Risky Business: Medicaid Managed Care in Louisiana

The Louisiana Nursing Home Association (LNHA) serves as the unified voice of the nursing facility profession and the residents we serve. For over 60 years, LNHA member facilities have provided efficient, quality care to thousands of Louisianans. We have also worked closely with the legislature and administration in crafting creative solutions to assist the State in funding the Medicaid program while maintaining quality care for our residents.

Across the country, several states have mandated their nursing facilities operate under managed care organizations (MCOs). These MCOs are big-box, out-of-state insurance companies. In light of this trend, we have reviewed the matter carefully and offer this document which explains the following:

1) how nursing facilities continually manage the care of their residents;
2) that national studies are inconclusive regarding the effectiveness of managed care;
3) how Louisiana’s current managed care system has experienced problems; and
4) that other states have experienced problems in managed care systems.

Forcing Louisiana’s nursing facilities into managed care would be detrimental to our ability to provide vital health care services to those we serve. In short, moving a frail and elderly population into a managed care system is risky business because it places an insurance company between the resident and their caregiver.

The Current Environment

Nursing facilities continually manage the care of their residents.

Unlike the general Medicaid population, residents in nursing facilities already receive care in an extremely regulated and managed environment. State and federally mandated regulations not only control whether a person is properly admitted to a nursing facility, but they also require continual monitoring to determine if the nursing facility placement is the best environment for treatment of the resident.

Residents live in nursing facilities because the individual and their family have agreed to the placement and placement aligns with state and federal regulations. Once the decision is made for placement, the resident is assessed by a team of healthcare professionals such as nurses, nurse practitioners, therapists, social workers and nutritionists. Based on this assessment, and with the involvement of the resident and/or the resident’s family, an individualized plan of care is created that includes medical and social needs to ensure the resident is receiving the most effective care. Health care professionals implement this plan of care daily. The assessment is updated at a minimum of every three months or upon a significant change in the resident’s conditions. Based on the new or updated assessment, the care plan is revised if appropriate. Additionally, the resident is seen by a physician at least once every 30 days for the first 90 days and at least once every 60 days thereafter.

Louisiana’s Medicaid reimbursement system (Case Mix) pays based on the amount of care the resident requires using a federally-approved standard. The more care that is required, the higher the reimbursement; the less care required, the lower the reimbursement. Additionally, if nursing facilities do not spend a minimum amount (commonly referred to as floor spending) on resident care, the facility is required to return funds to the State. This payment structure establishes predictability in state spending and safeguards against runaway costs. As demonstrated above, an out-of-state insurance company cannot do anything to improve this process. Our residents’ care is managed by local health care providers and operators. The Medicaid nursing facility rate system employed by the State is extremely predictable and economical as it results in the fourth lowest Medicaid rate in the nation.

Overview of State and National Case Studies

National studies are inconclusive regarding the effectiveness of managed care.

In an attempt to control spending, several states have turned to privatized managed care controlled by big box insurance companies. The success of managed care varies greatly from state to state. Each state is unique in its
structure (administrative framework, patient population, and reimbursement rates, etc.) making an “apples to apples” comparison difficult. Similarly, studying individual state success is also problematic due to the difficulty in quantifying data and measuring outcomes. While various studies have been performed, the true value is questionable because the studies are often conducted by parties that study processes rather than clinical outcomes. There are very few independent peer-reviewed studies regarding managed care. Of those studies, many have resulted in inconclusive findings.

- Herring and Adams (2010) concluded from a six-year study of national data that direct medical costs remain relatively constant under managed care, but add in administrative costs and the overall cost in managed care systems could well be higher than under fee-for-service (FFS). (*Health Economics*)

- Duggan and Hayford (2011) examined a dozen years of national data and concluded Medicaid managed care had no effect on overall Medicaid spending. The study also concluded that if a state did experience savings, it was due to a switch from high reimbursement rates to managed care rates. In states with low reimbursement rates, the state lost money as insurance companies had to raise prices to attract providers. (National Bureau of Economic Research) **Note: Louisiana has the fourth lowest reimbursement rate in the nation. (Genworth)**

- Burns (2009) examined eight years of national data regarding disabled adults in capitated managed care and found no difference in costs with their counterparts in FFS. (*Medical Care*)

- A Columbia University study in 2012 determined that managed care results in lower-than-expected fiscal savings for many reasons. The reasons include 1) rates are already so low it is hard to get additional price discounts, 2) states already use prior authorization and utilization review, and 3) any savings are gobbled up by the cost of setting up the administrative infrastructure of managed care. Despite these obstacles, policymakers and analysts continue to tout the potential savings of managed care. An exchange between two analysts (Iglehart and Burns 2011) in *Health Affairs* is illustrative of this point. After Iglehart cited a study that stated “available evidence does suggest that states will reap savings from enrolling the aged and disabled into Medicaid managed care,” Burns responded by citing a study noting “there is no evidence that Medicaid managed care yields long-term cost savings for this population.” In the end, Iglehart agreed with Burns’ analysis but pointed to New York’s Medicaid director who said: “we are going to need the federal government to take a leap of faith with us with some of these populations.”

The elderly and frail should not be test cases for governmental leaps of faith. In fact, the director’s words are somewhat ominous as New York’s leap of faith resulted in findings of fraud by the managed care companies to the tune of $47 million and an ongoing class-action lawsuit filed by hundreds of beneficiaries claiming they were improperly denied services.

The highest criteria any plan affecting the elderly and frail should be judged by is the following question: does it improve the quality of care? There is scant evidence that managed care results in quality improvement. Despite a host of state initiatives, there are very few (if any) independent peer-reviewed studies that examine the clinical effectiveness of managed care. One possible explanation is that managed care cannot alter the various social determinants of health and has even less ability to improve health outcomes. Perhaps the greatest impact managed care can have regarding outcomes is the ability to put the beneficiary in touch with a primary care physician and dissuade the reliance on emergency room care. Neither of these issues is present in a nursing facility setting as residents are seen daily by health care professionals.

**Healthy Louisiana: Time for a Check-up**

*Louisiana’s current managed care system has experienced problems.*

Although Louisiana is relatively new to managed care, issues have already occurred. Healthy Louisiana, formerly known as the Bayou Health program, is comprised of five insurance companies that run Healthy Louisiana as part of the State’s managed care model of Medicaid-funded health insurance. A legislative audit in October 2016 revealed that the Louisiana Department of Health improperly paid millions of dollars from 2012 to 2016 to the Medicaid MCOs for recipients who no longer resided in Louisiana. The report notes that under managed care,
although the recipients were out of state and received zero services, the State still paid the monthly Medicaid cost for them. The erroneous payments continued for years. Also, in February 2016, the Louisiana Attorney General announced that a breach of one of the State’s managed care companies exposed sensitive data of approximately 13,000 of the State’s Medicaid recipients.

It is also questionable whether managed care is saving the State money. When comparing the rate of expenditure growth of Healthy Louisiana to traditional Medicaid fee-for-service programs, Healthy Louisiana expenditures increased 11.5% compared to 3% increase for traditional fee-for-service providers (SFY 2015/16 compared to LDH’s SFY 2016/17 expenditure forecast). (Note: the cost for the Medicaid expansion population is excluded from Healthy Louisiana expenditures.)

Heed caution from other states

Other states have experienced problems in managed care systems.
Louisiana is not the only state that has experienced difficulty in managed care. Other states have taken a gamble with managed care and have proven to be unsuccessful. In 2012, Connecticut fired the insurance companies running its managed care system and returned to a more traditional FFS system. An audit in 2009 discovered that Connecticut was overpaying the insurance companies it contracted to manage care by nearly $50 million dollars annually. Also, the state was routinely flooded with complaints from beneficiaries complaining of an inability to receive medical services. As a result of the transition back to fee-for-service, the average cost per patient decreased from $718 in mid-2012 to $670 per patient in 2015.

New York also experienced difficulties with its managed care system. As mentioned previously, the enrollees in New York’s managed long term care plans recently filed a class action lawsuit against the insurance companies for failing to provide a legally mandated level of care and deceiving them as to their ability to challenge their care levels. This lawsuit comes on the heels of a settlement in which a New York-based managed long term care company agreed to pay $47 million to settle claims it fraudulently enrolled more than 1,200 Medicaid beneficiaries in a managed care plan they didn’t qualify for.

States’ struggles have been well-documented in media outlets across the country. These states include Tennessee, New York, Illinois, Iowa, Wisconsin, Nebraska, Florida, Kansas and New Jersey. Reports include complaints of the decline of the quality of patient care, cuts to vital services delivered to patients, payment shortages for providers, etc.

We have also heard firsthand stories of the issues with managed care for the nursing facility population. Some Louisiana nursing facility providers also operate nursing facilities in other states that have adopted managed care. Their experience is that managed care shifts limited resources from providing patient care to overhead costs in the form of added administrative staff. The added administrative staff is needed to complete the myriad of forms required by various insurance companies. They also appeal denials of care for residents needing nursing facility services and work the nonstop process of collecting past due monies owed by insurance companies for the care that was properly billed and provided. Shifting resources from patient care to administrative costs does not improve the quality of care delivered.

Commitment to Protect

Studies and other states’ experiences have shown managed care for the elderly to be risky business. LNHA represents more than 250 nursing facilities statewide. We serve the needs of more than 30,000 Louisiana seniors who rely on the vital services and 24/7 care our facilities provide. Unlike big box, out-of-state insurance companies, we are members of our communities. We are honored to serve our communities and pride ourselves on providing loving environments and quality health care services to thousands of frail and elderly Louisianaans every day. Our residents do not need a large insurance company standing between them and the care they need. A managed care program for nursing facilities would not only be risky business; it would be a poor decision to make on behalf of Louisiana’s frail and elderly. Please join us in protecting Louisiana’s nursing facility population.