North Carolina Medicaid Reform
Medical Care Commission

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Medicaid Reform

* Governor, Legislature, DHHS, and even providers are pushing Medicaid toward a value-based purchasing system, where providers are rewarded for the quality of their care and not just the volume of residents served.

* Some have stated that Medicaid is broken.

* I see a system in need of repair, not replacement.

Medicaid Reform

* Whole-Person Care Coordination
* Better Patient Outcomes
* Better Health Outcomes
* Cost Effective Care / Service for NC Taxpayers

Medicaid Reform – Options

* Managed Care Organization (MCO)
* Accountable Care Organization (ACO)

Medicaid Reform – MCO

* Focus is on payment reform – usually in isolation of care delivery reform
* State contracts with an insurance company that serves as "gatekeeper"
* Emphasis on Cost Containment
* Budget Predictability
* Requires pre-authorization (case management) by insurance company

MCO – Eligibility to Placement

Potential LTSS Beneficiary	Eligibility: Financial and Medical	MCO: Program Contractor	MCO: PCP Case Manager	HCBS (includes ALF) Skilled Nursing Facility (SNF) ICF/MR Hospice Behavioral Health Case Management

MCO – Case Management Drives Utilization

* Case managers authorize all LTC services not covered by Medicare or other insurance policies.

* Each Medicaid Beneficiary is assigned a case manager.

* Each case manager assigns level of care which determines payment to the providers.

MCO – State Contracts with MCOs

* The state establishes a (RFP) public bid process for service delivery areas. Once awarded regions, a capitation rate is established for each MCO, based case mix, historical cost factors, etc…
  * Capitation rates include a profit factor and an administrative factor for the MCO (typically 7% -15%).
  * Incentives are built into the rate setting system for MCOs.

MCO – General Provider Issues

* The state does not set rates. There may be a “floor” established for individual services, but the facilities are required to negotiate individual rates with the insurance company.
* MCO rates are low in national context
* Limited expertise with managed care and negotiation process.
* Viability of ALF and SNF network (due to loss of beds)
* MCO/Program Contractor financial problems
* Claims and payment concerns due to duplication

MCO – Ensuring Access to Care

* Providers reduce Medicaid beds
* Medicare/Private Pay Only facilities increase
* Managed care plans have difficulty with single point of service entry in rural areas
* In some MCO states – reduction in number of LTC providers

ACO – Accountable Care Organization

* ACO – Is a health care organization that is accountable for the expenditures and care of a defined population of patients.

* Three main areas of focus:
  * Organization of all activities
  * Measurement of outcomes and costs
  * Distribution of cost savings to ACO members

ACO – Accountable Care Organization

* Medical Homes frequently serve as the entry point for consumers in an ACO.

* Medical Home is not a building, a house, or a hospital, but rather a concept based on the premise that healthcare delivery, especially for patients with chronic diseases, should be provided and coordinated by a team of healthcare providers.

ACO Differences

* Rather than tackling payment reform in isolation of care delivery, ACOs and Medical Homes offer a consolidated approach to both issues.

* The incentives of the ACO are clearly different from the current fee-for-service reimbursement system. The focus of the ACO is to streamline its processes and care while exceeding the norm on quality and outcomes.

ACO Differences

* While in an MCO it is the payers (i.e. the insurance companies) that set the standards, in an ACO the providers have input in determining the standards for care and monitoring.

* Under MCOs, the cooperation between healthcare providers is forced, whereas under an ACO, healthcare providers work together by choice.

Long-Term Care Providers Support

* Focus on resident/patient outcomes
* Adequate service delivery network
* Reform framework that demands quality and promotes best practices
* Quality incentives
* Pilot Programs
* Phased-in implementation that is tied to both financial goals and quality care outcome goals