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## LOUISIANA'S MEDICAID WAIVER PROPOSAL

### Is it the Right Fit for Louisiana?

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#### Summary

In the Louisiana Health Care Reform Act of 2007, the Louisiana legislature put the state on a path intended to transform how Medicaid beneficiaries and low-income uninsured people get health care services. The Act directed the state Department of Health and Hospitals (DHH) to establish a “medical home system of care” with the goal of improving patient outcomes and increasing cost-effectiveness. In the medical home system envisioned by the Louisiana legislature, each individual would have a health care provider who would provide preventive and primary care and coordinate other care the individual may need from specialists and other health care providers.

The Department of Health and Hospitals is seeking approval from the legislature to submit a proposal for a section 1115 Medicaid waiver to the U.S. Department of Health and Human Services (HHS). The state claims that the proposal would establish a medical home system like that described in the Health Care Reform Act. However, there are serious questions about whether the design of the Department's plan is appropriate or even possible for Louisiana, because Louisiana lacks the type of managed care organizations on which the plan primarily depends.

Key features of the Louisiana proposal come straight from a Medicaid initiative in Florida, which was spearheaded by Louisiana's current Secretary of Health and Hospitals when he headed Florida's Agency for Health Care Administration. After two years, it is too early to say whether Florida's effort has saved money or improved health outcomes. However, there is evidence that it has caused confusion and disrupted care for beneficiaries.<sup>1</sup>

As in Florida, the proposed Louisiana waiver would allow managed care plans to vary the benefit packages for current beneficiaries and those eligible under the expansion of coverage.<sup>2</sup> For example, some plans may limit benefits like home health services or physical therapy while others may put

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<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, “Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status,” October 2008.

<sup>2</sup> As explained later, for some beneficiaries, the value of the benefit package would be based on a reduced benefit package, which has significant limits on benefits and cost-sharing charges well above what Medicaid beneficiaries now pay for care. Thus it is even more likely that these beneficiaries would end up without the care they need.

limits on prescription drugs. Thus, Medicaid beneficiaries could end up being enrolled in health plans that do not meet their needs.

The waiver proposal also does little for uninsured Louisiana residents. While it would provide coverage for some very low-income parents and other adults, the benefits available would be substantially less than the benefits available in standard Medicaid, and the out-of-pocket costs would be substantially greater. Thus, these newly eligible individuals would likely still experience barriers to getting the care they need because of cost-sharing charges and gaps in the benefit package.

In considering how to move the state forward toward its goal of a medical home system of care, the Louisiana legislature and other policy makers should give careful consideration to alternative approaches, which may be a better fit for Louisiana. In particular, Louisiana's current CommunityCARE program could be enhanced in ways that have been shown to improve outcomes and save money in other states. This alternative approach would be more suited to the state's current health care environment and infrastructure, and have a higher likelihood of success.

## **The Louisiana Health First Plan**

Louisiana's reform proposal seeks approval to waive certain federal Medicaid requirements.<sup>3</sup> The plan, called Louisiana Health First, would move beneficiaries into managed care and change the benefits for some beneficiaries. The plan would affect most Medicaid beneficiaries in Louisiana, including children, parents, and people with disabilities.<sup>4</sup>

The state proposes to contract with entities called "Coordinated Care Networks" to deliver care to Medicaid beneficiaries. These networks would be responsible for administering benefits, recruiting providers to participate, and ensuring that beneficiaries have a medical home. Coordinated Care Networks could take two different forms:

- They could be private managed care plans, which would be paid a fixed monthly fee, called a capitated payment, for each beneficiary enrolled in the plan. These plans would be at full financial risk for any difference between the capitated payments and the costs of providing care. The amount of reimbursement these plans receive from the state would not change based on the amount or type of services used by people enrolled in the plan.
- They could be enhanced primary care case management programs. These programs pay providers on a fee-for-service basis for individual health care services received by beneficiaries. In addition to payments for health care services, primary care providers receive a flat monthly

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<sup>3</sup> Section 1115 Medicaid waivers give the Secretary of Health and Human Services broad authority to waive certain requirements of the Medicaid statute in authorizing research and demonstration projects. For example, states can deviate from rules that generally require programs and services to be statewide and benefits to be comparable among different groups of beneficiaries. Waivers can also allow states to get federal financial participation for expenditures on benefits and people not usually covered by Medicaid. Cynthia Shirk, "Shaping Medicaid and SCHIP Through Waivers: The Fundamentals," National Health Policy Forum, July 22, 2008.

<sup>4</sup> People who get both Medicaid and Medicare benefits would not be affected, so most seniors would not be in the plan.

fee to provide care management and serve as a medical home for each patient they care for. Enhanced primary care case management programs use strategies similar to what private managed care plans employ, such as credentialing providers, providing comprehensive disease and care management, and rewarding providers who meet certain quality benchmarks.

Besides the difference in the way the state would pay for services, Medicaid beneficiaries would receive different benefits depending on whether they received services through a managed care plan or an enhanced primary care case management program.

- Private managed care plans paid on a capitated basis would be allowed to offer benefits packages which “vary the amount, scope or duration of services” they provide to beneficiaries as long as the benefit package is actuarially equivalent to the state benchmark benefits package.
- Enhanced primary care case management programs would not be allowed to vary the amount, duration or scope of benefits, although as explained below, some beneficiaries would get a reduced benefits package.

To engage Medicaid beneficiaries in their health management, Louisiana proposes to create an incentive program to encourage healthy behaviors, similar to what has been implemented in Florida. Beneficiaries could earn rewards, in the form of enhanced benefit dollars, which could be redeemed by beneficiaries and used for health-related services or products not covered by Medicaid.

In addition to the proposed delivery system changes, the state proposes to expand coverage for a segment of the estimated 842,000 uninsured people in Louisiana.<sup>5</sup> First, the state would increase the income level at which parents of children eligible for Medicaid could enroll in the program. Eligibility, which is now set at 12 percent of the poverty line (\$2,112 a year for a family of three), would increase to 50 percent of the poverty line (\$8,800 a year). According to the financial information included in the waiver application, this would result in coverage of about 65,000 additional parents by the end of the five-year waiver period.<sup>6</sup> However, the waiver itself says that the expansion may be limited to parents who have certain chronic conditions. If that is the case, fewer parents would be covered.

The second expansion would be limited to the Lake Charles region of the state and would only occur after Coordinated Care Networks are in place. In that area, both parents and adults without children with incomes below 200 percent of the poverty line would be eligible. The waiver assumes that about 24,000 adults in the Lake Charles region would gain coverage by the end of the waiver period.

Beneficiaries eligible under these expansions would not get the full Medicaid benefit package, but a lesser “benchmark benefits package.” This package has higher cost-sharing and significant limits on benefits such as physician’s visits. It also has a \$100,000 annual cap and a \$1 million lifetime cap.

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<sup>5</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

<sup>6</sup> Federal authority for this expansion of eligibility is being requested separately through a Medicaid state plan amendment. Under section 1937 of the Social Security Act, which was part of the Deficit Reduction Act of 2005, states can provide “benchmark benefit packages” that vary from usual Medicaid rules to certain groups of beneficiaries, including low-income parents.

Managed care plans would be allowed to vary the benefits specified in the benchmark plan, so these beneficiaries could face even greater limits on benefits depending on how the managed care plans choose to vary the benefits.

## **Reform Proposal Does Not Consider the State's Environment and Infrastructure**

As expressed in the Health Care Reform Act of 2007, there is broad consensus on the need to restructure Louisiana's health care delivery system to improve outcomes and improve efficiency. In designing a proposal to reach these goals, the state's current environment and existing infrastructure needs to be taken into account. Instead, the state is insisting on a reform package that takes several key elements from Florida's Medicaid reform — a program that has not been proven to work. Moreover, Florida's plan was developed for a state with a health care infrastructure that bears little resemblance to Louisiana's.

A critical issue is DHH's push for capitated managed care. While contracted networks would have the option of implementing either the enhanced primary care case management or capitated managed care model, the state has clearly expressed a preference for the latter approach. Indeed, most press accounts of the reform proposal have assumed that care would be delivered through private managed care plans. While managed care plans have been shown to improve quality and reduce costs, their success hinges on certain market conditions. There needs to be a competitive provider market to ensure that private managed care plans participate, and the market for private managed care plans needs to be developed enough to ensure stability and continuity of care. Neither of these conditions exists in Louisiana, and it does not make sense to pursue a model that the state's infrastructure would not be able to support.

In 2007, only 7.1 percent of Louisiana's population was enrolled in managed care. In contrast, states that have experienced success in moving Medicaid beneficiaries into managed care plans, such as California and Maryland, have typically had higher managed care enrollment at the start of their initiatives. In other states, Medicaid agencies have had to encourage managed care development in the private sector so that they would have credible plans with which to contract. These efforts have not always been successful.

For example, several states that planned an expansion to capitated managed care have had to reconsider their strategy because of concerns about the insurance market. When Maine implemented managed care, it originally intended to do so through contracts with private managed care plans that would be paid on a capitated basis. Instead, the state ended up revising its approach and relying on a fee-for-service arrangement due to a lack of plans willing to bid. In Oklahoma, officials have acknowledged that their original plan of enrolling Medicaid beneficiaries throughout the state in private managed care plans was unrealistic, especially given the rural nature of the state.<sup>7</sup> Unless there is more managed care development in the state, Louisiana could find itself in similar circumstances.

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<sup>7</sup> Joanne Rawlings-Sekunda, Deborah Curtis, and Neva Kaye, "Emerging Practices in Medicaid Primary Care Case Management Programs," National Academy for State Health Policy, June 2001.

Moreover, private plans are unlikely to jump at the chance to enter the Louisiana market and serve Medicaid beneficiaries because the state is experiencing a provider shortage. A key approach that managed care plans use to reduce costs is to negotiate rate discounts with providers in exchange for a guaranteed stream of patients. This strategy is only effective in a competitive market where there are enough providers who are willing to accept reduced rates in exchange for the promise of more patients. In Louisiana, 97 percent of the state faces a primary care work force shortage, making it extremely difficult for insurers to develop a provider network.<sup>8</sup> This will be especially problematic in the rural areas, where only 13 percent of the licensed physicians in Louisiana serve 25 percent of the state's population.<sup>9</sup>

### **Other Alternatives Exist that Are Better Suited to Louisiana**

The medical home concept that is being promoted by Louisiana's legislature has been implemented in other state Medicaid programs using different financing arrangements and delivery system models. Capitated managed care is *not* the only way to encourage care coordination and generate savings. There are a broad range of options to improve care for Medicaid beneficiaries that are a better fit with Louisiana's current environment and existing infrastructure.

Louisiana currently operates a Medicaid primary care case management program called CommunityCARE. Under this program, Medicaid recipients are assigned to a primary care physician who is responsible for coordinating all of the patient's medical care and providing referrals to needed specialty care. Providers are paid on a fee-for-service basis, and primary care physicians receive an enhanced fee for office visits, as well as an additional per member per month care management fee.

With certain changes to its current model, CommunityCARE could be readily adapted to provide a medical home system of care. Louisiana could implement more sophisticated financing, care management and quality improvement strategies, comprehensive disease and care management, and arrangements where providers share in savings that are realized through reducing inappropriate utilization.

Over the last decade, "enhanced primary care case management" programs, which use these strategies, have gained significant appeal among states like Louisiana that have large rural areas. For a number of states, they have offered a solution to the difficulty of maintaining capitated managed care contracts in rural communities, and to the problems of managed care plan withdrawals. States such as North Carolina, Indiana, Oklahoma and Rhode Island have implemented such programs and used them to support the development of medical home initiatives in their Medicaid programs. Louisiana could follow a similar path.

Many of these state-run programs have been hailed as promising practices in delivering care, particularly for populations with complex needs. They have also demonstrated improvements in quality of care and outcomes in state Medicaid programs. Community Care of North Carolina, the

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<sup>8</sup> Louisiana Interagency Task Force on the Future of Family Medicine, "Report to the Secretary to the Department of Health and Hospitals and the House and Senate Committees on Health and Welfare," October 2006.

<sup>9</sup> Kristy Nichols, "Issue Brief on Rural Health," Louisiana Bureau of Primary Care and Rural Health, September 2003.

state's enhanced primary care case management program, has identified chronic conditions that it targets through specific disease management programs. Its asthma program, in particular, has achieved tremendous success. In 1999, 67 percent of children with asthma in North Carolina's Community Care program were on medication to control their asthma, compared to just 53 percent of children with asthma in unmanaged fee-for-service Medicaid.<sup>10</sup> In Virginia, children enrolled in the primary care case management program had higher immunization rates than those in either mandatory or voluntary capitated managed care.<sup>11</sup>

Enhanced primary care case management programs have also been shown to generate significant savings. Independent evaluations of these programs have recorded initial savings in the range of five to 15 percent compared to the costs of serving for a similar population in unmanaged fee-for-service. This is the same range that other states report saving under private managed care plans.<sup>12</sup> North Carolina's program saved the state between \$425 million and \$475 million in 2003 and 2004.<sup>13</sup> Massachusetts' program, the Primary Care Clinician Plan, has saved between 9 and 14 percent compared to unmanaged fee-for-service.<sup>14</sup> In both these cases, a significant advantage is that savings accrue to the state which administers the program, rather than the private managed care plans contracting with the state.

Rather than replicating Florida's Medicaid reform — which is unproven and unsuitable for Louisiana — the state should look to other states such as North Carolina and Oklahoma as models for how to leverage its current CommunityCARE program to support the medical home system of care.

### **Private Managed Care Plans' Ability to Vary Benefits Could Lead to Confusion and Coverage Problems**

The proposed Louisiana reform would allow private managed care plans to offer “customized benefit packages.” These customized benefit packages must cover mandatory Medicaid services, but may “vary the amount, duration and scope of some services and may contain service-specific coverage limits.” The state has noted that it will evaluate packages to ensure “actuarial equivalency to the Medicaid benchmark or alternative benchmark as approved by CMS.” Thus some beneficiaries would be offered benefit packages tied to the value of the state's Medicaid program while those eligible under the coverage expansion and possibly others would get benefits based on the lesser benchmark plan.<sup>15</sup>

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<sup>10</sup> Pam Silberman, Stephanie Poley, Rebecca Slifkin, “Innovative Primary Care Case Management Programs Operating in Rural Communities: Case Studies of Three States,” The University of North Carolina at Chapel Hill, 2003.

<sup>11</sup> Louis Rossiter, Michelle Whitehurst-Cook, Ralph Small, et al., “The Impact of Disease Management on Outcomes and Cost of Care: A Study of Low-Income Asthma Patients,” *Inquiry*, 37(2): 188-202.

<sup>12</sup> Vernon Smith, Terrisca Des Jardins, and Karin A. Peterson, *Exemplary Practices in Primary Care Case Management: A Review of State Medicaid PCCM Programs*, Center for Health Care Strategies, June 2000.

<sup>13</sup> Pam Silberman, *op cit*.

<sup>14</sup> Vernon Smith, *op cit*.

<sup>15</sup> It is not clear whether the state established benchmark is just for the expansion groups or other adults. The waiver is inconsistent on this point. See, for example page 34, which states that plans must offer benefits “actuarially equivalent

This means that benefit packages could vary widely, creating significant risk that beneficiaries will be enrolled in plans that do not meet their health care needs. People may not get coverage for needed services, or they may find that the benefits they need are limited in amount, duration, or scope. The risks are especially great for people with disabilities and chronic health care conditions who are more likely to need services not covered by their plans.

Florida's Medicaid reform allowed plans to vary benefits, and a recent study published in *Health Affairs* found significant confusion among beneficiaries. According to the study, many enrollees were not aware that they had a choice of health plans, and they also did not know that health plans could vary benefits and benefit levels.<sup>16</sup> In addition, Florida's own Inspector General has found that Medicaid beneficiaries did not have the information they needed to choose the right health plan, because accurate information about what drugs are covered and which providers participate in the plans was not always available.<sup>17</sup>

The ability of plans to vary benefits could be even more problematic for beneficiaries in Louisiana. At least for parents with income between 13 and 50 percent of the poverty line and for newly eligible adults in the Lake Charles region and possibly for other beneficiaries, plans would be able to fashion benefit packages equivalent to the "state established benchmark benefit package" rather than the traditional Medicaid package.

The state-established benchmark package provides far less than Medicaid and has considerably higher cost-sharing. For example, only 12 doctor or mental health clinic visits would be covered each year, and there is a \$100,000 annual cap on benefits. In addition, there are substantial co-payments — \$5 for a primary care visit and \$10 for a specialist, \$5 for prescriptions, and 5 percent of the cost for lab and x-rays.

A parent of two children with income below \$8,800 a year would not be able to afford these amounts, which are more than what is allowed in Medicaid. A substantial body of research shows that even modest cost-sharing causes low-income people to forgo needed care.<sup>18</sup>

A recent study found that *more than half* of the people at all income levels who are "underinsured" — meaning that their out-of-pocket medical costs exceed 10 percent of their income (or 5 percent of income for people below 200 percent of the poverty line) or that their deductibles alone exceed 5 percent of income — went without needed care during the year. Some 45 percent of these people reported problems paying medical bills. Moreover, the researchers found that *underinsured* people

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to the state-established benchmark plan," with page 35, which states that all mandatory Medicaid services must be covered.

<sup>16</sup> Teresa Coughlin, Sharon Long, Timothy Triplett, et al., "Florida's Medicaid Reform: Informed Consumer Choice?" *Health Affairs*, 27(6): 523-532.

<sup>17</sup> Agency for Health Care Administration Office of the Inspector General, "Program Review of the Medicaid Reform Pilot Project," September 2007.

<sup>18</sup> The research on cost-sharing and premiums is summarized in Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.

## Results of Florida's Medicaid Reform: The Right Model for Louisiana?

In July 2006, Florida began implementing its Medicaid reform pilot, which was aimed at promoting consumer choice and market competition. Under the new program, beneficiaries can choose among different plans participating in Medicaid, and plans have new authority to vary benefits. Two years after implementation, studies are showing little improvement in the Medicaid program.

- **There were gaps in beneficiary knowledge of the reform and health plan choices.** In a survey of Medicaid beneficiaries, almost one-third indicated that they were unaware of changes to Florida's Medicaid program. A majority of enrollees had difficulty understanding plan information and choosing a plan. Some reported difficulty in obtaining information about available plans and benefits.<sup>a</sup>
- **Reform may have hurt provider participation in Medicaid.** According to a physician survey, the counties involved in the pilot experienced a 10 percent net decline in the pool of physicians participating in Medicaid. One-fourth of physicians who participated in Medicaid before the reform indicated that they are not in the networks of any reform plans. Providers cited increased paperwork demands and administrative complexity as key concerns about the Medicaid reform.<sup>b</sup>
- **Beneficiaries are experiencing access problems.** In the same physician survey, two-thirds reported that some or many of their patients had difficulty accessing needed treatments because the plan either limits benefits, or requires prior authorization that was not received. In a series of focus groups, beneficiaries also described problems finding physicians who would take Medicaid patients.<sup>c</sup>

<sup>a</sup> Teresa Coughlin, Sharon Long, Timothy Triplett, et al., "Florida's Medicaid Reform: Informed Consumer Choice?" *Health Affairs*, 27(6): 523-532.

<sup>b</sup> Joan Alker, Jack Hoadley, and Jennifer Thompson, "Florida's Experience with Medicaid Reform: What Has Been Learned in the First Two Years?" October 2008.

<sup>c</sup> Joan Alker, Jack Hoadley, and Jennifer Thompson, *op cit*.

experienced problems with access to care and paying medical bills at "remarkably similar rates" to those who were *uninsured*.<sup>19</sup>

The very low-income Louisiana parents who would get coverage under the proposed expansion would clearly fare better with the regular Medicaid benefit package. With limited cost-sharing and comprehensive benefits, the Medicaid package is specifically designed to protect low-income people from the risks of underinsurance.

## Louisiana Healthy Living Attempts to Replicate a Program that Has Shown Little Evidence of Success

Similar to what was implemented in Florida, Louisiana proposes to establish a rewards program, called Louisiana Healthy Living, to engage consumers in the management of their health. This program would give beneficiaries access to rewards, in the form of enhanced benefit dollars, which

<sup>19</sup> Schoen *et al.*, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* web exclusive, June 10, 2008.

could be redeemed and used for health-related services and products not covered by Medicaid. It is intended to provide enrollees with an incentive to “participate in activities that improve their health, and/or comply with important chronic care management initiatives designed to reduce hospitalization or improve outcomes.”

Providing incentives for healthy behaviors is increasingly gaining appeal, but the impact of incentives on cost and outcomes is still unclear. Rigorous evaluations of incentive programs have yielded mixed results. The federal Agency for Healthcare Research and Quality has noted the lack of evidence that financial incentive programs promote healthy lifestyle changes or impact health care outcomes.<sup>20</sup>

The resources needed to market and administer these programs have also raised questions about cost-effectiveness. Florida’s experience thus far suggests that Louisiana may be investing a substantial amount of resources on a program that is unlikely to yield significant benefits. The Florida Office of Program Policy Analysis and Government Accountability found that the state will spend over \$2 million to launch, promote and oversee its rewards program in the first two years. As of April 2008, beneficiaries had earned nearly \$13.8 million in credits, but only redeemed 11.4 percent of these rewards, valued at \$1.6 million.<sup>21</sup> It is uncertain whether the program has led to any increase in healthy behaviors by Medicaid beneficiaries.

## Conclusion

A significant opportunity exists in Louisiana to improve care and expand coverage. Unfortunately, the Department of Health and Hospitals' insistence on using private managed care plans represents a step in the wrong direction. Louisiana needs to develop a model that takes into account the state’s health care environment and infrastructure, rather than merely imitate Florida’s Medicaid reform.

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<sup>20</sup> See Robert Kane, Paul Johnson, Robert Town, and Mary Butler, *Economic Incentives for Preventive Care*, AHRQ Publication No. 04-EO24-2. Rockville, MD. Agency for Healthcare Research and Quality, August 2004. Also see AHRQ Consumer Financial Incentives: A Decision Guide for Purchasers. AHRQ publication 07(08) 0059. November 2007. Available at: [www.ahrq.gov](http://www.ahrq.gov).

<sup>21</sup> Office of Program Policy Analysis and Government Accountability, “Medicaid Reform: Beneficiaries Earn Enhanced Benefit Credits But Spend Only a Small Proportion,” Report No 08-45, July 2008.