

## Health Care Reform or Health Care Dystocia?

Where do ACO's fit in??

*The Changing Landscape at DMA:  
Medicaid and Health Choice  
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## *Starting Point*

**Using the power of the  
Medicaid program to  
improve the standard of  
care across the State of  
North Carolina**

## ***Background Health Care Reform Implementation in the middle of:***

- Huge State Budget Deficits and Reductions
- Rampant Fraud and Abuse – especially among ancillary providers
- A Volume-driven reimbursement system
- Sagging standards of care among many medical providers
  - No C-section surveillance at local level
  - Over-utilization
  - Legal – Trial attorney greed and misuse of science
- Archaic Medicaid business practices and standards
- Legislative micromanagement

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## ***Setting the Stage in NC for Health Care Reform***

- Develop a Strategic Plan for Medicaid
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- Moved program from Abacus-model of management to the electronic model
- Implemented dashboard tracking system
- Developed reliable forecasting tools
- Train and retain staff to manage a real insurance benefit for members.
- De-politicize Medicaid
  - Reduce adverse influence of special-interests
  - Improve listening skills for good ideas from all sources
  - Engage providers (all types) as partners but not as opportunists
  - Move from a reactive organization to a health policy leadership role

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## ***The ACA, it's the law—What are we doing about it?***

- Advisory group is chaired by Secretary Cansler and Commissioner Goodwin. Subgroups consist of: New Models of Care, Exchange, Medicaid, Prevention, Safety Net, Work Force Development, Fraud and Abuse, Quality. Website is: [www.nciom.org](http://www.nciom.org)
- Medicaid and SCHIP (Health Choice) are not the only players
  - Private Insurance Companies
  - Department of Insurance (DOI)
    - *Leadership in Exchange and High Risk Pool*
      - Many decisions to be made
      - Board Representation—Insurance exchange
      - Conflicts of Interest—New Models of Care
      - Sustainability—Medicaid Expansion, Insurance Exchange



## ***It's the Law—What are we doing about it?***

- **Building off initiatives and vision of the State and Medicaid**
  - Coordination among other activities such as Governor's Goals and Priorities, HIE, HIT, EHR, Project Excel goals, and Performance Budgeting
  - Balancing budget restraints, Medicaid sustainability and health care vision
  - Planning for New Models of Care—Accountable Care Options
- **All states and state agencies face endless questions**
  - There are simply more questions than answers



## ***The Budget Reductions are Real and Measurable***

- Medicaid has reduced the program by \$1.8 BILLION since 2009
- Legislatively mandated changes in 2011-2012 total \$356,151,356 in state dollars--multiply by three to get total dollars=\$1.068B
- **Includes:**
  - Program reductions
    - Changes in dental program
    - Changes in private duty nursing
  - Improvement in clinical outcomes with collateral savings
    - CCNC savings
    - Pregnancy medical home
  - Service elimination
    - Adult optical

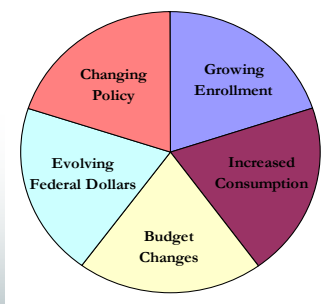
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## ***MEDICAID - YESTERDAY***

### **The color of change**



- Enrollment growth highest in 15 years
- Consumption increased by over 4%
- Policy changes to implement budget requirements
- What is the role of CCNC?

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## MEDICAID - TODAY

- Key Medicaid Factors—\$10B program
- If the new enrollees (because of the bad economy) created this much new demand—what will it be like with >500,000 new members in 2014?

**Eligible - Actual**

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## Organizational Logic

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**MISSION, VISION and VALUES**

- Short Term Medical Services
- Long Term and Residential Services
- Behavioral Health Services
- Infrastructure

**Care Continuum**

**Long Term Operational Goals:**

- Benchmark services and operations to commercial plan
- Segment and manage separate lines of business
- Align management, reporting and operations with business segments and service lines
- Define role of Medicaid in care continuum operation and management and populations to be served
- Implement, monitor, manage and tie payment to performance standards

**Systems and Services**  
 Claims Processing, Prior Approval, Disease Management, Clinical Data Sharing

**Network Management**  
 Provider Relations, Recipient Relations, Enrollment, CCNC, Eligibility, Single Source Contracting

**Internal Capabilities**  
 Actuarial, Case Management, Rate Setting, Clinical Policy, Cost Reporting, Discharge Planning, Audit, PI, P&T

**Management Capabilities**  
 Reporting and Analysis, Management Expertise, Trending, Utilization Review, Profiling

Integration and Interface with other Agencies and Organizations

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## ***What is the Impact of ACA on Medicaid Operations?***

- **Requires easier and more efficient Medicaid enrollment process—NC FAST**
- **Establishes exchanges and are required to interface with Medicaid and vice versa**
  - Requires that if individuals who are eligible for Medicaid/SCHIP apply for tax credits, they are also enrolled in Medicaid.
  - Establishes training/outreach requirements to individuals
  - Coordinate enrollment procedures with other programs
  - Must consult with stakeholders, etc.
- **Modifies portions of Medicaid in order to ensure affordable health coverage**
- **Major categories**
  - Eligibility – expanded (Medicaid looks like the “Public/Option”)
  - Services – basic package and improvements of coverage, prescription drugs
  - Enrollment Simplification – No wrong door
  - Funding – FMAP and Disproportionate Share Hospital (DSH) Payments
  - New Options to cover long term services and supports – move to community-based care
  - Quality outcome-driven metrics
  - Program Integrity refinement and effectiveness

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## ***Medicaid/Health Choice Eligibility Everything Changes***

- **Creates a MANDATORY eligibility group that expands Medicaid to 133% FPL without regards to categorically eligibility effective 1/2014**
  - NC Medicaid currently has approximately 15 eligibility categories ranging from 100% FPL to 185%
  - Excludes individuals if eligible for one of the existing mandatory groups - if enrolled or not such as ABD, Pregnant Women
- **Increases mandatory eligibility of children 6-19 yrs to 133% FPL**
  - Will impact Health Choice since eligibility for HC is 101 to 200%
- **Allows the states to implement the new eligibility category options effective 4/2010 but at the original NC FMAP - not the current enhanced FMAP.**
  - Not implementing this option – No money! Phase in option is also not anticipated - same reason!
- **Allows option to expand coverage above 133% FPL up to the highest eligibility either through waiver or State Plan.**
  - “Can’t get there from here” [quotation from Western North Carolina farmer]

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## “Let them eat cake” Projected Impact to Medicaid/Health Choice

### Eligibility in 2014

<ul style="list-style-type: none"> <li>• Expanded Eligibility</li> <li>Children                      77,072</li> <li>Childless Adults            246,956</li> <li>Parents                        <u>175,329</u></li> <li>New Enrollees              499,357**</li> </ul>	<ul style="list-style-type: none"> <li>• Children Moving from Health Choice</li> <li style="text-align: right;">57,714</li> </ul>
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These estimates include individuals who will become eligible because of mandatory Medicaid expansion (i.e. “expansion” population), and people who are currently eligible but not enrolled (i.e. “woodwork” population).

**\*\* Depending on the source, this number has been as high at 700,000 new eligibles.**

\* Currently Medicaid monthly averages 1.4 million active recipients up to approx 1.8 million per year



## Do the Math

• Expanded Eligibility New Enrollees	500,000 (499,357)
• Woodwork effect	200,000
– 20%/yr dropouts	
• Enrolled population	1,400,000
• State Health plan active and retired	<u>600,000</u>
	2,700,000

NC Total population = 9,000,000

We are entering a “Brave New World” in state-sponsored healthcare.



## ***Services for the 133% FPL category***

- **Being defined by CMS but must include**
  - Ambulatory Patient
  - ER and Hospitalization
  - Maternity and newborn care
  - MH/SA screening and treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices \*\*\*
  - Laboratory Services
  - Preventative/wellness and chronic disease management
  - Pediatric, including oral and vision care
  - Family Planning
- ***NC Medicaid currently covers some level of all the mandatory package.***
- ***Does allow for differences in the benefit package for eligibility category***
  - *Can be benchmarked like Health Choice*
- ***Can change existing benefit package in Medicaid***
- ***NC has draft benefit package that we are working through***

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## ***Enrollment and Eligibility***

- **New formula for determining financial eligibility**
  - MAGI (modified adjusted gross income)
    - *Equivalent income test*
  - Eliminates assets test for new category but not for existing categories
  - New training requirements for eligibility workers
  - Interface with NC FAST
  - New manuals and rules
  - Legislative changes will be needed
- **Excludes existing categories such as SSI, ABD, Medically Needy**
  - There will continue to be multiple methodologies for determination

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## ***Enrollment Simplification***

- **Opening the door wider**
  - Enrollment through website ensuring high level of security features – NC FAST
  - Single application process for multiple programs
  - Expanded outreach efforts to targeted groups
  - Express lane eligibility
- **Analyzing comparison to NC's existing simplification activities**
  - What changes need to happen to NC FAST and what interfaces need to be built into the health exchange
- **Allows hospitals to make presumptive eligibility determinations**
  - Expands current out-stationed workers (FQHCs, hospitals, large clinics)
  - Allows for others to conduct eligibility determination other than the local DSS
  - LMEs or CABHAs as points of access and eligibility determination

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## ***Improving Quality Outcome-driven Metrics for Medicaid Patients and Providers***

- **Creation of health care outcome measurements for adults similar to those in effect for children**
  - All Medicaid services will have metrics including Mental Health
  - Reviewing in terms of Meaningful Use requirements of EHRs and other measures being implemented. Moves Medicaid faster to Metric-driven service areas.
  - The standards of clinical performance are shifting toward greater accountability
- **Prevention of payments for preventable health care acquired conditions**
  - Never Events and HACs currently for hospitals and mandated for DMA implementation during last legislative session
  - Live January 1, 2011

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### ***Improving Quality of Medicaid for Patients and Providers***

- **Demonstration projects - waiting for CMS guidance/ requirements. Turn around time is rapid.**
  - Integrated care around hospitalization
    - *Bundled payments*
    - *PACE (not a demonstration project)*
    - *Episodes of Care – is pregnancy an episode of care? Is a total knee an episode of care? How about CHF?*
  - Payments based upon performance (*currently under development at Medicaid – not as demonstration projects*)
    - *Incentives for meeting certain criteria (Smart PA, demonstration of achieving metrics)*
      - *Pregnancy Home – exempt from PA and incentive payment for meeting criteria*
    - *CCNC PMPM and contract requirements—performance based PMPM?*
    - ***The plan: pay for delivery of evidence-based services and health outcomes – not for process and volume***
      - *Pregnancy Home—a dynamic value added program*

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### ***Improving Quality of Medicaid for Patients and Providers***

- **Demonstration projects - waiting for CMS guidance/requirements. Turn around time is rapid.**
  - ACO guidelines out and under comment
  - Pediatric Accountable Care Organizations sharing in savings due to implementation of performance guidelines and monitoring
  - Reimbursements for IMDs between ages of 21-65 to stabilize emergency psychiatric condition
  - Personal responsibility for one's own health care—telemonitoring under careful clinical guidelines
    - Monitored by personal physician

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### ***Improving Quality of Medicaid for Patients and Providers***

- **Option for “health home” for patients who have at least 2 chronic conditions or at risk. Will include mental health, substance abuse, asthma, diabetes, heart disease, overweight/obesity (1/2011).**
    - Better oversight and utilization of home health
    - CCNC and LME/CABHA – linkages between primary care and behavioral health
    - Provider qualifications – linkages with primary care, IT capability and capacity
      - Data sharing for coordination
    - Outcomes (care coordination, discharge planning, referrals and linkages and health information linkages.
      - Hospital readmissions, medication reconciliation, Hospital discharge planning
- CCNC will be our health home**
- Obstetricians are now a part of the “pregnancy medical home”
  - Other specialists/what about hospitals?

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### ***Who is Going to Do This Dream?***


#### ***Workforce Issues***

- Increased efforts to expand and promote better training for the health professional workforce
  - Increased emphasis on increasing the supply of health professionals in underserved areas—there needs to be some creative thinking here
    - Loan forgiveness
    - Geriatricians
    - Pediatricians
    - Primary physicians
- WILL THE OLD MODELS STILL WORK?**  
Will the ACO drive practice change
- **Enhanced training in prevention, quality initiatives, interdisciplinary care, community-based education, and diversity**
    - Providers functioning at the top of their training and license

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## ***9.0 on the Richter Scale***

Do you feel the ground shifting under your feet?

- Real workforce issues
- Who is going to do what?
- Will the workforce pressures in the market shift your work flow?
- Is this the beginning of a major change in OUR practice patterns?
- How do physicians maintain leadership of health care in your community.....is the real question
  - do we still have it?

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## ***A New Meaning to Program Integrity***

- **The Governor’s plan is to address Medicaid fraud, abuse and misuse across the state**
- **Enhances claims screening**
  - CCI—CMS clean claims initiative >6,000 new edits in payment system
  - IBM Fraud Solutions
    - *Prepayment*
    - *Post payment*
  - Enrollment
    - *New credentialing process*
    - *Interstate data sharing*
    - *SAS recipient analytics*
  - Enforcement
    - *Added 25 new investigators/attorneys in Attorney General’s office*

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***NC has not printed money since  
 April, 1865***

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***MEDICAID - TOMORROW***

- **New level of accountability for all providers**
- **Reporting and Outcome-driven metrics**
- **Sustainability must be addressed**
- **Is this time of tremendous conflict also a time of great opportunity?**
  - Turn the benefit program right-side-up
  - Introduce value added clinical models?
    - Pregnancy home 2011
    - Emergency Room utilization
    - Oncology Home
    - ACOs
  - Increase clinical influence and decrease political influence
  - Continue shift to proven, time-tested, and reliable business principles

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