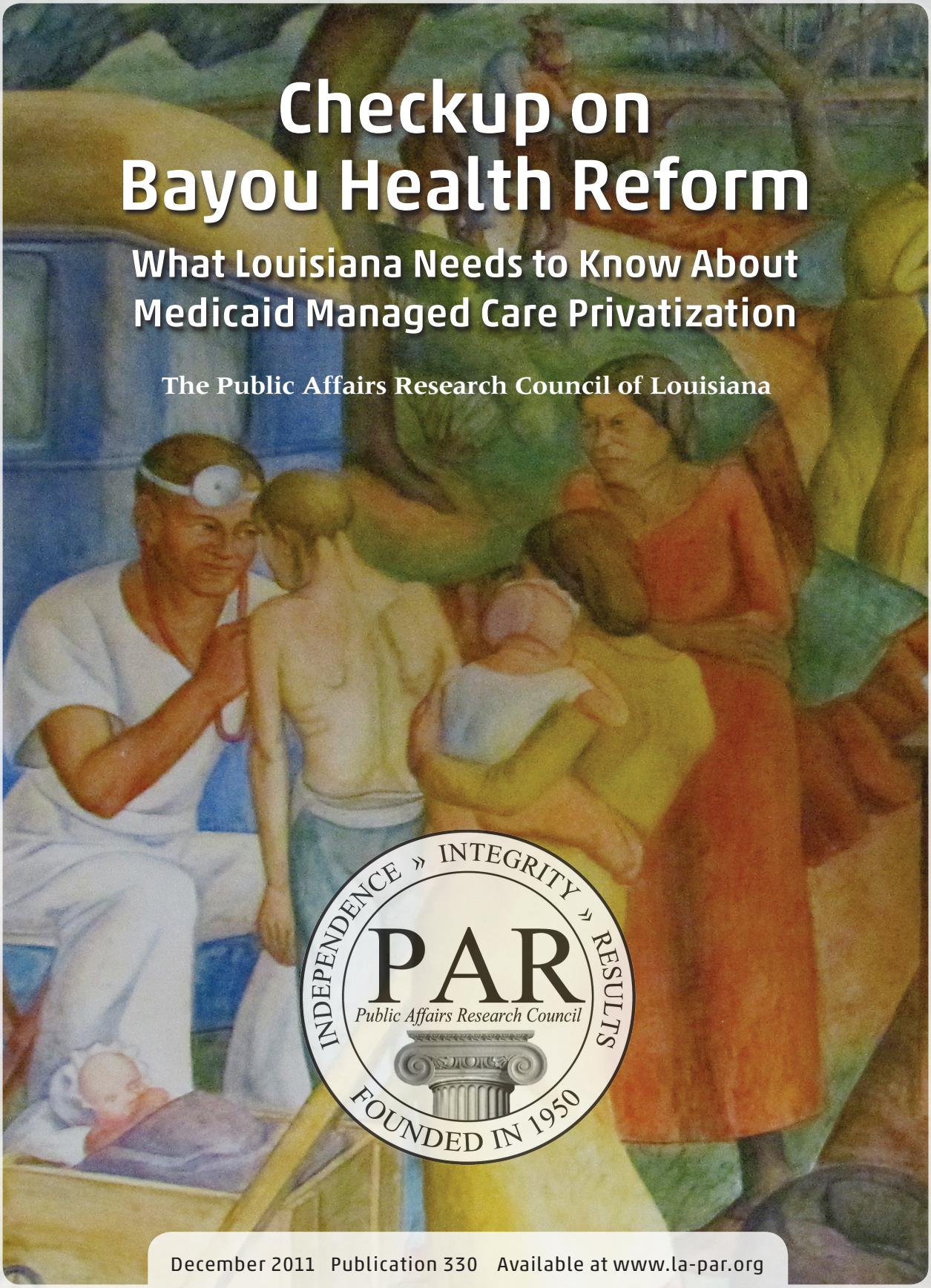

Checkup on Bayou Health Reform

What Louisiana Needs to Know About Medicaid Managed Care Privatization

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David Hood
Primary Author of Report and former Secretary of the LA Department of Health and Hospitals
dwhood@la-par.org

Robert Travis Scott
President
robertscott@la-par.org

Alison Neustrom, Ph.D.
Research Director
alison@la-par.org

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Public Affairs Research Council of Louisiana
4664 Jamestown Ave., Suite 300
Baton Rouge, LA 70808
Phone: (225) 926-8414
www.la-par.org

TABLE OF CONTENTS

Executive Summary

Health care is among the most controversial and complex public policy issues facing leaders today. How to best provide health care, what choices should be available and at what cost are all questions being asked of every segment of the system, whether Medicaid, Medicare or the private insurance market.

Medicaid poses a unique and growing challenge to states. The federal government provides the majority of funds for the program, which serves low-income individuals and many people with special disabilities. But states must carry a large and probably increasing financial burden. Although the American Recovery and Reinvestment Act of 2009 provided states a temporary boost in federal Medicaid spending, these funds have expired. Meanwhile, states have been grappling with higher unemployment, increased private health insurance premiums and decreased employer-sponsored health coverage. Projections indicate that spending of states' dollars on Medicaid will increase by 18.6 percent during the current fiscal year while federal spending is expected to decrease by 13 percent. All of these factors affect Medicaid costs and enrollment, both of which continue to march upward. Enrollment is scheduled for a substantial uptick in 2014 when the new federal health care law expands eligibility in Louisiana by an estimated 400,000 or approximately 30 percent. Federal funds are supposed to pay 100 percent of costs for these new eligibles for the first four years and Louisiana will pay 10 percent of costs thereafter.

Louisiana is no exception to these challenges. Medicaid is one of the largest public programs in Louisiana in terms of cost and number of enrollees, most of whom are children. Medicaid expenditures in fiscal year 2010 totaled $6.6 billion and the number of enrollees increased by 7 percent. An estimated 29 percent of Louisiana's population, about 1.3 million people, were enrolled in Medicaid at some point in the fiscal year or had payments made on their behalf from the Medicaid system.

Each state must choose its own model for running the Medicaid program. Many states are urgently pursuing programs that will bring savings in Medicaid spending. A recent issue of Governing magazine reports that the five key strategies utilized by states include reducing provider payment rates, reducing fraud and misuse, capping jury awards in medical malpractice suits, managing care for the chronically ill and reforming the entire delivery system.

This report examines Louisiana's latest strategy to improve health care outcomes and contain costs by further privatizing the management of Med-

icaid care. Currently, about 63 percent of Louisiana's Medicaid recipients are enrolled in a form of managed care called CommunityCARE. Under this system, an individual's care is managed by a primary care physician who receives a small additional fee per member each month to pay for case management, coordination of care and follow-up with patients who need further assistance. Also, the physicians and other health care providers charge fees for each service rendered and seek compensation directly from the state Medicaid program. Some other states have a similar system and have provided additional resources to enhance the coordination of care provided through this model. Continuing improvement of the program stalled in the wake of Hurricane Katrina and the privatization efforts pursued by the current administration. There is widespread agreement that improvements are needed in the Medicaid system along with a disparity of views on how to achieve those improvements.

Louisiana is shifting to a different model wherein managed care will be outsourced to five private insurance companies. Never before have private companies had so much responsibility for managing Medicaid care in Louisiana. Called Bayou Health, the program uses a concept called Coordinated Care Networks (CCNs). The companies will create networks of health care providers available to Medicaid recipients who enroll in their plans. Three of these companies will operate under a "prepaid" system. The state will pay these companies a monthly fee for each member. The companies, in turn, will manage the care of recipients within the provider networks.

The system of fixed prepayment is known as capitation: premiums paid to the company are established for various groups of patients according to calculations of risk for disease, age and other factors. The companies are accepting financial risk because they agree to provide the services needed regardless of whether the costs exceed the agreed-upon rate. The risk is tempered by provisions in federal law that mandate "actuarial soundness" in capitation rates for Medicaid managed care plans. The Governmental Accountability Office (GAO) recently admonished states to ensure that rates paid to managed care organizations are not set artificially low to maximize state savings. Two other companies are offering Shared Savings plans where providers are paid on a traditional fee-for-service basis. Companies can share in the savings found by coordinating care for their enrollees.

This privatized Medicaid managed care model is based on the theory that private companies can make up-front investments in data infrastructure, patient education and disease prevention while providing health care that will yield savings for the state and profit for the companies. One concern about the model is that some private companies have attempted to increase profits by reducing necessary health services to Medicaid recipients.

Privatized managed care has received mixed reviews. Some states have found savings and improved health outcomes for patients while other states

have wrestled with fraud and unexpected demands by private companies for higher capitation rates. Some states have tried the model only to bring care management back under state control. Many states use a hybrid approach of privatizing managed care for certain populations while letting government staff manage care for other populations.

Coordinated Care Networks initially were met with strong resistance from many stakeholder groups in Louisiana. These groups, in addition to the Public Affairs Research Council, advised the state to carefully consider all models of care before embarking on a massive program implementation. The administration broadened its support for the initiative and now is moving forward on a schedule for statewide implementation in 2012.

The key public policy issue at this juncture is the need for effective oversight, accountability and program authority, especially given the public dollars involved and the impact on citizens. A proposed legislative oversight function was removed from a bill without proper warning to lawmakers during the appropriations process in 2010. Later, an attempt to strengthen legislative authority was approved unanimously by lawmakers but vetoed by the governor after the 2011 legislative session. The state is proceeding without the benefit of having conducted a pilot program, which could have offered a useful way to make mid-course corrections before statewide implementation. Updated actuarial projections have raised questions about the anticipated savings from Coordinated Care Networks. These events highlight the need for the CCN program to be administered with full transparency under the watchful eye of both the executive and legislative branches.

The financial performance of the model should be closely monitored. Under the current system, Louisiana Medicaid spends among the least in the country on a per-enrollee basis, ranking 48th on spending per child and 41st on spending per person for all enrollees compared to other states. That relatively low rate of spending could be a potential impediment for Coordinated Care Network companies seeking to cut health care costs through efficiencies and lower expenditures on enrollees while also finding room to make a profit. Blue Cross Blue Shield of Louisiana, the state's largest private health care insurer, decided not to seek a CCN contract after the company's actuaries advised against participating in the Bayou Health program.

The Prepaid program by design is supposed to trim a portion of the state's Medicaid budget even though some of those expenditures will be used to cover a major new cost factor: administrative costs and profit for the CCN companies. Meanwhile, overall spending on actual health care services for

these Medicaid patients is expected to decline significantly. What this means for the future is that state officials and the Legislature must consider whether reduced spending on health care comes as a result of more efficient operations and a reduction in unnecessary services or a cutback in health care services truly needed by Medicaid recipients. Careful oversight of this issue, as well as the need to guard against potential fraud, will place demands on the state to expend agency resources. In other words, government administrative and oversight expenses, despite the privatization, are expected to continue at similar levels.

Although this study identifies potential areas of concern and the need for more legislative oversight, PAR strongly encourages Medicaid recipients – especially eligible families with children – to learn about their options under the new Bayou Health program and to select a plan as soon as possible that is best suited to their particular needs. Bayou Health has the best chance of succeeding if Medicaid-eligible people step forward and learn how to participate in the program. The new system is beginning enrollments and qualified citizens should get on board. Health care providers and Medicaid enrollees are encouraged to become educated about the program so that they can make informed decisions about their participation by visiting the website www.bayouhealth.com for more information. The time has come for strong legislative oversight for a program that deserves full scrutiny. A public spotlight on all major issues about the CCN program is needed on an ongoing basis to ensure that potential problems are detected in a timely manner.

PAR MAKES THE FOLLOWING RECOMMENDATIONS (PLEASE SEE PAGE 32 FOR FULL EXPLANATIONS)

1. The Legislature should assert its authority and take the lead in providing oversight of this program by establishing a special committee or commission on oversight of health care reform with bipartisan membership from the House and Senate and other stakeholders.

2. DHH should ensure that the state maintains the authority and control of systems and processes and that all private managed care companies operate in a transparent manner. Companies should be held to the same standards as state agencies in terms of public records related to the Bayou Health contracts.

3. DHH should adhere to the federal definitions of "medical care" and "administrative costs." Some managed care plans have creatively redefined certain administrative costs as medical care to maximize profits and overhead. DHH should remain vigilant that any redefinitions are transparent and in the best interest of citizens.

4. The Legislative Auditor should monitor the impact and effectiveness of the Coordinated Care Networks and be given access to information to perform its analysis and report its findings to the Legislature.

Introduction

Louisiana stands on the brink of major change in delivering vital health care services to its low-income population. Medicaid is a health care program funded jointly by the federal and state governments. The federal government provides a match for state Medicaid spending based on a formula. The federal match varies by state and for Louisiana is typically about 70 percent of Medicaid expenditures. This match has varied in recent years due to an influx of economic stimulus and disaster relief funds. Through Medicaid, states provide health care to certain low-income individuals who meet designated eligibility criteria. The Medicaid program, now in its 45th year, will undergo privatization of services in the form of managed care for almost 900,000 of the 1.2 million persons enrolled on an annual basis in Louisiana. Bayou Health is a product of the governor's administration. It will operate under a system that the state health department calls Coordinated Care Networks (CCNs). Enrollment into the CCN plans will begin on Dec. 15, 2011, and the program is scheduled to be fully operational by mid-2012.

Providers and consumer advocates in Louisiana have raised questions about the privatization of Medicaid managed care since 2008. There has been general agreement among all parties that reform of the Medicaid system was needed, but less agreement on the type of delivery system to be adopted. Funding was approriated in the 2011 legislative session, clearing the way for implementation of CCNs.

Louisiana is not the first state to make the transition to privatized managed care, instead it is one of 16 states that had resisted the nationwide movement. That privatization trend has gathered strength since the beginning of the current economic downturn as more states attempt to implement Medicaid managed care for the first time and others expand existing programs in the hope that it will reduce costs and help to balance tight budgets.

Subsequent to this initial trend, a smaller but notable counter-trend has developed with several states choosing to abandon private contracting and take full control of their Medicaid programs once again. In each case, state policymakers had strong convictions about making this contrarian course reversal. The declared reasons included:

- A state-operated program could be less expensive than private contracting.
- State-operated programs could match or exceed quality of care improvements achieved by private plans.
- Full state control would end disruptions caused by private plans that abruptly terminated their contracts.
- In some cases, states had difficulty obtaining key data from contract health plans.

After more than 30 years of Medicaid managed care, there still is no con-

sensus on whether it saves money or improves quality, despite study after study on both sides of the issue. The uncertainty surrounding managed care in general and CCNs in particular should alert the state to the need for strong oversight of every phase of the program. A bill was unanimously passed in the recent legislative session to improve oversight, only to be vetoed by the governor. Yet, opportunities remain to exert legislative authority that would assist providers and other stakeholders, including the general public, to become well-informed and able to offer clear advice about this important program.

The existing managed care program in Louisiana is not meeting all the needs of Medicaid enrollees. The CommunityCARE program, implemented a decade ago, has made important and notable progress but efforts to update that program have stalled since the administration began pursuing a privatization model. Any health care delivery system must grow and transform, and CommunityCARE has not been able to do this given the pursuit of the privatized managed care model.

The Legislature can and should take steps to preserve its oversight authority, which is an integral part of the checks and balances in the state's system of government.

In PAR's research and dialogue with stakeholders about Medicaid reform, broad agreement was found in some areas. Louisiana Medicaid needs more patient education, disease management, data infrastructure to track progress and access to specialists. These deficits are combined with a sense of urgency given the substantial increase in the Medicaid population in 2014 that is expected to come with the implementation of federal health care reform.

This analysis will examine the lessons learned in other states about privatized Medicaid managed care, identify potential pitfalls and advantages in applying this model to Louisiana and make recommendations to policymakers as Louisiana moves ahead with Bayou Health. It also will highlight PAR's main concerns with the CCN model. These concerns include the need for transparency in authorization and oversight and the rushed statewide implementation without a successful pilot project. A key concern is how the current low level of Medicaid spending per child could present challenges to the Bayou Health business model. The report also will address the peripheral aspects of the current health care arena in Louisiana that may impact this policy shift.

The report will focus on issues that need to be resolved in favor of excellent patient care for the Medicaid population, as well as the need to conserve scarce budget dollars and direct them toward cost-effective solutions. Although the Legislature has played a subordinate role in the development and implementation of the CCN program until now, it has not been relieved of its responsibility to ensure that vital health services for nearly one-third of the state's citizens are maintained and properly delivered.

Likewise, the Legislature has a duty to oversee spending in the Medicaid program and certify to the public that tax dollars are spent cost-effectively and directed toward the goal of providing quality medical care. Public funds exceeding $2 billion will now be in the hands of for-profit companies and legislative oversight appears to be minimal. However, the Legislature can and should take steps to preserve its oversight authority, which is an integral part of the checks and balances in the state's system of government. In this report, PAR will offer suggestions on what steps are needed to assure transparency and accountability as the state transitions its largest and most critical program into unfamiliar territory. The experiences in other states will be described in the hope that problems will not be repeated and successes can be built upon.

What is Medicaid Managed Care?

The term "Medicaid managed care" is used to describe a wide range of delivery system models designed to improve care and care coordination, improve quality and reduce costs by assuring that enrollees are assigned a primary care provider (PCP) and have access to appropriate specialty and hospital care when needed. Some Medicaid managed care programs are operated directly by the state, often with assistance from contractors that provide specific services, while other Medicaid managed care programs are outsourced to private or nonprofit organizations. Non-managed fee-for-service systems, such as Louisiana Medicaid prior to 2001, typically allow patients to seek medical care as they see fit without guidance and supervision from a primary care provider familiar with their medical needs. Managed care provides an organizational structure where patients are assigned to a primary care physician who oversees a "medical home" to deliver preventive and primary medical care and coordinate specialty and hospital care as needed for the patient.

In Louisiana, the Department of Health and Hospitals (DHH) previously implemented a program known as CommunityCARE, which is a Primary Care Case Management (PCCM) system and, according to the federal definition of Medicaid managed care, a form of managed care. The PCCM model is designed so that the primary care provider administers preventive and primary care, and also coordinates and authorizes referrals to specialty, hospital and emergency services for the patient.

The PCCM model partly retains fee-for-service payments, in which patients get care from a health provider who then bills the state for the service. The PCCM method also adds a per-member-per-month fee, typically from $3 to $5, for each enrollee assigned to a primary care physician or practice. These fees are typically used to hire or contract with case managers to ensure better coordination of care and follow-up with patients who are chronically ill or otherwise in need of assistance. Some states, such as North Carolina, Oklahoma and Connecticut, have invested in an "enhanced" version of PCCM to improve coordination of primary care.

About 63 percent of Louisiana Medicaid recipients are enrolled in CommunityCARE, or 752,977 enrollees, according to the Centers for Medicare and Medicaid Services (CMS) in December 2010. The national rate of Medicaid managed care is about 72 percent as reported by CMS in 2010. Children represent about three-quarters of total enrollment in CommunityCARE. Approximately 1,700 primary care physicians participate in the program to provide patient-centered medical home care. There are an estimated 500 "physician extenders," or physician assistants and nurse practitioners, who provide care under physician supervision.

CommunityCARE of Louisiana succeeded in its goal of reducing Medicaid costs per enrollee from well above the national average to well below the national average. It also provided a structured system of care with medical homes for some 750,000 Medicaid enrollees and improved quality and access to services for children.

States can outsource management of substantial portions of Medicaid programs to Managed Care Organizations (MCOs). While some Medicaid managed care plans are not-for-profit, most plans are for-profit and most specialize exclusively in Medicaid contracting. When states take the privatization route, they contract with private insurers utilizing variations of the managed care template, such as Health Maintenance Organizations (HMOs), Provider Service Networks or, in the case of Louisiana, Coordinated Care Networks. These insurers provide managed care plans for enrollees and the state pays the insurers a fee, usually on a per-member-per-month basis. The fee is usually "capitated," or set at a limited amount. The insurers assume a financial risk because they agree to accept a set monthly rate per enrollee for providing a medical home with a range of primary care services, benefits and referrals to specialty or inpatient services. The actual cost that the insurer must bear may range considerably from one enrollee to another and in some cases exceed the value of the capitated fee. The insurers expect that their total revenue from Medicaid fees will be greater than the overall costs for care. The concept is designed to set up an incentive for the insurers to keep a close eye on costs, catch illnesses in early stages and reduce the number of health treatments that might be unnecessary.

About 50 percent of the country's Medicaid enrollees are in private managed care.

The central argument against a fee-for-service reimbursement system is that it cannot be efficient because it provides the wrong incentives, meaning physicians and other providers will generate high volumes of services in order to maximize revenue. For example, physicians will order more office visits, lab tests, imaging, etc., than necessary to produce a higher level of revenue but not necessarily better outcomes for the patient.

The solution offered through Medicaid managed care is to substitute a different incentive structure whereby physicians and providers are rewarded for producing good patient outcomes rather than high volumes of procedures. This is said to reduce costs, increase quality and improve health outcomes. However, there is disagreement with these assumptions and questions about whether outcomes actually improve.

Some states have found success in improving outcomes with privatized Medicaid managed care, while others have experienced dismal failure and decided to abandon this form of managed care to resume other models that allow the state to have full control of its Medicaid program. Thirty-five states outsource parts of their Medicaid programs to private insurers, according to October 2010 federal data. Half of those states also offer non-privatized programs. As a result, about 50 percent of the country's Medicaid enrollees are in private managed care. Only 10 states have chosen to put 70 percent or more of enrollees into private insurance plans, which is the approximate amount proposed by DHH for Louisiana. Louisiana's approach includes both a Prepaid model, where an insurer receives a monthly fee per enrollee to provide health care through its network, and a Shared Savings model, where insurers coordinate care of members and are paid on a fee-for-service basis. In the Shared Savings model, insurers can receive a portion of the savings generated through the coordination of care.

Proponents of the CCN model have portrayed Louisiana as a rare exception among states for not relying on a privatized program such as Coordinated Care Networks. In fact, 2010 federal data summarized in Kaiser State Health Facts show that 33 states have a non-privatized form of Primary Care Case Management (PCCM) like Louisiana. Some states use both forms.

HISTORY OF MEDICAID MANAGED CARE PRIVATIZATION EFFORTS IN LOUISIANA

The DHH plan for Coordinated Care Networks is the latest iteration of a privatized managed care approach for Medicaid. The administration first proposed a Medicaid Provider Service Network delivery model called Louisiana Health First that was similar to a pilot reform project in Florida. That project ran into numerous problems and while there was controversy around whether to expand it, the new Florida governor decided to implement the program statewide.

The advent of Medicaid privatized managed care was met with approval on Wall Street.

Louisiana Health First ran into stiff opposition from some provider groups, with pediatricians leading the charge. After initial difficulty in gaining support from the Legislature, DHH got legislative approval to apply for a waiver from CMS, the federal agency that administers Medicaid and Medicare, to move the project forward. A waiver was necessary to expand eligibility to 200 percent of the federal poverty level in the pilot region and to allow changes to the amount, duration and scope as defined in federal law. Although DHH was counting on an approval from the outgoing Bush administration, CMS announced that it had no intention of approving a last-minute request, thereby dooming the Louisiana Health First plan.

The state then embarked on the Coordinated Care Network initiative. Changes to the privatization plan have nullified the need for a federal waiver and the state proceeded with an easier to obtain amendment to the Medicaid state plan. Controversy surrounded the manner in which legislative authorization was given to Coordinated Care Networks. The administration's budget proposed during the 2010 legislative session initially included language directing the Department of Health and Hospitals to implement CCNs. This language was removed by legislators during the budget deliberations process and replaced by language that allowed for implementation after detailed studies and plans were approved by the Joint Legislative Committee on the Budget. The original authorization language was put back into the budget in the waning days of the session, embedded in a massive set of amendments. Legislators reported they queried the author of the amendments as to whether all information was "technical" in nature, meaning primarily minor typographical edits or legal details. Legislators reported they were assured the amendments were technical, meaning they did not contain anything substantive or vastly different. This particular amendment outraged some legislators who in the 2011 legislative session introduced a bill that was unanimously passed requiring detailed reports on outcomes and an end to the program in December 2014 if improved outcomes did not materialize. If good performance was found, legislators could vote to continue the program. This bill was subsequently vetoed by the governor. The administration says it has taken public input and received comments from a statewide tour conducted by the DHH secretary in creating the CCN model. Although commendable, this outreach does not substitute for structured legislative input. These early efforts minimizing legislative oversight did not instill confidence that the administration of CCNs was being adequately reviewed by lawmakers.

For enrollees, there is an initial choice of plans. If an enrollee is in a Prepaid plan, he must use providers in that network.

Meanwhile, the advent of Medicaid privatized managed care in Louisiana was being met with overwhelming approval on Wall Street. An investor newsletter celebrated the roll-out of the CCN plan, saying it would put more than 800,000 Medicaid recipients on the market and more than $2 billion a year in revenue up for grabs. That report, published by Citigroup Global Markets, touted the Louisiana plan as "a high-profit opportunity" for investors and "the next big catalyst" for the Medicaid managed care market.

A large coalition of physician and hospital groups was formed early in the process and threatened to derail the CCN proposal. Much of that opposition has been defused. Some of the groups' short-term financial concerns

over the future of Medicaid dollars were alleviated by a new program not directly related to the CCN proposal. The administration established a complex financial mechanism that creates a new revenue source for Medicaid providers. This funding mechanism, utilizing Medicaid's Upper Payment Limit system, is currently approved by CMS; however, as federal Medicaid reimbursement policies shift, this may not be a sustained source of funding for Louisiana.

The administration's initial plan for Coordinated Care Networks had two features to which PAR objected:

- Plans were to allow private insurers to sign up to provide care with a simple certification process that would allow any willing company that met minimum standards to participate in the program.
- The CCN proposal had no enforceable requirements to ensure that companies would spend at least a minimum amount of premiums paid to them by the state Medicaid program on medical care for enrollees. In other states, minimum health care spending is often set at 85 percent of premiums with a provision that if the company spends less than that threshold, it will return to the state the amount of the difference. This threshold is known as the Medical Loss Ratio (MLR).

PAR recommended that these policies be corrected. The certification process was replaced with a more appropriate competitive bidding process, known as request for proposals or applications, to choose companies as contractors. Also, DHH adopted new Medical Loss Ratio rules, although these provisions could be made stricter.

CCN ENROLLMENT

The CCN program is fully titled as "Bayou Health: Your Health Your Choice." It is important to distinguish what specific choices are actually available to enrollees. Enrollees can choose between two types of Coordinated Care Networks that are being served by five different insurance plans. In September 2010, DHH announced plans for Medicaid Coordinated Care Networks, which included the Prepaid model but not the Shared Savings version. Shared Savings was added to the CCN proposal in November 2010 based on feedback from Medicaid providers. DHH officials

Key Elements of Prepaid and Shared Savings Plans

The Prepaid program: (1) The insurer is paid a monthly fee for each Medicaid enrollee it covers. **(2)** The network established by the insurer provides all core benefits and services. **(3)** The network can include providers who will not accept a fee-for-service patient in the CCN -Shared Savings plan but will accept patients in the CCN-Prepaid plan in exchange for higher reimbursement rates. **(4)** The insurer handles authorizations and claims payments.

The Shared Savings program: (1) It is a fee-for-service reimbursement model. **(2)** The provider network for all core services and benefits, except primary care, is the Medicaid fee for service provider network. **(3)** The plans cannot offer expanded benefits such as pain management and other health services not in the Louisiana Medicaid state plan. **(4)** The Medicaid claims payment system, rather than CCN-Shared Savings insurer, will pay providers. **(5)** Savings will vary according to the number of enrollees, with statewide annual savings estimates for 2013 ranging from $11.8 million at a 15 percent enrollment rate to $39.2 million at a 50 percent rate. **(6)** DHH will retain 40 percent of savings generated by a CCN-Shared Savings plan. **(7)** DHH will pay management fees to CCN-Shared Savings plans but if there are no savings then up to 50 percent of the fees may have to be returned to DHH.

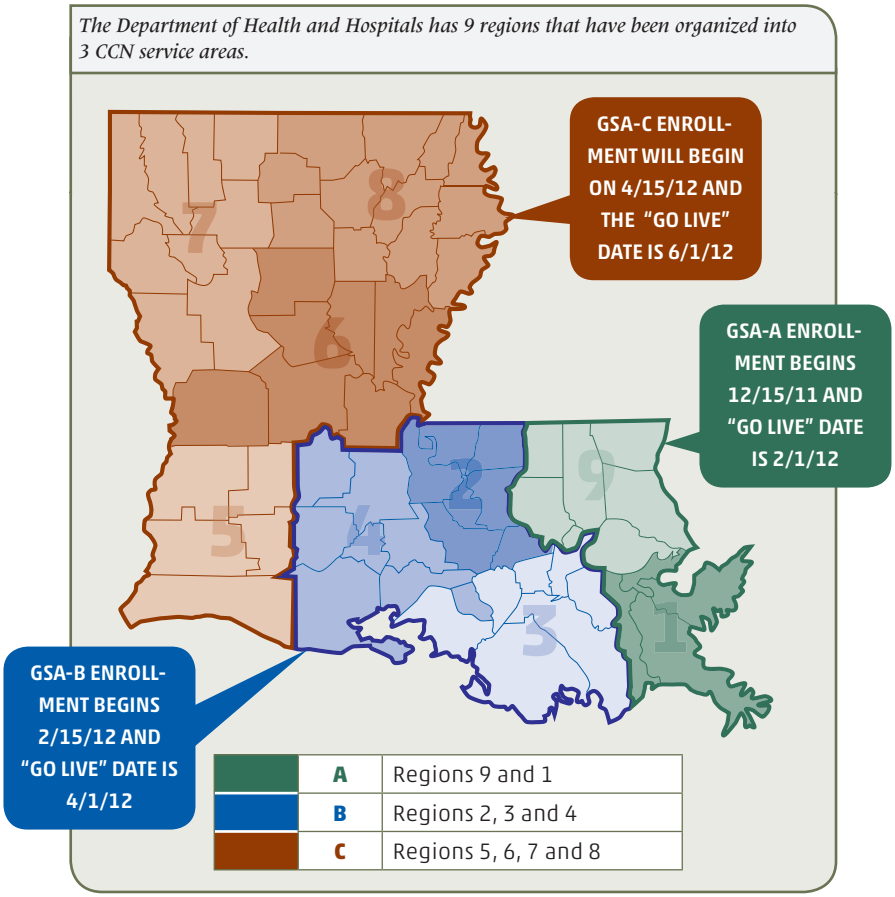
Both plans will provide members with incentives for healthy behaviors and compliance with treatment.

said CCN-Shared Savings would be similar to the North Carolina model and there would be no "big insurance company involved" (Baton Rouge Advocate, November 25, 2010). Providers have pointed out that the CCN-Shared Savings program is different from North Carolina, where physicians (not plans) manage care coordination networks. DHH in July 2011 awarded CCN-Shared Savings contracts to two private health insurers.

A **CCN-Prepaid** plan is a traditional capitated managed care model in which insurance companies establish networks of providers. The companies will receive a monthly fee for each covered enrollee to provide core benefits and services, with prior authorization and claims payment handled directly by the insurer. A **CCN-Shared Savings** plan is an Enhanced Primary Care Case Management plan in which the network receives a monthly per-member fee to provide enhanced care management services, with opportunities for network providers to share in cost savings resulting from coordinating care. In this model, the company approves the health care service payments and the state processes the payments.

Figure 1. CCN Geographic Service Areas

The Department of Health and Hospitals has 9 regions that have been organized into 3 CCN service areas.



The Department of Health and Hospitals has secured five contractors to administer the Coordinated Care Networks. Enrollment in the New Orleans and Northshore regions begins in December, with the remainder of the state conducting enrollment over the next five months.

DHH has awarded the following CCN-Prepaid contracts:

- Louisiana Healthcare Connections Inc. (parent company: Centene)
- Amerihealth Mercy of Louisiana Inc.
- Amerigroup Louisiana Inc.

DHH has awarded the following CCN-Shared Savings contracts:

- UnitedHealthcare of Louisiana Inc.
- Community Health Solutions of America Inc.

Each of the five plans will operate statewide in all three Geographical Service Areas as shown on the map. Statewide potential enrollment totals 892,122, including 847,138 mandatory and 44,984 voluntary enrollees. Enrollees will be contacted and provided information on CCN plans, both Prepaid and Shared Savings. If an enrollee does not select a plan within an allotted period, he or she will be assigned to a plan by DHH. They may change plans during the first 90 days after enrollment. The enrollee may select a primary care physician from a panel of doctors who have contracted with the CCN plan.

Louisiana's Case

Over the past two decades many studies of managed care have been published on every aspect of the delivery systems and how they perform. It is unfortunate that there is disagreement instead of a more unified opinion that would provide guidance for states in their quest for a low-cost, high-performing health care system. It is important to note that the findings relative to Medicaid managed care are decidedly mixed, at best.

To reiterate, there is little debate about the areas needing reform within Medicaid. Clients with chronic diseases need better management to prevent worsening conditions and unnecessary hospitalization and emergency room visits. Oversight of Medicaid spending and administration is essential. More data are needed to coordinate care and examine trends to identify successful treatments. Access to specialists needs to increase. The CCN model is based on the following assumptions: that public health care dollars can be spent with transparency and accountability, quality and outcomes will improve, costs will be reduced and health data will be used to manage care. Each assumption deserves unique attention.

OVERSIGHT AND TRANSPARENCY

Any spending of public dollars requires careful monitoring, auditing and oversight to assure expenditures are appropriate and programmatic outcomes are as intended. Oversight of public health care programs is admittedly complex but essential given the opportunities for fraud and inefficient spending.

As the research will show, other states implementing privatized managed care have learned hard lessons about oversight of costs and outcomes. The consequences have ranged from repayment of millions of dollars to the state from private Medicaid managed care companies to changing regulations to prohibit cherry picking the healthiest patients, to a complete reversal of policy and bringing care management back under state control.

Despite the relatively young history of CCNs in Louisiana, there is already a deficit of adequate oversight from the Legislature. As described earlier, legislators sought stronger oversight in 2011 after their attempts to insert more oversight were removed from a bill in 2010. The bill passed in 2011 was vetoed by the governor and the Legislature did not reconvene for an override. Legislators did, however, allow administrative rules to be promulgated and funded CCNs in the budget bill passed in 2011.

This limited involvement of the legislative branch, combined with troubling practices in other states of misuse of Medicaid privatized managed care, underscores the need for full transparency in all aspects of the implementation of the CCNs. It also highlights the need for a balanced oversight of

programmatic and budgetary aspects of the program from both the executive and legislative branches.

Thirty-one states and the District of Columbia have developed one or more commissions to assist in implementation of the federal Affordable Care Act. Of the total entities established, 18 were created by legislatures and 20 were created by state executive branches, mostly through executive orders issued by governors.

Clearly, most states have opted for an open process to allow the public and stakeholders to participate in implementation of this important federal law. The efforts of two of these states are described below.

The limited involvement of the legislative branch, combined with troubling practices in other states of misuses of Medicaid privatized managed care, underscores the need for full transparency in all aspects of the implementation of the CCNs.

The state of Maryland has created a well-organized approach to the massive problem of implementing federal health care reform. The Maryland Health Care Coordinating Council was formed shortly after passage of federal reform by Executive Order of the Governor with a termination date of Dec. 31, 2015. The council membership consists mainly of key department officials from the executive branch and legislators.

The council has a host of duties, including development of a blueprint for "a well-planned and inclusive implementation of health care reform that is at once both visionary and realistic." The council is directed to maintain an open and transparent process to serve as a vehicle for informing the public, soliciting input and using that input to improve planning and operations.

North Carolina established eight work groups through the North Carolina Institute of Medicine to assist in health care reform activity. The work groups, which are coordinated by an Overall Advisory Group, meet monthly to examine key issues, including prevention, safety net, workforce, health insurance exchange, insurance oversight, Medicaid, new models of care, quality and fraud and abuse. Members include representatives from state government, academia, insurers, provider groups and consumer advocates.

Louisiana could adopt a model similar to these states or a variation to suit this state's diverse needs. While Maryland's overriding interest is a successful implementation of federal reform, Louisiana must handle that as well as a complex, statewide effort to install a new and (to this state) untried Medicaid delivery system. Confronted with two colossal and concurrent tasks, Louisiana would be well advised to establish a single entity to assist with ensuring that all of these critical efforts are successful. Louisiana would benefit from a public and transparent process with participation by the executive and legislative branches as co-equal partners and formal input by experts and stakeholders.

QUALITY AND OUTCOMES

There are many surveys on health outcomes and quality, all utilizing differing populations and various health care delivery systems. While there is some variance in Louisiana's ranking in each survey, Louisiana is all too often near the bottom of the rankings. However, Louisiana fares better in some surveys than others, often because progress has been made in some areas of health care.

In dialogues about Medicaid reform, administration officials normally utilize outcome measures that include the entire Louisiana population, with Louisiana typically ranking low. However, Louisiana ranks high on several measures when looking explicitly at the performance of health care delivery systems. For example, the National Survey on Children's Health from 2007 includes a number of indicators, seven of which are related to delivery systems for child health, rather than several health conditions that have only an indirect relationship to health delivery systems.

Louisiana has demonstrated that outcomes can, in fact, improve with changes in Medicaid policy under the current model of CommunityCARE. Louisiana Medicaid experienced a decrease in hospital emergency room usage after implementing CommunityCARE. Children received more immunizations when a pay for performance initiative was implemented and Louisiana went from 40th to fifth in the nation for immunization of children ages 19 to 35 months (Appendix A). The state more recently has fallen back into the 30th ranking for childhood immunizations.

The best-known annual survey is "America's Health Rankings," which is published by the United Health Foundation. In the United Health Foundation rankings, factors that can be influenced by health care delivery systems account for only about one-third of the total score for a state. Those include lack of health insurance, immunization coverage, early prenatal care, supply of primary care physicians and preventable hospitalizations. Like most other surveys, this one is geared toward measuring the effectiveness of disease prevention, rather than disease treatment. Until we have surveys that evaluate and compare the performance of individual delivery systems (Medicare, Medicaid, private insurance), it will be difficult to profoundly change the total health scores for a state. Quality measures such as HEDIS (Healthcare Effectiveness Data and Information Set) are a step in the right direction but have only been adopted by about half of the managed care plans.

Population-wide measures reveal much about poverty, obesity and other factors that contribute to poor health outcomes, but they reflect very little about the effectiveness of the state's Medicaid program. Administration officials argue that it is appropriate to use the population-wide measures as a baseline because changing the outcomes for the 900,000 Medicaid enrollees

will affect overall population health measures. Improving Louisiana's low ranking on national surveys that compare states according to population-wide health statistics would require a much broader campaign to improve all delivery systems, including the private market, Medicare and the uninsured, as well as Medicaid.

COST

What is the current spending on Medicaid and how might this change under the CCN model?

Medicaid programs in all 50 states comprise a substantial share of each state budget. Since Medicaid started in 1965, the program has grown due to inflation, the addition by Congress of new programs and in part because the cost of private insurance has risen much faster than family and individual income. This trend has rendered private plans unaffordable for more of the population. Compared to other state health systems, Louisiana Medicaid appears to be one of the more cost-effective programs in the nation, albeit still a large part of the state budget. Mathematica Policy Research in 2010 found that Louisiana was among 13 states that had low costs in Medicaid and high quality scores on health care indicators for children (Appendix B).

In contrast, private insurance premium costs are increasing rapidly in Louisiana although they dipped slightly after 2009. This is important not only because unaffordable private insurance could potentially increase Medicaid enrollment, but it also hints at the potential costs of privatizing Medicaid managed care. Louisiana private insurance premiums for families have increased by 51percent since 2003 and now account for one-fifth of family incomes (Appendix A). The CCN contracts will maintain rates paid by the state for three years and will be renegotiated at that point. Rapidly rising premiums in the private market may lead CCN plans in a pursuit for rate increases that Louisiana can ill afford.

Medicaid has grown in terms of who is covered and the type of services covered. For example, most of the institutional care and much of the home care for the elderly, as well as care for persons with developmental disabilities and mental illness, is now paid by Medicaid. Many of those services and beneficiaries were not eligible in 1965. Spending for these groups alone occupies 71 percent of the Louisiana Medicaid budget but only 28 percent of program enrollment.

The CCN model is based on the premise that health care expenses such as unnecessary emergency room visits and inpatient care will decrease, and savings will be redirected into enrollee education, data infrastructure and disease management, as well as yielding a profit margin. In theory, this makes sense. Better care reduces costs, yielding new savings to invest in

data infrastructure, patient education and care management. In the non-privatized model, up-front investments must be made in such efforts and the subsequent cost savings are returned to the program for reinvestment. Compared to the state, the private sector does bring the ability to invest cash in such improvements up-front and quickly implement a data infrastructure. In turn, there is a risk that the state will not own the data infrastructure and will become administratively dependent on plans, making it harder to terminate contractors if problems arise.

Health care cost measures can be sliced and diced many different ways. In terms of average spending per child in Medicaid, Table 1 demonstrates that Louisiana Medicaid is not a high-spending program, ranking 48th in the nation. Louisiana spent $1,687 per child vs. the national average of $2,171 per child in 2008. It is important to note that despite low spending per child, Louisiana was categorized by Mathematica as a state that has low Medicaid spending per enrollee and higher than median quality scores (Appendix B). A key aspect of the CCN program is that Louisiana, like most other states with managed care, is enrolling mostly low-cost patients: children, healthy adults , pregnant women, and adults ages 65 and older. Higher cost enrollees are not included at this time. The challenge to private management will be to find ways to lower an already low cost per enrollee. These facts raise questions about how much money a privatized managed care system might save. Actuarial estimates suggest a savings of around 3.5 percent, which is

Table 1. Medicaid Enrollment and Spending 2008*

Children represent the largest group within Medicaid enrollment. Comparatively speaking, Louisiana is a low spender per Medicaid enrollee, especially for children and the elderly.

Enrollment	U.S.	Louisiana	LA Rank
Children	29,239,700	601,300	15
Adults	15,023,300	182,500	19
Elderly	6,034,800	110,700	16
Disabled	9,171,000	203,100	14
Total	59,468,700	1,097,700	15

Average Spending per Enrollee	U.S.	Louisiana	LA Rank
Children	$2,171	$1,687	48
Adults	$2,646	$2,942	34
Elderly	$12,950	$8,720	46
Disabled	$14,865	$12,872	39
Total	$5,342	$4,675	41

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

Source: Kaiser State Health Facts

Table 2. Medicaid Spending per Child in 16 Southern States FY 2008

Children are a large segment of Louisiana Medicaid enrollment but spending per child is among the lowest in the nation.

State	Children Covered	Average Payment per Child	US Rank in Medicaid Spending per child	Children as % of Medicaid Enrollment	Rank in Children as a Percent of Medicaid Enrollment
Missouri	566,300	$3,046	7	55%	17
Maryland	395,600	$2,643	13	51%	27
Texas	2,716,300	$2,601	14	64%	2
North Carolina	900,000	$2,531	15	53%	25
Kentucky	398,000	$2,495	19	47%	39
Virginia	481,700	$2,279	26	54%	21
West Virginia	191,200	$2,246	27	48%	36
Oklahoma	440,200	$2,245	28	59%	10
Alabama	439,900	$2,177	30	48%	36
Tennessee	729,900	$2,160	31	49%	34
South Carolina	440,800	$2,099	35	51%	27
Mississippi	368,000	$1,972	38	50%	31
Arkansas	378,400	$1,948	41	54%	21
Georgia	979,200	$1,837	46	58%	11
Florida	1,525,400	$1,787	47	50%	31
Louisiana	**601,300**	**$1,687**	**48**	**55%**	**17**
United States	29,239,700	$2,171		49%	

Source: Kaiser State Health Facts
Duplicate rankings are due to equal rounded percentage values.

lower than most other states and lends credence to the view that savings will be limited.

In the past, some private managed care organizations have attempted to increase their profit margin by reducing needed patient care. In 2011 the Robert Wood Johnson Foundation funded a study conducted by Johns Hopkins University faculty that found that neither commercial nor Medicaid Managed Care Organizations (MCOs) caused significant decreases in costs or improvements in access to care for the period 1996 to 2002. The managed care model was constructed on the premise that fee-for-service medical care provided an incentive for providers to increase the volume of services beyond what was required for patient care in order to increase profits. The remedy was to establish an actuarially determined capitated rate to be paid to insurers who would maintain a proper level of medical care for patients. In some cases insurers reduced the volume of services below what was required for patient care in order

Louisiana is not a high-spending Medicaid program measured by spending per child, which ranks the state as 48th in the nation. The challenge to private management will be to find ways to lower an already low cost per enrollee.

to increase profits. Clearly, an improved reimbursement methodology is needed and many are being tested. In the meantime, the level of accounting, quality assurance, monitoring and fraud detection will continue to need substantial investments to assure proper oversight.

A Wall Street Journal article published in March 2008 indicated that such fraud is a very serious concern, although many states had turned to Medicaid managed care on the assumption that fraud would be significantly reduced. Many of those states reduced the numbers of fraud investigators on staff because they thought there would be less fraud but subsequently staffed up to prior levels. For example, in 2008 the U.S. Department of Justice announced that Amerigroup Corp. (a top five company for Medicaid managed care) agreed to pay $225 million to resolve claims that it defrauded the Illinois Medicaid program by withholding services from pregnant women and unhealthy patients in its managed care program in Illinois.

ESTIMATED SAVINGS FOR LOUISIANA

The success or failure of any transition from a state-operated managed care program will depend in large part on the accuracy of actuarial studies that attempt to quantify risk by estimating the cost of care to be provided by the new delivery model for various segments of the population. Those estimates are then measured against other unknown variables, such as the projected cost of care that would be incurred if the current delivery model were to continue in operation. Typically, savings are projected that would be adequate to ensure a comfortable margin so that a state Medicaid agency can have a predictable budget without shortfalls and contractors can receive an expected profit.

Mercer Consulting, a private consulting group, was hired by the Department of Health and Hospitals to project savings based on various scenarios for the Coordinated Care Network program for years 2012 to 2017. Mercer projected that Louisiana would save around 2 percent to 3 percent annually compared to the expenditures for the current Medicaid model.

An August 2011 report from the Louisiana Legislative Auditor compared Louisiana's projected 3 percent savings to similar Medicaid managed care initiatives in other states. Actual cost savings in five states were reported as follows:

- North Carolina, 2003 to 2007 – 6 percent to 11 percent
- Arizona, 1983 to 1993 – 7 percent
- Michigan, 2001 to 2004 – 9 percent to 19 percent
- Kentucky, 1999 to 2003 – 3 percent to 10 percent
- South Carolina, 2009 – 8 percent

It is important to note that the following analyses offer different estimates of savings and costs based on varying assumptions of rates of enrollment in the Prepaid and Shared Savings plans and state administrative costs. These varying assumptions lead to cost savings estimates ranging from $55 million to $136 million. Mercer's projections anticipate cost savings to grow after statewide enrollment and program implementation are completed in 2012. Nonetheless, Mercer's initial projected savings in Louisiana were smaller than actual cost savings found in other states.

The actuarial projections made by Mercer Consulting are different than those used by DHH before and during the 2011 legislative session. The savings figure used by the secretary of DHH, the commissioner of administration and the governor indicated a savings of $135 million for the first full year (FY 2012-13) of CCN operations. For the same time period Mercer projects a savings of $54.8 million. Table 3 shows both sets of estimates for the first three years of CCN operations. Both estimates assume that equal proportions of enrollees would sign up for both plan types (CCN Prepaid and CCN Shared Savings). The $99.5 million DHH estimate for FY 2011-12 reflects start-up costs for the CCN program.

The disparity between those savings estimates and the actuarial projection produced by Mercer in January 2011 can be attributed to a difference in methodology. DHH explains that it calculated its estimates, including the $135.9 million figure, using a budget reconciliation approach rather than the actuarial process employed by Mercer. While the DHH estimates reflect the impact on the budget, Mercer indicates that its projections "represent the level of change the state and its contracted vendors will need to generate in order for the programs to meet the state's financial targets."

Table 3. Estimates of CCN Savings (-) or Added Costs (+) in $ Millions

DHH estimates that the CCN program will cost $99 million in the first year and yield nearly $136 million in savings in FY 2012-2013. These estimates vary from those provided by Mercer Consulting.

	Mercer Estimate	DHH Estimate
FY 2011-12	-$16.9 million	+$99.5 million
FY 2012-13	-$54.8 million	-$135.9 million
FY 2013-14	-$60.4 million	-$16.3 million

Note: Both sets of estimates assume 50 percent of enrollees will choose Prepaid plans and 50 percent will chose Shared Savings plans.

It is troubling that the margin of savings is thin next year and well into the future. Mercer projections show a savings of 2.5 percent or $55 million, in FY 2012-13 (first full year of operation) and also show a savings of 2.5 percent, or $81 million, in FY 2016-17. Because Louisiana is near the bottom of national rankings in spending per Medicaid enrollee, medical care spending on that population will now have to be significantly reduced in order

to show 2.5 percent savings while incurring new expenses for contractors' administrative costs and profits that total 12 percent or more.

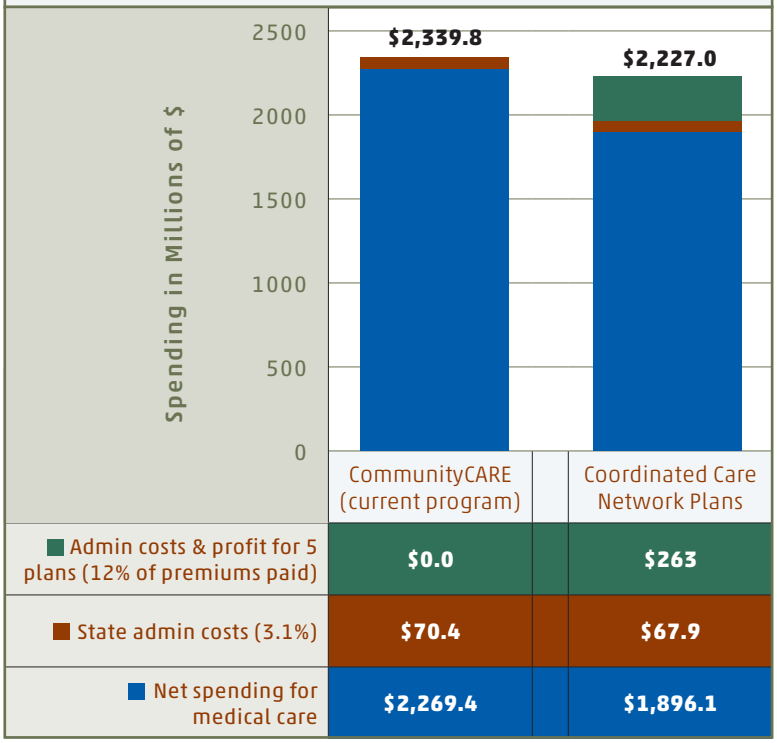
After analyzing the financial outlook, the largest insurance carrier in Louisiana opted not to participate in the CCN program. Blue Cross Blue Shield of Louisiana notified Louisiana officials in May 2011 that the program was "not feasible" for the company, according to its actuaries. This assessment creates further concern about the profitability of CCNs for private companies, and hence concerns about the long-term projections that the program will offer savings for the state.

WHERE WOULD SAVINGS ACTUALLY COME FROM?

Actuarial projections are summarized in Chart 1 for the proposed Coordinated Care Networks to replace the state-operated managed care model of CommunityCARE.

Chart 1. FY 2012-13 CCN plans add $263 million in administrative costs and profit but reduce spending on medical care by $373 million

Amounts shown in millions of dollars. State administrative costs reflect proportionate share of expenses paid through the Medicaid administration budget but do not include new contracts for CCN operations.



Source: Department of Health and Hospitals data. These estimates assume an 85 percent enrollment in the Prepaid plan and a 15 percent enrollment in the Shared Savings plan.

These estimates assume a 12 percent administrative and profit for the five plans, although plans can actually receive up to 15 percent.

The consequences of reducing costs in an already low spending area should be closely monitored to assure that access to medical care or timely treatment is not impaired.

Chart 1 shows that while overall spending is anticipated to be 5 percent less than it would have been under CommunityCARE, spending on actual medical care is anticipated to be $373 million, or 16 percent, in the first full year of operation (FY 2012-13). The chart combines Prepaid and Shared Savings plans for the purpose of comparing overall CCN spending, administrative costs and profit to CommunityCARE spending and administrative costs. The chart shows combined CCN administrative costs and profit at 12 percent. DHH expects that CCN plans will generate sufficient reductions in spending to cover expenses, profits for plans and savings for the state.

Of particular interest in Chart 1 is the red bar depicting that the state administrative costs will remain at 3.1 percent under the CCN model, the same as under the existing model. The chart adds this to an estimated 12 percent kept by companies for administrative costs and profit, resulting in an overall increase in administrative costs for Medicaid. According to DHH rules, Prepaid plans are allowed to earn administrative costs and profits totaling 15 percent, although the chart estimates 12 percent.

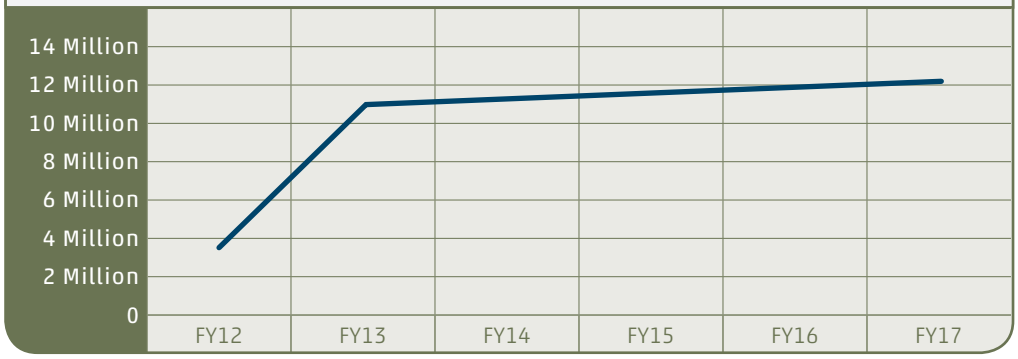
As described earlier, reduced health care spending might be easily achieved if Louisiana Medicaid were a high-spending program but that is not the case. Louisiana ranks in the bottom quintile of states in most cases when comparing the amounts expended per enrollee. Children, for example, make up three-fourths of the 900,000 CCN enrollees. Average annual payment per child is 78 percent of the national average. Spending on adults exceeds the national average by a small amount but they are a small component of the target population. It is critical that the consequences of reducing costs in an already low spending area are closely monitored to assure that access to medical care or timely treatment is not impaired.

WILL SAVINGS INCREASE AS MORE PEOPLE ENROLL?

Figures 2 and 3 show the anticipated enrollment pattern and savings for the Coordinated Care Networks through 2017. Enrollment will predictably increase in early 2012 during program implementation and then slightly inch up through 2017. According to Figure 3, the variance between CCN and CommunityCARE projections remains very small through 2017. This is critical for policy leaders to be aware of, given the experiences in other states that costs actually come in higher than initially anticipated. The projected savings are mapped out in Figure 3, essentially indicating that savings will

Figure 2. Projected Member Months of CCN Enrollee Participation

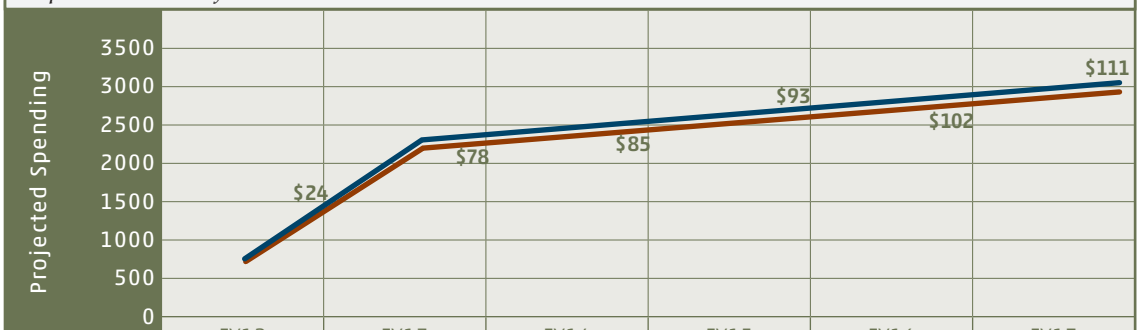
Projected enrollment will surge during statewide implementation in 2012. Each month an enrollee participates counts as a member month.



Source: Mercer Consulting Actuarial Studies for the CCN Program, January 2011.

Figure 3. Projected Cost for Coordinated Care Networks Compared to Equivalent Cost for Current System ($ millions)

CCNs are projected to spend less than the current system, ranging from $24 million less in 2012 to $111 million less in 2017 compared to Community Care.



	FY12	FY13	FY14	FY15	FY16	FY17
Comm CARE	$718	$2269	$2433	$2611	$2805	$3015
CCNs	$694	$2191	$2348	$2518	$2703	$2904

Source: Mercer Consulting Actuarial Studies for the CCN Program, January 2011. Chart shows actuarial projections of total dollars spent for CommunityCARE and CCN systems and the difference between the two. Actuarial projections of true savings are calculated differently to account for retention of 60 percent savings generated by CCN Shared Savings plans. Projected savings for each fiscal year would be slightly less than the spending gap numbers listed above. Calculations by Mercer Consulting based on assumptions that 85 percent of enrollees will choose Prepaid plans and 15 percent will choose Shared Savings plans. Other scenarios that assume higher percentages for Shared Savings produce lower amounts of total savings.

remain fairly modest, at 2 percent to 3 percent through 2017. These figures do not consider the impact of the Affordable Care Act.

In sum, it is a fair concern that Louisiana could quickly face demands for increases in fees or administrative costs or threats to abandon the program by the private insurers after full statewide implementation, similar to what some other states experienced. Ideally, these concerns would have convinced policymakers to proceed deliberately, with a pilot demonstrating strong evidence before going statewide to assure cost and quality assumptions were met. However, at this juncture, these data should alert policymakers of the need for close monitoring of implementation and the potential for mid-course correction.

DATA AND INFORMATION

Accurate and consistent data in a health care system are critical to review quality, outcomes and efficiency of care, while protecting individual patient privacy rights. Currently, "transactional data" are the main data available for analysis, such as the numbers of a certain medical procedure, hospitalizations, etc. Some say these data are limited in usefulness and that more robust, comprehensive data on care and outcomes are needed to fully assess the efficiency of health care.

The Department of Health and Hospitals has established a Louisiana Medicaid Electronic Health Record (EHR) Incentive Payment Program. The program is designed to enhance care coordination and patient safety, reduce paperwork, improve efficiency and establish faster, more effective lines of communication between providers and payers. It would allow the exchange of health information to authorized users through state Health Information Exchanges (HIEs) and the National Health Information Network (NHIN). The Louisiana Health Care Quality Forum is also working on this issue.

Health care providers are being urged to register for the Incentive Payment Program with the Centers for Medicare and Medicaid and then with Louisiana Medicaid in order to receive incentive payments. Providers authorized to receive such payments include eligible doctors, hospitals and Critical Access Hospitals. These providers must meet certain standards for using EHR technology for a requisite time period.

Eligible providers may receive up to $63,750 in incentive payments over six years under the program. Providers must enroll by 2016, but payments will be reduced for providers who register in 2014 or later.

THE ROLE OF COORDINATED CARE NETWORKS IN THE STATEWIDE INFORMATION EXCHANGE.

The rules for incentive payments do not reference Coordinated Care Networks, although CCNs would appear to be an important link in any statewide information system. According to the Prepaid Plan Q&A on the Making

Medicaid Better website, CCNs will have a presence in helping to establish a viable health information exchange system in Louisiana:

"The CCN shall participate in a statewide effort to link all hospitals, physicians, and other providers' information into a data warehouse that shall include, but not be limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each CCN."

This references an all payer statewide Health Information Exchange. CCNs will be expected to participate in any statewide efforts to incorporate all hospital, physician and other provider information into a statewide health information exchange and will have the opportunity for input. Electronic Health Records are an important component of achieving National Committee for Quality Assurance certified medical home status and CCNs are expected to provide assistance to their contractors in attaining certification. Additionally, CCNs can provide technical assistance to their providers in qualifying for American Recovery and Reinvestment Act Medicaid Electronic Health Record incentive payments.

CCNs, though playing an important role in helping to establish the Health Information Exchange system, do not have direct responsibility for the success of that system.

It appears that CCNs, though playing an important role in helping to establish the Health Information Exchange system, do not have direct responsibility for the success of that system. Although each CCN plan can assist providers in achieving EHR status and certification from the National Committee for Quality Assurance, direct responsibility lies with the providers. It would seem, therefore, that the push for an electronic system in Louisiana is mostly dependent on the state agency and individual providers, with CCNs being an important presence in helping to move the effort forward. Questions that remain unanswered include whether there will be a standardized approach to the assistance offered by each CCN; whether the CCNs will expect compensation for the assistance provided; and whether DHH will expect CCNs to use the new system to furnish more complete information to the Medicaid program than has been the case in many other states.

Medicaid Managed Care Experiences in Other States

Several other states recently have conducted re-evaluations or made significant changes to their Medicaid managed care programs. DHH reports that it has integrated some lessons learned from other states into Louisiana's CCN contracts, such as not allowing contractors to terminate enrollees or "cherry pick" the healthiest patients. DHH has required that CCNs must have a transition plan for each carrier to prevent disruptions to the clients and avoid problems experienced in other states. Some states have continued to use a privatized managed care model with success, while others have faced significant problems. While many examples in the public dialogue about this model have highlighted the successes, it is important to examine those states that have not found success or that have utilized a different model.

FLORIDA

The Florida Medicaid program is of particular interest because the architects of its pilot managed care project also designed Louisiana's first foray into privatized Medicaid managed care. In Florida, four counties piloted the program which, in the end, failed to prove that money was saved or that access or quality was improved compared to fee-for-service. WellCare, a Tampa-based HMO company, dropped out in year two (2009) of the pilot project complaining it was "economically unfeasible" to continue to participate. The company continued to operate as a plan in the regular Medicaid program but its executives were indicted in 2009 for allegedly withholding $40 million that should have been returned to the state (and eventually settled with the DOJ and paid a fine).

There is no clear evidence that the Florida pilot program is saving money or, if it is, whether it is through efficiencies or at the expense of needed care.

Also, private plan companies that were unsatisfied with the payment rates walked out and their patients had to be assigned into the remaining plans. There was widespread dissatisfaction with the project from patients and advocates because accessing care was often difficult. Advocates of the program have continued to push for its expansion and Florida's new governor has decided to take the pilot statewide.

There are programmatic differences between the CCN model and the Florida reform pilot. The CCN proposal is much more ambitious than either Louisiana Health First or the Florida pilot and is planned to be operational by mid-2012. Enrollment will begin on Dec. 15 and will be completed within five months. That is an aggressive pace compared to what other states are doing. Florida, for example, will take almost two years to enroll its Medicaid population.

Many evaluation reports have been issued on the Florida effort. These are detailed in an appendix to this report. Thus far, there is no clear evidence that the pilot program is saving money or, if it is, whether it was through efficiencies or at the expense of needed care. Little data are available to determine whether access to care has improved or worsened under the pilot program.

A January 2011 evaluation of the Florida program highlighted the benefits of Medicaid managed care but contained almost no comparative data. The report was published in the Journal of Public Health Management Practice and the three authors were faculty members at the Department of Health Services Research, Management and Policy, at the University of Florida who at the time held the contract for Medicaid reform evaluation. The authors noted that "successful implementation" can be defined two ways: (1) consequences of program action or (2) the extent to which the designer's plans are fulfilled. They further state that due to an absence of data on the reform project, the report was to focus on the extent to which the designer's plans were completed. The report concludes that "it is too soon to assess the consequences of this implementation on cost, quality, and access to care within Florida's Medicaid program."

A further caveat in that report is more telling: "Although all of the participating managed care programs are required to begin reporting experience data that can provide some insight on beneficiary health behaviors and status, the collection of this data has proved difficult for the state. Furthermore, the quality of the reported data might not be completely uniform among plans. In addition, the number of plans joining and leaving Medicaid Reform makes data analysis challenging. Finally, the cycling of Medicaid beneficiaries on and off of Medicaid will make any improvements of health status as a result of Reform programs difficult to measure."

NORTH CAROLINA

Community Care of North Carolina (CCNC) is an Enhanced Primary Care Case Management (E-PCCM) system similar to Louisiana's current system, only more advanced in terms of coordination of care. North Carolina contracts with community networks, whereas Louisiana contracts with individual primary care providers.

It was started in 1998 in three of the 14 state regions but has grown since then to statewide with almost a million enrolled. The feature that makes it unique is its decentralized structure. Instead of a top-down approach like most state Medicaid agencies, CCNC has a relatively small state staff, reportedly only about 20 full-time staffers for clinical, data and program personnel. More robust staffing is found at the regional level where most of the care management activity occurs.

Local control is seen as a major key to success. The broad medical community participates in the network and the collaboration fosters creativity and ownership. Each network has considerable freedom to implement programs and set priorities. The statewide structure enables initiatives piloted in one of the networks to be implemented on a statewide basis if it has proved to be successful locally. The state office also provides support services, including data analysis, recruitment, etc.

North Carolina Community Care - Enhanced PCCM

- 945,000 enrollees
- Decentralized program has 14 local networks to provide primary care, care coordination and care management.
- Physician-led networks include primary care physician (PCP) and medical home, hospitals and other providers.
- Local networks hire case managers to assist physician practices with care coordination.
- The typical network has 60,000 enrollees. The state pays $3 per member per month, or about $2.1 million per year, to fund case managers and other resources.
- CCNC has 14 networks covering the 14 regions in North Carolina, 3,500 primary care physicians and 1,200 medical homes.
- Annual savings to state about $120 million per year.

ALABAMA

In a March 2011 press release, Alabama Medicaid announced that a pilot project would begin in mid-2011 in 12 counties to test a Patient Care Network system. Alabama has operated a Primary Care Case Management (PCCM) system since the late 1990s similar to the Louisiana CommunityCARE program. The pilot project will introduce an Enhanced PCCM program modeled in part after North Carolina.

"Alabama Medicaid's care networks are set up to function as 'medical neighborhoods' in which doctors, pharmacists and others work cooperatively to coordinate care for patients," said Dr. Robert Moon, Medicaid medical director and deputy commissioner for health systems. According to the press release, Moon "explained that care networks are specifically designed to ensure that patients gain access to specialists, tests or services they need, to encourage consumers to have greater involvement in their care, facilitate communication across settings and providers, and ultimately result in patient care that is less fragmented and more holistic."

The plan to move to an enhanced PCCM system was undertaken after careful study of Community Care of North Carolina, the most successful example of this type of managed care.

CONNECTICUT

The state of Connecticut announced in February 2011 that it would abandon its current system run by for-profit managed care organizations and transfer 600,000 Medicaid clients to an Enhanced Primary Care Case Management program, which would provide medical homes with care coordinated by their providers. Lt. Gov. Nancy Wyman said under the new system, the state would assume the risk of paying medical claims, but it would now know what it is paying for. With 600,000 people in

a network, there would be more predictability and accountability. The MCO contracts are costing the state $863.6 million this year.

"We were not getting what we wanted in terms of coordinated care with the MCOs (managed care organizations)," said Wyman, who added there was little transparency in terms of profits and administrative overhead, and generally the use of MCOs has not saved money over the last decade.

OKLAHOMA

In the late 1990s, the Oklahoma Health Care Authority had established two separate programs for Medicaid care delivery; a capitated private Managed Care Organization (MCO) model operational in three urban areas and a partially capitated state-run PCCM model in rural areas. Oklahoma in 1999 elected to enroll a portion of its high-cost population — the aged, blind and disabled — as a cost-control measure. This proved to be difficult for private capitated plans in urban areas that found it more expensive to care for this group than they had anticipated and they began to demand higher rates.

The state-run PCCM model seemed more able to handle the new caseload and indeed a 2003 evaluation indicated that the state-run PCCM model was performing better than the private capitated MCOs. After several private MCOs dropped out and the remaining ones demanded higher rates, officials decided to expand the state-run PCCM model to the urban areas at one-fourth of the private MCO cost and staff.

In Connecticut, the use of privatized managed care has not saved money over the past decade.

After abandoning the private MCO model, the state improved its state-run PCCM program with new initiatives such as nurse care management, a health management program and a patient-centered medical home.

After abandoning the private managed care model, Oklahoma improved its state-run program with new initiatives.

Recommendations

The Legislature must assert its rightful and constitutional authority for oversight of new programs administered by the Department of Health and Hospitals. DHH is embarking on an initiative that will transfer to private contractors responsibility for more than $2 billion in vital health care services for 900,000 Medicaid enrollees. Actuarial estimates range from 2.5 percent to 3.5 percent savings annually (depending on how enrollment is divided between Prepaid and Shared Savings plans) for fiscal years 2013 through 2017, a low savings rate compared to other states.

Making the privatized Medicaid managed care equation work in any given state starts with an assumption that there is sufficient waste or fraud in a state Medicaid program to allow major reductions in services or rates paid to providers without depriving patients of needed care or forcing providers to drop out of the program.

Under the most favorable assumptions for Louisiana, cuts in spending for medical care for the Medicaid population will total $373 million, or 16 percent in 2013. Most of those savings will be used to pay the five CCN plans for the annual costs of administration and profits, which will total approximately $263 million in 2013. In order to assure that these funds are properly managed, the Legislature must exercise its oversight role as outlined in the 1974 Louisiana Constitution. Louisiana.gov, the website of state government, succinctly describes legislative duty and authority on these matters as follows:

> The appropriation of funds to finance programs and functions of state government is a power vested solely in the legislature. Another major legislative power is oversight of implementation and administration of state programs by executive branch agencies. Legislative rules continue to be effective even when the Legislature is not in session and standing committees of the Legislature have authority to conduct studies and hearings during the interim between sessions.

The Legislature exercises this oversight authority on an ongoing basis using its standing committees and, if necessary, can subpoena witnesses for testimony and production of documents or other evidence. The case at hand calls for a more deliberate focus on a single area.

In prior publications, PAR recommended that the Legislature delay implementation of Coordinated Care Networks to undertake a detailed review of various Medicaid managed care delivery systems, including the CCN proposal being advanced by DHH. Given the shifting actuary estimates and minimal legislative authority and oversight, it is important for leaders who will ideally monitor the performance of the Coordinated Care Networks to be aware that several effective models for managing Medicaid spending exist, in addition to the model being implemented in Louisiana.

DHH is to be commended for building upon lessons learned in other states; however, one must assume Louisiana will also have lessons of its own that cannot be foreseen. A pilot effort would have identified problems earlier. The rushed statewide implementation does not allow for much mid-course correction of certain unanticipated problems. The Department of Health and Hospitals is proceeding with full implementation of a privatized Medicaid model. After reviewing lessons learned in other states, hearing from key stakeholders and examining the assumptions the CCN model is based on, PAR makes the following recommendations:

1 The Legislature should assert its authority and take the lead in providing oversight of this program, including establishing a special committee or commission to provide oversight and verification of program implementation.

In the past, the Legislature has established special committees to investigate and monitor government operations for a specific purpose. In similar fashion, the Legislature could establish a select or special committee, or commission on oversight of health care reform with bipartisan membership from the House and Senate and preferably other participants as well.

While some may criticize a recommendation to create a new committee or commission, the reality is that public health care as we know it is amidst historic change with little focused oversight separate from DHH. This committee should carry out oversight of Coordinated Care Network activities and should also be engaged in close scrutiny of national health care reform implementation in accordance with the federal Affordable Care Act. Both Coordinated Care Network and Affordable Care Act activities will happen concurrently and will affect each other in numerous ways.

While the committee or commission would lack power to direct DHH to alter the program or the implementation schedule, it could still have the power granted by the Constitution to subpoena records and witnesses from DHH or other agencies, as well as the contract health plans. Public meetings should be held frequently, but not less often than bi-monthly, to review Coordinated Care Networks and Affordable Care Act implementation activity, including problem areas and other relevant issues that would help to assure transparency and credibility in the process of transforming the Medicaid system in Louisiana.

Additional members could serve on the commission or in workgroup subcommittees. These members could include state agency representatives, providers, consumer advocates, former lawmakers and academics. The mission of the committee would be to organize and manage an open process to help guide the state through the period of adaptation to new state and federal health reforms. This would also provide a forum for collecting and analyzing information separately from the department and seeking independent verification of the program's impact.

This would follow the example of several states that have opted for transparency and open debate on decisions affecting vital services for their citizens (See section on Oversight and Transparency in this report). The committee would be advisory in nature and would provide recommendations to the Legislature and the governor.

The Legislature should continue to employ other mechanisms already at its disposal for monitoring the implementation and performance of privatized Medicaid managed care by utilizing the Health and Welfare committees and the appropriations process. Committees dealing with budgetary matters, for example, will surely need to have in-depth discussions about financing of the Coordinated Care Network plans. The Legislature should carefully watch the costs, care and outcomes associated with this policy shift. The Department of Health and Hospitals has committed that this policy shift can produce better outcomes statewide while private providers make a profit. However, if savings are insufficient to fund profit and administrative costs for plans, the state's options may be limited. Plans could demand higher premiums or threaten to abandon the program as has happened in other states. Despite the governor's veto of Senate Bill 207, which would have provided a measure of legislative oversight of the CCN program, the Legislature need not be deprived of its rightful role in monitoring the progress of Bayou Health.

The goal of a commission on oversight of health care reform would be to verify the impact of the reforms. It would also provide recommendations to the Legislature and the governor.

The select committee or commission should engage advisers who are wholly independent with national reputations as experts on Medicaid, in addition to support from legislative staff, the Legislative Auditor's Office and the Legislative Fiscal Office. In its oversight capacity, the commission will want an impartial expert to analyze and report on complex issues.

2 DHH should ensure that the state maintains the authority and control of systems and processes and that all private managed care companies operate in a transparent manner. Companies should be held to the same standards as state agencies in terms of public records related to the Bayou Health contracts.

Patients or providers in need of information regarding treatment, payment or other issues should have the ability to make a public records request to the plan and receive the requested document within an established time frame. Obviously, patient information must be protected. But it is critical that enrollees and providers have access to information about plan coverage, treatment options, etc. Provisions guaranteeing such access should be included in every contract with an insurance plan, as well as in administrative rules.

Early indications do not bode well for full transparency. Companies that were not awarded CCN contracts had to go to court to see the winning proposals. The court made a ruling that supported transparency and the

release of the proposal documents. The state health agency took a position supporting transparency but in the future DHH should lead the charge to demand the most transparency in all aspects of this program so basic information requests do not require litigation.

3 DHH should adhere to the federal definitions of "medical care" and "administrative costs."

Managed care plans can appeal to DHH to redefine certain administrative costs as medical care expenses to meet new Medical Loss Ratio requirements, including "quality improvement activities," which could allow redefinition of an administrative cost as a medical service while adding no dollars to spending for medical care. This is an area for potential abuse and strict oversight is needed by both DHH and legislative oversight bodies. Medical Loss Ratio definitions are referenced as federal definitions at 45 CFR Part158 (the code of federal regulations) and rules have been provided to CCN plans. DHH should remain vigilant that any redefinitions are transparent and in the best interest of citizens. Given the shrinkage in projected savings, if CCN plans do not see anticipated profits or they experience unexpected costs, they may seek relief through creative redefinition practices.

4 The Legislative Auditor should monitor the impact and effectiveness of the Coordinated Care Networks and be given access to information to perform its analysis and report its findings to the Legislature.

The Legislature and the public deserve reliable and objective analysis of the CCN initiative and its financial impact on the state and Medicaid coverage. This point is particularly salient because the administration has staked its reputation for health care reform on the success of this program. Independent verification of the program's impact and its performance measures would be a vital tool for the Legislature in its oversight role as well as a necessary component of a fair and productive public discussion of the issues.

The Legislative Auditor is a fiscal adviser to the Legislature in addition to its role as auditor of state agencies. The Auditor recently published a report on the CCN program that helped shed light on the estimated financial impact of the initiative and revealed important information that had not been released previously by the Department of Health and Hospitals. The Legislature should encourage and support the Auditor's continued examination of CCNs and welcome frequent reports on the program's progress.

As a vital part of that support, the Legislature must ensure that the Auditor is able to obtain the information and documents it needs to perform a thorough and balanced analysis. For example, the Auditor should have access to reports by private consulting firms hired by DHH to study the CCN program.

So far there has been no news of the Auditor being denied documents related to the CCN program, but legislators have raised legitimate concerns about lack of access to administration documents on other policy matters. PAR urges the administration to uphold transparency in practice and spirit in an effort to keep the Legislature truly informed on the CCN program. If left unsatisfied, the Legislature could place pressure on the administration, use its subpoena power or make changes in statute if necessary to ensure the right of the Auditor to obtain pertinent information.

Conclusion

Louisiana's new Medicaid system – Bayou Health – is scheduled for statewide implementation over the next seven months. PAR strongly encourages Medicaid recipients – especially eligible families with children – to learn about their options under the new Bayou Health program and to select a plan best suited to their needs. Bayou Health has the best chance of succeeding if Medicaid-eligible people learn how to participate in the program. Health care providers are encouraged to become educated about the program so that they can make informed decisions about their participation. The state's website is www.bayouhealth.com.

The current Louisiana Medicaid system is in need of significant improvement, including better health outcomes for Medicaid enrollees, upgraded data systems, more patient education and access to specialists. Reform is needed especially given the anticipated surge in Medicaid enrollment in 2014 with the onset of federal health care reform.

Administration officials have committed that the Bayou Health model will bring cost savings and improved outcomes for Medicaid enrollees as well as improvement in overall Louisiana health indicators. Of primary concern is how cost savings and profits will be derived from the targeted Medicaid population – mostly children who already are being served at relatively low expense rates – and at what consequence to care, access and health outcomes. Undoubtedly some unnecessary health care expenditures can be eliminated. The prevention and management of chronic conditions could rightly reduce costs. However, it is vital that health care services be provided in a timely and appropriate manner driven by the needs of the patient and not the quest for profit.

Because this policy shift will unquestionably impact the care received by Medicaid enrollees, the role of oversight, transparency and accountability is critical. The administration should be fully transparent in sharing the actual costs and savings of the program and the health outcomes of enrollees. The management companies must be held accountable for their performance, spending and care of Louisiana's neediest citizens.

The Legislature should use the mechanisms already established to provide oversight and accountability of both the health department and the managed care companies. Utilizing the Health and Welfare committees and the appropriations process, the Legislature should require that key data be provided on an ongoing basis. The Legislature has identified the comprehensive measures by which to gauge the privatized managed care process, and these data should drive the assessment of the program.

The Legislature also should take the lead in establishing a special committee or commission to provide year-round review of the CCN program and the implementation of federal health care reform in Louisiana. The panel should include current and possibly former lawmakers as well as participation by representatives of various stakeholders and people knowledgeable of the issues. Their participation could be in the form of working groups or as members of the commission.

This panel would make recommendations to the governor and the Legislature. It would provide a state body capable of remaining focused on the Medicaid and health reform issues and providing assessments – separate from the administration – of the impact of new programs. The mere process of a special commission would help illuminate the issues for the public, spot problem areas and keep the Medicaid reforms in the spotlight.

The Public Affairs Research Council of Louisiana is a non-partisan, non-profit organization founded in 1950. PAR's mission is to be an independent voice, offering solutions to critical public issues in Louisiana through accurate, objective research and focusing public attention on these solutions. If you would like to support PAR's work, please contact us at staff@la-par.org or **225-926-8414**. This report is available on PAR's web site: **www.la-par.org**.

Appendices

APPENDIX A – TABLES AND CHARTS

Table 4. Comprehensive Managed Care Enrollment by State October 2010

Louisiana is one of 32 states that currently utilize Primary Care Case Management, one version of Medicaid Comprehensive Managed Care. Louisiana is prioritizing and shifting much of its Medicaid enrollment to Managed Care Organizations (MCOs) under the Bayou Health initiative. The state's PCCM numbers soon will decrease as its MCO numbers increase.

	Total MCO Enrollment	Total PCCM Enrollment	Total Comprehensive Enrollment
United States	26,739,516	8,771,832	35,511,348
Alabama	0	512,771	512,771
Alaska	0	0	0
Arizona	1,209,559	0	1,209,559
Arkansas	0	575,239	575,239
California	4,079,334	0	4,079,334
Colorado	45,182	25,893	71,075
Connecticut	391,377	517	391,894
Delaware	142,483	7,264	149,747
District of Columbia	168,706	0	168,706
Florida	1,286,884	594,409	1,881,293
Georgia	1,133,405	135,558	1,268,963
Hawaii	262,290	0	262,290
Idaho	0	185,958	185,958
Illinois	187,734	1,653,807	1,841,541
Indiana	721,146	33,846	754,992
Iowa	0	182,718	182,718
Kansas	135,088	22,893	157,981
Kentucky	168,638	361,565	530,203
Louisiana	**0**	**752,977**	**752,977**
Maine	0	197,312	197,312
Maryland	685,420	0	685,420
Massachusetts	512,814	319,830	832,644
Michigan	1,251,434	70	1,251,504
Minnesota	477,000	0	477,000
Mississippi	56,758	0	56,758
Missouri	427,060	0	427,060
Montana	0	77,267	77,267
Nebraska	84,815	0	84,815
Nevada	171,366	0	171,366
New Hampshire	0	0	0
New Jersey	974,122	0	974,122
New Mexico	334,950	0	334,950

Table 4 Continued next page

Table 4 *Continued*

	Total MCO Enrollment	Total PCCM Enrollment	Total Comprehensive Enrollment
New York	3,001,571	16,345	3,017,916
North Carolina	0	978,579	978,579
North Dakota	0	42,553	42,553
Oregon	443,863	3,690	447,553
Ohio	1,729,602	0	1,729,602
Oklahoma	0	451,961	451,96
Pennsylvania	1,222,349	334,965	1,557,314
Rhode Island	133,936	2,400	136,336
South Carolina	391,433	112,692	504,125
South Dakota	0	91,295	91,295
Tennessee	1,219,443	0	1,219,443
Texas	1,697,907	858,439	2,556,346
Utah	52,282	66,054	118,336
Vermont	0	100,399	100,399
Virginia	527,360	56,440	583,800
Washington	627,179	7,574	634,753
West Virginia	160,824	8,552	169,376
Wisconsin	624,202	0	624,202
Wyoming	0	0	0

Definitions

MCO: Managed Care Organization. States contract with MCOs to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitation basis. Data are for both Medicaid-only MCOs and MCOs that include commercially insured members.

PCCM: Primary Care Case Management. States contract with primary care providers who agree to provide case management services to Medicaid enrollees assigned to them. Louisiana has used the PCCM model of comprehensive Medicaid managed care on a statewide basis since 2003. The program, known as CommunityCARE, has an enrollment of 752,977 Medicaid clients as of October 2010. Provider participation includes more than 800 physician practices, 1,600 physicians and 500 mid-level practitioners.

Source: Kaiser State Health Facts, September 2011 www.statehealthfacts.org

Table 5. National Survey on Children's Health 2007 (16 Southern states)

a % children currently insured, including Medicaid

b % children lacking consistent insurance coverage in past year. Smaller values equal better rankings

c % children with preventive medical visit past year

d % children with preventive dental visit past year

e % children ages 10 months to 5 years receiving standardized screening for developmental or behavioral problems

f % children ages 2 to 17 with problems requiring counseling who received mental health care

g % children who received care within a medical home

	Current Health Insurance (a)	Rank	Lacking Insurance Coverage Consistency (b)	Rank*	Preventive Health Care (c)	Rank	Preventive Dental Care (d)	Rank	Developmental Screening (e)	Rank	Mental Health Care (f)	Rank	Medical Home (g)*	Rank*
US	90.9%		15.1%		88.5%		78.4%		19.5%		60.0%		57.5%	
AL	92.3%	8	15.1%	10	87.4%	9	78.4%	7	12.1%	16	61.7%	7	56.1%	12
AR	92.9%	6	11.4%	6	83.5%	14	74.7%	14	15.9%	14	56.5%	10	60.7%	6
FL	88.0%	15	21.5%	15	91.5%	2	68.5%	16	17.1%	13	52.0%	13	56.8%	11
GA	90.0%	13	17.3%	13	88.3%	5	80.3%	3	22.7%	5	51.3%	14	58.5%	10
KY	93.3%	5	10.5%	3	88.1%	7	78.4%	7	15.5%	15	65.5%	4	61.8%	3
LA	**94.8%**	**1**	**9.4%**	**1**	**88.6%**	**4**	**76.5%**	**11**	**28.7%**	**4**	**55.3%**	**11**	**55.3%**	**14**
MD	94.2%	3	11.0%	4	93.5%	1	79.1%	4	22.3%	6	59.4%	9	58.6%	9
MS	90.7%	11	21.0%	14	82.3%	16	75.5%	12	20.0%	8	43.0%	15	51.6%	15
MO	94.4%	2	11.2%	5	87.1%	11	75.4%	13	19.0%	11	73.9%	1	64.8%	1
NC	91.7%	10	12.0%	7	88.3%	5	78.3%	9	47.0%	1	61.7%	7	60.9%	5
OK	89.9%	14	16.8%	12	83.5%	14	78.2%	10	20.8%	7	53.6%	12	55.7%	13
SC	90.2%	12	15.4%	11	87.0%	12	82.0%	1	19.1%	10	62.7%	6	58.8%	7
TN	91.8%	9	12.0%	7	87.4%	9	78.8%	6	29.0%	3	64.1%	5	61.4%	4
TX	82.9%	16	26.3%	16	85.6%	13	74.0%	15	19.2%	9	41.7%	16	50.3%	16
VA	92.8%	7	12.4%	9	88.1%	7	79.0%	5	18.2%	12	72.2%	2	58.8%	7
WV	94.1%	4	9.5%	2	91.4%	3	80.4%	2	31.9%	2	72.0%	3	64.7%	2

** 2007 data show percentage of children with a medical home. This measure would have improved dramatically in past four years, thanks to aggressive post-Katrina campaign to expand patient-centered medical homes. According to latest NCQA data, Louisiana ranks 12th in U.S. for primary care physicians recognized for providing patient-centered medical homes.*

Source: National Survey of Children's Health, sponsored by the U.S. Department of Health and Human Services

Table 6. Percent of Children Ages 19 to 35 Months Who Are Immunized, 2009 & 2010

Louisiana ranked 40th for childhood immunization in 2004, rose to 7th place in 2009 but fell to 30th in 2010

	2009	Rank	2010	Rank	Change
United States	72.0%		75.0%		3.0%
Alabama	74.4%	14	77.3%	14	2.9%
Alaska	68.7%	31	70.2%	45	1.5%
Arizona	71.9%	22	76.3%	17	4.4%
Arkansas	64.6%	40	79.3%	8	14.7%
California	75.8%	10	71.3%	37	-4.5%
Colorado	67.1%	35	71.3%	37	4.2%
Connecticut	48.4%	52	75.7%	22	27.3%
Delaware	67.2%	33	72.9%	35	5.7%
District of Columbia	75.7%	11	81.2%	6	5.5%
Florida	77.9%	5	85.8%	1	7.9%
Georgia	71.0%	25	73.9%	28	2.9%
Hawaii	66.9%	36	76.0%	18	9.1%
Idaho	56.6%	48	61.2%	52	4.6%
Illinois	74.4%	14	75.9%	21	1.5%
Indiana	69.7%	27	73.9%	28	4.2%
Iowa	66.9%	36	77.3%	14	10.4%
Kansas	77.5%	6	77.6%	13	0.1%
Kentucky	67.2%	33	72.5%	36	5.3%
Louisiana	**77.2%**	**7**	**73.8%**	**30**	**-3.4%**
Maine	55.4%	50	70.4%	42	15.0%
Maryland	80.5%	3	73.3%	32	-7.2%
Massachusetts	84.9%	1	79.9%	7	-5.0%
Michigan	73.4%	19	83.4%	3	10.0%
Minnesota	61.2%	45	74.3%	26	13.1%
Mississippi	74.4%	14	79.3%	8	4.9%
Missouri	63.4%	41	70.3%	43	6.9%
Montana	60.1%	46	64.3%	51	4.2%
Nebraska	62.9%	42	78.9%	10	16.0%
Nevada	62.6%	43	66.6%	49	4.0%
New Hampshire	82.7%	2	84.1%	2	1.4%
New Jersey	69.4%	28	66.4%	50	-3.0%
New Mexico	69.4%	28	70.9%	40	1.5%
New York	72.2%	20	69.1%	47	-3.1%
North Carolina	56.4%	49	77.0%	16	20.6%
North Dakota	57.6%	47	76.0%	18	18.4%
Ohio	75.4%	12	76.0%	18	0.6%
Oklahoma	71.3%	24	70.3%	43	-1.0%
Oregon	66.9%	36	69.3%	46	2.4%

Table 6 Continued next page

Table 6 *Continued*

	2009	Rank	2010	Rank	Change
Pennsylvania	71.8%	23	78.8%	11	7.0%
Rhode Island	52.1%	51	75.3%	23	23.2%
South Carolina	68.0%	32	77.7%	12	9.7%
South Dakota	78.4%	4	73.2%	33	-5.2%
Tennessee	76.9%	8	82.3%	4	5.4%
Texas	74.4%	14	74.8%	25	0.4%
Utah	76.3%	9	70.6%	41	-5.7%
Vermont	73.7%	18	71.0%	39	-2.7%
Virginia	70.3%	26	74.2%	27	3.9%
Washington	75.4%	12	73.7%	31	-1.7%
West Virginia	69.0%	30	73.0%	34	4.0%
Wisconsin	61.9%	44	81.7%	5	19.8%
Wyoming	65.1%	39	67.5%	48	2.4%

Note
Louisiana initiated a campaign to improve child immunization rates that ranked the state 40th in 2004. A key feature was an incentive program started in 2007 for CommunityCARE physicians. By 2009 the state had climbed to 7th place but has now fallen to 30th.

Definitions
For the purpose of this dataset, immunized children are those who receive 4:3:1:3:3:1, which is four or more doses of diphtheria, tetanus and pertussis, three or more doses of poliovirus vaccine, one or more doses of any MMR vaccine, three or more doses of Haemophilius Influenza type B (Hib), three or more doses of hepatitis B vaccine (HepB), and 1 or more doses of varicella vaccine.

Notes
Data are self-reported by respondent. Children in the Q1/2010-Q4/2010 National Immunization Survey were born between January 2007 and July 2009. Margin of error is within 1% - 8% of stated figures.US estimate excludes the territories.

Source: Kaiser State Health Facts www.statehealthfacts.org

Sources: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State — U.S., National Immunization Survey, Q1/2010-Q4/2010. National Immunization Program, Centers for Disease Control and Prevention. Available at http://www2a.cdc.gov/nip/coverage/nis/CountNIS.asp?fmt=r&rpt=tab38_431331_race_iap.xlsx&qtr=Q1/2010-Q4/2010.

Table 8. Louisiana Insurance Costs Rising Much Faster Than Personal Income

	2003	2010	% change
U.S. avg family premium	$9,249	$13,871	41%
LA avg family premium	$8,735	$13,230	51%
LA rank	39th	35th	21st
LA family income	$46,757	$64, 402	38%
LA premium as % of income	19%	21%	+ 2 pts

Source: Commonwealth Fund 2011

APPENDIX B – MATHEMATICA RESEARCH NOTE

Mathematica Policy Research Inc. in August 2010 published "Value for the Money Spent? Exploring the Relationship Between Medicaid Cost and Quality." This study measures the efficiency of state Medicaid programs in terms of spending on children and quality without regard to the type of delivery system. It is a significant departure from other surveys and studies in that it ranks states according to the level of quality obtained for dollars spent. High-spending states with medium or low quality do poorly. Louisiana, a very low-spending state, does surprisingly well. The study's findings suggest that low-spending states can often achieve progress at low cost, i.e., better value for each dollar spent. The tiers are defined as follows:

Table 7. Relationship Between Medicaid Cost and Quality

Tier A Seven of 13 states, including Louisiana, are Southern states.	**↓Costs and ↑Quality Scores** These 13 states have lower than median costs and higher than median quality scores according to the National Survey of Children's Health (NSCH) and the National Immunization Survey (NIS). These quality indicators are in use by all states, thus enabling a nationwide comparison.	**13 states in Tier A:** in alphabetical order: Alabama, California, Georgia, Hawaii, Indiana, Louisiana, Michigan, Ohio, South Carolina, Tennessee, Texas, Utah, Virginia.
Tier B Eight of 26 states are Southern states.	**Quality Scores and Costs Aligned** These 26 states have near-median quality and costs; high quality and costs; or low quality and costs.	**26 states in Tier B:** Arizona, Arkansas, Colorado, Connecticut, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Vermont, Washington, West Virginia, Wisconsin, Wyoming.
Tier C Maryland is the only state in this tier counted as a Southern state (according to the Southern Legislative Conference).	**↑Costs and ↓Quality Scores** These 11 states have lower than median quality scores and higher than median costs.	**11 states in Tier C:** Alaska, District of Columbia, Delaware, Maryland, Minnesota, Montana, Nevada, New Jersey, New Mexico, North Dakota, Oregon.
Note: Maine excluded from study due to insufficient data		

Source: Mathematica Policy Research, "Value for the Money Spent? Exploring the Relationship Between Medicaid Costs and Quality," August 2010

The least desirable would be tier C — high-spending, low-performing states. In one view, the study examines how states perform on six health care indicators that are common to all 50 states. Louisiana places in tier A, along with 12 other states, including six Southern states, most of them with relatively high levels of poverty and uninsured populations. Tier C is populated

by 11 states, including some that are rich, high-spending states that do well on annual health surveys. How can this low grade be reconciled with top scores on other surveys?

In sum, it depends on whether the survey is of the entire population or Medicaid recipients. In wealthier states, the average person is relatively healthy and the state scores are high on surveys that include all citizens. Louisiana has a poverty level of 44 percent, low income and education levels and plenty of uninsured adults, all of which adds up to low rankings. Surveys of only Medicaid patients more precisely reveal how well each Medicaid program performs on a standardized set of indicators that measure program performance and how much money it spends to accomplish that. In that respect, some poor states may finally be recognized as being efficient spenders of health care dollars.

APPENDIX C – ADDITIONAL STUDIES ON FLORIDA'S MANAGED CARE PILOT PROJECT

During the five-year term of the Florida pilot project, an ongoing independent study by the Georgetown University Health Policy Institute monitored the performance of the project and issued a series of eight reports. The final report was released on April 4, 2011.

Here are the key findings:

- Children, parents and people with disabilities who rely on Medicaid have experienced enormous disruption as a result of plan turnover in Broward, Duval and surrounding counties. Patients appear to be "voting with their feet" and moving from HMOs to Provider Sponsored Networks.
- Certain features of Medicaid reform, such as the opt-out program designed to encourage the use of employer-sponsored insurance and the enhanced benefits program designed to encourage healthy behaviors, lack evidence to suggest they are achieving their goals and may be an inefficient use of scarce funds.

Numerous reports have also been produced by the University of Florida under contract with the state Medicaid program to evaluate the reform pilot project. Beginning in 2006, the Medicaid Reform Evaluation Team at the University of Florida produced no less than 19 reports, six issue briefs, two journal articles and 27 presentations on the reform pilot project (see http://mre.phhp.ufl.edu/aboutus/index.htm). Although these documents show the reform pilot in a generally positive light, the data on quality improvement and particularly on cost savings are scant. Most of the reports and briefs include caveats that point out serious limitations in the data and acknowledge that the results thus far are inconclusive.

A June 2009 report ("An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration" by R. Paul Duncan and Jeffrey S. Harman) includes data that compare Medicaid eligibility groups in control counties to reform counties before and after implementation of the reform pilot project. The report concludes that Medicaid expenditures in the reform counties were lower during the first two years after reform "than would have been the case in the absence of the demonstration project." This is followed by a paragraph of qualifications stating that encounter data from the health plans are not available and therefore it cannot be determined if the cause of the spending reduction is due to more efficient care delivery or reduced access to medical care.

A second report on the same subject ("Changes in Member Per Month Expenditures After Implementation of Florida's Medicaid Reform Demon-

stration" by R. Paul Duncan, Jeffrey S. Harman and others) was published in January 2011 in the Health Services Research Journal. The results of this study were slightly more definitive but even less impressive than the June 2009 report. "After adjusting for demographic differences in the multivariate analysis that included the full population of enrollees, there was essentially no impact of the demonstration on PMPM expenditures for SSI enrollees, and slightly higher PMPM expenditures among TANF enrollees. Although the unadjusted results mirror those of other state Medicaid programs that have implemented managed care and found savings among the SSI population (LewinGroup 2009), the adjusted results for Florida's demonstration diverges from those in previous studies, showing essentially no reduction in expenditures."