On the Health Record

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Medicaid Managed Care for Louisiana: Round 2

After a two-year hiatus, the Louisiana Department of Health and Hospitals (DHH) has weighed in again with an elaborate plan to reconstruct the way Medicaid services are delivered in Louisiana. The proposal, designated by DHH as Coordinated Care Networks (CCNs), has similarities to the unsuccessful Louisiana Health First plan from the fall of 2008. However, there are also a number of differences this time, with the most prominent being much broader opposition to the proposal itself.

DHH recently requested a state Senate Health and Welfare Committee oversight hearing to approve an Emergency Rule that would establish a Medicaid managed care program utilizing CCNs. A meeting was scheduled to hear the proposal on Oct. 21, but it was cancelled after DHH Secretary Bruce Greenstein rescinded the rule following stiff opposition from provider groups who felt the plan was being pushed through without adequate public debate.

Organizations contesting the proposal have grown from a single association representing pediatricians in 2008 to a group of five major health care associations representing both physicians and hospitals that have formed the Coalition to Protect Louisiana's Healthcare. The purpose is to oppose the CCN proposal as well as to explore ways to alleviate unprecedented levels of budget cuts that are looming in the current fiscal year and next year.

The coalition has urged the governor and other elected officials "to support short and long-term strategies to ease cuts to community hospitals, as well as delay the implementation of Coordinated Care Networks to allow for input from provider stakeholders and the legislature on how best to achieve our common goals of care coordination and quality improvement."

As in 2008, PAR continues to ask the question: Will this version of managed care be the most effective in producing better health outcomes and lower costs for Louisiana? The evidence presented thus far is unconvincing.

DHH's current version of Medicaid remodeling drops some key features of the 2008 Louisiana Health First proposal and proposes to implement the most troubling aspect of the former plan. The focus of the current plan is to outsource management of medical care for some 844,000 Medicaid recipients to private insurance companies. The Louisiana Health First label has been dropped and DHH refers to the proposal as simply "Coordinated Care Networks" or CCNs. The rationale for the CCNs is that the current program, called CommunityCARE, is broken, with deficiencies in care coordination, quality, specialty access and a reimbursement system that rewards quantity rather than quality.

Coordinated Care Network Plan

Approximately 800,000 Medicaid enrollees now in CommunityCARE would be transferred to a CCN under the DHH proposal. These are mandatory enrollment groups that include (1) children, parents and pregnant women and (2) persons who are disabled, blind or elderly. Another 44,000 voluntary enrollees are expected, including certain special needs children, foster children and Native Americans. Groups that would be excluded are (1) elderly persons who qualify for Medicaid but are also Medicare eligible (dual eligibles), (2) persons who are parties to certain class action lawsuits (3) persons who reside in nursing facilities for the elderly, those with developmental disabilities or those in hospice care, (4) anyone who receives services under a home and community-based waiver, regardless of age or type of disability and (5) those individuals who are Medicaid-eligible but also have partial coverage with private insurance.

In This Issue

Each year state officials make decisions about health and hospital programs to provide essential services to Louisiana's medically indigent, aged and disabled. More than 30 percent of the state budget is spent on health care. These are arguably the most important public policy decisions that will be made at the state level over the next several decades.

PAR is the only independent organization solely focused on providing public policy research for the citizens of Louisiana. We have never accepted state government funds.

PAR's research and analysis provide Louisiana citizens and decision-makers with an independent, reliable and knowledgeable resource to evaluate proposed changes. This newsletter series places a spotlight on some of the facts and figures central to the public debate and explored further with in-depth PAR reports available at www.la-par.org.

It is important to note that the excluded groups listed comprise persons who have the greatest need for complex institutional or in-home care and therefore are much more expensive to treat. While mandatory groups include persons with a disability or those over age 65, these are relatively healthy compared to those in institutions or receiving in-home care. Also, Medicare covers most persons over 65, so there will be few enrollees over 65. By and large, the CCN proposal focuses on the segment of Medicaid enrollees who are in relatively good health and have much lower costs than the groups that would be excluded from the program.

Louisiana Medicaid is not a big spender and, in fact, ranks very low in most categories (see Table 1) in a comparison across states. Like other states with a large low-income population, Louisiana has high enrollment levels but low spending per enrollee. Budget constraints are often a barrier to higher levels of spending per person.

Enrollment of the CCN target populations of children and adults constitute 72 percent of the 1.1 million total enrollment over 12 months in 2007. However, Medicaid spending for the same population represented only 29 percent of $4.5 billion in total spending for 2007. Figure 1 shows a comparison of costs to enrollment levels for each type of patient group.

Since 2007, despite warnings of economic collapse and reductions in federal matching funds, Medicaid spending for all groups shown has increased by more than 30 percent, or $1.3 billion, to a total of $5.9 billion (not including $700 million in Disproportionate Share Hospital (DSH) payments for the uninsured).

Projections from Mercer Consulting, actuaries hired by DHH, show that if CCN is implemented, a total of $50 million for FY 2012 would be saved.

Table 1. Medicaid Enrollment and Spending 2007*

	U.S.	Louisiana	LA rank
Enrollment			
Children	28,754,500	622,200	14
Adults	14,627,000	163,200	21
Elderly	5,934,900	112,200	16
Disabled	8,789,500	199,000	14
Total	**58,105,900**	**1,096,600**	**15**
Average spending per enrollee			
Children	$2,135	$1,191	51
Adults	$2,541	$3,260	21
Elderly	$12,499	$7,576	49
Disabled	$14,481	$11,678	39
Total	**$5,163**	**$4,055**	**49**
Total spending ($millions)			
Children	$61,378	$741	26
Adults	$37,166	$532	21
Elderly	$74,180	$850	25
Disabled	$127,278	$2,324	17
Total	**$300,002**	**$4,447**	**22**

**Medicaid enrollee spending only. Excludes $1 billion DSH payments for uninsured. Dollar amounts include state and federal funds. State share typically 30% of total.*

SOURCE: Kaiser State Health Facts

That number represents slightly less than 1 percent of the total Medicaid budget (minus DSH funds for the uninsured). Savings for FY 2013 are projected to be $71 million, or about 1 percent of the total Medicaid budget. Those who are expecting a solution to Louisiana's seemingly endless budget woes should look beyond managed care for Medicaid.

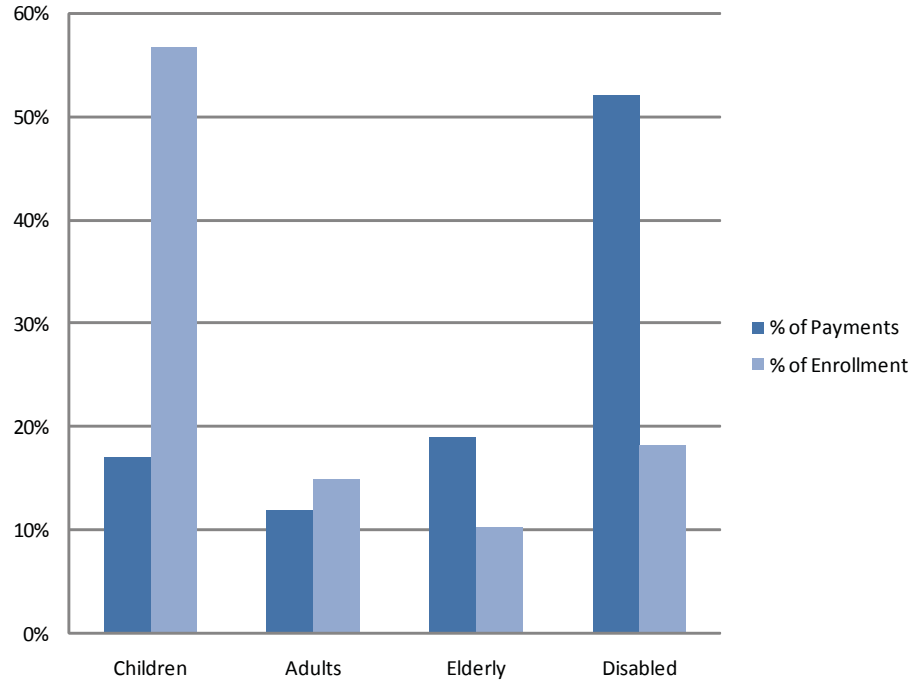
High-Profit Opportunity

Although the CCN plan may not be a panacea for the state budget, it is being touted as a high-profit opportunity for Wall Street investors – which raises serious concerns about the wisdom of this approach. A report ("Highlights from the Louisiana Medicaid RFP") produced by Citigroup Global Markets in early October says the "Louisiana opportunity is the next big catalyst for Medicaid" and is expected to produce $2 billion in revenue annually for major insurers in the Medicaid market.

The report found several features of the CCN plan particularly attractive for investors. The first is the absence of an RFP (request for proposals) by the state, which will instead allow any plan meeting minimum requirements to participate. Citigroup does point out that if too many plans participate, there may not be sufficient enrollment to sustain smaller plans. So far, DHH is said to have received letters of intent from six major insurers that would join as risk-based participants, including Aetna, Amerigroup, Centene, Coventry, United and WellCare. A start-up called UniHealth also has notified DHH that it will join in a non-risk capacity.

Another highly favored feature is the absence of a required medical loss ratio, defined as the minimum

Figure 1. Medicaid Spending and Enrollment Levels as % of Total*



**Medicaid enrollees only. Approximately $1 billion in DSH payments excluded.*
SOURCE: Kaiser State Health Facts

amount of the Medicaid premium paid to the insurer that will be spent on medical care for those enrolled in the plan. The medical loss ratio also measures administrative costs and profits. The research report had this to say about the medical loss ratio in the CCN proposal:

"One noticeable difference between this opportunity and many of the more recent Medicaid requests for proposals is the lack of a minimum medical loss ratio requirement. The state has soft language surrounding such a requirement, and we don't expect plans to be held to strict guidelines. DHH considers 85% to be the desired minimum MLR for at risk plans. However, the department would also like to incentivize initiatives that improve quality of care and health outcomes. Costs associated with improving the quality of care will be considered medical expense and counted toward the medical loss ratio. The department does not plan to include a requirement that money be refunded if the loss ratio is less than 85%."

The lack of an RFP plus the absence of a strict medical loss ratio with a provision for an orderly process to assure that the state could recoup money that the plan should have spent on medical care suggests a very free-wheeling approach to managed care and one that lacks adequate safeguards. Recently some top insurance companies in other states were involved in similar situations and failed to repay funds to states, thus prompting lengthy lawsuits and expensive settlements.

Medical loss ratios have received much attention recently because national health care reform has a provision that calls for minimum ratios of 85 percent for large business plans and 80 percent for individuals and small businesses.

Most Medicaid managed care plans maintain ratios in the 80 percent to 85 percent range (see Table 2), though there are cases of ratios as low as 60 percent or less, which in at least one case prompted a lawsuit by the state agency.

Pursuing Better Alternatives

The new DHH business plan ("A Road Map for a Healthier Louisiana," released Oct. 25) correctly notes many of the problems that impact Louisiana's delivery system and its low overall health ranking. These include a broken federal Medicare program that in 2006 had the highest cost and the lowest quality in the nation; an antiquated charity hospital system badly in need of an overhaul; and a fragmented system of private health care that suffers from the same well-documented problems that plague the entire nation. Louisiana Medicaid is much improved compared to 10 years ago but much remains to be done.

Table 2. Medical Loss Ratios*
2010 2nd Quarter Earnings Report

	Medical care	Non-medical care
Health plan		
Aetna	89.2%	10.8%
Amerigroup	82.3%	17.7%
Centene	83.8%	16.2%
Cigna	84.3%	15.7%
Humana	85.4%	14.6%
United Health	84.1%	15.9%
Wellpoint	82.9%	17.1%
Medicaid 2007		
Louisiana	97.3%	2.7%
Southern avg.	95.3%	4.7%

**Medical loss ratios show the percentage of premiums collected by a health plan that are paid out for medical care expenses. Amounts not paid for medical care are used for non-medical expenses, including administrative costs, advertising, commissions and profit.*

SOURCE: corporate earnings reports; LA Legislative Fiscal Office

There are other alternatives available that would produce better long-term but would require leadership, hard work and a determination to stay the course. The North Carolina model is an example of a very successful program that could be adapted to Louisiana. In fact, the current North Carolina and Louisiana programs are very similar: both are Primary Care Case Management (PCCM) programs, a form of managed care. Louisiana started its program in 1992 on a very small scale, then expanded it statewide in 2001-2003. Community Care of North Carolina (CCNC) started in 1998 and slowly expanded statewide by 2007. The program has received praise for its effective structure of medical homes and care coordination, which has improved access, reduced cost and enhanced quality.

CCNC relies on local networks to provide care coordination through case managers who link patients to services in each region and arrange transportation services. A small state staff assists local networks. North Carolina also made a determined effort to work with physicians to build a successful program. Physicians in both rural and urban areas across the state responded positively.

Other options should be considered by DHH and the Legislature before any decision is made to move forward with significant changes for Medicaid such as those proposed in the DHH CCN plan. The litmus test for a viable program is one in which the provider community feels comfortable and is committed to the hard work and difficult changes needed to build a better system of care for Louisiana.

Recommendation 1

Before considering the CCN proposal, the Joint Committee on Health and Welfare preemptively should request that DHH undertake a rewrite of its plan to ensure that, at a minimum, the following items have been corrected:

- The traditional RFP process should be used to select potential plan participants in lieu of "any willing health plan" that meets minimum requirements.
- A minimum medical loss ratio should be established at the 85 percent level in concert with the federal health care reform law, and plans should be directed to adhere strictly to that. Provisions should be included that describe how plans that fail to maintain the minimum are to return money to the state.

Recommendation 2

The Joint Committee on Health and Welfare should undertake a comprehensive and thorough study of the viability of different models of Medicaid service delivery that have achieved success in improving care coordination, enhancing quality and reducing unnecessary utilization and costs, including administrative costs. The committee should hold open meetings to solicit input from a wide variety of stakeholders, to include providers, consumers, health plans and other interested parties.

The committee should produce a report that outlines the material reviewed during the study process and also should make recommendations to the governor and the full Legislature as to the most viable ways to achieve a better Medicaid delivery system for the state. The implications of federal health reform and how it should be coordinated with state efforts should be a high priority-focus of the study.

Recommendation 3

The governor should immediately by Executive Order establish a permanent commission to hold public meetings and conduct studies to determine how best to implement the provisions of the federal health care reform act. The commission should be advisory only and should make recommendations to the governor and DHH. The commission should solicit information from the public, including providers, consumers, health plans and other interested parties. The commission should also solicit input and provide recommendations on coordination of federal health reform with state-level reform activities, such as the CCN program proposal.

The commission should make all meetings and documents easily accessible by the public.

PAR's ongoing research on health care policy in Louisiana includes an analysis of best practices for state implementation of federal reforms. This analysis evaluates decision-making processes, cost estimates and policy approaches for implementing coverage expansion across the nation with a special focus on changing the rules for Louisiana's Medicaid program.

For more information on health care reform options for Louisiana, access these PAR reports and commentaries at www.la-par.org:

- Working Toward a Cost-Effective Approach to Medicaid Long-Term Care for the Elderly, April 2010
- Public Mental Health Care in Louisiana, December 2009
- Assessing the Louisiana Health First Plan, December 2008
- Realigning Charity Health Care and Medical Education in Louisiana, May 2007
- Action Steps for Access to Care, June 2006

PAR Presents

Senior Health Care Policy Analyst David W. Hood frequently contributes to the public debate about health care reform options in Louisiana by delivering presentations and participating in various task force and advisory activities. The underlying research and analysis that form the basis of PAR research reports are a valuable resource to help guide policy-makers and interested citizens as proposals are considered. The following list represents a sampling of his recent and upcoming presentations and speaking engagements:

Oct. 14, 2009	Tulane Medical School Faculty "Grand Rounds." Presented information on national health reform and its impact on Louisiana health delivery system, medical education and public hospital system.
Oct. 23, 2009	Louisiana Health Care Commission. Participated in panel discussion on impact of national health care reform on Louisiana.
March 23, 2010	Louisiana Department of Insurance 2010 Annual Conference. Served as moderator for panel discussion of LSU-Our Lady of the Lake Regional Medical Center partnership to establish OLOL as a replacement for the Earl K. Long Regional Medical Center in Baton Rouge.
April 8, 2010	Southern University Law Center, Justice Revius O. Ortique Symposium: "Addressing Louisiana's Health Care Crisis." Delivered presentation on the impact of national reform on cost and affordability of health care in Louisiana.
May 7, 2010	Louisiana Health Care Commission. Presented report on legislation introduced in 2010 Regular Session of the Legislature related to health care reform and budgetary issues.
June 2, 2010	Met with delegation from Robert Wood Johnson Foundation. Presented overview of Louisiana health care system to include comparisons to other states, achievements and challenges.
June 24, 2010	ODK Alumni (honor society) Conference. Participated in panel discussion on the current and future role of the LSU hospital system for health care delivery and medical education.
July 13, 2010	AARP Coalition for Change – meeting on long-term care topics. Presented overview of problem areas and recommendations outlined in April 2010 PAR report urging reform of Medicaid programs for the elderly.
July 15, 2010	Baton Rouge General Regional Medical Center, Grand Rounds for Tulane MD/MPH residents. Served as member of panel discussion and delivered presentation on impact of national health care reform on Louisiana.
September 2010	Participated in a panel discussion sponsored by the Oil Marketers and Convenience Stores Association concerning the impact of federal health reform on small business enterprises.
September 2010 to April 2011	Serves on the Cost Containment Subcommittee of the Louisiana Health Care Commission. The subcommittee is investigating ways to reduce excess costs in private health plans and public programs in Louisiana. The subcommittee plans to complete its work and make recommendations to the LHCC to consider possible proposals to the Legislature in the 2011 Regular Session.

The Public Affairs Research Council (PAR) is a private, nonprofit, non-partisan public policy research organization focused on pointing the way toward a more efficient, effective, transparent and accountable Louisiana government. PAR was founded in 1950 and is a 501(c)(3) tax-exempt organization supported by foundation and corporate grants and individual donations. PAR has never accepted state government funds.

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