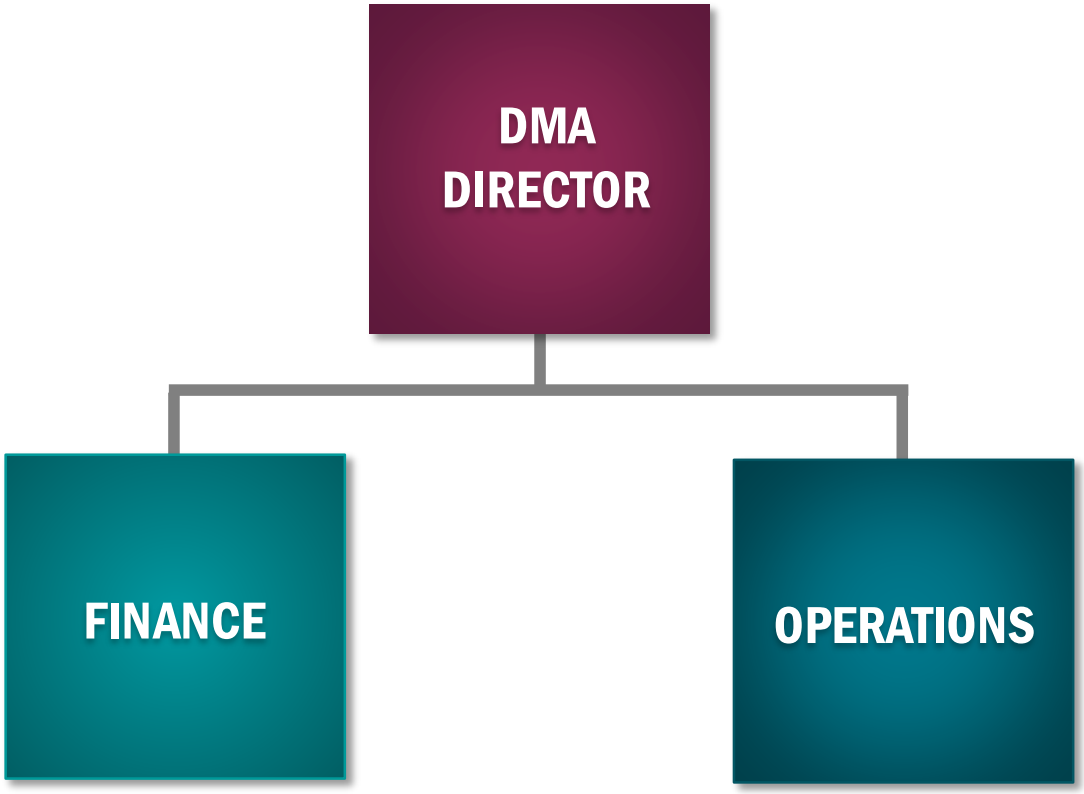
# DHHS NORTH CAROLINA MEDICAID REFORM

## North Carolina Medical Care Commission

**Robin Gary Cummings, M.D.**
Deputy Secretary, Division of Medical Assistance
Deputy Secretary for Health Services
Acting State Health Director

February 11, 2015

# DMA Functions Before Realignment



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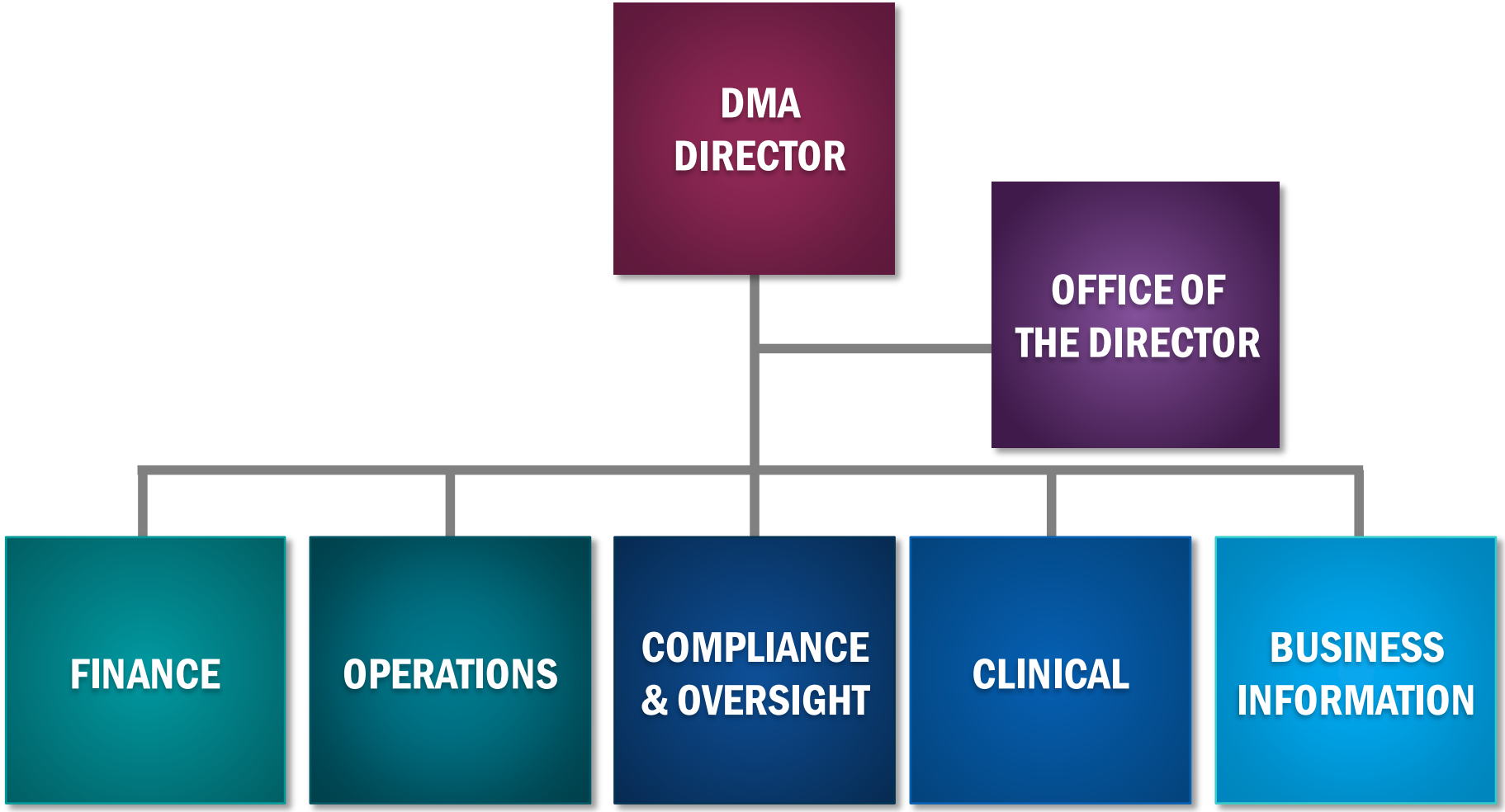

# Strategy & Vision

**"Would you tell me, please, which way I ought to go from here?"**

**"That depends a good deal on where you want to get to," said the Cat.**

**"I don't much care where—" said Alice.**

**"Then it doesn't matter which way you go," said the Cat.**

**"—so long as I get SOMEWHERE," Alice added as an explanation.**

**"Oh, you're sure to do that," said the Cat, "if you only walk long enough."**

*Alice's Adventures in Wonderland*
Lewis Carroll, 1865

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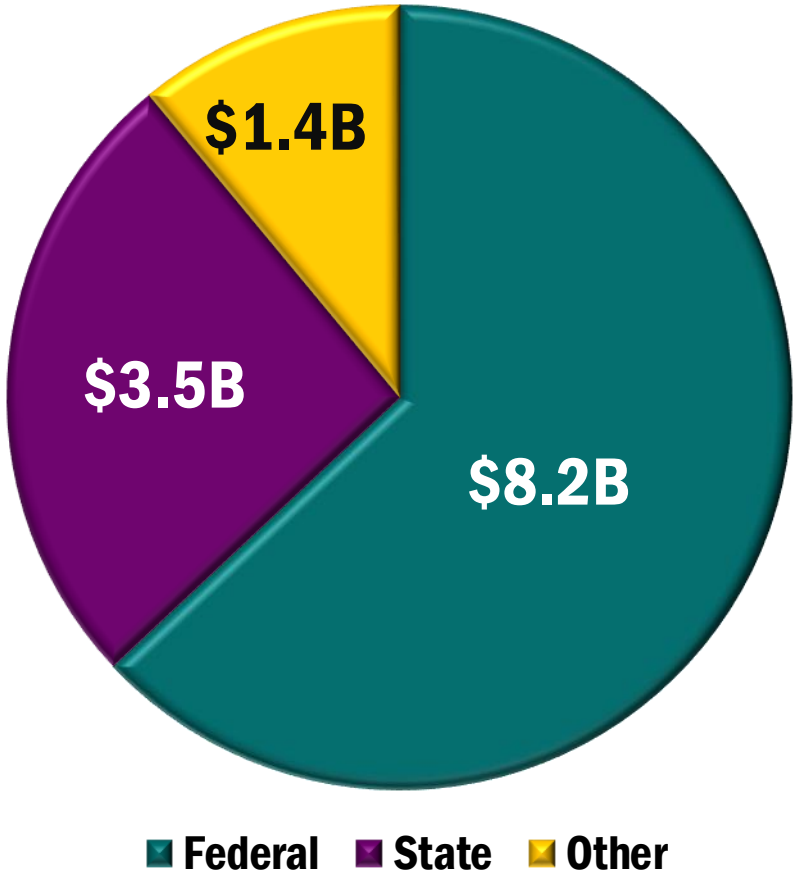
Transforming
Health Care in
North Carolina
The future is here.
2015

# Scope of U.S. Medicaid Programs

- Median Medicaid program budget ($5.5 billion) would place it in the rankings of a Fortune 500 company
- Coverage of a substantial variation in populations (aged, blind, disabled, pregnant women, children, etc.) and services offered
- Medicaid is the largest payer for practically every complex health care condition and is strongly affected by social determinants
- While responsibilities grow, programs must continue to meet previous obligations and offer services provided in the past

# NC Medicaid Funding Sources




**Provider payments are the most significant part of the budget at 92%**

"Other" includes drug rebates (approx. $630M), bed taxes, fraud recoveries and cost settlements

# Medicaid Program Beneficiaries

North Carolina:

- 10th largest Medicaid program in the U.S.
- Covers more than 1.8 million North Carolinians
- Approx. $13 billion in expenditures

| ENROLLMENT RATES BY POPULATION 2010 | | | |
|---|---|---|---|
| | Total | Elderly/ Disabled | Parents/ Children |
| North Carolina | 1.8M | 27% | 73% |
| Ohio | 2.3M | 25% | 75% |
| Texas | 4.8M | 22% | 78% |
| Arizona | 1.5M | 16% | 84% |
| Georgia | 1.8M | 25% | 75% |

Figures are from 2010 as reported by the MacArthur Foundation's *State Health Care Spending on Medicaid* published July 2014 via PCG

# Medicaid Spending

Medicaid spending is stretched across designated categories of assistance, with aged, blind and disabled members representing the most expensive population

Medicaid now covers one in five people who live in North Carolina

| | Enrollment Rates 2010 | | | Payments for Services 2010 | | |
|---|---|---|---|---|---|---|
| | Total | Elderly/ Disabled | Parents/ Children | Total | Elderly/ Disabled | Parents/ Children |
| North Carolina | 1.8M | 27% | 73% | $10.5B | 62% | 38% |
| Ohio | 2.3M | 25% | 75% | $14.5B | 72% | 28% |
| Texas | 4.8M | 22% | 78% | 25.6B | 55% | 45% |
| Arizona | 1.5M | 16% | 84% | $9.2B | 42% | 58% |
| Georgia | 1.8M | 25% | 75% | $7.3B | 59% | 41% |

Figures are from 2010 as reported by the MacArthur Foundation's *State Health Care Spending on Medicaid* published July 2014 via PCG

# Medicaid Spending

Medicaid spending is concentrated on the elderly and disabled

- Small segment of population, yet…
- More complex health care needs, and
- More costly acute and long-term care services

Elderly and disabled costs range from $8,000 in Alabama to $26,000 in New York

| | Elderly and Disabled | Parents and Children |
|---|---|---|
| North Carolina | $13,366 | $2,989 |
| Ohio | $18,080 | $2,352 |
| Texas | $12,985 | $3,058 |
| Arizona | $15,945 | $4,108 |
| Georgia | $9,472 | $2,109 |

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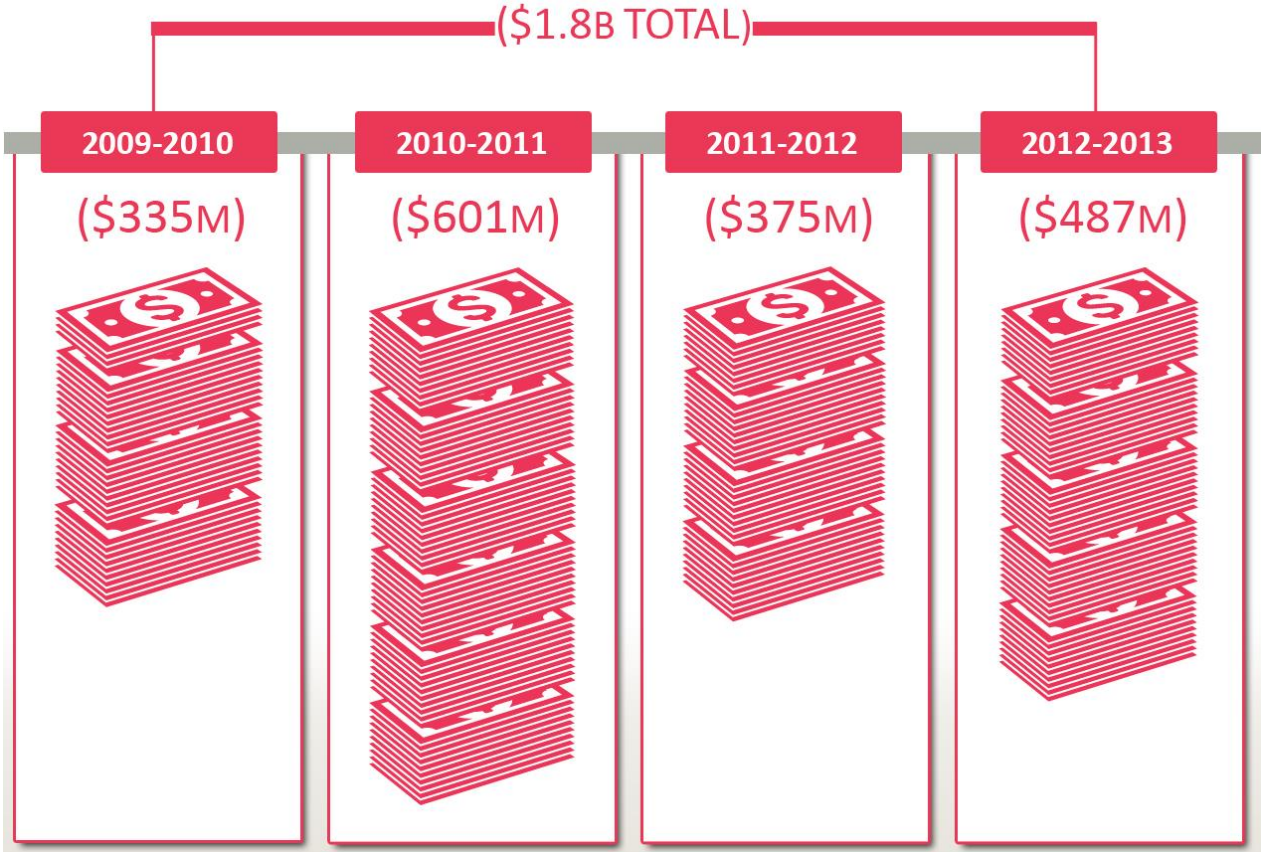
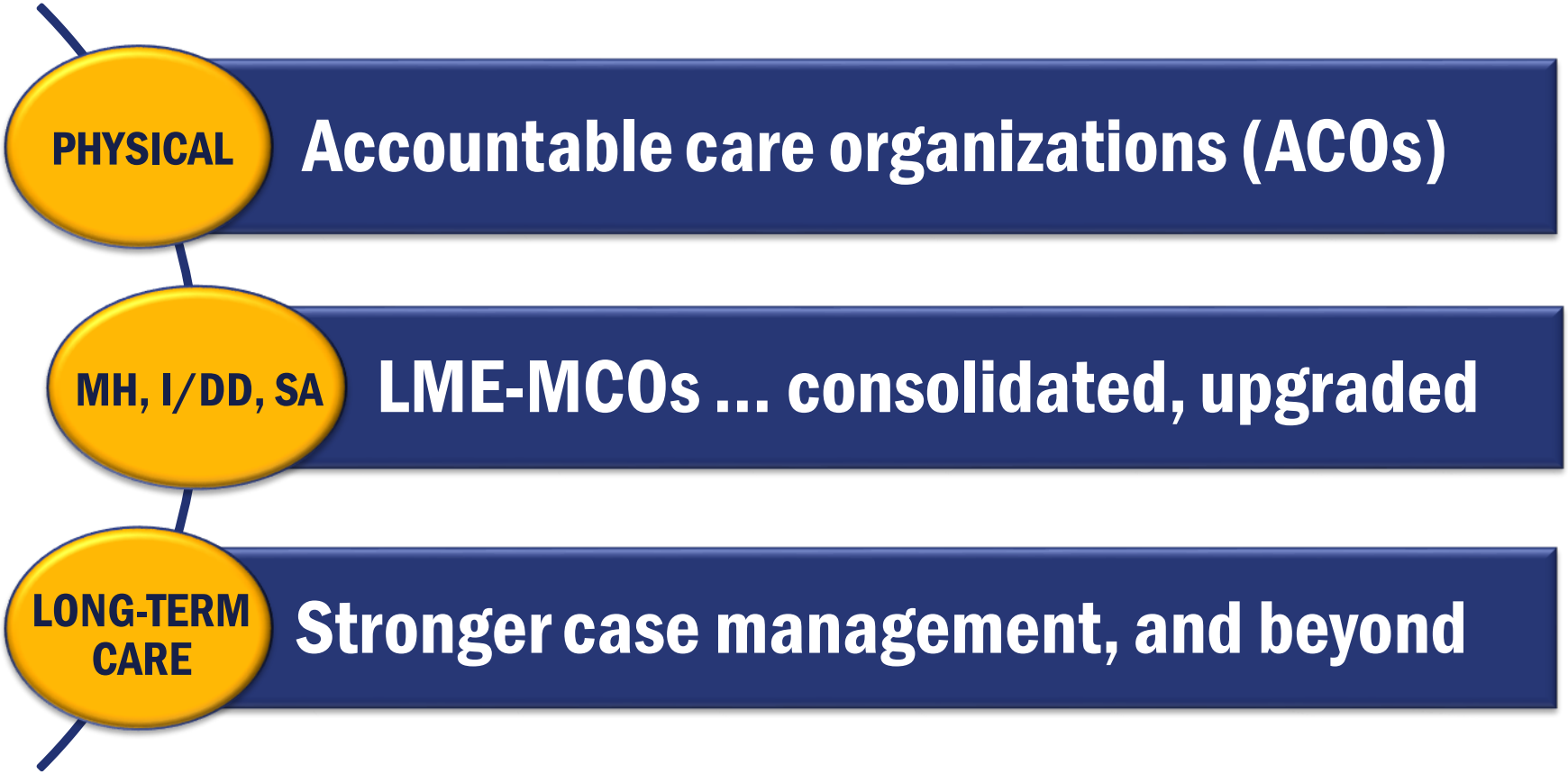
# Budget Predictability



# Why Reform Medicaid?

- Better value for North Carolina taxpayers
- Strengthen Medicaid fiscally
  - Flatten cost growth trend
  - Make budget more predictable
- Improve beneficiaries' health outcomes
  - Address population-wide needs
  - Consider whole person in coordinating care
  - Reward quality explicitly

# Multi-faceted Reform, Tailored to NC




MH, I/DD, SA = Mental Health, Intellectual/Developmental Disability, Substance Abuse
LME-MCO = Local Management Entity – Managed Care Organizations

# What are ACOs?

Accountable Care Organizations are integrated groups of health care providers who:

- Deliver coordinated care across health care settings
- Agree to be held accountable for achieving:
  - Measured quality improvements, and
  - Reductions in the rate of spending growth

**Medicare, private payers, and a few state Medicaid programs have started using ACOs**

**NC has approximately 18 ACOs today; 12 accepted into Medicare**

# Key Attributes of ACOs

- Participating providers lead
  - Other entities (e.g., insurers) may share in owning and running
  - Community participation beneficial
- Management capability
  - Adequate executive and medical leadership
  - Programs and tools for beneficiary health care management
- Provider network
  - Breadth and diversity of physician specialties and provider types
  - PCP exclusivity to allow beneficiary assignment to ACO

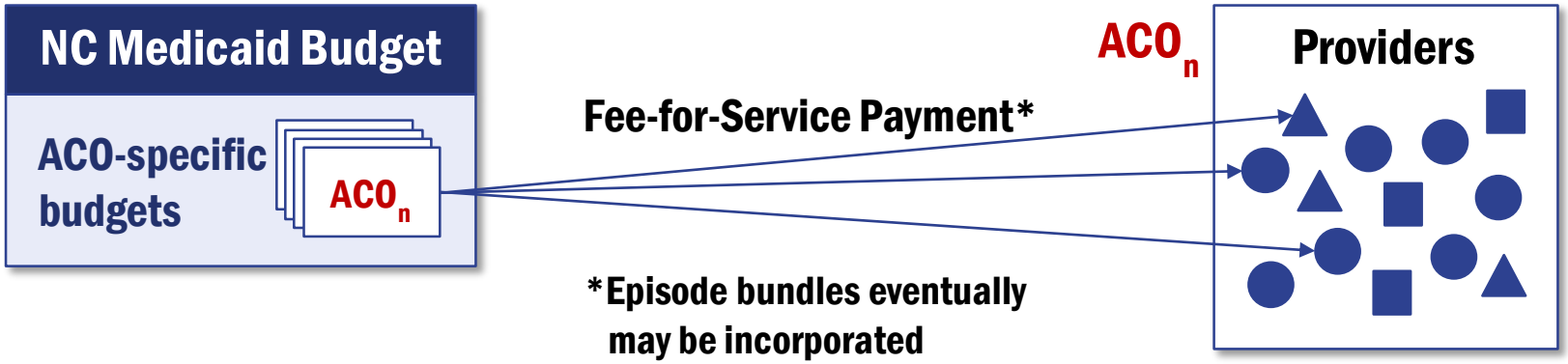
# Quality Factors into Incentives

## Medicare Shared Savings Program Quality Measures a Starting Point

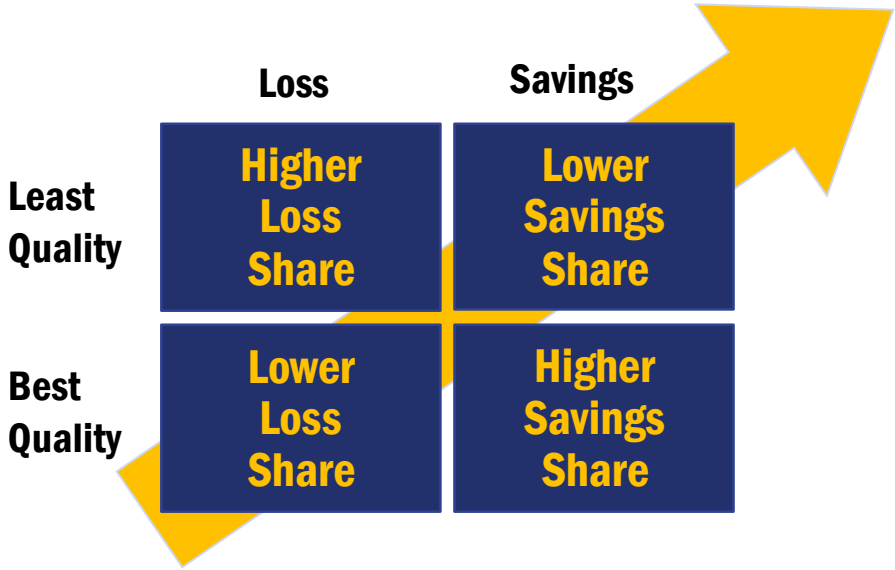
| Domain | Examples |
|---|---|
| Patient/Caregiver Experience<br>*7 measures* | • Patient rating of provider<br>• Timely appointments, information<br>• Access to specialists |
| Preventive Health<br>*8 measures* | • Influenza immunization<br>• BMI screening and follow-up<br>• Screening for clinical depression |
| At-Risk Population<br>*12 measures* | • Diabetes: Hemoglobin A1c control<br>• Hypertension control<br>• Coronary artery disease: lipid control |
| Care Coordination<br>Patient Safety/EHR<br>*6 measures* | • Hospital readmissions<br>• % of PCPs who qualify for EHR incentive payments |

BMI = Body Mass Index  EHR = Electronic Health Record

# ACO Value-based Payment Concept




At Year's End, Measure ACO$_n$ Performance on Cost & Quality:



# ACOs' Risk of Loss Partly Mitigated

- Services not controlled by ACO not in ACO risk pool
  - Mental health, substance abuse, I/DD (under LME-MCOs)
  - Portion of outpatient Rx (shared with LME-MCOs)
  - Long-term services and supports
  - Dental
- Portion of individual high-cost cases excluded
  - 90% of costs above $50,000 for a beneficiary in one year
- Total ACO loss and reward capped at % of budget

| | YEAR 1 | YEAR 2 | YEAR 3 | YEAR 4 | YEAR 5 |
|---|---|---|---|---|---|
| Max Award | 15% | 15% | 15% | 15% | 15% |
| Max Payback | 5% | 7.5% | 7.5% | 7.5% | 10% |

# Whole-person Care

- Match physical and behavioral health care to patient needs through:
  - Co-located and fully integrated physical and behavioral health personnel
    OR
  - Tightly coordinated physical and behavioral health services
- Common physical and behavioral health documentation system
- Unified outcomes

**Behavioral Health & Physical Health are Inseparable**

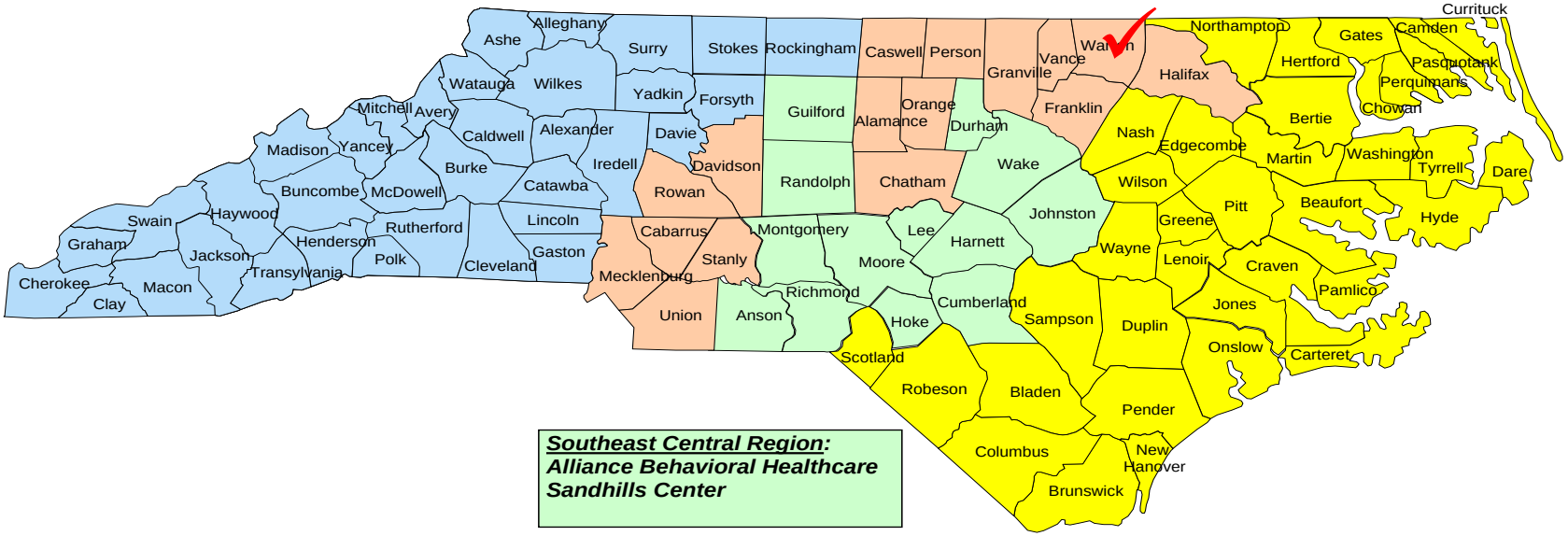
# LME-MCO Consolidation

## Proposed Mergers of LME-MCOs

***Western Region:***
***CenterPoint Human Services***
***Partners Behavioral Health Management***
***Smoky Mountain Center***

***Northwest Central Region:***
***Cardinal Innovations Healthcare Solutions***
***MeckLINK Behavioral Healthcare***

***Eastern Region:***
***CoastalCare***
***East Carolina Behavioral Health***
***Eastpointe***




***Southeast Central Region:***
***Alliance Behavioral Healthcare***
***Sandhills Center***

# LME-MCO Improvements

| CONTRACTING | OVERSIGHT | SERVICE ARRAY |
| --- | --- | --- |
| • Enhanced process and outcome measures<br>• Penalties and incentives for performance | • More sophisticated monitoring<br>• Technical assistance | • Solutions for I/DD waiting list<br>• Re-evaluate LME-MCO benefit package |

# Long-term Services & Supports (LTSS) Defined

| LTSS | Post-Acute / Intermittent | Capitated Programs |
|---|---|---|
| • Community alternative programs (CAP)<br>– Adults with disabilities (CAP-DA)<br>– Children (CAP-C)<br>• Personal care services (PCS)<br>• Private duty nursing<br>• Skilled nursing facility services | • Home Health<br>• Hospice<br>• Post-Acute Rehab<br>• Home Infusion Therapy (HIT) | Program of All-inclusive Care for the Elderly (PACE) |

# LTSS Reform Goals

- Engage beneficiaries earlier, before needs worsen and require more intensive, costly care
- Coordinate care better, with focus on transitions between care settings
- Build on what has worked – both within NC and nationally – to fullest extent possible
- Ensure capacity of providers and health plans to meet the specific needs of LTSS beneficiaries

**Stakeholder work groups enlisted to develop a reform plan for LTSS delivery system**

LTSS = Long-Term Services & Supports
Does not encompass services for I/DD disabilities currently covered under the Innovations Waiver

# Activities Proposed to Strengthen LTSS Core Functions

**1** Develop mechanisms that ensure whole person support

- Create stronger quality measures of contracted entities
- Streamline screening and assessments used for LTSS services
- Ensure continuity through transitions

**2** Build better IT platform to meet short- and long-term needs of a reformed LTSS system

- Enhance integration of primary care and behavioral care into LTSS
- Elevate care integration competencies

**3** Improve information about options

- Provide clear, responsive, user-friendly points of access
- Inform beneficiaries about available LTSS options

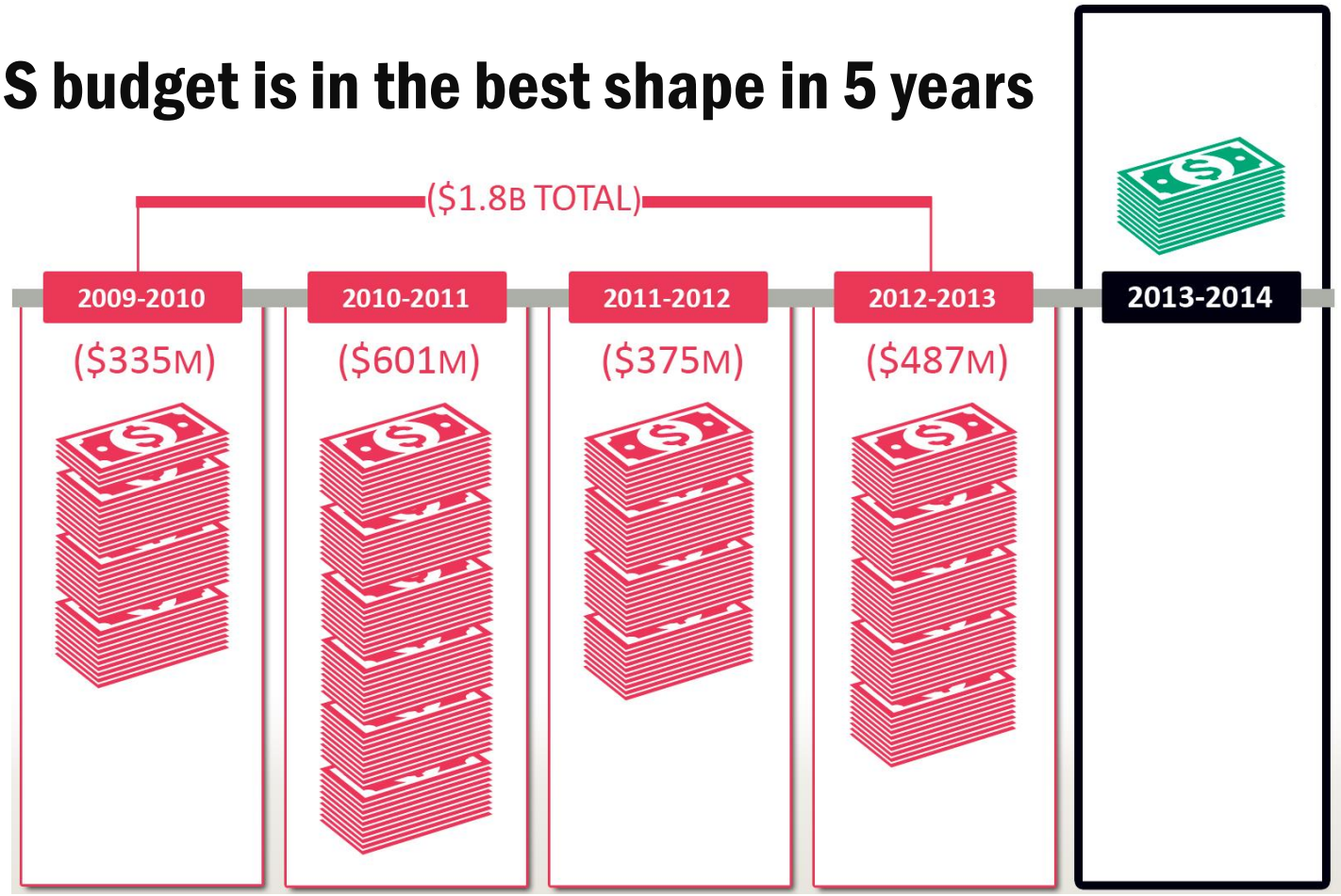
**LTSS reform will depend on legislative direction for Medicaid reform**

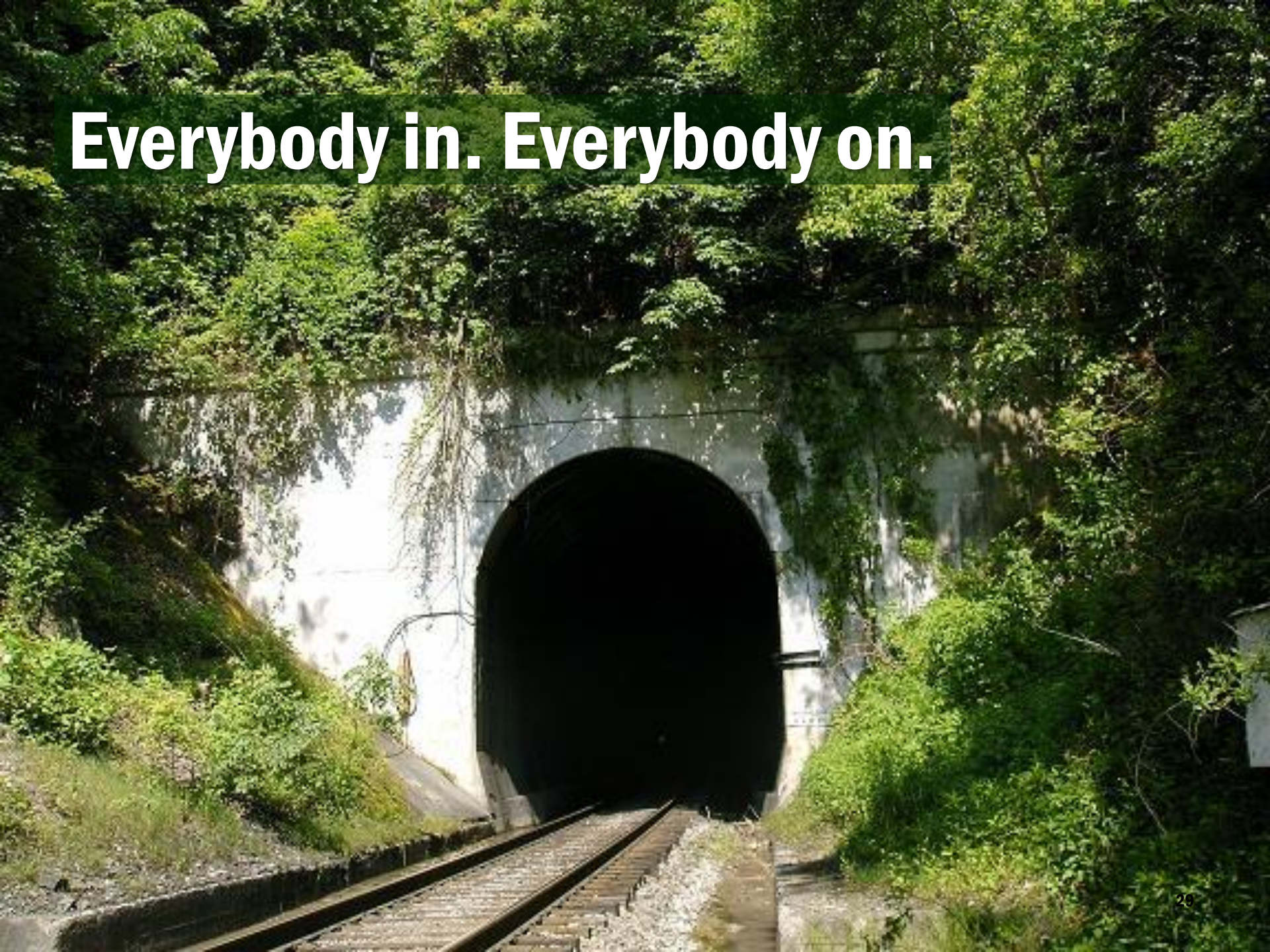
# Where We are Today

- General Assembly returned Jan. 28
  - Subcommittees met in 2014 to consider options
  - Program Evaluation Oversight Committee met Feb. 9
- DHHS continues laying groundwork
  - Improve health cost forecasting
  - Strengthen IT capabilities
  - Learn from other states about implementation needs
  - Prepare reform implementation tools
    - Data analyses
    - Evaluation criteria
    - Quality measures

# Budget Predictability

## DHHS budget is in the best shape in 5 years




Everybody in. Everybody on.


Partnering with
Physicians and Providers
to care for our patients
Clinical Autonomy
Professional Security
Personal Satisfaction

# What about Classic Savings Tools?

| Cost Savings Measure | Possible Consequence |
|---|---|
| Cut eligibility | Increase uninsured population |
| Cut provider rates | • Hurt providers<br>• Reduce access as providers exit |
| Cut optional benefits | Save some $ but much care shifts to alternate services |
| Limit units of care per patient | Prevent abuse but may harm high need patients |
| Enhance program integrity | Favorable but marginal impact |

# States Starting to Use ACOs in Medicaid


15 regional Coordinated Care Organizations (CCOs)

- One CCO budget for physical and behavioral care
  - Global budget per enrollee; grows at fixed rate
- CCOs accountable for population health outcomes


4 ACOs covering 4 counties with 70% of state's Medicaid population

- ACOs paid full-risk capitations
- UT says key differences from traditional managed care are:
  - ACO payments eliminate incentive to provide excess care
  - Contracts maintained only if ACO meets quality & access criteria


Accountable Care Collaborative (ACC)

- 7 regional care collaborative organizations (RCCOs)
- FFS payment plus PCCM per capita fee to PCPs; no set budget target
- Goals for inpatient hospital readmissions, ER usage, high cost imaging
- Goals correlated with cost savings; RCCOs get bonus if goals met

Sources

1. S.L. Kocot, "Early Experiences with Accountable Care in Medicaid," Population Health Management, Vol. 16 Supplement, 2013
2. "Utah Medicaid Payment and Service Delivery Reform," 1115 Waiver Request, July 1, 2011

# States Starting to Use ACOs in Medicaid


9 Health Care Delivery System sites in Twin Cities; 150,000 enrollees

- Total cost of care calculated from claim history - for services influenced by primary care coordination
- Savings shared 50-50 if quality targets reached
- Loss sharing starts in year 2


Collaboration of Medicaid plus 2 commercial insurers

- Providers designated as principal for specific episodes of care
  - ADHD, upper respiratory infections, congestive heart failure, hip & knee replacements, perinatal care
- Claims paid on regular fee schedule; average cost per episode tallied
- Shared gain/loss opportunity if quality goals satisfied


5 Care Coordination Entities (CCEs) run in parallel with full-risk MCOs

- CCEs choose from 3 incentive payment models:
  - PMPM care coordination fee
  - 50% budget savings share if quality targets achieved
  - Other innovative payment models as agreed upon

Source

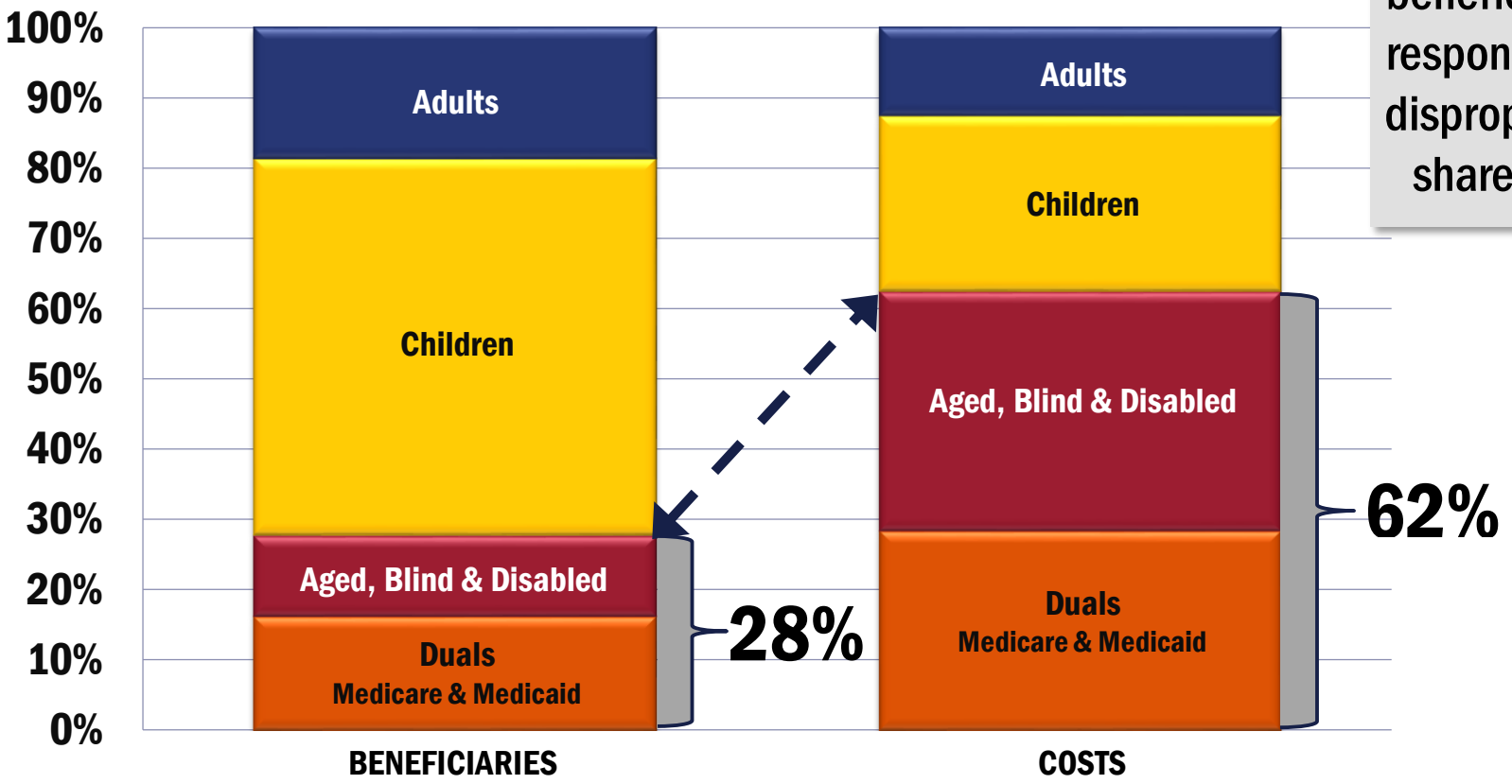
S.L. Kocot, "Early Experiences with Accountable Care in Medicaid," Population Health Management, Vol. 16 Supplement, 2013

# Providers Aligned, with Incentives

| TODAY | AFTER ACO |
|---|---|
| Providers fragmented | Providers linked in organized systems of care |
| Beneficiary may choose a PCP | Beneficiary selects a PCP, is assigned to that PCP's ACO |
| Fee-for-service payment – rewards volume & intensity | Providers rewarded for value delivered |
| CCNC coordinates primary care | CCNC helps State and/or ACOs manage utilization and quality |

PCP = Primary Care Provider

# Bending the Cost Curve and Improving Clinical Outcomes

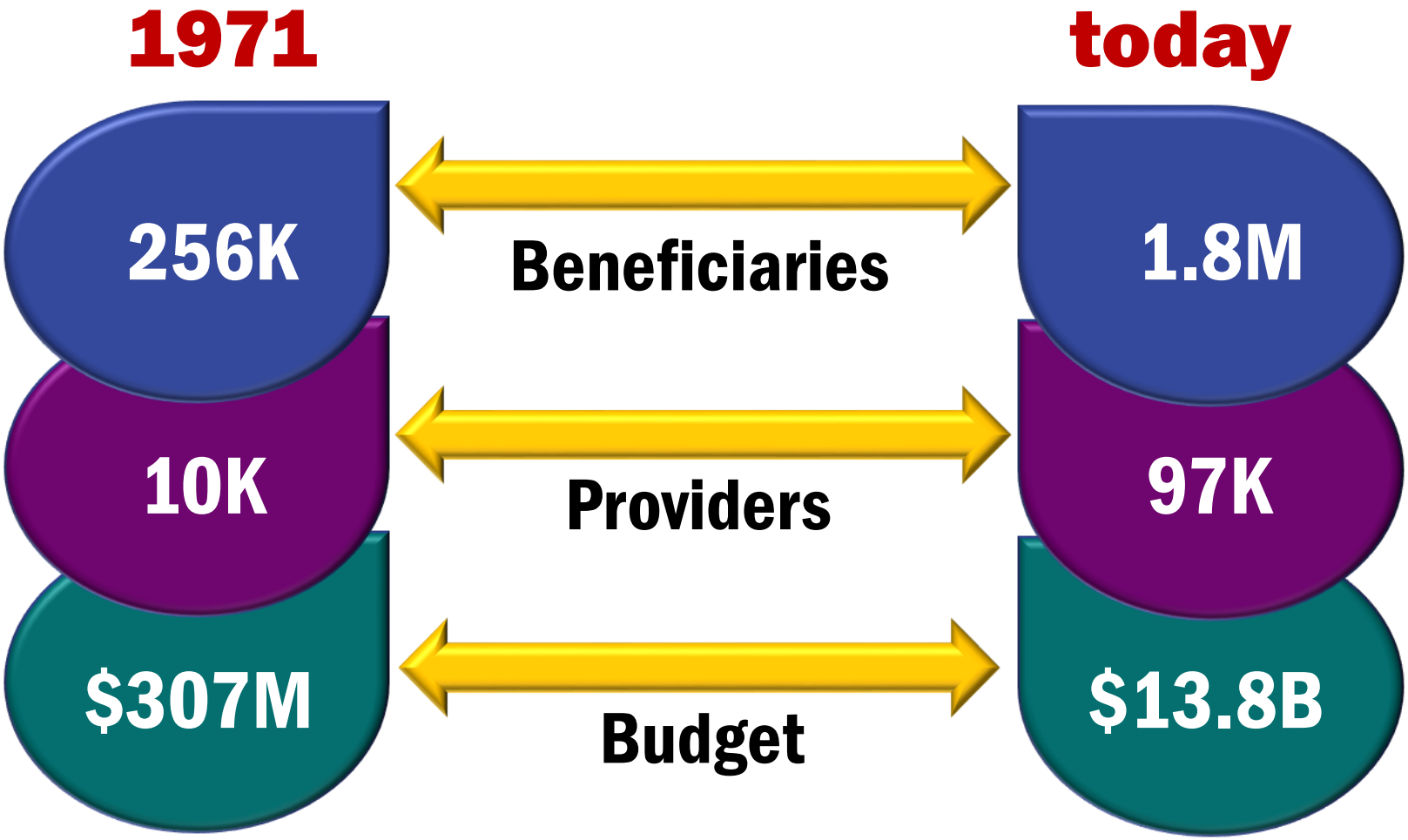



Small portion of beneficiaries are responsible for a disproportionate share of costs

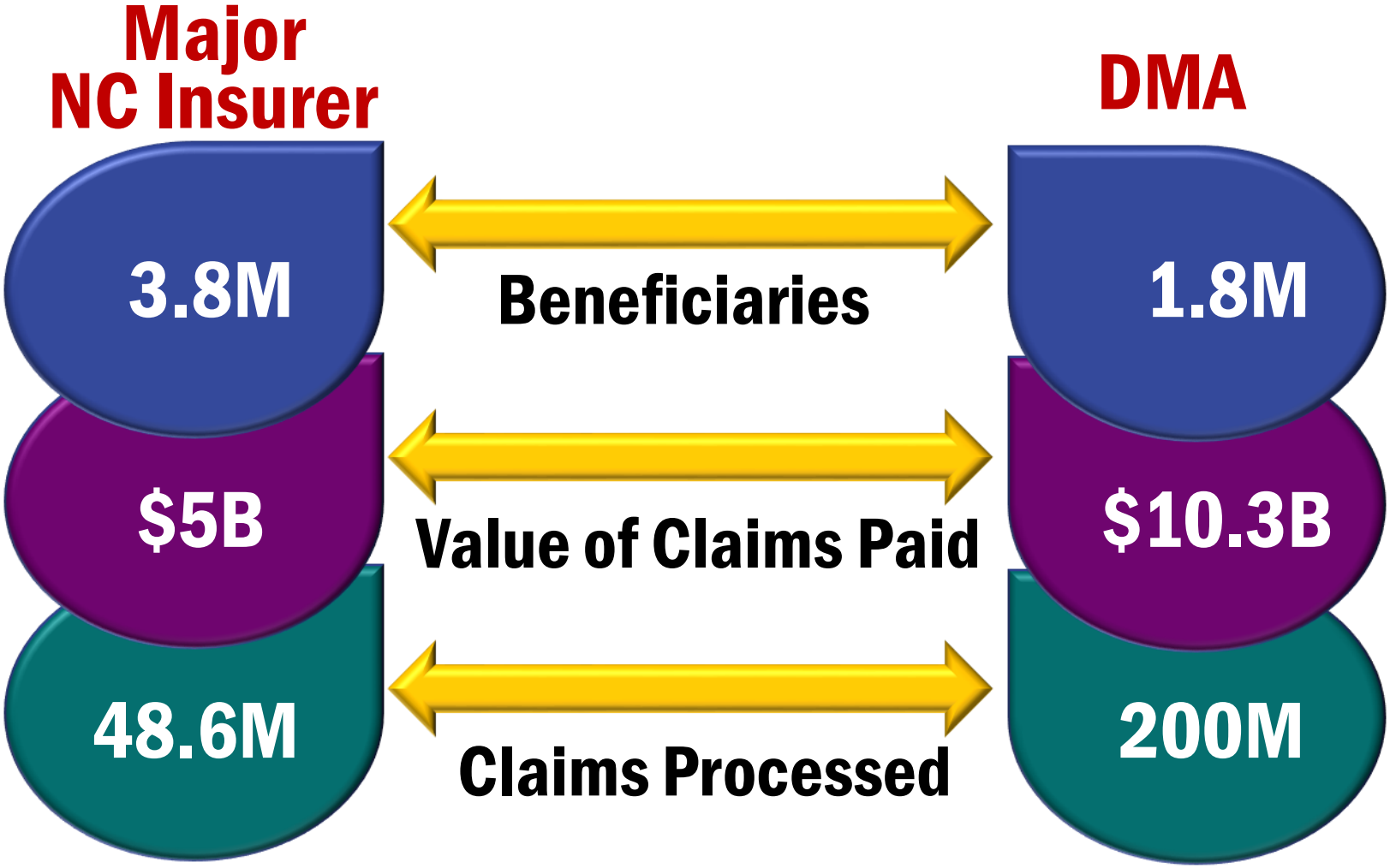


*Source: CCNC Informatics Center*

# A Snapshot of North Carolina Medicaid



# Food for Thought



# Medicaid Reform Improves Stability

## Yearly Savings By Program Area – Total and State Share

| Program Area | Year 1<br>July 2015 - June 2016 | Year 2<br>July 2016 - June 2017 | Year 3<br>July 2017 - June 2018 | Year 4<br>July 2018 - June 2019 | Year 5<br>July 2019 - June 2020 | Total, Years 1-5<br>July 2015 - June 2020 |
|---|---|---|---|---|---|---|
| **OVERALL MEDICAID SAVINGS** | | | | | | |
| Physical Health (ACO Model) | $20,078,062 | $74,785,855 | $136,021,499 | $196,896,955 | $209,111,721 | $636,894,093 |
| MH, I/DD, SA (LME MCO) | $0 | $50,801,839 | $62,854,575 | $76,179,745 | $80,788,619 | $270,624,777 |
| LTSS | -$5,250,000 | $4,102,358 | $14,586,352 | $26,304,677 | $39,368,313 | $79,111,701 |
| **Total** | **$14,828,062** | **$129,690,052** | **$213,462,426** | **$299,381,377** | **$329,268,653** | **$986,630,570** |
| **STATE FUNDS SAVINGS** | | | | | | |
| Physical Health (ACO Model) | $6,003,971 | $24,555,384 | $45,320,390 | $65,963,257 | $70,105,284 | $211,948,287 |
| MH, I/DD, SA (LME MCO) | $0 | $17,226,903 | $21,313,986 | $25,832,551 | $27,395,421 | $91,768,862 |
| LTSS | -$2,625,000 | $546,385 | $4,101,507 | $8,075,191 | $12,505,070 | $22,603,153 |
| **Total** | **$3,378,971** | **$42,328,672** | **$70,735,884** | **$99,871,000** | **$110,005,775** | **$326,320,301** |

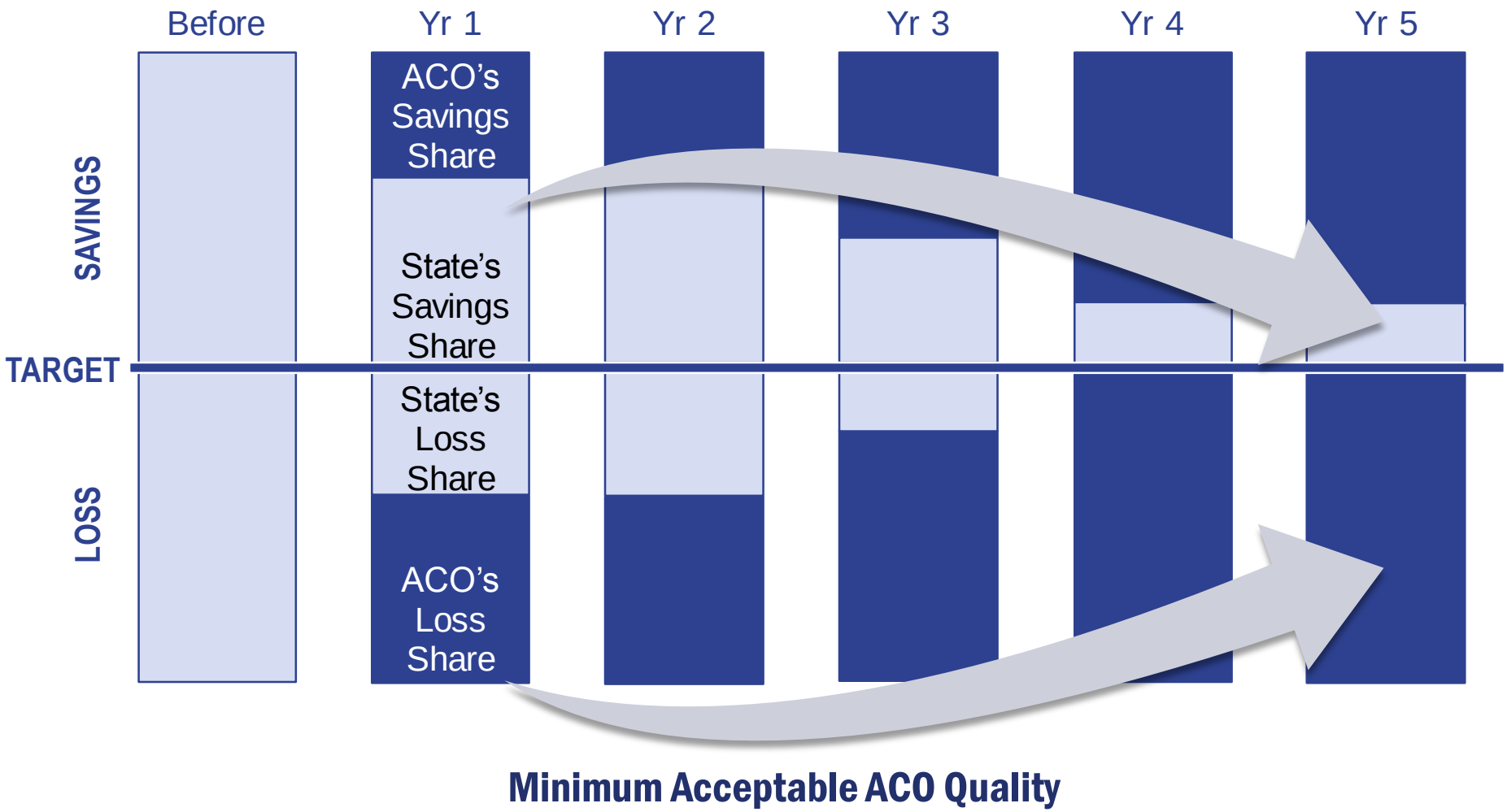
# MCO and ACO Differences

| Managed Care Organization | | Accountable Care Organization |
|---|---|---|
| Insurer governs (providers may, too) | ⟷ | Providers govern (insurer role possible) |
| Substantial risk capital required | ⟷ | Little/no risk capital needed |
| Broad territory, many provider systems | ⟷ | Service area local to provider system |
| Beneficiary enrolls formally | ⟷ | Beneficiary attributed by care usage |
| Patient must use MCO's providers | ⟷ | Patient free to use non-ACO providers |
| MCO accepts full risk via capitation | ⟷ | ACO shares in savings … and losses (?) |
| Quality may factor into payment | ⟷ | Quality is key factor in reward/penalty |

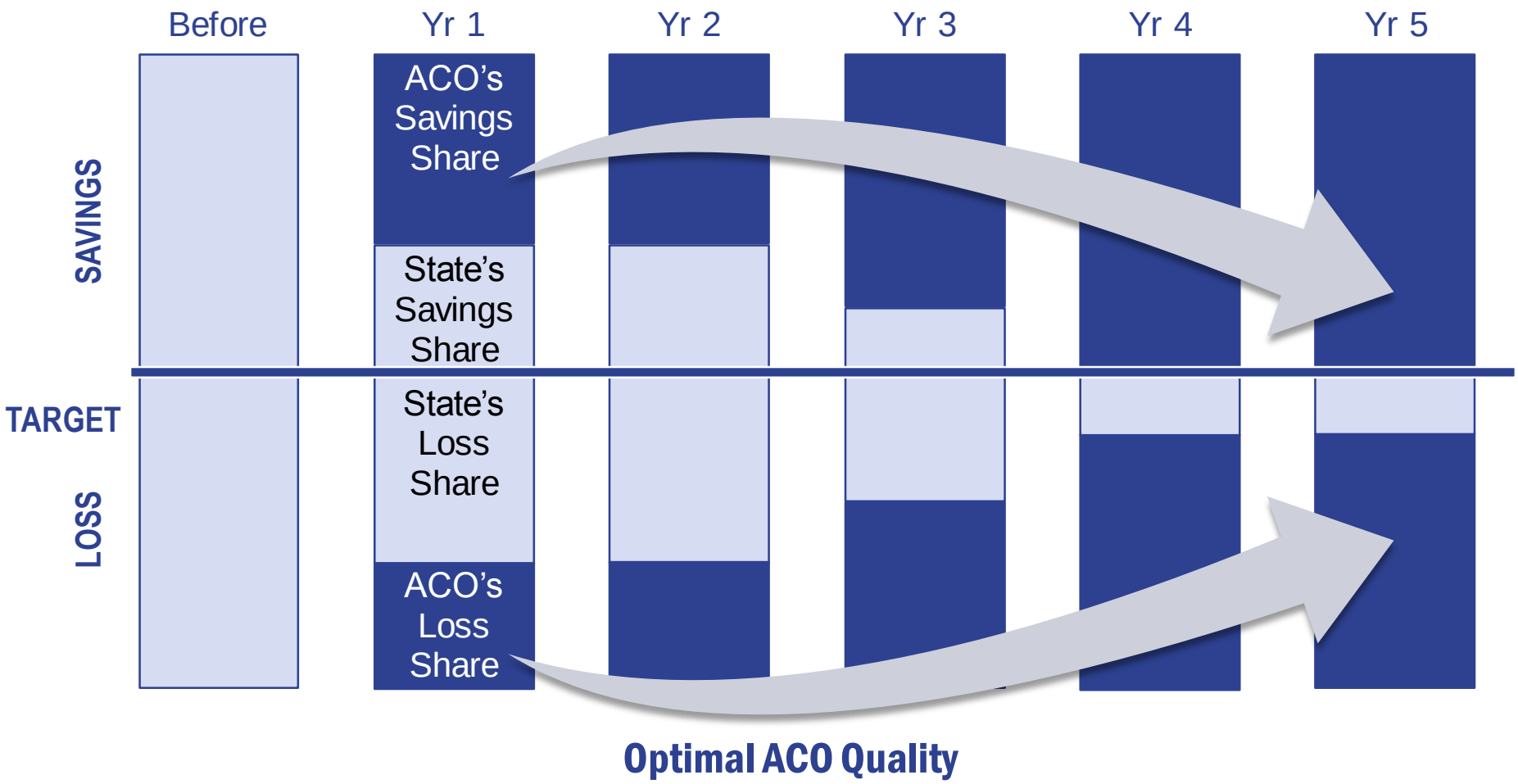
# Benchmark Budget Determination

- Historical costs, trended
  - Subtraction for share of catastrophic case costs held by State
  - Adjust for changes to payment rates, benefit coverage
- Population-specific adjustments
  - Computation of base by eligibility category
  - Age and sex variation as warranted
  - Risk adjustment according to disease state of each beneficiary
- Resetting baseline
  - Initial baseline used for first 3 years
  - Baseline reset periodically after – between 1 and 3 years

# ACOs' Risk Share Rises



# ACOs' Risk Share Rises



# Is There a Stronger Alternative?

- Full-risk managed care was considered
  - Potentially, more budget predictability and savings
- Unacceptable to NC health care providers
  - Reject intervention by commercial managed care companies
  - Providers not capable of forming own managed care entities
- Supplemental payments threatened w/o 1115 waiver
- Savings reduced by insurer industry tax under ACA
- Conclusion: Managed care not viable

# Q1 Total Expenditure Analysis

## SEPTEMBER YTD EXPENDITURE COMPARISON SFY2015 VS. SFY2014

| | September YTD Actuals $M | | $ Variance |
|---|---|---|---|
| **Fund Name** | **SFY2014 [1]** | **SFY2015** | **SFY14 to SFY15** |
| Medical Assistance Payments | 2,487 | 3,014 | 528 |
| Medical Assistance Adj. & Refunds | (68) | (218) | (150) |
| Consolidated Supp. Hospital Payments | 485 | 248 | (237) |
| All Other Funds | 184 | 189 | 4 |
| **Total[2] $** | **3,088** | **3,233** | **145** |

**Enrollment and Drug Spend Continue to Drive Overall Increase**

[1] adjusted for periodic payments for UPL of $287M and Hospital Equity Payments of $301M made in SFY14, and not yet in SFY15

[2] state and federal dollars

Primary drivers of $528M increase in medical assistance payments from SFY14Adj to SFY15 YTD September

- Additional week of claims payments in SFY15 Q1: $153M
- Increased enrollment of 5.8%: $144M
- Additional drug spending above normal associated with an increase in enrollment: $74M
- Remainder primarily due to lower-than-normal payment activity in SFY14Adj due to rollout of NC Tracks: $157M

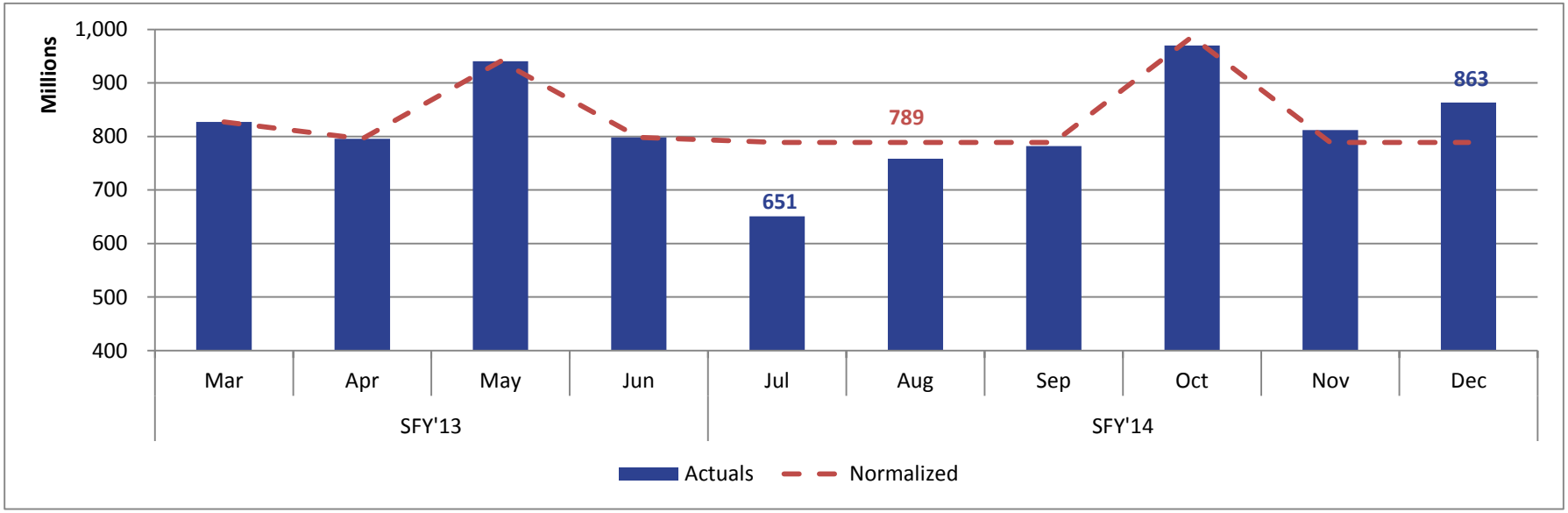
Increase in total claims payments partially mitigated by timing differences of drug rebates and supplemental hospital payments

# SFY13/14 Claims Expenditure Analysis

## KEY OBSERVATIONS

- Underspending vs. normalized expenditures as a result of NCTracks issues persisted for first 3 months of SFY14, resulting in $175M YTD variance at end of Q1 2013
- However, Q2 SFY2013 expenditures were greater than normalized estimates, indicating that payments were catching up, reducing YTD variance to $94M at end of 2013 calendar year

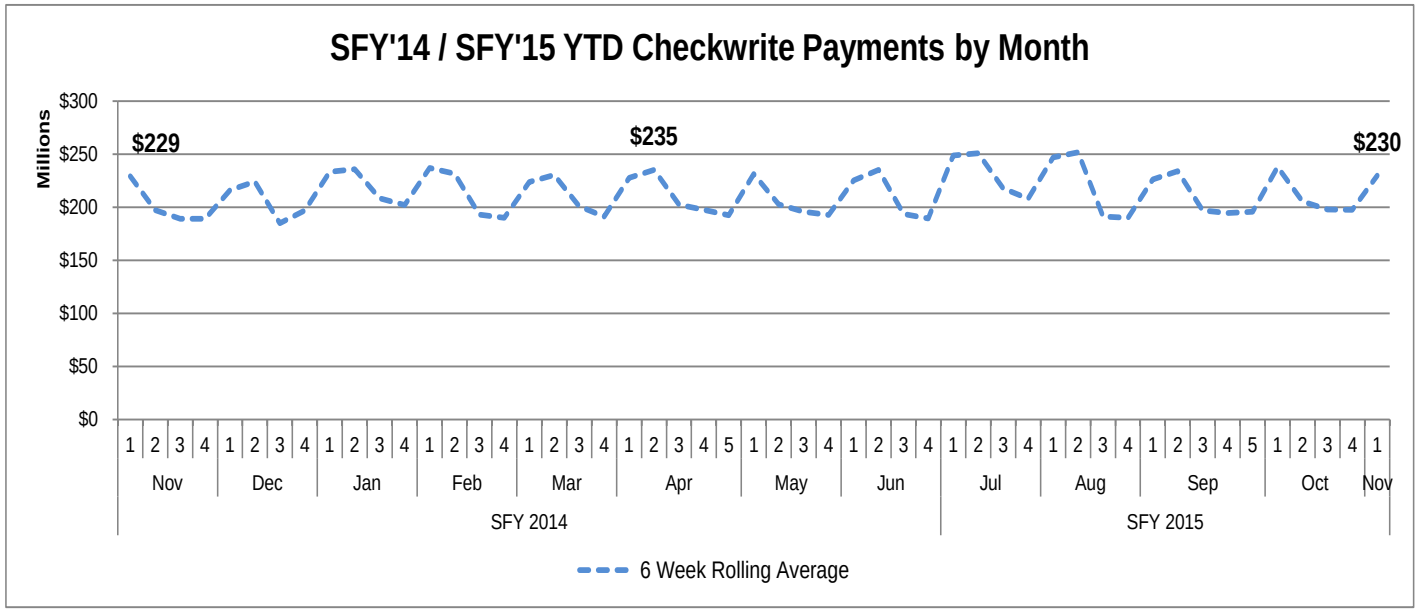
## SFY13/SFY14 CLAIMS EXPENDITURES BY MONTH




Note: "Normalized" estimates refers to hypothetical monthly expenditures based on average weekly checkwrites from March - May SFY13

# Checkwrite Expenditures YTD

## CHECKWRITE ANALYSIS THROUGH NOVEMBER 4




**Checkwrite Expenditures Remained Constant over Last 12 Months**

## YEAR-OVER-YEAR COMPARISON

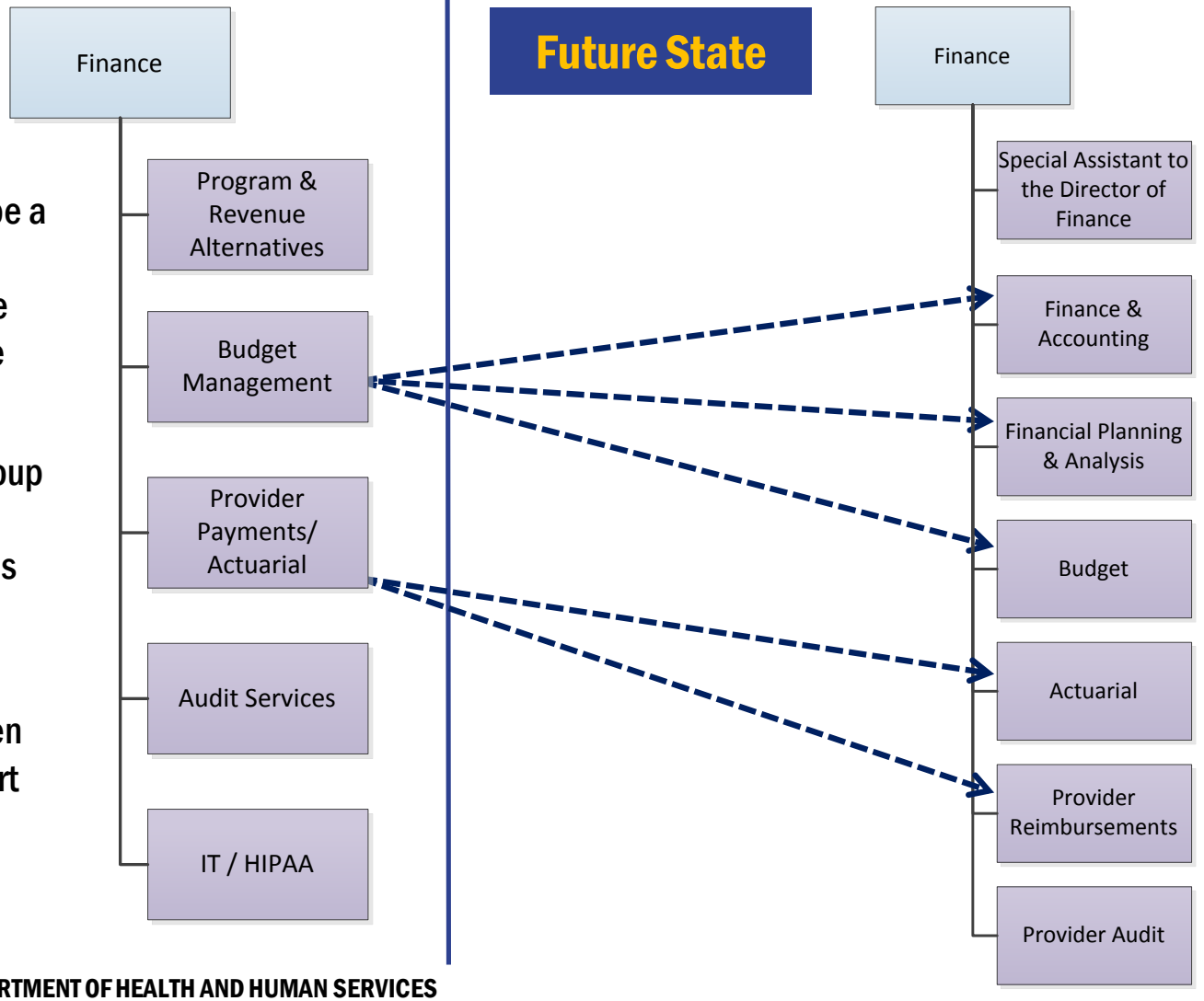
- Overall, Medicaid and Health Choice Q1 SFY2015 claim payments remain relatively constant compared to latest 12 months
- HMO payments, typically made in first week of every month, have been higher-than-forecasted due to a correction to Medicaid eligibility business rules; a one-time payment of $19.6M was made in September


Being concerned about what you can't CONTROL does not empty TOMORROW of its TROUBLES.
It empties TODAY of its STRENGTH.

# DMA Finance Section Realignment

**Current State**

- Director of Finance will be a direct report to DMA Director, focused on core financial functions of the organization
- Budget Management group will be split into three separate functional areas
- Additionally, Business Information (formerly IT/HIPAA) group has been elevated to a direct report to DMA Director



# Medicare ACOs in North Carolina

| ACO Name | HQ Location | Eff. Date | Other Payers Using ACO |
|---|---|---|---|
| Accountable Care Coalition of Caldwell County | Lenoir | 4/2012 | |
| Accountable Care Coalition of Eastern NC | New Bern | 4/2012 | |
| Bayview Physicians Group | Norfolk, VA | 1/2014 | |
| Carolinas Health System ACO | Charlotte | 1/2014 | Aetna |
| Caromont | Gastonia | 1/2014 | Cigna |
| Central Virginia Accountable Care Collaborative | Lynchburg, VA | 1/2014 | Aetna |
| Coastal Carolina Quality Care | New Bern | 4/2012 | |
| Cornerstone Health Care | High Point | 7/2012 | BCBSNC, Cigna, United |
| Duke Connected Care | Durham | 1/2014 | |
| Physicians Healthcare Collaborative | Wilmington | 1/2013 | BCBSNC |
| Triad Healthcare Network | Greensboro | 7/2012 | Humana, United |
| WakeMed Key Community Care | Raleigh | 1/2014 | BCBSNC, Cigna |
| **Provider-owned Medicare Advantage Plan:** | | | |
| First Carolina Care Insurance Co. | Pinehurst | 1/2013 | Employers |

Source: NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACOs' websites and press releases

# Other ACOs Emerging in NC

| ACO Name | HQ Location | Payers Using ACO |
|---|---|---|
| Accountable Care Alliance | Wilmington | BCBSNC |
| Boice Willis Clinic | Rocky Mount | Cigna |
| Cape Fear Valley Health System | Fayetteville | BCBSNC |
| Carolina Advanced Health | Durham | BCBSNC |
| Children's Health Accountable Care Collaborative | Chapel Hill | CMS (Pediatric) |
| Novant Health | Winston-Salem | Cigna |
| Pinehurst Accountable Care Network | Pinehurst | |
| UNC Health | Chapel Hill | |
| Wake Forest Baptist Medical Center | Winston-Salem | |
| WNC IPA | Asheville | |

Source: NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES websites and press releases