DEPARTMENT OF HEALTH AND HOSPITALS

FACTS

January 10, 2011

Fact or Fiction?

Louisiana Medicaid's Proposed Coordinated Care Networks

FICTION: Doctors will be paid less by the CCNs than by Medicaid fee for service.

FACT: CCNs will be required to reimburse doctors and hospitals at least the rate they would receive under fee-for-service Medicaid. In a CCN, networks and providers can negotiate higher rates.

FICTION: CCNs will make it harder for Medicaid enrollees to obtain health care.

FACT: The opposite is true. CCNs will be required to have an adequate network of primary care physicians, specialists and hospitals that are geographically accessible to the recipients. Now, instead of the primary care physicians being responsible for finding a specialist willing to see their patients, the prepaid networks will be required to ensure access to this care. With the partnership of a Coordinated Care Network, doctors can focus on treating their patients. Tools like prior authorization, utilization management, and use of InterQual criteria for hospital admissions will continue to be used as a way to ensure appropriate access to sometimes costly services.

FICTION: This is all about saving money and balancing the budget on the backs of the poorest and sickest people in our state by providing them with less care.

FACT: We contend that there are enough dollars in the system today to pay for care, but they are too often spent in the most expensive, inappropriate setting, with bad health results. By better coordinating care, some people can avoid being hospitalized, take fewer prescriptions and be treated before they need costly procedures, affording them a higher quality of life. Achieving better health and outcomes while spending less money is a position that DHH will defend vigorously.

FICTION: Insurance companies will make double digit profits and provide less care.

FACT: This is a gross exaggeration and simply not true. Actual profit margins for Medicaid managed care in other states are in the range of 2%. Some argue that we should be required to spend every dollar on direct patient care, but this is pretty close to the system we have today that produces terrible outcomes. By investing some of our resources in administrative costs to pay for preventive steps like disease management, aggressive management of high-risk pregnancy, outreach and education, we will achieve better quality of life and better outcomes (and save money at the same time). If directly provided by Medicaid, the same kinds of activities would require more state jobs and dollars.

FACT: Based on provider feedback, DHH will incorporate a Medical Loss Ratio (MLR) into the CCN contracts, ensuring that a significant portion of payments to health plans will go to direct patient care and programs to help physicians with care management and training needed as well as provide tools to help Medicaid enrollees become not only compliant but active participants in their health care.

FICTION: By implementing CCNs, DHH will "leave federal money on the table" and therefore deny rate increases that providers could otherwise expect to receive.

FACT: There is no such thing as free money. Even if Louisiana had the additional state dollars to draw down more federal money (which we don't), we could do so by simply increasing reimbursement rates or eligibility. Even with full CCN implementation, approximately 40% of all hospital inpatient days still will qualify for UPL. Unlike other states, Louisiana also has significant unspent DSH allotment that could be used for hospital rate increases (more than $400 million) if we had available state match.

FACT: One of the major tenants of our reform is to decrease reliance on hospital-based care and increase use of primary and preventive services to keep people healthier, and to treat chronic conditions more effectively. It's time Louisiana moved away from a payment system

OVER

that encourages care in the most expensive settings and doesn't focus on improving patients' health and quality of life.

FICTION: Louisiana is only interested in pursuing an insurance model that takes doctors out of the driver's seat.

FACT: This is simply not the case. CCNs are not designed to act as a barrier between a doctor and their patient, but rather be the infrastructure that helps that patient navigate the system and be a responsible consumer of health care. DHH also has simultaneously developed a CCN "shared savings" model in which a group of providers could organize to provide care without the involvement of an insurance company. To even the playing field, both models would have the benefit of first-market entry. With both models available, Medicaid enrollees (and providers) will be able to "vote with their feet," and play a more active role in the health care delivery system, selecting the plans or models that best work for them. However, even though projected savings will be less than what we expect to be achieved by the risk-bearing models, DHH intends to evenly assign those recipients that do not choose between both types of CCNs if capacity exists.

FICTION: The behavior of Medicaid enrollees (such as going to the ER for non-emergencies and failing to keep appointments or follow medical advice) can't be changed.

FACT: Experience in other states by Medicaid managed care entities proves that behavior can be changed. With or without CCNs, federal regulation significantly hinders the state from taking punitive action against an enrollee who consumes health care irresponsibly. The CCNs will have the flexibility under federal rules (to redirect savings in other areas like inpatient hospital utilization to providing patient outreach and training, navigation assistance, and one-on-one follow-up and case management.) CCNs can offer incentives or enhanced benefits to patients, encouraging them to adopt healthier behaviors. These methods, which the state cannot afford and is prohibited from providing in fee-for-service Medicaid, have proven to work very effectively in other states the department studied in developing this proposal.

FICTION: Doctors will be forced to contract with upward of 15 health plans with varying reimbursement methodologies and protocols—an unwieldy burden.

FACT: As a result of the unexpected number of entities submitting Letters of Intent to provide services to Louisiana Medicaid enrollees through the CCN Program open application process, DHH now will pursue a competitive procurement process for plan selection (RFP). This will allow the State to select a manageable number of the highest-quality entities to provide coordination of care for Louisiana citizens under both the prepaid and shared-savings models. This will reduce confusion for enrollees as well as reduce administrative complexity for providers.

FICTION: CCNs are a replication of Florida Health Reform (or TennCARE).

FACT: Louisiana's approach is unique to our state. As one of the last states to implement risk-bearing Medicaid managed care, we have the benefit of lots of states to research and study. Our staff has spent years poring over RFPs, contracts and evaluations as well as conducting meetings, interviews and discussions with dozens of other states about their lessons learned and what they would do differently if given the opportunity. The proposed plan for Louisiana's Medicaid program is based on these years of research.

FICTION: There have been many other plans developed that involved stakeholders' and providers' input that have been put on the shelf. Medicaid ignored those plans in development of the new plan.

FACT: Medicaid has taken these previous plans off the shelf and pulled recommendations where consensus was achieved. These ideas were essential for development of a "Louisiana model" for coordinating recipients' care in Medicaid that meets our state's needs while ensuring appropriate oversight and accountability for networks, providers, recipients and the State. These plans included but were not limited to: 1996 Committee of 100 (formed to implement capitated managed care); 2004 Governor Blanco's Health Care Reform Committee Reports; Levitt's Health Care Redesign Collaborative and Regional Consortia (2005-06) Report; Louisiana Health First Proposal (2008); Medicaid Reform Advisory Group (2008-09). The consensus areas included in the Coordinated Care Network Program DHH is now proposing include the medical home system of care, centered around core, evidence-based health care services; monitoring of utilization through a group of core quality indicators; network development requirements; network adequacy; financial management; appropriate staffing; subcontracting requirements;

OVER

enrollment process; grievances and appeals process; and sanctions. Medicaid has incorporated these essential Louisiana requirements, along with lessons learned from research and discussions with many other states, into the development of the proposed CCN Program.

FICTION: DHH developed this proposal for Coordinated Care Networks rapidly, and hasn't sought input from the Legislature and stakeholders or allowed time for them to participate in the process.

FACT: Even prior to DHH pulling the emergency rule and conducting more robust public engagement, the plan has been in development for several years. In July 2010, a public forum was held that discussed the program through the Draft Model Provider Agreements. DHH received more than 500 responses and questions and included those in the final agreements. DHH eventually pulled back the emergency rule on Coordinated Care Networks and provider agreements in October and delayed implementation specifically so Secretary Greenstein and DHH staff could have more time to meet with stakeholders before proposing a plan. Through November and December, DHH conducted nine meetings in every region of the state, with nearly 1,000 participants representing recipients, providers, health care organizations, advocacy groups and others. Legislators from each region participated in these meetings with their constituents. These meetings were publicized in advance to an e-mail list of more than 10,000 that DHH created to share news and updates about this important transition with stakeholders posted online, and issued to media as news advisories. DHH also has provided video, presentations, questions received with answers, and other materials from each forum online at www.MakingMedicaidBetter.com, and provides an online form through this site for people to submit their comments or questions electronically. Separate from these regional forums, DHH has held nearly 40 meetings with provider groups since April to discuss the proposal for coordinating care.

FICTION: CCNs won't have any accountability to the people of the state and will operate without transparency.

FACT: As designed, CCNs will have some of the most extensive standards, oversight and transparency requirements of any Medicaid coordinated care system in the country. Coordinated Care Networks under our model are required to report detailed health outcomes and are subject to hefty sanctions, up to and including termination of their contract with the state, for failure to comply. CCNs will be further required to submit comprehensive quarterly financial reports as well as complete monthly, quarterly, and/or annual reporting for areas such as authorization denials, claim-processing timeliness, reasons for claim denials, physicians in network with open panels, existing and new specialists, grievances, and customer service hotline statistics. None of this accountability exists under the current fee-for-service model.

FICTION: Fraud and abuse are already bad in Louisiana Medicaid, and would get even worse in a program with private insurance companies not subject to state oversight.

FACT: The majority of "fraud and abuse" incidents in Medicaid represent wasteful spending or negligent billing practices rather than criminal activities. For spending, because they assume the financial risk instead of taxpayers, CCNs have a huge incentive to reduce duplicative and unnecessary services and provide care in the most cost-effective setting (e.g., the primary care provider's office or an urgent-care center rather than a hospital emergency room). CCNs also have the financial resources to provide enrollee outreach and education, teaching them to use health care services in the most appropriate manner. For negligent billing, CCNs would have the resources to more effectively and efficiently monitor their provider networks and remove those who abuse the Medicaid system and/or routinely produce poor health outcomes.

FACT: DHH's Medicaid Program Integrity Unit will continue its relationship with the Attorney General's office and other law enforcement agencies to monitor for and prosecute Medicaid fraud. Citizens who suspect recipients are abusing Medicaid or receiving fraudulent benefits can report this anonymously through the toll-free hotline, 1-800-488-2917, or by filling out a form online at the Medicaid website at medicaid.dhh.louisiana.gov.