North Carolina Medicaid Reform: Advisory Team

Duke UNIVERSITY | BASS CONNECTIONS

Brandon Yan | Public Policy
Brooke Bekoff | Political Science (UNC)
Graeme Peterson | Public Policy
Haley Hedrick | Psychology
Jackie Lin | Biology & Economics

Kushal Kadakia | Biology & Public Policy
Leah Yao | Psychology
Riley Herrmann | Public Policy
Shivani Shah | Biology & Public Policy
Sonia Hernandez | Political Science

Deanna Befus | Nursing
Madhulika Vulimiri | Public Policy
Patrick O'Shea | Business & Medicine
Shanna Rifkin | Law
Trey Sinyard | Business & Medicine

BASS CONNECTIONS IN GLOBAL HEALTH

Project Summary

The North Carolina Medicaid Reform Advisory Team analyzed Medicaid reform proposals from the McCrory Administration (Section 1115 Waiver), Cooper Administration (*Berger vs. Burwell*), and General Assembly (House Bill 662) and presented recommendations to state legislators and policymakers.

NC Medicaid

Background

- Medicaid covers more than 2 million NC residents with diverse health needs
- Medicaid accounts for roughly 30% of total state spending
- Expenditures have increased by $7 billion since 2000

Figure 1: NC Medicaid Funding Breakdown

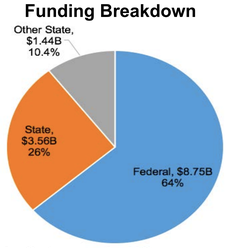


Table 1: FY16 Cost Distribution by Eligible Category in NC

Program Category	Percent of Eligibles	Cost of Program	Percent of Service Dollars
Aged	6.4%	$1,665,597,183	15.1%
Blind & Disabled	14.2%	$5,089,609,780	46.1%
TANF, Family Planning	42.9%	$2,512,019,222	22.8%
Pregnant Women	1.5%	$163,777,101	1.5%
Infants and Children	22.8%	$1,232,275,654	11.2%
Other*	12.3%	$365,305,652	3.3%

Includes Qualified Medicare Beneficiaries, Aliens and Refugees, Breast and Cervical Cancer, and MCHIP

Mechanisms of Care Delivery

- NC operates a public-private partnership with Community Care of North Carolina (CCNC)
- CCNC uses 14 local, independently operated networks that collaborate and share successful initiatives to provide case management and care coordination to Medicaid recipients

Drivers of Expenditures

- Highest service costs – physician services, nursing facilities, and hospital car
- Highest program allocation – behavioral health, hospitals, and nursing facilities
- Highest per capita cost – community options for patients with disabilities, elderly assisted living

Figure 2: Breakdown of Medicaid Spending

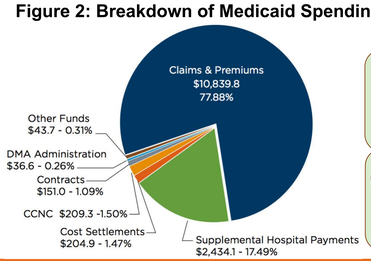
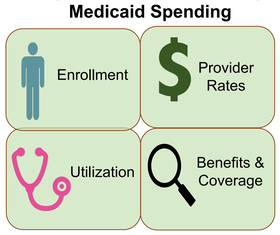


Figure 3: Factors Affecting Medicaid Spending



Section 1115 Waiver

Overview

- A Section 1115 Waiver allows a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the the waiver meets the objectives of the Medicaid program
- Currently, 43 Section 1115 waivers have been approved and are active in 30 other states and DC
- Previous waivers have expanded Medicaid to those who were otherwise not covered by the program, provided services typically not covered by Medicaid, or piloted innovative service delivery systems

NC 1115 Waiver

- McCrory Administration submitted in June 2016
- Proposes to shift from the current fee-for-service (FFS) model of primary care care management to a managed care system financed on a capitated basis
- Contracts would be negotiated with local provider-led entities (PLEs) and statewide commercial plans (CPs), with such pre-paid health plans including incentives for value-based payments

Table 2: Proposed Changes to NC Medicaid

	Current System	Section 1115 Waiver
Who bears the financial risk?	The State	Providers, Commercial Insurers
Who does DHHS contract with?	CCNC	CPs or PLEs
How is care paid for?	Fee For Service	Capitation

State Case Studies

Lesson Learned	State Example
Medicaid will not be transformed overnight – policy changes occur incrementally and require room for adaptation	• Reforms cannot be rushed; time and flexibility is needed to trains staff, lower administrative burden for providers, and monitor plan networks (Alabama, Kentucky) • Expanding Medicaid programs and populations may lead to adverse selection (Indiana)
Savings can be overhyped – reforms may initially incur losses and take time to generate savings	• Programs may lose money and experience rising expenditures during the transition from FFS to managed care (Arkansas, Indiana, Kentucky)
Survival of the fittest – Medicaid managed care runs the risk of consolidation and insurer exits	• Consolidation in managed care can reduce patient choice (North Carolina) • Local organizations may not be able to compete with commercial plans (Alabama) • Managed care organizations may exit markets due to elevated risk and short-term losses (Alabama, Kentucky)
Payment reforms must trickle down – policymakers should engage providers in value-based payments	• Financial incentives can include minimum rates for provider reimbursement and converting per-diem costs to diagnosis-related groups for hospitals (Alabama)
Invest early in health IT – improving data systems can drive reductions in cost	• Auto-enrollment tools can increase appropriate care and lower state costs (Kentucky)

Managed Care Analysis

	Medicaid Managed Care (MMC)	Primary Care Case Management (PCCM)
Structure	• State makes capitated payment to managed care organization (MCO) that provides comprehensive primary and acute care • Providers bear financial risk	• Providers are paid $3-5 per-member per-month to coordinate care and are reimbursed for additional care on a fee-for-service basis • States bear risk
Access	• May increase access to primary care services, but limit access to specialists, inpatient, and outpatient care	• CCNC serves 1.4 million of NC's 2 million Medicaid beneficiaries • 76.4% of providers in NC accept Medicaid
Cost	• Evidence is mixed • Most cost savings occur due to reimbursement cuts, not care management strategies States with higher fee-for-service (FFS) fee rates see the greatest savings	• CCNC uses evidence-based interventions to target high-risk and high-cost patients • 2015 audit estimated CCNC to reduce spending for non-elderly, non-dual populations by $312 per enrollee per year
Outcomes	• Outcomes may improve on measures influenced by primary care doctors, but worsen on health measures that require specialists	• Admissions and prescription drug use have been reduced by 25% and 10.7% respectively, indicating improvement in patient health
Vulnerable Populations	• Capitation may under-budget the needs of high-risk, high-cost patients suffering from chronic diseases	• No capitation, so care of high-cost and high-risk patients should not be affected

Recommendations

Enrollment

- **Streamline** enrollment by improving online and telephone enrollment processes and simplifying forms
- **Cross-reference** state programs (e.g. NC HealthConnex) with other federal databases (e.g. Temporary Assistance for Needy Families) to identify and enroll eligible individuals

Telemedicine

1) **Establish** parity laws
2) **Improve** reimbursement mechanisms
3) **Apply** Money Follows the Person program order to increase provider buy-in

Dual-Eligibles

- Patients eligible for both Medicare (based on age and/or disability status) and Medicaid (due to income)
- NC dual-eligibles account for 16% of patients and 31% of Medicaid spending

Table 3: Strategies to Reduce Dual Eligible Expenditures

Proposed Reform	State Example
Invest in long-term care (LTC) to reduce risk of institutionalization	• Florida – LTC generated savings of 5% and positive reviews from 75% of patients
Align program administration and payment to increase benefits for dual eligibles	• Minnesota – allowed Medicaid MCOs to qualify as Medicare Advantage plans to improve care coordination; reduced ER visits
Engage in passive enrollment to increase care integration	• Virginia – 92% of enrollees were due to passive enrollment

Hotspotting

- **Leverage** a set of proven techniques to address social disparities that create health disparities
- **Use** existing data to identify high-risk, high-cost patients and reorganize care system accordingly
- **Coordinate** medical care with social services to address social determinants of health

ACKNOWLEDGMENTS

Faculty Leaders
Barak Richman | Business & Law
Don Taylor | Public Policy

Collaborators
Allison Rice | Law
Leigh Ann Simmons | Nursing
Susan Kline | Pediatrics

Staff
Amanda McMillan | Medicine
Hillary Campbell | Margolis

Funding
Bass Connections | Global Health, Education & Human Development