UNC HEALTH CARE SYSTEM

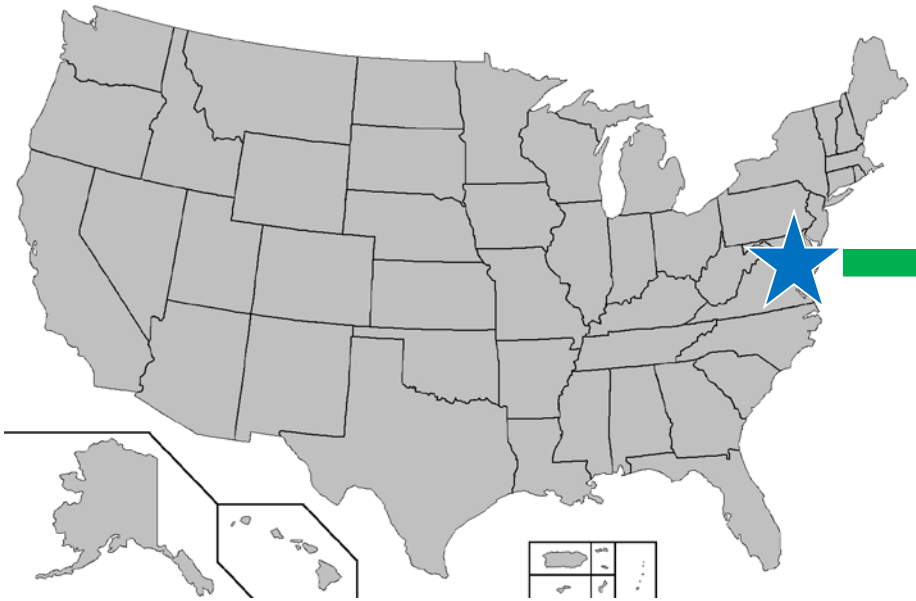
Medicaid

The view from one state:
Will collaboration with providers be sustained?

UNC HEALTH CARE

May 16, 2015

Public Health Care Funding



CMMS

Medicare
$583 Billion
14% of the Federal Budget
54 Million Beneficiaries
($10,796 per person)

Medicaid
$ 242 Billion
8% of the Federal Budget
66 Million Beneficiaries
($6,636 per person State and Federal

Total Medicaid spending $438 Billion (including state share)

FY2014

Medicaid

- **Once mandated Federal requirements are met, states generally control structure of Medicaid on a state by state basis (e.g. EPSDT (Early Periodic Screening Diagnostic and Treatment) benefit for children required, income eligibility may be increased to higher level by state)**
- **States provide funds to state Medicaid and receive "match" funds directly from CMS (Range is 1:1 to 1:4)**

- **Medicaid eligibility based on family income and set by the state (generally no lower than "National Poverty Level")**
- **Eligible individuals once enrolled receive Medicaid benefits/services as an entitlement. "Optional eligibility and services determined by the state.**

Not All Medicaid Programs are Alike

- **State Legislatures determine what optional recipients and services are available**
- **When compared to other states NC's program is more robust and also results in higher costs per eligible recipient.**

Optional People/Services COVERED by NC	States where NOT COVERED
Medically-Needy	AL, MS & SC
Non-SSI Adults	AL, FL, GA, MS, & VA
Adult dental	GA & TN
Hearing aids	AL & KY
Private Duty Nursing	GA
Restriction NOT IN PLACE in NC	**States with RESTRICTION**
Hard limit on # of Hospital & ER Visits	AL & FL

50 States, DC, Territories…52 Medicaid structures

NC Department of Health and Human Services

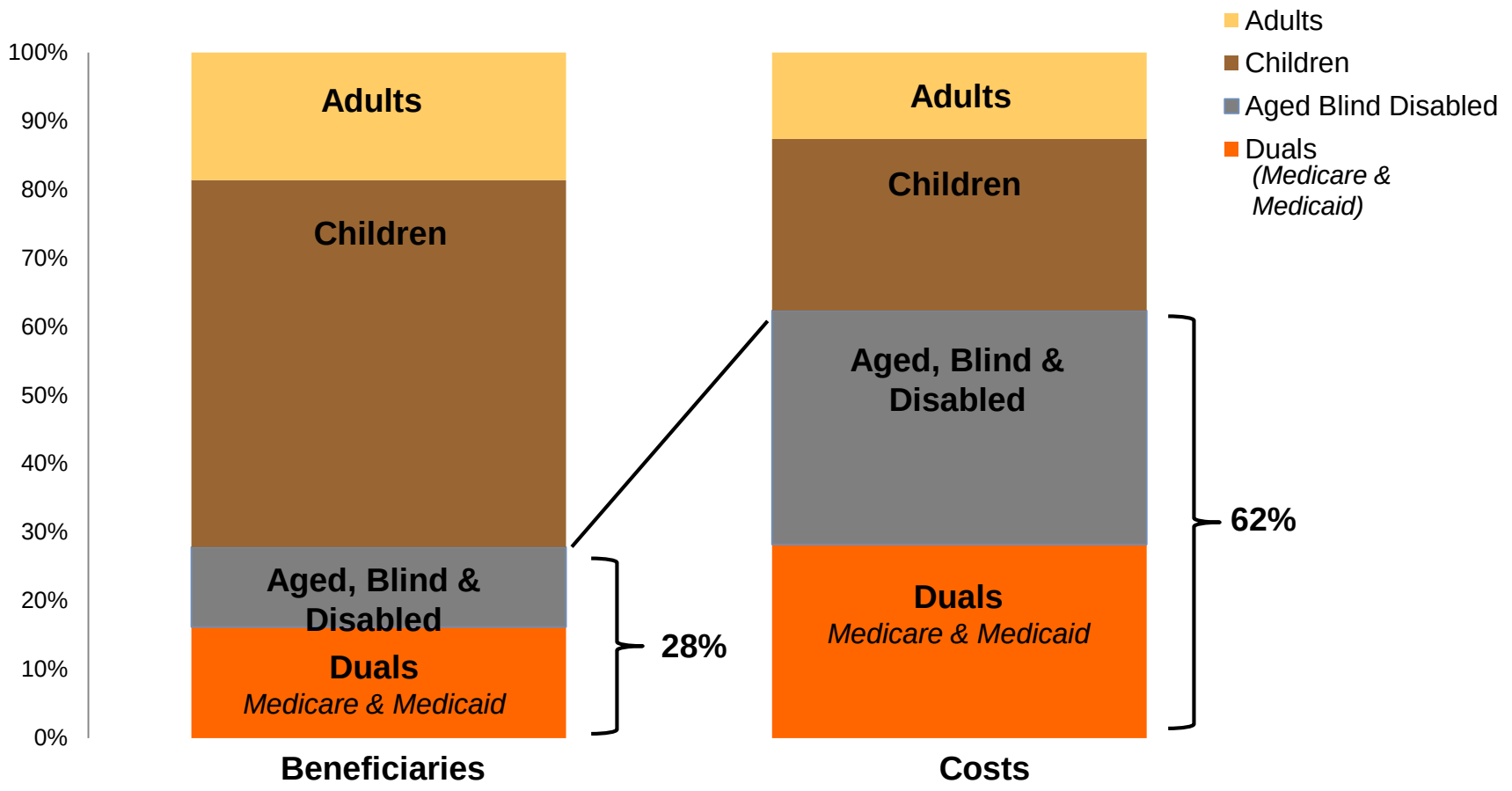
NC Medicaid Patients
Medicaid Costs and Demographic Information for NC Medicaid Patients

Total NC Medicaid Costs in CY 2014*

- Patients Under 21 – $3.9 Billion 1.2 Million
- Dual patients – $3 Billion 235,000
- **All Patients –$10.3 Billion 17 Million**

Demographics of Patients under 21	Percent
Race	
African American	36.7%
White	45.8%
American Indian	1.8%
Other	1.8%
Unreported	13.9%
Age	
0-5	34.8%
6-10	26.7%
11-15	23.0%
16-20	15.6%

A Small Portion of NC Medicaid beneficiaries are responsible for a disproportionate share of costs



Medicaid Population: 1.6 Million *(as of SFY 2012)*
Enrolled in CCNC: 1.3 Million (NOT enrolled most are Duals)

Source: CCNC Informatics Center

Evolution of Provider Managed Medicaid in NC

Primary Care Provider driven Medicaid program

Access I, II, III

- Several projects were started in the 1990's as a partnership of primary care practices with Medicaid
- Goals: quality improvement, better access, cost reduction
- Tools: Care management, improvement collaboratives, utilization data
- Per member per month payment (PMPM) incentive for practice innovation, extended office hours, and 24/7 access to call lines to reduce ED visits--IN ADDITION TO--fee for service payments

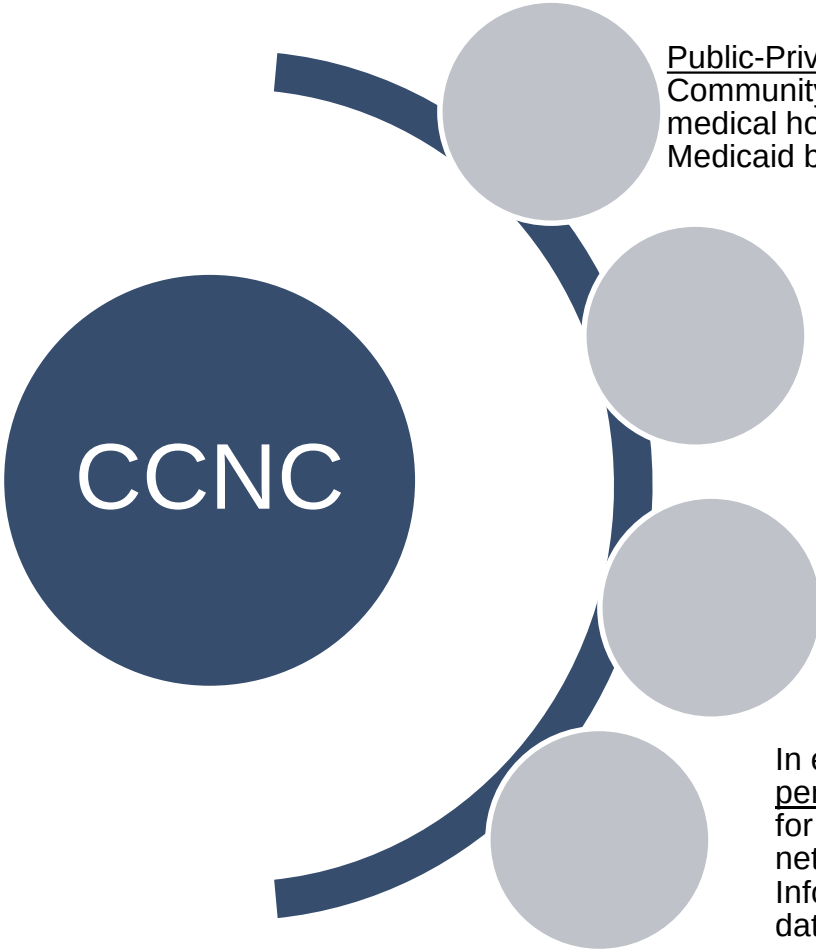
CCNC

- CCNC formed as an umbrella entity for county based regional provider networks (non-profits with boards)
- Each network had its own contract with the state (DMA) and used a PMPM for network expense and transferred a practice PMPM to participating providers
- Intent: expand Access I, II and III processes, focus on primary care management, expense reduction, & practice innovation/improvement
- By 2007 CCNC geographically encompassed all 100 counties within 14 networks

N3CN

- North Carolina Community Care Networks (N3CN) was created as a separate non-profit with a governing board as part of the Medicare Demonstration Project to manage dual-eligible patients (Medicare and Medicaid) through CCNC structure
- N3CN centralized business operations for the CCNC networks (data management, contracting, coordinating quality/patient care collaboratives) and established a governing board over CCNC
- NC DMA now has one contract with N3CN, which in turn contracts with each of the 14 networks
- N3CN has developed relationships with other payors, taken on responsibility for NCHIE, and has been a resource to other states looking at managing care for Medicaid beneficiaries

Physician-led NC Medicaid management organization: Community Care of North Carolina (CCNC/NCCCN)



Public-Private partnership, Community based, provider led medical homes coordinating care for Medicaid beneficiaries

~1800 practices, ~6000 providers with more than 95% of all primary care providers in NC participating. Focused on practice innovation, development of medical home, and expense containment. Active QI and pharmacy Initiatives

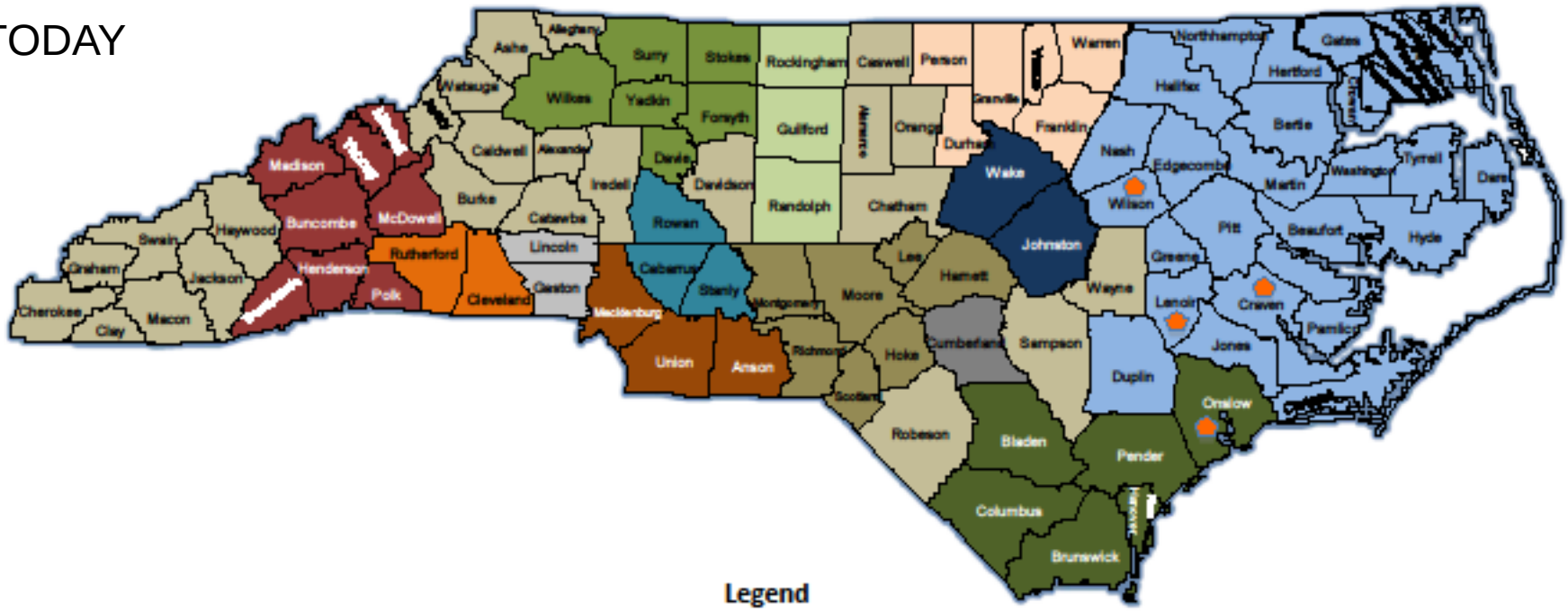
Participating providers are expected to improve quality and care, and have ownership of improvement processes

In exchange, providers receive a PMPM ($2.50 per patient) to the practice, care coordination for Medicaid patients in their practice (paid by network), and have access through the CCNC Informatics Center to practice and patient level data to guide care innovation.

But, providers have not been rewarded or penalized for quality or total cost of care and continue to receive fee for service for care provided

Community Care of North Carolina

TODAY



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Source: CCNC 2011

CCNC Influences Some, BUT NOT ALL, Medicaid Services for Individuals Enrolled in CCNC

CCNC

primary care

hospitals & emergency departments

referrals to specialists

medications

< 45% of total Medicaid claims spending

CCNC and its care teams have minimal influence over utilization of these services:

personal care services

nursing homes & other LTC settings

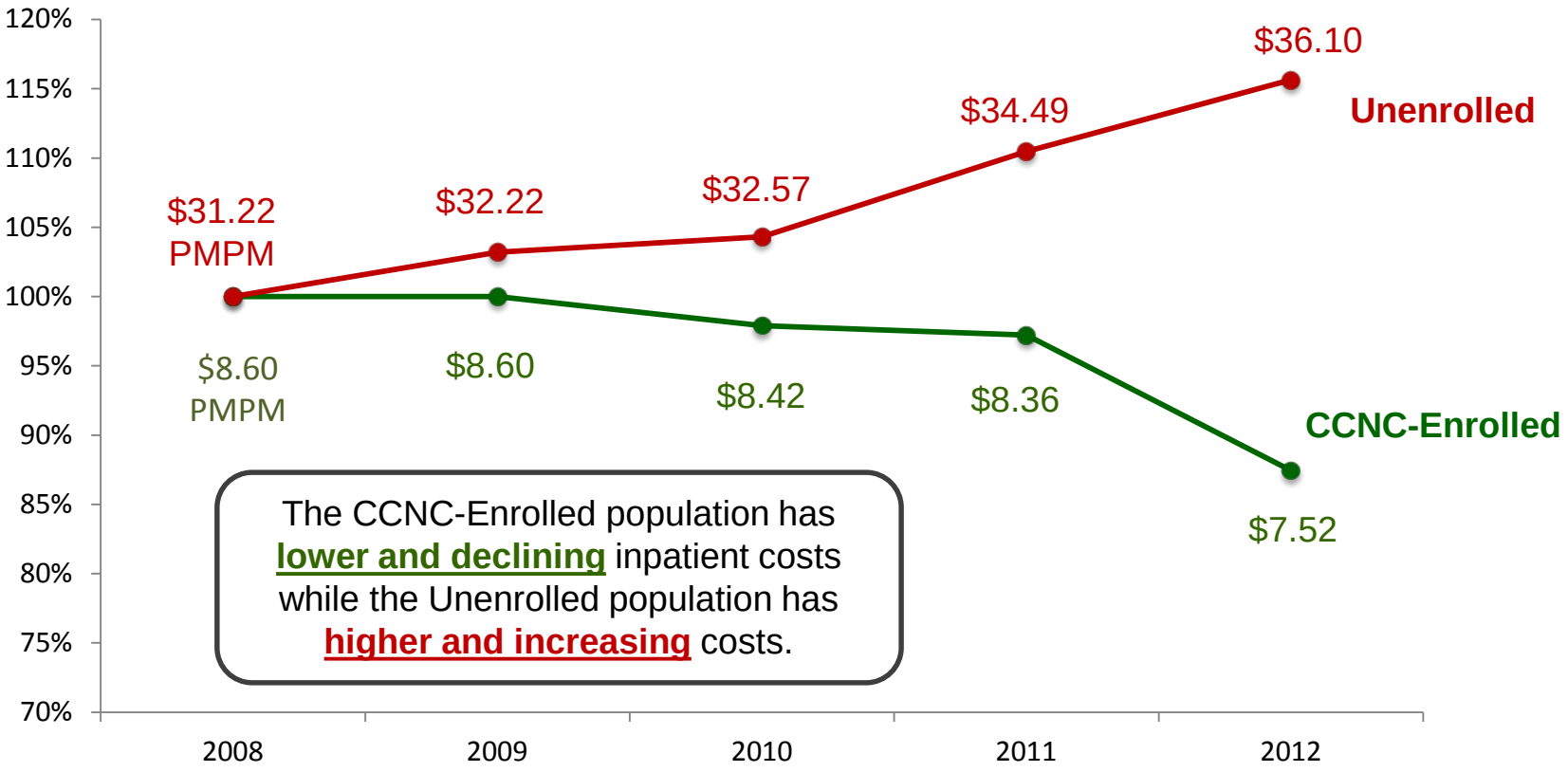
diagnostic testing

* behavioral health care

medical equipment

* Managed by LME/MCOs

CCNC-Enrolled Members Have Lower and Declining Potentially Preventable Inpatient & ER Costs

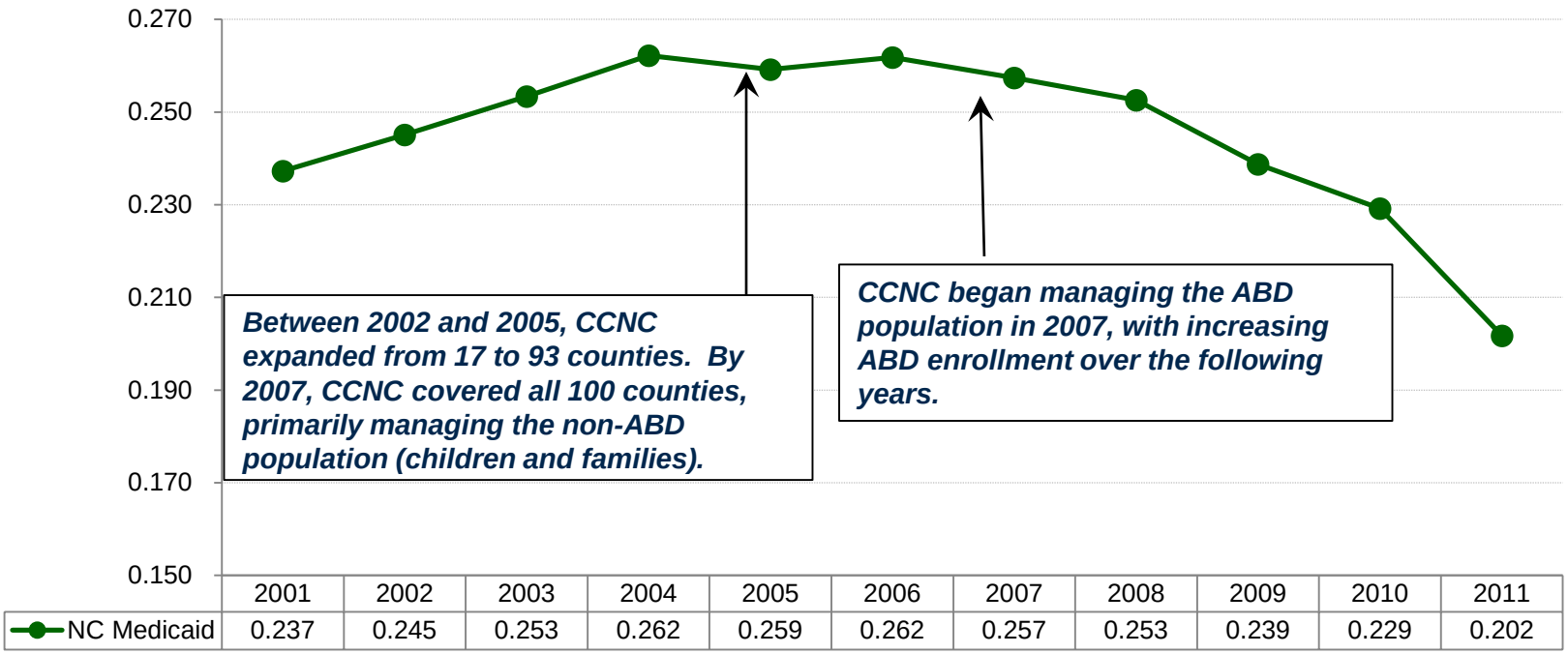


PMPM per member per month

Source: CCNC Informatics Center, Non-Dual CCNC-Enrolled, Excluding Health Choice Population.

Long Term Trend in NC Medicaid Inpatient Admission Rates

Inpatient Admissions for all Medicaid Beneficiaries, including Duals

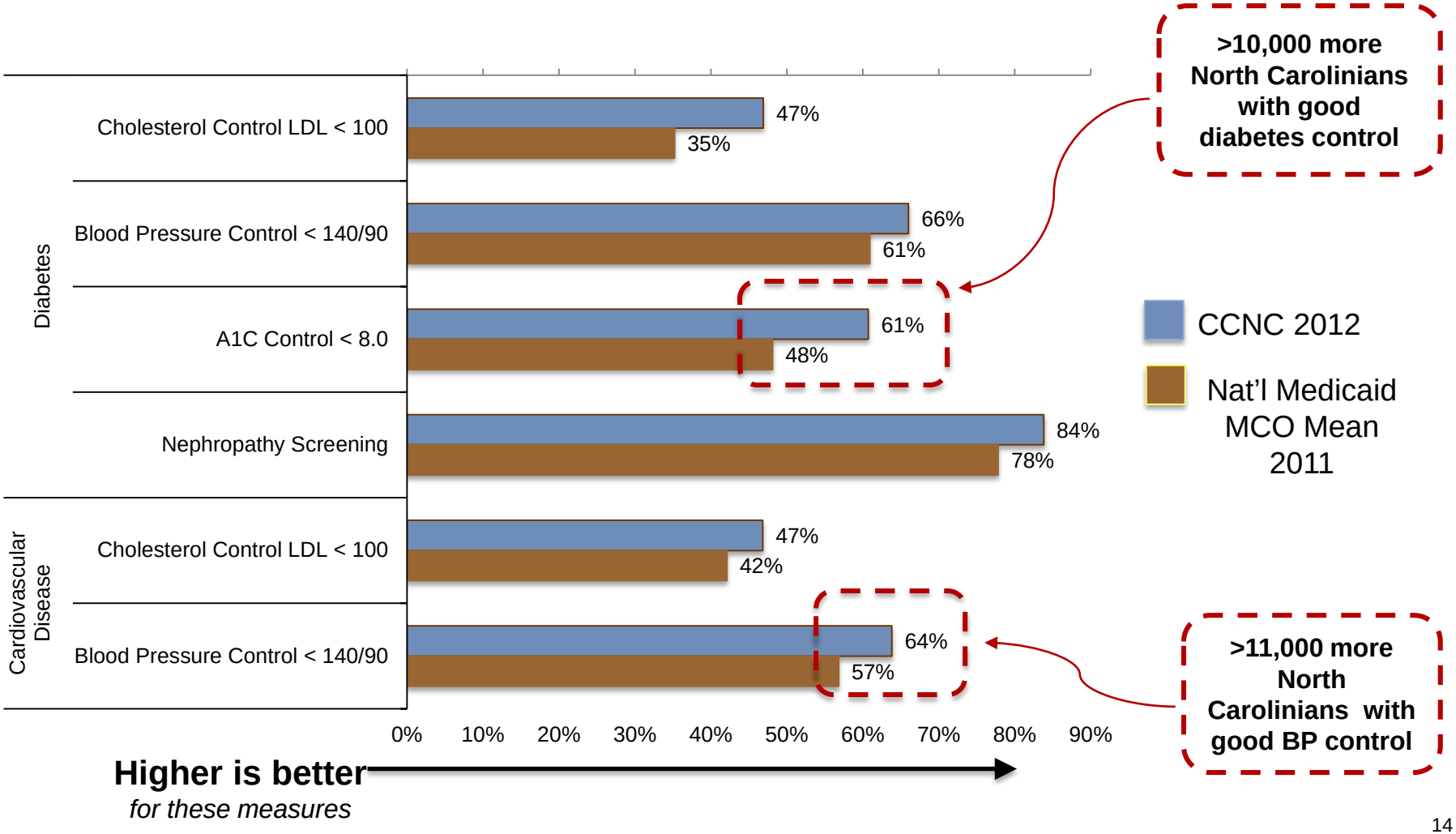


	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NC Medicaid	0.237	0.245	0.253	0.262	0.259	0.262	0.257	0.253	0.239	0.229	0.202

Source: Inpatient data obtained from AHRQ Healthcare Cost and Utilization Project (HCUP), hcupnet.ahrq.gov. Enrollment from Kaiser Family Foundation website, kff.org.

HEDIS Quality Benchmarks:
Comparing CCNC to National Medicaid MCO

HEDIS= Health Effectiveness Data and Information Set



Per Member Per Month (PMPM) Costs By Eligibility Group, CY 2012

	Adults *Non-Dual, Non-ABD*	Children *Non-Dual, Non-ABD*	Aged, Blind & Disabled *Non-Dual*	Duals
All Medicaid	$ 482.79	$ 206.33	$ 1,429.15	$ 960.90
CCNC Enrolled	**$ 447.33**	**$ 183.83**	**$ 1,335.77**	**$ 488.67**
CCNC Unenrolled	$ 550.81	$ 424.74	$ 1,692.85	$ 1,632.34

NOTE: *There is an opportunity to reduce the PMPM costs for each of the unenrolled groups. However, two of the CCNC unenrolled groups (children and duals) are considerably more frail. Costs may be reduced, but it is unlikely that these groups can be brought down to the CCNC enrolled PMPM average.*

Source: CY 2012 Medicaid Paid Claims Expenditures; CCNC Informatics Center

Medicaid Upper Payment Limit (UPL)

NC Medicaid applied for and received approval for a waiver to allow UNC HCS and East Carolina Medical School (the two state institutions) to receive Upper Payment Limit reimbursement for Medicaid beneficiaries cared for in the selected clinics and hospitals for the two systems

UPL allows a differential payment for allowed care approximating the average of commercial payment to the provider.

The funds to pay UPL comes from a match of UNC HCS state funds to allow additional federal Medicaid funds pulldown.

Last year the NC Legislature has tightened the payment options progressively to limit the number of providers eligible to receive payment under this option. If a transition to MCOs occurs the UPL will not be available.

STATE GOVERNMENTS

North Carolina Reverts to Red

The state Obama famously captured from Republicans in 2008 is about to enact a flurry of conservative laws.

By Maya Rhodan @m_rhodan | July 30, 2013 | 168 Comments

Four years ago, North Carolina was thought to be in transition, a Southern state turning blue in President Obama's "new America." But at the close of its legislative session last Friday, the Tar Heel State showed its true hue: deep red.

Since the state's legislative session began in January, lawmakers have blocked a Medicaid expansion under Obama's Affordable Care Act, reduced access to federal unemployment benefits, cut the corporate tax rate, trimmed public-education funding, passed a bill that allows concealed weapons in bars and restaurants, tackled welfare reform, proposed a ban on Shari'a, restricted access to abortion and enacted stricter voting laws.

Corey Lowenstein / AP

Governor Pat McCrory, flanked by members of North Carolina's general assembly at the Executive Mansion in Raleigh on July 23, 2013.

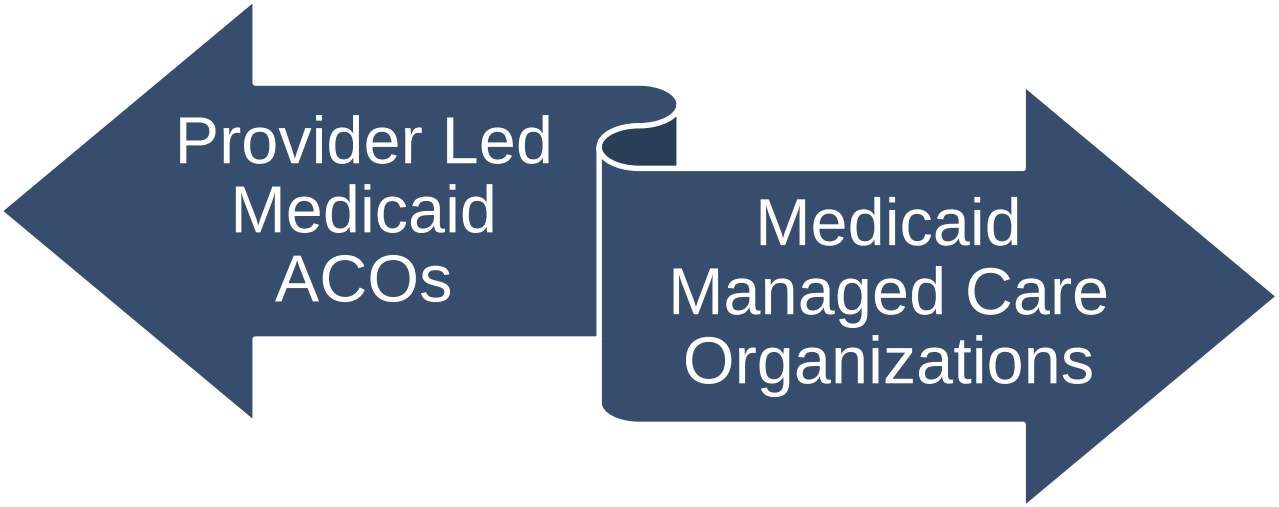
Cast of Characters in NC Medicaid Political Theater

- Governor
- Secretary of Health and Human Resources
- Division of Medical Assistance
- NC Senate
- NC House
- NC Hospital Association
- Large Health Care Systems
- ACO's/CIN's
- CCNC
- National MCO's
- NC Medical Society
- NC Association of Family Physicians
- NC Pediatric Society

NC Political Leadership Goals for Medicaid Restructuring

- **Fixes a “broken” Medicaid system in NC**
- **Budget Predictability**
- **Increase in administrative efficiency**
- **Cares for the “whole” person**
- **Transitions to Value-based care with risk transition to the providers**
- **Creates a competitive environment for care of Medicaid patients**

NC Political Leadership Considerations: Last and Current Session



Governor and House: Build on Community Care "Model," at risk ACO Model. Retain current oversight model by Department of Health and Human Services.

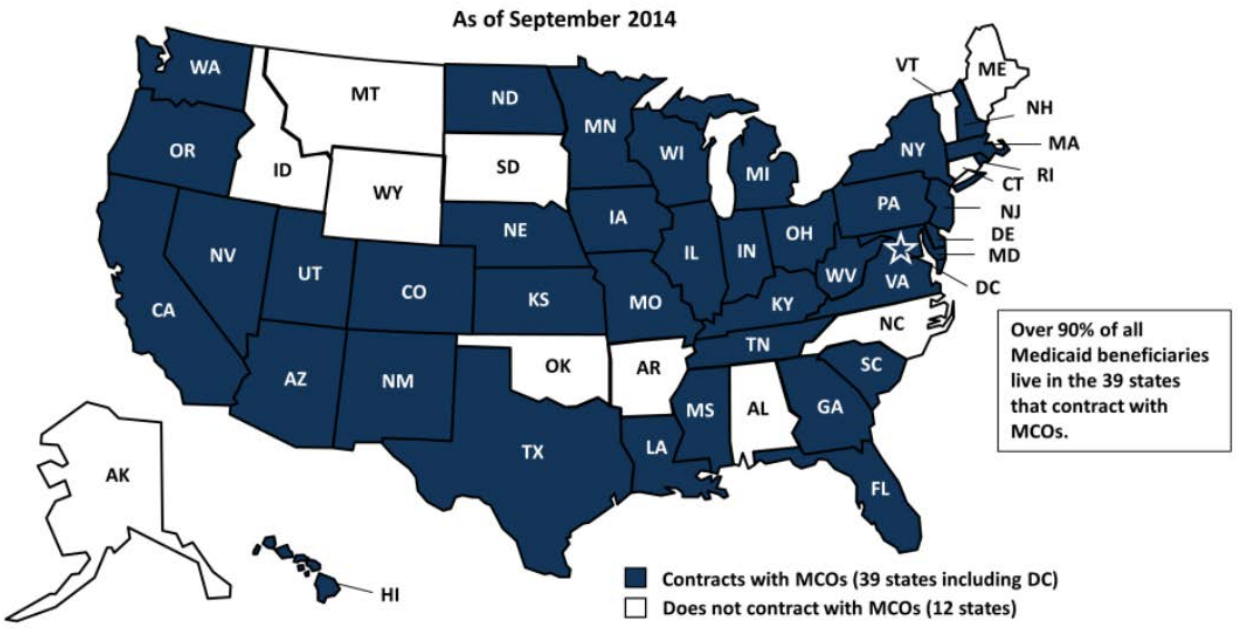
Implementation Timeline 3-5 years

Senate: Medicaid Managed Care Companies (out of state) take over NC Medicaid and provide budget and efficiency predictability. Separate oversight of NC Medicaid from Department of Health and Human Services?

Implementation Timeline: <1-2 years

What will be NC's future?

39 state Medicaid programs contract with comprehensive MCOs.



SOURCE: KFF Medicaid Managed Care Market Tracker

The “Tea leaves” for NC Medicaid—MCO/ACO/Hybrid???