DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAID MANAGED CARE

INFORMATIONAL REPORT
PERFORMANCE AUDIT SERVICES
ISSUED AUGUST 31, 2011

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

August 31, 2011

The Honorable Joel T. Chaisson, II,
President of the Senate
The Honorable Jim Tucker,
Speaker of the House of Representatives

Dear Senator Chaisson and Representative Tucker:

This report provides the results of our informational report on the Department of Health and Hospital's plan for Medicaid managed care.

The report contains our findings, conclusions, and recommendations. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of DHH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/dl

DHH MMC 2011

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE, Legislative Auditor

Department of Health and Hospitals - Medicaid Managed Care

August 2011

Audit Control # 40110004

About This Informational Report

We conducted this informational audit in response to legislative interest in the proposed changes to the Louisiana Medicaid managed care model. The purpose of this report is to provide information regarding how the components of Louisiana's model for Medicaid managed care compare to successful models in other states[1] and to determine how Louisiana has addressed problems and issues that other states have experienced.

Background on Medicaid Managed Care

What is Medicaid Managed Care?

Managed care is defined as any arrangement for health care in which an organization, such as a Health Maintenance Organization (HMO), an insurance company, or a doctor-hospital network, acts as a gatekeeper or intermediary between the person seeking care and the physician.

> The goal of managed care is to improve access and reduce costs by eliminating inappropriate and unnecessary services through improved coordination of care.

Medicaid managed care involves enrolling certain Medicaid recipients into managed care arrangements rather than the traditional fee-for-service (FFS) Medicaid delivery system. In FFS, the state reimburses providers directly for services provided to Medicaid recipients. The following are the primary models of Medicaid managed care that states have used:

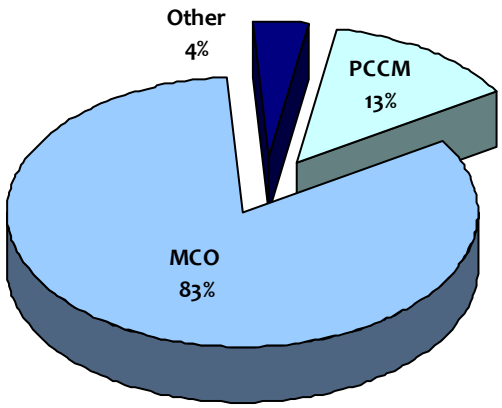
Managed Care Organizations (MCO) - Similar to private insurance, health care organizations are paid a fixed monthly fee per Medicaid enrollee to deliver specific services. Generally, MCO managed care models create financial incentives to control medical costs because they transfer the risk for medical expenditures to third parties (MCOs).

Primary Care Case Management (PCCM) - A provider is paid a monthly per member fee to serve as a "gatekeeper" to approve and monitor Medicaid services. These programs are a mix of FFS and traditional managed care. These programs are more common in rural areas where MCO-based managed care is not available.

[1] We considered successful states those with cost savings and increased health outcomes. These include, among others, Arizona, North Carolina, Michigan, Kentucky, and South Carolina.

Most states use some form of both models. According to data from the Centers for Medicare and Medicaid Services (CMS) as of June 2009, 71 percent of Medicaid recipients across the nation are enrolled in some type of managed care program. Exhibit 1 summarizes enrollees by the Medicaid Managed Care Model as of June 2009.

Exhibit 1: National Medicaid Managed Care Enrollees by Model, June 2009



Source: Created by legislative auditor's staff using information from Kaiser Family Foundation.

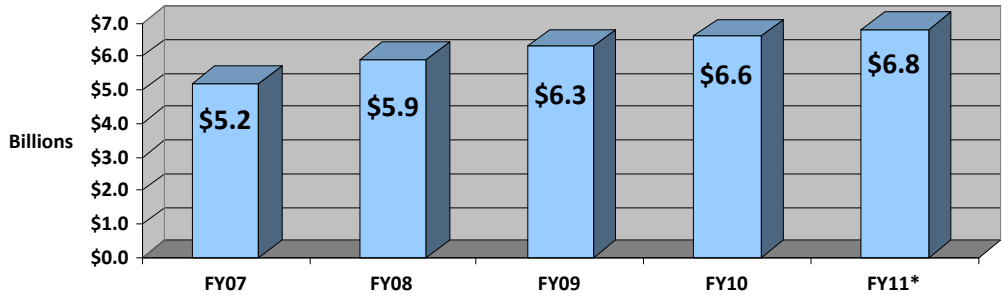
As the exhibit shows, approximately 83 percent of the 54,451,773 total Medicaid managed care enrollees in the United States are enrolled in some type of risk-based MCO plan.

Why is Louisiana changing its traditional (FFS) Medicaid system?

According to Department of Health and Hospitals (DHH), Louisiana is changing its traditional Medicaid system to reduce costs and improve health outcomes. Although Louisiana Medicaid spending has recently grown faster than the national average, there has been no corresponding improvement in health outcomes.

Reduction of Costs. Many states have experienced cost savings with the implementation of Medicaid managed care through decreased use of unnecessary services. For example, North Carolina saved between 6 and 11 percent annually between 2003 and 2007. In Louisiana, Medicaid expenditures have increased for the past five years, likely resulting from increases in both health care costs and Medicaid enrollment. Exhibit 2 summarizes total Medicaid expenditures in Louisiana from FY2007 to FY2010.

Exhibit 2: Total Louisiana Medicaid Expenditures FY 2007-2011 (in billions)



Source: Prepared by legislative auditor's staff using information provided by DHH.
*FY11 is appropriated funds, not actual expenditures.

Improved Health Outcomes. Some studies have also shown improved health outcomes for Medicaid recipients enrolled in managed care. For example, some states have found that Medicaid managed care programs resulted in improvements in several key health outcomes, including decreased hospitalizations and emergency room visits and an increase in immunizations, well child visits, and prenatal care. Improved outcomes are also important for Louisiana because Louisiana has poor health rankings in many areas. For example, the United Health Foundation ranks Louisiana 49th in its state-by-state ranking of overall health. In addition, Louisiana has one of the highest death rates from cancer in the nation.

While DHH has never implemented the MCO model of managed care, DHH implemented the PCCM model on a small scale in 1992 with its CommunityCARE program. CommunityCARE is a statewide PCCM program designed to improve accessibility to health care services for certain groups of Medicaid recipients. Although CommunityCARE achieved some cost savings, it has not resulted in significant improvements to overall health outcomes.

What is the implementation timeline for Louisiana's move to managed care?

Act 243 of the 2007 Regular Legislative Session authorized DHH to develop and implement Medicaid managed care. Over the last three years, DHH has evaluated other states' successes in managed care, developed different models, and held meetings with various stakeholders to obtain their feedback on managed care. Implementation of DHH's plan will be done in stages for certain areas of the state (geographical service area or GSA). As of July 25, 2011, DHH selected five entities to participate as Coordinated Care Networks (CCNs). Exhibit 3 details the timeline in the implementation of managed care in Louisiana.

Exhibit 3: Timeline for Managed Care Implementation	
April 11, 2011	DHH issued Requests for Proposals (RFP)
April 29, 2011	Written Questions to the RFP due to DHH
June 30, 2011	CCN Proposals due to DHH
July 25, 2011	Announcement of CCN Contract Awards
November 15, 2011	Choice Letters Mailed to Enrollees in GSA 1 (New Orleans and Northshore regions)
January 1, 2012	Go Live Date for Enrollees in GSA 1
January 15, 2012	Choice Letters Mailed to Enrollees in GSA 2 (Capital area, South Central Louisiana and Acadiana regions)
March 1, 2012	Go Live Date for Enrollees in GSA 2
March 15, 2012	Choice Letters Mailed to Enrollees in GSA 3 (Southwest Louisiana, Central Louisiana and North Louisiana Regions)
May 1, 2012	Go Live Date for Enrollees in GSA 3
Source: Making Medicaid Better Website.	

How does Louisiana's model for Medicaid managed care compare to other states?

Louisiana's model for Medicaid managed care is generally comparable to other states with successful models. The populations included and the services offered are reflective of what other states have done. However, the cost-savings projections for the Louisiana Medicaid managed care model are lower than actual cost savings achieved in other states. We compared the following components of Louisiana's model for Medicaid managed care to successful models used in other states and various practices cited in national research:

- Type of model chosen
- Populations included and excluded
- Services included and excluded
- Cost savings

Type of Model. DHH's model for Medicaid managed care is called the Coordinated Care Network (hereinafter referred to as the CCN program) and incorporates both the MCO and PCCM models. Similar to Louisiana, most states use some form of both models. The two models that are a part of the CCN program are summarized as follows:

- **Coordinated Care Network-Shared (CCN-S)** is an enhanced PCCM model. In this model, the CCN organization(s) contracts with a network of primary care providers and acts like a health care gatekeeper. Recipients must choose a primary care physician who is responsible for coordinating other health care services. In this model, the CCN-S processes the claim, and then sends it to the state for reimbursement on a FFS basis. The CCN organization will also receive a

monthly fee to provide enhanced primary care case management, and providers will have an opportunity to share in cost savings.

- **Coordinated Care Network-Prepaid (CCN-P)** is a risk-based MCO model. In this model, the CCN organizations are selected through a competitive Request for Proposal (RFP) process. These organizations will receive a monthly per member per month fee for each enrollee covered to provide core benefits and services. The organizations will be responsible for prior authorization of services and processing and paying claims.

Medicaid recipients can choose either of the models. DHH will contract with an enrollment broker contractor to place eligible Medicaid recipients into either model. This contractor will handle all aspects of enrollment, including education and disenrollment. If recipients do not choose a plan within a certain timeframe, the broker will automatically assign recipients to a model, taking into consideration their historical claims history, previous PCP relationships, and location.

Populations Included and Excluded. Initially, not all 1,185,703 Medicaid recipients will be required to enroll in the CCN program. Approximately 70 percent of the current population will be mandatory enrollees, and 30 percent will be either voluntary or excluded. DHH made the decisions on which populations to include or exclude based on a variety of factors, including legal requirements, program goals, and opportunities for improvement. Exhibit 4 shows which populations will be mandatory, voluntary, and excluded enrollees.

Exhibit 4: CCN Program Enrollment Status for Medicaid Populations and Current Percentages in Each Population

Population Type	Enrollment Option	Number and Percent in Current Medicaid Population
Uninsured women eligible through Louisiana Children's Health Insurance Program (LaCHIP) Prenatal Option	Mandatory	847,138 (71.4%)
Children under the age of 19		
Pregnant women		
Supplemental Security Income (SSI) population (blind, disabled or aged)		
Women with breast and/or cervical cancer		
Medically needy individuals		
Native Americans	Voluntary	44,984 (3.8%)
Children receiving SSI		
Children in foster care or foster care assistance		

Exhibit 4: CCN Program Enrollment Status for Medicaid Populations and Current Percentages in Each Population

Population Type	Enrollment Option	Number and Percent in Current Medicaid Population
Hospice patients	Excluded	293,881* (24.8%)
Medicaid recipients who also receive Medicare		
Nursing home patients		
Programs for All-inclusive Care for the Elderly (PACE) recipients		
Individuals under the age of 21 and registered with the New Opportunities Waiver Request		
Individuals enrolled in Louisiana Health Insurance Premium Program (LaHIPP)		
Tuberculosis patients		
Participants in the Take Charge Family Planning Waiver		
Individuals eligible through the LaCHIP Affordable Plan Program		

*Includes some Medicaid partial qualifiers.
Source: Prepared by legislative auditor's staff using information provided by DHH.

Other states also enroll similar populations. For example, Louisiana will require that adult Medicaid recipients who receive SSI enroll in managed care. Research from other states shows that cost savings are significant for this population. For example, in Arizona, 60 percent of the $102.8 million in savings over eight years came from the SSI population. Other states, such as Texas and Kentucky, have also seen cost savings from mandating enrollment of this population.

Some states, such as Arizona and Kentucky, that have been cited as successful in cost-savings studies, mandate enrollment for all Medicaid recipients. DHH is not currently requiring mandatory enrollment of additional populations but may do so in the future depending on the success of the program.

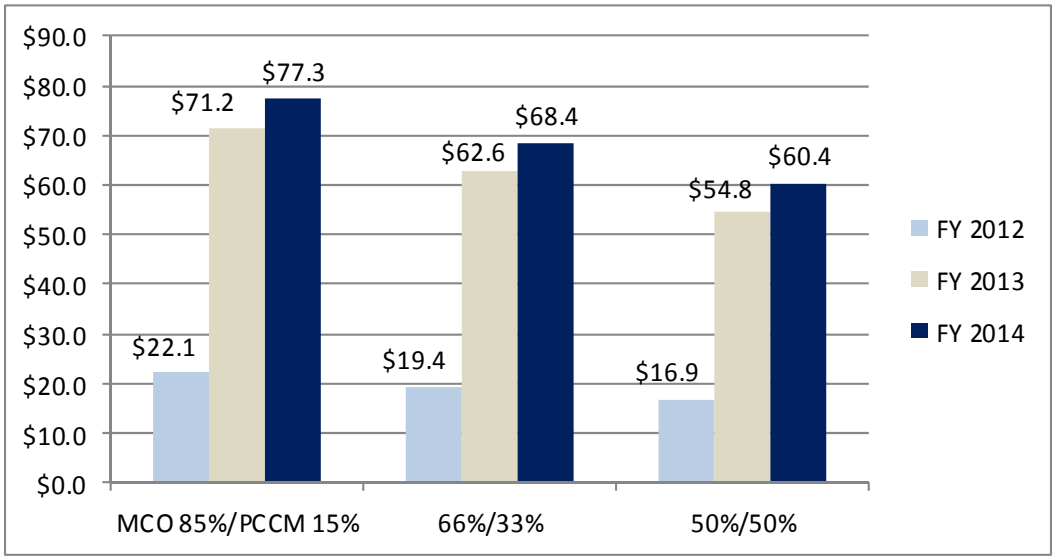
Services Included and Excluded. The CCN-S model is only required to provide primary care case management services. The CCN-P model will include core services, such as chemotherapy, physical therapy, hospital services, transportation, and immunizations. Federal law requires that the amount, duration, and scope of services provided by managed care not be less than what the current Medicaid program provides. The CCN-P model may allow organizations to provide more medical services than the current Medicaid program requires. In addition, some services will be "carved out," meaning they remain Medicaid FFS treatments. Exhibit 5 summarizes services included and excluded in Louisiana as compared to some other states.

Exhibit 5 Comparison of Services Included and Excluded		
State	**Services Included**	**Services Excluded (Carve-outs)**
Louisiana	Standard Medicaid Benefits*	Pharmacy, Dental, Specialized Behavioral Health, Hospice, Targeted Case Management, Long-Term Care (LTC), Special education school-based services
Arizona	All services	n/a
Kentucky	Standard Medicaid Benefits	LTC, mental health, and school-based services
Tennessee	Standard Medicaid Benefits	LTC provided by Nursing Facilities and ICF/DDs, Home and Community-Based Services
Pennsylvania	Standard Medicaid Benefits	Behavioral Health, LTC
Texas	All services	n/a
*Standard Medicaid Benefits: Unless specifically excluded, this means physicians' services, laboratory and X-ray services, inpatient hospital services, outpatient hospital services, etc. **Source:** DHH staff and other studies.		

As the exhibit shows, Arizona includes all services in its Medicaid managed care program. However, some states exclude certain service such as LTC, behavioral or mental health, and dental services. As the exhibit shows, pharmacy will initially be an excluded service in Louisiana. According to the Lewin Group's synthesis of 24 studies on Medicaid managed care, pharmacy is an area where states experienced increased in cost savings. For example, a comparison of drug costs under FFS and Medicaid managed care found that the per member per month cost of the drugs in the managed care setting was 10 to 15 percent lower than in the FFS setting. According to DHH, pharmacy, in addition to other services that are initially carved out, may be added as an included service as the program progresses.

Cost Savings. DHH contracted with the Mercer Group to develop cost-savings projections for the first six years of the CCN program based on different enrollment scenarios. According to the Mercer report, the Louisiana managed care model will save from approximately $17 million to $98 million (2-3 percent) annually relative to the current FFS Medicaid delivery system. Exhibit 6 shows the amount of potential cost savings by state fiscal year for the first three years of the CCN program, given different scenarios regarding the percentage of enrollees in each model (MCO and PCCM).

Exhibit 6: First Three Years of Estimated Savings for CCN Program (in millions)



Source: Cost-savings projections provided by DHH.

As the exhibit shows, the level of expected savings depends upon the number of Medicaid recipients enrolled in each model type. According to Mercer, projected savings result from eliminating inappropriate services and moving services to more appropriate settings (i.e., from emergency room to primary care physician office).

The cost savings anticipated for FY2012 are lower than the other years because of implementation costs associated with the CCN program and full implementation will not be complete until May 2012. According to DHH, implementation costs consist of overlapping FFS and managed care claims that will exist during the first two to three months. DHH anticipates this cost to be approximately $114 million for FY2012.

Based on our review, the savings projected for the CCN program are lower than what some states have actually experienced. DHH attributes this to the absence of pharmacy in the CCN program and the fact that DHH will enforce a rate floor for providers that enter into network agreements with CCNs. Exhibit 7 compares Louisiana's annual cost-savings projections to actual cost-savings achieved in other states.

Exhibit 7: Cost-savings Comparison		
State	**Cost-savings (%)**	**Year(s)**
Louisiana	2-3% (Estimate)	SFY 2012 - 2017
North Carolina	6-11 %	SFY 2003 - 2007
Arizona	7%	SFY 1983 - 1993
Michigan	9-19%	SFY 2001 - 2004
Kentucky	3-10%	SFY 1999 - 2003
South Carolina	8%	SFY 2009
Source: Prepared by legislative auditor's staff using various studies on cost savings.		

What problems have other states experienced in the implementation of Medicaid managed care and how has DHH addressed them?

Although many states and national studies have found that Medicaid managed care decreases costs and improves health outcomes, some states have also experienced problems with implementing managed care. We reviewed various studies that evaluated Medicaid managed care programs and identified common issues, such as improper denial of claims, lack of state oversight, and issues with rates. We also determined whether DHH has or will address each of these issues. The sections below summarize the issues and how DHH plans to address them.

Taking Low Risk Beneficiaries. Since unhealthy or risky recipients often need complex or expensive services, enrolling only healthy recipients will reduce costs and increase profits. To prevent CCNs from only enrolling healthy recipients, DHH allows eligible recipients to have their choice of plan and within each plan to select their CCN. DHH also prevents CCN organizations from speaking directly to potential enrollees. The enrollment broker contractor staff are the only individuals allowed to speak to a Medicaid recipient. In addition, per member per month rates will be adjusted periodically based on the health and risk of enrollees.

Improper Denial of Claims. CCNs may try to reduce costs by denying claims because they believe services are not medically necessary. To address this, DHH will require that claims denied for certain reasons be sent to DHH monthly. DHH will review a sample of these denied claims to determine that the denials were appropriate. If DHH determines that the CCN organization is inappropriately denying claims, the monetary penalty is $5,000 per occurrence.

Failure to Hold CCNs Accountable. DHH should hold CCNs accountable for meeting performance standards, health outcomes, and cost savings. To address this, DHH will tie monetary benefits to health outcomes. Each CCN organization must meet different benchmarks that will be included in the contract. In addition, CCN organizations must submit quarterly financial reports to evaluate whether cost savings were met. If certain outcomes are not met, CCN organizations will have to repay part of the funds. DHH will also post performance outcome measures, sanctions, and other information on the DHH Making Medicaid Better Website. Senate Bill 207 of the 2011 Regular Session also would have required that DHH submit outcome information to the legislature and provide the legislature with the authority to sunset the program. However, this bill was vetoed by the governor.

Inadequate or Excessive Rates. Member rates set high can result in states having greater expenditures under their managed care program than in their FFS programs. However, member rates set too low will make it difficult to attract or retain health plans and could violate the federal requirement that rates must be actuarially sound. Some states, such as Connecticut and Oklahoma, eliminated their MCO models of care because of provider disputes over rates.

According to DHH, rates for CCN organizations will be determined by DHH acting on the advice of its actuaries, and the rates must be actuarially sound as required by law. Rates will initially be set using historical FFS data with appropriate adjustments made for the expected impact of managed care on the utilization of the various types of services (both increases and reductions), unit cost trend, Medicaid program changes, third party liability recoveries, and

expected cost of CCN administration and overhead. After three months, rates will be adjusted to account for the health risk of the enrollees in each CCN organization. According to DHH, rates will be reviewed and may be periodically adjusted; however, all adjustments must be actuarially sound and consistent with federal requirements.

In addition, because DHH has established two models for Louisiana and multiple CCNs for each model, it will be easier to fall back on one or the other should one not be successful or organizations decide to leave the state.

Short-term Enrollments. Some populations, such as the Temporary Assistance for Needy Families population, often have short-term enrollment duration. This results in continuous processing of enrollments and dis-enrollments and increases administrative costs. In addition, shorter enrollment times reduce the CCN organization's ability to influence long-term health outcomes. According to DHH, Louisiana has one of the best Medicaid retention rates in the country because of aggressive policies and procedures to prevent disenrollment of eligible people at annual renewal. DHH has also made the process completely paperless to lessen the administrative hassle of enrollment and disenrollment.

Insufficient Number of Providers. A common concern among states is that recipients may have to wait months or travel long distances to see providers because specialists and other providers are not within their area. To address this concern, DHH requires that CCNs must have the capacity to enroll a minimum of 75,000 Medicaid beneficiaries. Through selection of CCNs through the RFP process, DHH will also ensure that each type of CCN model has the required number of providers to meet Medicaid enrollee capacity requirements and also to ensure choice for recipients.

Increased Administrative Cost/Less Spent on Direct Care. Another common concern is that private, for profit CCNs will have higher administrative costs than states did under FFS Medicaid and they will be spending less on actual health care. To help address this concern, DHH is including Medical Loss Ratio (MLR) restrictions in CCN contracts. According to DHH, this concern will ensure a certain percentage of program funds go toward direct patient care, limiting CCNs' profits. Currently, the minimum MLR is set at 85 percent, which means that 85 percent of funds must go to patient care. The remaining 15 percent can go toward administrative costs, network adequacy requirements, and profits. If actual MLR is less than 85 percent, the difference must be refunded to the state.

APPENDIX A: SCOPE AND METHODOLOGY

To answer our informational objectives, we conducted the following procedures:

- Collected information through internet searches, Kaiser Foundation, and meetings with DHH officials to determine the types of Medicaid Managed Care (MMC) and the relevant issues related to those MMC plans.

- Met with DHH officials to determine which states that Louisiana modeled their MMC plan after. Collected information from internet searches and official state websites to determine the types of MMC plans for the states identified as model states by DHH officials.

- Used research on outcome and cost savings to identify successful states. Considered states successful if they achieved cost savings or improved health outcomes. In addition to research into successful states, conducted research into outcomes and cost savings from managed care in general.

- Conducted internet searches and used official state websites to determine any cost savings and outcome information available for each model state's plan.

- Met with DHH officials, gathered information from the Making Medicaid Better website, and reviewed Federal Statute 42 CFR 438.2 to determine what the Louisiana MMC plan was.

- Obtained copies of the draft RFPs for monitoring the CCN-Ps and CCN-S's and received additional guidance through e-mail correspondence with DHH officials.

- Obtained from DHH officials the methodology and the cost-savings projections for the Louisiana MMC conducted by Mercer Government Human Services Consulting.

- Conducted internet searches and contacted DHH officials to determine what current issues and findings surround MMC and how the Louisiana MMC plan addresses these concerns.

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