

In Louisiana, Necessity Breeds Innovation to Bring Medicaid Expansion

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When historic floods struck the Baton Rouge area last month,¹ Louisiana health officials were able to offer the working poor who fled their homes something they could not give to the musicians, waiters, and hotel maids left homeless by Hurricane Katrina 11 years ago: access to healthcare.

Just a few months ago, those left in the “coverage gap” after the US Supreme Court left Medicaid expansion up to the states would have been out of luck. But on July 1, 2016, Louisiana became the 31st state under the Affordable Care Act (ACA) to bring Medicaid to those earning up to 138% of the federal poverty level (FPL).² With a goal to enroll 375,000 in this population the first year, by August 24, 2016, the state had reached 289,742—past the three-fourths mark, according to an e-mail from Louisiana Department of Health (LDH) spokeswoman Samantha Faulkner. That means more than 11,000 individuals gained coverage through expansion in just the 2 weeks following an August 10, 2016, update³—and Faulkner confirmed for *The American Journal of Accountable Care (AJAC)* in an interview that some flood victims had signed up in shelters.

Louisiana’s simplified enrollment process—which makes heavy use of data already on hand—has created a new model for states with no stomach for bureaucracy. By design, expansion is like flipping a switch. With limited effort for the enrollees, Louisiana is giving coverage to thousands of low-wage workers and self-employed contractors who drive the tourism economy. That is as it should be, according to Governor John Bel Edwards, who has traveled the state to emphasize that far from a handout, 70% of those gaining coverage are working folks, people “caught in a trap.”⁴

To find those eligible, Louisiana has deployed longtime LDH staff into clinics and hospitals to capture potential enrollees at the point of care. And, in a move destined to be copied, state officials used data from the Supplemental Nutrition Assistance Program (SNAP) to identify families likely eligible. So far, according to Faulkner, this method accounts for 23,413 Medicaid certifications, although many involve more than 1 person.

Edwards’ decision to plow ahead with expansion amid a budget crisis has gained notice. In late August, he was named to Modern Healthcare’s “Top 100 Most Influential People in Healthcare,”⁵ at number 35—while a governor who is scaling back Medicaid expansion, Matt Bevin of Kentucky, came in at 89. Edwards calls expansion, “the easiest big decision I’ll ever make” and said work remains on delivery system and payment reform.

In June, Mary Caffrey, managing editor of the *Evidence-Based* series from *The American Journal of Managed Care*, visited New Orleans during the early days of enrollment to hear from providers and an advocate for safety net clinics about the promise of Medicaid expansion after a long wait and what it might mean for Louisiana.

Serving the Poor for Generations

It was mid-morning, and the Daughters of Charity Health Center on Carrollton Avenue was bright and busy. One of 9 centers the Catholic order operates across 25 miles, the Carrollton site, was bursting with patients, mostly women and children. In the waiting area for the optometry and dental clinics, there was not a chair to be had.

The Daughters have cared for New Orleans’ poor since before

the Civil War,⁶ and today, 90% of the clinics' patients earn less than 200% of the FPL, with 70% below the 100% mark.⁷ According to Daughters of Charity vice president and chief operating officer Frank Folino, 24% of the clinics' patients are "self-pay," so a sizable number of them might need to see the young woman tucked in a quiet corner who registers patients for Medicaid expansion, which was scheduled to take effect in a few weeks.

Behind the young woman, separated by a partition, was a long-time employee from the state's Medicaid office. Armed with digital application tools and a direct line to the state capital, he had been dispatched from LDH to handle Medicaid renewals and to speed eligibility for anyone who signs up at the Carrollton clinic. The idea is to integrate Medicaid enrollment right into the workflow, when patients are least likely to be lost. Although the numbers of these trained staff were still small in June, Faulkner said they were projected to grow to 100 at 80 sites.

There is much hope that Medicaid expansion has finally come to one of the country's poorest states, but no one is blind to the challenges that remain. Those who have never had insurance must learn to use it, and there are questions on whether there will be enough primary care doctors for this new wave of patients. The governor himself has said that Medicaid payments to doctors must increase to ensure access over the long haul. And, according to Susan Todd, executive director of 504HealthNet, a health policy umbrella for 60 primary and behavioral healthcare sites in the New Orleans region,⁸ everyone must remember there will still be uninsured individuals after expansion.

Expansion on a Shoestring Budget

"This is right versus wrong, not right versus left," Edwards said on the first day of enrollment (June 1, 2016) during a visit to University Medical Center (UMC), the \$1.2-billion replacement for historic Charity Hospital, which served generations of New Orleans' poor before it shuttered after Hurricane Katrina. "At the end of the day ... we're going to improve health outcomes. We want a better quality of life for our people. We want them to be happier, healthier, more productive people."^{9,10}

When he campaigned last fall, Edwards promised Medicaid expansion knowing full well that a budget deficit awaited his arrival. He got expansion rolling with an executive order on January 12, 2016, his second day on the job.¹¹ Weeks later, his administration announced the shortfall was worse than expected: this year's \$24.5 billion budget had a gap of \$943 million, with a deficit of \$2 billion looming for the fiscal year that started on July 1, 2016.¹² Keeping his promise would take creativity, because the legislature would not pay for administrative help, even though expansion is projected to save \$184 million.²

"We didn't get one additional dime from the state," said Secretary of Health Rebekah Gee, MD, MPH, MS, in her June interview with *AJAC*. That meant no money for new staff to figure out who



Rebekah Gee

Louisiana Secretary of Health, Rebekah Gee, MD, MPH, MS, has overseen the state's Medicaid expansion efforts.

was eligible—to say nothing of funds for education or advertising. So, Louisiana tapped eligibility data it already had, using rolls from existing Medicaid waivers and the SNAP data, a first among the states. Gee's move to "outstation" the LDH Medicaid staffers—like the one at Daughters of Charity—counted as a piece of Louisiana's 25% share of the administrative costs of enrollment (the federal government is paying 75%), according to information from state health officials.

With these steps, Edwards and Gee have rewritten the playbook for low-cost, low-bureaucracy Medicaid enrollment that is well-suited to expansion's holdout states—places where poverty and chronic disease exceed the norm, along with resistance to government spending. And it's all working. In the week before expansion coverage took effect, new or expanded benefits were already scheduled to reach more than 225,900 people at 100% to 138% of the FPL; these included families of 4 earning \$33,564 or single adults earning \$16,404, according to LDH data provided to *AJAC*. Thus, Louisiana enrolled 60% of its eligible population in less than a month; more than 186,800 of them were automatically signed up when enrollment opened on June 1, 2016.

Use of SNAP Data Is a Novel Idea

A week into enrollment, Gee had the number of new Medicaid enrollees at her fingertips: 197,026 at that point. Most of them were transferred based on eligibility for 2 existing programs: 1) 61,000 enrollees who had limited primary care and behavioral health benefits through the Greater New Orleans Community Health Connection (GNOCHC)—a program funded in the aftermath of Hurricane Katrina that concluded when Medicaid began July 1, 2016—living in New Orleans and 3 parishes (counties) that make up the immediate suburbs; and 2) enrollees across the state with income levels just above traditional Medicaid who were receiving various family planning, contraception, and screening services under a separate Medicaid waiver.

Louisiana broke new ground with its use of SNAP eligibility rolls to quickly qualify individuals. Gee explained in the interview that SNAP clients received a notice letting them know of their likely Medicaid eligibility, along with 3 income-related questions. Clients could respond by phone, fax, e-mail, or regular mail. Within days, Gee said, the state Medicaid office had fielded 10,000 phone calls; over time, the state expects up to 105,000 people to enroll this way, because in the future, low-income families will be able to enroll in SNAP and Medicaid at the same time.

Louisiana hospitals, which went through a transformative relationship with the state's charity care system under Edwards' predecessor, Bobby Jindal, have greeted expansion warmly.⁵ It comes a year into the life of UMC, which was under construction before the Supreme Court ruled that Jindal could decline Medicaid expansion dollars.²⁵

Rachel Verville, system vice president for Revenue Cycle at LCMC Health—which operates 4 hospitals in the New Orleans area besides UMC—has seen Medicaid expansion in former posts in Massachusetts and New Hampshire, and is impressed with Louisiana's innovation. "It's very refreshing to use data that is already available," she said in an interview with *AJAC*, adding that the automatic enrollment from GNOCHC (pronounced no-key) will allow a smooth transition for these patients.

Gee had to fill gaps to cover Louisiana's share of administrative costs. With a background in academia, she tapped the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and other sources. To promote expansion, Gee and Edwards toured the state, answering constituent questions and drawing free media coverage.

"People want to know, 'Is this real Medicaid?' We've had some tears shedded," Gee said. "We've had a lot of happy faces at these enrollment events." What didn't happen, based on interviews and media reports, are the computer glitches and downtime that plagued the ACA's early days.

For Some, Coverage for the First Time

Grasping the magnitude of Louisiana's expansion requires understanding of just how hard it was to get traditional Medicaid. According to data provided by Louisiana LDH, the previous income limit for parents and caretaker relatives (if a child 19 years or younger was at home) was 24% of the FPL for a family of 4—just \$5820 a year, or \$485 a month. Adults without children could not get coverage at all unless they qualified for disability.

Verville said there is excitement at the chance to change Louisiana's healthcare story. "There are people who are going to have coverage, maybe for the first time in their lives," she said. Gee also portrays Medicaid expansion as a piece of a larger picture, of raising not only the population's healthcare profile, but its economic one as well.

"It's quite rewarding to participate in helping a population gain access to healthcare," Verville said. For providers, "It opens a whole world of opportunity."

It's not that Louisiana doesn't have a history of caring for the poor. The Daughters of Charity operated hospitals in New Orleans for more than a century, and Governor Huey P. Long expanded this system and created the Louisiana State University (LSU) Medical School. As the system evolved, in 1997, LSU took full control of the charity hospitals.¹³ Although care for the poor at the state's charity hospitals was free, preventive and primary care networks were sparse. The divide perpetuated generations of separation between the poor, who went to the emergency department (ED) for most of their care, and the insured, who could see the doctor, the dentist, and specialists.

After the ACA passed, Louisiana readied itself for Medicaid expansion. However, when the US Supreme Court made expansion optional, to the dismay of healthcare leaders, Jindal refused to accept additional Medicaid funds. Instead, he ended the charity hospital system, pairing off most of the former state hospitals with private ones and offering state contracts to manage them.^{13,14} When the state capital, Baton Rouge, lost its charity hospital, another city ED was flooded with so many uninsured patients that it closed.¹⁵

It's little wonder, then, that CDC data show that Louisiana ranks poorly in rates of diabetes (10.4%)¹⁶ and obesity (34.9%).¹⁷ CDC data from 2012, before the ACA took full effect, show Louisiana ranked second in cancer incidence (483.4 cases per 100,000 residents) behind Kentucky and third in deaths from cancer (190.5 per 100,000 residents) behind Kentucky and Mississippi.¹⁸ Kentucky's experience shows what is possible: after expansion, Kentucky cut its uninsured rate from 20.4% in late 2013 to 7.5% as of December 2015.¹⁹ According to Gallup, Louisiana retains one of the highest uninsured rates at 16.3%.²⁰

The stability for newly insured patients—not having to patch together services or drug coverage—will extend somewhat to hospitals and other providers. Ayame Dinkler, assistant vice president for Government Affairs and Strategy Development at LCMC Health, said that although public-private partnerships like UMC will still require support through state funding from the Governor and the legislature, Medicaid expansion will save the state a tremendous amount of money. "We can't train the next generation of physicians without state funding," Dinkler said.

New Orleans' Transition to Primary Care

Twenty years ago, after the Daughters of Charity sold its last hospital, the order created a holistic system of primary and behavioral healthcare across the New Orleans region, according to President and CEO Michael G. Griffin. Last year, the centers treated 40,000 patients and handled 107,000 primary and behavioral health visits. Concepts like the patient-centered medical home are not new here. "Our job is to keep you healthy," Griffin said.

In the aftermath of Katrina, however, it became clear that the working poor, who lacked insurance, needed a different way to access primary and especially behavioral healthcare. Charity Hospital was gone, but as Todd explained, there was now an opportunity: a more complete network of community-based care could replace the bus rides and long waits in the ED. In 2007, Congress awarded a \$100-million grant to help provide basic services to those with incomes above the Medicaid range. From those beginnings, GNOCHC emerged.²¹

The GNOCHC parishes will have a head start on Medicaid expansion, Todd says. All the centers in 504HealthNet have electronic health records (EHRs), so there is baseline information for many Medicaid expansion patients. Expansion will mean improved benefits, access to dental care, and prescription drugs beyond the \$4

formulary at Wal-Mart, she said. (For example, patients with diabetes will get coverage for insulin.) It also means staff will spend less time piecing together payments for prescriptions and to cover other operations. “There’s more stability,” Todd said. “They can go forward and not worry that we’re not going to have financing for this group of adults that we’ve been caring for.”

There’s agreement that patients who have coverage are more likely to keep appointments and less likely to wait until a health problem is acute to seek care. Although GNOCHC patients may have less of a learning curve, Verville said that LCMC Health is preparing to work with managed care plans to teach the newly insured how to use their coverage—including the need to replace the ED with primary care. Since taking control of Interim LSU Hospital in 2013—which provided care until UMC opened last year—LCMC Health has produced a huge drop in the no-show rate in the clinic (from 62% to 22%) and an upward trend in patient satisfaction scores, which are now above 75%.²²

For both LCMC Health and Daughters of Charity, improved stability likely means a change in the “payer mix,” with a higher share of insured patients. Since 2013, LCMC Health has shifted the share of Medicaid patients from 42% to 34% in 2015, and the share of self-pay/indigent patients from 39% to 37%. The share of patients with commercial coverage has increased from 8% to 13% over the same period, and Medicare patients have increased from 11% to 16%.²²

Medicaid expansion will be a game changer for Daughters of Charity, says Folino, offering more resources to pour back into the mission. The current payer mix includes 55% of patients with Medicaid and 13% with commercial coverage, according to data provided in an e-mail. Folino said the average self-pay fee is \$45 for an office visit compared with a Medicaid reimbursement of \$135; he projects that 10% of the current uninsured patient base will enroll. This means Daughters of Charity will not only get increased revenue for these office visits, but these patients will also gain coverage for dental care and the center’s pharmacy.

Support for institutions is only part of the equation. Support for primary care physicians (PCPs) is important too, according to Pamela M. Wiseman, MD, associate professor of Clinical Family Medicine at LSU Health Sciences Center. Although she is “cautiously optimistic” about expansion, she has long been concerned about the number of PCPs in the pipeline, and wonders if there’s enough capacity to treat the newly insured.

Wiseman points to data from the Robert Graham Center that projects Louisiana will need an additional 392 PCPs to meet demand through 2030.²³ To make primary care attractive, Louisiana must fund more training positions and help young doctors with student debt, Wiseman said.

Will Other Holdout States Expand?

The apparent popularity of Medicaid expansion in Louisiana is no guarantee that other Deep South states will follow—or even that

expansion will survive where it exists. Kentucky’s Matt Bevin, a Republican who succeeded Democrat Steve Beshear, has proposed premium requirements, “lock outs” for nonpayment, and he would ask enrollees to earn dental and vision benefits. Enrollees would have to work or volunteer.²⁴ In Arkansas, Republican Governor Asa Hutchinson used a procedural maneuver to protect the “private option” with some modifications; however, after enrollment numbers topped 300,000, some state legislators wanted cutbacks.²⁵ Louisiana’s neighbor to the east, Mississippi, rivals its rates of poverty and chronic disease, and in mid-August, the state’s physicians seemed to support a resolution supporting expansion. Except, at the last minute, they took the words “Medicaid expansion” out of the document for fear that would rile political leaders opposed to anything associated with “Obamacare.”²⁶ Meanwhile, Todd told *AJAC* in June that some uninsured patients from Mississippi visit New Orleans area clinics because they have nowhere else to go.

In Louisiana, there’s also the issue of getting more physicians to accept Medicaid. It is not clear yet how many physicians in each of Louisiana Medicaid’s 5 managed care plans will accept patients from this new group. According to the LDH website, that information will come directly from the plans.²⁶

Expansion will bring an opportunity to work on longer-range goals, like being able to bill for both primary and behavioral health-care if they happen the same day, Todd said. Most of all, those involved say they look forward to moving the needle on core measures and health outcomes.

Amid her concerns, Wiseman remembers the patients she treated at her old clinic who lacked insurance and could not follow her to LSU Health. “Now, they can come see me.”

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