$650M	$4.39 billion	$4.07 billion	139.4%	129.0%	82.4%
Proposed by LDH: Scenario 3: +$900M	$4.64 billion	$4.50 billion	154.3%	142.7%	91.1%
Scenario 4: +$1.0B	$4.77 billion	$4.69 billion	160.8%	148.7%	95.0%

Note: Consistent with CMS preprint reporting requirements, the payment amounts in Figure 1 represent gross payments and have not been offset by provider contributions used to partially finance the non-federal share of Medicaid payments.

As shown in Figure 1, statewide aggregate Medicaid hospital reimbursement levels under each scenario are above estimated costs and Medicare payments, yet below commercial payments. From our analysis, we found these benchmarks ranged significantly across hospital classes, with modeled DFS payments resulting in payments no less than 100% of Medicare FFS at the aggregate hospital class level in Scenarios 3 and 4.

SUPPLEMENTAL INFORMATION

In developing the directed payment options presented in this report, we conducted research and analyses for the purposes of understanding the background of the Louisiana Medicaid program, directed payment arrangements used in other state Medicaid programs, and potential policy items for consideration. This information is included in the following report appendices:

- **Appendix A.** Includes background information on CMS directed payment requirements. Users of this report that are not familiar with the history of Medicaid supplemental payments and CMS directed payment requirements may find value in reviewing this appendix prior to the remainder of this report.
- **Appendix B.** Provides a summary of hospital payment information in the state of Louisiana. Users of this report unfamiliar with current and historical Louisiana hospital payment information may benefit from reviewing the information in this appendix.
- **Appendix C.** Information related to our analysis of CMS directed payment options in consort with LDH directed payment policy options can be found in this appendix. This information was used to inform the development of the DFS options included in this report.

[10] Claim payments include calendar CY 2019 Medicaid managed care claim payments as reported in LDH encounter data (excluding out-of-state hospitals, freestanding psychiatric hospitals, and Medicare dual eligibles), estimated Medicaid DSH/UCC payments, estimated UPL payments, and modeled DFS payments. Payments have not been offset by provider contributions.
[11] Claim payments include calendar CY 2019 Medicaid managed care claim payments as reported in LDH encounter data, excluding out-of-state hospitals, freestanding psychiatric hospitals, and Medicare dual eligibles. Supplemental payments include managed care "Full Medicaid Pricing" payments under the current methodology and modeled DFS payments for Scenarios 1 through 4. Payments have not been offset by provider contributions.
[12] Total Medicaid managed care payments and benchmarks exclude hospital outlier payments of approximately $21 million as described in the State Plan. These payments will be considered and reflected consistent with CMS preprint reporting requirements for any proposed preprint submission.

Section 2: Directed Payment Options for Consideration

Our state directed payment modeling has focused on DFS "uniform percentage increase" options. Under DFS, MCOs would be directed to pay specified percent increases to claim-based payments (under negotiated rates). These payment increases would be determined by establishing fixed payment pools, where payments would be distributed to the hospitals within each pool based on contract year utilization, to be calculated using managed care encounter data.

The modeled DFS options have two different primary methodologies for establishing the payment pools, distinguished by the number of pools, the hospitals assigned to each pool, and the size of the pools, as described below.

- **Methodology 1 (tiered approach):** establishes separate payment pools based on five **hospital tiers**, each with its own directed payment increase percentage (ascending from low to high). Hospital tiers were determined based on ranges of point values using eight hospital categories, each with assigned weightings. The hospital categories include four mutually-exclusive "base" categories based on provider types, and four "add-on" categories based on non-mutually-exclusive key Medicaid service lines.
- **Methodology 2 (class approach):** establishes separate payment pools based on four **hospital classes**, each with its own directed payment increase percentage. Hospital classes were determined based on mutually exclusive provider types. Modeled DFS payment increase percentages by class were determined based on the funding need to achieve each class' target percentage of payments under Medicare or Commercial reimbursement.

Under both methodologies, hospital FMP expenditures are transitioned to the DFS funding pool, and DSH and UPL payments are offset by modeled DFS payment increases exceeding current hospital FMP. This modeling approach is based on LDH's plans to maintain DSH and UPL payment methodologies under the current SPA, where payments are allocated based on uncompensated care costs.

A detailed description of each methodology is described in further detail as follows.

MODELING METHODOLOGY 1 – HOSPITAL TIERED APPROACH

DFS Methodology 1 establishes separate payment pools based on distinct hospital tiers. The hospital tiers are developed as ranges of hospital points, which are assigned based on hospital categories with specific assigned weightings. The steps for modeling DFS payments under the Hospital Tiered Methodology are described as follows.

Step 1: Determine Hospital Categories: For modeling purposes, we developed eight hospital categories, including a "base" set of four mutually exclusive provider types (where each hospital qualities for one category), and an "add-on" set of four non-mutually exclusive key Medicaid service lines (where a hospital may qualify for several, one, or none of the categories). The base provider type categories represent general hospital categorizations, whereas the add-on provider characteristic categories focus on key Medicaid service lines where opportunities to cost shift are limited, and maintaining access to care and network adequacy is critical for the Medicaid population.

The modeled hospital categories are shown in Figure 2 below.

Figure 2. Modeled Hospital Categories

Hospital Categories	Description/Comments
Base Hospital Categories (Mutually Exclusive Provider Types)	
Urban Public Hospital	Urban public hospitals (non-rural), as defined in rule in Louisiana's State plan.
Rural Hospital	Rural hospitals as defined in rule in Louisiana's State plan and by Louisiana's Legislature, through the Rural Hospital Preservation Act, as a unique reimbursement class critical to the State's healthcare safety net and to the well-being of rural communities.
Teaching Hospital	Based on hospital per diem payment Peer Group 1 for "Major Teaching Hospitals" and Peer Group 2 for "Minor Teaching Hospitals" as defined in rule in Louisiana's State plan.
Other Urban	All other hospitals.
Add-on Hospital Categories (Non-Mutually Exclusive Provider Characteristics)	
Neonatal Intensive Care Unit (NICU)	Hospitals with level 2 and 3 NICUs eligible for enhanced neonatal per diem rates as defined in the SPA. Selected as a high Medicaid utilization service; Louisiana has the nation's largest percentage of births (62.8%) covered by Medicaid (per MACPAC's 2020 Fact Sheet).[13]
Pediatric Intensive Care Unit (PICU)	Hospitals with level 1 and 2 PICUs eligible for enhanced pediatric per diem rates as defined in the SPA. Selected as a high Medicaid utilization service; for example, Children's Hospital New Orleans reported 72.9% Medicaid utilization for FYE 2018.[14]
Psychiatric Unit	Hospitals with psychiatric district part units as defined in the SPA. Selected as a high Medicaid utilization service; for example, Louisiana's highest Medicaid volume psychiatric units (with over 2,000 Medicaid days) have an aggregate **47%** Medicaid utilization for FYE 2019.[15]
Trauma Unit	Hospitals with state-designated trauma centers as established by LDH under LA RS 40:2173. Selected due to the limited number of trauma centers for high intensity services with high "standby" costs.

Step 2: Determine Weighted Points by Category: The point weightings for each hospital category were developed by conducting a regression analysis to target the optimal category-specific point values to achieve the goals established by LDH. Figure 3 illustrates the point weightings by hospital category. ***Please note that final points for actual implementation may vary from the values in this illustration.***

[13] MACPAC, "Advising Congress on Medicaid and CHIP Policy Medicaid's Role in Financing Maternity Care", January 2020. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf
[14] Children's Hospital of New Orleans, "Fact Sheet". https://www.chnola.org/documents/newChnolaFactSheet.pdf
[15] Based on review of Louisiana hospital FYE 2019 Medicare cost report data extracted from CMS' HCRIS electronic cost report database.

Figure 3. Modeled Point Weighting by Hospital Category

Hospital Categories	Tiered Model Point Weighting
Base Hospital Categories (Mutually Exclusive Provider Types)	
Urban Public Hospital	7.0
Rural Hospital	5.5
Teaching Hospital	2.0
Other Urban Hospital	1.0
Add-on Hospital Categories (Non-Mutually Exclusive Provider Characteristics)	
Neonatal Intensive Care Unit	3.0
Pediatric Intensive Care Unit	2.5
Psychiatric Unit	1.0
Trauma Unit	1.0

In this example, an urban public hospital (7.0) with a neonatal intensive care unit (3.0) and pediatric intensive care unit (2.5) would be assigned a point value of 12.5.

Step 3: Determine payment increase percentages by hospital tier: Using the sum of points assigned to each hospital in Step 2, we developed five different hospital tiers based on point ranges. We grouped the hospital point values into percentiles, weighted by base hospital claim payments, and assigned tiers to each hospital such that there was a similar percentage of hospital base payments within each tier.

The payment increase percentages for each tier were modeled using a regression analysis to develop the estimated funding pool for each modeled hospital category to be allocated to all hospitals within that category. The rate increase percentage for each tier were calculated by averaging the composite rate increase across all hospitals within each tier, and to result in ascending percentage increases across tiers from the lowest tier 1 to the highest tier 5 (limited to a maximum of 95% of average commercial rates, per LDH guidance). The payment increase percentages were modeled to target LDH's anticipated funding level for the state-directed payment. The modeled payment increase percentages for each tier considered net hospital system impacts from directed payments and retained UPL and DSH amounts as described in the following Steps 4 and 5. Note the modeled hospital system groupings consisted of larger hospital systems as well as groupings of smaller hospitals with similar attributes (for example, rural hospitals, which are not in the same system but have been grouped together for summary purposes).

Step 4: Estimate DFS Payment Impact: DFS payments for each hospital were estimated by applying the modeled payment increase percentages by service category to the inpatient and outpatient hospital Medicaid managed care encounter payments, as follows:

> *(Inpatient hospital Medicaid managed care encounter payments) X (Inpatient hospital tier payment increase percentage)*

Inpatient and outpatient hospital DFS payments were aggregated by hospital, with hospital-specific impacts calculated as follows:

> *(Modeled DFS payments + retained UPL + retained DSH) –*
>
> *(Current FMP + Current DSH + Current UPL)*

Per CMS guidance, DFS payments cannot be conditioned upon entering into IGT arrangements.

Note actual DFS payment impacts will be based on each hospitals' actual contracted managed care utilization during the contract year, which is certain to vary from values analyzed and modeled using historical data (models utilized inpatient and outpatient managed care claims payments from calendar year 2019).

Step 5: Determine retained DSH and UPL: Calculated based on current DSH and UPL payments, less modeled directed payments (not to be less than $0).

MODELING METHODOLOGY 2 – HOSPITAL CLASS APPROACH

DFS Methodology 2 establishes separate payment pools based on **hospital classes**, each with directed payment increase percentages based on the funding need to achieve each class's target percentage of payments under Commercial (or Medicare). The steps for modeling DFS payments under the Hospital Class Methodology are described as follows.

Step 1: Determine Hospital Classes: For modeling purposes, we developed four mutually exclusive hospital classes based on key provider characteristics, as described in Figure 4 below.

Figure 4. Hospital Class Descriptions

Hospital Classes	Description
Hospital Service Districts	Hospital service districts established under the provisions of Louisiana Revised Statute 46:1051.
Public-Private Partnership (PPP) hospitals	PPP hospitals as defined in rule in Louisiana's State plan, or with Cooperative Endeavor Agreements.
Other Teaching	Other teaching hospitals not included in prior classes, as defined in rule in Louisiana's State plan.
Other Non-Teaching	Other urban hospitals not included in prior classes, as defined in rule in Louisiana's State plan. This class includes rural hospitals, as defined in Louisiana's State plan

Based on guidance from LDH, the hospital classes in Figure 4 are listed in hierarchical order. For example, a teaching hospital defined as a PPP is categorized in the PPP class.

Step 2: Determine Target Percent of Commercial (or Medicare) by Class: For each hospital class, a percent of estimated payments under Commercial or Medicare was modeled as the target basis for DFS payment increases.

The target percent of Commercial (or Medicare) for each hospital class was modeled via an iterative process to achieve target funding levels established by LDH, with the following considerations.

- Provide enhanced funding for each hospital class while ensuring no class is less than 100% of payments under Medicare
- Minimize the range in effective percent of Commercial (or Medicare) payments across hospital classes compared to the current system
- Consider net payment impacts (compared to current supplemental payments) at the hospital system level and provider contributions at the hospital class level.

Step 3: Determine payment increase percentages by class: For each hospital class, we modeled the directed payment increase percentages based on the additional funding needed to achieve each class' target percentage of Commercial (or Medicare) payments (per Step 2). The modeled payment increase percentages by class varied between inpatient and outpatient hospital services and generally follow a descending pattern based on the hierarchy.

Step 4: Estimate DFS Payment Impact: DFS payments for each hospital were estimated by applying the modeled payment increase percentages by service category to the inpatient and outpatient hospital Medicaid managed care encounter payments, as follows:

> *(Inpatient hospital Medicaid managed care encounter payments) X (Inpatient hospital class payment increase percentage)*

Inpatient and outpatient hospital DFS payments were aggregated by hospital, with hospital-specific impacts to be calculated as follows:

(Modeled DFS payments + retained UPL + retained DSH) –

(Current FMP + Current DSH + Current UPL)

Note actual DFS payment impacts will be based on each hospitals' actual contracted managed care utilization during the contract year, which is certain to vary from the values analyzed and modeled using historical data (models utilized inpatient and outpatient managed care claims payments from calendar year 2019)..

Step 5: Determine transitional retained DSH and UPL: Calculated based on current DSH and UPL payments, less modeled directed payments (not to be less than $0).

MODELING METHODOLOGY SELECTION

Following a review of each modeling methodology and preliminary impact estimates, **LDH proposes the use of methodology 1 (tiered approach).** Figure 5 provides a comparison of the two payment methodologies considered by LDH and includes key characteristics which informed LDH's decision making process.

Figure 5. Comparison of Modeling Methodologies

	Methodology 1 (Tiered)	Methodology 2 (Class)
Mechanics	• **Creates 5 different hospital tiers,** each with its own increase percentages • Tiers based on point system, with **4 "base"** categories by hospital type and **4 "add-on"** categories by hospital characteristics	• Establishes separate payment pools for up to **4 different hospital classes** • Hospital classes based on mutually exclusive peer groups
Granularity	• Recognizes key Medicaid service lines across hospital types • Granularity in reimbursement increases for hospitals within the same base category	• No granularity within a hospital class (all providers have the same uniform payment increase percentage)
Simplicity	• More complex and difficult to explain (although more transparent than the FMP approach) • May require a more complex CMS submission process	• Simple and easy to understand • More likely to have a streamlined CMS submission process

LDH indicated that the following considerations influenced the decision to suggest the tiered modeling approach. While LDH recognized the potential benefits associated with the class modeling approach, the considerations outlined below were determined to outweigh the benefits associated with the simplicity of Methodology 2.

Hospital System Impacts. Our analyses suggested that Methodology 1 (tiered approach) can more effectively mitigate payment impacts by hospital system relative to funding levels based on a combination of the existing DSH, FMP, and UPL payments. As mentioned, the modeled hospital system groupings consisted of larger hospital systems as well as groupings of smaller hospitals with similar attributes.

Payment Granularity. The tiered approach allows for more granularity in directed payment funding by hospitals within a base class relative to payments by hospital under the class approach.

Value Based Purchasing. The tiered methodology would enable a more streamlined process to integrate quality metrics in subsequent years, which is likely to be required by CMS. For example, LDH could modify the add-on categories in subsequent years to include VBP metrics that would influence point assignments and ultimately payment amounts by hospital.

Section 3: Summary of Results and Methodology

At LDH's direction we modeled payments under DFS **Methodology 1** described previously, using four separate funding level assumptions ranging from a $400 million to approximately $1 billion payment increase relative to existing hospital supplemental payment levels. A summary of each funding scenario is described as follows.

- **Scenario 1 (+$400 Million).** Assumes aggregate Medicaid supplemental payment levels **$400 million** higher than the $1.7 billion currently provided under the hospital FMP, UPL, and DSH programs combined. This funding level was established to enable key hospital systems to remain breakeven with supplemental payments under hospital FMP.
- **Scenario 2 (+$650 Million).** Adds approximately **$650 million** in supplemental payment funding. The methodology underlying scenario 2 builds on the framework established under scenario 1 and increases supplemental payments to several hospital systems that received lower increases under scenario 1.
- **Scenario 3 (+$900 Million) – proposed by LDH.** Adds approximately **$900 million** in supplemental payment funding. The methodology underlying scenario 3 builds on the framework established under scenario 1 and provides additional supplemental payments to several hospital systems. Hospital tiers 2 through 5 are funded at 95% of ACR for inpatient and outpatient services under scenario 3.
- **Scenario 4 (+$1.0 Billion).** Adds approximately **$1.0 billion** in supplemental payment funding. This scenario brings all hospital payments up to 95% of average commercial reimbursement (at the provider class level). This scenario reflects the maximum supplemental payments that LDH is considering implementing based on prior discussions with CMS related to the existing preprint approval process.

Based on a review of the DFS impacts by hospital system and the evaluation described in this section, **LDH proposes the Scenario 3 with approximately $900 million increase** relative to existing hospital supplemental payment levels. This was selected to balance hospital system impacts with the need to finance the non-federal share of DFS payment increases.

Note that all modeled aggregate payment changes are relative to $1.7B in current aggregate hospital FMP, UPL, and DSH payments. ***While funding scenarios lower than scenario 1 were considered, they were ultimately not pursued due to observed payment reductions for some hospital systems.*** Our evaluation of each scenario considered supplemental payment changes at four different levels of granularity, as illustrated in Figure 6.

Figure 6. Scenario Evaluation

Statewide	• Consistent with the metrics outlined in the description of each scenario above. • Assists with understanding total program funding relative to the existing funding levels.
Hospital Class	• Enables review of hospital payments based on the payment stratifications underlying the directed payment modeling. • Assists with understanding ACR metrics subject to CMS review.
Hospital System	• Payment impacts at the hospital system level was one of LDH's key considerations. • The model maximizes provider's ability to manage impacts between the hospitals in their systems.
Hospital	• Some stakeholder feedback may be based on impacts at the individual hospital level. • With over 100 hospitals in the state of Louisiana, negative impacts cannot be entirely mitigated at this level of granularity.

A key focus in our work with LDH was comprised of reviewing funding impacts at the hospital system level. Figure 7 provides a summary of existing funding sources for the 15 hospital system groupings included in our analysis.

Figure 7. Summary of Existing Funding by Hospital System (Values in $ Millions)

HOSPITAL SYSTEM	CY 2019 PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS			TOTAL
		DSH/UCC	FMP	UPL	
Rural (Public and Private)	$ 226.3	$ 0.0	$ 109.3	$ 4.5	$ 340.1
Other Urban Private	6.3	0.0	0.0	0.0	6.3
Glenwood Regional Medical Center	16.0	13.8	0.0	0.0	29.8
Lake Charles Memorial Hospital	46.8	38.1	3.5	0.0	88.4
Hospital Service Districts	176.3	28.5	171.3	0.0	376.1
Baton Rouge General / Baton Rouge Mid City	47.1	39.3	0.0	0.0	86.4
Louisiana Children's Medical Center	343.7	261.7	153.7	14.1	773.3
Christus	62.2	57.5	1.6	0.0	121.3
Allegiance Health	24.9	0.0	0.0	0.0	24.9
Ochsner / Lafayette General	326.9	199.4	52.9	10.8	589.9
Ochsner LSU Shreveport	154.1	134.1	160.1	0.0	448.3
Rapides Regional / Tulane University	108.4	74.6	0.0	0.0	183.0
Franciscan Missionaries of Our Lady	316.2	57.1	61.2	34.1	468.6
Willis-Knighton	76.6	40.8	0.0	0.0	117.4
Woman's Hospital	68.7	0.0	20.0	1.1	89.7
Total	**$ 2,000.6**	**$ 944.8**	**$ 733.5**	**$ 64.6**	**$ 3,743.6**

Note: Values have been rounded. The sum of DSH/UCC, hospital FMP, and UPL payments represents the $1.7 billion in current supplemental payments.

MODELING RESULTS BY HOSPITAL SYSTEM

Our modeled payment impacts for each scenario are summarized in Figure 8 below. This summary provides the net payment change by hospital system, considering the impact of the existing DSH, hospital FMP, and UPL payments relative to total modeled DFS payments (including modeled remaining DSH). ***Please note that the values in figure 8 represent preliminary estimates and should not be taken as a guaranty of payment amount.***

Figure 8. Preliminary Supplemental Payment Change by Funding Scenario (Values in $ Millions)

HOSPITAL SYSTEM	SCENARIO 1 +$400M	SCENARIO 2 +$650M	SCENARIO 3 +$900M (PROPOSED BY LDH)	SCENARIO 4 +1.0B
Rural (Public and Private)	$ 20.4	$ 64.9	$ 79.0	$ 79.0
Other Urban Private	3.1	3.2	8.0	10.5
Glenwood Regional Medical Center	0.0	0.0	3.7	9.6
Lake Charles Memorial Hospital	0.0	0.0	5.7	5.7
Hospital Service Districts	115.0	135.4	137.2	137.2
Baton Rouge General / Baton Rouge Mid City	7.8	8.7	23.3	31.1
Louisiana Children's Medical Center	17.5	60.3	106.0	133.5
Christus	0.0	0.0	12.9	34.3
Allegiance Health	10.4	10.9	28.8	38.4
Ochsner / Lafayette General	70.4	105.9	155.1	181.1
Ochsner LSU Shreveport	(42.5)	(32.3)	(27.3)	(27.3)
Rapides Regional / Tulane University	115.4	128.4	128.4	128.4
Franciscan Missionaries of Our Lady	27.1	85.2	113.3	114.8
Willis-Knighton	53.3	75.8	75.8	75.8
Woman's Hospital	2.1	3.5	50.0	75.0
Total	**$ 400.0**	**$ 650.0**	**$ 900.0**	**$ 1,027.1**

Note: Values have been rounded. Payment change is defined as the difference in total supplemental payments (DSH/UCC, hospital FMP, and UPL) under FMP relative to the respective alternative funding scenario.

Note that total payments in Figure 8 represent changes in gross supplemental payments, and do not consider any provider contributions used to partially finance the non-federal share of Medicaid payments. This topic is discussed in more detail under the Financing section below.

Further details on the modeled payment impacts are provided in the appendices. Appendix F provides a summary by hospital class and Appendix G provides a summary by hospital system.

FINANCING

It is our understanding that LDH is exploring different approaches to fund the non-federal share of DFS payments increases, which may include a combination of intergovernmental transfers (IGTs)[16] and provider assessments. Figure 9 provides a summary of the additional funding requirement under each of the modeled scenarios.

Figure 9. Preliminary Supplemental Payments Sources (Values in $ Millions)

PAYMENTS	CURRENT	SCENARIO 1 +$400M	SCENARIO 2 +$650M	SCENARIO 3 +$900M (PROPOSED BY LDH)	SCENARIO 4 +1.0B
DSH/UPL	$ 1,009.4	$ 352.2	$ 326.8	$ 143.6	$ 80.4
Directed Payment	$ 733.5	$ 1,790.7	$ 2,066.1	$ 2,499.3	$ 2,689.6
Total Gross Supplemental Payments	**$ 1,742.9**	**$ 2,142.9**	**$ 2,392.9**	**$ 2,642.9**	**$ 2,770.0**
Gross Supplemental Payment Change	N/A	$ 400.0	$ 650.0	$ 900.0	$ 1,027.1
Additional Funding Requirement	N/A	$ 57.9	$ 102.2	$ 126.3	$ 142.4
Net Payment Change	**N/A**	**$ 342.1**	**$ 547.8**	**$ 773.7**	**$ 884.7**

Notes:

- Gross Supplemental Payment change calculated as the difference between the Total Gross Supplemental Payments calculated under a given scenario and the Total Gross Supplemental Payments under current payment arrangements (sum of FMP, UPL, and DSH payments).
- Funding requirement amounts provided by LDH and consider non-federal share of provider payments along with identified downstream implications.
  - DSH/UPL Federal Match = 68.02%
  - Estimated Directed Payment Blended Federal Match = 77.91%
  - Managed Care Premium Tax = 5.5%
- Current funding is primarily financed through IGTs.

Based on our discussions with LDH, it is our assumption that generally the same IGT financing framework currently in place could be utilized under the alternative options, depending on the extent of aggregate payment increases over current supplemental payment levels. However, given the more widespread distribution of payments across hospitals under directed payments compared to the current FMP payments, we anticipate that many hospitals' Medicaid uncompensated care costs may be reduced or eliminated by new directed payments.

Based on our review of hospital assessment models provided by LDH, we understand LDH currently assesses non-rural hospitals at a rate of approximately 1% of net patient revenues (assessment is based upon 2015 base data period). This assessment rate is materially below the federal maximum for permissible health care-related assessments under the "hold harmless" test specified in 42 CFR § 433.68(f), which limits the size of Louisiana's aggregate hospital assessments to 6.0% of net patient revenues. As discussed earlier in this report, LDH hospital financing currently has a high reliance on IGTs corresponding to a relatively low usage of provider assessments. To better balance the funding sources, LDH proposes to finance the non-federal share via a new provider assessment.

Based on the hospital assessment model provided by LDH, we estimate there is approximately $567 million in gap between a 6.0% assessment rate (applied to non-rural hospitals) and the current assessment rate. Note that CMS' evaluation of hospital assessment changes may involve factors beyond the 6% hold harmless test and P1/P2 test, including evaluation of net hospital impacts and other considerations. Also note that due to the uniform application of an assessment, the resulting net payment impacts would vary relative to impacts under IGT funding.

PAYMENT BENCHMARKING

The CMS preprint approval process and new preprint guidance require states to submit a payment benchmarking analysis that estimates the base claim payments and other supplemental payments (including the proposed directed payment) "as a percent of Medicare, or some other standardized measure."[17] To inform directed payment options and parameters and provide insight on CMS evaluation considerations, we calculated payment benchmarks to compare Medicaid payments (under the current system and under each modeled scenario) to estimated costs (incurred by the

[16] IGTs are transfer of funds from another government entity to the state Medicaid agency.
[17] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021

hospitals for performing Medicaid managed care services), estimated payments under Medicare, and estimated payments under commercial insurance.

Aggregate benchmarking results under each scenario are summarized in Figure 10. Current payments include CY 2019 Medicaid managed care claim payments and hospital FMP payments.[18] Benchmarking percentages in Figure 10 represent gross payments and have not been adjusted by provider contributions used to partially finance the non-federal share of Medicaid payments.

Figure 10. Hospital Payment Benchmarking – Inpatient and Outpatient Hospital Services

	AS % OF ESTIMATED COST		AS % OF MEDICARE PAYMENTS		AS % OF COMMERCIAL PAYMENTS	
BENCHMARKING	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT
Scenario 1: +$400M	115.1%	146.3%	89.4%	170.8%	77.3%	76.3%
Scenario 2: +$650M	123.1%	157.2%	95.7%	183.5%	82.7%	82.1%
Scenario 3: +$900M – proposed by LDH	135.8%	174.5%	105.5%	203.7%	91.2%	91.1%
Scenario 4: +$1.0B	141.4%	182.0%	109.9%	212.5%	95.0%	95.0%

As shown in Figure 10, Scenarios 3 and 4 produce statewide aggregate inpatient and outpatient Medicaid hospital reimbursement levels above estimated costs and Medicare payments and below commercial payments. Please note that values provided in Figure 10 represent a weighted average of all hospital classes; however, each class is established to be at or below 95% of commercial payments separately for inpatient and outpatient services. Also as shown above, these benchmarks range significantly by scenario. We calculated payment benchmarks as follows:

- ***Estimated costs:*** based on hospital-specific aggregate cost-to-charge ratios (CCRs) from hospital fiscal year ending (FYE) Medicare cost report data extracted from the Healthcare Cost Report Information System (HCRIS) dataset, CMS's electronic cost report database. We calculated separate aggregate CCRs for inpatient and outpatient and applied them to CY 2019 Medicaid managed care encounter charges. Note estimated Medicaid costs do not include an allocation of potential increases in hospital assessments.
- ***Estimated payments under Medicare:*** based on hospital-specific aggregate Medicare pay-to-charge ratios from hospital FYE Medicare cost report data extracted from the HCRIS dataset. We calculated separate aggregate Medicare pay-to-charge ratios for inpatient and outpatient and applied them to CY 2019Medicaid managed care encounter charges.
- ***Estimated payments under Commercial:*** based on aggregate hospital commercial pay-to-charge ratios for each metropolitan statistical area (MSA) within Louisiana, including a separate rural area pay-to-charge ratio, applied to CY 2019 Medicaid managed care encounter charges. We calculated commercial pay-to-charge ratios by MSA (and rural areas outside of an MSA) and by inpatient and outpatient service lines based on commercial payer billed and allowed charges from Milliman's Consolidated Health Cost Guidelines Sources Database (CHSD).

We compared these benchmarks to the sum of historical (e.g., CY 2019) Medicaid managed care claim payments and modeled DFS payments. Note that estimated hospital outlier payments may also be considered, consistent with CMS preprint requirements, upon final preprint submission.

VALUE-BASED PURCHASING

As discussed previously, a VBP approach can be layered on top of the DFS to more closely link the payment to quality and value. Specific VBP options for LDH consideration are discussed below.

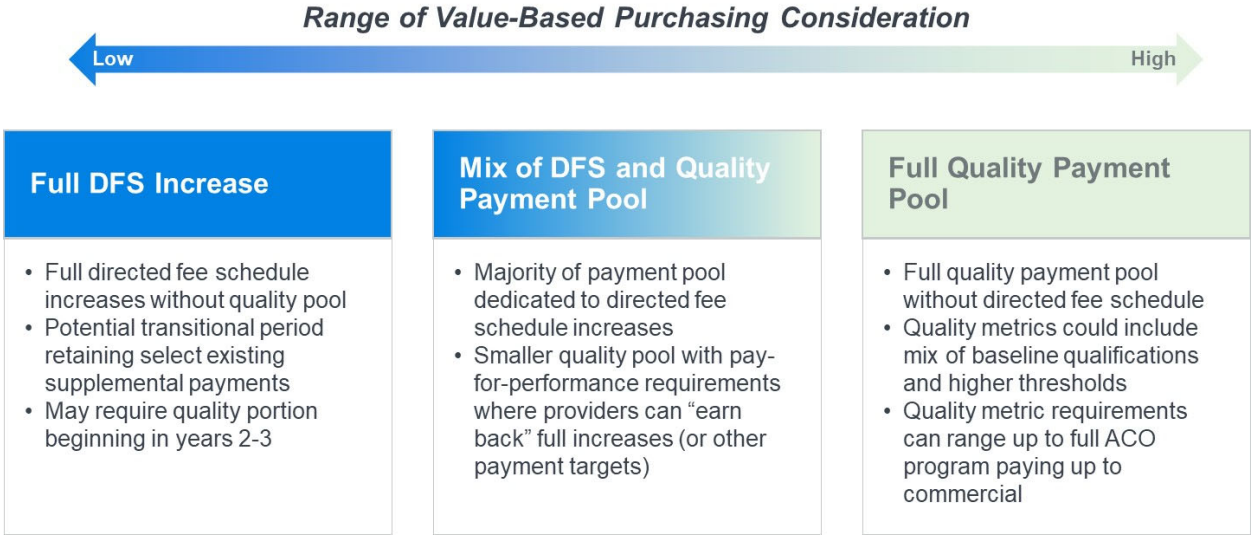
LDH currently includes provisions in its MCO contracts where 1% of capitation is tied to meeting quality metrics and an additional 1% of capitation is tied to meeting annual APM targets for contracted providers.

[18] The Medicaid managed care benchmarking analysis does not include UPL payments, as these are made on a fee-for-service basis.

In addition, the MCO contracts provide for certain hospital-directed payments. However, the quality and APM requirements are not linked to the directed payment requirements. One option for meeting CMS requirements that directed payments support the state's quality strategy would be to design a connection between these contractual requirements. A benefit of this approach is that synergies may be achieved by aligning incentives so that both MCOs and hospitals are rewarded for working toward the same quality strategies.

Both CMS and HCP-LAN, a public-private partnership supporting the move toward VBP, emphasize that implementing VBP can be done on a phased-in basis. Figure 11 provides an illustration of how a phased-in approach can be implemented by LDH.

Figure 11. Value-Based Purchasing Balancing



Utilizing supplemental payments provides an opportunity for states to implement VBP methodologies that work to achieve the state's quality, access, and utilization goals. VBP approaches can be layered on top of the DFS-directed payment options discussed above, where a portion of the "full" DFS payment pool can be withheld and used for a quality payment pool. Initially, LDH may consider establishing a smaller quality pool (as a subset of the total dollars available) with pay-for-performance opportunities established on a hospital-class basis, while the majority of payment pool dollars remain dedicated to a directed fee schedule increase. Over time, as hospitals achieve the desired quality goals, LDH may consider increasing the targets in order for hospitals to earn those dedicated dollars.

There are a variety of mechanisms under the HCP-LAN framework where providers can begin to be incentivized to begin investing in value-based care, such as through the use of certain HCP-LAN Category 2 payment types:

- Foundational spending to improve care (linked to quality)
- Pay-for-reporting payments paid to fee-for-service providers
- Bonus payments (linked to quality) paid to fee-for-service providers

These strategies may be attractive as a starting point because their requirements are relatively easy for providers to achieve (thereby alleviating concerns about revenue reductions) or because they layer on top of traditional fee-for-service payment mechanisms, while intentionally beginning the shift in focus to quality and encouraging providers to grow new capabilities to support value.

CMS requires that VBP requirements must be reasonable and achievable.[19] With these factors in mind, LDH may choose to begin this shift by allocating a portion of the directed payment dollars to reward hospitals that meet reporting or infrastructure-building goals, or that earn quality dollars for meeting metrics related to quality and access. An example approach would be to dedicate 5% of full DFS funding towards a quality payment pool. The hospital-level impacts of the quality payment would vary depending on the nature of the quality metrics, the thresholds established, and ultimately the performance of the hospitals. LDH could utilize this approach at DFS implementation, or transition

[19] 42 CFR §438.6(3)

towards this approach over time (for example, in years 2 or 3), with further potential transitions or evolution over the duration of the program.

LDH will also want to consider what happens to unearned quality pool dollars if one or more hospitals within a class fail to meet its quality goals. Potential options could include:

- Allowing the dollars to roll forward and be earned in the future, if the hospital meets its goal at a later date
- Reapportioning the dollars to those hospitals in the class that were successful in meeting the goal
- Allowing the successful hospitals to earn the additional dollars in some other way (e.g. submit proposals for one-time funding to support projects like quality infrastructure development or recipient outreach projects)

Section 4: Data Sources

The data sources utilized in our analysis are described in further detail as follows.

MEDICAID CLAIMS DATA

Medicaid managed care hospital claim-based payments used to model DFS payments were based on CY 2019 Medicaid managed care inpatient and outpatient encounter data provided by LDH on December 18, 2020. The encounter data was validated by comparing total payments and charges to summary control totals provided by LDH on December 17, 2020. Additionally, LA encounter reconciliation reports provided by LDH on December 7, 2020 were reviewed for each of the participating managed care organizations. The base CY 2019 Medicaid managed care payment and charges relied upon for our directed payment modeling includes in-state general acute hospitals and psychiatric distinct part units, and excludes at LDH's direction FFS claims, Medicare dual eligibles, out-of-state hospitals, freestanding psychiatric, rehabilitation, long-term acute care hospitals, and the state-owned hospital Lallie Kemp.

MEDICAID SUPPLEMENTAL PAYMENT DATA

Medicaid hospital supplemental payments included in our analysis were from the following sources:

- ***Hospital FMP payments:*** based on estimated FMP payments by hospital, provided by LDH on May 20, 2021.
- ***DSH/UCC payments:*** based on estimated SFY 2020 DSH payments by hospital, consistent with the Money Follows the Patient (MFP) model provided by LDH on November 24, 2020.
- ***UPL payments:*** based on estimated UPL payments, provided by LDH on May 20, 2021.
- ***Hospital outlier payments:*** based on SFY 2021 estimated provider-specific hospital outlier payments, provided by LDH on January 22, 2021.

MEDICAID HOSPITAL CONTRIBUTIONS DATA

Medicaid hospital contributions (used to help fund the non-federal share of supplemental payments) included in our analysis were from the following sources:

- ***IGT contributions:*** based on the current and proposed IGT and Certified Public Expenditures (CPE) amounts, by hospital, provided by LDH on May 20, 2021.
- ***Hospital assessments:*** based on SFY 2021 hospital assessments, by hospital, provided by LDH on January 27, 2021.
- ***Provider funding requirements*****:** based on estimated funding requirements considering non-federal share of provider payments along with premium tax collections and CPEs, provided by LDH on June 22, 2021.

MEDICAID INPATIENT PER DIEM RATES

LDH's current inpatient per diem rates and hospital unit and peer group assignments are based on the inpatient hospital per diem listing downloaded from the LDH website on December 17, 2020.[20]

MFP MODEL

MFP model amounts were obtained from the Excel workbook "Louisiana Money Follows the Patient Model (May 23 2020 Final).xlsx" received from LDH on November 24, 2020. Our understanding of the MFP model methodology is based on review of the LDH presentation "LDH Budget – FY21 Hospital Money Follows the Patient (MFP) Payment Model" dated June 10, 2020, and provided by LDH on November 24, 2020, as well as on discussions with LDH.

[20] https://www.lamedicaid.com/Provweb1/fee_schedules/InPat_Fee.htm

This information was used to understand the background of directed payment options discussed in Louisiana, yet in no way informed the development of the options presented in this report.

MEDICARE COST REPORT DATA

For benchmarking Medicaid payments compared to estimated costs and payments under Medicare, we relied upon Medicare cost report data extracted from CMS' HCRIS dataset. We used the most recently available Medicare cost report data for each hospital, which for most hospitals was the fiscal year ending (FYE) 2019, and some hospitals with FYE 2018 data.

Aggregate cost-to-charge ratios (CCRs) were calculated separately for inpatient and outpatient for each hospital to reflect differences in routine costs and charges for inpatient services versus ancillary-only outpatient services. CCRs for each hospital were calculated using cost report worksheet B part I and C part I data. Total costs with medical education were allocated to inpatient and outpatient at the cost center level based on the proportion of reported inpatient and outpatient charges. Allocated inpatient and outpatient costs, as well as inpatient and outpatient charges, were then summed across cost centers for each hospital. Aggregate CCRs were calculated for each hospital by dividing total inpatient and outpatient costs by inpatient and outpatient charges, respectively. For a limited set of hospitals missing Medicare cost report data (approximately 3% of total charges), we relied upon statewide averages.

Aggregate Medicare pay-to-charge ratios were calculated separately for inpatient and outpatient for each hospital using data from Medicare cost report worksheets D-3, D Part IV, E Part A, E Part B, and E-3 Parts I-3 and 5. Aggregate Medicare pay-to-charge ratios were calculated for each hospital by dividing total inpatient and outpatient Medicare payments by total inpatient and outpatient Medicare charges, respectively. Inpatient Medicare payments relied upon include Medicare inpatient prospective payment system (IPPS) payment components, uncompensated care adjustments, and other settlement amounts. For a limited set of hospitals missing Medicare cost report data, we relied upon statewide averages.

MILLIMAN'S CONSOLIDATED HEALTH COST GUIDELINES SOURCES DATABASE (CHSD)

Milliman CHSD data used to calculate commercial pay-to-charge ratios consists of CY 2019 national commercial payer claims received from health plan contributors, including approximately 11-15 payers in Louisiana (depending on the MSA). CHSD data contains aggregated billed and allowed charges data across by Louisiana MSA, including separate data for rural Louisiana (outside of an MSA). Aggregate commercial pay-to-charge ratios were calculated for each MSA and inpatient and outpatient service line by dividing total commercial allowed by total commercial billed. For three MSAs with more limited sample sizes, we relied upon statewide averages.

Section 5: Conclusions and Next Steps

Milliman appreciates the opportunity to present this report to LDH, in response to Senate Concurrent Resolution Number 27, and appreciates the assistance provided by LDH staff and the Medicaid Agency specifically.

We provide the following potential next steps to this report for LDH's consideration, should it wish to pursue an alternative state directed payment methodology:

1. Review of the options with LDH, the Louisiana State Legislature, and the administration.
2. Evaluate options provided including continued and increasing investment in value-based purchasing methodologies.
3. Establish final funding amount for the state-directed payment program and financing options to fund the program.
4. Continue stakeholder engagement with the hospital community on directed payment arrangement parameters and quality metrics.
5. Schedule informal discussion with CMS to review proposed directed payment arrangement parameters prior to preprint submission.
6. Develop final directed payment model, approach, quality metrics, and evaluation plan, and summarize in the preprint application and supporting documentation for submission to CMS. Preprint application would need to be submitted no later than April 1, 2022 to achieve an effective date of July 1, 2022.
7. Review and evaluate actuarial rate-setting implications related to documenting and incorporating state directed payments into the managed care capitation rates, consistent with CMS requirements outlined in the 2020-2021 Medicaid Managed Care Rate Development Guide.
8. Monitor ongoing issues related to financing the non-federal share of Medicaid costs. As we begin a new Administration and a new Congress, with new leaders in HHS and CMS, it is vitally important to evaluate the interpretations of the new Administration and Congress and its impact on states, particularly with financing mechanisms.

Section 6: Limitations

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and the Louisiana Department of Health dated December 8, 2020.

The information contained in this report has been prepared for the Louisiana Department of Health (LDH). We understand that this report may be shared with the Louisiana Legislature, specifically the Joint Legislative Committee on the Budget. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in healthcare modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for LDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The recommendations or analysis in this report do not constitute legal advice. We recommend that users of this material consult with their own legal counsel regarding interpretation of applicable laws, regulations, and requirements.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to analyze and evaluate state-directed payment options. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes CY 2019 Medicaid encounter data, Medicaid supplemental payment data, MFP model results, and Medicaid hospital contributions provided by LDH. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent the actual experience deviates from LDH's projected experience Medicaid coverage payments. This could be driven by a number of factors including changes in enrollment, hospital utilization and service mix, COVID-19-related impacts, and other factors.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Jason Clarkson, Carmen Laudenschlager, and Colin Gray are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

Appendix A

Appendix A: Background

As Medicaid becomes one of, if not the largest part of a state's budget, many states are struggling to find ways to finance their Medicaid program while balancing all other state needs. Nationally, the Medicaid program has grown from 12.1% of the state's budgets in 1992 to 20.0% in 2018.[21]

As a result, Medicaid programs throughout the country utilize various funding sources to finance their Medicaid program. Programs like Provider-Specific Taxes (PSTs), Intergovernmental Transfers (IGTs), and Certified Public Expenditures (CPEs)[22] are utilized for Medicaid funding by every state except for Alaska.[23] The use of public funds for IGTs and CPEs is permitted in 42 CFR Appendix C33.51[24] as long as they are not federal funds. Health care-related assessments are a growing funding source for Medicaid programs nationally and federal financial participation (FFP) is permissible according to the parameters specified in 42 CFR 433.68.[25] These funding sources are used to provide the non-federal share of Medicaid payments.

SUPPLEMENTAL PAYMENTS

Supplemental payments are Medicaid payments made to providers above the payments the provider receives for individual Medicaid services.[26] Directed payments are a subset of supplemental payments. These supplemental payments have evolved as a way for states to increase reimbursement to healthcare providers through the revenue generated by these various funding sources. Hospitals are often a focus of supplemental payments. In FY 2019, over $87.7 billion in supplemental payments was paid nationally to hospitals.[27] Based on our analysis of Louisiana Medicaid hospital supplemental payments provided by LDH, there is currently a total of $1.7 billion in supplemental payments, with approximately $945 million in DSH payments made to hospitals and $798 million in non-DSH supplemental payments (amounts do not consider any physician FMP payments that may be made directly to hospitals).

As managed care programs began to grow in Medicaid, states often "passed through" or "directed" the MCOs to pay the supplemental payments on a specific time schedule and/or for a specific amount. Over time, both Congress and CMS have limited the use of these pass-through and/or directed payments.[28] Given the widespread use of these payments, CMS created a "preprint" that allows each state to submit their proposed directed payment methodology for review in a consistent and compliant manner.[29] CMS has approved more than 450 state-directed payment arrangements that start on or after July 1, 2017.[30] CMS has continued to offer guidance on this topic, and on January 8, 2021, CMS issued enhanced requirements for supplemental payments and additional reporting requirements (discussed further below).[31]

FEDERAL REQUIREMENTS FOR DIRECTED PAYMENTS

State directed payments are defined as "arrangements [that] allow states to require MCOs to make specified payments to healthcare providers when the payments support overall Medicaid program goals and objectives." [32] On

[21] MACStats: Medicaid and CHIP Data Book, December 2020, https://www.macpac.gov/wp-content/uploads/2020/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2020.pdf, Exhibit 13, retrieved January 8, 2021
[22] Medicaid and CHIP Payment and Access Commission (MACPAC), Non-federal financing, https://www.macpac.gov/subtopic/non-federal-financing/, retrieved January 8, 2021
[23] "States and Medicaid Provider Taxes or Fees," KFF Fact Sheet, June 2017 http://files.kff.org/attachment/fact-sheet-medicaid-provider-taxesfees-an-update, retrieved January 8, 2021
[24] 42 CFR § 433.51 – Public Funds as the State share of financial participation, https://www.govregs.com/regulations/expand/title42_chapterIV_part433_subpartB_section433.51#title42_chapterIV_part433_subpartB_section433.51, retrieved January 8, 2021/or
[25] https://www.govinfo.gov/app/details/CFR-2011-title42-vol4/CFR-2011-title42-vol4-sec433-68 (introduction section), retrieved January 6, 2021
[26] https://www.everycrsreport.com/files/20181217_R45432_e7264e139470177b402b2ddf06220f50a36322fa.pdf, retrieved January 9, 2021.
[27] MACStats: Medicaid and CHIP Data Book, December 2020, https://www.macpac.gov/wp-content/uploads/2020/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2020.pdf, retrieved January 8, 2021
[28] https://www.everycrsreport.com/files/20181217_R45432_e7264e139470177b402b2ddf06220f50a36322fa.pdf (p. 16), retrieved January 9, 2021
[29] CMS Pre-Print for § 433.6(c), https://www.medicaid.gov/Medicaid/downloads/438-preprint.pdf, retrieved January 8, 2021
[30] 20210108 CMS SMD#21-001, Additional Guidance on State Directed Payments in Medicaid Managed Care and Health and Human Services, Centers for Medicare & Medicaid Services § 438.6(c) Preprint, January 2021
[31] 20210108 CMS SMD#21-001, Additional Guidance on State Directed Payments in Medicaid Managed Care and Health and Human Services, Centers for Medicare & Medicaid Services § 438.6(c) Preprint, January 2021
[32] Approved Medicaid State Directed Payments: How States are Using §438.6(c) "Preprints" to Respond to the Managed Care Final Rule, https://us.milliman.com/en/insight/approved-medicaid-state-directed-payments-how-states-are-using-4386c-preprints-to-res, retrieved January 12, 2021

November 2, 2017, CMS issued the "§438.6(c) Preprint" to be utilized by states when seeking approval for state-directed payments.

According to 42 CFR 438.6(c)(1), the state may not unilaterally direct specific payments to providers through their Medicaid managed care contracts without meeting certain requirements, which are discussed below. The state may, however, require MCOs to:[33]

- Adopt a minimum fee schedule for network providers using State plan approved FFS rates (where payments must be at least FFS rate levels).
- Adopt a minimum fee schedule for network providers using rates other than the State plan approved rates (based on either payments under Medicare or an alternative fee schedule established by the State).
- Provide a uniform dollar or percentage increase for network providers
- Adopt a maximum fee schedule for network providers as long as the MCO has the ability to manage risk and manage the requirement under the contract

Directed payment policies must: [34]

- Be based on utilization and delivery of services
- Direct expenditures equally and use the same terms of performance for a ***class of providers***
- Advance at least one of the goals and objectives in the state's quality strategy
- Not require participation in an IGT program
- Be renewed annually

In 2019, CMS issued a proposed rule entitled the Medicaid Fiscal Accountability Regulation (MFAR). The goal of this rule was to increase transparency and accountability for Medicaid financing.[35,36] The provisions of this regulation included increasing the reporting requirements for supplemental payments, clarifying the financing definitions, and reducing questionable financing mechanisms. While CMS withdrew their proposed MFAR rule[37] accountability and transparency regarding the financing of Medicaid on a state level is expected to continue to be a critical, bipartisan issue.

Building on its earlier 2017 guidance[38], on January 8, 2021, CMS provided clarifying guidance on permissible types of state directed payment initiatives. The 2017 Informational Bulletin had defined three types of state-directed payment arrangements through which states may direct MCOs to:

- **Implement VBP models.** Examples include bundled payments, episode-based payments, accountable care organizations, and other models that reward providers for delivering greater value and achieving better outcomes
- **Implement multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives.** Examples include pay-for-performance arrangements, quality-based payments, and population-based payment models.
- **Adopt specific types of parameters for provider payments**. Examples include minimum fee schedules, uniform dollar or percentage increases, and maximum fee schedules.[39]

[33] 42 CFR §438.6(c)(1)(iii)
[34] 42 CFR §438.6(c)(2)(i)
[35] "What You Need to Know About the Medicaid Fiscal Accountability Rule (MFAR), KFF Issue Brief, January 2020, http://files.kff.org/attachment/Issue-Brief-What-You-Need-to-Know-About-the-Medicaid-Fiscal-Accountability-Rule, retrieved January 8, 2021
[36] "Fact Sheet: 2019 Medicaid Fiscal Accountability Regulation (MFAR), CMS, November 12, 2019, https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar, retrieved January 8, 2021
[37] September 14, 2020, via Twitter, Administrator Seema, Verma https://twitter.com/SeemaCMS/status/1305608634165010443?s=20
[38] Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts, Centers for Medicare and Medicaid Services (CMS) CMCS Informational Bulletin, November 2, 2017, page 1 - 2. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib11022017.pdf, retrieved January 7, 2021.
[39] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf, retrieved January 10, 2021

As part of the January 2021 guidance, CMS released a revised "Section 438.6(c) Preprint" form for states to use in applying for approval of state-directed payments.

The preprint now groups the above three permissible state directed payments into two categories:

1. **State Directed Value-Based Payments/Delivery System Reform** (*combines the first two permitted arrangements described in the 2017 bulletin above*)
2. **State Directed Fee Schedules**[40]

Furthermore, the recently enacted Consolidated Appropriations Act of 2021 (Public Law 116-270),[41] which funded the government for the Fiscal Year ending September 30, 2021 addressed some of the COVID-19 emergency funding issues and imposed additional requirements on states for reporting supplemental payments to CMS. This legislation added a new section to 42 USC 1396b. The January 8, 2021 State Medicaid Director Letter and preprint also further clarified the rules and increased the reporting requirements for approval of supplemental payments. New clarifications and CMS reporting mandates for contract rating periods that begin on or after July 1, 2021 include:[42]

- Clarified that all supplemental payments must be made for a "specific service or benefit provided to a specific enrollee." State directed payment would be considered out-of-compliance if they do not provide this level of accountability.
- Requires prior written approval of all state directed payment programs before implementation – specifically CMS recommends that states submit preprints at least 90 days prior to the start of the rating period.
- States must justify that provider payment rates are "reasonable, appropriate and attainable." CMS' evaluation of proposed directed payments will include a required benchmarking of managed care payments streams against payments under Medicare or another standardized measure.
- Requires the state to justify their payments by provider class, average base rate paid by plans, and the effect on total reimbursement of the state-directed payment or pass-through payments.
- Revises the 438.6 preprint to require more transparency regarding state-directed payments.
- Clarifies that provider classes cannot be defined to only include providers that provide IGTs.
- Requires significant transparency for the IGT contributions, including information such as the name of each entity transferring funds and the total amounts to be transferred by entity. This means that LDH will need to determine the hospital-specific allocation of IGTs before submitting the new preprint form.

In addition, CMS is currently working to formalize its benchmarking requirements. Due to these new and evolving CMS requirements, LDH should carefully consider any new developments and engage early with CMS during the development of new state-directed payment arrangements.

FEDERAL REQUIREMENTS FOR ALTERNATIVE PAYMENT MODELS AND DELIVERY MODELS AND VALUE-BASED PURCHASING ARRANGEMENTS

CMS has encouraged states to increase the number of alternative payment models (APMs) and value-based purchasing (VBP) programs in their managed care programs and to consider VBP concepts in directed payment methodologies. In a State Medicaid Director letter issued on September 15, 2020,[43] CMS further outlined strategies a state could take to implement VBP through Alternative Payment and Delivery Models (APMs).

[40] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021
[41] https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf, retrieved January 6, 2021
[42] CMS SMD #21-001, Re: Additional Guidance on State Directed Payments in Medicaid Managed Care, January 8, 2021, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf, retrieved January 8, 2021.
[43] CMS, Value-Based Care State Medicaid Directors Letter, September 15, 2020, Value-based Care State Medicaid Directors Letter | CMS, retrieved January 7, 2021

Some of those strategies include:

- "Payment Models built on Fee-for-Service Architecture" such as targeting a certain population or service and shared savings. CMS identified four concepts under shared savings
  - "*a total cost of care benchmark,*
  - *provider payment incentives to improve care quality and lower total cost of care,*
  - *a performance period that tests the changes, and*
  - *an evaluation to determine the program cost savings during the performance period."*
- "Payments for Episodes of Care" such as bundled payments for a specific healthcare event, may include "upside" and "downside" risk
- "Payment Models Involving Total Cost of Care Accountability" where providers are responsible for meeting certain benchmarks and performance metrics and are at financial risk for all services.

Another focus area states can promote in their value-based purchasing programs are those items that address Social Determinants of Health (SDOH). The Centers for Disease Control and Prevention (CDC) defines SDOH as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."[44] CMS recently issued a State Health Officer (SHO) letter outlining options states could utilize to address SDOH under current law.[45] In this SHO letter, CMS outline three components: (1) principles that CMS expects states to comply with; (2) currently covered services and supports that address SDOHs; and (3) federal authorities that permit Medicaid payment for programs that address SDOHs.[46] Three overarching principles identified by CMS are:

1. "Services must be provided to Medicaid beneficiaries based on individual assessments of need, rather than take a one-size-fits-all approach"
2. Medicaid is the payer of last resort
3. Programs and payments for services and benefits must be consistent with "efficiency, economy, and quality of care" requirements for the Medicaid program.

CMS also identifies several types of SDOH-related services that can be supported under current law and regulations including:

- Housing-related services and supports such as "home modification, one-time community transition costs and housing and tenancy supports"
- Non-medical transportation for waiver (HCBS) service recipients
- Home-delivered meals for waiver (HCBS) service recipients
- Educational services for children in coordination with the Individuals with Disabilities Education Act (IDEA)
- Employment including incentives to gain Medicaid eligibility for participating in work related activities and employment services for individuals in the HCBS waivers.
- Community integration and social supports for waiver (HCBS) service recipients.
- Case management

Separately, the Office of the Inspector General (OIG) of HHS has encouraged states to identify strategies to protect the Medicaid program from fraud, waste, and abuse as they implement VBP programs.[47] Issues identified by the OIG include misalignment of incentives, 'cherry picking' healthier beneficiaries, and lack of quality due to reduction of care/services. Recommendations made to CMS include:

- Clearly define actionable and meaningful quality measures and ensure their reliability, accuracy, and utility
- Utilize evidence-based measures

[44] https://www.cdc.gov/socialdeterminants/about.html, retrieved January 10, 2021
[45] "Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)", SHO#21-001, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf, retrieved January 8, 2021
[46] Ibid.
[47] U.S. Department of Health and Human Services, Office of Inspector General, 2019 Top Management and Performance Challenges Facing HHS, https://oig.hhs.gov/reports-and-publications/top-challenges/2019/2019-tmc.pdf#page=13, retrieved January 7, 2021

NATIONAL LANDSCAPE FOR MEDICAID HOSPITAL PAYMENTS

There is a growing trend to tie Medicaid hospital reimbursement to APMs (tying payments to meeting quality-related requirements, rather than volume of services), particularly in managed care programs. Many of these arrangements are pursued as a private negotiation between the MCO and individual hospital systems. States are also beginning to include APM requirements in their MCO contracts, either as a contractual requirement with flexibility for how to adopt APM or layered on top of existing or new directed payment methodologies. These VBP and directed payment requirements can apply to various provider types, but we will primarily focus here on the landscape of hospital-focused options.

Alternative Payment Methodologies

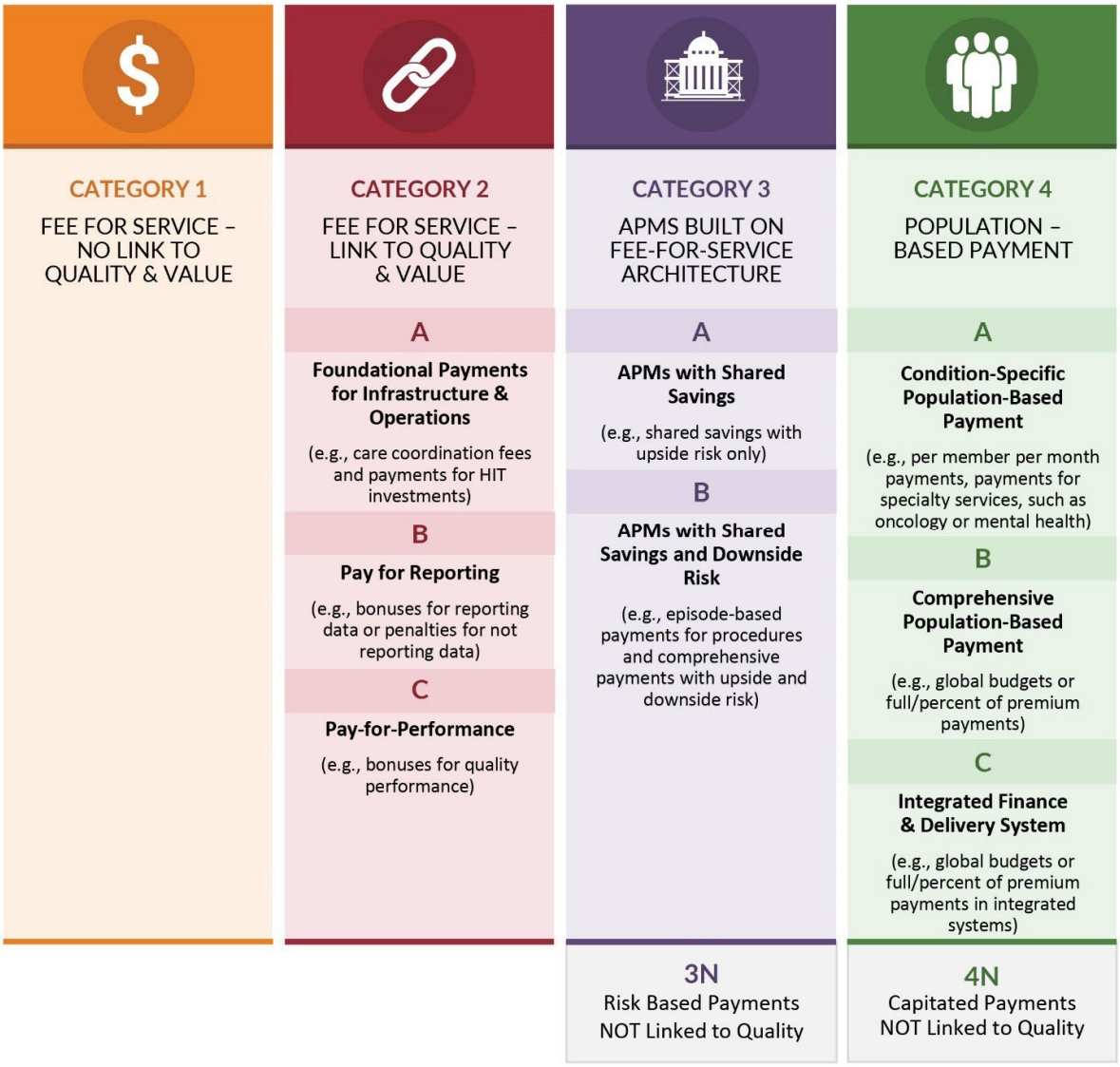
Using provider reimbursement as a way to reward providers for delivering higher-value care has become a theme in healthcare coverage programs across all market segments. The Health Care Payment Learning & Action Network (HCP-LAN)[48] was launched by the U.S. Department of Health and Human Services in 2015 as a public-private effort to support and promote this move toward VBP. With a goal to align efforts and identify best practices, the HCP-LAN has adopted the following APM framework as a national model for how government and private payers may work with healthcare providers toward this goal.

Figure A-1 below outlines the HCP-LAN framework, which has become a widely accepted way to describe the glidepath from volume-based, fee-for-service payment structures to increasing levels of provider payments based on value.

Important to this structure is the vision that payments should be significant enough to motivate providers to invest in new approaches to care delivery that support access and quality while not jeopardizing the provision of healthcare services. The goal should be to pursue a “glidepath”, moving intentionally from left to right on the spectrum of APM categories (with most spending ultimately focused in Categories 3 and 4), while providing ample support to providers in this advancement. The lower-level categories are useful to support this investment and build provider capabilities to advance their ability for taking risk and driving outcomes. Payments that are not tied to quality do not qualify as an APM and do not contribute to payment reform as defined by the HCP-LAN.[49]

[48] Health Care Payment Learning & Action Network (HCPLAN), https://hcp-lan.org/, retrieved January 10, 2021
[49] http://hcp-lan.org/workproducts/apm-factsheet.pdf, retrieved January 9, 2021.

Figure A-1: HCP-LAN APM Framework (as refreshed in 2017)[50]



The HCP-LAN Survey – Extent of APM Adoption

HCP-LAN works with several other national groups to annually assess progress toward these payment reform goals, including the Blue Cross Blue Shield Association (BCBSA), America's Health Insurance Plans (AHIP), and CMS. Each year, these groups work together to conduct surveys with common questions and aggregate responses about APM payments from health plans, fee-for-service states, and traditional Medicare. In 2019, these combined surveys captured data from approximately 77% of the national all-payer market and 51% of the national Medicaid market (based on calendar year 2018 provider payments). The chart below indicates the distribution of total dollars (including medical, behavioral health, and to the extent available, pharmacy) that were paid to providers under each payment type category. Long-Term Services & Support (LTSS), dental, and vision payments were excluded from this survey.[51]

[50] https://hcp-lan.org/apm-refresh-white-paper/, retrieved January 9, 2021
[51] http://hcp-lan.org/workproducts/apm-methodology-2019.pdf, retrieved January 7, 2021.

Figure A-2. HCP-LAN Survey Summary: Distribution of Provider Payments by APM Category

APM Framework Category	All Payers	Medicaid Only
Category 1 (FFS only)	39.1%	66.1%
Category 2 (FFS with a link to quality and value)	25.1%	10.6%
Category 3 (APMs built on FFS Architecture)	30.7%	17.4%
Category 4 (Population-Based Payment)	5.1%	5.9%

This data suggests that those states that want to link Medicaid reimbursement to value and quality have the opportunity to promote and benefit from VBP, relative to other types of payers given that 66.1% of all Medicaid payments are still based on FFS without a link to quality and value. However, the same survey found that payers believed "the impact of government" to be one of the top three drivers for APM adoption. As one of the major government payer types, state Medicaid programs are in a unique position to promote APMs and use their purchasing power to achieve quality and outcome goals through payment reform.

State-Led APM Requirements

While Medicaid may be behind other payer types in adoption of APMs, notable progress is being made in a number of states. In part spurred by CMS pressure to link supplemental payments to value, as well as concerns for growing Medicaid budgets and a need to tie payments to value rather than volume, VBP is becoming more common in Medicaid managed care programs. For instance:

- 8 states (CA, FL, GA, IA, MN, OH, RI, TN) had MCO contracts that included a state-VBP initiative in 2019 and 7 states (IL, KS, LA, MO, MS, PA, VA) were set to start one in 2020; and
- 12 states (AZ, DE, GA, HI, IA, KS, LA, MI, MN, NM, NY, RI) required MCOs to develop a VBP strategy within state-specific guidelines in 2019 and another 5 states (MO, NH, OR, PA, UT) were set to do the same in 2020.[52]

Detailed information about a subset of these state Medicaid MCO contract requirements can be found in Appendix D. In some cases, these contract requirements place the obligation to earn quality withhold dollars solely on the MCO, (which may or may not pass those requirements down to providers) and in other cases, the state mandates the way the MCO must include providers in the quality incentive.

While these programs can apply to various types of providers, it is notable that several states have instituted VBP requirements related to hospitals, including the following examples.

- **California** requires MCOs to have VBP programs for designated public hospitals on quality measures including prenatal/postpartum care, early childhood preventive care, chronic disease management, and behavioral healthcare
- **Hawaii** requires MCOs to develop a VBP program that must include hospitals, including critical access hospitals; while the MCO has flexibility to design its own plan, the state may require MCOs to include standard metrics and reporting across payers
- **Oregon** sets annual VBP targets for its plans (starting at 20% and increasing year over year), which must cover focus areas including hospital care, maternity care, children's healthcare, behavioral healthcare, and oral healthcare.

Medicaid APMs for Hospitals

APMs for hospitals often focus on healthcare services that may be more within the hospital's control – reducing readmissions, and coordinating post-acute services, for example. However, for hospital systems that own physician practice groups or clinics, options may also include physician-led APMs, such as preventive care, immunization rates, reducing admissions, or referring patients to lower-cost care alternatives. MCOs and hospitals will often negotiate the terms of APMs that may be best suited to the hospital's particular services or patient caseload. Because these factors can vary greatly across facilities, allowing flexibility for these negotiations may be preferred. Themes from other state

[52] https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/, retrieved December 30, 2020.

Medicaid programs in how they design APM requirements for MCOs, while allowing such flexibility, have included the following: characteristics summarized in Figure A-3[53]

Figure A-3. Common Characteristics of Medicaid APM Requirements

Setting Targets	▪ Many states have set targets for the percentage of providers or percentage of covered lives whose care must be covered by VBP contracts (often with increasing targets year over year) ▪ Some set additional targets for VBP contracts involving shared risk (APM category 3 or 4)
Focus Areas	▪ Some states require focus on particular healthcare issues (like social determinants of health, behavioral health, chronic conditions, or primary care access and outcomes) ▪ Other states focus on total cost of care, sometimes by allowing MCOs to create a plan to drive results or by requiring each MCO that fails to meet state-determined targets to develop a roadmap for how they will increase performance
Prescriptive Design Versus Innovation by MCOs	▪ Some states permit discretion about how to implement value-based purchasing but require MCOs to use the same quality measures and meet outcome targets (often based on HEDIS) ▪ Some states require particular provider types that must be included in an MCO's VBP efforts ▪ Other states require particular types of APMs like bundled payments for certain episodes of care (e.g., maternity care, cardiac care, or total joint replacement) ▪ Some align efforts as part of a multi-payer collaboration
Form of Payments	▪ Payments to the MCOs may be designed, by states, as a bonus, withhold, or even a disincentive (payback or assessment) and sometimes require evidence that a portion of the total reimbursement is paid out to participating providers

State Medicaid agencies launching VBP programs may wish to engage MCOs with an active role in the shift to VBP by using contract terms to require the MCOs to support providers through quality reporting, data analytics, and other technical support to providers. Depending on the level of local support for VBP across payer types, Medicaid agencies may also consider alignment with similar efforts by private payers so that this shift is not be a totally new ask to the provider community. Also, large provider types, such as hospitals, may represent a good starting point because they often have greater resources available to begin addressing access and quality at a population health level, as well as capabilities to track and report on quality measures.

States that wish to take a more active design approach for their VBP programs for Medicaid managed care may wish to pair MCO VBP requirements with a directed payment requirement, as described below.

Common Types of Hospital Directed Payments

As discussed earlier, there are many forms of directed payments based on CMS guidance and language in the Consolidated Budget Act of 2021. Given the January 2021 State Medicaid Directors' Letter regarding directed payments, it may be important for LDH to review current directed payment programs and ensure compliance with the revised guidance while preparing for the additional reporting requirements. One of the permissible payment methodologies specifically identified by CMS is VBP, further supporting CMS guidance that directed payments must be tied to a state's Medicaid quality strategy.[54]

Several states use directed payments to pursue VBP objectives to impact quality and access for hospital services, particularly focusing on appropriate utilization of these services. Themes in these directed payment arrangements include the following:

[53] https://www.pcpcc.org/sites/default/files/resources/%7Ba7b8bcb8-0b4c-4c46-b453-2fc58cefb9ba%7D_Change_Healthcare_Value-Based_Care_in_America_State-by-State_Report.pdf, retrieved January 7, 2021

[54] CMS SMD#21-001, Additional Guidance on State Directed Payments in Medicaid Managed Care and Health and Human Services, Centers for Medicare & Medicaid Services § 438.6(c) Preprint, January 8, 2021

    - Payments typically based on achievement of targets on national Medicaid quality performance measures (such as National Quality Forum or HEDIS); targets often increase year-over-year
- Focus on measures related to specific health issues that hospitals may be able to impact such as inpatient or outpatient utilization, chronic illness care, post-acute care, or reductions in readmissions or inappropriate emergency department visits. Some payments include requirements to support care management (such as appointment scheduling or coordination with primary care providers or community behavioral health providers)
- Different weighting might occur based on facility type (such as hospitals with psychiatric beds)
- One state (Hawaii) created a separate directed payment to be applied for its critical access hospitals, as distinct from other hospital types.

Hospital systems that include primary or specialty care clinics may be well suited for incentives on additional healthcare topics, such as screening rate, well care, or prenatal measures, as well. Please see Appendix E for details on these state directed payments.

Appendix B

Appendix B: Louisiana's Current Hospital Reimbursement Methodologies

OVERVIEW OF CURRENT LANDSCAPE

Louisiana currently employs a mix of hospital reimbursement strategies, including minimum hospital rates, supplemental payments to hospital providers, and MCO payments to hospitals. Details for each of these elements are provided below.

Current Hospital Reimbursement Methodologies

Louisiana's current State plan[55] provides a per diem payment, supplemental payments, and DSH payments for hospitals. The per diem is the minimum payment an MCO can make to a hospital. There are five hospital peer groups established in the State plan:

- Major teaching hospitals
- Minor teaching hospitals
- Non-teaching hospitals with less than 58 beds
- Non-teaching hospitals with 58 – 138 beds
- Non-teaching hospitals with more than 138 beds

In addition, there are separate payments for the following peer groups and services:[56]

- Long-term ventilator hospitals (not psychiatric treatment)
- Children's Hospitals
- Free-Standing Rehabilitation Hospitals as defined by Medicare
- Neonatal Intensive Care Units
- Pediatric Intensive Care Units
- Burn Care Units

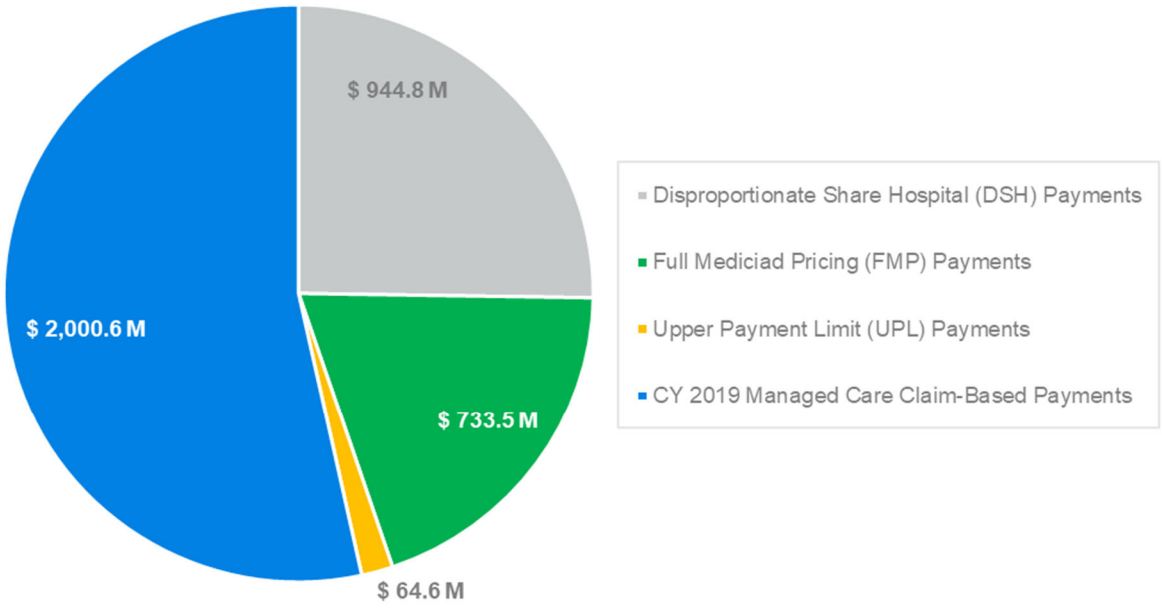
Louisiana determines a base rate for hospitals based on 1991 allowable costs and adjusted for inflation. In addition, there are supplemental payments for Low Income and Needy Care Collaboration (Small Rural Hospitals), non-rural, non-state government Hospitals, private hospitals, and teaching hospitals. Hospitals also receive a DSH payment. However, a 2019 CMS rule (84 FR 50308)[57] and the Consolidated Appropriations Act of 2021 will reduce DSH payments by $8 billion per year from 2024 to 2027 which could materially decrease the allotment available to states like Louisiana.[58] DSH reductions were originally imposed in the Patient Protection and Affordable Care Act of 2010.[59] After the ACA imposed the DSH reductions, Congress used several pieces of legislation to delay these reductions.[60]

Supplemental Payments for Hospitals

A material portion of Louisiana Medicaid payments to hospitals are in the form of supplemental payments, made separately from claim-based payments, as shown in Figure B-1:

[55] Louisiana Department of Health, Medicaid State Plan, Appendix C.19a Item 1, https://ldh.la.gov/index.cfm/page/1718, https://ldh.la.gov/assets/medicaid/StatePlan/Sec4/Attachment4.19-AItem1.pdf, retrieved January 12, 2021
[56] *Id.*
[57] CMS Final Rule. 84. FR 50308. https://www.govinfo.gov/content/pkg/FR-2019-09-25/pdf/2019-20731.pdf, retrieved December 9, 2020
[58] H.R. 133. Consolidated Appropriations Act of 2021. https://docs.house.gov/billsthisweek/20201221/BILLS-116HR133SA-RCP-116-68.pdf, retrieved January 11, 2021
[59] Patient Protection and Affordable Care Act of 2010, ACA, Public Law 111-148, as amended
[60] Disproportionate Share Hospital Payments, Medicaid and CHIP Payment Access Commission, https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/#:~:text=As%20a%20result,%20the%20current%20schedule%20and%20amounts,2024;%20and%205%20$8.0%20billion%20in%20FY%202025. Retrieved January 20, 2021

Figure B-1. Louisiana Hospital Medicaid Supplemental Payments and Managed Care Claim-Based Payments



The figure above illustrates a total of $2,001 million in claim-based payments along with $1,743 million in supplemental payments from a combination of DSH, FMP and UPL payments. Each of the Louisiana Medicaid hospital supplemental payments types shown above are described below.

- ***Disproportionate share hospital (DSH) payments:*** Medicaid supplemental payments based on uncompensated costs related to hospital services to Medicaid and uninsured patients, as defined in rule in the Louisiana State plan. Uncompensated care costs are based on the difference between the estimated costs of hospital services to these populations and the payments received (including both Medicaid fee-for-service and managed care). Total current DSH payments made to hospitals are approximately $944.8 million (not including CPE DSH) and consist of the following DSH payment pools:
  - Low Income and Needy Care Collaboration Agreement (LINCCA) hospitals
  - High Medicaid (federally mandated) hospitals
  - Major Medical Center hospitals
  - Non-State Large Public (hospital service district CPEs only – not payments to hospitals)
  - Public Small Rural hospitals (CPEs only – not payments to hospitals)
- ***Full Medicaid Pricing (FMP) payments:*** Medicaid managed care supplemental payments, distributed from an aggregate funding pool determined based on the estimated gap between payments under Medicare and Medicaid claim-based payments. We understand FMP payments consist of series of funding pools included in the managed care capitation payments to MCOs to enable reimbursement levels up to Medicare and then distribute from MCOs to hospitals based on negotiations. Total current FMP payments are approximately $733.5 million, and consist of the following FMP payment pools:
  - Rural hospitals
  - Public-Private Partnership (PPP) hospitals
  - LINCCA hospitals

  - Hospital Service Districts
  - Other select hospital systems and hospitals

- ***Upper Payment Limit (UPL) payments:*** Medicaid fee-for-service supplemental payments, distributed from an aggregate funding pool determined based on the estimated gap between payments under Medicare and Medicaid claim-based payments. Total current UPL payments are approximately $64.6 million, and consist of the following UPL payment pools (which are made directed from LDH to hospitals as a fee-for-service payment):
  - Rural hospitals
  - LINCCA hospitals
  - Hospital Service Districts

In addition to the payments illustrated in Figure B-1, as part of the State Plan, hospital outlier payments are made for catastrophic costs associated with inpatient services provided to children under age six.[61] Total current hospital outlier payments are approximately $21 million, and are primarily paid by the MCOs within the managed care program. These payments will be considered in accordance with CMS preprint reporting requirements for directed fee schedule preprint submissions.

The scale of Medicaid managed care hospital FMP supplemental payments relative to claim-based payments ranges significantly across Louisiana hospitals. Hospital FMP payments are currently allocated to approximately one third of hospitals, and of those receiving hospital FMP, there is a material range in hospital FMP payments relative to managed care claim-based payments. Whereas LDH has the opportunity to maintain current hospital payment levels to hospitals receiving DSH (because LDH can reimburse up to their DSH limit), repurposing hospital FMP payments to directed payments will more widely distribute hospital FMP payments across all hospitals.

Hospital Contributions

We understand LDH utilizes hospital contributions to help fund the non-federal share of multiple different types of Medicaid hospital expenditures, including the supplemental payments described previously. These hospital contributions include the following:

- **Intergovernmental transfers (IGTs).** IGTs are a transfer of funds from another government entity to the state Medicaid agency. In Louisiana, hospital service districts and several public hospitals have entered into IGTs arrangements with LDH totaling approximately $255 million. These IGTs currently contribute toward the non-federal share of DSH payments, FMP payments, and UPL payments.

  As mentioned, under new CMS preprint requirements, LDH will need to determine the IGTs to be transferred by each entity. We note that allocating all of the new IGTs to hospital service districts may result in adverse impacts at the hospital level depending on the final selected IGT distribution and payment methodologies. As such, LDH may wish to consider the inclusion of other provider types for its new IGT allocations.

- **Hospital assessments.** We understand LDH currently assesses non-rural hospitals at a rate of approximately 1.0% of net patient revenues, which generates an estimated $114 million for SFY 2021. Assessment proceeds fund the non-federal share of inpatient per diem rate increases and managed care capitation payments for the Medicaid expansion population.

MFP Model

LDH considered implementing a proposed hospital MFP payment model; however, after discussions with CMS and identifications of several issues in the model, LDH management made the decision to rescind the preprint from CMS consideration. The former MFP model was originally submitted as a hospital-directed payment “minimum fee schedule” (under a methodology not included in the FFS State plan) that transitions a significant amount of the $1.7 billion in funding from current Medicaid hospital supplemental payment amounts, replacing the existing hospital FMP

[61] https://ldh.la.gov/assets/medicaid/StatePlan/Sec4/Section4.19.pdf

payments and significantly reducing the existing DSH and UPL payments. The former MFP program was projected to result in a net increase of $787 million in total supplemental payments (total computable, non-federal and federal share).

Managed Care Contract Requirements

Under the Model Contract[62] included in the Request for Proposal (RFP) for managed care organizations and in the individual contracts[63] with MCOs, LDH requires MCOs to pay hospitals at the FFS rate.

Rural Hospital Payments as Defined in Rural Hospital Preservation Act

Louisiana state law (La. Stat. tit. 40 § 1189.3) defines rural hospital as a licensed hospital that met one of 13 designated criteria by the July 1, 2003 deadline for a rural hospital designation. There are 49 such hospitals, 27 of which are also designated as critical access hospitals (CAH). Additionally, rural hospitals are required to receive the maximum reimbursement levels under CMS regulations.[64]

Louisiana utilizes a unique hospital payment structure based on services performed. Inpatient care receives a per diem rate defined by the Louisiana Medicaid State plan.[65] These per diem rates are based on hospital type and services offered. The per diem rates are separated into eight categories including children's, rural, state hospital, and peer group designations.[66] Additionally, hospitals are reimbursed for outpatient services using a fee schedule which is updated annually.

LSU's Public-Private Partners who are Parties to Cooperative Endeavor Agreements

Nine of the ten LSU public hospitals entered a public-private partnership starting in 2012. This partnership was designed to improve care, reduce state costs, create a more efficient hospital network, and maintain access.[67] In addition to the LSU hospitals, there is the LSU Health Care Services Division (HCSD), a university-based healthcare delivery organization, which supports the LSU healthcare system.[68] Hospitals are located throughout the state, with facilities in Baton Rouge, Bogalusa, Houma, Lafayette, Lake Charles, Monroe, New Orleans, Pineville, and Shreveport.[69]

CURRENT LDH MEDICAID QUALITY STRATEGY AND VALUE-BASED PURCHASING

Federal regulations require each state with a Medicaid managed care program to develop a quality strategy in order to support and promote quality, compliance, and access to and appropriateness of care and services for managed care enrollees.[70] Federal managed care rules further require state-directed payments to advance at least one goal in the state's quality strategy.[71] Louisiana's current Medicaid Managed Care Quality Strategy establishes a strong framework upon which it could structure MCO state-directed payments to hospitals.[72]

LDH's Quality Strategy currently outlines three aims (described in Figure B-2 below), each with corresponding goals and specific objectives driving the areas of quality focus. In alignment with the quality strategy goals listed below,

[62] Appendix E: Model Contract, Louisiana Managed Care Organization, Model Contract, Louisiana Department of Health, Bureau of Health Services Financing, https://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf, retrieved January 12, 2021
[63] Office of State Procurement, PROACT Contract Certification of Approval, Aetna Better Health, Inc., December 12, 2019, https://ldh.la.gov/index.cfm/page/3989, retrieved January 12, 2021
[64] La. Stat. tit. 40 § 1189.4
[65] Louisiana Department of Health, Medicaid State Plan, Appendix C.19a Item 1, https://ldh.la.gov/index.cfm/page/1718, https://ldh.la.gov/assets/medicaid/StatePlan/Sec4/Attachment4.19-AItem1.pdf, retrieved January 12, 2021
[66] Louisiana Medicaid Hospital Provider Inpatient Per Diem Rates. Effective 7/1/12020. https://www.lamedicaid.com/provweb1/fee_schedules/Inpatient_Hospital_Per_Diem_Listing_Current.pdf, retrieved 1/11/21
[67] "State Health Officials Announce Landmark Public-Private Partnership Agreements for LSU Hospitals", Louisiana Department of Health, December 10, 2012, https://ldh.la.gov/index.cfm/newsroom/detail/2722, retrieved January 14, 2021
[68] LSU Health website, About HCSD page, https://www.lsuhospitals.org/about_us.aspx, retrieved January 14, 2021
[69] LSU website, "Hospital Cooperative Endeavor Agreements", https://www.lsu.edu/bos/hospital-ceas.php
[70] https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html, retrieved February 9, 2021
[71] 42 CFR 438.6(c)(2)(ii)(C) https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.4.438&rgn=div5#se42.4.438_16, retrieved January 7, 2021
[72] Louisiana's Medicaid Managed Care Quality Strategy (March 2019), https://ldh.la.gov/assets/docs/MQI/MQIStrategy.pdf, retrieved January 7, 2021

LDH sets annual performance measures that MCOs are required to measure and report. Sixteen of these measures are incentivized through a 1% capitation withhold that MCOs can earn back by meeting the target for that measure or improving their performance by at least two points from the prior measurement year.[73]

LDH recognizes and requires usage of the HCP-LAN APM framework in the current MCO VBP program requirements. Within this model, MCOs are subject to an additional 1% capitation withhold to incentivize the use of VBP in their provider contracts. Plans earn back the VBP withhold amount for maintaining or increasing their reported use of VBP models across categories 2A, 2C, 3, and 4 as defined in the HCP-LAN APM Framework. These VBPs must align to the Incentive Based Quality Measures defined by LDH, which comprise the other 1% withhold described above. In addition to the contract withholds, LDH also incentivizes performance and quality outcomes through the Managed Care Incentive Program which allows MCOs to earn up to 5% over the approved capitation payment. The approved arrangements will include specific activities, targets, quality measures, and desired outcomes so that each arrangement can be properly evaluated at the end of the designated term.

While the MCOs may be using hospital incentives to help meet their quality goals, the MCO quality withhold is not specifically tied to the state's directed payment program. LDH could consider connecting elements of its current quality strategy and VBP requirements to align with its directed payment requirements, in order to demonstrate a quality-based approach to CMS.

Figure B-2. Louisiana Medicaid Quality Strategy Aims, Goals, and Objectives[74]

Aim	Goal	Objective
Better Care: Make healthcare more person-centered, coordinated, and accessible so it occurs at the "Right care, right time, right place."	Ensure access to care to meet enrollee needs	Ensure timely and approximate access to primary and specialty care
	Improve coordination and transitions of care	Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management
	Facilitate patient-centered, whole-person care	Engage and partner with enrollees to improve enrollee experience and outcomes
		Integrate behavioral and physical health
Healthier People, Healthier Communities: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.	Promote wellness and prevention	Ensure maternal safety and appropriate care during childbirth and postpartum
		Prevent maturity and reduce infant mortality
		Promote healthy development and wellness in children and adolescents
		Promote oral health in children Improve immunization rates
		Prevent obesity and address physical activity and nutrition in children and adults
		Prevent prematurity and reduce infant mortality
		Improve cancer screening
		Improve HIV and Hepatitis C virus infection screening
		Promote healthy development and wellness in children and adolescents

[73] Ibid.
[74] Ibid.

Aim	Goal	Objective
		Promote use of evidence-based tobacco cessation treatments
	Improve chronic disease management and control	Improve hypertension, diabetes, and cardiovascular disease management and control
		Improve respiratory disease management and control
		Improve HIV control
		Improve quality of mental health and substance use disorder care
	Partner with communities to improve population health and address disparities	Stratify key quality measures by race/ethnicity and rural/urban status and narrow health disparities
		Advance specific interventions to address social determinants of health
Smarter Spending: Demonstrate good stewardship of public resources by ensuring high-value, efficient care	Pay for value and incentivize innovation	Advance value-based purchasing arrangements and innovation
	Minimize wasteful spending	Reduce low value care

The state's independent external quality review organization (EQRO)[75] evaluated the managed care program against the Quality Strategy in 2019 and found that the managed care program was overall successful in meeting the targets for the sixteen Incentive Based Quality Measures, improvement objectives, or both. MCO performance was mixed across the measures, with their individual improvement areas not always matching the state's as a whole, presenting different sets of improvement opportunities for each MCO.

Due to the COVID-19 pandemic and the challenges it posed in meeting the requirements to earn back the withholds, LDH suspended the 2% withholds for calendar year 2020 but have reinstituted the withhold requirements for calendar year 2021.

[75] State of Louisiana Department of Health, Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2019 – March 19, 2020, FINAL, September 2020, IPRO, https://www.ldh.la.gov/assets/docs/MQI/Task1.10-MMCQuality-Strategy-Evaluation-FY20.pdf, retrieved December 29, 2020

Appendix C

Appendix C: Evaluation of Directed Payment Options Consistent with Policy Goals

CMS permits two categories of options for state-directed payments, as outlined in the January 8, 2021 preprint form:[76]

1. **State Directed Value-Based Payments/Delivery System Reform**
2. **State Directed Fee Schedules**

Applying these options against the six assumptions LDH provided to Milliman to guide our analyses of directed payment options suggests that a mix of strategies may be most effective to accomplish these policy goals. Figure C-1 summarizes our assessment of how each option may meet LDH goals.

Figure C-1. Assessment of How Various CMS-Approved Options May Accomplish LDH Policy Goals[77]

LDH Criteria/Assumption	Value-Based Purchasing	Delivery System Reform	State Directed Fee Schedules
Preserves access in both urban and rural areas	Yes	Yes	Yes
Advances goals and objectives of LDH quality strategy	Yes	Yes	Yes
Does not require any additional State General Fund dollars	Yes	Potentially	Potentially
Maintains reimbursement levels for Rural Hospitals and LSU's Public-Private Partners	Yes	Yes	Yes
Minimizes reductions to current hospital reimbursement levels inclusive of base rates and supplemental payments	Yes	Yes	Yes
Utilizes "follow the patient" principle in reimbursement methodology	Yes	Yes	Yes
Includes alternative sources of state matching funds	Potentially	Potentially	Potentially
Utilizes value-based purchasing principles	Yes	Yes	No

Please note the options are not intended to be mutually exclusive and the adopted state-directed payment methodology may include more than one payment arrangement. More detailed assessments for each of the three options are provided below.

CMS Option #1: VBP and Delivery System Reform Models

State-directed VBP and delivery system reform (DSR) models recognize value or outcomes over volume of services. The CMS preprint lists the following types of VBP/DSR arrangements that are permissible as state-directed payments:

- **Quality Payment/Pay-for-Performance** (Category 2 APM, or similar): foundational payments for infrastructure and operations, pay-for-reporting, and pay-for-performance
- **Bundled Payment/Episode-Based Payment** (Category 3 APM, or similar): shared savings arrangements, bundled payments, and episode-based payments

[76] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021
[77] "Yes" indicates the option is likely to meet the criteria/assumption; "Potentially" means the option could be structured in such a way that would meet the criteria/assumption; and "No" means challenges or barriers may exist to the option meeting the criteria/assumption.

- **Population-Based Payment/Accountable Care Organization** (Category 4 APM, or similar): condition-specific, population-based payments (capitated payments for specialty services), comprehensive population-based-payments (e.g., global budgets), and integrated, comprehensive payment and delivery systems (e.g., accountable care organizations).
- **Multi-Payer Delivery System Reform**: initiatives to align payers across the state, including payment policies, quality measurement, administrative practices, and data-sharing.
- **Medicaid-Specific Delivery System Reform**: Medicaid delivery system and payment transformation efforts as alternatives to traditional fee-for-service arrangements.
- **Performance Improvement Initiative**: incentive programs to report and demonstrate improvements in access and quality.
- **Other Value-Based Purchasing Models**[78, 79]

Rural and safety-net hospitals often lack the technology infrastructure and financial resources to participate in VBP arrangements.[80] Delivery system reform initiatives seek to build the capacity of these providers by providing initial incentive funds for infrastructure investment and project implementation. Over time, they receive additional funds for reporting quality and other metrics and eventually are rewarded and held at financial risk for their performance.[81] Outside of simple performance improvement initiatives, DSR efforts can be resource intensive and may require a section 1115 demonstration waiver or State plan amendments in addition to the state-directed payment preprint application to implement.

LDH already has a VBP contracting requirement in the current MCO contract tied to a capitation withhold. LDH could choose to be more prescriptive in the types of VBP arrangements, quality and financial outcomes, and rate of VBP adoption it desires to achieve.

Figure C-2. Evaluation of VBP Models

LDH Criteria/Assumptions	VBP Model Evaluation
Preserves access in both urban and rural areas	**Yes**. Options in this category can be structured to limit negative financial risk to hospitals, minimizing any disruption to access. Additionally, these models reward value and outcomes and can provide hospitals with added revenue.
Advances goals and objectives of LDH quality strategy	**Yes**. Utilizing VBP directly advances the LDH goal "pay for value and incentivize innovation." Additionally, the achievement of LDH quality goals can be incentivized through VBP arrangements and other performance improvement initiatives.
Does not require any additional State General Fund dollars	**Yes**. LDH can direct MCOs to enter into VBP arrangements that are cost-neutral to the state as long as the MCO rates remain actuarially sound.
Maintains reimbursement levels for Rural Hospitals and LSU's Public-Private Partners	**Yes**. LDH has flexibility to set the VBP arrangements between MCOs and hospitals to not include any downside risk, maintaining reimbursement levels for rural hospitals and LSU's public private partners.
Minimizes reductions to current hospital reimbursement levels inclusive of base rates and supplemental payments	**Yes**. LDH has flexibility to set the VBP arrangements between MCOs and hospitals to either not include any downside risk or to limit the risk exposure within defined ranges based on performance. LDH can increase hospitals' financial risk exposure overtime, following the LAN-APM glide path model.
Utilizes "follow the patient" principle in reimbursement methodology	**Yes**. VBP arrangements can be developed to be tied to Medicaid utilization so that hospitals who treat more Medicaid patients receive more reimbursement.

[78] https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/approved-medicaid-state-directed-payments-full.ashx, retrieved January 10, 2021
[79] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021
[80] https://www.medicaid.gov/medicaid/downloads/accel-adoption-vp-pay.pdf, retrieved January 10, 2021
[81] https://www.medicaid.gov/medicaid/downloads/accel-adoption-vp-pay.pdf, retrieved January 10, 2021

LDH Criteria/Assumptions	VBP Model Evaluation
Includes alternative sources of state matching funds	**Potentially**. Funding sources for VBP beyond the State General Fund include intergovernmental transfers or health-care related taxes (e.g., provider taxes).
Utilizes value-based purchasing principles	**Yes**.

Figure C-3. Evaluation of Delivery System Reform Models

LDH Criteria/Assumptions	Delivery System Reform Model Evaluation
Preserves access in both urban and rural areas	**Yes**. DSR initiatives can be structured to provide only positive financial support to providers, limiting their negative risk exposure.
Advances goals and objectives of LDH quality strategy	**Yes**. Utilizing DSR directly advances the LDH goal "pay for value and incentivize innovation." Additionally, other the achievement of LDH quality goals can be incentivized through DSR and other performance improvement initiatives.
Does not require any additional State General Fund dollars	**Potentially**. Many DSR initiatives require funds to support providers' transition to VBP.
Maintains reimbursement levels for Rural Hospitals and LSU's Public-Private Partners	**Yes**. DSR initiatives can be developed to maintain (or increase) reimbursement levels.
Minimizes reductions to current hospital reimbursement levels inclusive of base rates and supplemental payments	**Yes**. DSR initiatives can be developed to minimize reduction in reimbursement levels and to limit financial exposure.
Utilizes "follow the patient" principle in reimbursement methodology	**Yes**. DSR initiatives can be specific to hospital classes that treat more Medicaid patients per CMS approval.
Includes alternative sources of state matching funds	**Potentially**. Funding sources for DSR beyond the State General Fund include intergovernmental transfers or health-care related taxes (e.g., provider taxes).
Utilizes value-based purchasing principles	**Yes**.

CMS Option #2: State Directed Fee Schedules

The CMS preprint lists the following types of fee schedule requirements that are permissible as state-directed payments.

- Minimum Fee Schedule for providers that provide a particular service under the contract using rates other than State plan approved rates
- Maximum Fee Schedule
- Uniform Dollar or Percentage Increase[82]

States seeking approval of minimum or maximum fee schedules must describe the basis for the fee schedule as 1) State plan approved rates; 2) Medicare or Medicare-equivalent rate; or 3) alternative fee schedule established by the state.[83] A 2018 Milliman review found that, nationally, state-directed fee schedules comprised the majority of the approved state-directed payment preprints between the two categories (fee schedules and VBP/DSR models).[84]

[82] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021
[83] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021
[84] https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/approved-medicaid-state-directed-payments-full.ashx, retrieved January 10, 2021

CMS requires that state directed payments be based on the delivery and utilization of services covered "under the contract for the applicable rating period."[85] While historical utilization data is used in capitation rate development, state-directed payments must be based on the applicable rating period utilization and service delivery. For many fee schedule arrangements, states determine prospective per member per month (PMPM rates) to pay MCOs based on projected utilization. States can require MCOs to pay providers based on more recent utilization (prior month or quarter) or may reconcile projected to actual utilization and adjust final payments via a settlement process.[86]

Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A) and the State Medicaid Director Letter #21-001 issued on January 8, 2021, states no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).[87]

As outlined in Figure C-4 below, directed fee schedules on their own will meet the majority of LDH's policy assumptions that we were asked to consider. By linking the directed payment to a VBP requirement, the final criteria could also be met. This linkage to VBP may also increase the connection to LDH's quality strategy and align incentives toward value, as required by CMS as well.

Figure C-4. Evaluation of State Directed Fee Schedules

LDH Criteria/Assumptions	State Directed Fee Schedules Evaluation
Preserves access in both urban and rural areas	**Yes**. Directing fee schedules can provide financial support to specific classes of hospitals and ensure continued access.
Advances goals and objectives of LDH quality strategy	**Yes**. State directed fee schedules meet the LDH goal to "ensure access to care to meet enrollee needs."
Does not require any additional State General Fund dollars	**Potentially**. The size of the uniform dollar/ percentage increase or minimum fee schedule may require additional State General Fund dollars.
Maintains reimbursement levels for Rural Hospitals and LSU's Public-Private Partners	**Yes**. State directed fee schedules can be developed to maintain (or increase) reimbursement levels.
Minimizes reductions to current hospital reimbursement levels inclusive of base rates and supplemental payments	**Yes**. State directed fee schedules can be developed to minimize reduction in reimbursement levels and to limit financial exposure.
Utilizes "follow the patient" principle in reimbursement methodology	**Yes**. State directed fee schedules can be developed to be tied to Medicaid utilization so that hospitals who treat more Medicaid patients receive more reimbursement.
Includes alternative sources of state matching funds	**Potentially**. Funding sources beyond the State General Fund include intergovernmental transfers or health-care related taxes (e.g. provider taxes).
Utilizes value-based purchasing principles	**No**, unless combined with payment pool carveout for VBP.

[85] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf, retrieved January 10, 2021
[86] https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/approved-medicaid-state-directed-payments-full.ashx, retrieved January 10, 2021
[87] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, retrieved January 10, 2021

Appendix D

Appendix D: APM Examples from Other State Medicaid Programs

Below are examples from state managed care organization (MCO) contracts that include alternative payment methodologies for participating MCOs. Throughout this appendix, the definitions for various types of APMs (such as shared savings, bundled payments, or pay for performance) often vary slightly by state. Where possible, we have used each state's own definition, indicated by quotation marks.

- **Arizona**
  - Requires MCOs to develop strategies within the Health Care Payment Learning & Action Networks (HCP-LAN) - Alternative Payment Models (APM) categories 2B and above.[88] HCP-LAN is a national organization of healthcare CEOs that promote the dialogue regarding APMs.
  - Models that Arizona Health Care Costs Containment System (AHCCCS) MCOs have implemented[89]:
    - Payment for Performance: "Pay-for-performance is a term that describes health-care payment systems that offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality and cost measures, as well as other benchmarks."
    - Patient-Centered Medical Home (PCMH): "The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into 'what patients want it to be.'"
    - Shared Savings: "Shared savings models have a baseline budget or target that is used to determine whether savings were achieved. Savings which result are shared between the payer and the provider. Quality measures are usually part of the shared savings methodology."
    - Bundled Payments: "A single, 'bundled' payment covers services delivered by two or more providers during a single episode of care or over a specific period of time, and usually includes accompanying quality requirements."
  - Section 72 of the AHCCCS Managed Care Contract "Value-Based Purchasing" (pg. 248-250) outlines the VBP strategies and requirements for MCOs.[90] Managed care organizations are required to participate in value-based purchasing initiatives. Items listed in the contract are:
    - Alternative Payment Model initiatives: Incentivizing quality improvement utilizing the HCP-LAN APM Framework
    - E-Prescribing: Increasing rate of E-Prescribing for original prescriptions.
    - Value-Based Providers: Directing members to providers that are participating in the VBP efforts
    - Centers of Excellence: Encouraging contracting with facilities and/or programs that are recognized as providing the highest level of quality, leadership and service.
- **California**
  - Requires MCOs to make payments to Designated Public Hospitals on performance measures in four strategic categories as part of Proposition 56 (Directed Payments).[91,92] Enhanced payments must be made to eligible network providers in the following areas:
    - Prenatal/postpartum care
    - Early childhood preventive care
    - Chronic disease management
    - Behavioral healthcare
  - In addition to these areas, MCOs are required to make enhanced payments for beneficiaries with a substance use disorder or serious mental illness or who are homeless.
- **District of Columbia[93]**
  - Section C.5.39 (pg196)
    - "Contractor shall utilize payment arrangements with its contracted Provider network to reward performance excellence and performance improvement in targeted priority areas conducive to improved health outcomes and cost savings for DHCF beneficiaries. Contractor's VBP arrangements with Providers shall include both fee for service (FFS)-based bonus arrangements and Alternative Payment Models (APMs) designed to align financial incentives its Network Providers to increase the value of care provided and not focus exclusively on the volume of care provided. APMs are defined as shared savings, shared risk, or capitated

[88] https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/, retrieved December 30, 2020
[89] https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html, retrieved December 30, 2020
[90] https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/YH190001_ACC_AMD9.pdf, retrieved December 30, 2020
[91] https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/, retrieved December 30, 2020
[92] https://www.dhcs.ca.gov/dpp56-vbp, retrieved December 31, 2020
[93] http://app.ocp.dc.gov/Award_attachments/CW69127-Base%20Period-Contract%20Award-Executed%20Contract.pdf, retrieved January 14, 2021

financial arrangements with Network Providers that specifically include quality performance as a factor in the amount of payment a Provider receives."
        - There are other sections that would provide VBP strategies and requirements, but further information is "reserved" and remains undefined in the contract.
    - Section C.5.32.3.4 (pg153) connects the performance measures with APMs.
        - "Contractor shall monitor Provider/Practitioner performance using performance measures that reflect currently accepted standards of evidence-based care and clinical practice guidelines, as described in section C.5.28.27[94], and provide feedback, and/or offer pay for performance programs or other Alternative Payment Models (APM) to Providers based on performance."
- **Delaware[95]**
    - Appendix 2: Value-Based Purchasing Care Initiative (pgs. 391-402) outlines the VBP process and strategy.
        - Section 9 (pg. 395) outlines the strategies, including 4 potential models:
            - Shared Savings (pgs. 395-396): "A purchasing strategy that provides a basis for providers or provider entities to reduce unnecessary health spending and concurrently improve quality/outcomes of care for a defined population of patients/members by offering providers a percentage of any realized net savings (i.e., upside risk only). "Savings" could be measured as the difference between expected and actual costs in the given measurement year that also involves obtaining specified quality/outcome goals."
            - Bundled/Episodic Payments (pg. 396): "A purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically-defined episodes that may involve several provider types, several settings of care or several procedures/services over a defined period of time. The provider receives a lump sum, prospectively or retrospectively, for all health services delivered for a single episode of care."
            - Risk/Capitation/Total Cost of Care (pgs. 396-397): "A purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically-defined episodes that may involve several provider types, several settings of care or several procedures/services over a defined period of time. The provider receives a lump sum, prospectively or retrospectively, for all health services delivered for a single episode of care."
            - Other Innovative Payment Arrangements (pg. 397): allows for MCOs to propose a VBP system of their own that would need to be approved by the Medicaid agency.
        - Delaware also establishes a Value-Based Purchasing Strategies (VBPS) Threshold Level represented by the portion of total medical/service expenditure to all providers for all members that are affiliated with one or more of the acceptable VBPS arrangements/models. For CY 2020 the threshold was 40%, CY 2021 it is 50%, and CY 2022 60%
        - Section 9 f-g (pg. 399) describes that for each calendar year, there is a financial penalty for those MCOs that do not achieve these thresholds. This penalty must be issued within 90-days of receiving the Year End Accomplishments Report.
            - The department can suspend the financial penalty if:
                - The MCO can demonstrate that through no material fault of their own and in good faith tried to achieve the thresholds,
                - Attained 50% of the threshold, and
                - Submits a performance improvement plan to achieve next calendar year's performance measurements to be approved by the department.
        - CY 2018 financial penalty:
            - A maximum penalty of up to 1.0% of the MCO's total net revenue received by the state department for all populations covered under the contractual agreement.
            - The penalty can be assessed/collected by means of deduction of future payments to the MCO or through remittance paid by the MCO to the state department.

[94] Contract outlines the utilization of Practice Guidelines
[95] https://dhss.delaware.gov/dhss/dmma/files/mco_msa2018.pdf, retrieved January 14, 2021.

- **Hawaii**
  - The Health Plan shall describe its approach to ensure payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Health Plan's response should address the following[96]:
    - The Health Plan's strategy for developing APMs that mature along the HCP-LAN continuum over the course of the Contract
    - The Health Plan's utilization of VBP strategies for two of the following provider types. The Health Plan shall choose two different provider types than for their response to the above §15.3.C.5.a:
      - Primary care providers;
      - Community health centers
      - Hospitals (including Critical Access Hospitals (CAHs));
      - Behavioral health providers (mental health and substance use disorder (SUD));
      - LTSS providers, or
      - Other specialists.
    - The Health Plan's specific approach to increase investment in, incentivization of, and medical spend on primary care providers in support of advancing primary care
  - Looks for VBP to encompass providers such as PCPs, hospitals, LTSS, behavioral health, SUD providers, rural health providers, and other specialty providers (pg. 303).
  - DHS can require MCOs to align standard metrics and reporting for providers participating in a VBP agreement with other payer, federal, or community metrics and reporting to reduce administrative burden for the provider community (pg. 303-304).
  - DHS intends to adopt the HCP-LAN APM framework to assess VBP engagement and levels of provider readiness within Quality Initiative along the VBP continuum.
  - DHS defines major provider types (pg.306) to be included in VBP plans, which are but not limited to:
    - Primary care providers;
    - Hospitals, including CAHs;
    - Behavioral health providers;
    - Specialists; and
    - LTSS providers
- **Kansas**
  - Requires MCOs to implement VBP models that expand service coordination, increase employment, and provide better outcomes for foster children.
  - Section 2.2 under "Specifications" (pg. 10) provides guidelines for the VBP models that MCOs would need to follow.[97] These measures include:
    - Strategies that increase integration of services, especially between physical and behavioral health
    - Increase employment and independent living supports
    - Use of telehealth
    - Expand use of IMDs
    - Cooperation with the Department of Children and Families (DCF) related to foster children
- **New Hampshire**
  - Sections 5.4 and 5.5 (pgs. 316-325) detail MCOs' roles responsibilities and the process of the state withhold and incentive program in cases that an MCO does not meet APM targets.[98]
    - Withhold is equal to 2% of the capitation rate, net of directed payments
  - Measures are identified in the NH Medicaid Care Management (MCM) Quality Strategy.[99]
    - Incentive payments may be up to 5% of the approved Capitation Payments attributable to the Members or services covered by the incentive program
  - In the SFY 2020 Withhold and Incentive Guidance (pgs. 3-5),[100] Medicaid identified the following areas for focus (quality improvement, care management, and behavioral health) and performance measures for each.
    - Minimum Performance Standards for earned withhold eligibility. Withhold performance measure points are weighted by performance category as well:

[96] https://hands.ehawaii.gov/hands/opportunities/opportunity-details/19793, retrieved January 8, 2021
[97] https://admin.ks.gov/offices/procurement-and-contracts/kancare-award, retrieved on January 7, 2021.
[98] https://www.dhhs.nh.gov/business/rfp/documents/rfp-2019-oms-02-manag-exhibits.pdf, retrieved January 6, 2021
[99] https://www.dhhs.nh.gov/business/rfp/documents/year1-withhold-incentive-guidance.pdf, retrieved December 31, 2020
[100] https://www.dhhs.nh.gov/business/rfp/documents/year1-withhold-incentive-guidance.pdf, retrieved December 31, 2020

Figure D-1: New Hampshire Contract Performance Measures

Performance Category	Performance Measure
Quality Improvement (50% of Withhold Points)	Frequent (4+/year) Emergency Department Users Age 6 and Older.
	Timeliness of prenatal care (HEDIS PPC).
	Percent of members with polypharmacy who completed a Comprehensive Medicaid Review and Counseling.
	Adolescent Well-Care Visits (HEDIS AWC)
	Follow-Up after Emergency Department visit for alcohol and other drug abuse or dependence – 7 Day (HEDIS FUA)
	Follow-Up after hospitalization for mental illness – 7 Day (Includes members discharged from NH Hospital) (HEDIS FUH modified to include unreimbursed NH Hospital stays)
Care Management (25% of Withhold Points)	The percent of MCM Members that received a Health Risk Assessment within 90 days of enrollment
	The percent of newborns diagnosed with Neonatal Abstinence Syndrome (and parents) who receive Care Management from the MCO directly, or via a Designated Local Care Management Entity
	The Percent of MCM Members that Received Care Management from the MCO Directly, or via a Designated Local Care Management Entity
Behavioral Health (25% of Withhold Points)	The Percent of Community Mental Health Program Eligible MCM members (as defined in He-M 4261 and described in Section 4.11.5.3 of the MCM Agreement) that Receive Assertive Community Treatment (ACT) services Consistent with a Fidelity Score of 85 or more
	The Percent of MCM Members in an Emergency Department or a hospital setting that are Awaiting Psychiatric Placement for 24 hours or more

Figure D-2: Earned Withhold Performance Point Scale

Range	Points
Minimum Performance Standard to less than 1/3 Filled Gap to Performance Standard.	0
1/3 to Less Than 2/3 of Gap to Performance Standard	1
2/3 to Less Than Performance Standard	2
Performance Standard or Greater	3

- **Ohio**[101]
  - Requires MCOs to participate in its State Innovation Model (SIM) payment efforts, episode-based payment model, and Comprehensive Primary Care (CPC) program.
  - Section 7e "Quality Improvement Strategy" (pg.186-187) discusses VBP strategies and process.
  - State sponsored Value-Based initiatives (page 256) to improve access to patient-centered medical homes and episode-based payments for an acute medical event.
  - Care Innovation and Community Improvement Program (CICIP) establishes a provider withhold and incentive payment program
- **Oregon**[102]
  - Requires MCOs to develop new or expanded VBP efforts in specified care delivery focus areas.
    - VBP minimum threshold
    - Expanding VBP beyond primary care to other care delivery areas
    - Patient-Centered Primary Care Home (PCPCH) VBP requirements
    - VBP targets by year starting at 20% and utilizing the HCP-LAN's "Alternative Payment Model Framework White Paper Refreshed 2017"[103]
    - Increases the number care delivery VBP programs each year until 2024 where the MCO is required to implement new or expanded VBP programs in all five care delivery areas.
    - Care delivery areas are (1) hospital care, (2) maternity care, (3) children's healthcare, (4) behavioral healthcare, and (5) oral healthcare.

[101] https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/Medicaid-Managed-Care-Generic-PA.pdf, retrieved January 14, 2021
[102] https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf, retrieved January 14, 2021
[103] https://hcp-lan.org/apm-refresh-white-paper/, retrieved December 31, 2020

    - Exhibit H (pg. 148-150) discusses these areas in more detail.
- **Tennessee**
    - Mandates that MCOs participate in the state's episodes of care, patient-centered medical home and behavioral health home initiatives.
    - The TennCare 2019 Update to the Quality Assessment and Performance Improvement Strategy outlines the VBP initiatives that are being undertaken (pgs. 117-122).[104]
        - LTSS: Quality Improvement in Long-Term Services and Supports (QuILTSS) rewards providers that improve member experience of care and promote a person-centered care delivery model. Rolled out in 2 phases:
            - Phase 1: the "bridge" payment process, with quarterly retroactive adjustments to facilities' per diem rates based largely on facilities' quality improvement activities (i.e. process measures).
            - Phase 2: (effective 7/1/18) the full VBP model with a transition to quality as a component of the prospective per diem rate based on nursing facility performance on specified quality measures compared against state and national benchmarks.
                - Funding for nursing facility services will be set aside during each fiscal year to calculate a quality-based component of each nursing facility provider's per diem payment (i.e., a quality incentive component).
                - The amount of funding for the quality-based component will be no less than forty million dollars ($40 million) or four percent (4%) of the total projected fiscal year expenditures for nursing facility services, whichever is greater.
                - Each subsequent year, the amount of funding set aside for the quality-based component will increase at two (2) times the rate of inflation and will increase or decrease as necessary to ensure that the quality-based component of the reimbursement methodology remains at ten percent (10%).
                - The quality-based component of each nursing provider's per diem payment will be calculated based on the facility's volume of Medicaid resident days and the percentage of total quality points earned for each measurement period.
        - Enhanced Respiratory Care (ERC):
        - Behavioral Health Crisis Prevention, Intervention, and Stabilization Services: "Systems of Support" (SOS) (pgs. 138-140): reimbursement approach that aligns the monthly case rate to support improvement and increased independence over time as the provider is successful in helping paid or unpaid caregivers increase their capacity to provide needed support in order to prevent and/or manage crises
            - Claims-based performance measures:
                - ED visits for behavioral health crises,
                - Inpatient psychiatric hospitalization,
                - behavioral respite utilization,
                - total service expenditures, and
                - Intensity/cost of HCBS.
- **Virginia**[105]
    - Section 8.8 (pg.229) begins outlining the VBP information linking financial incentives to performance with an emphasis on the development, adoption, and provider readiness for models under categories 3 and 4 of the HCP-LAN.
    - MCO VBP plan should consider at least the following state department goals (pg. 231):
        - Improved birth outcomes
        - Appropriate, efficient utilization of high-cost, high-intensity clinical settings
        - Reduce all-cause hospital readmissions
        - Reduce hospital readmissions for chronic disease complications
    - The state department can request revisions to MCO VBP plans in reference, but not limited to:
        - Alignment across patient populations
        - Payer types to align with multi-payer in which Medicaid is a participant
    - MCOs are also responsible for developing programs or establishing partnerships to address social factors that affect health outcomes, or social determinants of health (SDOH) (pg. 233). MCOs must work to address at least the following state department identified SDOH:

[104] https://www.tn.gov/content/dam/tn/tenncare/documents/qualitystrategy.pdf, retrieved January 4, 2021
[105] https://www.dmas.virginia.gov/files/links/4144/Medallion%204.0%202019%20Contract.pdf, retrieved January 12, 2021.

        - Economic Stability – poverty, employment, food security, housing stability
        - Education – high school graduation, enrollment in higher education language and literacy, early childhood education and development
        - Social and Community – context, social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization
        - Health and Healthcare – access to healthcare, access to primary care, health literacy neighborhood and built environmental conditions
    - Section 8.10 (pg. 233) outlines a Medallion System and Innovation Partnership (MSIP) with the goal to improve health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services provided by MCOs in the Health Care Homes program and allows MCOs to test different VBP payment systems.
        - As part of the program, MCOs must enter 2 contractual agreements: a program innovation initiative and a performance-based incentive initiative that includes: 1) gain and/or risk sharing and/or 2) other incentive reforms tied to Commonwealth-approved quality metrics and financial performance.
        - Payment types:
            - Incentives and Performance Results: subcontracts must establish incentives and performance results must be reported annually with the MCO providing data to verify reported results
            - Requirements: Care coordination, quality metrics, financial performance measures, state department review and acceptance, and reporting requirements are required for each payment.
            - Medallion System and Innovation Partnership (MSIPs) Payment Types (MCOs must at least 2):
                - Model 1.1.A: MCO contracts with Primary Care Providers – Performance rewards: performance pool or pay for performance
                - Model 1.2.B: MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees – Primary care coordination of care payment; or partial sub-capitation for primary care and care coordination by Primary Care Coordinator within Medallion Care System Partnership (MCSP)
                - Model 2.C: MCO contracts with provider Care System or a collaborative (primary care providers) with delegated management of care to the provider Care System or collaborative, using risk/gain/performance payment models across services – Sub-capitation or virtual capitation for total cost of care across multiple defined services including primary, acute, and long-term care.
                - Model 3.A: MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or mental health services with acute/primary care services. May include designated HCH or Health Homes - Performance rewards: performance pool or pay for performance
                - Model 3. B: MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or mental health services with acute/primary care services. May include designated HCH or Health Homes - Primary care coordination of care payment; or partial sub-capitation for primary care and care coordination by Primary Care Coordinator within MCSP
                - Model 3.C: MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or mental health services with acute/primary care services. May include designated HCH or Health Homes - Sub-capitation or virtual capitation for total cost of care across multiple defined services including primary, acute, and long-term care.
                - Model 4.D: Alternative defined by proposal – alternative proposals

- Section 9.9 (pg. 244) outlines the Performance Incentive Awards (PIA) process.
  - PIAs will be made according to criteria established by the state department.
  - Criteria will include measures designed to evaluate managed care quality.
  - PIA awards/penalties will be proportionate to the extent by which the MCO's performance compares with benchmarks and thresholds for each measure established by the state department, and relative performance as compared against other MCOs.
  - The max amount at risk for each MCO will be a percentage of the PMPM capitation rate system payments.
  - Total awards for all MCOs will be equal to total penalties for all MCOs.

Quality Measures

In 2019, 36 of the 40 states with MCOs reported having quality initiatives in place with an additional 2 states planning to implement quality initiatives in FY 2020, bringing the total to 38 of 40 states. Of the states that reported implementing performance measures as a factor for their quality initiative projects, 31 states reported chronic disease management as a performance measurement of interest. More than half of the states reported performance areas of interest in perinatal/birth outcomes, mental health/substance use disorder, and potentially preventable events. Additionally, 17 of the states reported that they link incentives to value-based purchasing metrics. The following table shows the performance areas of interest that states with MCOs used to guide quality initiatives.[106]

Figure D-3: State MCO Performance

Performance Measures Focus Areas for MCO Incentives		
Performance Area	**# of States**	**States (39 of 40 MCO States Responding) ***
Chronic Disease Management	31	AZ, CA, CO, DC, DE, FL, GA, HI, IA, IL, IN, KS, LA, MA, MI, MN, MO, MS, NE, NJ, NM, NV, NY, OH, OR, PA, RI, SC, TX, WA, WI
Perinatal/Birth Outcome	26	CA, CO, DC, DE, FL, HI, IL, IN, KS, LA, MI, MO, MS, NE, NH, NJ, NM, NV, OH, OR, PA, RI, SC, TX, VA, WI
Mental Health	24	CA, CO, FL, GA, HI, IA, IL, IN, KS, LA, MA, MN, MO, NH, NM, NY, OH, OR, PA, RI, SC, TX, WA, WI
Potentially Preventable Events	22	AZ, CA, DC, DE, FL, GA, IA, LA, MA, MI, MN, MO, NE, NH, NJ, OH, PA, RI, SC, TX, VA, WI
Substance Use Disorder	19	CO, FL, HI, IL, IN, KS, LA, MA, NH, NM, OH, OR, PA, RI, SC, TX, VA, WA, WI
Value-Based Purchasing	17	AZ, CA, DE, GA, KS, LA, MI, MN, NH, NM, OH, PA, RI, SC, TN, TX, WA
Dental	13	AZ, CA, GA, IN, KS, MI, MN, MO, NY, OR, PA, TX, WI
Member Satisfaction	12	DC, GA, HI, LA, MA, MI, NH, NY, OH, OR, SC, TX
Health Info Exchange	4	CA, MI, OH, WI
Health Disparities	2	CA, MI
Telehealth	1	NY
Other	12	CA, DE, HI, IA, IL, IN, MA, MI, NE, NV, TN, WI
*MD did not report		

Below are contract examples of what quality measures are used to evaluate the progress of the state's quality initiative. Many states use the HEDIS measures and many use other measures in conjunction with HEDIS. As stated above and depicted in the table, many states guide their quality measure decisions based on certain performance areas of interest.

- **California**

[106] https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/, retrieved January 4, 2021

- Sections “Quality Improvement Annual Report” and “External Quality Review Requirements” (pgs. 19-23) outline the Quality Improvement process and oversight
  - The MCO will collect and analyze data from HEDIS measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and then audited by a third-party of the Medicaid agency’s choosing.
- Quality Measures of interest[107]
  - Dashboard Initiative to strengthen public reporting practices
    - Enrollment trends
    - Eligibility count (county level)
  - Dental Managed Care Performance Measures
    - Annual visits
    - Use of preventative services
    - Use of sealants
    - Count of fluoride varnishes
    - Use of diagnostic services
    - Treatment/Prevention of Caries
    - Use of dental services
    - Preventative services to fillings ratio
    - Utilization of dental services (within 1,2,3 years)
  - CMS Core Set Measures
    - Adult Core[108]
      - Primary care access and preventative care
      - Maternal and Perinatal Health
      - Care of Acute and Chronic Conditions
    - Child Core[109]
      - Primary Care Access and Preventive Care
      - Maternal and Perinatal Health
      - Care of Acute and Chronic Conditions
      - Behavioral Healthcare
      - Dental and Oral Health Services
      - Experience of Care
  - Mental Health
    - Adult crisis residential services
    - Adult residential services
    - Crisis intervention
    - Therapeutic Behavioral Services
  - Neonatal quality improvement
    - Reducing/Eliminating catheter associated blood stream infections (CABSIs) and other hospital-acquired infections in Neonatal Intensive Care Units (NICUs).
  - Foster care quality of care
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication includes an initiation phase and a continuation phase
    - Follow-Up After Hospitalization for Mental Illness includes a 7 day and a 30-day follow-up
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics

- **District of Columbia[110]**
  - Section C.5.32.1.7.2 (pg 149) lists performance measures that should be used.
    - “Contractor shall use performance measures including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all External Quality Review Organization (EQRO) activities as part of its QAPI program.”

[107] https://www.dhcs.ca.gov/dataandstats/Pages/QualityMeasurementAndReporting.asp, retrieved on January 4, 2021
[108] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf, retrieved January 4, 2021
[109] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf, retrieved January 4, 2021
[110] http://app.ocp.dc.gov/Award_attachments/CW69127-Base%20Period-Contract%20Award-Executed%20Contract.pdf, retrieved January 14, 2021

  - Section C.5.32.1.7.10 (pg. 150) states that performance improvement projects must follow performance measures outlined in 42 C.F.R. § 430.330(a)(2).
  - Section C.5.32.6 "Performance Measures" (pg 155-157) provides more detail on the process and implementation of performance measures and using those to guide alternative payment models.
- **Delaware**[111]
  - Section 3.13 "Quality" (pgs. 231- 241) outlines the process of how performance measures will be set annually, the MCOs' responsibilities to meet and report performance measures, and Federal and State oversight.
    - "The Contractor shall comply with the State's Quality Management Strategy (QMS). The QMS includes, among other things, details on the State's expectations and requirements for quality activities." (pg. 231)
    - "The QMS is reviewed annually and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The Contractor will have an opportunity to review and comment on proposed changes to the QMS through the Contractor's regular participation in the QII Task Force. The Contractor shall comply with any revisions to the QMS." (pg. 231)
    - "The Contractor shall comply with the requirements in the QMS regarding performance measures for medical, behavioral health and LTSS. The Contractor shall use the methodology established by the State for all performance measures specified in the QMS." (pg. 235)
- **Michigan**
  - Requires MCOs to report performance measures for their performance improvement projects (PIPs) to address racial disparities in the timeliness of prenatal care.
  - Section XI. "Quality Improvement and Program Development" (pgs. 64-73) outlines the performance measure requirements and process for reporting.
  - 2019 HEDIS Aggregate Report for Michigan reported the following performance measures:[112]
    - Child & Adolescent Care
      - Childhood Immunization status
      - Well-Child Visits (first 15mo, 3-6yrs)
    - Women – Adult Care
      - Breast cancer screening
      - Cervical cancer screening
    - Access to Care
      - Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years
      - Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65+ Years, and Total
    - Obesity
      - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total
    - Pregnancy Care
      - Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care
    - Living with Illness
      - Medication Management for People with Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total
      - Controlling High Blood Pressure
      - Medical Assistance with Smoking and Tobacco Use Cessation
    - Health Plan Diversity
      - Race/Ethnicity Diversity of Membership
      - Language Diversity of Membership—Spoken Language Preferred for Healthcare, Preferred Language for Written Materials, and Other Language Needs
    - Utilization
      - Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department (ED) Visits—Total and Outpatient Visits—Total

[111] https://dhss.delaware.gov/dhss/dmma/files/mco_msa2018.pdf, retrieved January 14, 2021
[112] https://www.michigan.gov/documents/mdhhs/MI2019_HEDIS-Aggregate_Report_rev_669299_7.pdf, retrieved January 4, 2021

- Inpatient Utilization—General Hospital/Acute Care
- Use of Opioids from Multiple Providers—Multiple Prescribers, Multiple Pharmacies, and Multiple Prescribers and Multiple Pharmacies
- Use of Opioids at High Dosage
- Risk of Continued Opioid Use—At Least 15 Days Covered—Total and At Least 31 Days Covered—Total
- Plan All-Cause Readmissions—Index Admissions—Total, Observed Readmissions Rate—Total, Expected Readmissions Rate—Total, and O/E Ratio—Total

- **Minnesota**
  - Hybrid HEDIS Performance Measures used in the Model MCO Contract in a recent RFP (pg. 151-152):[113]
    - Adult BMI Assessment
    - Childhood Immunization Status
    - Immunizations for Adolescents
    - Cervical Cancer Screening
    - Controlling High Blood Pressure
    - Comprehensive Diabetes Care
    - Prenatal and Postpartum Care
    - Well-Child Visits in the First 15 Months of Life 6+ Visits
    - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
    - Adolescent Well-Child Visits
  - Risk Corridor Quality Incentive Measures (pgs. 152-155)
    - Baseline rate period: 1/1/19-12/31/19 with the performance rate beginning 1/1/21
    - Performance measures will be stratified by race and ethnicity
    - Quality Measures
      - Prevention and Screening
        - Breast Cancer Screening ages 52-74
        - Colorectal Cancer Screening ages 51-75
        - Childhood Immunization Status (Combo 10) age 2
      - Access to Care
        - Well Visits in first 15mo: 6 or more visits
        - Well Child Visits: 1 or more visits ages 3-6
      - Care for At-Risk Populations
        - Comprehensive Diabetes Care: HbA1c ages 18-75
        - Asthma Medication Ratio ages 5-64
      - Behavioral Health
        - Follow-up After Hospitalization for Mental Illness (30-day) ages 6+
        - Initiation and Engagement of Alcohol, Opioids, and Other Drug Dependence Treatment ages 13+
        - Antidepressant Medication Management: Acute Phase and Continuation Phase ages 18+
      - Utilization
        - Plan All-Cause Readmissions: 1 to 3 Index Hospital Stays ages 18-64
        - Ambulatory Care: Emergency Department
- **Ohio**[114]
  - Requires MCOs to report PIPs related to hypertension control and reducing preterm birth/infant mortality.
  - In Appendix O “Pay-for-Performance (P4P) and Quality Withhold” (pgs. 239-246) outlines the performance measures that MCOs are required to meet and the process to report and potential consequences of not meeting the requirements.
- **Tennessee**
  - In 2019, TennCare implemented a quality of life and satisfaction survey for residents of nursing homes, family members, and nursing home staff to inform QuILTSS value-based initiatives, including

[113] https://mn.gov/dhs/assets/2021-rfp-004-3-19-PrepaidHC-AttachmentJ-Contract-1-4-doc_tcm1053-462237.pdf, retrieved on January 8, 2021
[114] https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/Medicaid-Managed-Care-Generic-PA.pdf, retrieved January 14, 2021

prospective nursing home payments based on outcomes, satisfaction, and improved quality of life. These efforts seek to improve overall quality and experience in nursing facilities (pg. 56).[115]

- LTSS Quality Monitoring (pg. 50) TennCare's LTSS Division monitors MCO performance through:
  - assessing care between settings;
  - comparing services and supports with those in the member's plan;
  - incorporating MCOs into efforts to prevent, detect, and remediate critical incidents; and
  - assessing member quality of life, rebalancing, and community integration activities.
- Section V (pgs. 109-117) lists the goals and objectives to reach quality measurements.
  - Timeliness of Prenatal Care;
  - Postpartum Care;
  - Medication Management for People with Asthma – 75% measure;
  - Diabetes – Nephropathy, Retinal Exam, and BP;
  - Follow-up Care for Children Prescribed ADHD medication-initiation phase;
  - Follow-up Care for Children Prescribed Attention Deficit and Hyperactive Disorder (ADHD) medication – continuation phase. Both initiation and continuation measures have to be calculated in order to receive the quality incentive payment;
  - Adolescent Well-Care Visits;
  - Immunizations for Adolescents – Combo 1;
  - Antidepressant Medication Management – acute and continuation; and,
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening ratio 80% or above.
- Section V (pg. 123) lists the HEDIS measures of interest
  - "Annually, each MCO must submit all HEDIS measures designated by NCQA as relevant to Medicaid, excluding dental measures. The MCOs must use the hybrid methodology for any measure containing Hybrid Specifications as identified by NCQA. The results must be reported annually for each grand region in which the Contractor operates. They must contract with an NCQA-certified HEDIS auditor to validate their processes in accordance with NCQA requirements."
  - "Each D-SNP that has signed a MIPPA agreement with TennCare also submits HEDIS and CAHPS measures designated for D-SNPs to both TennCare and Qsource, who then aggregates the data and provides a written report."
- Behavioral Health Crisis Prevention, Intervention, and Stabilization Services: "Systems of Support" (SOS) (pgs. 138-140) Nonclaims-based performance measures:
  - Use of psychotropic medications,
  - Number of crisis events requiring intervention by SOS provider,
  - In-person assistance by the SOS provider,
  - Out-of-home placement (including length of out-of-home placement),
  - Community tenure – days/periods without institutionalization or out-of-home placement,
  - Stability in living arrangements,
  - Participation in community activities,
  - Integrated competitive employment,
  - Perceived quality of life, and
  - Satisfaction with services.

- **Virginia[116]**
  - HEDIS measures that are used for Quality Initiatives:
    - Childhood Immunization Status (Combo 3)
      - Each vaccine must be reported separately
    - Comprehensive Diabetes Care
      - A1c testing and control
      - Retinal eye exam
      - Medical attention for nephropathy
      - Blood pressure control
    - Controlling high blood pressure

[115] https://www.tn.gov/content/dam/tn/tenncare/documents/qualitystrategy.pdf, retrieved January 4, 2021
[116] https://www.dmas.virginia.gov/files/links/4144/Medallion%204.0%202019%20Contract.pdf

- Medication Management for People with Asthma
- Postpartum visits
- Timeliness of Prenatal Care
- Breast Cancer Screening
- Antidepressant Medication Management 2 Indicators Acute Phase and Continuation Phase
- Follow-up Care for Children Prescribed ADHD Medication 2 indicators, initiations phase; continuations and maintenance phase
- Follow-up after Hospitalization for Mental Illness (7-day follow up only)
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3-6 Years of Life
- Adolescent Well-Care Visits
- Cervical Cancer Screening
- Medical Assistance with Smoking and Tobacco Use Cessation
    - Advising smokers to quit
    - Discussing cessation medication
    - Discussing cessation strategies
- Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Adults' Access to Preventative/Ambulatory Health Services
- Children and Adolescents Access to Primary Care Practitioners
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Colorectal Cancer Screening
- Flu Vaccinations for Adults Ages 18-64

- Other Measures of interest
    - OHSU: Developmental Screening in The First 3 Years of Life
    - Early Elective Deliveries Rate
    - CDC: Percent of Live Births <2,500 Grams
    - AHRQ: PQI 14: Asthma Admission Rate (2-17)
    - AHRQ: PQI 15: Asthma in Younger Adults Admission Rate
    - AHRQ: PQI 05: COPD and Asthma in Older Adults Admission Rate
- Consumer Assessment of Healthcare Provider and Systems (CAHPS)

Appendix E

Appendix E: Examples of State Directed Payments for Hospitals

Based on our review of state directed payment preprints, we have identified selected examples of Medicaid state directed payments focused on hospitals.

Arizona[117]

- VBP Payment Type: Medicaid-specific delivery system reform
- Length: 5yr payment arrangement (1/18/17-9/30/21) - 3yrs integration/baseline, year 4 & 5 evaluated
- General Notes
    - Makes payments to managed care organizations (MCO) associated with their targeted investments (TI) program specified in their 1115 waiver for hospital projects associated with community adult discharges for enrollees with a primary diagnosis for mental health or Substance Use Disorder (SUD) or enrollees determined to have a Serious Mental Illness (SMI).
    - Per Milestone Per Discharge Per Year (PDPY) amounts are finalized once the participant discharges are known for TI Y3 and can include an urban/rural differentiator
    - Payments are made to hospitals based on ∑ (discharges × earned milestone weights× $PDPY per milestone
    - Emphasis on whole-person care:
        - Development of procedures for warm hand-offs to primary care providers (PCP) and Community Behavioral Health Providers (CBHP)
        - Scheduling follow-up appts
        - Effective processes for transitions of care

California[118]

- VBP Payment Type:
    - Quality Payments/Pay for Performance (Category 2 APM, or similar)
    - Performance Improvement Initiative
- Length: 4yr payment arrangement (2017-2021) – year 1 baseline years 2-4 are evaluated
- Four main strategic quality categories: primary care provider (PCP), Specialty Care, Inpatient care, Resource utilization (pg.10)
- Any revisions from year 1 (2017) must be approved by the State and meet one or more of the following (pg.11):
    - Is a National Quality Forum (NQF)-endorsed measure
    - Considered a national Medicaid performance measure
- Has been used with financial performance accountability in a CMS approved performance program and is not duplicative of a current CMS approved Medicaid program
- Performance measures (pgs. 12-13):

Figure E-1: California Performance Measures

Category	Type Service	Measures Sources
Primary Care	Comprehensive Diabetes Care: Eye exam	(CDC-E) (NQF 0055, Quality ID 117)
	Comprehensive Diabetes Care: Blood Pressure Control	CDC-BP
	Comprehensive Diabetes Care: A1C Control	CDC-H8
	Asthma Medication Ratio	AMR
	Children and Adolescent access to PCP (pediatric)	CAP
	Medication reconciliation Post Discharge	MRP
	Immunization for Adolescents (IMA) Combination 2 (pediatric)	NQF 0038, Quality ID 240
	Childhood Immunizations (CIS) Combination 3 (pediatric)	NQF 0038, Quality ID 240

[117] AZ_438.6(c) Proposal G_Preprint_2018-2021, obtained through a Freedom of Information Act request.
[118] CA_438.6(c) Proposal F_Rvsd Preprint v3_2018-2021, obtained through a Freedom of Information Act request.

Category	Type Service	Measures Sources
	7-Day Post-Discharge Follow-Up Encounter for High-Risk Beneficiaries	
Specialty Care	Coronary Artery Disease (CAD): Antiplatelet Therapy	NQF 0067, Quality ID 006
	Coronary Artery Disease (CAD): ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	NQF 0066, Quality ID 118
	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	NQF 0070, Quality ID #007, eMeasure ID CMS145v6
	Heart Failure (HF): ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD)	(NQF: 0081, Quality ID 005) (eMeasure ID: CMS135v6, eMeasure NQF: 2907)
	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	(NQF 0083, Quality ID #008) (eMeasure ID CMS144v6, eMeasure NQF 2908)
	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	(NQF 1525, Quality ID 326)
Inpatient (part of DSRIP but not PRIME)	Surgical Site Infections (SSI)	
	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	NQF 268, Quality ID 21
	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis	NQF 239, Quality ID 23
	Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	Quality ID 76
	Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia	Quality ID 407
	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic	TJC STK-2, eMeasure ID: CMS104v6
Resource Utilization	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patient 18 years and Older	Quality ID 415
	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 to 17 years old	Quality ID 416
	Unplanned Reoperation within 30 Day Postoperative Period	Quality ID 355
	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients	Quality ID 322
	Concurrent Use of Opioids and Benzodiazepines	

- "The gap is defined as the difference between the DPH system's end of program year performance and the Medicaid 90th percentile benchmark. The target setting methodology will be as follows for PY 2-PY 4:
  - 10.0% gap closure for 1st year of QIP reporting, or subsequent PYs assuming the California Department of Public Health (DPH) failed to meet a 10.0% gap closure in the prior year,
  - 8.5% gap closure for 2nd year of QIP reporting, or subsequent PYs assuming the DPH failed to meet an 8.5% gap closure in the prior year,
  - 6.0% gap closure for 3rd year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 6.0% gap closure in the prior year." (pg. 13)

Hawaii[119]

- VBP Payment Type: Other Value-Based Purchasing Model
  - Adding public hospitals under the umbrella of a CY17 pay for performance pool for private hospitals but evaluated separately.
- Length: indefinite beginning 1/1/18
- General Notes:
  - Public and Private hospitals are evaluated on a standard set of quality measures and bonuses will be paid according to the hospitals' evaluated pay for performance pool.

[119] HI_438.6(c) Proposal A_Preprint_2018, obtained through a Freedom of Information Act request.

        - Quality metrics to include process measures and State Department of Health (SDOH)-type measures
        - Additionally, payment is based on a combination of the number of quality metrics the hospital achieves times the volume of patients it receives.
        - Hospitals with psychiatric beds have a slightly different weighting for one of the quality metrics
    - Applies to all Hawaii hospitals
    - Methodology used to set performance targets
        - Used a vendor's baseline/target with intermediate targets to encourage continued progress across all quality metrics
        - Process measure example
            - Used a predetermined number of employees by hospital within a specific time period, based on a reasonable proportion of intake staff per the size of the hospital.
    - Quality Measures

Figure E-2: Hawaii Performance Measures[120]

Goal	Objective	Measures	Measures' Sources
Improving preventative care for women and children	Childhood Immunizations	Childhood Immunization (combination 2) measure to meet/exceed the 2015 Medicaid 75th percentile.	HEDIS
	Frequency of Ongoing Prenatal Care	Frequency of Ongoing Prenatal Care measure to meet/exceed the 2015 Medicaid 75th percentile.	HEDIS
	Timeliness of Prenatal Care	Timeliness of Prenatal Care measure to meet/exceed the 2015 Medicaid 75th percentile.	HEDIS
	Breast Cancer Screening	Breast Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile.	HEDIS
	Cervical Cancer Screening	Cervical Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile.	HEDIS
		Participant Ratio to meet/exceed 80 percent for children of all ages.	EPSDT
Improve healthcare for individuals who have chronic illnesses	Comprehensive Diabetes Care Measures	Diabetes Care Measure for A1c testing to meet/exceed the 2015 HEDIS 75th percentile.	HEDIS
		Diabetes Care Measure for A1c control (>9) to meet/exceed the 2015 HEDIS 50th percentile	HEDIS
		Diabetes Care Measure for A1c control (>8) to meet/exceed the 2015 HEDIS 50th percentile	HEDIS
		Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed	HEDIS

[120] QUEST Integration Quality Strategy, July 7, 2016, https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/quality-strategy/7-7-2016-HI-MQD-Quality-Strategy-Approved.pdf, retrieved January 14, 2021

Goal	Objective	Measures	Measures' Sources
		the 2015 HEDIS 75th percentile	
		Diabetes Care Measure for eye exams to meet/exceed 2015 HEDIS 75th percentile.	HEDIS
	Blood Pressure Control in the General Population	Blood Pressure Control (BP<140/90) measure to meet/exceed the 2015 HEDIS 75th percentile.	HEDIS
	Appropriate Medications in Asthma	Asthma (using correct medications for people with asthma) measure to meet/exceed 2015 HEDIS 75th percentile.	HEDIS
	Reduce the percent of asthma related ED visits for Medicaid beneficiaries ages 0-20	Decrease the percent of asthma related ED visits to less than or equal to 6%	
Improve beneficiary satisfaction with health plan services	Improve beneficiary satisfaction with health plan services	'Getting Needed Care' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile	CAHPS
		'Rating of Health Plan' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.	CAHPS
		'How well doctors communicate' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.	CAHPS
Improve cost-efficiency of health plan services		Monitor Plan All Cause Readmission annually to identify if improving from baseline that was established in CY13	MCOs will perform Performance Improvement Programs (PIPs) on Plan All Cause Readmission to improve this measure.
	Follow-Up After Hospitalization for Mental Illness	Follow-Up After Hospitalization for Mental Illness measure to meet/exceed the 2015 HEDIS 75th percentile.	HEDIS
	Medication Reconciliation Post-Discharge	Medication Reconciliation Post Discharge measure to meet/exceed the 2015 HEDIS 75th percentile.	HEDIS
		Emergency Department Visits/1000 rate to meet/fall below the HEDIS 2015 10th percentile.	HEDIS
Home and Community Based Service (HCBS)	Expand access to HCBS and assure that individuals have a choice of institutional and HCBS	Increase the proportion of beneficiaries receiving HCBS instead of institutional-based long-term care services by 5% over the waiver demonstration (to 70%).	CMS Approved Waiver

Goal	Objective	Measures	Measures' Sources
	Improve access to community living and the opportunity to receive services in the most integrated setting appropriate for individuals receiving HCBS	Assure that settings are integrated and support full access to the greater community by each setting meeting/exceeding 85% compliance with the HCBS final rules	CMS
		Optimize individuals' initiative, autonomy and independence in making life choices (including daily activities, physical environment, and with whom to interact) by beneficiaries confirming their setting meets/exceeds 85% compliance with the HCBS final rules.	CMS

Kentucky[121]

- VBP Payment Type: Quality Payments / Pay for Performance (Category 2 APM, or similar)
- Length: 4yr program (7/1/19 – 6/30/23)
    - Year 1 (7/1/19-6/30/20) is the baseline for performance measures and performance improvement targets
    - Years 2-4 (7/1/2020-6/30/2023) will be for evaluating participating providers' improvement and programmatic impacts.
- General Notes:
    - VBP Payment arrangement applies to:
        - State public schools of medicine, dentistry, and nursing.at the University of Kentucky, the University of Louisville, and state university teaching hospitals
    - State requires MCOs to have network provider agreements with all state university providers.
    - Quality goals are like ones used for Medicare's Quality Payment Program and commercial insurers, and focus on:
        - Reducing the burden of chronic disease and substance use disorder
            - Promote evidence-based treatment for heart disease, diabetes, and hypertension
            - Improve treatment for depression; prevent opioid abuse, provide treatment and recovery support, and decrease opioid-related deaths
        - Increase preventive services to improve population health
            - Promote evidence-based preventive services for cancer, obesity, and tobacco cessation
        - Maintaining timely access to high-quality care for Medicaid beneficiaries and reducing unnecessary and wasteful care
            - Improve access to primary and specialty care, improve care coordination, and reduce avoidable readmissions
        - Improve care and outcomes for children
            - Ensure access to preventive services (e.g., vaccinations and well-child visits).
    - Providers would qualify for annual value-based bonus payments from MCOs if certain reporting requirements are met in Year 1 and the provider meets performance thresholds established by the state Medicaid department for each subsequent year under the KY Medicaid MCO value-based payment program
        - Bonus payments increase throughout the time of the program

[121] KY_438.6(c) Proposal B_Preprint_2019-2020, obtained through a Freedom of Information Act request.

- Year 1 (baseline): at most 5% of the average commercial rate (ACR) for the services provided (e.g., inpatient hospital, outpatient hospital and professional services).
- Year 2: at most 10% of ACR for services provided
- Year 3: at most 15% of ACR for services provided
- Year 4: at most 20% of ACR for services provided

▪ Performance measure thresholds for Years 2+ will be set by the state Medicaid department using Year 1 performance data as a baseline and will not exceed the 50th percentile of national benchmarks established under the Quality Payment Program.
▪ Additionally, providers must also conduct performance improvement activities in line with Medicaid's quality goals, including participating in opioid-related improvement activities in order to qualify for value-based bonus payments.

o Performance measures

Figure E-3: Kentucky Performance Measures

Measure	Measure Steward/Developer
Breast Cancer Screening	NQF 2372
Colorectal Cancer Screening	NQF 32
Tobacco Use: Screening and Cessation Intervention	NQF 28
Body Mass Index (BMI) Screening and Follow-Up	NQF 421
Screening for Clinical Depression and Follow Up Plan, 418	NQF 418
Statin Therapy for Patients with Cardiovascular Disease	CMS PREV-13; CMS 347v1 eCQM
Diabetes Care: Hemoglobin (HbA1c) Poor Control (>9.0%), 59	NQF 59
Controlling High Blood Pressure (Hypertension)	NQF 18
Medication Reconciliation Post-Discharge	NQF 97
30 day All Cause Readmissions	NQF 1768
Childhood Immunization Status	NQF 38 (Combo)
Well Child Visits, 3-6 years and First 15 months	NQF 1516, NQF 1392
Well Child Visits, First 15 months	NQF 1392
Use of Opioids at High Dosage (proposed)	NCQA

Ohio[122]

- VBP Payment Type: Quality Payments/Pay for Performance (Category 2 APM, or similar)
- Length: 3yr program; 7/1/19 – 6/30/22
- General Notes:
  - VBP program goals are to improve health outcomes for patients with:
    - An opioid or other substance abuse disorder, mental illness
    - At-risk mothers, infants, and children
  - Monthly per member per month (PMPM) payments will be made to participating providers by the MCO and will be allocated based on:
    - Historical utilization data
    - Quality improvement initiative work each participating provider is implementing and executing.
  - Providers are also eligible to receive annual quality incentive bonus payments at 100% of the statewide ACR.
    - Bonus amounts will be calculated as the difference between the provider's actual utilization, priced at the statewide ACT, and the total monthly VBP program per-member per-month (PMPM) payments received by the agency during the rate year.

[122] OH_438.6(c) Proposal A_Preprint_2019-2022, obtained through a Freedom of Information Act request.

        - The total potential bonus pool will equal the sum of each individual provider's potential bonus amounts.
        - If providers do not meet requirements, bonus payments will not be made.
    - Collective Impact Standard: if the coalition of providers have met the collective impact standard if the unweighted collective rate meets or exceeds the established threshold for a given metric in that performance year.
        - In this case, bonus payments are based on the participating providers must collectively meet a specified number of metrics each performance year
            - The number of standards that need to be met to earn a higher percent payout increase with each subsequent performance year (i.e. Year 1: 4+ standards, Year 2: 5+ standards, Year 3: 6+ standards to receive 100% payout).
    - The first 6 months were focused on implementing quality initiatives, baseline evaluation, and necessary data reporting
    - Performance measures
        - State baselines for all measures are updated annually
            - Preliminary baseline years
                - Opioid measures: SFY 18
                - Clinical measures: CY 17
        - Reporting years for all measures: CY19 – 21

Figure E-4: Ohio Reporting Measures

Measure	Measure Steward/Developer	Notes
Opioid Solid Doses Dispensed (without Suboxone)	PQA	Rate of Opioid Solid Doses Dispensed Per Patient of Doctors Prescribing Opioids
Patients at ≥ 80mg MED	PQA	Rate of patients receiving > 80mg MED of patients with opioid prescriptions
Patients on both opioid & Benzos	PQA	Rate of patients receiving opioids also receiving Benzodiazepine
Initiation and Engagement of Alcohol and other Drug Dependence Treatment; 0004	NCQA	
Follow-Up After Hospitalization for Mental Illness; 0576	NCQA	
Timely Prenatal	NCQA	
Postpartum Care; 1517	NCQA	
Emergency Room Utilization Reduction	HEDIS	

Pennsylvania

Potentially Preventable Admissions[123]

- VBP Payment Type: Quality Payments/Pay for Performance (Category 2 APM, or similar)
- Length: 5yr payment arrangement; 1/1/16 – 12/31/21
- General Notes:
    - Specifically refers to the potentially preventable admissions (PPA) measures in the state's Hospital Quality Incentive Program
    - VBP arrangement applies to private general acute care hospitals enrolled in the Pennsylvania (PA) Medical Assistance (MA) Program
    - General incentive goals are to improve utilization and delivery of healthcare services within the community
    - Incentive amounts are based on the previous year's inpatient hospital admission information from the state's Medicaid Management Information Systems (MMIS) as submitted by MCOs and evaluated for PPAs identified by the state health department using the 3M™ Population Focused Preventable software

[123] PA_438.6(c) Proposal A_Preprint_2019, obtained through a Freedom of Information Act request.

        - Each admission will be defined from the date of admission to the date of discharge with each admission only to be counted once.
        - Admissions are based solely on individuals in the PA MA's Health Choices program
    - The payment arrangement targets all enrollees that have an inpatient stay paid for by a physical health MCO
        - Admissions for dual-eligible enrollees over 21 years old are not included
    - Children's and non-children's general acute care hospitals will have separate benchmarks and will be evaluated separately.
    - Incremental improvement calculation:
        - $\frac{CY18\ MA\ PPA}{CY18\ Total\ MA\ Admissions} - \frac{CY19\ MA\ PPA}{CY19\ MA\ Total\ Admissions} = incremental\ improvement$
        - A hospital must improve by at least 0.5% in order to qualify

Figure E-5: Pennsylvania Performance Incentives

Incremental Improvement	Percent Payout
≥ 3 Percentage Point Improvement	100%
≥ 2 and < 3 Percentage Point Improvement	90%
≥ 1 and < 2 Percentage Point Improvement	80%
≥ 0.5 and < 1 Percentage Point Improvement	70%

    - Benchmark Achievement calculation
        - $\frac{CY18\ MA\ PCY19\ PA\ MA\ PPA}{CY19\ PA\ MA\ Total\ Admissions} = Preventable\ Event\ Statistic$
        - Non-children's acute care hospital can earn benchmark incentive payment based on a sliding scale as long as they perform at or below the 50th percentile of the previous year's statewide PPA benchmark.

Figure E-6: Pennsylvania Performance Incentives for Acute Care Hospitals

Percentage/Payout	At or below 25th Percentile	At or below 50th Percentile
CY 2018 Preventable Event Benchmark Percentage	11.53%	8.45%
Percent Payout	100%	90%

- Children's hospitals have a separate benchmark based on the previous year's median PPA statistic among children's hospitals, which excludes low-volume children's hospitals.
- Children's hospitals are eligible for payment if their PPA statistic is at or below one standard deviation above the median according to the sliding scale.

Figure E-7: Pennsylvania Performance Incentives for Children's Hospitals

Percentage/Payout	At or below the Median	At or below one standard deviation above the Median
CY 2018 Preventable Event Benchmark Percentage	17.9%	22.9%
Percent Payout	100%	90%

Opioid Use Disorder[124]

- VBP Payment Type:
    - Quality Payments/Pay for Performance (Category 2 APM, or similar)
    - Performance Improvement Initiative
- Length: 5yr payment arrangement; 1/1/16 – 12/31/21

[124] PA_438.6(c) Proposal D_Revised Preprint_2019, obtained through a Freedom of Information Act request.

- General Notes:
    - VBP arrangement applies to private general acute care hospitals enrolled in the PA MA Program
    - 2 phase initiative
        - Phase 1: hospitals will be provided with incentives to build at least one of four specific clinical pathways that individuals can use following treatment in an emergency department (ED) setting to increase access and quality of care.
            - The goal is to avoid the need for repeat treatment in an ED setting.
            - Hospitals will be awarded incentive funds based on the number of pathways developed and the number of recipients enrolled in MA HealthChoices being treated through the new pathways and the following tiers in Figure E-8:

Figure E-8: Hospital Tiers for Volume of Opioid Use Disorder Patients

Tier 1	Low-volume Emergency Departments (EDs) – Hospitals that had less than 20 OUD ED visits must serve a minimum of 1 MA Health Choices recipient through a newly established pathway.
Tier 2	Standard EDs – Hospitals that had between 20 and 200 OUD ED visits must serve a minimum of 10 MA Health Choices recipients through the newly established pathways.
Tier 3	High Volume EDs – Hospitals that had more than 200 OUD ED visits must serve a minimum of 20 MA Health Choices recipients through the newly established pathways

        - Phase 2: is designed to maintain phase 1 progress by giving each hospital the opportunity to earn both benchmark and incremental improvement incentive payments based on benchmark or incremental achievement of the HEDIS® measure:
            - 7-day OUD follow-up treatment initiation with the following modification:
                - Limited to just Opioid/Opioid Poisoning diagnoses, evaluation of the top nine diagnoses positions.
    - 4 specified pathways that are acceptable for clinical treatment of opioid use disorder (OUD)
        - ED initiation of buprenorphine with warm hand-off to the community
        - Direct warm hand-off to the community for medically assisted treatment (MAT) or abstinence-based treatment
        - Specialized protocol developed by the hospital to address pregnant women with OUD
        - Direct inpatient admissions for methadone or observation for buprenorphine induction
    - The more pathways a hospital chooses to undertake and meet requirements in phase 1 will result in higher payouts
        - Remaining funds will be distributed proportionally to hospitals successfully implementing the defined clinical pathway(s) based on an individual's hospital's OUD related ED visits divided by the total OUD related ED visits for all hospitals collectively
    - Incremental improvement calculation:
        - $\frac{CY18\ MCCY19\ MA\ MC\ recipients\ from\ denominator\ seen\ for\ OUD\ treatment\ within\ 7-days\ of\ ED}{CY19\ MA\ MC\ recipients\ seen\ in\ the\ ED\ for\ OUD} - \frac{CY18\ MA\ MC\ recipients\ from\ denominator\ seen\ for\ OUD\ treatment\ within\ 7-days\ of\ ED}{CY18\ MA\ MC\ recipients\ seen\ in\ the\ ED\ for\ OUD} = incremental\ improvement$
        - A hospital must improve by at least 0.5% in order to qualify

Figure E-9: Pennsylvania Performance Measures for Opioid Use Disorder

Incremental Improvement	Percent Payout
≥ 3 Percentage Point Improvement	100%
≥ 2 and < 3 Percentage Point Improvement	90%
≥ 1 and < 2 Percentage Point Improvement	80%
≥ 0.5 and < 1 Percentage Point Improvement	70%

- Benchmark Achievement calculation
  - $\frac{CY19\ MA\ recipients\ from\ denominator\ seen\ for\ OUD\ treatment\ within\ 7-days\ of\ ED\ visit}{CY19\ MA\ recipients\ seen\ in\ the\ ED\ for\ OUD} = Hospital's benchmark\ comparison\ statistic$
  - A hospital can earn benchmark incentive payment based on a sliding scale as long as they perform at or above the 50th percentile of the previous year's statewide preventable event benchmark.

Figure E-10: Pennsylvania Incentive Benchmark for Opioid Use Disorder

Percentage/Payout	At or below 75th Percentile	At or below 50th Percentile
Percent Payout	100%	90%

- Performance Measures

Figure E-11: Pennsylvania Performance Measures for Opioid Use Disorder

Measure	Measure Steward/Developer	Notes
Attestation to having implemented each clinical pathway for which funding is requested	PA	
Number of MA recipients served in each pathway	PA	
OUD treatment within 7 days of discharge from the ED – modified HEDIS® as described in response #5	NCQA/PA modified	The event denominator will be any MA recipient seen in the ED for OUD. The event numerator will be anyone in the denominator seen for OUD treatment within 7 days of discharge from the ED.

Appendix F

LOUISIANA DEPARTMENT OF HEALTH

STATE DIRECTED PAYMENTS CONSIDERATIONS

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH (SCENARIO 1: ADDITIONAL $400 MIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL TIER	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
1	$ 243,797,912	$ 255,459,926	28.7%	51.8%	$ 70,089,224	$ 132,319,506	$ 321,266,651	$ 0	$ 523,675,381	$ 489,972,690	$ 33,702,691
2	235,403,976	339,285,285	41.9%	60.3%	98,632,348	204,674,616	4,695,118	2,923,643	310,925,725	414,420,618	(103,494,893)
3	149,452,687	118,983,519	41.9%	93.1%	62,619,458	110,733,841	11,129,514	-	184,482,813	169,804,345	14,678,468
4	170,357,204	164,132,819	117.9%	128.6%	200,927,524	211,133,975	7,198,394	-	419,259,893	272,028,117	147,231,776
5	174,706,751	149,056,417	197.4%	238.0%	344,829,719	354,699,827	5,000,000	-	704,529,546	396,697,588	307,831,958
Total	**$ 973,718,529**	**$ 1,026,917,966**	**79.8%**	**98.7%**	**$ 777,098,274**	**$ 1,013,561,764**	**$ 349,289,677**	**$ 2,923,643**	**$ 2,142,873,358**	**$ 1,742,923,358**	**$ 399,950,000**

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH (SCENARIO 2: ADDITIONAL $650 MIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL TIER	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
1	$ 243,797,912	$ 255,459,926	30.7%	54.1%	$ 74,805,072	$ 138,145,514	$ 314,584,822	$ 0	$ 527,535,408	$ 489,972,690	$ 37,562,718
2	235,403,976	339,285,285	59.8%	80.5%	140,660,477	273,115,127	3,499,593	2,342,706	419,617,903	414,420,618	5,197,285
3	149,452,687	118,983,519	59.8%	117.4%	89,302,171	139,636,658	1,406,001	-	230,344,830	169,804,345	60,540,485
4	170,357,204	164,132,819	146.8%	158.9%	250,081,009	260,814,636	-	-	510,895,644	272,028,117	238,867,527
5	174,706,751	149,056,417	197.4%	238.0%	344,829,719	354,699,827	5,000,000	-	704,529,546	396,697,588	307,831,958
Total	**$ 973,718,529**	**$ 1,026,917,966**	**92.4%**	**113.6%**	**$ 899,678,449**	**$ 1,166,411,761**	**$ 324,490,416**	**$ 2,342,706**	**$ 2,392,923,331**	**$ 1,742,923,358**	**$ 649,999,973**

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH (SCENARIO 3: ADDITIONAL $900 MIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL TIER	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
1	$ 243,797,912	$ 255,459,926	95.9%	131.0%	$ 233,802,197	$ 334,572,216	$ 133,342,589	$ 0	$ 701,717,002	$ 489,972,690	$ 211,744,312
2	235,403,976	339,285,285	65.8%	87.3%	154,778,290	296,105,215	3,098,000	2,147,562	456,129,067	414,420,618	41,708,449
3	149,452,687	118,983,519	72.8%	135.1%	108,842,893	160,803,242	-	-	269,646,135	169,804,345	99,841,790
4	170,357,204	164,132,819	146.8%	158.9%	250,081,009	260,814,636	-	-	510,895,644	272,028,117	238,867,527
5	174,706,751	149,056,417	197.4%	238.0%	344,829,719	354,699,827	5,000,000	-	704,529,546	396,697,588	307,831,958
Total	**$ 973,718,529**	**$ 1,026,917,966**	**112.2%**	**137.0%**	**$ 1,092,334,109**	**$ 1,406,995,135**	**$ 141,440,589**	**$ 2,147,562**	**$ 2,642,917,394**	**$ 1,742,923,358**	**$ 899,994,036**

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH (SCENARIO 4: ADDITIONAL $1.0 BIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL TIER	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
1	$ 243,797,912	$ 255,459,926	130.8%	172.1%	$ 318,925,082	$ 439,733,913	$ 70,160,243	$ 0	$ 828,819,239	$ 489,972,690	$ 338,846,549
2	235,403,976	339,285,285	65.8%	87.3%	154,778,290	296,105,215	3,098,000	2,147,562	456,129,067	414,420,618	41,708,449
3	149,452,687	118,983,519	72.8%	135.1%	108,842,893	160,803,242	-	-	269,646,135	169,804,345	99,841,790
4	170,357,204	164,132,819	146.8%	158.9%	250,081,009	260,814,636	-	-	510,895,644	272,028,117	238,867,527
5	174,706,751	149,056,417	197.4%	238.0%	344,829,719	354,699,827	5,000,000	-	704,529,546	396,697,588	307,831,958
Total	**$ 973,718,529**	**$ 1,026,917,966**	**120.9%**	**147.3%**	**$ 1,177,456,994**	**$ 1,512,156,832**	**$ 78,258,243**	**$ 2,147,562**	**$ 2,770,019,631**	**$ 1,742,923,358**	**$ 1,027,096,273**

Appendix G

LOUISIANA DEPARTMENT OF HEALTH

STATE DIRECTED PAYMENTS CONSIDERATIONS

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH BY HOSPITAL (SCENARIO 1: ADDITIONAL $400 MIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL SYSTEM	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
Rural (Public and Private)	$ 62,510,820	$ 163,817,945	46.1%	62.5%	$ 28,812,891	$ 102,445,948	$ 0	$ 2,923,643	$ 134,182,482	$ 113,813,839	$ 20,368,643
Other Urban Private	937,269	5,396,622	28.7%	51.8%	269,454	2,795,266	-	-	3,064,720	-	3,064,720
Glenwood Regional Medical Center	10,005,021	6,002,797	28.7%	51.8%	2,876,334	3,109,244	7,814,423	-	13,800,000	13,800,000	-
Lake Charles Memorial Hospital	25,657,028	21,171,259	41.9%	93.1%	10,750,086	19,703,358	11,129,514	-	41,582,958	41,582,958	-
Hospital Service Districts	69,483,624	106,776,636	166.7%	186.3%	115,847,988	198,978,092	-	-	314,826,080	199,819,684	115,006,396
Baton Rouge General / Baton Rouge Mid City	26,690,661	20,366,973	73.1%	100.1%	19,502,750	20,381,224	7,198,394	-	47,082,368	39,300,000	7,782,368
Louisiana Children's Medical Center	164,393,694	179,334,168	63.7%	79.4%	104,727,439	142,366,380	199,975,636	-	447,069,454	429,543,095	17,526,359
Christus	33,307,154	28,942,454	28.7%	51.8%	9,575,441	14,991,201	34,533,357	-	59,100,000	59,100,000	-
Allegiance Health	10,766,628	14,126,789	28.7%	51.8%	3,095,287	7,317,194	-	-	10,412,481	-	10,412,481
Ochsner / Lafayette General	163,524,784	163,330,526	72.5%	91.9%	118,574,496	150,129,795	64,755,125	-	333,459,417	263,044,716	70,414,701
Ochsner LSU Shreveport	83,531,529	70,591,527	142.4%	181.0%	118,960,763	127,743,418	5,000,000	-	251,704,181	294,169,656	(42,465,475)
Rapides Regional / Tulane University	69,070,912	39,355,344	164.0%	194.9%	113,258,313	76,707,719	-	-	189,966,033	74,600,000	115,366,033
Franciscan Missionaries of Our Lady	157,776,255	158,450,214	41.7%	59.8%	65,783,449	94,792,776	18,883,228	-	179,459,452	152,370,417	27,089,035
Willis-Knighton	41,982,273	34,601,870	117.9%	128.6%	49,515,923	44,510,479	-	-	94,026,402	40,767,158	53,259,244
Womans Hospital	54,080,879	14,652,841	28.7%	51.8%	15,547,659	7,589,671	-	-	23,137,330	21,011,835	2,125,495
Total	**$ 973,718,529**	**$ 1,026,917,966**	**79.8%**	**98.7%**	**$ 777,098,274**	**$ 1,013,561,764**	**$ 349,289,677**	**$ 2,923,643**	**$ 2,142,873,358**	**$ 1,742,923,358**	**$ 399,950,000**

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH BY HOSPITAL (SCENARIO 2: ADDITIONAL $650 MIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL SYSTEM	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
Rural (Public and Private)	$ 62,510,820	$ 163,817,945	64.6%	83.0%	$ 40,352,500	$ 136,026,652	$ 0	$ 2,342,706	$ 178,721,859	$ 113,813,839	$ 64,908,020
Other Urban Private	937,269	5,396,622	30.7%	54.1%	287,584	2,918,341	-	-	3,205,925	-	3,205,925
Glenwood Regional Medical Center	10,005,021	6,002,797	30.7%	54.1%	3,069,863	3,246,143	7,483,993	-	13,800,000	13,800,000	-
Lake Charles Memorial Hospital	25,657,028	21,171,259	59.8%	117.4%	15,330,794	24,846,163	1,406,001	-	41,582,958	41,582,958	-
Hospital Service Districts	69,483,624	106,776,636	175.8%	199.5%	122,139,566	213,059,221	-	-	335,198,787	199,819,684	135,379,103
Baton Rouge General / Baton Rouge Mid City	26,690,661	20,366,973	88.4%	119.9%	23,589,108	24,426,853	-	-	48,015,961	39,300,000	8,715,961
Louisiana Children's Medical Center	164,393,694	179,334,168	76.8%	93.0%	126,302,905	166,712,566	196,834,452	-	489,849,923	429,543,095	60,306,828
Christus	33,307,154	28,942,454	30.7%	54.1%	10,219,710	15,651,262	33,229,028	-	59,100,000	59,100,000	-
Allegiance Health	10,766,628	14,126,789	30.7%	54.1%	3,303,549	7,639,369	-	-	10,942,918	-	10,942,918
Ochsner / Lafayette General	163,524,784	163,330,526	84.0%	104.0%	137,427,762	169,898,712	61,653,713	-	368,980,187	263,044,716	105,935,471
Ochsner LSU Shreveport	83,531,529	70,591,527	148.7%	187.8%	124,232,740	132,587,478	5,000,000	-	261,820,218	294,169,656	(32,349,438)
Rapides Regional / Tulane University	69,070,912	39,355,344	176.1%	206.8%	121,638,877	81,398,760	-	-	203,037,637	74,600,000	128,437,637
Franciscan Missionaries of Our Lady	157,776,255	158,450,214	59.3%	78.9%	93,560,582	125,092,427	18,883,228	-	237,536,237	152,370,417	85,165,820
Willis-Knighton	41,982,273	34,601,870	146.8%	158.9%	61,629,147	54,983,971	-	-	116,613,119	40,767,158	75,845,961
Womans Hospital	54,080,879	14,652,841	30.7%	54.1%	16,593,760	7,923,843	-	-	24,517,603	21,011,835	3,505,768
Total	**$ 973,718,529**	**$ 1,026,917,966**	**92.4%**	**113.6%**	**$ 899,678,449**	**$ 1,166,411,761**	**$ 324,490,416**	**$ 2,342,706**	**$ 2,392,923,331**	**$ 1,742,923,358**	**$ 649,999,973**

LOUISIANA DEPARTMENT OF HEALTH

STATE DIRECTED PAYMENTS CONSIDERATIONS

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH BY HOSPITAL (SCENARIO 3: ADDITIONAL $900 MIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL SYSTEM	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
Rural (Public and Private)	$ 62,510,820	$ 163,817,945	70.2%	89.6%	$ 43,894,712	$ 146,767,692	$ 0	$ 2,147,562	$ 192,809,965	$ 113,813,839	$ 78,996,126
Other Urban Private	937,269	5,396,622	95.9%	131.0%	898,841	7,067,878	-	-	7,966,719	-	7,966,719
Glenwood Regional Medical Center	10,005,021	6,002,797	95.9%	131.0%	9,594,815	7,861,778	-	-	17,456,593	13,800,000	3,656,593
Lake Charles Memorial Hospital	25,657,028	21,171,259	72.8%	135.1%	18,685,413	28,612,426	-	-	47,297,839	41,582,958	5,714,881
Hospital Service Districts	69,483,624	106,776,636	176.5%	200.8%	122,628,464	214,382,423	-	-	337,010,887	199,819,684	137,191,203
Baton Rouge General / Baton Rouge Mid City	26,690,661	20,366,973	121.2%	148.5%	32,346,619	30,248,831	-	-	62,595,450	39,300,000	23,295,450
Louisiana Children's Medical Center	164,393,694	179,334,168	113.9%	138.0%	187,241,150	247,489,777	100,860,463	-	535,591,390	429,543,095	106,048,295
Christus	33,307,154	28,942,454	95.9%	131.0%	31,941,561	37,905,519	2,112,529	-	71,959,608	59,100,000	12,859,608
Allegiance Health	10,766,628	14,126,789	95.9%	131.0%	10,325,196	18,501,654	-	-	28,826,850	-	28,826,850
Ochsner / Lafayette General	163,524,784	163,330,526	102.7%	144.3%	167,882,695	235,685,850	14,584,369	-	418,152,913	263,044,716	155,108,197
Ochsner LSU Shreveport	83,531,529	70,591,527	152.4%	190.6%	127,283,319	134,552,186	5,000,000	-	266,835,504	294,169,656	(27,334,152)
Rapides Regional / Tulane University	69,070,912	39,355,344	176.1%	206.8%	121,638,877	81,398,760	-	-	203,037,637	74,600,000	128,437,637
Franciscan Missionaries of Our Lady	157,776,255	158,450,214	66.2%	89.8%	104,479,738	142,345,775	18,883,228	-	265,708,741	152,370,417	113,338,324
Willis-Knighton	41,982,273	34,601,870	146.8%	158.9%	61,629,147	54,983,971	-	-	116,613,119	40,767,158	75,845,961
Womans Hospital	54,080,879	14,652,841	95.9%	131.0%	51,863,563	19,190,617	-	-	71,054,180	21,011,835	50,042,345
Total	**$ 973,718,529**	**$ 1,026,917,966**	**112.2%**	**137.0%**	**$ 1,092,334,109**	**$ 1,406,995,135**	**$ 141,440,589**	**$ 2,147,562**	**$ 2,642,917,394**	**$ 1,742,923,358**	**$ 899,994,036**

DIRECTED FEE SCHEDULE OPTIONS ANALYSIS - TIERED APPROACH BY HOSPITAL (SCENARIO 4: ADDITIONAL $1.0 BIL)

	BASE PAYMENTS		MODELED DFS INCREASE		MODELED DFS PAYMENTS						
HOSPITAL SYSTEM	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	MODELED REMAINING DSH	MODELED RETAINED UPL	TOTAL MODELED PAYMENTS	CURRENT SUPPLEMENTAL PAYMENTS	MODELED PAYMENT CHANGE
Rural (Public and Private)	$ 62,510,820	$ 163,817,945	70.2%	89.6%	$ 43,894,712	$ 146,767,692	$ 0	$ 2,147,562	$ 192,809,965	$ 113,813,839	$ 78,996,126
Other Urban Private	937,269	5,396,622	130.8%	172.1%	1,226,091	9,289,432	-	-	10,515,523	-	10,515,523
Glenwood Regional Medical Center	10,005,021	6,002,797	130.8%	172.1%	13,088,102	10,332,867	-	-	23,420,970	13,800,000	9,620,970
Lake Charles Memorial Hospital	25,657,028	21,171,259	72.8%	135.1%	18,685,413	28,612,426	-	-	47,297,839	41,582,958	5,714,881
Hospital Service Districts	69,483,624	106,776,636	176.5%	200.8%	122,628,464	214,382,423	-	-	337,010,887	199,819,684	137,191,203
Baton Rouge General / Baton Rouge Mid City	26,690,661	20,366,973	138.8%	163.8%	37,035,160	33,365,765	-	-	70,400,925	39,300,000	31,100,925
Louisiana Children's Medical Center	164,393,694	179,334,168	133.5%	161.2%	219,523,023	289,006,197	54,514,397	-	563,043,617	429,543,095	133,500,522
Christus	33,307,154	28,942,454	130.8%	172.1%	43,570,869	49,819,863	-	-	93,390,732	59,100,000	34,290,732
Allegiance Health	10,766,628	14,126,789	130.8%	172.1%	14,084,401	24,317,036	-	-	38,401,438	-	38,401,438
Ochsner / Lafayette General	163,524,784	163,330,526	108.3%	161.6%	177,084,619	263,933,846	3,098,000	-	444,116,464	263,044,716	181,071,748
Ochsner LSU Shreveport	83,531,529	70,591,527	152.4%	190.6%	127,283,319	134,552,186	5,000,000	-	266,835,504	294,169,656	(27,334,152)
Rapides Regional / Tulane University	69,070,912	39,355,344	176.1%	206.8%	121,638,877	81,398,760	-	-	203,037,637	74,600,000	128,437,637
Franciscan Missionaries of Our Lady	157,776,255	158,450,214	66.8%	92.3%	105,338,708	146,171,817	15,645,846	-	267,156,371	152,370,417	114,785,954
Willis-Knighton	41,982,273	34,601,870	146.8%	158.9%	61,629,147	54,983,971	-	-	116,613,119	40,767,158	75,845,961
Womans Hospital	54,080,879	14,652,841	130.8%	172.1%	70,746,089	25,222,552	-	-	95,968,641	21,011,835	74,956,806
Total	**$ 973,718,529**	**$ 1,026,917,966**	**120.9%**	**147.3%**	**$ 1,177,456,994**	**$ 1,512,156,832**	**$ 78,258,243**	**$ 2,147,562**	**$ 2,770,019,631**	**$ 1,742,923,358**	**$ 1,027,096,273**