


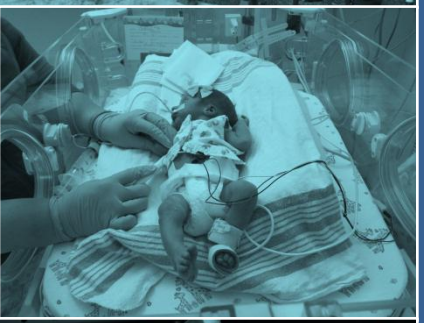


DEPARTMENT OF HEALTH AND HOSPITALS

Opportunities for Value-Based Insurance Design in Medicaid

Bruce D. Greenstein
Secretary
Louisiana Department of Health and Hospitals

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Secretary

Art or Science?


Wine quality = 12.145 + 0.00117 winter rainfall + 0.0614 average growing season temperature - 0.00386 harvest rainfall

Reality Check

Years of Successive Revenue Shortfalls

- **FY 2009: $340.9 million**
- **FY 2010: $780 million**
- **FY 2011: $106.8 million**
- **FY 2012: $251.3 million**

States must balance budgets.

A $7 billion Medicaid Program delivers:

Overall Rank: **49**

America's Health Rankings

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

49

march of dimes®

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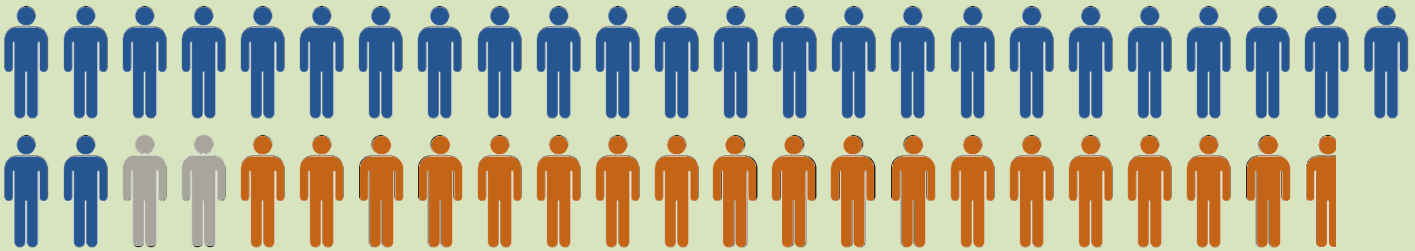
And yet?

= 10,000 people

Louisiana Medicaid under ACA

Year 1:

467K new enrollees



Almost 260,000 would have been newly eligible individuals that were previously uninsured

More than 20,000 would have been individuals currently eligible but not enrolled

Nearly 187,000 would have come from private insurance rolls

Our ~~Opportunity~~ Imperative

How can Government use its position as a payer to produce better value for the taxpayer dollars we invest?

By addressing 

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- **Move away from fee-for-service and invest in innovative payment models.**
- **Organize a healthy marketplace and hold it accountable for producing better outcomes.**

- **Provide transparency of health care costs and outcomes at the consumer level.**
- **Incent patients to utilize higher-value care by better aligning the incentives and organizing benefits.**

Medicaid and VBID

- Medicaid is ripe for reallocation of resources to promote value, but significant barriers exist:
  - Rigid federal benefit design
  - Limits on cost sharing
  - Health literacy of enrollees
  - Political influence over policy decisions
- Medicaid can use VBID principles in program design, but must shift value proposition to providers and health plans more than enrollees.

For Medicaid, Value Must Drive More

VALUE

Benefit

- States sometimes implement barriers to high-value benefits, often brought about by budget constraints and inability to manage utilization. Examples:
  - Prescription drug limits (LA @ 4)
  - Primary care physician limits (LA @ 12)

Network

- Medicaid is entitlement for recipients, not providers. States are often faced with political or other pressure to keep networks open.
- Allow program to value high—performing providers and keep others out.
- Give MCOs flexibility to manage network.

For Medicaid, Value Must Drive More

VALUE

Payment

- Either directly, or through MCOs, states can use provider payments as tool to promote value. Examples:
  - Shared savings (either at provider or plan level)
  - DRGs
  - Bundled payments for episodes of care

Health Plan

- Medicaid best equipped as purchaser of high value care.
- States can structure relationships with MCO's to reward value. Examples:
  - Preference in auto-assignment for quality performance
  - Penalties and bonus payments for hitting or missing targets

Also: The Value of Coverage

- VBID requires that plans have time to recoup costs associated with opening access to high-value services.
- Some Medicaid programs might dissuade MCOs from making investment due to churn.
- With focus on improving value, states should make case to improve reenrollment processes to prevent gaps in care.

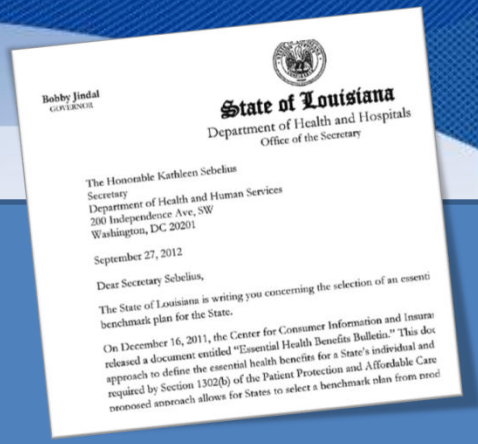
Louisiana's Rate of Children lost in Annual Renewal
2001: 22%
Now: 1.5%

VBID at Macro-Policy Level
Example: 39 Week Initiative

- VBID principle: Increase barriers to low-value or overused "preference-sensitive services".
- In Louisiana, we observed an increasing number of non-medically indicated elective inductions before the 39th week of pregnancy. Why?
  - Convenience of scheduling
  - Discomfort of final weeks of pregnancy
- DHH worked to have every birthing hospital in state pledge to end these early induction practices.
  - Some hospitals have seen up to a 60% decrease in unnecessary deliveries before 39 weeks and significant reductions in NICU admissions (as much as 20%).
  - In one example, a Lafayette hospital went from 30% elective delivery rate before the policy change to 4% by June 2012.

VBID and ACA

- The federally mandated, top down essential health benefit package (for which there are no current regulations) would require coverage of ten benefits.
- The law gives states and insurers little flexibility to design benefit packages that focus on the needs of an individual or similar group of individuals.



Bobby Jindal
GOVERNOR

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

September 27, 2012

Dear Secretary Sebelius,

The State of Louisiana is writing you concerning the selection of an essenti
benchmark plan for the State.

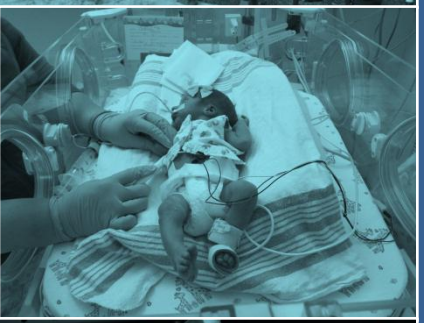
On December 16, 2011, the Center for Consumer Information and Insura
released a document entitled "Essential Health Benefits Bulletin." This doc
approach to define the essential health benefits for a State's individual and
required by Section 1302(b) of the Patient Protection and Affordable Care
proposed approach allows for States to select a benchmark plan from prod

Example of Frustration: 9/27 Letter from LA: No decision on EHB.

- **No formal rulemaking and insufficient guidance**
- **Lack of information on benchmark plans**
- **Lack of clear definitions of service categories**

No state choice, and no federal authority to make one either.

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