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Restructuring health care for La. uninsured

Former DHH secretary rejects proposed model

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A former Louisiana health chief and a state pediatricians' group say an existing program should serve as the foundation for health-care restructuring, instead of the private insurance-based plan the Jindal administration is pushing.

They say Louisiana already has the CommunityCARE program that's been in existence statewide for children and some adults who qualify since late 2003.

The administration is proposing "coordinated care networks."

In 2005, the federal Centers for Medicare and Medicaid Services called CommunityCARE "a model of excellence." It has also been praised for its early identification of children with developmental problems by the Center for Healthcare Strategies.

Former state health chief David Hood and the Louisiana Chapter of the American Academy of Pediatricians said an updated program — along the lines of one operating in North Carolina — could be just the remedy for the state's health-care woes.

But Louisiana Department of Health and Hospitals Secretary Alan Levine said much more needs to be done than what CommunityCARE offers.

"Why would you want to stop there?" asked Levine.

Today, statewide enrollment in CommunityCARE is 703,966. Enrollees include 582,866 people up to 20 years old, according to the latest DHH statistics.

CommunityCARE

The program provides "medical homes" for those enrolled in Medicaid — the government's health insurance program for the poor and uninsured. Patients are assigned to physicians who provide

preventive and primary care. Currently, there are 1,915 participating providers.

The physicians are the overseers of their care and steer patients to specialists as needed. The physicians are paid extra for managing the patient's care.

CommunityCARE uses the "medical home" model of health care that Gov. Bobby Jindal and Levine are now talking about and that former Gov. Kathleen Blanco pushed before them.

One feature that the current state program does not include is a move toward a private sector insurance model that's in administration plans. The Jindal administration insists that the private firms would provide the oversight needed to hold physicians, hospitals and other providers more accountable for the type of care delivered and at what price.

In June, the Louisiana Chapter of the American Academy of Pediatrics recommended that the state embark on an expansion of the CommunityCARE program, said Steve Spedale, an academy executive and physician who specializes in neonatal care.

Louisiana's pediatricians and general practice physicians provide the bulk of the care offered through the Medicaid health insurance program for the poor and uninsured.

The idea of exposing the state's children to out-of-state companies that make 15 to 20 percent profit is not appealing, Spedale said.

Nor is the potential for private insurance companies to hold hostage states and patients over compensation disagreements desirable, he said.

A good place to start

Hood, who followed Jindal as DHH secretary, leading the department from 1998 to 2004, said the current program needs some updating but it is a good starting point. Its foundation forms more of "a Louisiana solution" to health-care problems than the insurance-based model the administration is pushing, said Hood.

"We have got a program. It's not perfect but it works," said Hood.

"Why not take that program and build on it?" Hood asked.

Hood is now senior health-care analyst for the Public Affairs Research Council of Louisiana.

Hood said that CommunityCARE is rooted in the same principles as a program that has drawn praise in North Carolina for improved patient health and cost reductions.

The Louisiana State Medical Society also advocates the North Carolina model.

Hood said North Carolina officials do a great job of working at the local level, linking physicians and other providers into networks that coordinate efforts to make sure the patient gets the care needed.

“Everybody gets involved. They have regional boards that share this responsibility,” Hood said. The regional boards perform the same functions as private health maintenance organizations, called HMOs, he said.

“It’s community-based and they seem to take whatever savings and plow it back into the system,” Hood said.

Levine said there are areas of the state where it would be possible to transform CommunityCARE into a North Carolina-type system.
“What we do has to be unique to the communities that you are focusing on,” said Levine. “It’s definitely a model that can be built upon in rural areas of the state where you don’t have a robust network of providers.”

Not such a good program
But Levine said CommunityCARE fails to achieve some of the goals needed for a successful plan. For instance, the program has not improved the general health of participants, particularly those with chronic diseases, and cutting health-care costs.

Seventy-five percent of other states with managed-care Medicaid systems outperform Louisiana’s Medicaid and CommunityCARE programs when it comes to doing well-children health checkups, Levine said.

Some entity has to manage and pressure the “infrastructure” to deliver the care that’s required, Levine said.

But Hood and Spedale counter that CommunityCARE is better suited to Louisiana’s situation. A revamp could make the required changes.

Florida, where Levine once was health chief, uses a system similar to what the Jindal administration is now pushing.

“I guess that comes natural to them. In Louisiana, that’s not the case,” Hood said. “We don’t have a lot of HMO penetration … and people are scared of it, quite naturally.”

Spedale said the state needs to adopt a program that protects its Medicaid patients from outside forces such as the managed-care companies that held the state of Florida hostage recently.

When Florida suggested cuts in reimbursements, three of the largest companies threatened to quit, he said.

“With this population of kids, I don’t want them exposed to that,” Spedale said.