



Health Care in
Louisiana:
Medicaid,
its Means of Financing
and
Considerations for the Future

Review of the Medicaid Program

Federal law and rules guide all aspects of the Medicaid program and Medicaid programs vary from state to state. A state must negotiate with the federal Centers for Medicare and Medicaid Services (CMS) to determine the structure of its Medicaid program in terms of eligibility, benefits, reimbursement methodologies, and financing mechanisms. So long as a state adheres to its approved state plan and any waiver agreements, the federal government will provide matching funds, according to the parameters it legislates, to aid in the financing of the Medicaid program.

The major items to consider in administering the Medicaid program include the following:

- Variations in Federal Financial Participation;
- Mandatory and Optional Populations –
 - MOE Requirements on CHIP Eligibility through September 30, 2019;
- Mandatory and Optional Services;
- Fee-for-Service versus Managed Care Medicaid Programs –
 - Actuarial Soundness Requirements for Managed Care Plans;
- Reimbursement Methodologies;
- Service Levels;
- Adequate Access to Services for Recipients; and
- Choice Requirements for the Elderly and Disabled under the Olmstead and Barthelemy Cases.

Medicaid Payments Means of Financing History

MEANS OF FINANCING	FY 2007-2008	FY 2008-2009	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
State General Fund (Direct)	\$906,630,895	\$1,158,230,748	\$722,361,378	\$583,143,501	\$1,335,319,929	\$1,424,860,360	\$1,787,722,480	\$1,720,180,960	\$2,208,939,008
State General Fund by									
Interagency Transfers	\$561,130	\$11,491,469	\$36,608,632	\$63,300,134	\$38,966,674	\$59,542,615	\$86,006,428	\$40,950,173	\$165,168,290
Fees and Self-generated Revenues	\$5,603,411	\$5,766,082	\$6,923,587	\$75,876,810	\$105,411,285	\$57,175,706	\$151,682,606	\$171,549,868	\$118,958,518
Statutory Dedications:									
2013 Tax Amnesty Collections Fund	\$0	\$0	\$0	\$0	\$0	\$0	\$292,860,822	\$190,987,435	\$52,000,000
Community and Family Support System Fund	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$110,100	\$182
Community Hospital Stabilization Fund	\$0	\$0	\$0	\$0	\$0	\$15,488,386	\$915,128	\$0	\$0
FMAP Stabilization Fund	\$0	\$0	\$0	\$0	\$0	\$111,677,000	\$0	\$0	\$0
Health Excellence Fund	\$17,321,427	\$20,532,059	\$21,660,319	\$15,007,885	\$13,878,675	\$24,917,657	\$25,763,940	\$35,547,603	\$30,484,924
Health Trust Fund	\$14,205,169	\$15,308,853	\$5,923,239	\$8,387,818	\$6,280,952	\$6,312,199	\$5,770,768	\$3,432,531	\$566,667
Louisiana Fund	\$6,441,342	\$6,696,071	\$6,696,071	\$7,149,052	\$9,755,047	\$5,119,644	\$11,971,046	\$10,764,970	\$4,942,942
Louisiana Health Care Redesign Fund	\$53,539,616	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana Medical Assistance Trust Fund	\$503,754,471	\$153,662,016	\$216,202,043	\$403,715,644	\$312,672,978	\$385,750,761	\$157,857,986	\$155,977,605	\$189,865,163
Medicaid Trust Fund for the Elderly *	\$27,373,789	\$46,137,618	\$109,939,381	\$124,620,068	\$97,222,925	\$121,102,705	\$183,505,794	\$232,916,144	\$1,133,333
Medical Assistance Program Fraud Detection Fund	\$2,004,458	\$2,677,967	\$0	\$0	\$0	\$0	\$0	\$0	\$0
New Opportunities Waiver (NOW) Fund	\$0	\$131,474	\$12,845,705	\$24,930,667	\$11,174,264	\$0	\$0	\$0	\$0
Overcollections Fund	\$0	\$0	\$61,953,953	\$359,500,000	\$0	\$0	\$0	\$339,988,256	\$114,556,548
Tobacco Tax Medicaid Match Fund	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$106,400,000
Federal Funds	\$4,428,447,394	\$4,972,766,818	\$5,515,670,248	\$5,213,097,302	\$4,705,297,353	\$4,901,394,910	\$4,873,605,782	\$4,960,125,703	\$5,387,723,644
TOTAL MEANS OF FINANCING	\$5,965,883,102	\$6,393,401,175	\$6,716,784,556	\$6,878,728,881	\$6,635,980,082	\$7,113,341,943	\$7,577,662,780	\$7,862,531,348	\$8,380,739,219
<i>TOTAL STATE FINANCING</i>	<i>\$1,537,435,708</i>	<i>\$1,420,634,357</i>	<i>\$1,201,114,308</i>	<i>\$1,665,631,579</i>	<i>\$1,930,682,729</i>	<i>\$2,211,947,033</i>	<i>\$2,704,056,998</i>	<i>\$2,902,405,645</i>	<i>\$2,993,015,575</i>

* The state had to repay the federal government for a disallowance stemming from the calculations used to generate the intergovernmental transfers (IGTs) that populated the Medicaid Trust Fund for the Elderly. In FY10, the repayment totaled \$60,706,514 and, in FY11, it was \$58,821,803.

Overview of the Revenue Sources

Financing Louisiana's Medicaid Program Today

The Medicaid program is funded with a mix of State General Fund (Direct), Interagency Transfers, Fees and Self-generated Revenues, Statutory Dedications, and Federal Funds.

Interagency Transfers

- From the Department of Children and Family Services and the Office of Juvenile Justice for the Coordinated System of Care component of the Louisiana Behavioral Health Partnership
- From other state agencies to fund the state's portion of supplemental payments made pursuant to the Low Income, Needy Care Collaborative Agreements
- From the Office of Group Benefits from premium payments collected from individuals participating in LaCHIP Phase V
- Community Development Block Grant funds via the Division of Administration serving as the state match for the Greater New Orleans Community Health Connection

Fees and Self-generated Revenues

- Refunds and recoveries, including Third Party Liability collections
- Intergovernmental transfers from non-state public providers

Overview of Revenue Sources

Financing Louisiana's Medicaid Program Today

Statutory Dedications

- 2013 Tax Amnesty Collections Fund is depository fund for the proceeds of tax collections received pursuant to the Louisiana Tax Delinquency Amnesty Act of 2013.
- Community and Family Support System Fund is comprised of the proceeds stemming from the sale or lease of all or part of any movable and immovable property previously operated by OCDD.
- Health Excellence Fund is one the three funds dividing the interest earnings of the Millennium Trust, which contains the preponderance of the moneys received prior to July 1, 2012, pursuant to the Master Settlement Agreement reached between certain states and participating tobacco manufacturers. In addition, the proceeds from four-cents of the per pack tax on cigarettes is deposited into this fund.
- Health Trust Fund is populated with the transfer of one-third of the interest earnings of the Medicaid Trust Fund for the Elderly.
- Louisiana Fund is payable out of the annual funding received pursuant to the Master Settlement Agreement reached between certain states and participating tobacco manufacturers.

Overview of Revenue Sources

Financing Louisiana's Medicaid Program Today

Statutory Dedications, continued

- Louisiana Medical Assistance Trust Fund is comprised of revenues generated by the provider fees on nursing homes, intermediate care facilities for the developmentally disabled and prescription drugs, and premium assessments on the Medicaid managed care plans.
- Medicaid Trust Fund for the Elderly is comprised of the proceeds from the nursing home intergovernmental transfer program that occurred over nine quarters in FY2001, FY2002 and FY2003.
- Overcollections Fund derives from a variety of sources as provided for in the Funds Bill each year.
- Tobacco Tax Medicaid Match Fund received the proceeds from the most recent changes to tobacco taxes, including the increase of the tax on cigarettes by 50¢ per 20-pack and the addition of a tax of 5¢ per milliliter of consumable nicotine solution.

Federal Funds

- Federal financial participation in the Medicaid program
- ARRA Health Information Technology Grant
- Certified Public Expenditures (CPEs) from state and non-state governmental entities

Developments in the Determination of Adequate Access to Services

In response to the Supreme Court decision in *Armstrong v. Exceptional Child Center, Inc.* [135 S. Ct. 1378 (2015)], CMS is strengthening its review and approval criteria for requests to alter fee-for-service reimbursement methodologies to ensure Medicaid access to care is preserved in a final rule published on November 2, 2015, and effective on January 4, 2016.

In this case, the Supreme Court ruled that Medicaid providers and beneficiaries do not have a private right of action to contest state-determined Medicaid payment rates in federal courts and that federal administrative agencies are more appropriate than federal courts to make these determinations.

CMS began the process of strengthening its efforts to ensure that rates are “consistent with efficiency, economy and quality of care” and to ensure sufficient beneficiary access to care as required in federal law in 2011. In response to the court’s action, CMS is finally moving forward in finalizing new processes to evaluate whether states are abiding by these provisions.

The final rule establishes new procedures for states when seeking CMS approval of provider rate reductions or rate restructuring that may impact access:

- States will need to perform an analysis of the effect that such rate change will have on beneficiary access to care;
- States will need to consider input from beneficiaries, providers, and other stakeholders within their analyses; and
- States will also need to monitor the effect the changes have on access to care for at least three years after the changes are effective.

Developments in the Determination of Adequate Access to Services

In addition, the rule also requires states to submit Access Monitoring Review Plans. These plans provide for a mandatory review of at least five services: primary care, physician specialist, behavioral health, pre- and post-natal obstetrics (including labor and delivery), and home health. States must also monitor access for any service for which payments have been reduced or restructured. Finally, if a state or CMS receive a significantly high number of complaints about access to care for any other services, then those services must be added to the review plan.

Within the review plans, states will choose the appropriate measures, data sources, baselines and thresholds that take into account state-specific delivery systems, reimbursement rates from multiple payers, and beneficiary characteristics and geography. The review plans will need to be reviewed and updated at least every three years.

These parameters could be altered as CMS is requesting comments on the access review requirements.

Finally, the rule requires states to implement ongoing mechanisms for beneficiary and provider input on access to care and to promptly respond to reported access problems, with an appropriate investigation, analysis, and response.

The Affordable Care Act

In 2010, Congress passed two bills that comprise what is commonly referred to as the Affordable Care Act (ACA) - the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act. The ACA made broad changes to the way health insurance is provided and paid for in the United States.

Since 2010, the ACA has been tweaked with additional amendments located in numerous legislative instruments.

One of the primary policy goals of the ACA was to significantly reduce the number of underinsured or uninsured individuals aged 19-64 by providing a continuum of coverage options through private coverage, the Health Benefit Exchanges/Health Insurance Marketplaces and the Medicaid program.

Health Benefit Exchanges/Health Insurance Marketplaces

The ACA created a new mechanism for purchasing coverage called the Health Benefit Exchanges (commonly referred to now as Health Insurance Marketplaces), which were entities that would be established to create a competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers understand the options available to them.

Low-income individuals utilizing the exchanges receive assistance in paying for their health benefits. Citizens and legal residents with household incomes between 100% and 400% of the federal poverty level (FPL) that purchase coverage through an exchange are eligible for a tax credit to reduce the cost of coverage. Those with incomes between 100% and 250% FPL also are eligible for reduced cost sharing (e.g., coverage with lower deductibles and copayments) paid for by the federal government. The premium tax credits and cost-sharing assistance began in 2014.

Medicaid eligibles do not qualify for premium assistance in the exchanges. Further, in states without expanded Medicaid coverage, adults with incomes at or below the federal poverty level are still not eligible for exchange subsidies, while those with incomes between 100% and 138% of the federal poverty level are.

Individuals offered coverage through an employer are also not eligible for premium tax credits, unless they meet certain thresholds deeming their employer-sponsored insurance unaffordable. Then, they are eligible to enroll in a health insurance exchange and may receive tax credits to reduce the cost of coverage purchased through the exchange.

Medicaid Eligibility Expansion Option

The ACA was enacted in 2010 mandating that states expand their Medicaid programs to extend eligibility thresholds include a new adult group composed of non-pregnant adults aged 19-64, with household incomes at or below 133% of the federal poverty level (plus a mandated income disregard of 5% essentially making the limit 138% FPL), and not already eligible for Medicaid under a mandatory eligibility category, beginning on January 1, 2014.

In 2015, to qualify under the ACA Medicaid expansion eligibility threshold of 138% FPL, an individual's annual income would have to be equal to or less than \$16,242 (plus \$5,740 for each additional family member). For example, the parents in a family of four with an annual income at or below \$33,465 would qualify for coverage under the ACA Medicaid expansion.

In 2012, the U.S. Supreme Court issued an opinion declaring this mandatory Medicaid expansion unconstitutional and thereby granting states the option to adopt the Medicaid expansion.

Medicaid Eligibility Expansion Option

To assist states in financing the expansion, ACA provided for an enhanced Federal Medical Assistance Percentage (FMAP), the rate of matching funds the federal government will provide, for the newly eligible members of the new adult group.

To deem an enrollee “newly eligible” and their coverage costs qualify for the enhanced FMAP, the enrollee could not have been eligible for full Medicaid benefits under the Medicaid state plan as of December 1, 2009.

The enhanced Medicaid federal match rate for services provided to the ACA “newly eligible” population is 100% in calendar years 2014, 2015, and 2016, and then the rate gradually decreases until it reaches a floor of 90% in 2020 and beyond – 2017 - 95%, 2018 - 94%, 2019 - 93%, and 2020 - 90%.

Reductions in Federal Disproportionate Share Hospital (DSH) Funding

Health care services for the uninsured are financed via Medicaid DSH payments for limited, allowable hospital-based services at the regular FMAP match rates. Between the Medicaid expansion option and the opportunities for individuals to access health insurance in the marketplaces, Congress anticipated savings in DSH payments across the nation due to a projected decline in the number of uninsured individuals and included a schedule of reductions to the federal DSH allotment in the ACA.

The statute originally required annual aggregate reductions in federal DSH funding from FFY 2014 through FFY 2020. The schedule of reductions has been amended at least four times. These reductions are now set to begin in FFY 2018 and continue through FFY 2025, with aggregate reductions of \$2 billion for FFY 2018, \$3 billion for FFY 2019, \$4 billion for FFY 2020, \$5 billion for FFY 2021, \$6 billion for FFY 2022, \$7 billion for FFY 2023, and \$8 billion for both FFYs 2024 and 2025.

In addition, there are also proposals to rebase DSH to adjust for the decline in the total number of uninsured individuals, especially after FFY 2025, when the federal DSH pool would return to its pre-ACA levels and the scheduled reductions end.

Reductions in Federal Disproportionate Share Hospital (DSH) Funding

The law does require that the Department of Health and Human Services make certain considerations in assessing the reductions on the states. These factors have not been amended when the schedule of yearly reductions was being altered.

The law required the HHS secretary to develop a methodology that imposes the largest reductions on states that have the lowest percentages of uninsured individuals or do not target their DSH payments to hospitals that have a large volume of Medicaid inpatients or high levels of uncompensated care (excluding bad debt). Low-DSH states are to have a smaller percentage reduction imposed on them.

The reduction methodology shall also consider the extent to which a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion prior to July 31, 2009, under a Section 1115 Demonstration Waiver.

Reductions in Federal Disproportionate Share Hospital (DSH) Funding

As the reductions do not begin until FFY 2018, the final methodology to distribute these aggregate reductions across states has not yet been adopted. Based on a draft methodology released before the first delay in the allotment reductions, it is most likely that the reductions will impact all states, regardless of a state's expansion decision.

Under the draft methodology to implement a \$500 million, or 4.3%, cut to the federal DSH pool for FFY 2014, the percentage cuts to individual state DSH caps ranged from a low of 1.86% to Nevada's \$49 million cap to a high of 7.14% to Arkansas' \$108 million cap. Louisiana's cap of nearly \$732 million would have been reduced by \$25.3 million, or approximately 3.46%.

The cuts to other states also with the highest DSH caps varied.

- New York's \$1.7 billion cap would have declined by \$65.5 million, or 3.83%.
- California's \$1.2 billion cap was to be cut by \$32.6 million, or 2.80%.
- Texas' \$1 billion cap would have been reduced by \$56.1 million, or 5.52%.
- New Jersey's \$685 million cap was to be decreased by \$29.3 million, or 4.28%.
- Pennsylvania's \$597 million cap would have dropped by \$33.9 million, or 5.67%.

ACA Medicaid Expansion

To date, 30 states and the District of Columbia have elected to expand their Medicaid programs and 20 states have elected to not adopt an expansion.

Coverage under the Medicaid expansion became effective under federal law on January 1, 2014, for all states that adopted the Medicaid expansion at the earliest opportunity.

Five states opted in at later dates: Michigan (4/1/2014); New Hampshire (8/15/2014); Pennsylvania (1/1/2015); Indiana (2/1/2015); and Alaska (9/1/2015). Implementation of the expansion in Montana will begin on January 1, 2016, as CMS approved their waiver on November 1, 2015.

ACA Medicaid Expansion

The 30 states and DC that have elected to expand their Medicaid programs under the ACA are taking a variety of approaches in implementing ACA Medicaid expansions.

- Twenty-two states and DC have elected to do so solely under a State Plan Amendment (SPA) without any special considerations or exemptions from federal rules or regulations.
- Five states elected to pursue state-specific demonstration waivers from the outset, with one state having a pending waiver amendment before CMS seeking to change to its program as required by state law so its expansion may continue beyond April 2016 and another is seeking approval to change its waiver due to changes in the availability of Marketplace plans.
- One state expanded under a state plan amendment and is now transitioning to a demonstration waiver and another has a waiver application pending with CMS to also transition its expansion program from a state plan to a demonstration waiver program.
- One state expanded under a waiver and is now serving the expansion population under its state plan.

States Adopting the ACA Medicaid Expansion Option

State	Demonstration Waiver	Coverage Effective Date
Alaska		9/1/2015
Arizona	Pending	1/1/2014
Arkansas	Approved	1/1/2014
California		1/1/2014
Colorado		1/1/2014
Connecticut		1/1/2014
Delaware		1/1/2014
District of Columbia		1/1/2014
Hawaii		1/1/2014
Illinois		1/1/2014
Indiana	Approved	2/1/2015
Iowa	Approved Waiver w/Waiver Amendment Pending	1/1/2014
Kentucky		1/1/2014
Maryland		1/1/2014
Massachusetts		1/1/2014
Michigan	Approved Waiver w/Waiver Amendment Pending	4/1/2014
Minnesota		1/1/2014
Montana	Approved	1/1/2016
Nevada		1/1/2014
New Hampshire	State Plan Amendment Approved Waiver	8/15/2014 1/1/2016
New Jersey		1/1/2014
New Mexico		1/1/2014
New York		1/1/2014
North Dakota		1/1/2014
Ohio		1/1/2014
Oregon		1/1/2014
Pennsylvania	Waiver Terminated as of 9/30/2015 State Plan Amendment	1/1/2015 9/1/2015
Rhode Island		1/1/2014
Vermont		1/1/2014
Washington		1/1/2014
West Virginia		1/1/2014

ACA Medicaid Expansion Demonstration Waivers

The demonstration waivers allow the states to implement the Medicaid expansion in ways that do not adhere to all federal rules and regulations and still retain the ability to access enhanced federal matching funds for the newly eligible adults. To date, six states have received approval of their waiver applications to implement Medicaid expansion (Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire), one waiver application is pending (Arizona), and one state withdrew its waiver (Pennsylvania).

Montana's waiver was just approved and coverage will begin January 1, 2016. Michigan has a pending amendment to its waiver program as required by state law.

New Hampshire originally implemented a Medicaid expansion through a SPA, but later sought a waiver to move to a mandatory Marketplace premium assistance model by January 2016 pursuant to the state legislation authorizing the expansion. Arizona is requesting to make the switch from a state plan to waiver program also due to state law.

Coverage under the Pennsylvania waiver went into effect January 1, 2015, but the state later transitioned its expansion to a state plan amendment. In February 2015, Pennsylvania announced it will withdraw the Healthy Pennsylvania waiver to implement a traditional Medicaid expansion called HealthChoices. The transition from Healthy Pennsylvania to HealthChoices was complete on September 1, 2015, and the waiver terminated on September 30, 2015.

ACA Medicaid Expansion Demonstration Waivers

	Arkansas	Indiana	Iowa	Michigan		Montana	New Hampshire
				Approved	Proposed Amendment		
Components of the Waivers							
Private Insurance Premium Subsidy	✓	✓	✓		✓		✓
Beneficiary Premium, Co-Payment, Co-Insurance or Monthly Health Account Contributions	✓	✓	✓	✓	✓	✓	
Beneficiary Costs above Statutory Limits		✓			✓		
Omit Non-Emergency Medical Transportation from Scope of Benefits		✓	✓				
Healthy Behavior Incentives		✓	✓	✓	✓		
Waive Retroactive Eligibility		✓					✓
Waive Reasonable Promptness in Conjunction with an Expansion of Presumptive Eligibility Program		✓					
Include 12-Month Continuous Eligibility						✓	
Limit on Length of Coverage Eligibility					✓		

Source: Kaiser Family Foundation; Kaiser Commission on Medicaid and the Uninsured; "The ACA and Medicaid Expansion Waivers"

ACA Medicaid Expansion Demonstration Waivers

CMS has issued guidance to states regarding ACA expansion waiver applications:

- States cannot receive the enhanced match rates unless they fully implement the expansion to include all newly eligible individuals up to 138% FPL;
- CMS will not approve enrollment caps; and
- CMS will only approve a limited number of premium assistance waivers to purchase Marketplace coverage for the expansion population.

Also, CMS has been consistent in denying certain requests in waiver applications:

- Charging premiums to individuals with incomes below under 100% FPL, where payment is a condition of eligibility;
- Omitting wrap-around services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program from the scope of benefits for those aged 19 and 20;
- Omitting free choice of family planning provider; and
- Implementing work requirements as a condition of eligibility.

**Elements for Consideration
in an Exploration of
Implementing Medicaid
Expansion Pursuant to the
ACA in Louisiana**

Who would be eligible for coverage under an expansion?

The “new adult” group eligible for Medicaid under an expansion pursuant to the Affordable Care Act includes people who are:

- Uninsured;
- Aged 19-64;
- Not pregnant;
- Not eligible for another mandatory Medicaid eligibility group; and
- Have an income no greater than 138% of the federal poverty level.

Who would be eligible for coverage under an expansion?

“New adults” can be new to Medicaid, including:

- An estimated 307,000 uninsured individuals in Louisiana who have no coverage at all, primarily non-disabled, non-elderly adults, both
 - parents of Medicaid-enrolled children with a household income between 24% and 138% of the federal poverty level and
 - childless adults below 138% of the federal poverty level.
- Approximately 224,000 people in Louisiana who are currently insured through private coverage, either employer-based or individual market, but would qualify as a “New Adult” if they dropped their current coverage to become uninsured and so eligible to enroll in the expansion. This population is often referred to as “Crowd Out.”

Who would be eligible for coverage under an expansion?

“New Adults” can also be currently enrolled in Medicaid in an eligibility group that is not federally-mandated, including:

- Enrollees in limited benefit programs –
 - 62,353 individuals currently receiving limited services in the Greater New Orleans Community Health Connection program and
 - 128,209 individuals currently receiving family planning services in the Take Charge Plus program.
- Enrollees in full benefit programs on a time-limited basis due to cancer, disability, pregnancy or catastrophic medical expenses –
 - Breast and Cervical Cancer;
 - Provisional Medicaid;
 - LaMOMS (Pregnant Women); and
 - Medically Needy Spend Down.

How would the expansion population receive their benefits?

State Plan Amendment to Extend Coverage

Under a state plan amendment, the expansion population would be enrolled in managed care plans under the Bayou Health program.

Waiver to Extend Coverage

The state would work with CMS to develop a coverage model amenable to both the state and federal governments, including the entity providing the insurance (Marketplace Plans, Another Private Insurance Model, Employer-Sponsored Insurance Plans, or Medicaid Managed Care Plans) and the scope of benefits covered under the plan(s).

If a premium subsidy model is selected, arrangements would have to be made for the provision of any mandated Medicaid services that would not be covered under the private plan(s), such as EPSDT wrap-around services, non-emergency medical transportation services, or freedom of choice in family planning provider.

What are the costs directly associated with an expansion?

Costs of Medical Coverage

The state pays the Bayou Health plans a per-member-per-month (PMPM) premium, with variations in the rate calculations for gender, age, location, disability or specialized care needs, etc. DHH would work with its actuaries in setting the PMPM premium costs of the expansion population. As service utilization trends develop for this population, adjustments in the initial assumptions by the actuaries may be required that could result in higher or lower PMPMs than originally assumed.

Under a premium assistance waiver, the PMPMs would depend on the coverage that would be subsidized and the state may not play any role in the establishment of the PMPMs it would pay. Also, any mandated Medicaid services that would not be covered by a directly private plan under a waiver would have to be paid for outside of the PMPM premium subsidies.

Under current Medicaid law, states may implement limited cost-sharing requirements on certain adult recipients with a family income in excess of the federal poverty level up to an aggregate cap of 5% of family income. Such cost-sharing requirements could be apart of an expansion and would be a factor in determining the PMPMs for this portion of the newly eligible population. Under a waiver, the state could negotiate to extend the cost-sharing requirements beyond what is currently allowed under federal law and further reduce the projected costs of an expansion, if successful.

The costs of coverage for the newly eligible population would be shared by the state and federal government at the ACA-enhanced match rates.

What are the costs directly associated with an expansion?

Administrative Costs

There are administrative costs associated with an expansion due to the volume of new enrollees and the need for timely processing of eligibility applications and annual redeterminations of programmatic eligibility. The state would need to hire additional eligibility staff as well as extend contracts for certain functions.

Ultimately, these costs will depend on the uptake of the newly eligible group and would be financed at the normal administrative match rates.

Are there any indirect costs associated with an expansion?

The Woodwork Effect

There are individuals currently eligible for Medicaid, but not enrolled. These individuals could enroll due to the outreach activities associated with an expansion.

The cost of coverage for anyone in this group that enrolls would be at the standard match rates, not the ACA-enhanced rates, as they are currently eligible and not part of the newly eligible group under the ACA.

Are there any reductions to current expenditures that could result from an expansion?

To the extent that “New Adults” currently enrolled in Medicaid are eligible for the enhanced federal match associated with expansion, the state would experience a decline in its obligation as the state match would decrease, for the most part, from the regular rate (currently 37.79%) to the enhanced rate provided for in the ACA - 100% in calendar year 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond – for the costs of care provided to these individuals.

Current enrollees that would be “New Adults” eligible for the enhanced match include:

- Greater New Orleans Community Health Connection (No state general fund savings are anticipated as the state match is currently comprised of federal CDBG funding to finance the state match requirement.)
- Take Charge Plus Program (Family planning services are already matched at 90% federal effort and 10% state effort so the state would only realize a minimal amount of savings.)

Are there any reductions to current expenditures that could result from an expansion?

But, not all “New Adults” are eligible for the enhanced federal match associated with expansion. “Newly eligible” individuals are a subset of the “new adult” group.

If a person could have been eligible for full Medicaid benefits under the Medicaid state plan eligibility rules in place as of December 1, 2009, the state does not receive the higher match—instead, regular match rates apply.

Current enrollees that would be “New Adults” but may or may not be eligible for the enhanced match, to be determined on an individual basis at application or renewal, include:

- Spend-Down Medically Needy (would be eligible if income below 138% FPL);
- Breast and Cervical Cancer (eligible if not enrolled through the CDC screening);
- Provisional Medicaid (eligible if they apply/renew not on the basis of disability); and
- Pregnant Women (would be eligible if they enroll before, after or not on the basis of pregnancy).

Are there any reductions to current expenditures that could result from an expansion?

It was originally anticipated that uncompensated care costs payments would decline if Medicaid eligibility would be extended. Now, pursuant to Article VII, Section 10.13 of the Louisiana Constitution and the subsequent base reimbursement level established in House Concurrent Resolution No. 75 of the 2015 Regular Legislative Session, questions have arisen regarding the level to which, if at all, UCC payments to hospitals may be reduced under an expansion. The base is established as all payments under all methodologies in effect as of June 30, 2013, excluding certain state plan amendments. The degree to which the state could realize any UCC savings will be determined by the resolution of the questions surrounding the true impact of these provisions.

In addition, patient-specific data on currently reimbursed costs by income level is not available. Therefore, an exact determination of costs that could shift under an expansion is not possible prior to its implementation. As such, once the ultimate level of UCC that ought to be reimbursed is determined, a credible methodology of estimation would have to be developed for budget reductions in UCC payments in the earliest stages of an expansion.

The final component to consider related to UCC payments is the question of whether or not the DSH cap will actually be reduced as scheduled and how the formula utilized for such reductions will impact Louisiana's DSH cap with and without an eligibility expansion.

Are there any reductions to current expenditures that could result from an expansion?

Under an expansion, a portion of inpatient prisoner healthcare costs could be transferred from purely state expenditures to state-federal shared expenditures under the enhanced expansion match rates.

With or without expansion, incarcerated people are eligible for Medicaid on the same basis as people who are not incarcerated. However, Medicaid reimbursement for incarcerated people is limited to inpatient stays of greater than 23 hours.

Today, Louisiana prisoners eligible for Medicaid are generally limited to those who qualify on the basis of disability. Under expansion, virtually all non-elderly adult prisoners will qualify on the basis of age, income, and uninsured status alone, and their inpatient costs over 23 hours will be paid for by Medicaid.

Are there any impacts on revenue generation that could possibly result from an expansion?

Premium Taxes

Currently, the state assesses a 2.25% tax on health insurance premiums. For the assessments on the Medicaid managed care plans, the revenues generated are deposited into the Louisiana Medical Assistance Trust Fund and utilized as state match in the Medicaid program. The proceeds from all other such assessments flow into the general fund.

Any revenues generated by new coverage under an expansion would be new revenues to the state and deposited according to state law based on the expansion coverage model.

To the degree that individuals drop private coverage and enroll in Medicaid under an expansion, then the premiums that were being collected on that coverage would cease and new premium assessments would be collected on the coverage provided under the expansion.

- If the new coverage is less expensive than the old coverage, then it would result in a net loss of revenues to the state.
- On the other hand, if the new premiums are greater, then the state would experience a net gain in revenues.

If coverage is shifted from private insurance to the Bayou Health plans, then those revenues would now be dedicated to the LMATF rather than flow into the general fund and any net gain or loss to the state would depend on the variances in the respective premium costs.

Are there any impacts on revenue generation that could possibly result from an expansion?

Hospital Provider Fees

Pursuant to House Concurrent Resolution 75 of the 2015 Regular Legislative Session, the hospitals would be assessed up to 1% of net patient revenues to finance the state's cost of the coverage under an expansion "directly attributable to payments to hospitals" once the federal financial participation in the costs of the expansion drops below 100%, provided that an expansion is implemented by April 1, 2016. This assessment must be reauthorized annually under the state constitution or the assessment terminates and the state would be responsible for these costs.

General State Tax Collections

The degree to which the expansion grows the health care sector of the state's economy, then an increase in economic activity could impact traditional tax collections for both state and local governments in a fashion similar to any growth in any industry comprising a sector of the state's economy.

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