

Health Care in Louisiana: Service Provision and Financing



Senate Finance Committee

October 26, 2015

Department of Health and Hospitals

Overview

The Department of Health and Hospitals (DHH) is the primary entity within state government responsible for the health of Louisiana's citizens.

Specifically, DHH provides services for the mentally ill, for persons with developmental and adult-onset disabilities, the elderly, and for those suffering from addictive disorders; public health services; and health and medical services under the Medicaid program for the uninsured and medically indigent citizens of Louisiana.

The department is comprised of 19 agencies, contains 5,502 authorized positions and 1,428 authorized Other Charges positions, and has a total FY16 budget of \$9.7 billion.

Department of Health and Hospitals

The Office of the Secretary (OS) houses DHH's executive administration and provides general and financial management, supervision and support services for the department. DHH-OS also houses the department's Health Standards Section, which licenses health care facilities to operate in the state of Louisiana and certifies these facilities for participation in the Medicare and Medicaid programs.

The Medicaid program is divided between two agencies.

- Medical Vendor Administration – Medical Vendor Administration (MVA) is responsible for the development, implementation, and enforcement of the administrative and programmatic policies of the Medicaid program with respect to eligibility, reimbursement, and monitoring the provision of health care services, in concurrence with federal and state rules and regulations.
- Medical Vendor Payments – Medical Vendor Payments (MVP) is the financial entity from which all health care providers serving Medicaid enrollees and the uninsured and the managed care plans are paid.

Department of Health and Hospitals

The human services authorities and districts are responsible for the operation and management of behavioral health (mental health and addictive disorders) and developmental disabilities community-based programs and services in specific parishes. The state is divided regionally into ten authorities/districts:

- Jefferson Parish Human Services Authority;
- Florida Parishes Human Services Authority;
- Capital Area Human Services District;
- Metropolitan Human Services District;
- South Central Louisiana Human Services Authority;
- Northeast Delta Human Services;
- Acadiana Area Human Services District;
- Imperial Calcasieu Human Services Authority;
- Central Louisiana Human Services District; and,
- Northwest Louisiana Human Services District.

Department of Health and Hospitals

The Office of Aging and Adult Services (OAAS) manages and oversees access to long-term care services and supports programs, including Medicaid home-and-community-based (HCBS) waiver programs, for the elderly and individuals with adult-onset disabilities. OAAS also provides protective services for vulnerable adults. The Traumatic Head and Spinal Cord Injury Trust Fund is located within OAAS. OAAS also operates the Villa Feliciana Medical Complex, which provides long-term care, rehabilitative services, and infectious disease services to medically complex residents.

The Office of Behavioral Health (OBH) is responsible for the prevention and treatment of mental health and substance abuse disorders and serves as the safety-net provider of behavioral health services in the state, including the operation of the state's inpatient psychiatric hospitals, which include the Central Louisiana State Hospital, East Louisiana State Hospital, and Feliciana Forensic Facility.

The Office for Citizens with Developmental Disabilities (OCDD) manages the delivery of individualized community-based supports and services, including four Medicaid home-and-community-based waiver programs, for individuals with developmental disabilities. OCDD also operates the Pinecrest Supports and Services Center.

The Developmental Disabilities Council is a 28-member, gubernatorial-appointed board whose function is to implement the federal Developmental Disabilities Assistance and Bill of Rights Act in Louisiana. The focus of the Council is to facilitate change in Louisiana's system of supports and services to individuals with disabilities and their families in order to enhance and improve their quality of life.

Department of Health and Hospitals

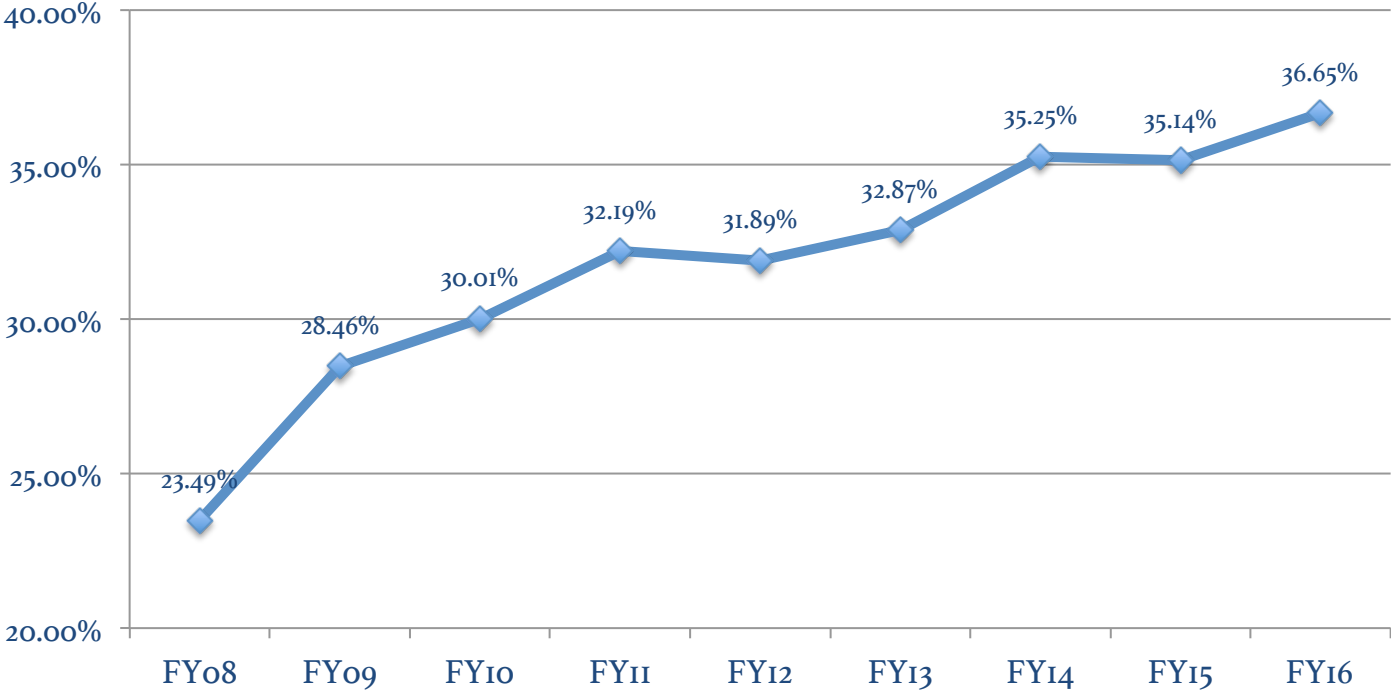
The Office of Public Health (OPH) is responsible for protecting and promoting the health and well-being of Louisiana's residents and communities. Specifically, OPH provides health education services; operates Louisiana's Women, Infants and Children (WIC) program; performs infectious disease and food-and-water-borne illness response and surveillance activities; oversees and enforces the Sanitary Code for retail food, public buildings and safe drinking water; emergency preparedness and response; maintains vital records for the state and its residents; and serves as a safety net provider of preventative health care services for uninsured, underinsured and covered individuals and families.

The Louisiana Emergency Response Network (LERN) is responsible for the development and maintenance of a statewide system of care coordination for patients suddenly stricken by serious traumatic injury or time-sensitive illness in accordance with the nationally recognized trauma system model created by the American College of Surgeons.

Health Care and the Budget

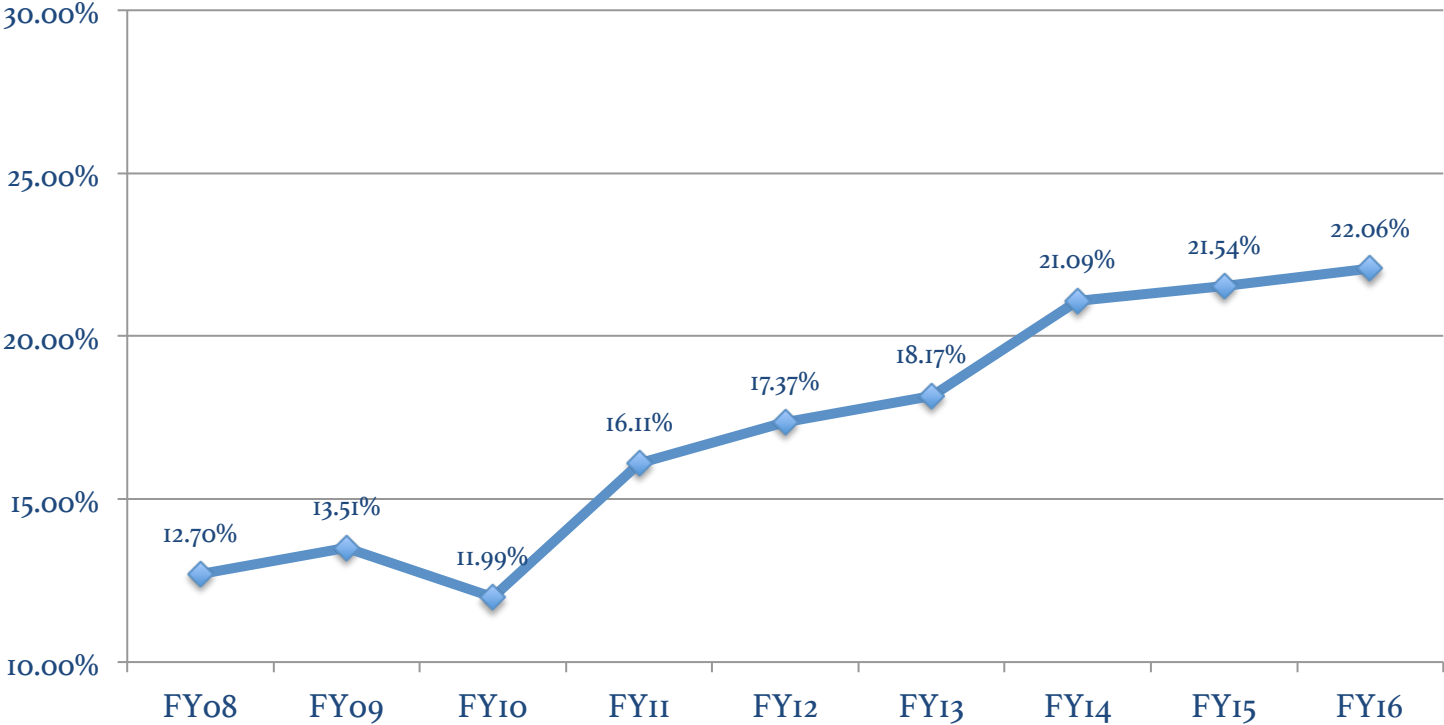
Comparison of Funding for Health Care Services to All State Spending

Total Funding for Health Care Services in Proportion to Louisiana's Total Budget



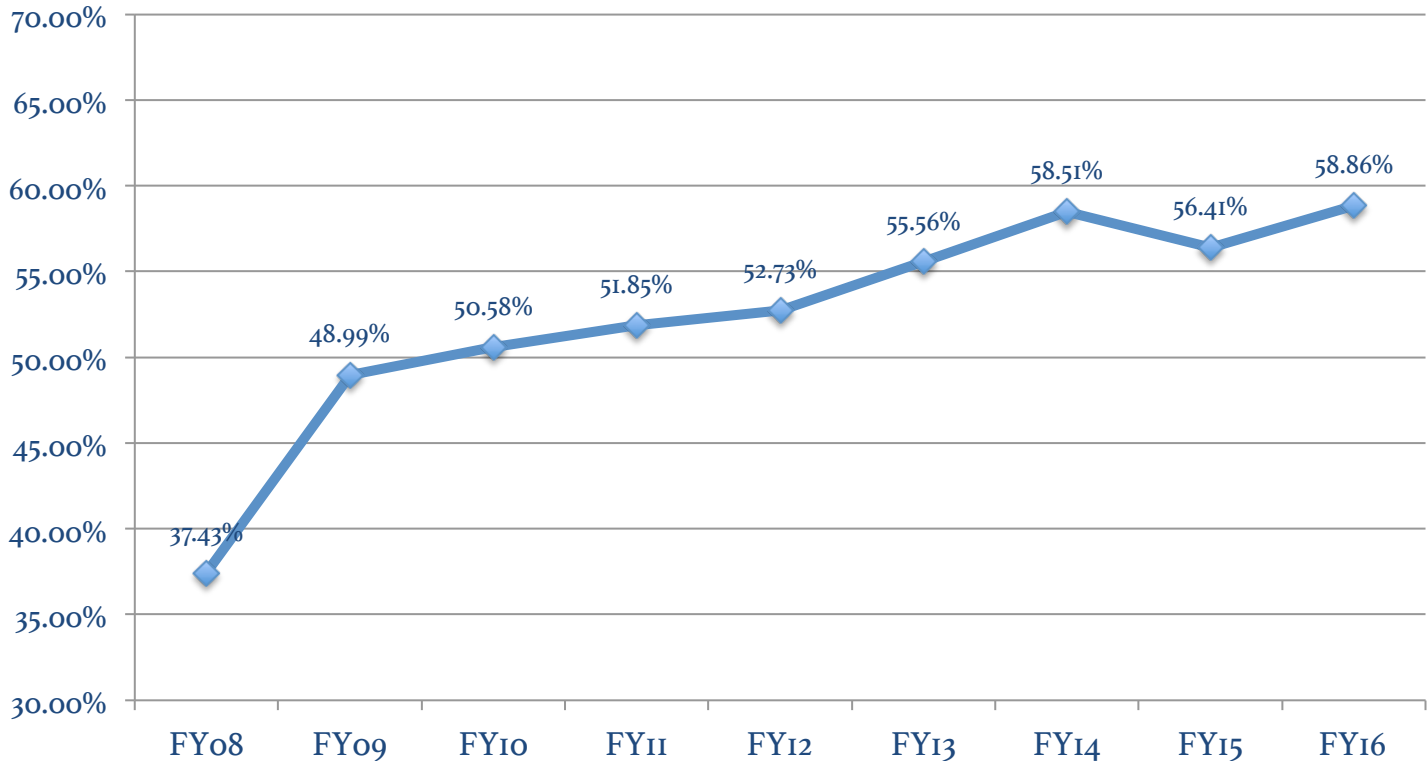
Comparison of Funding for Health Care Services to All State Spending

State Funding for Health Care Services in Proportion to Total State Funding in Louisiana's Budget



Comparison of Funding for Health Care Services to All State Spending

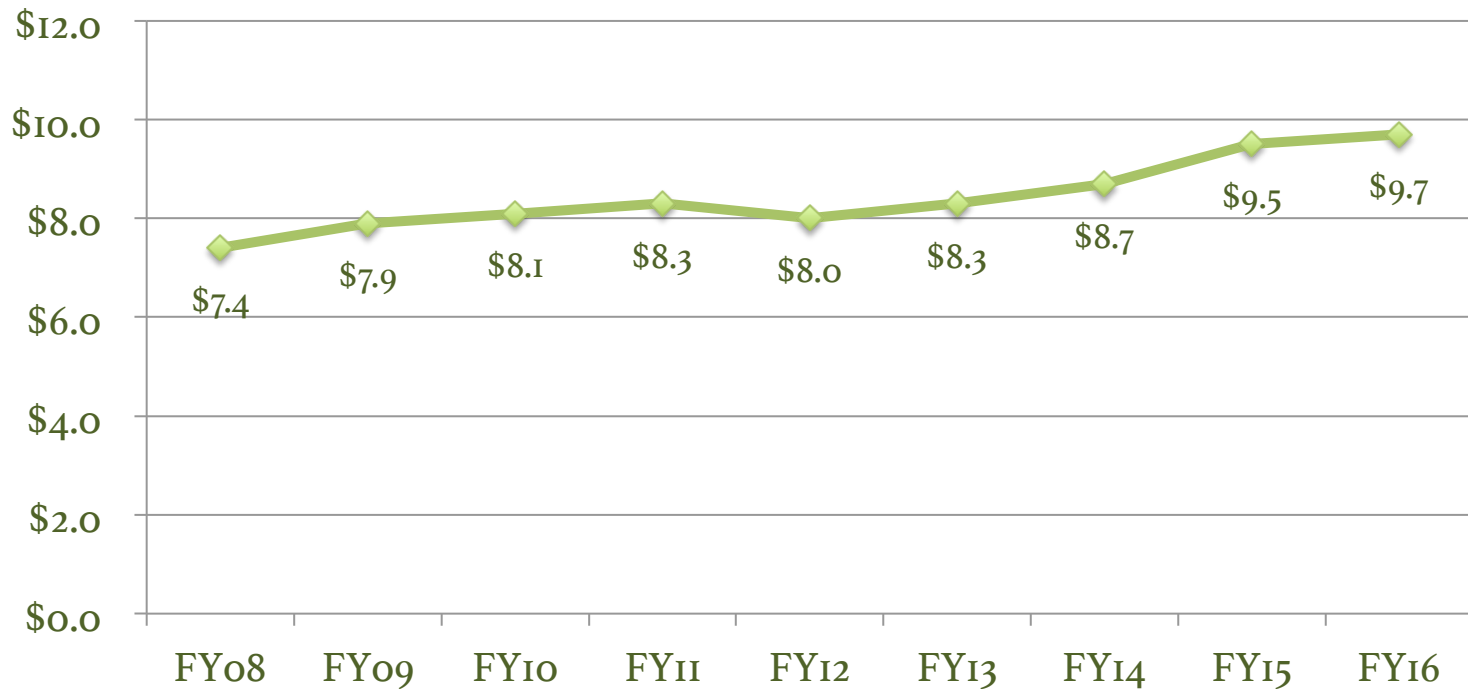
Federal Funding for Health Care Services in Proportion to Total Federal Funding in Louisiana's Budget



Growth in Funding for Health Care Services Since Fiscal Year 2008

Total funding for DHH increased by 30.6% from FY08 to FYI6 – from \$7.4 billion to \$9.7 billion.

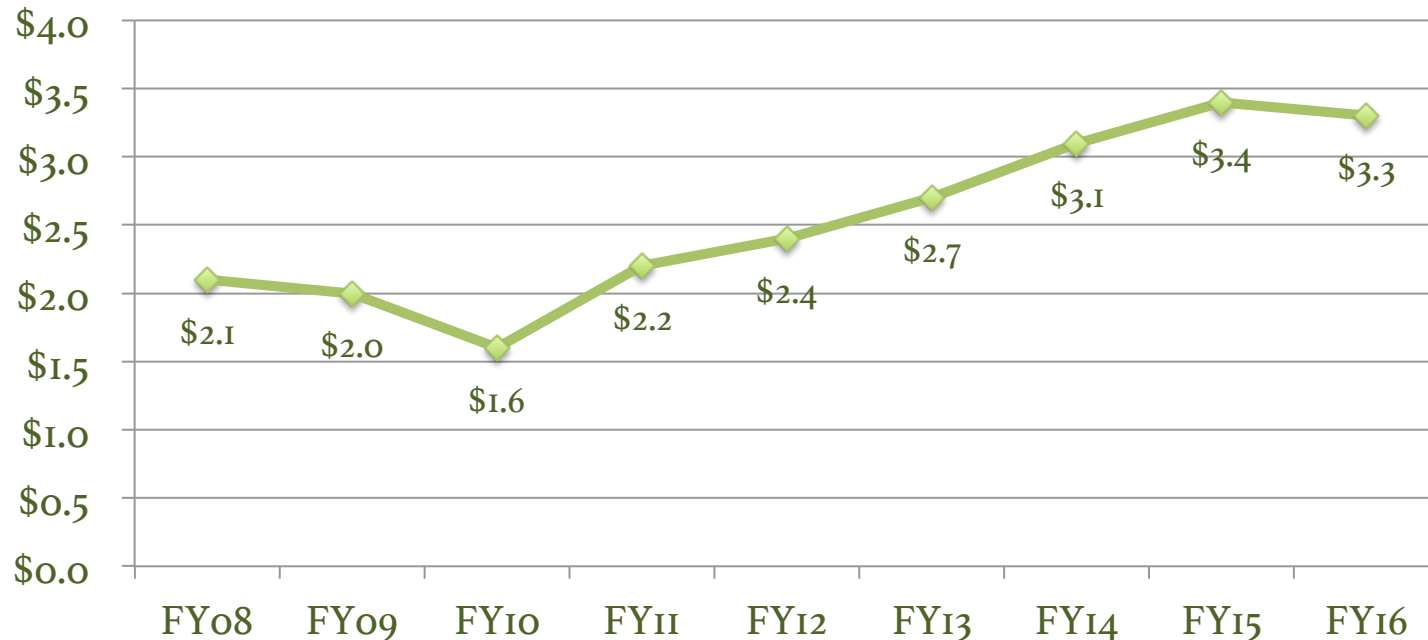
Total Funding for Health Care Services (in billions)



Growth in Funding for Health Care Services Since Fiscal Year 2008

During the same time period, the state's portion of the funding for DHH increased at the even greater rate of 58.2% – from \$2.1 billion in FY08 to \$3.3 billion in FY16.

State Funding for Health Care Services (in billions)



Growth in Funding for Health Care Services Since Fiscal Year 2008

Department of Health and Hospitals	PRIOR YEARS ACTUALS							BUDGETED	APPROPRIATED	DIFFERENCE
	Fiscal Year 2007-2008	Fiscal Year 2008-2009	Fiscal Year 2009-2010	Fiscal Year 2010-2011	Fiscal Year 2011-2012	Fiscal Year 2012-2013	Fiscal Year 2013-2014	Fiscal Year 2014-2015 <small>(as of 12/01/14)</small>	Fiscal Year 2015-2016	FY16 Over/(Under) FY08
State General Fund (Direct)	\$1,364,557,884	\$1,704,216,301	\$1,107,838,087	\$1,077,423,620	\$1,794,164,101	\$1,877,026,687	\$2,230,111,000	\$2,305,324,137	\$2,750,281,415	\$1,385,723,531
Interagency Transfers	\$459,917,183	\$483,455,143	\$581,563,728	\$444,419,274	\$387,344,513	\$344,798,360	\$347,156,178	\$430,747,524	\$451,483,478	(\$8,433,705)
Fees & Self-generated Revenues	\$60,616,387	\$52,281,961	\$46,748,788	\$103,207,543	\$142,885,198	\$94,468,728	\$190,638,530	\$211,404,894	\$180,268,358	\$119,651,971
Statutory Dedications	\$692,468,674	\$275,643,392	\$455,705,617	\$971,514,811	\$492,181,728	\$697,095,246	\$696,441,798	\$880,342,076	\$419,017,336	(\$273,451,338)
Interim Emergency Board	\$0	\$152,833	\$280,500	\$233,750	\$0	\$0	\$0	\$0	\$0	\$0
Federal Funds	\$4,822,653,111	\$5,364,798,479	\$5,954,697,164	\$5,660,779,334	\$5,138,520,286	\$5,290,029,000	\$5,261,916,319	\$5,684,100,054	\$5,866,633,553	\$1,043,980,442
TOTAL DHH MEANS OF FINANCING	\$7,400,213,239	\$7,880,548,109	\$8,146,833,884	\$8,257,578,332	\$7,955,095,826	\$8,303,418,021	\$8,726,263,825	\$9,511,918,685	\$9,667,684,140	\$2,267,470,901
Jefferson Parish Human Services Authority	\$25,188,189	\$27,228,690	\$25,261,757	\$26,191,787	\$22,666,193	\$18,669,625	\$18,159,172	\$20,222,396	\$19,464,555	(\$5,723,634)
Florida Parishes Human Services Authority	\$19,238,095	\$21,739,066	\$20,020,423	\$19,537,213	\$19,638,223	\$18,543,021	\$16,731,230	\$18,822,784	\$17,524,438	(\$1,713,657)
Capital Area Human Services District	\$32,623,629	\$33,674,060	\$30,784,740	\$31,071,332	\$29,360,862	\$28,803,840	\$26,665,922	\$28,266,209	\$26,884,006	(\$5,739,623)
Developmental Disabilities Council	\$2,140,747	\$2,129,229	\$1,954,212	\$1,676,596	\$1,763,744	\$1,783,109	\$1,759,627	\$2,081,142	\$1,982,316	(\$158,431)
Metropolitan Human Services District	\$32,875,723	\$31,134,913	\$29,826,481	\$31,558,695	\$26,731,154	\$25,167,504	\$23,007,870	\$29,081,503	\$27,152,227	(\$5,723,496)
Medical Vendor Administration	\$188,382,663	\$186,272,108	\$198,291,054	\$222,041,602	\$245,749,932	\$219,656,578	\$220,520,293	\$324,937,103	\$255,380,981	\$66,998,318
Medical Vendor Payments	\$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	\$8,111,626,149	\$8,382,290,230	\$2,416,407,128
Office of the Secretary	\$96,567,630	\$95,042,397	\$95,743,468	\$74,542,726	\$74,650,389	\$74,371,514	\$79,376,872	\$93,243,863	\$93,108,910	(\$3,458,720)
South Central Louisiana Human Services Authority	\$0	\$0	\$0	\$13,761,267	\$22,772,330	\$20,475,273	\$20,655,745	\$23,483,201	\$21,787,978	\$21,787,978
Northeast Delta Human Services Authority	\$0	\$0	\$0	\$0	\$0	\$0	\$9,362,299	\$16,500,156	\$15,557,203	\$15,557,203
Office of Aging and Adult Services	\$38,992,725	\$42,136,465	\$43,837,963	\$40,961,486	\$44,822,430	\$50,339,436	\$44,632,227	\$52,340,612	\$48,312,853	\$9,320,128
Louisiana Emergency Response Network	\$0	\$3,886,257	\$3,088,423	\$2,831,370	\$2,371,528	\$2,506,729	\$1,523,871	\$1,748,519	\$1,926,133	\$1,926,133
Acadiana Area Human Services District	\$0	\$0	\$0	\$0	\$0	\$12,730,830	\$15,073,394	\$18,107,180	\$17,173,536	\$17,173,536
Office of Public Health	\$308,005,213	\$336,902,936	\$325,278,240	\$317,836,889	\$304,544,826	\$298,186,359	\$278,994,111	\$346,563,320	\$327,584,400	\$19,579,187
Office of Behavioral Health	\$414,992,369	\$425,930,378	\$379,654,674	\$345,640,802	\$300,740,305	\$258,248,579	\$230,485,164	\$225,825,408	\$224,325,692	(\$190,666,677)
Office for Citizens with Developmental Disabilities	\$275,323,154	\$281,070,435	\$276,307,893	\$251,197,686	\$223,303,828	\$160,593,681	\$139,581,158	\$153,419,537	\$143,776,133	(\$131,547,021)
Imperial Calcasieu Human Services Authority	\$0	\$0	\$0	\$0	\$0	\$0	\$6,723,655	\$12,316,232	\$11,609,967	\$11,609,967
Central Louisiana Human Services District	\$0	\$0	\$0	\$0	\$0	\$0	\$6,735,529	\$16,510,905	\$16,362,666	\$16,362,666
Northwest Louisiana Human Services District	\$0	\$0	\$0	\$0	\$0	\$0	\$8,612,906	\$16,822,466	\$15,479,916	\$15,479,916
TOTAL DHH EXPENDITURES	\$7,400,213,239	\$7,880,548,109	\$8,146,833,884	\$8,257,578,332	\$7,955,095,826	\$8,303,418,021	\$8,726,263,825	\$9,511,918,685	\$9,667,684,140	\$2,267,470,901
TOTAL DHH TABLE OF ORGANIZATION (T.O.)	12,324	11,634	11,322	9,247	8,458	6,718	5,776	5,669	5,502	(6,822)

Growth in Funding for Health Care Services Since Fiscal Year 2008

The driver of health care expenditures in Louisiana is the Medicaid program. Since FY08, Medicaid has comprised an average of 83.9% of DHH's total budget each year. In FY16, Medicaid is approximately 86.7% of the total budget for health care.

There are nearly 1.4 million individuals eligible for services under the Medicaid program in Louisiana. In addition, the Medicaid program finances health care services for the roughly 16.6% of Louisiana's population, or an estimated 751,000 individuals, that are uninsured.



The Medicaid Program

Summary

Medicaid is a state-administered, state-federal program that reimburses health care providers for medical treatment provided to qualified individuals and the uninsured. Long-term care services are also covered, including both institutional and community-based care. In general, eligibility for Medicaid is determined annually.

The budget for Louisiana's Medicaid program totals \$8.4 billion for FY16. The costs of Medicaid services are shared between the federal government and the states at rates determined annually by the federal government based on a state's per capita income. Louisiana's base match rates for FY16 are 37.79% state effort and 62.21% federal effort.

Each state administers its own Medicaid program, within rigid federal guidelines. States are required to provide certain mandated services and may choose to offer other optional services. In addition, states must provide services to certain populations, but may expand coverage to select individuals beyond those mandated under federal law.

Furthermore, Medicaid is an entitlement program; for those who qualify for services under federal guidelines, a state is required to provide both mandatory and any optional services it elects to offer to that Medicaid enrollee, within certain parameters.

Finally, states may seek waivers from the federal Department of Health and Human Services (DHHS) to develop specific programs that operate in exception to federal guidelines under certain conditions.

History of the Medicaid Program

Creation and Evolution

In 1965, Title XIX of the Social Security Act was enacted establishing Medicaid as a voluntary federal-state partnership program to provide health care services to low-income children and their parents or caretaker relatives, the elderly, the blind, and individuals with disabilities.

Louisiana began its Medicaid program in 1966, along with 25 other states. Within two years, the number of states participating in the Medicaid program grew to 37. By 1970, all states, except Alaska and Arizona, had a Medicaid program. Alaska joined in 1972 and Arizona, by waiver, in 1982.

The Medicaid program is constantly evolving. Over the years, the federal government has amended the scope and structure of the program and it has grown. The growth has been evident not only in the costs of providing basic medical services, but also in terms of the number of eligibility categories and the number and types of services offered.

In terms of coverage, in 1966, 4 million people were enrolled in Medicaid; an estimated 71.1 million are enrolled today. Turning toward costs, national Medicaid expenditures totaled roughly \$900 million in 1966. Today, spending is projected to reach an estimated \$529 billion this year. Looking forward, by 2023, the CMS Actuary's Office projects that enrollment will grow to total 78.8 million individuals and costs will total \$835 billion.

Evolution

Examples of Major Federal Adjustments to Medicaid

1971 – States are given the option to both cover services in intermediate care facilities (ICFs) for the elderly and individuals with disabilities with lower level of care needs than those available in skilled nursing facilities and to cover services in facilities for individuals with developmental disabilities (ICF/DDs).

1981 – States are allowed to make additional Medicaid payments to hospitals that provide treatment for a “disproportionate share” (DSH) of Medicaid and low-income patients and the Section 1915(b) Freedom-of-Choice Waivers and Section 1915(c) Home-and-Community-Based Services waivers are created.

1988 – The federal government begins requiring states to use Medicaid funds to pay the Medicare premiums and cost-sharing for low-income Medicaid beneficiaries with incomes below 100% Federal Poverty Level (FPL), known as Qualified Medicare Beneficiaries (QMBs).

1989 – States are required to provide Medicaid coverage to pregnant women and children up to age 6 with family incomes at or below 133% FPL and to cover services provided by federally-qualified health centers (FQHCs).

Evolution

Examples of Major Federal Adjustments to Medicaid

1990 – States are required to pay for Medicare premiums for Medicare beneficiaries with incomes between 100% and 120% FPL, also known as Special Low-Income Medicare Beneficiaries (SLMBs).

1997 – The Children's Health Insurance Program (CHIP), which gives states the option to cover uninsured children with family income at or below 200% FPL who are ineligible for Medicaid, is established as Title XXI of the Social Security Act. Also, states are given a state plan option to mandate Medicaid beneficiary enrollment into managed care rather than only via a 1915(b) waiver.

1999 – States are given the option to extend Medicaid coverage to working disabled individuals with incomes above 250% FPL and impose income-related premiums for the coverage.

1999 – The U.S. Supreme Court rules in *Olmstead v. L.C.* (527 U.S. 581) that the Americans with Disabilities Act (ADA) can, under certain circumstances, require states to provide community-based services to individuals for whom institutional care is inappropriate.

Evolution

Examples of Major Federal Adjustments to Medicaid

2003 – The Medicare Part D prescription drug program was established and drug coverage for dual eligible beneficiaries, or individuals enrolled in both Medicare and Medicaid, was transferred from Medicaid to Medicare with the requirement that states must make a monthly "clawback" payment to the Medicare program for state savings from the transferred drug coverage.

2010 – The “Affordable Care Act” (ACA) was enacted providing for states to expand their Medicaid programs to extend eligibility thresholds to offer coverage to all adults aged 19-64 with household incomes at or below 133% of the federal poverty level (FPL) (plus a mandated income disregard of 5% essentially making the limit 138% FPL) beginning on January 1, 2014, at enhanced match rates of 100% of the cost of care through 2016 and then declining to 90% by 2020 and beyond. (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.)

Mandatory versus Optional Services and Populations

Overview

Under federal law, any state that opts to operate a Medicaid program must offer a core set of basic health care services to certain groups of individuals.

A state, with the necessary federal approval, determines the rates reimbursed for such services as well as scope of the service provision.

In addition, states may choose to offer additional optional medical services as well as extend eligibility to other individuals as provided for in law.

Louisiana has made the decision to expand its Medicaid program beyond the federal mandates for services, eligibility and minimum payment requirements.

Federally Mandated Medicaid Services

- Inpatient and Outpatient Hospital Services
- Physician Services
- Laboratory and X-Ray Services
- Prescription Drugs for children, pregnant women and nursing home residents
- Long-term Care Facilities (Nursing Homes) for those over age 21
- Home Health Services for those over age 21 who are eligible for nursing facility services (including medical supplies and equipment)
- Family Planning Services
- Services for early and periodic screening, diagnosis and treatment (EPSDT) of those under age 21
- Transportation services necessary to ensure an enrollee's access to care
- Rural Health Clinics and Federally Qualified Health Centers
- Pediatric and Family Nurse Practitioner and Nurse Midwife Services

Key Optional Services under Louisiana's Medicaid State Plan

- Adult Dentures
- Prescription Drugs for Adults
- Hemodialysis
- Intermediate Care Facilities for the Developmental Disabled (ICF/DDs)
- Various Home-and-Community-Based Waivers
- Long-term Personal Care Services
- Program for All-Inclusive Care for the Elderly (PACE)
- Pediatric Day Health Centers
- Inpatient Mental Health and Psychiatric Rehabilitation Services
- Rehabilitation Services
- Hospice Services
- Case Management Services
- Certified RN Anesthetists (CRNA) Services

Mandatory Eligibility Groups

- Children under age 6 below 133% FPL
- Children age 6 and older below 100% FPL
- Parents below state's AFDC cutoffs from July 1996
- Pregnant women $\leq 133\%$ FPL
- Elderly and disabled SSI beneficiaries with income $\leq 74\%$ FPL
- Certain working disabled
- Medicare Buy-In groups (QMB, SLMB, QI)

Largest Optional Eligibility Groups in Louisiana

- Low-income children above 100% FPL who are not mandatory by age (LaCHIP)
- Pregnant women >133% FPL
- Disabled and elderly below 100% FPL, but above SSI level
- Long-term care facilities residents above SSI levels, but below 300% of SSI
- Individuals at risk of needing nursing facility or ICF/DD care under HCBS waiver
- Certain working disabled (>SSI levels)
- Medically needy
- Adults up to 138% FPL for family planning services
- Women under age 65 diagnosed with breast and cervical cancer (or a precancerous condition) up to 200% FPL

Other Medicaid Expenditures

The payments of Medicare Parts A and B premiums and supplements and the clawback payments for Medicare Part D premiums for the individuals dually eligible for both Medicare and Medicaid are mandatory.

But, the vast majority of disproportional share hospital (DSH) payments, also referred to as uncompensated care costs (UCC) payments, are optional. The only federal mandate related to these payments is the maintenance of a minimum pool to reimburse for Medicaid shortfall for the hospitals with the highest percentages of Medicaid utilization in the state.

The Respective Roles of State and Federal Governments in Administering and Paying for the Medicaid Program

Operational Structure

Medicaid is a state-administered, joint state-federal program that reimburses health care providers for medical treatment provided to either Medicaid-eligible or uninsured individuals, pursuant to federal guidelines using a combination of state and federal funds.

States receive federal matching funds for these health coverage programs, provided they meet certain requirements with respect to eligibility, benefits, payment structures and financing mechanisms. When the federal government believes a state has misused federal Medicaid dollars, the federal government will “disallow” those expenses and states are required to repay the federal government the federal financial participation for the services in question.

Medicaid State Plan

States administer their Medicaid programs under Medicaid state plans.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program in accordance with federal rules. The state plan establishes the groups covered, services provided and methodologies for provider reimbursements as well as describes the administrative activities of the state.

When a state wants to make a change to its program policies or operational approach, states may submit state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) for review and approval. States may also submit SPAs to request to make corrections or update their Medicaid state plans with new information.

In addition, mechanisms have been established allowing states to apply for approval to structure aspects of Medicaid in a manner that does not conform to all federal rules and regulations. The federal law permits the U.S. Department of Health and Human Services secretary to approve waivers of some federal requirements so that the federal government and states may explore new approaches to the delivery of and payment for health care services within certain budgetary constraints.

Medicaid Waivers

Medicaid waivers can be divided into two categories: research and demonstration projects and program waivers.

- Section 1115 Research & Demonstration Projects allow states flexibility to design and improve their Medicaid programs by testing new or existing approaches to financing and delivering health care services in experimental, pilot, or demonstration projects.
- Section 1915(b) Managed Care Waivers allow states to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- Section 1915(c) Home-and-Community-Based Services Waivers allow states to provide long-term care services in home and community settings rather than institutional settings.
- Concurrent Section 1915(b) and 1915(c) Waivers allow states to simultaneously implement these two waivers to provide a continuum of services to the elderly or disabled, as long as all federal requirements for both programs are met.

Louisiana's Approved Waiver Programs

Section III5 Demonstration Projects

Greater New Orleans Community Health Connection

Provides primary care services; preventative care services; immunizations and vaccinations; care coordination services; lab work and x-rays; behavioral health services (both mental health and substance abuse); and some specialty care services to uninsured adults between the ages of 19 and 64 in Orleans, Jefferson, St. Bernard, and Plaquemines parishes.

Section 1915(b) Managed Care Waivers

Louisiana Behavioral Health Partnership

The LBHP coordinates the provision of behavioral health services for eligible children and adults.

Dental Benefit Program

The DBP coordinates the provision of dental services for all Medicaid beneficiaries eligible for dental services, including both children and adults.

Louisiana's Approved Waiver Programs

Section 1915(c) Home-and-Community-Based Services Waivers

Adult Day Health Care Waiver

Provides adult day health care, support coordination, transition intensive support coordination, and transition services for individuals aged 65 and over, or with disabilities aged 22-64.

Children's Choice Waiver

Provides center-based respite, support coordination, specialized medical equipment and supplies, aquatic therapy, art therapy, environmental accessibility adaptations, family support, family training, hippotherapy/therapeutic horseback riding, housing stabilization, housing stabilization transition, music therapy, and sensory integration services for children from birth to age 18 with developmental disabilities.

Community Choices Waiver

Provides adult day health care, caregiver temporary support, support coordination, assistive devices and medical supplies (assistive technology), environmental accessibility adaptation, home delivered meals, housing stabilization, housing transition or crisis intervention, monitored in-home caregiving, non-medical transportation, nursing, personal assistance, skilled maintenance therapy, transition intensive support coordination, and transition services for individuals aged 65 and over, or with disabilities aged 22-64.

New Opportunities Waiver

Provides center-based respite, day habilitation, employment-related training, supported employment, supported living, skilled nursing, specialized medical equipment and supplies, adult companion care, community integration and development, environmental accessibility adaptations, housing stabilization, housing stabilization transition, individual and family support, one-time transitional, personal emergency response system, professional, remote assistance, and substitute family care services for individuals with developmental disabilities aged 3 and over.

Louisiana's Approved Waiver Programs

Section 1915(c) Home-and-Community-Based Services Waivers

Residential Options Waiver

Provides day habilitation, prevocational, respite care-out of home, shared living, support coordination, supported employment, assistive technology/specialized medical equipment and supplies, dental, community living supports, companion care, environmental accessibility adaptations, host home, nursing, one-time transitional services, personal emergency response system, professional, and transportation-community access services for individuals with developmental disabilities.

Supports Waiver

Provides day habilitation, habilitation, prevocational, respite, support coordination, supported employment, housing stabilization, housing stabilization transition, and personal emergency response system services for individuals with developmental disabilities aged 18 or over.

Coordinated System of Care

Provides crisis stabilization, independent living/skills building, parent support and training, short-term respite, and youth support and training services for children with complex behavioral health needs who are either at-risk for or in out-of-home placement and aged 21 or younger.

Cost Sharing

The costs of Medicaid services are shared between the federal government and the states at varying rates depending upon the service provided or function performed. The various cost sharing methodologies are established in federal law.

Administrative match rates are set by function and do not fluctuate, by design, year-to-year.

The match rates for medical services also possess some variety depending upon service or eligibility category and mostly do fluctuate year-to-year as the base rate is adjusted annually based on the formula established in federal law.

Administrative Match Rates

In general, administrative match rates are a 50%/50% split between the state and federal governments. However, there are certain functions matched at higher rates, between 75% and 100%.

100% Federal Funding

- Immigration status verification

90% Federal Funding

- Citizenship verification, including design, development, and installation of related information systems
- Design, development and installation of Medicaid Management Information Systems (MMIS)
- Upgrades to Eligibility and Enrollment systems (through 12/31/2015)

75% Federal Funding

- Management and operation of MMIS
- Management and operation of citizenship verification information system
- Independent, external review of managed care plans
- Medical and utilization review
- Preadmission screening and resident review
- State survey and certification
- Translation and interpretation services for children
- State fraud and abuse control unit activities
- Compensation and training for skilled professional medical staff

Medical Services Match Rates

The Federal Medical Assistance Percentage

The primary match rate for services, the Federal Medical Assistance Percentage (FMAP), does fluctuate year-to-year as it is adjusted annually by the federal government for each federal fiscal year based on a rolling three-year average of a state's per capita income relative to the U.S. average with an floor of 50% and ceiling of 83%. Currently, the range is from a high of 74.17% in Mississippi down to the 50% floor for 13 states (Alaska, California, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Virginia, Washington, and Wyoming).

From 1966 to 1986, the FMAP was determined on a biennial basis. In 1987, the federal government shifted to the current yearly recalculation of a state's FMAP, with a one-year "hold harmless" provision for states that would have experienced a decline in 1987 under the annual determination in relation to what the FMAP would have been under the former two-year calculation timeframe.

Only one incidence could be located in which the federal government cut the base FMAP. Under the Omnibus Budget Reconciliation Act (OBRA) of 1981, Congress passed a three-year reduction, cutting the federal matching rates by 3 percentage points in FFY1982, 4 in FFY1983, and 4.5 in FFY1984, for states whose growth exceeding certain targets. The rates returned to the their previous levels in 1985.

Medical Services Match Rates

Over the years, the base FMAP for Medicaid services has been temporarily augmented, for both Louisiana and the nation as a whole. Recent examples include the following legislative actions:

- Jobs and Growth Tax Relief Reconciliation Act in 2003, which held all states harmless from base FMAP reductions and provided a bump of 2.95 percentage points for the last two quarters FFY2003 and first three quarters of FFY2004;
- American Recovery and Reinvestment Act in 2009, which included a nine-quarter increase in FMAP for all states of 6.2 percentage points plus an unemployment-related increase in addition to holding states harmless from any decrease in their base FMAP; and,
- Affordable Care Act in 2010, which established a disaster-recovery FMAP adjustment for any state for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act under which every county or parish in the state is eligible for individual and public assistance or public assistance from the federal government, and for which the FMAP as determined for the fiscal year is less than the FMAP (for the first year of assistance) or the disaster-adjusted recovery FMAP (for each subsequent year of assistance) for the preceding fiscal year by at least three percentage points (Louisiana is the only state qualify for this adjustment and did so for both Hurricane Katrina in 2005 and Hurricane Gustav in 2008).

Louisiana's Base FMAP History

<u>Federal Fiscal Year</u>	<u>FMAP</u>	<u>Yearly Change</u>	<u>Federal Fiscal Year</u>	<u>FMAP</u>	<u>Yearly Change</u>
1965-66 & 1966-67	74.16%		1991-92	75.44%	0.96%
1967-68 & 1968-69	74.58%	0.42%	1992-93	73.71%	-1.73%
1969-70 & 1970-71	73.57%	-1.01%	1993-94	73.49%	-0.22%
1971-72 & 1972-73	73.49%	-0.08%	1994-95	72.65%	-0.84%
1973-74 & 1974-75	72.80%	-0.69%	1995-96	71.89%	-0.76%
1975-76 & 1976-77	72.41%	-0.39%	1996-97	71.36%	-0.53%
1977-78 & 1978-79	70.45%	-1.96%	1997-98	70.03%	-1.33%
1979-80 & 1980-81	68.82%	-1.63%	1998-99	70.37%	0.34%
1981-82 & 1982-83	66.85%	-1.97%	1999-2000	70.32%	-0.05%
1983-84 & 1984-85	64.45%	-2.40%	2000-01	70.53%	0.21%
1985-86	63.81%	-0.64%	2001-02	70.30%	-0.23%
1986-87	65.77%	1.96%	2002-03	71.28%	0.98%
1987-88	68.26%	2.49%	2003-04	71.63%	0.35%
1988-89	71.07%	2.81%	2004-05	71.04%	-0.59%
1989-90	73.12%	2.05%	2005-06	69.79%	-1.25%
1990-91	74.48%	1.36%	2006-07	69.69%	-0.10%
			2007-08	72.47%	2.78%
			2008-09	71.31%	-1.16%
			2009-10	67.61%	-3.70%
			2010-11	63.61%	-4.00%
			2011-12	61.09%	-2.52%
			2012-13	61.24%	0.15%
			2013-14	60.98%	-0.26%
			2014-15	62.05%	1.07%
			2015-16	62.21%	0.16%
			2016-17*	62.02%	-0.19%

* As projected by Federal Funds Information for States (FFIS)

Cost Sharing

Enhanced Federal Medical Assistance Percentage

The enhanced FMAP (eFMAP) was established in law to determine the federal match rate for the Children's Health Insurance Program and equates to a decrease of 30% in a state's share under its FMAP rate. Louisiana's eFMAP is 73.55% in FY16. This rate is also used for services provided under the Breast and Cervical Cancer Treatment program.

In addition, the Affordable Care Act provides for a temporary increase in the eFMAP for the CHIP population. Beginning October 1, 2015 and continuing through September 30, 2019, the eFMAP for CHIP will increase by 23 percentage points (up to a cap of 100%). Louisiana's eFMAP grew to 96.55% for the CHIP eligibles at the beginning of this month.

Cost Sharing

Other Federal Match Rates

In addition to the eFMAP, there are under provisions under federal law for increased federal financial participation in the Medicaid program, including the following:

- Clinical preventive services for adults, FMAP + 1 Percentage Point;
- Home-and-community-based attendant services and supports for the disabled, FMAP + 6 Percentage Points;
- Family planning services, 90%;
- Newly eligible, non-disabled adults under age 65 up to 138% FPL, 100% through 2016, 95% for 2017, 94% for 2018, 93% fir 2019 and 90% for 2020 and beyond;
- Medicare Part-B premiums for Qualified Individuals (QIs), 100%; and,
- Services provided through Indian Health Services and Tribal Facilities, 100%.

Medicaid's Structure in Louisiana

Overview

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the state pays a monthly fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all of the Medicaid services a beneficiary may require that are included in the plan's contract with the state. Louisiana's Medicaid program possesses both FFS and managed care aspects.

In addition, Medicaid will pay Medicare premiums, deductibles and co-insurance (to varying degrees based on income) for elderly or disabled persons who are eligible for both Medicare and Medicaid.

Finally, Medicaid pays disproportionate share hospital (DSH) or uncompensated care costs (UCC) payments to hospital-based medical care providers for the allowable costs associated with serving a disproportionately large number of poor clients.

Legacy, or Fee-for-Service, Medicaid Program

Louisiana's legacy or fee-for-service (FFS) Medicaid program consists the mandatory and optional services, except specialized behavioral health and non-emergency medical transportation services, provided to the populations not mandated to or excluded from enrolling in the managed care plans:

- People eligible for both Medicaid and Medicare (dual eligibles);
- People eligible for family planning services under the Take Charge Plus program;
- People with limited periods of eligibility and participating in either the Spend-Down Medically Needy Program or Emergency Service Only Program;
- People eligible for the Greater New Orleans Community Health Connection Waiver program;
- People enrolled in the Program for All-Inclusive Care for the Elderly (PACE);
- People with developmental disabilities who are receiving care at an intermediate care facility for the developmentally disabled (ICF/DDs) or HCBS waiver services;
- People with adult-onset and age-related disabilities who are receiving nursing home or HCBS waiver services; and,
- Children and young adults under age 21 who are on the OCDDs' Request for Services Registry (Chisholm Class Members).

Legacy, or Fee-for-Service, Medicaid Program

The state's Medicaid program manages the provision of care for these groups directly and engages a Fiscal Intermediary to pay the claims for services provided to them.

Funding for the legacy Medicaid program totals approximately \$3 billion in FY16, nearly two-thirds of which is projected to be spent on institutional services or the community-based alternative services for the elderly and disabled:

- \$948.1 million in payments to nursing homes;
- \$264.1 million in payments to ICF/DDs;
- \$524.4 million in payments for the various home-and-community-based waiver programs; and,
- \$193.2 million in payments for personal care services.

Managed Care – Primary and Acute Care Services

In 2012, Louisiana implemented the **Bayou Health** program, a managed care delivery model for approximately 900,000 Medicaid enrollees. In its first phase, the Bayou Health program consisted of two “shared-savings” plans and three “prepaid” plans.

Beginning with the new contracts entered into in February 2015, the second phase of Bayou Health is a “pre-paid” risk-bearing MCO model, in which managed care organizations are paid a monthly flat fee for managing the care of Medicaid recipients and reimbursing directly the providers of health care services to the plan’s enrollees. The “shared-savings” plans, plans to which a smaller fee is paid for care management but claims for services run through the traditional Medicaid fee-for-service system, are no longer a part of Bayou Health.

Now, Bayou Health consists of five “prepaid” plans serving approximately 969,000 individuals (as of July 2015) and \$3.2 billion has been allocated for the Bayou Health program in the FY16 budget.

To insure quality and effectiveness in the program as it enters a new phase, the Bayou Health health plans will be measured against 20 new performance metrics in addition to the 25 performance and 10 administrative measures utilized in the first phase as well as 8 quality metrics to which financial rewards are tied – 6 of these are new and 2 are continued from the old contracts.

Managed Care – Mental Health Services

The **Louisiana Behavioral Health Partnership (LBHP)** was created under the Medicaid program to centralize the coordination and management of the provision of behavioral health services, including mental health services and treatment services for addictive disorders, for both children and adults in the state in FY12.

In addition, for children with extensive behavioral health needs either in or at-risk for out-of-home placement, the state created the Coordinated System of Care (CSOC) that operates under the LBHP for the coordination of all related state services provided to these individuals by the Department of Health and Hospitals, Office of Juvenile Justice, Department of Children and Family Services, and Department of Education for this unique subset of young people with significant behavioral health challenges.

The LBHP has served approximately 85,000 children and 106,000 adults with serious mental illness, major mental disorders, acute stabilization needs and/or addictive disorders.

By the end of FY15, the state was spending \$396.8 million on behavioral health services statewide via the LBHP.

The non-CSOC services and their coordination and financing will transition into the Bayou Health plans during FY16 and a total of \$235.5 million has been allocated for LBHP in FY16.

Managed Care – Dental Benefits Program Manager

The most recent Medicaid services to move under managed care are dental services.

In January 2014, DHH began the process of selecting a dental benefits program manager to coordinate dental services for Medicaid enrollees. In March 2014, Managed Care of North America Dental was selected from the four entities responding to the RFP. Then, in June of that year, CMS gave its approval to DHH to proceed with the new dental managed care program.

The projected cost for these services in FY16 totals approximately \$150.2 million.

Upper Payment Limit and Full-Medicaid Pricing Payments

UPL and FMP payments are supplemental payments to providers of the difference between the current Medicaid rates for those services and the maximum payment amount allowed under federal regulations. Usually, this maximum is the Medicare rate or a computation of what Medicare would pay for that service under fee-for-service payments or actuarially soundness for services under managed care plans.

In total, these UPL/FMP payments cannot exceed the aggregate difference between Medicaid and the maximum payment amount for the class of hospitals to which the hospital(s) getting these payments belong(s).

Currently, these payments are estimated to total \$711.6 million in FY16 and are made to rural hospitals, services district hospitals, our Low Income Needy Care Collaborative Agreement (LINCCA) partners, and LSU Public Private Partnership (PPP) hospitals.

It is important to note that, with the growth in the payments to the LSU PPPs and the commitment to rural hospitals under the Rural Hospital Preservation Act, these payments are being reduced for LINCCA partners in the current year and future growth in payments to the PPPs must be considered as this is a capped payment methodology.

Medicare Buy-Ins and Supplements

Medicare enrollees, who fall within specific income and resource guidelines, may receive help paying for their Medicare premiums and out-of-pocket medical expenses from the Medicaid program and qualify for services under both programs. (Medicaid covers additional services beyond those provided under Medicare, such as nursing facility care beyond Medicare's 100-day limit.) Services covered by both programs are first paid by Medicare with Medicaid making up the difference up to the state's payment limit.

The Medicaid program will spend an estimated \$288.6 million in FY16 on Medicare Part-A and Part-B premiums and supplements for select individuals dually eligible for both Medicaid and Medicare. In addition, the state will pay approximately \$139 million in "clawback" payments to federal government to help finance Medicare prescription drug coverage offered under Medicare Part-D for certain dual eligibles in FY16.

Disproportionate Share Hospital Payments

Disproportionate share hospital (DSH) or uncompensated care cost (UCC) payments are the primary source of reimbursements for health care services provided to the uninsured in Louisiana.

The state is budgeted to pay \$997.7 million in UCC payments in FY16:

- \$778.1 million to the LSU Public Private Partnership Hospitals;
- \$26.7 million to Lallie Kemp Regional Medical Center;
- \$70.7 million for behavioral health services;
- \$100 million to the Low-Income, Needy Care Collaborative Agreements (LINCCA) partners;
- \$1 million for the High-Medicaid DSH pool; and
- \$21.2 million for the Greater New Orleans Community Health Connection (GNOCHC) Waiver program.

Disproportionate Share Hospital Payments

The Federal DSH Cap and Reductions under the Affordable Care Act (ACA)

The federal government caps the funding it will provide to each state for “disproportionate share” (DSH) payments to hospitals that have larger ratios of Medicaid and low-income patients in their overall patient mix. The FY16 budget is very close to Louisiana’s DSH cap.

Further, the ACA originally required annual aggregate reductions in federal DSH funding from FFY 2014 through FFY 2020. However, recent federal legislation delays again these reductions and now they are scheduled to start in FFY 2018 and continue through 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.

The final methodology to distribute these aggregate reductions across states has not yet been developed. Based on a FFY 2014 draft methodology released before the first delay in the allotment reductions, it is most likely that the reductions will impact all states, to some degree, regardless of a state’s Medicaid expansion decision.

Health Information Technology Initiative

The state has secured approximately \$444.7 million in federal grant funding since FY11 to assist health care providers with the implementation of electronic health records.

FY11 – \$31.7 million

FY12 – \$89.8 million

FY13 – \$54.4 million

FY14 – \$42.1 million

FY15 – \$113.4 million

FY16 – \$113.4 million

Through the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program, eligible medical professionals and hospitals with qualifying Medicaid patient volume may receive incentive payments for adopting, implementing or upgrading and meaningfully using certified EHR technology.

Louisiana was the fourth state in the nation to launch its incentive payment program in January 2011. Since that time, more than 2,500 medical professionals and hospitals in Louisiana have qualified for incentive payments.

Since the program's inception, Louisiana has remained among the top 10 states in incentive payments.

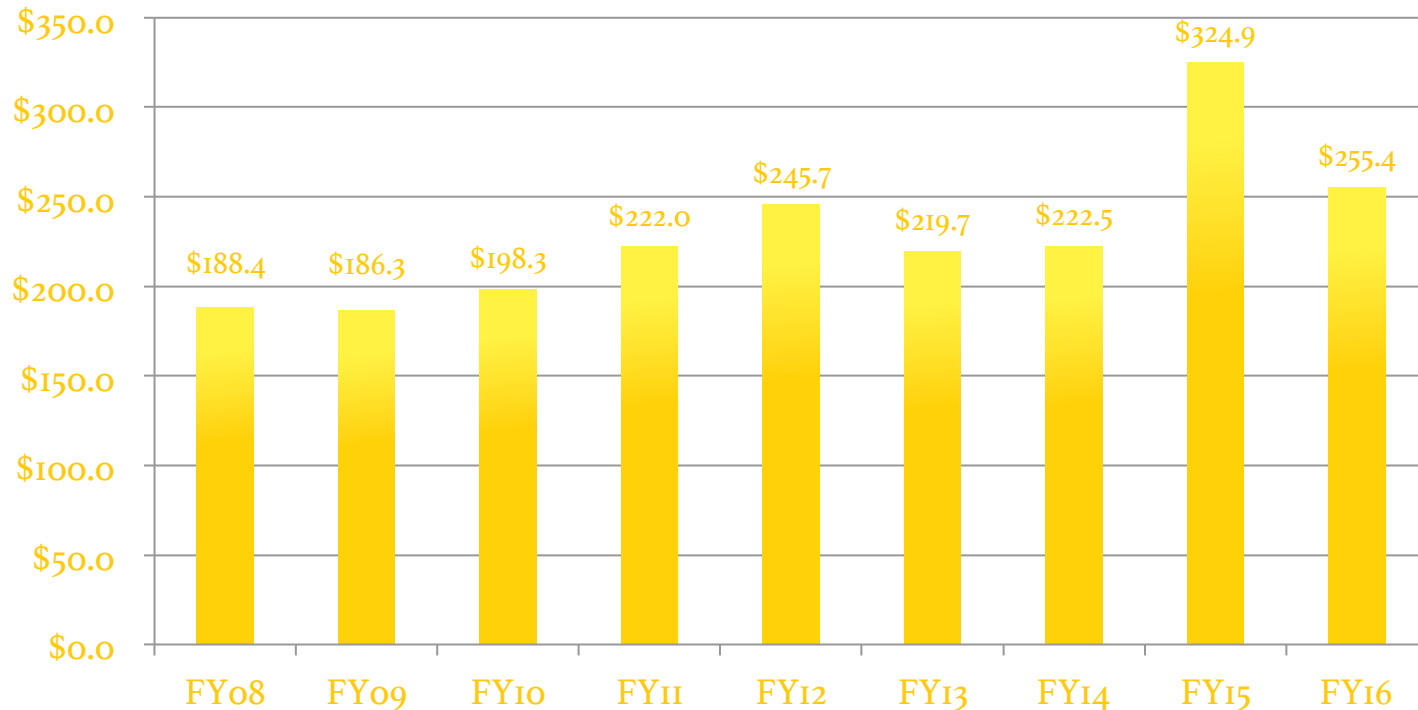
Medicaid Funding

Funding for Medical Vendor Administration Since Fiscal Year 2008

Total funding for Medicaid's administrative program increased by 35.6% from FY08 to FY16 – from \$188.4 million to \$255.4 million – with an average growth rate of 5.5% per year.

Total Administration Funding

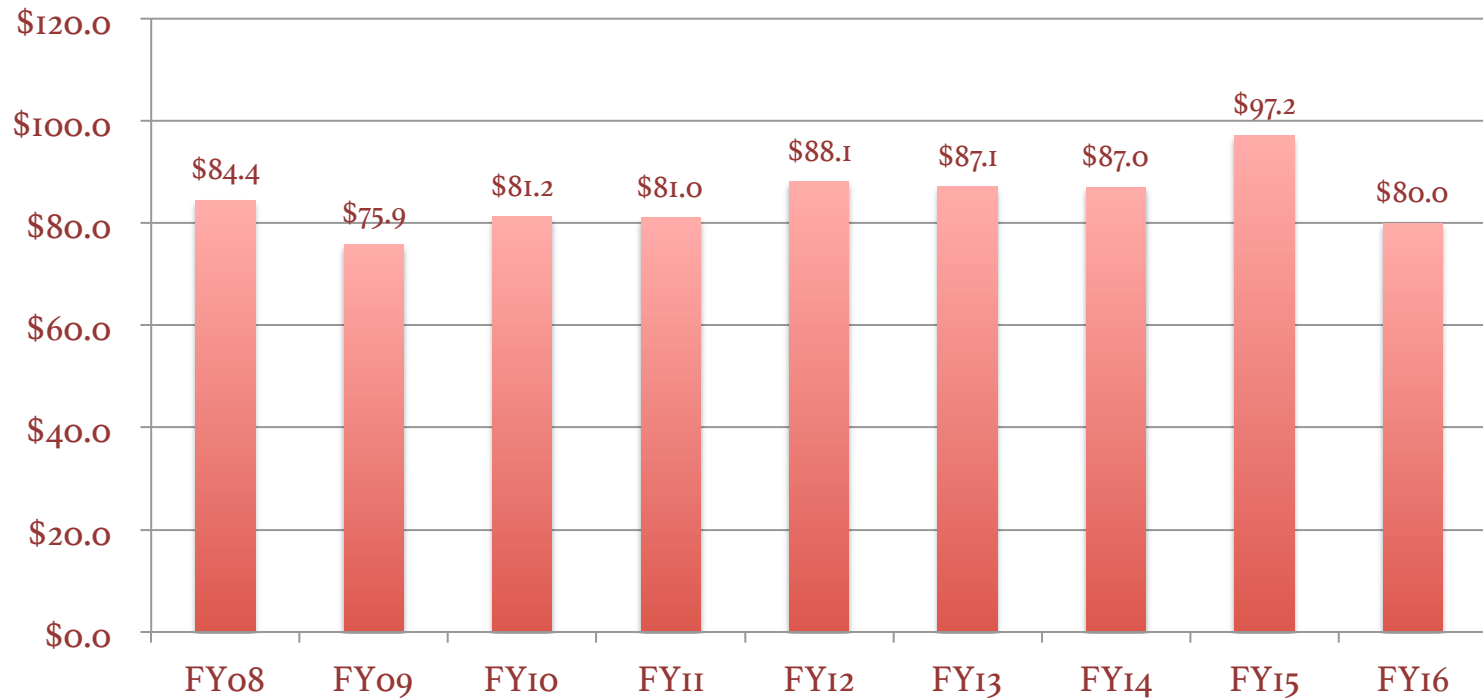
(in millions)



State Funding for Medical Vendor Administration Since Fiscal Year 2008

State funding for Medicaid's administrative program declined by 5.6% from FY08 to FY16 – decreasing by \$4.4 million from approximately \$84.4 million in FY08 to total almost \$80 million in FY16.

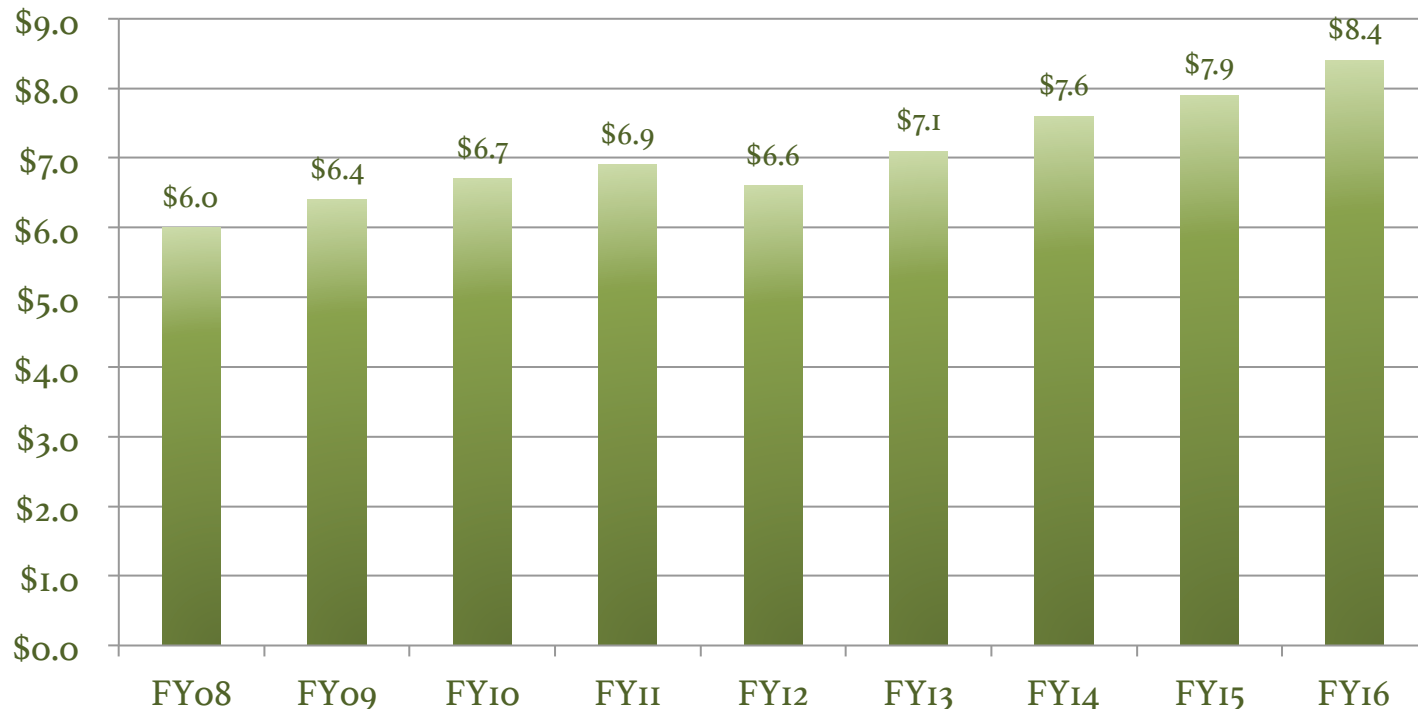
State Funding for the Administration Program (in millions)



Total Funding for Medical Vendor Payments Since Fiscal Year 2008

Total funding for Medicaid's Payments program increased by 40.5% from FY08 to FY16 – from \$6 billion to \$8.4 billion – with an average growth rate of 5.3% per year.

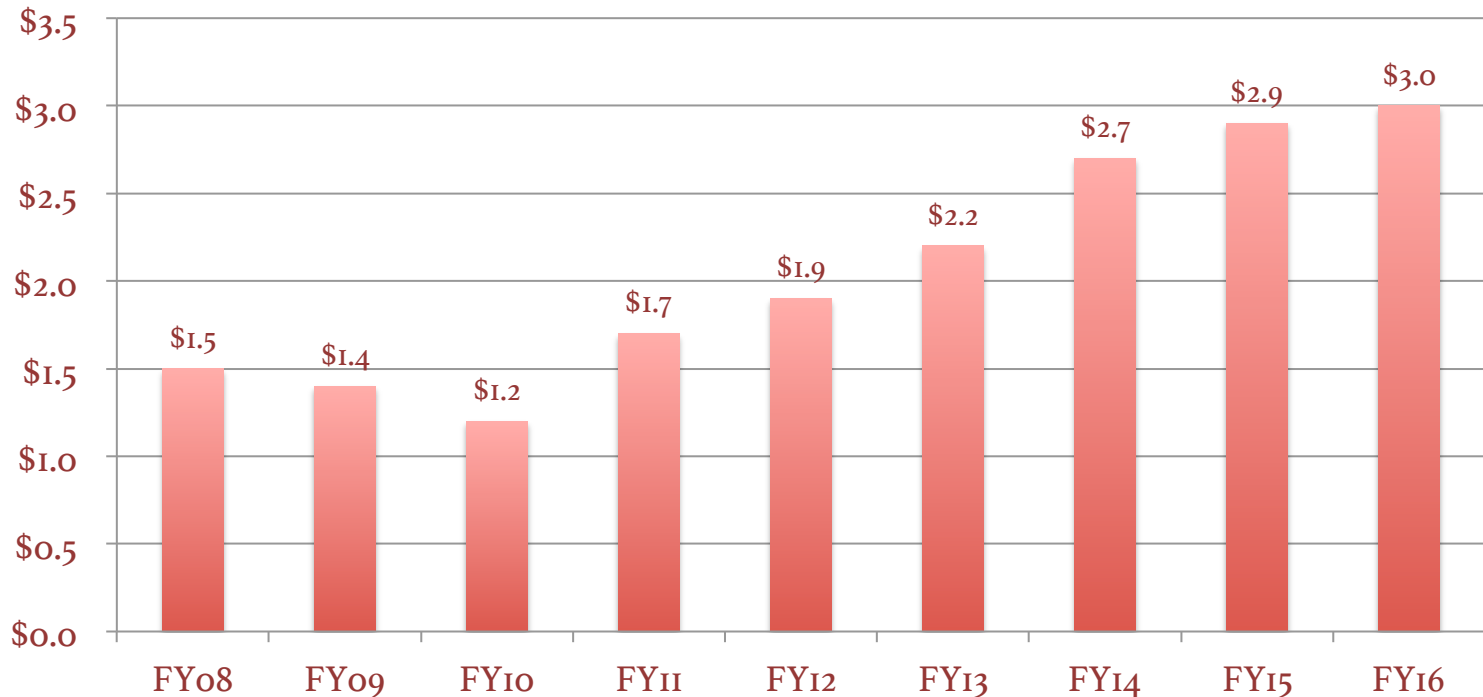
Total Payments Funding (in billions)



State Funding for the Medical Vendor Payments Since Fiscal Year 2008

State funding for Medicaid's Payments program nearly doubled from FY08 to FY16 – increasing by 94.7% from approximately \$1.5 billion to total almost \$3 billion. The growth in state funding averaged 9.9% annually for this time period.

State Funding for the Payments Program (in billions)



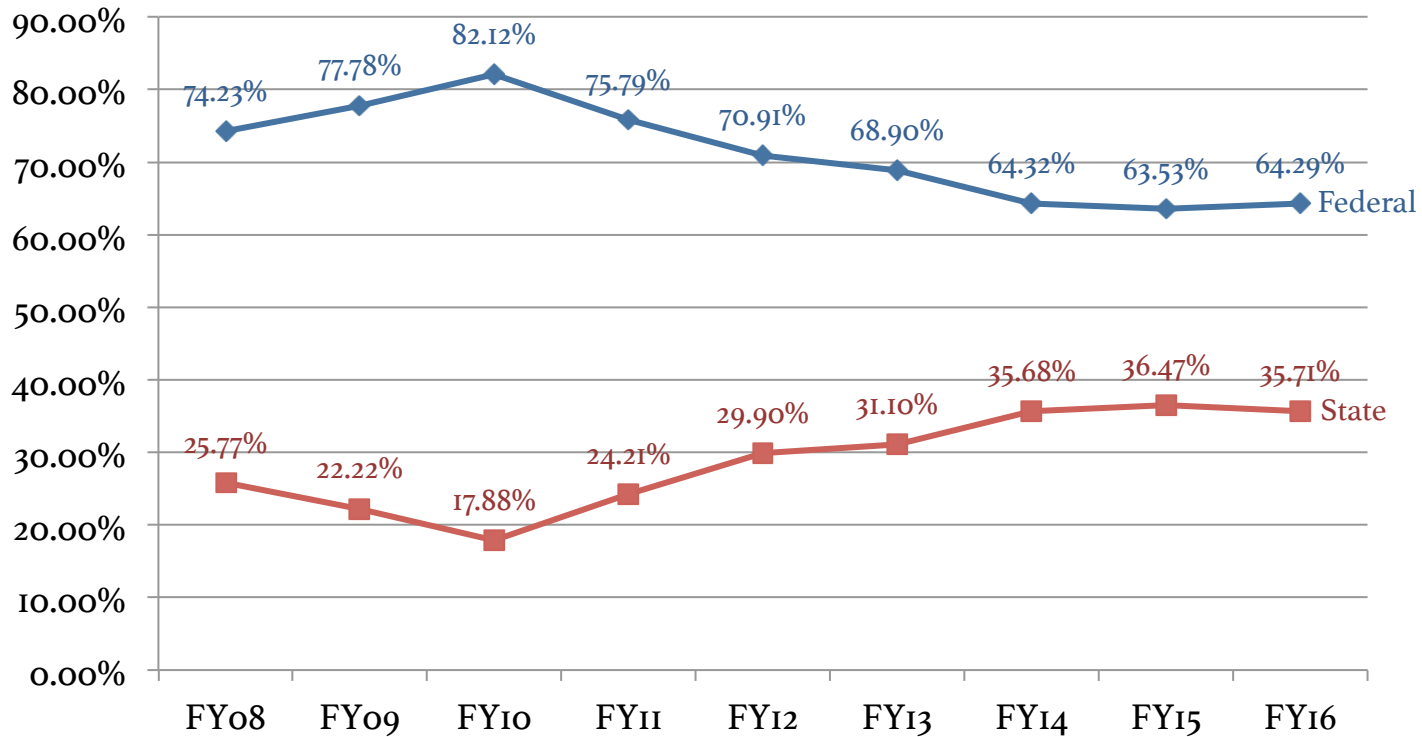
The Growth in State Funding for the Medicaid Payments Program

The sharp increase in state financing is due primarily to two factors.

- First, the overall growth in the Medicaid program resulted in the state having to provide a greater amount of state funding to maintain the program as it grew.
- Second, the federal match rate declined by nearly 10 cents for every dollar spent from FY08 to FY16 thereby resulting in an overall actual state financing rate for all Medicaid expenditures of 25.77% in FY08 growing to 35.71% by FY16. This decline in federal effort and subsequent increase in state effort were due to the expiration of the enhanced federal stimulus and disaster match rates as well as the decline in our base match rate that is the basis of federal financial participation in the Medicaid program.

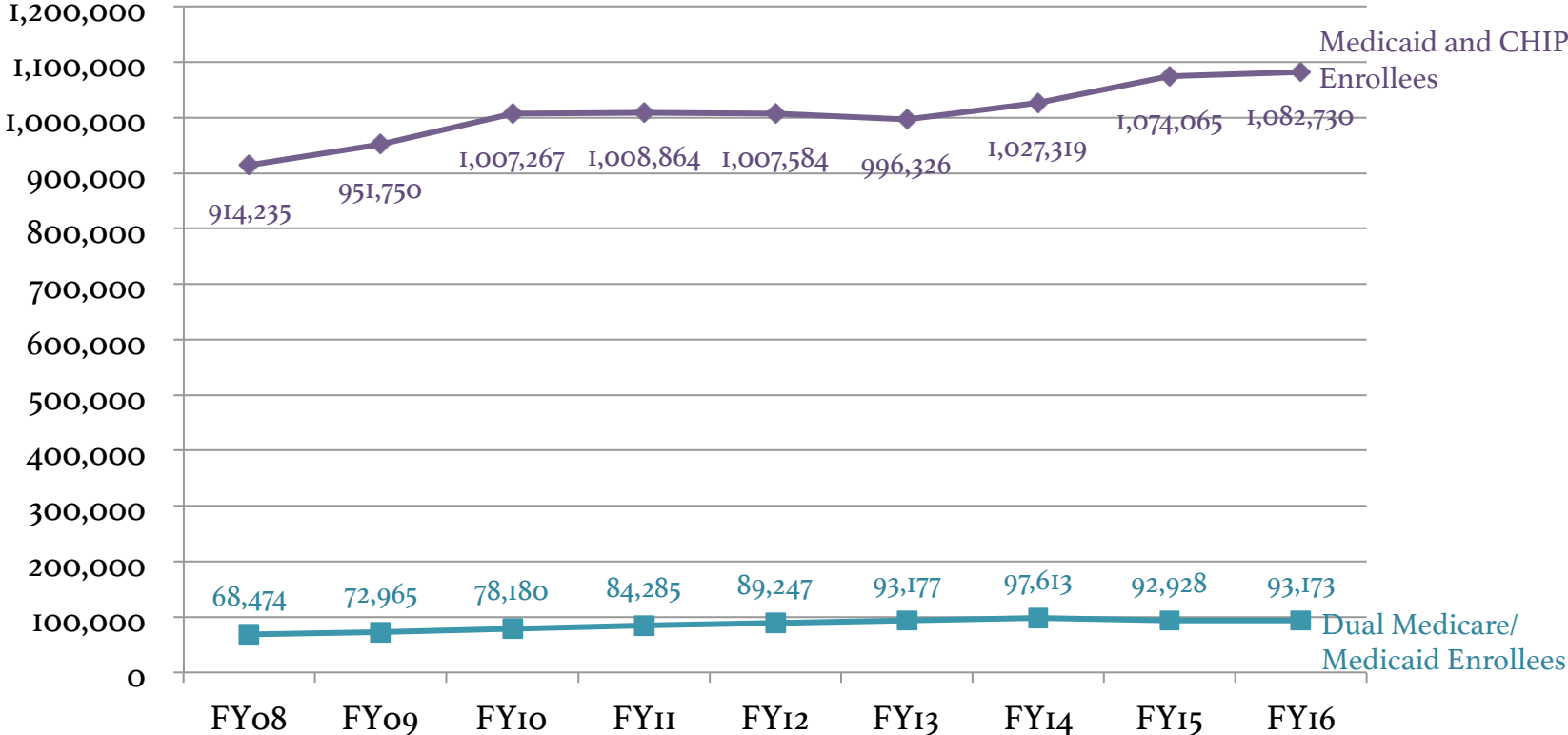
Shifts in State and Federal Financing of Medicaid Payments

State and Federal Financial Participation Rates



Growth in Medicaid, CHIP and Dual Medicare/Medicaid Enrollees

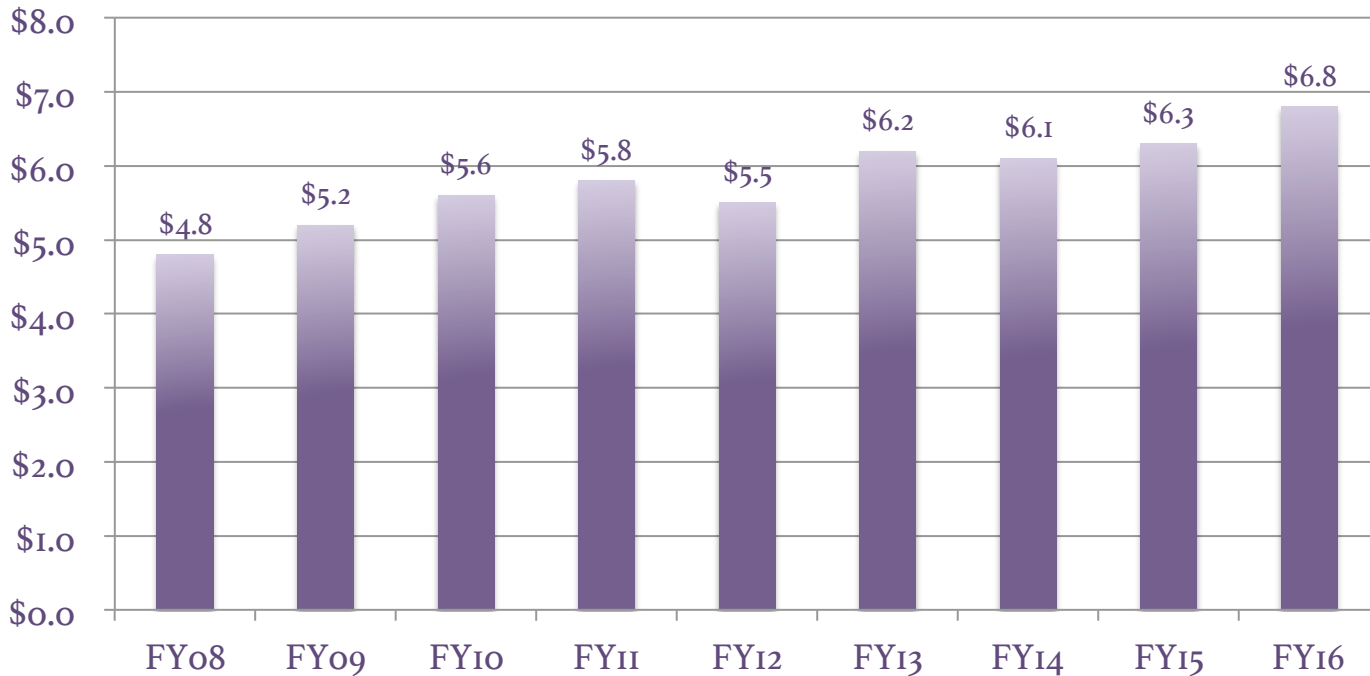
Number of Enrollees



Growth in the Medicaid Program Since Fiscal Year 2008

Expenditures on Medicaid and CHIP enrollees increased by 43.3% from FY08 to FY16 – from \$4.8 billion to \$6.8 billion – with an average annual growth rate of approximately 4.8%.

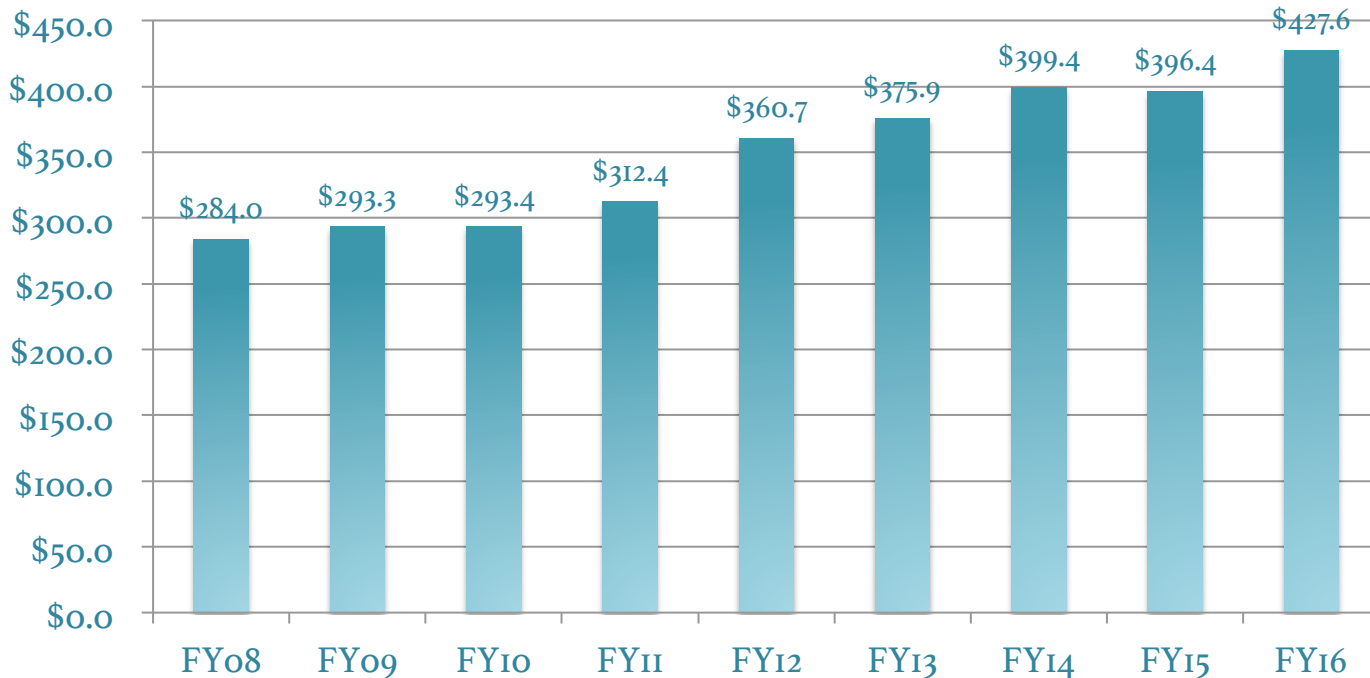
Expenditures on Medicaid and CHIP Enrollees
(in billions)



Growth in the Medicaid Program Since Fiscal Year 2008

Expenditures on premiums, supplements and clawback payments for dual Medicare/Medicaid eligible enrollees increased by 50.5% from FY08 to FY16 – from \$284 million to \$427.6 million. This growth equates to an average annual growth rate of 5.4%.

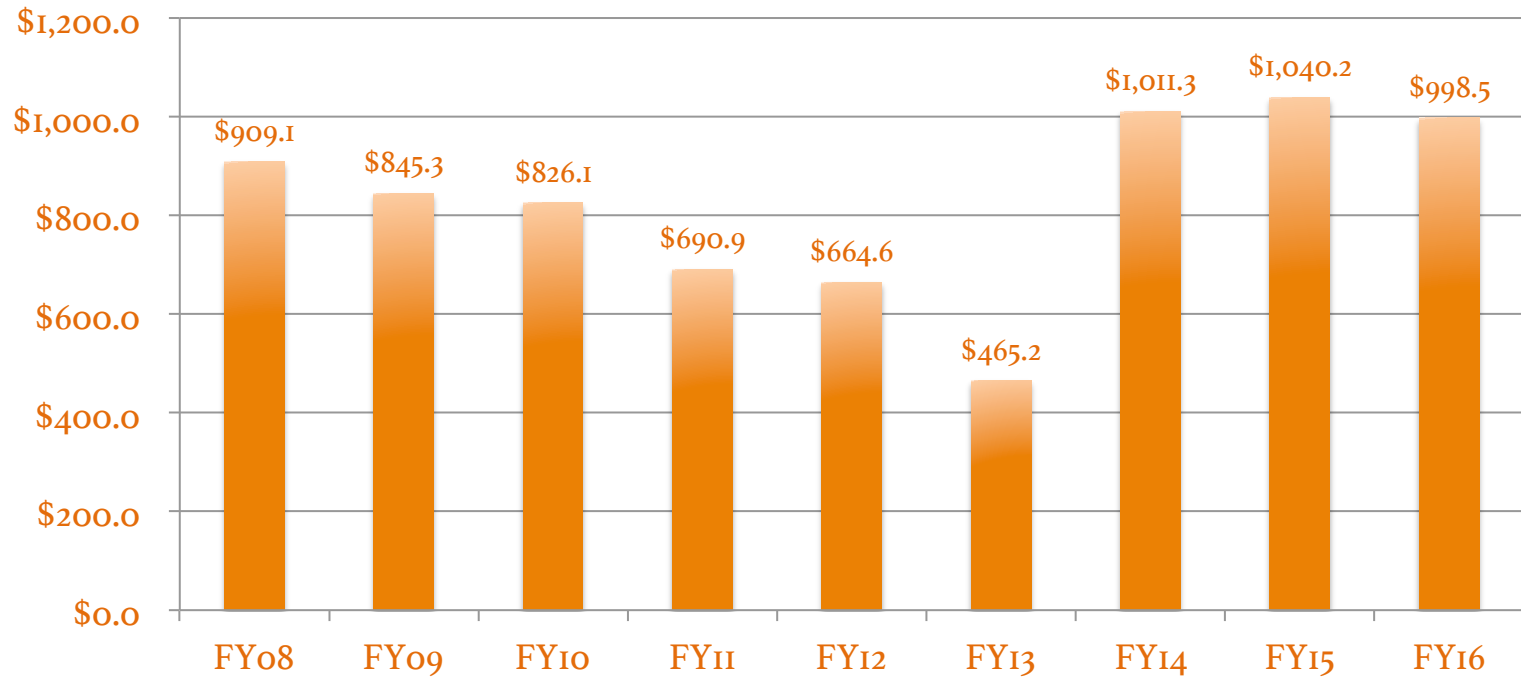
Expenditures on Duals (in millions)



Growth in the Medicaid Program Since Fiscal Year 2008

Expenditures on health care services for the uninsured increased by 9.8% from FY08 to FY16 – from \$909.1 million to \$998.5 million.

Expenditures on the Uninsured (in millions)



Options to Control Costs and Program Size

Under Mandates on Services and Covered Populations

Reductions in Medicaid reimbursement rates as well as authorized service levels are permissible. Federal law allows these for both mandatory and optional services. The key is that a state does not make reductions to a level that then fails to meet the benchmark for adequate access to services. The entire Medicaid program would be in danger if Louisiana violates access.

Under state law, however, the restrictions on provider reductions are more stringent. Last fall, the citizens of Louisiana ratified two constitutional amendments governing how reductions are made that impact hospitals and those providers (nursing homes, ICF/DDs and pharmacies) paying fees deposited into the Louisiana Medical Assistance Trust Fund (LMATF).

Any reductions to hospitals and the LMATF provider groups will have to be less than or equal to the average reductions to the appropriations and reimbursement rates for all other Medicaid provider groups and will require a two-thirds approval by the members of the legislature, if in session, or the Joint Legislative Committee on the Budget (JLCB), if the legislature is not in session.

Options to Control Costs and Program Size Under Mandates on Services and Covered Populations

Another concern to keep in mind when making cuts is the federal requirement to maintain actuarial soundness for the managed care programs. Once again, cuts may only be made to certain levels before the managed care initiatives would be placed at risk.

The state could also change its service offerings and eliminate optional programs or seek waivers to bypass certain federal requirements. Unfortunately, there are limitations on the elimination of optional services that would ultimately result in a reduction in eligibility and waivers must meet stringent federal guidelines and pass arduous review and approval processes.

Traditionally, the other option would be to begin reducing the pool of Medicaid eligibles. Beyond the long-term implications of eliminating health care services for children, pregnant women and our most vulnerable citizens, there are practical limitations on reducing such eligibility. Further, eligibility standards for children must be maintained until October 1, 2019 under federal law.

Finally, under the U.S. Supreme Court decision in *Olmstead v. L.C.* and the precedent set in the settlement of Louisiana's own *Barthelemy* case, Louisiana cannot severely restrict community-based alternatives to institutional care for the elderly and disabled.