



Research Brief

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Assessing the Louisiana Health First Plan

Introduction

The recent public release of the Louisiana Health First (LHF) plan by the Department of Health and Hospitals (DHH) marks the beginning of long-overdue public debate among administration officials, legislators and care providers in Louisiana regarding the specifics of health care reform. The LHF plan outlines the state's proposed course of action to avoid a pending health care funding shortfall while also expanding access to care for uninsured citizens.

The LHF plan is the latest in a number of health care reform proposals introduced since Hurricane Katrina in 2005. PAR proposed an aggressive approach in 2007 that focused on statewide expansions of coverage for the low-income uninsured to be phased in over a period of several years, as well as a systematic overhaul of the charity hospital model of care for those uninsured who could not be covered. The LHF plan incorporates limited versions of the PAR proposals but the key feature is a retooling of the existing Medicaid program. The LHF plan has four major components:

1. Reorganizing the charity hospital system currently run by LSU by changing the function or governance of two hospitals: W.O. Moss in Lake Charles and Medical Center of Louisiana, aka Big Charity, in New Orleans;
2. Expanding Medicaid health coverage to more low-income adults;
3. Developing a state subsidy program in which low-income employees and their employers would share the cost of private insurance premiums; and
4. Redesigning the way Medicaid services are provided and paid for by adopting the model used in Florida, which coordinates care through HMO-style private companies.

Negotiations between state and federal officials regarding the use of federal money to pay for these changes have been ongoing for months. Having reached preliminary agreement on the plan's elements, state officials are now seeking legislative approval prior to making the official request to federal officials to secure special permission – called a waiver – to implement the Medicaid redesign.

Final federal approval also is being sought for a plan to resolve two disputes with federal officials regarding how much the federal government (FEMA) owes the state for the damage to Medical Center of Louisiana (MCLNO) caused by Hurricane Katrina and how much the state owes the federal government for \$771 million in federal disallowances, some of which have been pending for at least 15 years. The LHF plan proposes to fund the Medicaid expansion with the money the state owes the federal government.

State health officials are hoping to get these federal agreements in place before the Bush administration leaves office. This short timeline would have the Legislature vote on the matter next week.

The goals articulated by LHF—better access, better quality, lower cost—are the same goals that every reform agenda aspires to accomplish. Determining whether the means for achieving those goals are sound and appropriate for Louisiana is a matter that should involve the Legislature and the health care community and should not be attempted on short order.

Despite the unreasonable timeline allowed for consideration of these very complex issues, the LHF plan brings some welcome context to the public debate over health care reform. The four components of the plan are described in further detail below with explanation of concerns that should be addressed before any state commitment is made.

1. LHF Plan: Reorganize the charity hospital system currently run by LSU by changing the function or governance of two hospitals: W.O. Moss in Lake Charles and MCLNO, aka Big Charity, in New Orleans.

PAR Concerns: The plan would transfer the governance of only one of the state’s charity hospitals to a non-state authority. MCLNO would be transferred to a private, not-for-profit entity. The plan would also convert W.O. Moss to an outpatient clinic. A comprehensive overhaul of the charity hospital system is necessary to reverse unsustainable growth in Medicaid disproportionate share hospital (DSH) payments that comprise more than 50 percent of revenue for the charity system. Those dollars can be better used to expand health coverage options for the uninsured to assure improved access to primary care.

In a 2007 report “Realigning Charity Health Care and Medical Education in Louisiana,” PAR recommended that the state upgrade the charity hospitals in New Orleans, Baton Rouge, Shreveport and Monroe to true regional academic medical centers. Under the PAR proposal, the other six charity hospitals would

be transferred to local or regional control following careful planning and implementation to assure that access to care and services are improved before any transition takes place. The conversion of W.O. Moss to an outpatient clinic is a welcome step in the right direction but the additional step of transfer to local control should be included.

2. LHF Plan: Expand Medicaid health coverage to more low-income adults.

PAR Concerns: The plan would provide some coverage expansion statewide and some only for Region 5 – Southwest Louisiana. The additional cost would be covered initially with non-recurring revenue. Any coverage expansion should be available to qualified citizens in all regions of the state. Moreover, Medicaid expansion

is a recurring expense and should not be funded with revenue made available by the one-time forgiveness of debt owed to the federal government.

3. LHF Plan: Develop a state subsidy program in which small businesses and their low-income employees would share the cost of private insurance premiums.

PAR Concerns: The plan would offer such coverage only to citizens living in Region 5. Similar to coverage expansion, this program should be offered in all regions of the state and should be developed with a sustainable funding source. This would require that funds be dispersed to a larger targeted population and a multi-year phase-in be created. The same statewide approach was used with Louisiana’s successful LaCHIP program.

4. LHF Plan: Redesign the way Medicaid services are provided and paid for.

PAR Concerns: The proposed model could siphon dollars away from patient care to a higher burden of administrative expense. LHF sees Medicaid as the central problem, rather than the ineffective charity hospital safety net that is unable to provide adequate access to primary and many types of specialty medical care. This part of the plan is modeled after a problematic pilot program in Florida and would increase administrative costs far above current levels.

Medicaid expansion is a recurring expense and should not be funded with revenue made available by the one-time forgiveness of debt owed to the federal government.

Without additional, recurring revenue to pay the new costs, provider payments, the number of patients served and/or the types of services offered would have to be reduced.

Redesigning Medicaid

According to the LHF plan, starting in 2010, most of the 750,000 Medicaid recipients in the current CommunityCARE program would be transferred in phases into risk-based managed care plans similar to HMOs to be known as Provider Service Networks (PSN) or Coordinated Care Networks (CCN). Some recipients in rural areas where no PSN could be established would remain in the current program. A number of concerns have been raised regarding this plan.

Medicaid management is not the big problem.

The Department of Health and Hospitals (DHH) rationale for converting Medicaid to a managed care system run by contract HMOs lies in poor health outcomes for Louisiana, which is often at the bottom of the rankings for “healthiest state.” Few dispute the state’s poor health performance, but the conclusion that Medicaid is the culprit is questionable. The statistics cited by DHH are statewide measures of death rates, disease incidence rates, avoidable hospitalization rates, etc. They apply to all segments of the population, including persons who are insured (private insurance, Medicare or Medicaid) and those who are uninsured.

DHH Secretary Alan Levine says that Medicaid is riddled with fraud and proposes managed care as the remedy. The allegation would have been true prior to 1996 before DHH Secretary Bobby Jindal waged war against fraud and abuse, passing very strict legislation, tripling the number of fraud investigators and equipping DHH with the best computers and software to address the problem. Louisiana Medicaid became a model for other states to follow in fighting fraud.

The assertion that managed care is the remedy for fraud is questionable. For example, an Illinois jury

in 2006 found AMERIGROUP, a large Medicaid managed care company, guilty of defrauding the state Medicaid program by refusing to enroll eligible pregnant women and persons who were in poor health. AMERIGROUP paid \$225 million and entered into a corporate integrity agreement to adopt correct procedures and a code of conduct regarding enrollment and marketing practices in 11 states, including Florida.

During a two-year period starting in 2002, the primary care case management program (PCCM), known in Louisiana as CommunityCARE, was expanded statewide to cover some 750,000 Medicaid recipients. Each recipient is required to choose a primary care physician who provides a medical home for the patient and is responsible for meeting patient needs for primary and preventive care. Excess utilization is reduced because the primary care physician (PCP) authorizes referrals to expensive specialty or hospital care.

The solution is to expand coverage to achieve true health care reform. Tinkering with the management of Medicaid is likely to increase spending with little improvement in outcomes.

PCCM is a managed care system that organizes Medicaid to ensure that patients have access to primary care physicians who provide a medical home. It is not, as suggested by certain DHH officials, an uncontrolled, unmanaged system that merely pays claims but provides no improved access to care and no savings. PCCM programs improve quality and save money by utilizing many of the same tools as HMOs,

including prior authorization of high-cost services, drug formularies, best-practice guidelines, coordination of patient care, case management for chronic disease, etc. Additionally, PCCM programs have advantages over the HMO model of care:

- PCCM programs assure continuity and eliminate the risk to the state when an HMO or PSN/CCN elects to depart from the program, usually for reasons of solvency or profitability. In such cases, patients would need to be reassigned or, in a worst case scenario, could be left without a health plan.

- Accountability and transparency can be better assured with PCCM because claims and quality data flow from providers directly to the state without intervention from a managed care organization.
- PCCM allows states to maintain direct control over Medicaid operations, rather than ceding a substantial portion of their authority to a managed care organization.

No Medicaid program is perfect and all are in need of continuous improvement. The Louisiana Medicaid program is no exception, but it has performed well in many respects, receiving praise from the federal Centers for Medicare and Medicaid Services (CMS) as a “model program.” A recent study of Medicaid programs by an independent watchdog group (Public Citizen, April 2007) ranked Louisiana 28th in the nation, compared to Florida (26th) and North Carolina (18th).

It has been well established that the central problem for Louisiana is lack of access to medical care, especially primary care. According to federal data, 36 percent of the state’s population does not have ready access to primary care (which is the worst access of any state in the nation), and 18.5 percent of the population is without insurance coverage. Every study shows that insurance coverage improves access to care and leads to better health outcomes. The solution is to expand coverage to achieve true health care reform. Tinkering with the management of Medicaid is likely to increase spending with little improvement in outcomes.

Administrative costs would rise.

Medicaid managed care organizations have made a remarkable comeback since the late 1990s when they deserted Medicaid programs in droves in nearly every state. Today the Medicaid market is dominated by “Medicaid-only” HMOs. They are often subsidiaries of “commercial” managed care organizations, which have a broader focus on serving private pay and Medicare populations. They generally find Medicaid difficult to deal with and have turned that over to subordinate enterprises, which have been very successful in producing profits by reducing unnecessary (and sometimes necessary) service utilization.

The Louisiana Medicaid program has historically operated with administrative costs of approximately 3 percent, leaving 97 percent of spending to be directed to medical care. Medicaid managed care organizations typically have “medical loss ratios” of 85 percent or less, meaning that 15 percent or more of spending goes to administration and profits, with the remainder going to patient care.

The table below shows the most recent medical loss ratios for the largest publicly traded companies that provide Medicaid managed care. The percentages show the amount of premium revenue paid out for medical care costs, i.e., for payment of provider claims. Imposing a managed care system on the CommunityCARE program at current spending levels would reduce provider payments by at least \$200 million, effectively transferring that amount to fund administrative costs and profit margins. Children represent 80 percent of the CommunityCARE population. Annual spending per child for Louisiana Medicaid is the lowest in the nation at \$1,044 (Kaiser State Health Facts, 2005). Reductions in the current level of spending may not be feasible, so administrative costs may have to be financed with additional spending. The expectation of a significant reduction in the rate of spending growth that can be attributed to managed care is unrealistic.

Medicaid Medical Loss Ratios
3rd Quarter Earnings Report*

	2008	2007
Aetna	81.1%	87.7%
AMERIGROUP	80.1%	82.9%
Centene	81.3%	80.9%
Coventry	84.2%	85.1%
United Health Group**	81.7%	n/a

*Five largest Medicaid managed care companies

**Consolidated for all lines of business

States can be successful with managed care if they have the knowledge and sophistication to engage in aggressive contract negotiation, aggressive enforcement of data collection and aggressive

oversight to ensure compliance. States with successful programs tend to be those that have a lengthy history of managed care participation in both the private and public sectors, a factor lacking in Louisiana.

Other management models have not been fully explored.

Other successful models of care should be studied closely by the Legislature before making a final decision. The North Carolina model, in particular, appears to have considerable merit for Louisiana. It has been widely praised in independent studies for its successful coordination of care at the local/regional level. Responsibility for coordination resides in each of the 14 regions, rather than at the state level, with financial and technical assistance provided by the state.

The proposal made by DHH is rooted in Florida's program, which has had mixed reviews and created considerable controversy. The Florida reform program was started in 2005 and so far there is insufficient data to determine whether the program has had any measure of success. The PSN demonstration project in Florida covers about 60,000 persons in four counties. The Florida legislature has thus far not seen fit to expand the program statewide. By contrast, the proposal for Louisiana would have a total of 370,000 persons in CCNs (aka PSNs) within two years and a complete transfer for most of the remaining 350,000 or more at a yet to be determined point after 2010.

Conclusion

Serious concerns remain about whether this proposed grand experiment can be supported with recurring revenue or whether it is yet another example of shortsighted creative financing by Louisiana health care officials reminiscent of an out-of-control, fraud-ridden Medicaid program in the early 1990s. PAR generally supports the first three plan components outlined above as long as any expansion of ongoing services is funded with a recurring revenue source. The fourth goal, however, is an unnecessary diversion of funding from patient care to administrative costs for private HMO-type organizations.

Although several of the plan's goals are generally in alignment with PAR's goals for health care reform,

the state should not commit itself to implementing the Medicaid service provision reforms as currently proposed. Legislative approval for state health officials to apply for a federal waiver should only be granted if it does not commit Louisiana to implementing a Florida-style Medicaid managed care system. Full public debate of other options, including the North Carolina program and other viable models, must first be engaged.

The urgency for legislative approval of the ideas presented in the Louisiana Health First plan is motivated by a desire to get a federal rule waiver approved before the next president takes office. The waiver would be needed to implement the proposed Medicaid changes. While it would be a shame for the state to lose ground on the lengthy negotiations regarding the amount FEMA owes the state and the separate amounts the state owes various federal government programs, the importance of health care reform overrides those concerns.

Louisiana should take an approach to reform that is as comprehensive and expedient as possible. This does not mean locking the state into a Medicaid management plan that is unproven. This means using the Louisiana Health First plan as a starting point for fully transparent stakeholder discussions of all the viable options for statewide, system-wide reforms to improve the quality and access to care for the long term.

**For more information, go to
www.la-par.org.**

Each report in PAR's ongoing health care policy research series is available online.

Upcoming reports will outline plans for expanding health coverage to nearly half of the state's uninsured population, investing in programs of excellence for medical education and research, and expanding networks of hospitals, clinics and medical homes throughout communities statewide.