



TRANSITION COMMITTEE ON HEALTHCARE
Transition Advisory Team

Governor-Elect John Bel Edwards

January 7, 2016
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TRANSITION COMMITTEE ON HEALTHCARE

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January 7, 2016

Governor-Elect John Bel Edwards
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Governor-Elect Edwards:

Thank you for the opportunity to serve the great state of Louisiana as co-chairs of the Transition Committee on Healthcare. It has been a pleasure and an honor to assist you and our state. We offer our services as you continue your efforts to “Put Louisiana First.”

The overall state of healthcare in Louisiana is dire. While the Department of Health and Hospitals accounts for the vast majority of the state’s overall annual appropriations, a budget amount that continues to grow, health outcomes in Louisiana are consistently among the worst in the nation. In addition, the Medicaid program has come up drastically short of necessary funds in recent years.

Tasked with offering you sound counsel on improving healthcare in the state, a group of 50 Louisianans from diverse backgrounds met over the last few weeks to discuss the challenges and opportunities in our system and to develop this accompanying report. It includes 33 recommendations which we believe will help move our state in a positive direction with respect to both healthcare finances and improved health outcomes.

We hope you find this advice prudent and encourage you to continue working with stakeholders across the state as we move Louisiana forward under your leadership. We wish you much success and stand ready to further assist you.

Sincerely,


Mr. Ronnie Goux
Co-Chair

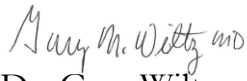

Dr. Gary Wiltz
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INTRODUCTION

The Governor's Transition Committee on Healthcare met six times over a period of three weeks to discuss the healthcare challenges facing our state. In particular, the committee was tasked with providing recommendations to immediately expand Medicaid, strengthen Louisiana's public-private partnerships, build on the Bayou Health managed care model and offer recommendations to improve health outcomes in Louisiana.

The committee was comprised of 50 individuals, many from across the spectrum of the healthcare industry. It included providers, administrators, pharmacists, advocates, and many other experts as well as citizens from sectors which count on access to strong healthcare. The committee was chaired by Dr. Gary Wiltz and Mr. Ronnie Goux.

Contained in this report is a brief summary of the current status of health and healthcare in Louisiana, in addition to key findings and a list of recommendations for consideration.

The committee was staffed by Andre Stoler and received briefings from Louisiana State Senate Senior Budget Analyst Heather Clark, DHH Undersecretary Jeff Reynolds, and DHH Medicaid Director Ruth Kennedy.

EXECUTIVE SUMMARY

Louisiana is at a crossroads in terms of healthcare, pertaining to both financing and efforts to improve health outcomes. Although the state spends more than \$9 billion a year through the Department of Health and Hospitals, Louisiana citizens are among the least healthy in the nation.ⁱ

According to the Louisiana Senate Fiscal Services Division and the Department of Health and Hospitals, healthcare spending has increased by more than 30% over eight years, while staffing has been reduced from more than 12,000 to fewer than 6,000. However, a review of health statistics shows that there has been no noticeable improvement in health outcomes as a result of the increased investment. Furthermore, the Medicaid budgetary situation is still tenuous at best.

The effort to privatize Louisiana's charity hospital system has received mixed reviews. While many statistics, such as wait times and patient satisfaction, have seen marked improvements, the fact remains that Louisiana's citizens are no healthier now than they were prior to these reforms.

The committee noted that Medicaid expansion will not solve the department's financial woes, although it will provide healthcare options at an attractive match rate to more than 300,000 citizens. However, an added challenge remains – many providers refuse to accept Medicaid patients if reimbursement rates remain at current levels.

According to a recent Senate Finance report, accepting these federal dollars may be the best means of covering the reductions in federal Disproportionate Share Hospital (DSH) funding for the safety-net hospital system.ⁱⁱ Therefore, the state should maximize efforts to draw down federal matches and dedicate as much of that revenue as possible to healthcare costs to address the department's budgetary shortfalls and improve services to citizens.

The state should also consider internal and, perhaps more importantly, independent review of both the public-private partnerships and managed care model of delivery to determine how best to strengthen these approaches.

In addition, this committee believes the incoming Department of Health and Hospitals secretary would be served well by an ongoing advisory committee of experts and stakeholders who can provide guidance as needed.

CURRENT STATUS

Department of Health and Hospitals

The Department of Health and Hospitals (DHH) is the primary state entity responsible for the health of Louisiana's citizens. DHH is composed of 19 separate agencies, each with their own budget unit, and contains over 5,500 personnel.ⁱⁱⁱ

DHH is Louisiana's largest state department. It represents more than 36% of the state's total budget in the current fiscal year, compared to 23.5% in FY08. A significant portion of the budget is covered through "match rates" where the federal government pays a percent of each dollar spent on healthcare. Federal funding of healthcare accounts for almost 60% of all federal support to Louisiana.

The department has a budget of \$9.7 billion for the current fiscal year. That total includes \$3.8 billion in state funds and \$5.9 billion in federal funds. The total budget for DHH has grown by 30.6% from FY08 to FY16, a total increase of approximately \$2.3 billion.^{iv} The state's portion of funding has increased by an even greater 47.5%, or \$1.2 billion.

The vast majority of DHH's expenditures pertain to its Medicaid program. Medicaid's share of DHH's budget has grown from 83.9% to 86.7% since FY08. Thus, approximately 31.8% of the state's budget in FY16 is used to provide healthcare for nearly 46% of the state's population.

Louisiana Medicaid Program

There are approximately 1.4 million individuals eligible for coverage under Louisiana's Medicaid program, although it also finances services for the roughly 16.6% of Louisianans who are uninsured; around 751,000 individuals. More than 300,000 uninsured will become eligible for Medicaid if the program is expanded.

Louisiana's Medicaid program budgeted \$8.4 billion for FY16, but recent projections from DHH show higher-than-expected utilization of the Medicaid program. In other words, more eligible people enrolled in the program than DHH initially projected, which means the program is likely to have a budget shortfall in this fiscal year.

The Administration is required by law to resolve this shortfall and claims to be doing so, although committee members express concern regarding their methodology. One example of concern shared by the Senate Fiscal Services Division is that payments were delayed from seven days to three weeks, rolling over two weeks of payments into the next fiscal year.^v

The federal government currently pays 62.2% of all Medicaid reimbursement. This is called the Federal Medical Assistance Percentages, or FMAP, rate. The FMAP rate is determined based on average state income levels. Louisiana enjoyed an enhanced FMAP rate post-Katrina, but that match rate was lowered to reflect Louisiana's income levels in recent years.

Public-Private Partnerships (PPPs)

The creation of public-private partnerships are, in part, a product of the post-recovery reduction of the “Disaster Recovery” enhanced FMAP rate. In FY11, FY12, FY13, and FY14 Louisiana qualified for this enhanced rate and had between a 5 and 9-point increase. At its peak in FY11, the FMAP rate covered 72.47% of every Medicaid dollar spent, meaning that today the federal government pays 14% less than it did in 2011.^{vi}

As a result of rate reductions in the years after Hurricane Katrina, DHH suffered a loss in revenue contributing to a funding gap. The state helped cover this shortfall by creating a new revenue stream by leasing non-revenue producing hospital properties to private operators and drawing down a federal match. As of today, there are 12 public-private partnerships operating across Louisiana.

Proponents of the public-private partnerships, of which there are many, point to the revenue and improvements in statistics like wait times and general patient satisfaction as indicators that the partnerships are working. Opponents, however, preferred management under the LSU/Charity Hospital system and point to a lack of improvements in health outcomes as an issue with public-private partnerships.

KEY ISSUES, THEMES, AND FINDINGS

Medicaid Expansion

Expanding Medicaid in Louisiana would increase eligibility by at least 300,000 individuals. According to a Senate Finance report, there are also approximately 224,000 additional individuals who would become eligible as well, if they dropped their current private coverage.^{vii}

It is estimated that Medicaid expansion would inject \$16 billion in federal funds into the Louisiana healthcare system over 10 years.^{viii} While the federal government covers 62.2% of standard Medicaid costs under the FMAP rate, expanded Medicaid is 100% federally funded through 2016 and then drops to 95%. Expanded Medicaid cannot, by federal statute, be less than 90% federally funded.

States that have adopted Medicaid expansion in the last two years have experienced promising economic benefits. In the first year of Washington's program, their savings outside of the Medicaid budget were equal to 1.7% of the general funds spending. A study by Deloitte Consulting projected that Kentucky's expanded Medicaid program will provide \$30 billion in net-new revenue to the state's economy and create 40,000 jobs in the first 6 years.

Louisiana also faces a loss in revenue as federal Disproportionate Share Hospital (DSH) payments are phased out, as mandated by the Affordable Care Act.^{ix} These funds are provided by the federal government for hospitals that serve a disproportionate share of uninsured or underinsured, but were to be replaced through the expansion of Medicaid eligibility. However, the Affordable Care Act did not account for the possibility that states could opt out of Medicaid expansion. Thus, as noted by the Senate Finance Committee, expanding Medicaid is the only option to prevent further state financial obligations as federal support for these indigent-care hospitals fades.^x

Health Outcomes

The committee reviewed several reports, including the United Health Foundation's (UHF) annual report ranking Louisiana 50th in the nation in terms of general health outcomes based on smoking rates, obesity rates and other factors. The committee recognizes that Louisiana's culture of indulgence and high levels of poverty exacerbate low health outcomes.

UHF's annual report for 2015 found that 11.3% of adults in Louisiana have been diagnosed with diabetes, ranking the state 39th in the country. Diabetes disproportionately affects the state's low-income population. Almost 18% of Louisiana adults with incomes of less than \$25,000 have diabetes compared to less than 8% of those making \$75,000 or more.

Evaluating the Current Model

A consistent focus throughout committee hearings centered on the models of delivery in Louisiana, specifically the value of public-private partnerships and the managed care model (Bayou Health).

While proponents point to improvements in statistics like wait times and patient satisfaction, some pointed to a lack of tangible improvements in health outcomes. As reflected in the committee's recommendations, many members believed the state should conduct a thorough internal review as well as commission independent analyses of these models.

Revenue

The committee unanimously supports additional revenue sources for healthcare funding. There was also broad consensus that many revenue streams related to healthcare (e.g. lease payments from PPPs, federal match dollars) should be dedicated specifically to healthcare costs.

The committee suggested additional revenue sources, some of which are proven to improve health outcomes such as "sin taxes" on harmful substances like alcohol and tobacco. They also stressed the need to maximize federal dollars received by drawing down a federal match wherever possible.

More details about suggested revenue sources can be found in the recommendations on the following pages.

RECOMMENDATIONS

Medicaid

- 1) The Healthcare Transition Committee unanimously supports expanding Medicaid in Louisiana. Medicaid should be expanded without initial consideration of waivers to expedite the intake of federal dollars. Mechanisms for cost-sharing and/or offsetting the state-share should be pursued later.
- 2) Pursue higher reimbursement rates for Medicaid to encourage all providers to participate in the program. Medicaid rates should be tied to Medicare rates.
- 3) Increase eligibility operations and communication efforts to maximize enrollment in an expanded Medicaid program and provide more information for providers and enrollees.
- 4) Commission a study on the current contracts surrounding and oversight of Bayou Health, Louisiana's Medicaid managed care model, to determine if this model is being optimally delivered. A particular focus needs to be on improved customer service and communication with patients and the provider community.
- 5) Pursue a comprehensive review of alternative mechanisms for funding indigent care and Medicaid to hospitals outside the state's public-private partnerships and how they impact the financial viability of health in Louisiana as well as overall

health outcomes. Ensure future providers who continue to receive alternative funding accept uninsured and Medicaid patients.

- 6) Consider implementation of Managed Long Term Support and Services for individuals with developmental disabilities to include all Medicaid services and settings.
- 7) Consider implementation of Managed Long Term Support and Services to involve all providers, including nursing homes and institutional services.
- 8) Evaluate the medical-necessity of the services currently covered by the Medicaid Fee Schedule. Create an evidence-based review team in Medicaid that regularly updates the fee schedule, evaluates new technologies for coverage, and sunsets items for coverage for which there is no evidence of benefit or evidence of harm.
- 9) Adopt, fund, and implement Section 2703 of the ACA as funding becomes available; accept federal match to fund certified Medicaid health homes.

Public-Private Partnerships

- 10) Pursue a rigorous independent and internal review of the public-private partnerships, including but not limited to: how they impact the financial viability of healthcare, overall health outcomes, medical education, and access to care.
- 11) Dedicate all revenue from lease payments for public-private partnership facilities to healthcare costs.

Department of Health and Hospitals

- 12) Retool existing DHH Healthy Communities initiative to create Chambers of Community Health in each parish.
- 13) Utilize and expand current infrastructure, in consultation with industry leaders, to increase adoption of a statewide telehealth network and establish a structure within DHH to administer the program.
- 14) Catalog all former and current behavioral health resources and prioritize a list of services to be restored by DHH.
- 15) Explore a partnership between DHH and DOE to maximize existing programs and consider new ones to educate students about the dangers of smoking, drinking, obesity, and diabetes.
- 16) Increase inter-agency cooperation with health and environmental departments.
- 17) Consider legislation to modify composition of Local Governing Entity Boards to ensure equal representation of all three service areas: developmental disability, mental health, and addiction recovery. Also require equal representation of professionals and service recipients/family members on the boards.

Public Health and Welfare

- 18) Consult with experts to expand models of delivery for community-based primary care and mental health services for vulnerable populations utilizing modern Health Information Technologies.

- 19) Explore and expand the utilization of Community Health Navigators statewide.
- 20) Implement and support evidence-based preventive strategies and programs for chronic diseases.
- 21) For matters of public health and safety affected by Title 51 and related regulations, include a state licensed Journeyman and a state licensed Master Plumber to DHH Standing Committees.
- 22) Support and expand the role of family caregivers by communicating and educating caregivers at hospital entry and exit points for both physical and behavioral-health patients.
- 23) Support additional funds in medication therapy management and other chronic disease management strategies.
- 24) Increase funding for the Rural Track Program to accommodate between 10 and 20 students per year to address lack of providers in rural areas.
- 25) Consider long-term support for housing for those suffering from mental illness.
- 26) Consider increasing the amount of assisted living grants, waivers, and adult day care.
- 27) Support and expand programs that improve the health status of children such as Early and Periodic Screening, Diagnostic and Treatment, Supplemental Nutrition Program for Women, Infants, and Children, School Based Health Services, etc.

Revenue Sources

- 28) Encourage repeal of local sales tax on prescription drugs and medical devices.
- 29) Consider increases for “sin taxes,” such as the cigarette and alcohol taxes; dedicate revenue to healthcare funding.
- 30) Increase the existing federally-mandated premium tax to generate additional revenue from the federal match; dedicate the resulting revenue to Medicaid.
- 31) Increase the provider assessment to generate additional revenue from the federal match; dedicate the resulting revenue to Medicaid.

Miscellaneous

- 32) Convene a Health Summit among experts from all healthcare arenas to discuss addressing health-related issues facing Louisiana.
- 33) Adopt best practices of the American Heart Association regarding Louisiana schools, such as:
 - Require a minimum time period for lunches
 - Renew mandatory physical education and health education/literacy programs in schools
 - Encourage more recess time for younger students

Finally, the committee stated that the Administration would be served well by establishing a permanent health care advisory committee to provide support and guidance to the Governor and incoming DHH leadership as they work to improve access to quality healthcare and improve health outcomes for the citizens of Louisiana.

CITATIONS

- ⁱ Louisiana Senate Fiscal Services Division. *Budget Information: Department of Health and Hospitals*. Baton Rouge, LA: 2015.
- ⁱⁱ Louisiana Senate Committee on Finance. *Health Care in Louisiana: Medicaid, its Means of Financing and Considerations for the Future*. Baton Rouge, LA: 2015.
- ⁱⁱⁱ Department of Health and Hospitals. *Health Care in Louisiana: Service Provision and Financing*. Baton Rouge, LA: 2015.
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- ^v Melinda Deslatte. “Lawmakers vote to spend \$28M from state ‘rainy day’ fund,” Associated Press, December 9, 2015.
<http://www.americanpress.com/outdoors/>
- ^{vi} Congressional Research Service. *Medicaid’s Federal Medical Assistance Percentage (FMAP), FY2014*. Washington, DC: 2013.
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- ^{viii} Staff Writer. “Louisiana: Lawmakers Refuse to Add More Working Poor to Medicaid,” The Associated Press, April 29, 2015.
<http://www.nytimes.com/2015/04/30/us/louisiana-lawmakers-refuse-to-add-more-working-poor-to-medicaid.html>
- ^{ix} Kaiser Family Foundation, *How do Medicaid Disproportionate Share Hospital (DSH) Payments Change Under the ACA?* 2013.
- ^x Louisiana Senate Committee on Finance. *Health Care in Louisiana: Medicaid, its Means of Financing and Considerations for the Future*. Baton Rouge, LA: 2015.