Healthy Louisiana

LHA ANNUAL CONFERENCE

July 23, 2018

HOSPITAL PAYMENT MODERNIZATION

KUDOS FOR A MODEL EFFORT

- *Sincere thanks* to the hospital community for a model effort at public policy decision making and programmatic change
  - Transparent, collaborative, data-driven **partnership** between LDH and external stakeholders
  - Inclusive, not just in terms of participation but in the consideration of issues to be addressed
    - Not restricted to issue of interest to State (inpatient payment method), but related issues of concern to stakeholders (post-acute care)
  - Strengthened key working relationships, built trust, leveraged industry expertise to inform public policy decision making
  - Laid the foundation for future collaboration
    - E.g., outpatient payment method, quality improvement, value-based payment

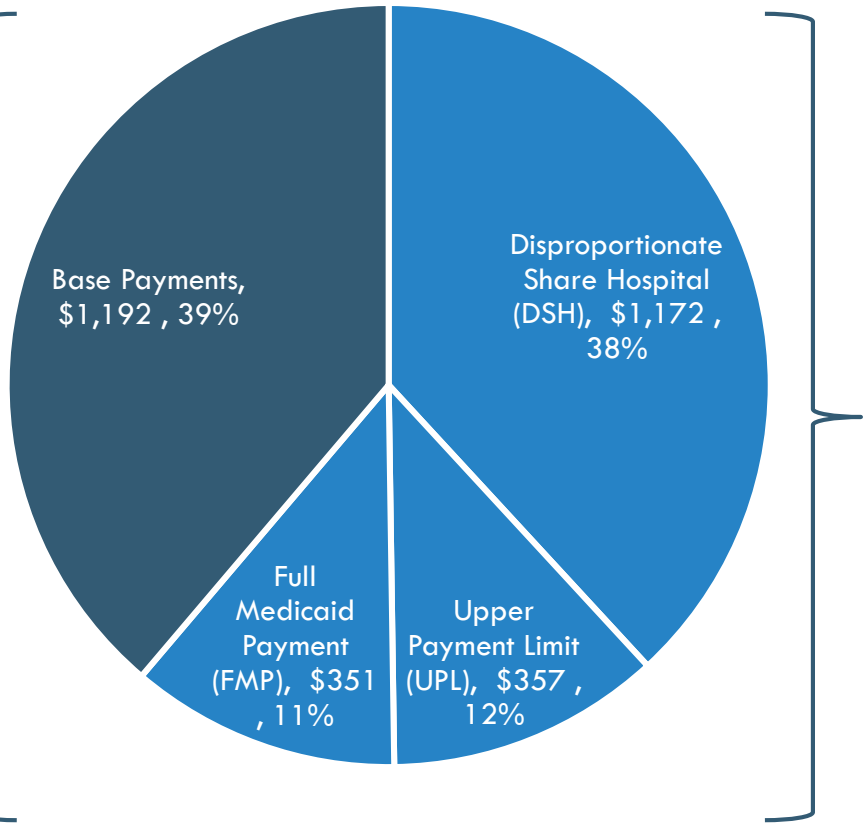
TODAY, MEDICAID HOSPITAL PAYMENTS ARE CHARACTERIZED BY AN OUTDATED BASE PAYMENT STRUCTURE AND HEAVY RELIANCE ON SUPPLEMENTAL PAYMENTS

Base Payments

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

- Inpatient daily rates (per diems) that incentivize long lengths of stay
- Outdated methodology based on 1990s cost reports; well below current costs
- Highly variable across hospitals
- Unit of payment (day) not reflective of service acuity or resource intensity

SFY16 Medicaid Hospital Payments, $M



Supplemental Payments

61% of Medicaid hospital payments totaling $1.9B spending in SFY16

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

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

HOSPITAL PAYMENT SYSTEM IS FINANCIALLY UNSUSTAINABLE AND DOES NOT PROPERLY ACCOUNT FOR RISKS IN THE CHANGING LANDSCAPE

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

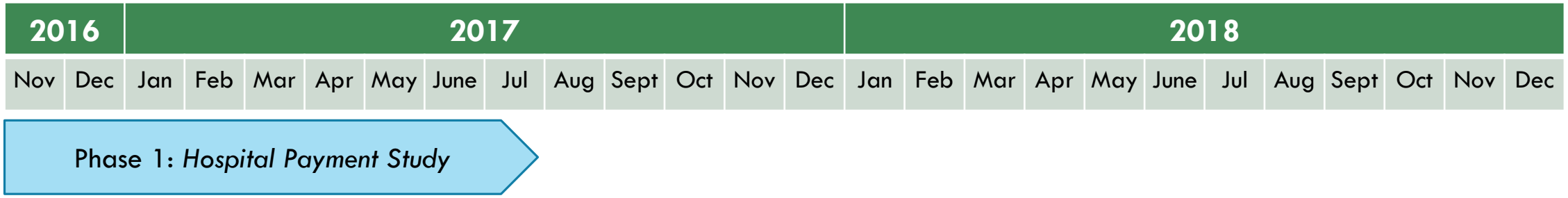
- Disproportionate Share Hospital" (DSH) reductions are mandated by Affordable Care Act; annual delays deepen out-year reductions
- Other types of supplemental payments are subject to a limit calculated based on fee-for-service Medicaid payments; managed care constrains Louisiana's ability to grow these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

Responsible course is to transition into more sustainable payment models

Source: Hospital Payment Modernization Project Analysis.

SINCE NOVEMBER 2016, LOUISIANA DEPARTMENT OF HEALTH HAS FACILITATED A TRANSPARENT, INCLUSIVE AND CONSULTATIVE PROCESS WITH HOSPITALS

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



Hospital Project Participants

- Louisiana Hospital Association
- Acadia Healthcare Company
- Brentwood Hospital
- Christus Health
- Franciscan Missionaries of Our Lady Health
- HealthSouth Corporation
- HCA MidAmerica Division
- Lafayette General Health
- Lake Charles Memorial Health System
- LCMC Health
- Louisiana Association of Behavioral Health
- North Oaks Health System
- Ochsner Health System
- Promise Hospital of Baton Rouge
- Regional Health System of Acadiana
- River Oaks Hospital
- Rural Hospital Coalition
- St. James Parish Hospital
- University Health Shreveport and Monroe
- Willis-Knighton Health System
- Woman's Hospital

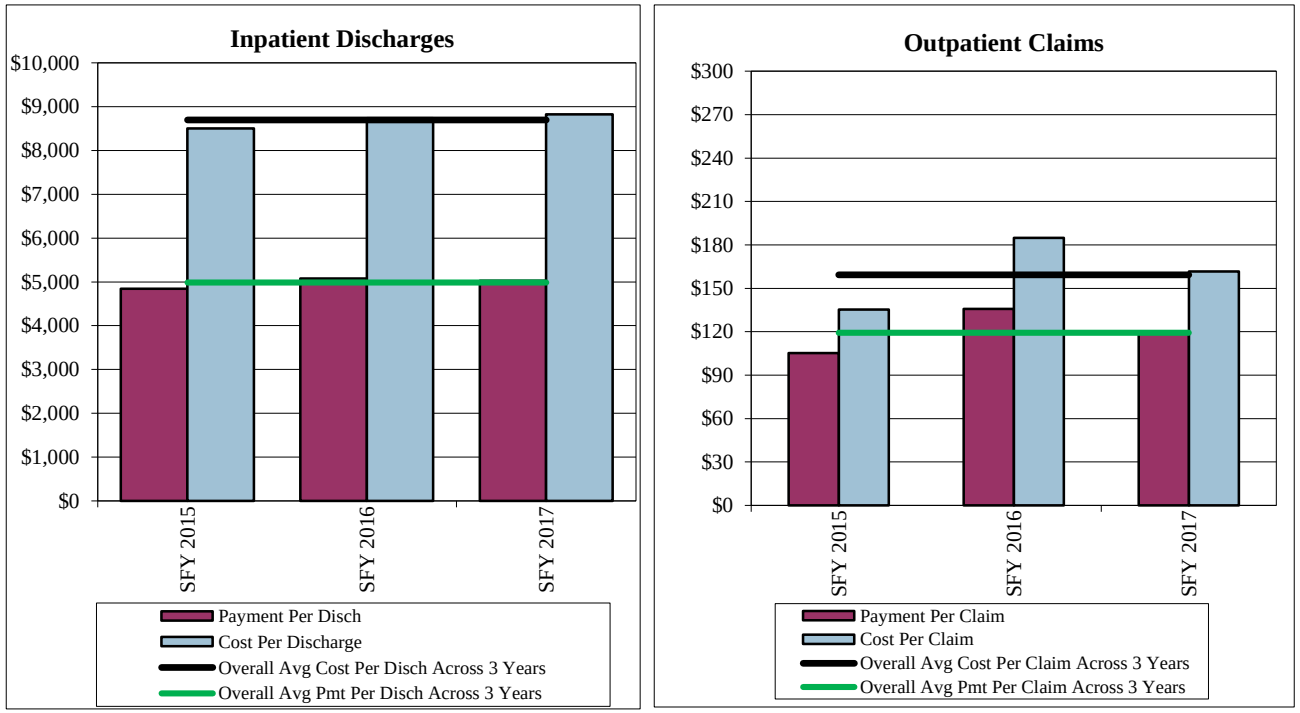
HOSPITAL BASE PAYMENTS COVER ONLY 63% OF HOSPITAL COSTS

Key Findings:

1. This analysis shows the extent to which current Medicaid base payments cover costs for inpatient and outpatient care.
2. Over three years, base payments accounted for only 63% of costs (outpatient and inpatient).
3. For <u>inpatient</u> services only, the 3-year average was 57%.
4. For <u>outpatient</u> services only, the 3-year average was 75%.

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

Medicaid Claims Only and Excludes Supplemental Payments



Source: Hospital Payment Modernization Project Analysis.
Notes: Excludes supplemental payments and cost settlements.

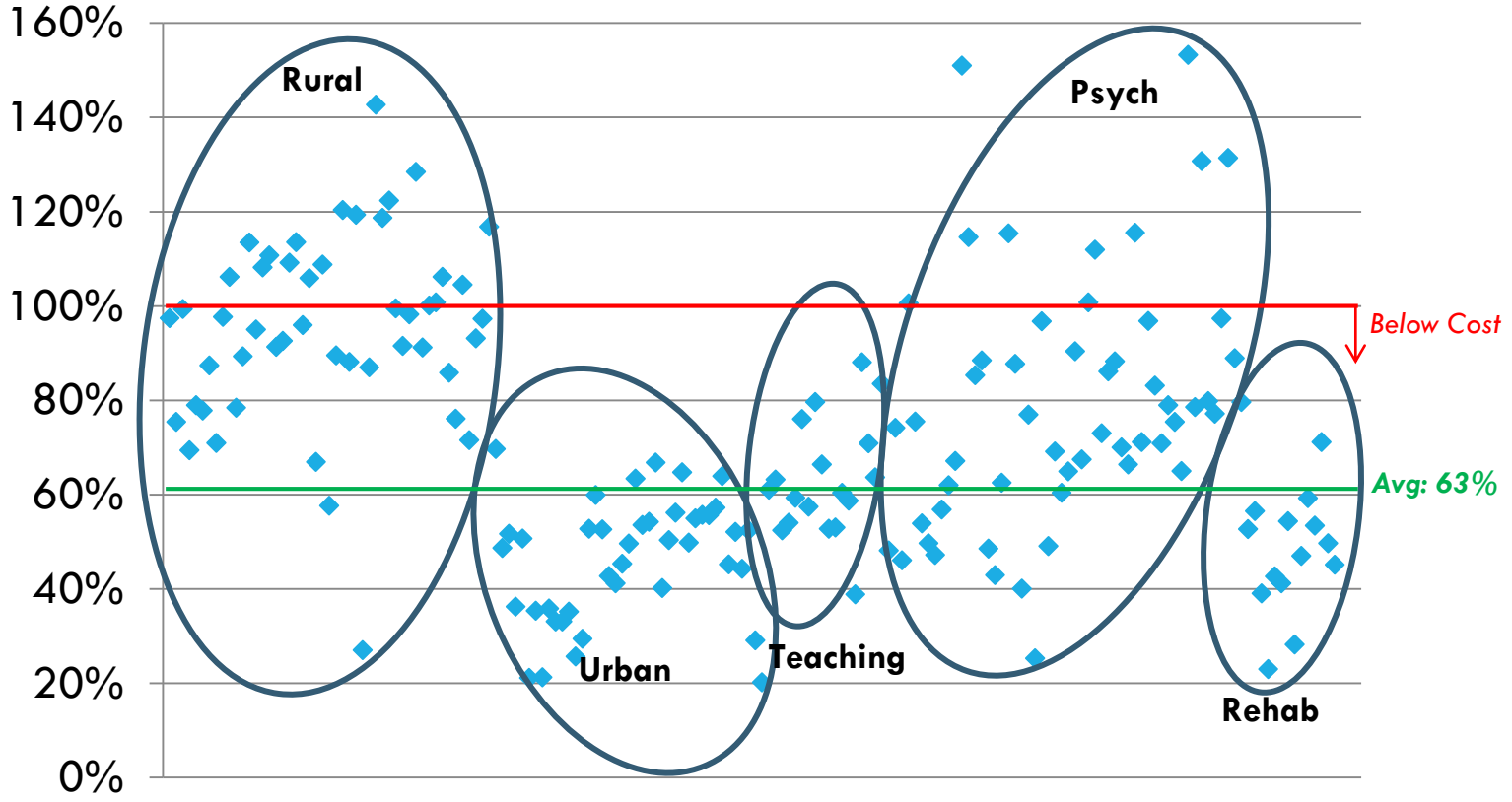
COST COVERAGE VARIES WIDELY ACROSS HOSPITALS WITH MOST HOSPITALS LOSING MONEY ON MEDICAID BASE PAYMENTS

Key Findings:

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

Cost Coverage By Hospital Medicaid IP & OP, SFY17

Medicaid Claims Only and Excludes Supplemental Payments

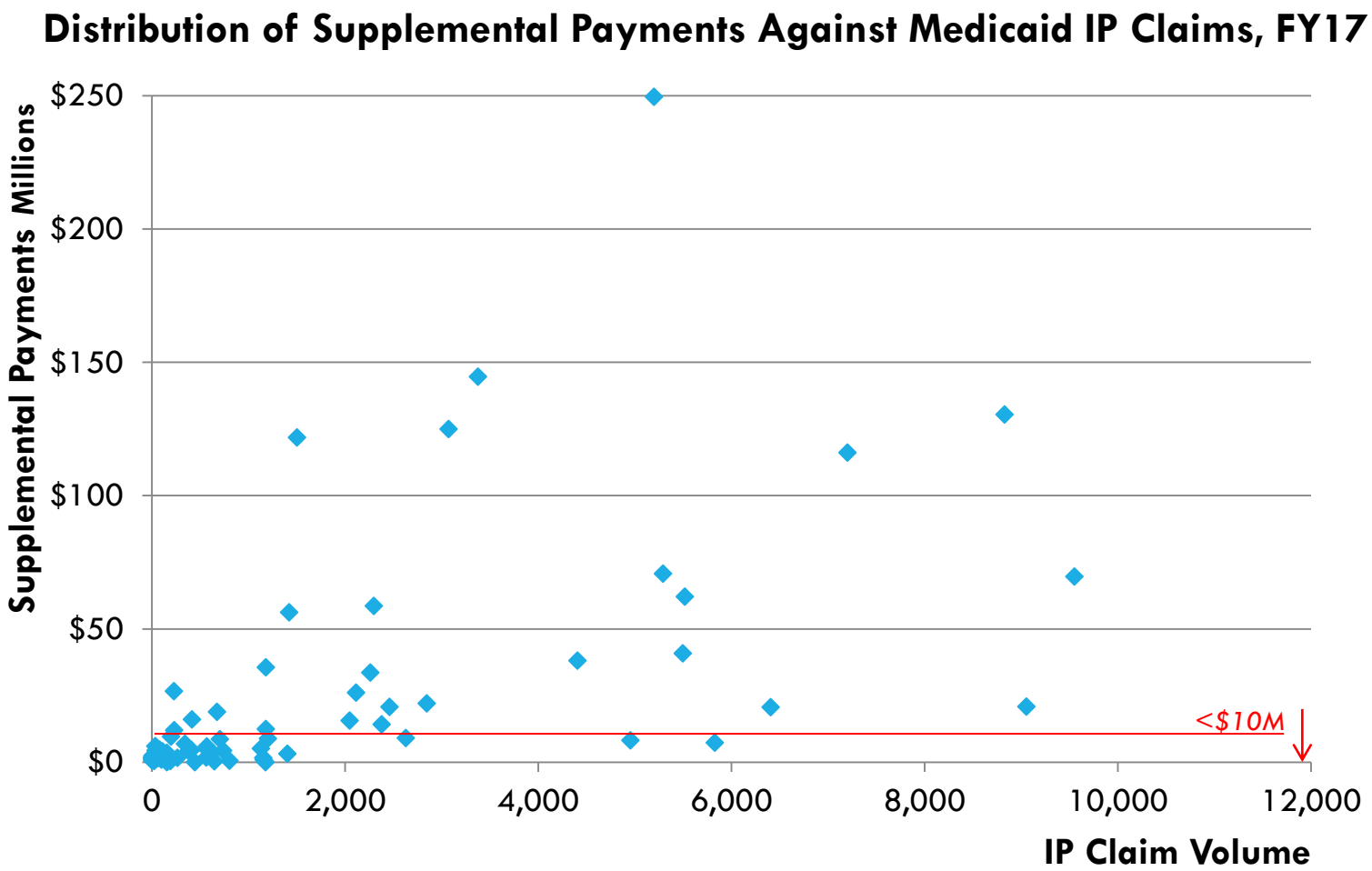


Source: Hospital Payment Modernization Project Analysis. Includes 176 hospitals from all peer groups.

SUPPLEMENTAL PAYMENTS ARE NOT TIED TO INPATIENT SERVICE VOLUME

Key Findings:

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

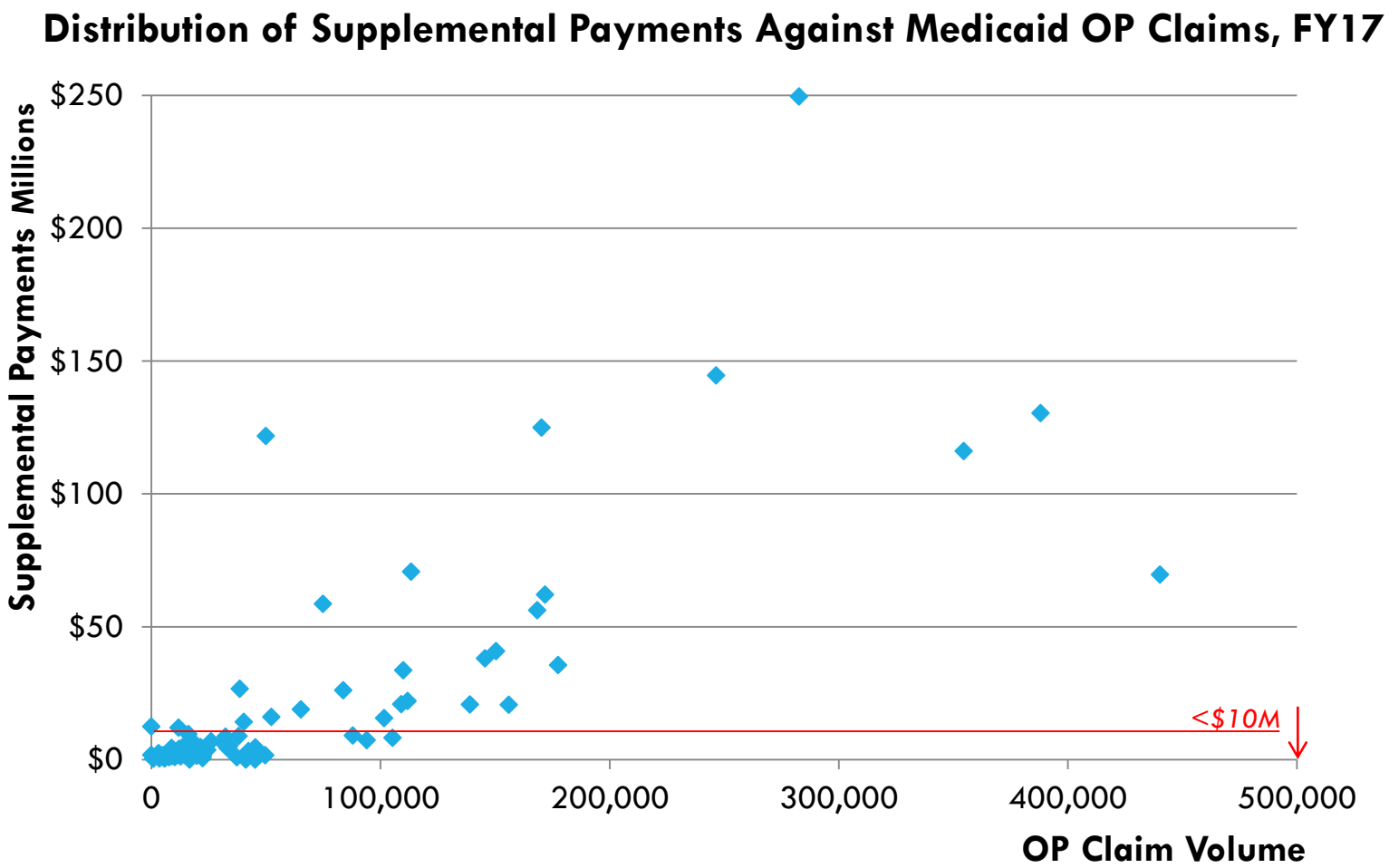


Source: Hospital Payment Modernization Project Analysis.
Notes: Uses FY17 IP Claims and supplemental payments. Graph only shows data for the 88 hospitals with supplemental payments.

SUPPLEMENTAL PAYMENTS ARE NOT TIED TO OUTPATIENT SERVICE VOLUME

Key Findings:

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



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

MEDICAID EXPANSION HAS RESULTED IN DRAMATIC IMPROVEMENT IN HEALTH INSURANCE COVERAGE AND ACCESS TO HEALTH CARE

As of July 16, 2018, 473,136 Louisianans had gained health insurance coverage through Medicaid expansion.

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

MEDICAID EXPANSION DASHBOARD

LIVES IMPACTED	OUTCOME
473,136	**Health Insurance** Adults enrolled in Medicaid Expansion as of July 16, 2018
76% 223,391	**Doctor Visits** Percentage of adults who had a doctor's office visit during the year*,** Adults who visited a doctor and received new patient or preventive healthcare services*
46,675 439	**Breast Cancer** Women who've gotten screening or diagnostic breast imaging* Women diagnosed with breast cancer as a result of this imaging*
26,133 8,355 362	**Colon Cancer** Adults who received colon cancer screening* Adults with colon polyps removed: colon cancer **averted*** Adults diagnosed with colon cancer as a result of this screening*

LIVES IMPACTED	OUTCOME
9,064	**Newly Diagnosed Diabetes** Adults newly diagnosed and now treated for Diabetes*
24,273	**Newly Diagnosed Hypertension** Adults newly diagnosed and now treated for Hypertension*
58,777 12,854	**Mental Health** Adults receiving specialized outpatient mental health services* Adults receiving inpatient mental health services at a psychiatr
10,582 11,848	**Substance Use** Adults receiving specialized substance use outpatient services* Adults receiving specialized substance use residential services

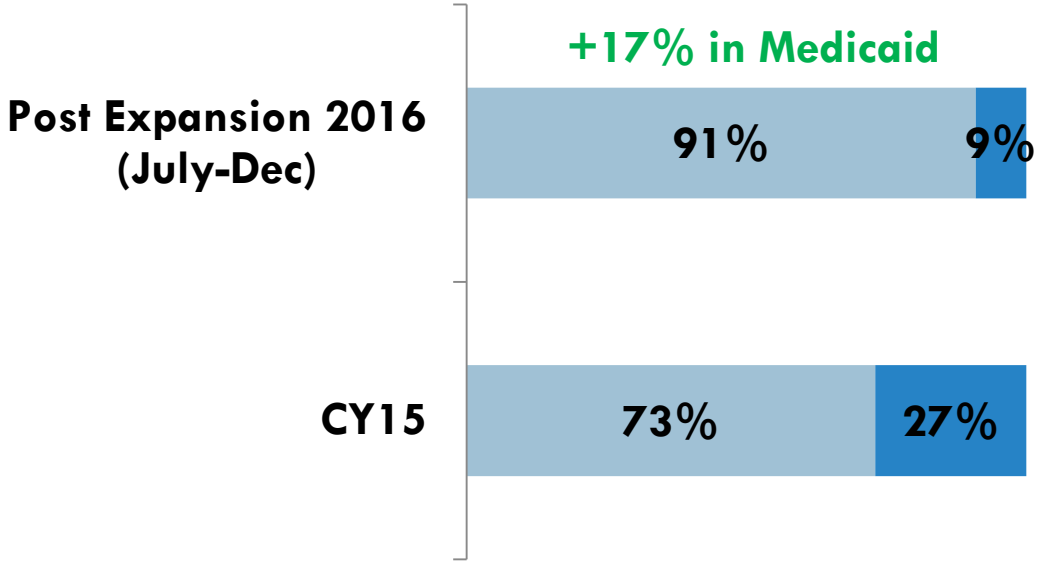
Source: http://www.ldh.la.gov/HealthyLaDashboard/

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

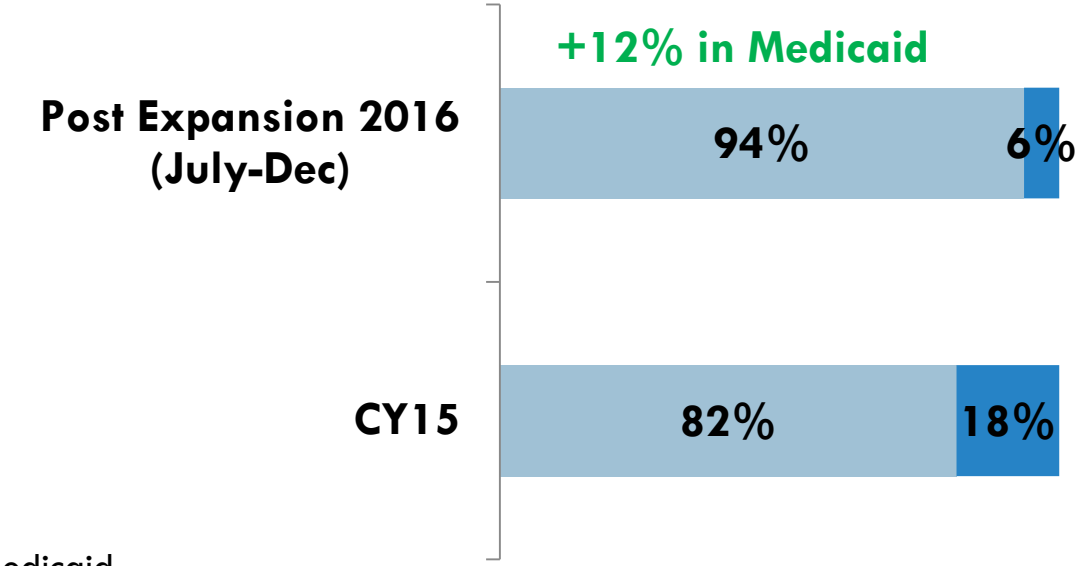
AS A RESULT OF MEDICAID EXPANSION, MEDICAID HOSPITAL CLAIMS HAVE INCREASED WHILE UNINSURED CLAIMS HAVE DECREASED

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

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



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



Medicaid
Uninsured

Source: Hospital Payment Modernization Project Analysis.

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

As expanded Medicaid coverage and managed care improves access, Louisiana has an opportunity to deploy state resources more efficiently and equitably through a modernized hospital payment system.

WITH MEDICAID COVERAGE EXPANSION AND IMPLEMENTATION OF MANAGED CARE

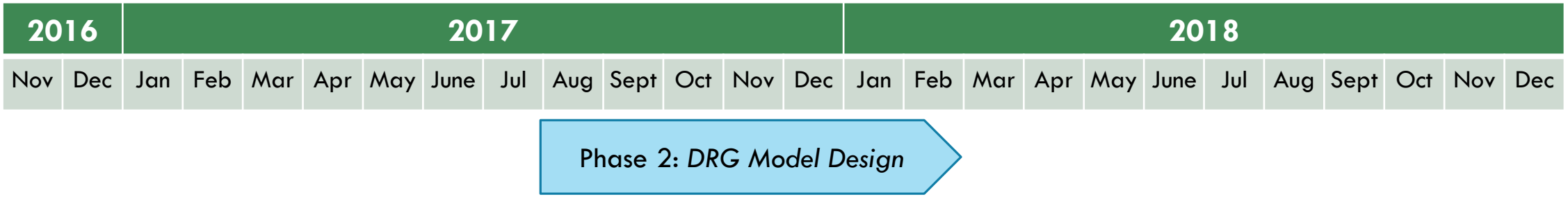
ACCESS AND BENEFICIARY CHOICE IMPROVE , CHANGING UTILIZATION PATTERNS

CREATES AN IMPERATIVE TO REALIGN THE HOSPITAL PAYMENTS WITH UTILIZATION

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

SINCE NOVEMBER 2016, LOUISIANA DEPARTMENT OF HEALTH HAS FACILITATED A TRANSPARENT, INCLUSIVE AND CONSULTATIVE PROCESS WITH HOSPITALS

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



Hospital Project Participants

- Louisiana Hospital Association
- Acadia Healthcare Company
- Brentwood Hospital
- Christus Health
- Franciscan Missionaries of Our Lady Health
- HealthSouth Corporation
- HCA MidAmerica Division
- Lafayette General Health
- Lake Charles Memorial Health System
- LCMC Health
- Louisiana Association of Behavioral Health
- North Oaks Health System
- Ochsner Health System
- Promise Hospital of Baton Rouge
- Regional Health System of Acadiana
- River Oaks Hospital
- Rural Hospital Coalition
- St. James Parish Hospital
- University Health Shreveport and Monroe
- Willis-Knighton Health System
- Woman's Hospital

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

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

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

Source: Hospital Payment Modernization Project Analysis.

LDH CONDUCTED MANY MEETINGS WITH HOSPITAL CEOS, CFOS, AND MEDICAL SCHOOLS TO DESIGN THE HOSPITAL PAYMENT MODERNIZATION PROPOSAL

Work Group Meeting Timeline, Participants, and Topics

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

Additional One-On-One Consultations

- Woman's Hospital (9/21)
- Franciscan Missionaries of Our Lady Health System (10/25 & 1/22)
- Lake Charles Memorial Health System (10/27)
- North Oaks Health System (10/30 & 1/25)
- River Oaks/Brentwood Hospitals (11/13)
- Ochsner Health System (11/13)
- Lafayette General Health (11/15)
- Rural Hospital Coalition (11/20 & 1/12)
- Christus Health (11/27 & 1/30)
- Willis-Knighton Health System (12/14 & 1/24)
- LCMC Health (10/24, 12/4, 12/21 & 1/31)
- Tulane University School of Medicine (12/21)
- Louisiana State University School of Medicine (12/21)
- HCA MidAmerica Division (1/25)

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

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

1. **MODERN INDUSTRY STANDARD**
   - DRGs are the prevailing Medicaid payment methodology for inpatient stays with 36 states using DRGs (69%)
   - Industry standard for Medicare and commercial payers
2. **EFFICIENT**
   - DRG-based methods de-incentivize unnecessarily long hospital stays and tie payments to clinical complexity
3. **TRANSPARENT**
   - Strengthens the link between payments to people and care delivery
   - Equitable across hospitals with updated peer groupings
   - Data-driven, collectively developed solution
4. **SUSTAINABLE**
   - Shifting some supplemental payments to the new base payment lessens the gap between Medicaid payments and costs
   - Decreases reliance on supplemental payments
   - Protects hospitals and the state against exposure risk in the changing supplemental payment landscape

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

DRG PAYMENT METHODOLOGY ALIGNS WITH PAYMENT PRINCIPLES

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

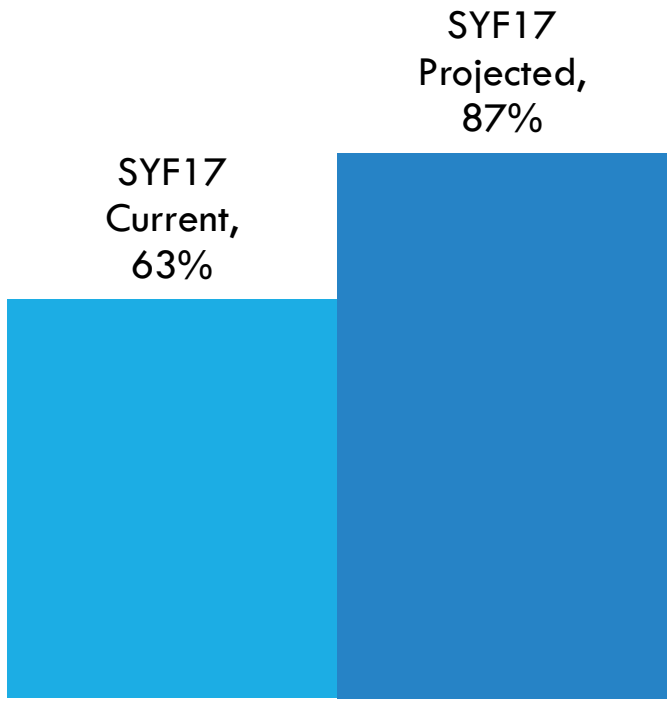
IN THE NEW DRG METHODOLOGY, HOSPITAL BASE PAYMENTS COVER 87% OF INPATIENT HOSPITAL COSTS

Key Findings:

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

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

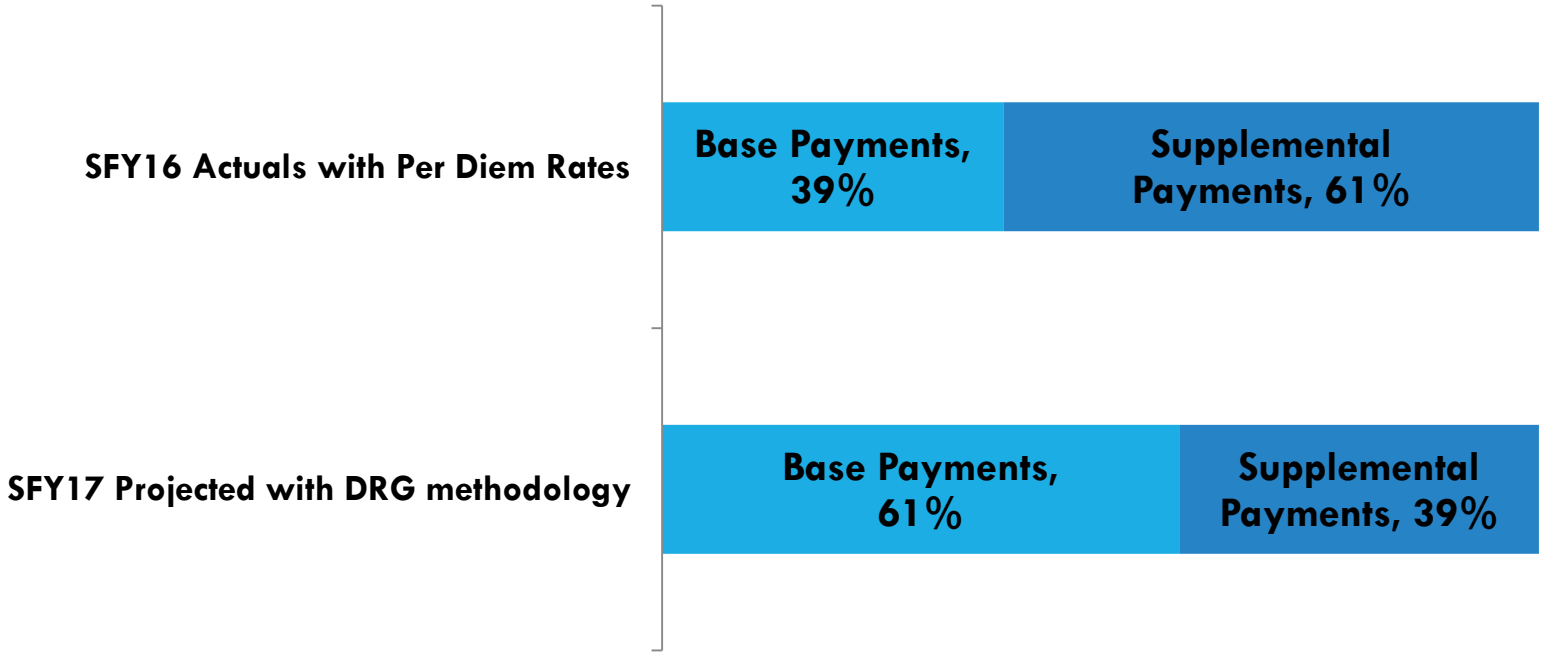
Medicaid Current and Projected Inpatient Cost Coverage
(SFY17 current methodology and projected with DRG methodology)
Medicaid IP Claims Only and Excludes Supplemental Payments



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

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

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



SFY17 Projection Results

Base Payments – Per Diems: 61% of Medicaid hospital payments totaling $2.17B of projected spending

Supplemental Payments: 39% of Medicaid hospital payments totaling $1.37B of projected spending

21% of supplemental payments ($379M) redirected to base payments, which links payments to services provided and improves financial sustainability

Source: Hospital Payment Modernization Project Analysis.
*Note: Includes DSH, UPL, and Waiver 1115 supplemental payments. SFY17 projections show the results of the DRG payment methodology.

FOCUS NOW IS PLANNING FOR IMPLEMENTATION ON JANUARY 1, 2019

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

Phase 1: *Hospital Payment Study*

Phase 2: *DRG Model Design*

Phase 3: *Implementation Preparation*

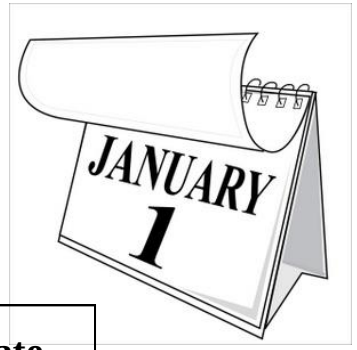
1) *Notice of Intent to be published 8/20/18*

2) *State Plan Amendments to follow*

3) *Medicaid policy and claims payment system changes*

Go-Live: *January 1, 2019*

DRG IMPLEMENTATION TASKS & TIMELINES



	Task	Due Date
1	B&A reads in all hospital cost reports received as of June 30, 2018 to compute latest add on values, CCRs, High Medicaid status, and stop loss hospital-specific base rates.	July 1-30
2	B&A delivers final pricing files to payers and to 3M.	July 31
3	B&A delivers final logic on transplant cases and post-acute care.	July 31
4	LDH prepares updated business rules or contractual language changes required pertaining to DRG pricing, as necessary.	July 31
5	B&A delivers sample claims to the payers as examples to illustrate each pricing example.	Aug 7
6	Target date for 3M to have Louisiana-specific pricing module ready for those interested in purchasing it.	Aug 15
7	Payers responsible for test-pricing claims to ensure payment accuracy and submit results to B&A.	October 26
8	B&A assesses the accuracy of each payer's test claim submissions.	Oct 29 - Nov 7
9	B&A provides feedback to each payer individually and facilitates 1-on-1 consultation, as needed, to resolve discrepancies.	Nov 8-14
10	B&A works with Molina on any changes required for future encounter submissions.	November 15
11	LDH provides readiness assessment to each MCO on claims pricing accuracy.	November 30
12	LDH provides guidance on new requirements for encounter submissions re: DRG payments.	November 30
13	LDH convenes with hospital industry on results of payers' readiness for DRG payments.	December 7
14	LDH publishes pricing rate schedule for fee-for-service.	December 14

POST ACUTE CARE PAYMENT

- Medicaid MCO contract:

  8.4.3. The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of ca

- With DRG implementation, MCOs will pay for post-acute care days
  - Hospital notifies MCO of end of medical necessity for inpatient stay
  - MCO responsible for placement in lower level of care
  - MCO pays hospital per diem pending placement, in addition to DRG case rate
    - Per diem applies to days in excess of Average Length of Stay for the case
    - MCOs may conduct post-authorization review but cannot pre-authorize post-acute days

Healthy Louisiana

DENIED SERVICE AUTHORIZATIONS AND CLAIMS ANALYSIS

- LDH contracted for independent analysis to better understand the rate and rationale for hospital service denials by Medicaid MCOs,
- Scope includes:
  - Denied authorization request for inpatient care (either as pre-service, concurrent review or retrospective)
  - Denied claim for services rendered to hospital inpatient or outpatient
- Method includes:
  - Desk review of claims and authorizations, initial interviews with each MCO
  - Onsite review of authorization sample
  - Summarize results and write report
- Results expected late summer, to be shared with stakeholders early fall
  - Findings will inform future LDH MCO oversight and contract compliance actions

Healthy Louisiana

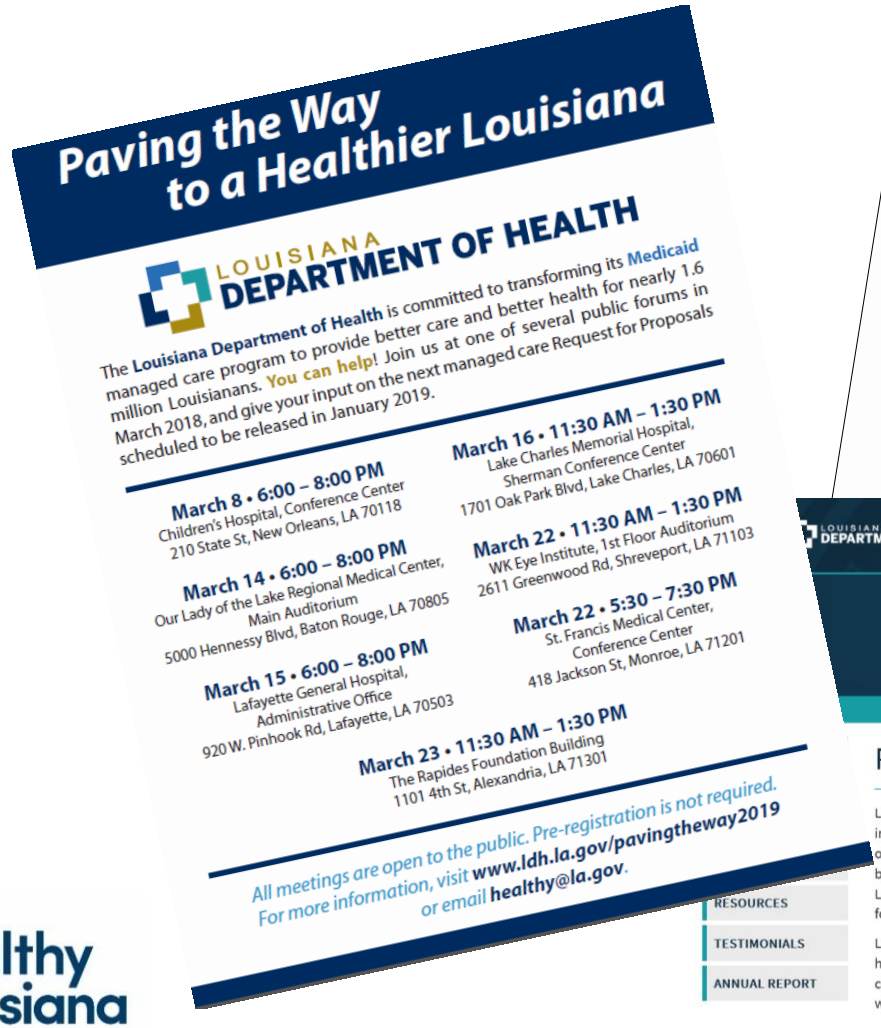
MANAGED CARE CONTRACTS

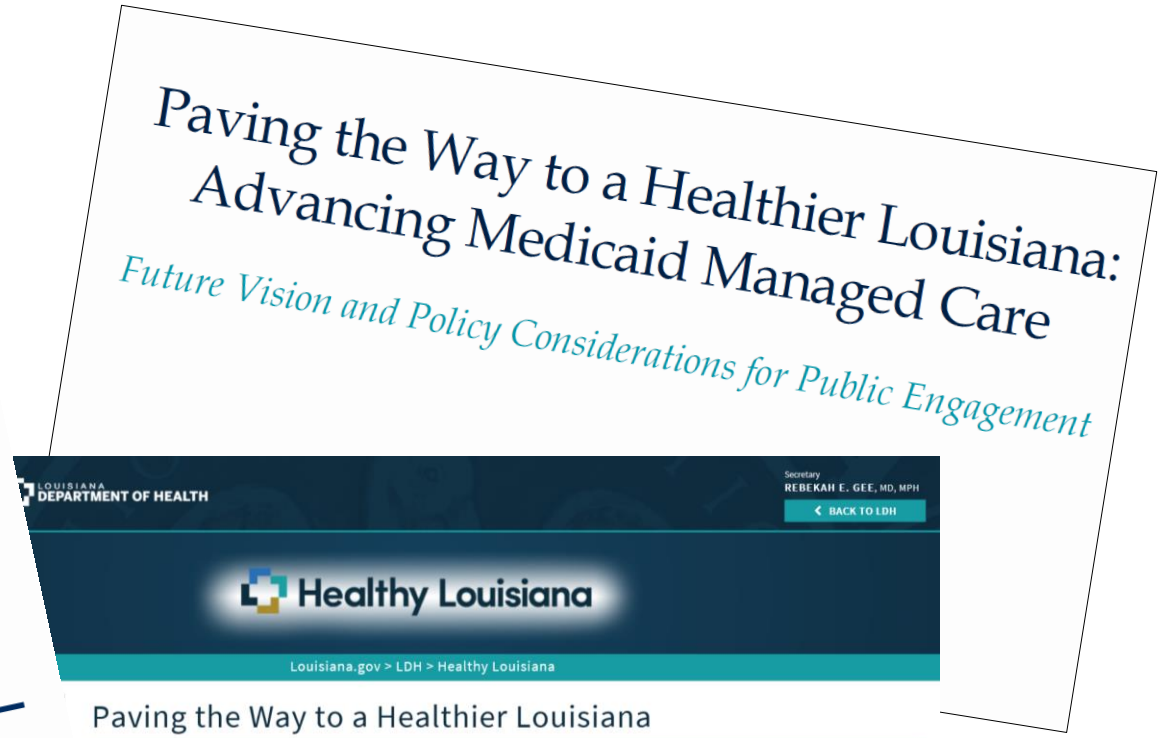
COMMON OBSERVATION POLICY

- 2017 MCO contract amendment required **common** observation policy applicable to FFS and MCOs on 7/1/18
- Hospital workgroup developed policy:
  - All MCOs and FFS will reimburse **up to 48 hours** of medically necessary care for a member to be in an observational status **without** notification, precertification or authorization.
- The change reduces administrative complexity/burden for hospitals by eliminating variation across health plans and between managed care and fee for service Medicaid

Healthy Louisiana

MCO RE-PROCUREMENT ACTIVELY UNDER DEVELOPMENT

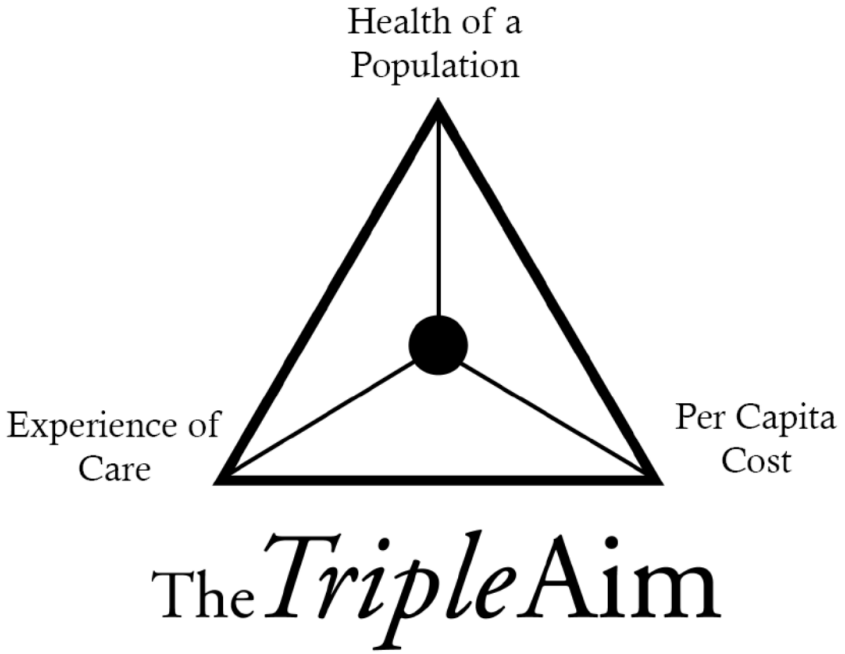




Healthy Louisiana

VISION FOR THE FUTURE

LDH will partner with enrollees, providers, and high-performing health plans to build a Medicaid managed care delivery system that improves the health of populations (**better health**), enhances the experience of care for individuals (**better care**) and effectively manages Medicaid per capita care costs (**lower costs**).



Healthy Louisiana

OBJECTIVES

1) Advancing evidence-based practices, high-value care and service excellence
2) Supporting innovation and a culture of continuous quality improvement in Louisiana
3) Ensuring enrollees ready access to care, including through non-traditional means such as medical homes and telehealth
4) Improving enrollee health
5) Decreasing fragmentation and increasing integration across providers and care settings, particularly for enrollees with behavioral health needs
6) Using a population health approach to maximize enrollee health, supported by health information technology, to advance health equity and address social determinants of health
7) Reducing complexity and administrative burden for providers and enrollees
8) Aligning financial incentives for plans and providers and building shared capacity to improve health care quality through data and collaboration
9) Minimizing wasteful spending, abuse and fraud

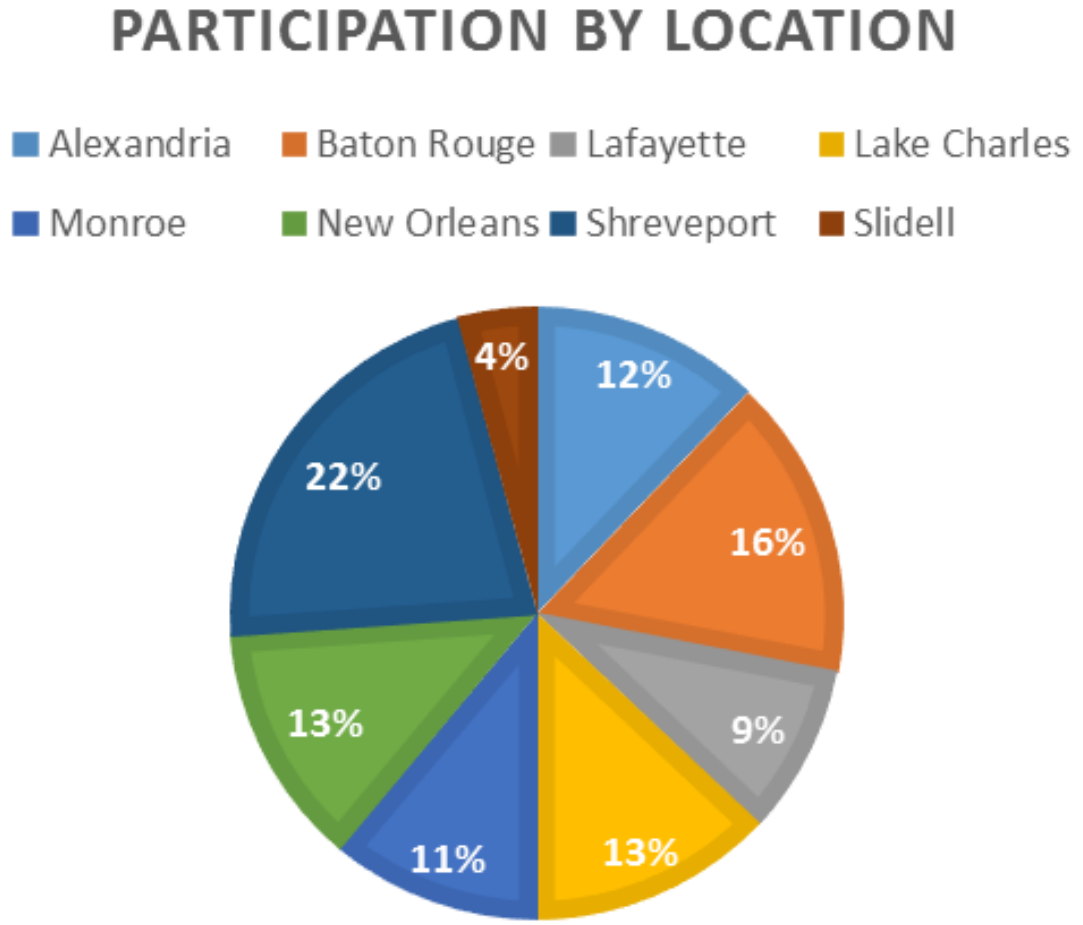
Healthy Louisiana

KEY DESIGN ELEMENTS

(a) Limit the number of statewide MCOs	(g) Promote population health
(b) Expect MCOs to operate as innovators to achieve the Triple Aim	(h) Improve care management/care coordination at MCO and provider levels
(c) Enhance network adequacy and access standards	(i) Increase focus on health equity and social determinants of health
(d) Invest in primary care, timely access to care, telehealth, and medical homes	(j) Apply insights from behavioral economics to facilitate enrollees' healthy behaviors and choices
(e) Improve integration of physical and behavioral health services	(k) Improve approach to value-added benefits
(f) Advance value-based payment and delivery system reform	(l) Achieve administrative simplification

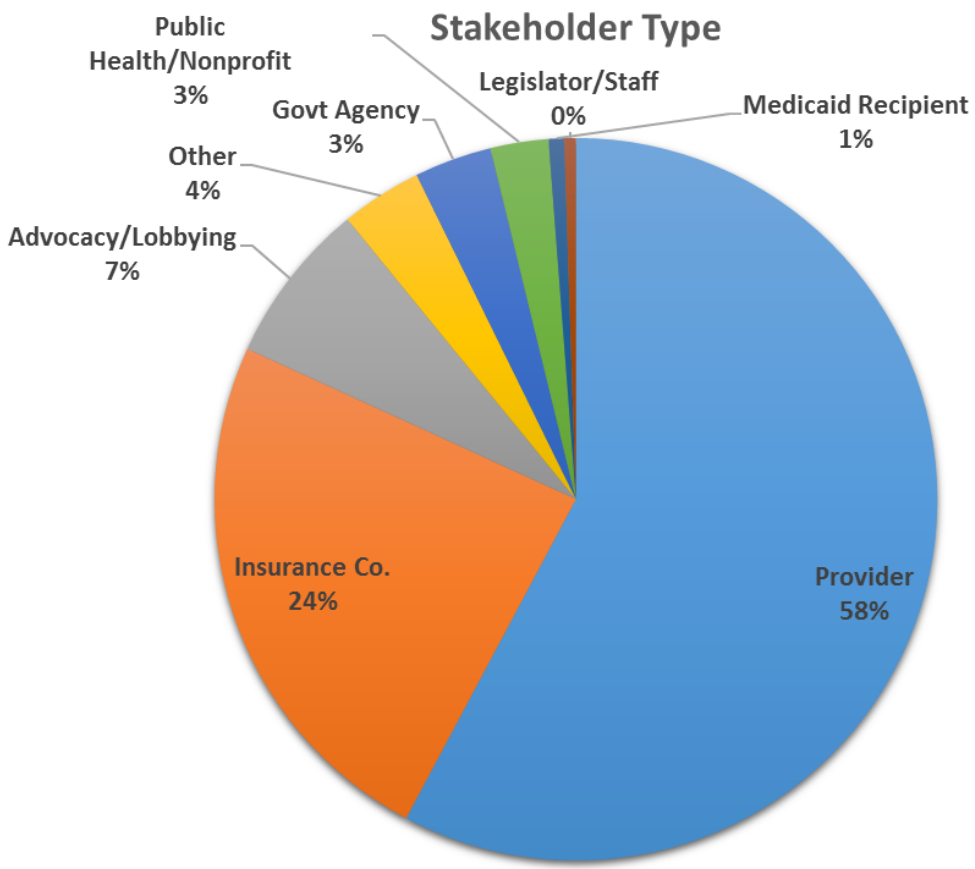
Healthy Louisiana

PUBLIC FORUM PARTICIPATION – 8 LOCATIONS, 500+ STAKEHOLDERS



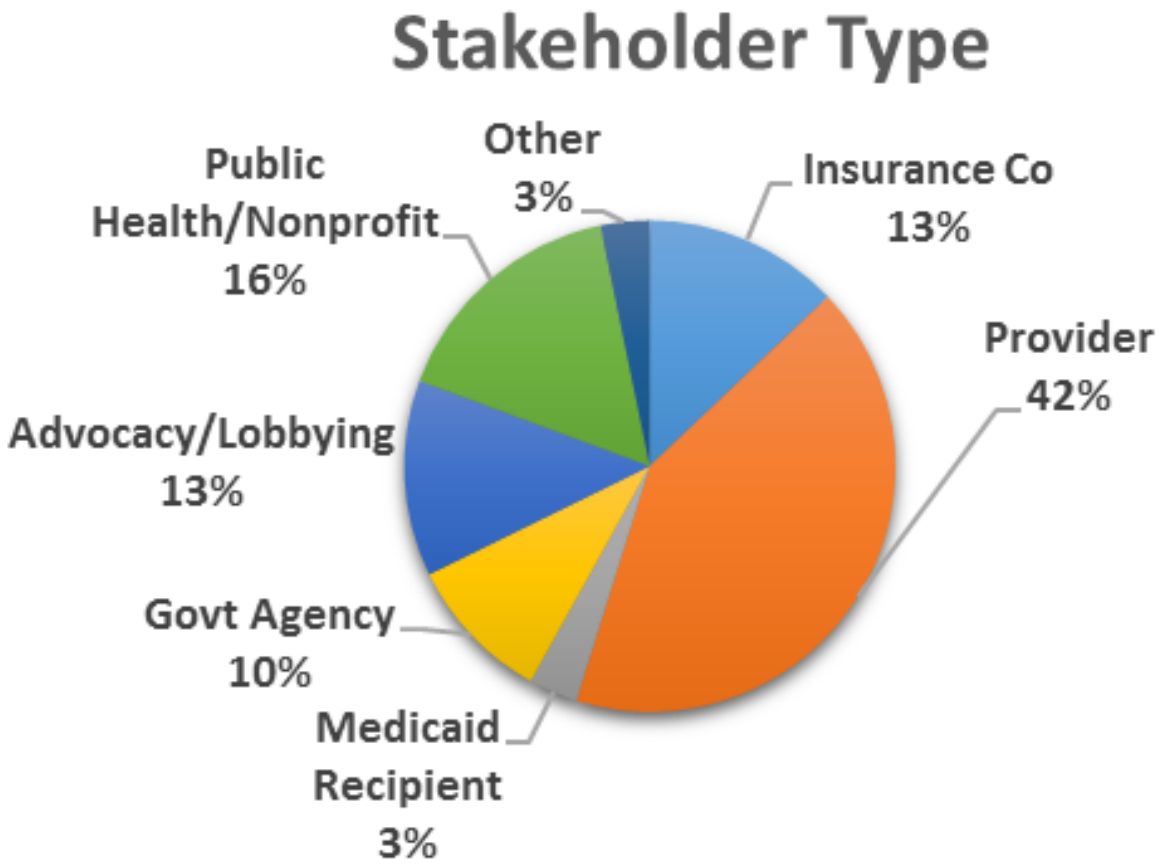
Healthy Louisiana

PUBLIC FORUM DEMOGRAPHICS – STRONG PROVIDER PARTICIPATION



Healthy Louisiana

OVER 30 WRITTEN RESPONSES TO WHITEPAPER



Healthy Louisiana

TIMELINE TO RFP & NEW CONTRACTS

Managed Care Procurement Activities	Timeframe
Develop White Paper	Completed
Conduct Public Forums	Completed
White Paper Comments Due	April 17, 2018
Develop RFP	August 30, 2018
Submit RFP to LDH Legal	August 30, 2018
Submit RFP to OSP for Approval	September 2018
Procurement Support Team Considers RFP	October 2018
Publish RFP (Must be posted 30 days)	January 2019
Evaluate RFP Responses, Recommend Winners	March - April 2019
Negotiate Contracts	April - May 2019
Submit Contracts to OSP for Approval	May 2019
Procurement Support Team Considers Contracts	May 2019
Submit contracts to LDH Legal	May - June 2019
Execute Contracts	September 2019
Conduct Readiness Activities	October - December 2019
Go Live	January 1, 2020

Healthy Louisiana

RFP BUILDS ON FOUNDATION OF 2017 CONTRACT EXTENSION

Historic 2% withhold of monthly capitation rate changed:

- *From* incentive for contract compliance (monetary penalties will still apply)
- *To* earn back for MCO performance on quality measures and value-based payment use

1% Withhold for Quality and Health Outcome Improvement

Updates quality measures based on stakeholder input and adds stretch goal targets for "money measures"

Shifts existing penalty for failure to meet money measure targets from CY15 to CY17

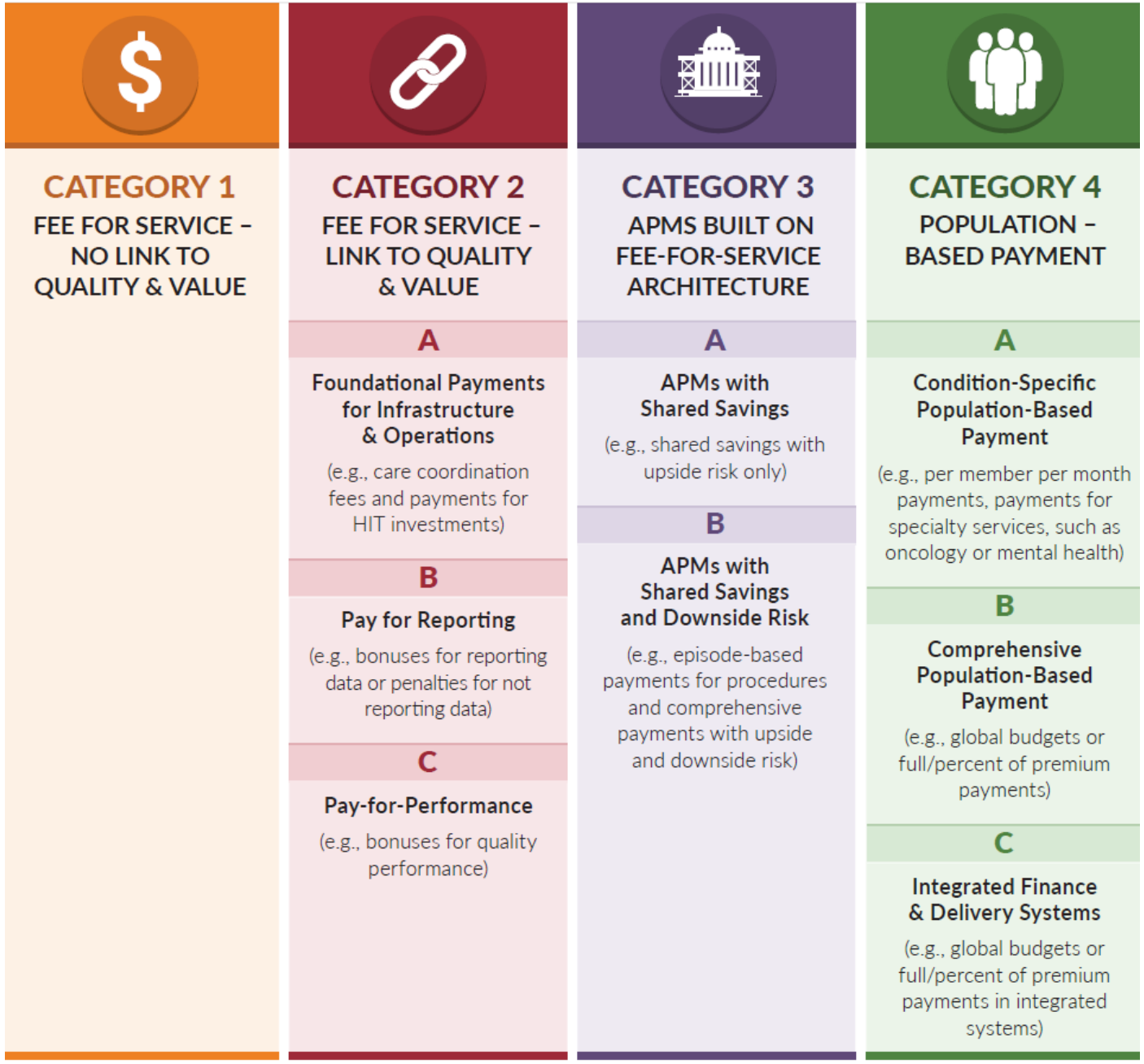
In CYs 18 & 19, replaces money measure penalty with earn back of withhold for meeting stretch goal targets or improving over prior year performance

1% Withhold for Increase in Alternative Payment Model Use

Adds withhold earn back for development of an LDH-approved strategic plan to increase APM use over time, including baseline measure of APM use

Adds withhold earn back for meeting implementation milestones of LDH-approved strategic plan, including increased APM use over baseline

Healthy Louisiana



HEALTH CARE PAYMENT LEARNING ACTION NETWORK

Alternative Payment Model Framework

LOOKING AHEAD: BEYOND DRGS AND MCO RFP

- Quality Improvement
  - Introduce hospital quality measures to Medicaid Quality strategy
- Value-Based Payment
  - Test 3M grouper for Potentially Preventable Events
    - Hospital admissions, readmissions, ED visits, ancillary services, hospital acquired conditions
      - Demo MCO and hospital-specific profiles
      - Potential tool for hospitals to engage MCOs in VBP contracting
- Further Payment Modernization
  - Outpatient hospital, EAPGs?

Healthy Louisiana

QUESTIONS?

Jen Steele, MPA

Medicaid Director

Louisiana Department of Health

Jen.Steele@la.gov

APPENDIX

DRG PAYMENT METHODOLOGY DESIGN ELEMENTS

Category	Design Consideration	Current State	Future State
Hospital Categories	Hospital peer groups	13 peer groups	8 peer groups
		1. Major Teaching 2. Children's	1. Teaching 1 (Must have at least 100 interns/residents, includes Children's)
		3. Minor Teaching	2. Teaching 2 (Must have at least 10 interns/residents)
		4. Non Teaching <58 beds 5. Non Teaching 58-138 beds 6. Non Teaching > 138 beds	3. Urban
		7. Rural	4. Rural
		8. Urban Distinct Psych Unit 9. Rural Distinct Psych Unit 10 .Free Standing Psych	5. All Psychiatric, any peer group including Teaching, Urban, and Rural
		11. Free Standing Rehab	6. All Rehab, any peer group
		12. Long Term Acute Hospitals	7. No change, not in DRG system
		13. State Owned Hospitals	8. No change, not in DRG system
	Hospitals with high Medicaid volume	No explicit preferred treatment	Hospitals with 20-40% of volume in Medicaid gets a 10% bump in payment and hospitals with 40%+ Medicaid volume or 5% of total Medicaid volume statewide among acute care hospitals gets a 20% bump
	Rural hospitals	110% of median per diem rate and 105% cost coverage	DRG methodology with 105% cost coverage

DRG PAYMENT METHODOLOGY DESIGN ELEMENTS

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