



COMMENTARY

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PAR sees House action as a good opportunity to rethink the Coordinated Care Networks initiative for Louisiana Medicaid reform

The Louisiana House of Representatives made two important accomplishments last week when it partially cut funding for a privatized Medicaid program proposed by the state health agency. The House's amendment to the appropriations bill would save scarce dollars in next year's state budget and slow the implementation of the administration's proposed Coordinated Care Networks (CCN), a privatized system of questionable benefit for Louisiana's Medicaid recipients and health care industry.

The governor's administration wants to implement the CCN system in place of Louisiana's current CommunityCare program. Both models use a managed care system in which Medicaid enrollees are assigned a primary care physician and have access to a network of health-care service providers. CommunityCare is operated by the state through a network of physicians, whereas under the proposed CCN system the state would contract with private companies to manage the care of Medicaid recipients.

While PAR applauds this administration's efforts to explore opportunities for greater efficiencies and potential privatizations of government operations, the CCN concept poses many questions about whether it would contribute to better health care or cost savings in Louisiana. Medicaid reform is needed but this model raises concerns about its viability in Louisiana given our demographics and Medicaid spending patterns. The right move – both in terms of budget savings and policymaking – is to shift money from this initiative to slow or stop its implementation, provided that the cuts are targeted mainly at the new program with minimum impact on existing services.

The CCN model would introduce a new cost factor into the state's Medicaid program. The coordinated-care companies would expect to find room for a profit assuming they actually could squeeze down health care expenditures for enrollees covered by limited Medicaid dollars. The expected allowance for administrative overhead and profit is 15 percent of expenditures compared with current administrative costs of 3 percent. The privatized system would be hard-pressed to find substantial cost savings and at the same time improve health care outcomes. The state also would have to pay for rigorous oversight to guard against the kind of fraudulent business practices that have plagued similar programs in some other states.

The challenge of cost savings would be especially difficult in Louisiana because it already is comparatively a very low-cost state measured by the amount of money spent per recipient of Medicaid, particularly children. In recent years Louisiana has ranked at the bottom or near the bottom of state rankings for Medicaid spending per child. Even under the rosier scenario, the maximum forecasted Medicaid savings under the CCN program would be \$135 million in the

2013 fiscal year, according to figures from a consulting firm hired by the Louisiana Department of Health and Hospitals.

A number of states have encountered serious problems with privatized managed care plans. Connecticut announced in February it would abandon its for-profit managed care system for Medicaid recipients because the program lacked transparency and had failed to save money over the past decade. Oklahoma had a similar experience.

PAR recommends that the current CommunityCare system be upgraded. A model worth considering is used in North Carolina, where an acclaimed state-run coordinated care system places a strong emphasis on regional networks. Alabama is improving its state-run Medicaid program based on the North Carolina model.

A great deal of misinformation has clouded the recent discussion of Medicaid reform. Louisiana has been portrayed as an outlier state because it does not have a privatized managed care system. The reality is that about 47 percent of the nation's Medicaid enrollees are in privately contracted managed care. In fact, 30 states have a non-privatized form of primary care case management like the one now used in Louisiana while 35 states utilize private managed care plans, with some states using both forms. Only 10 states use a privatized model to cover more than 70 percent of Medicaid enrollees, which is the extent of the administration's plan for Louisiana.

As in other states, the large majority of people in Louisiana covered by Medicaid are children but the large majority of the Medicaid expenditures are for institutional and home care for the elderly, the mentally ill and those with developmental disabilities. Louisiana also uses many Medicaid dollars to reimburse public and private hospitals and other health care providers for services rendered to the uninsured.

These higher-cost portions of Louisiana's Medicaid budget make the state one of the larger spenders of Medicaid dollars overall, which is not surprising in light of the state's high level of poverty. Yet these expensive services are not the focus of the administration's CCN program, which is aimed at coverage for children and adults in mostly urban areas but does not target the elderly and disabled population.

For the next fiscal year, the proposed budget for DHH will see large reductions in statutory dedications and federal funds, particularly as a result of federal stimulus money running out and the unfortunate and misguided reduction of federal matching rates (Federal Medical Assistance Percentages, or FMAP) for Louisiana. As proposed by the Jindal administration, the DHH budget would compensate for these losses by increasing the state's general fund allocation for medical vendor payments by 114 percent. This state cash infusion is the central reason behind an overall \$629 million increase for DHH under the administration's plan. After cutting medical provider rates earlier in the term, the administration has taken a justifiable stance with the new budget to resist further reductions in Medicaid reimbursement rates to health care vendors.

In its effort to balance the budget and make new priorities, the House last week removed \$81 million from the general fund allocation for DHH and made clear its intent in the amendment that the cut was targeted at the CCN implementation and not toward a reduction in provider rates. The Legislative Fiscal Office and legislative leaders reported that, with this amendment, DHH would not be forced to cut provider rates if it applied the reductions to the CCN initiative. Citing the House amendment, the health agency has threatened cuts of up to 8 percent for private providers. But the agency has the capacity to slow the CCN implementation while avoiding cuts to Medicaid vendors.

The reduction does not eliminate state funding for the CCN program. The Legislative Fiscal Office figures there is about \$97 million remaining in the DHH budget for the CCN program even after the amendment.

What we have here is a budget process in which the House has identified an item ripe for cutting from the administration's spending plan. Slowing the CCN implementation does not appear to force a situation that would have a serious negative effect on health care for Medicaid recipients or reduce provider rates. Regardless of funding levels, DHH still might not be able to start the program on time next year due to other delays.

This is not to say that the House cut will have no consequences. The amendment decreases the Medicaid budget by just under 4 percent, counting state and matching federal dollars. But it would save money for other priorities and offer more time to re-examine a dubious privatization venture. Even with the amendment in place, DHH might have the flexibility to spend according to its own priorities. The agency could choose to sacrifice the health care vendors so that it can propel the CCN initiative at full steam. In the end, all parties with a stake in the decision would be better off if DHH accepted a reduction to the CCN model rather than reducing provider rates.

This administration has served the state well by igniting long overdue debates on many issues related to government agency consolidations and proposed privatizations. Not every idea with merit proves on balance to be worth implementing and some proposals have turned out to be unpopular with the Legislature. Yet serious public discussions on many initiatives, including the CCN program, would not have taken place had the administration not been willing to re-examine many fundamental assumptions about government spending and operations, sometimes down to the level of a few hundred thousand dollars. This is a commendable approach, even when it sometimes becomes contentious.

The CCN program is an idea that carries more risk of cost inflation and oversight problems than the program is probably worth for Louisiana. As the budget process continues this session, cutting the CCN program and putting the money to better use for the next 12 months is the best way to go.

This commentary is based in part on a forthcoming PAR report about Louisiana's Medicaid reform proposals.

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