NC MEDICAID PROVIDER ACCESS

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November 8, 2011
DISCUSSION TODAY

• Current North Carolina Provider Infrastructure

• Impact in 2014

• Challenges
NC PROVIDER INFRASTRUCTURE

Community Care of North Carolina
Using the power of the Medicaid program to improve the standard of care across the State of North Carolina
COMMUNITY CARE OF NORTH CAROLINA (CCNC)  
“Home of the Medical Home”

• Statewide medical home and care management system in place to address quality, utilization and cost

• 100 percent of all Medicaid savings remain in State

• A private sector Medicaid management solution that improves access and quality of care

• Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers

• Network has 90% crossover to best commercial network
COMMUNITY CARE OF NORTH CAROLINA

- Public-private partnership began in 1983
- “Managed not regulated”
- CCNC is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs primarily by greater quality, efficiency
- Providers who are expected to improve care must have ownership of the improvement process
COMMUNITY CARE OF NORTH CAROLINA

• Primary Goals of Community Care:
  – Improve the care of Medicaid population while controlling costs
  – A “medical home” for patients, emphasizing primary care
  – Community networks capable of managing recipient care through care and case management teams
  – Local systems that improve management of chronic illness in both rural and urban settings
    – Health care is local
COMMUNITY CARE OF NORTH CAROLINA

• How it works:
  – Primary care medical home available to 1.1 million individuals in all 100 counties
  – Provides 4,500 local primary care physicians with resources to better manage Medicaid population-supported by locally managed CCNC care/case managers
  – Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
COMMUNITY CARE OF NORTH CAROLINA

• How it works:
  – State identifies priorities and provides financial support through an enhanced PMPM payment to community networks
  – Networks pilot potential solutions and monitor implementation (physician-led), i.e., asthma, diabetes, pharmacy management, etc.
  – Networks voluntarily share best practice solutions and best practices are spread to other networks
  – The State provides the networks access to data
  – Cost savings/effectiveness evaluated by the State and third party consultants (Mercer, Treo Solutions)
COMMUNITY CARE NETWORKS

- Networks are:
  - Non-profit organizations that receive a PMPM payment from the State (Central office of CCNC also a 501(c)(3) nonprofit)
  - Resources needed to manage enrolled population, reducing costs
  - Medical Management groups that have local committee oversight
  - Care management groups with locally managed staff
COMMUNITY CARE NETWORKS

• Each network has:
  – Clinical Director (20 in total)
    • A physician who is well known in the community
    • Works with network physicians to build compliance with care improvement objectives
    • Providers oversight for quality improvement in practices
    • Serves on the State Clinical Directors Committee
    • Network Director who manages daily operations
  – Care managers to help coordinate services for enrollees/practices (600)
  – PharmD to assist with Med management of high cost patients (26)
  – Psychiatrist to assist in mental health integration (14)
  – Palliative care practitioners
COMMUNITY CARE NETWORKS

• Grassroots networks ensure broad local provider buy-in and participation

• Focus on quality of care ensures better medicine and better outcomes

• Flexible structure invests in rural and urban communities and provides jobs

• Very low administrative costs
IMPACT IN 2014
HEALTH CARE REFORM IMPLEMENTATION IN THE MIDST 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
  – Minimal C-section surveillance at local level
  – Legal – Trial attorney greed and misapplication of science
• Archaic Medicaid business practices and standards
• Everyone wants a piece of Medicaid – last bastion of provider influence in health care
### PROJECTED IMPACT IN 2014

<table>
<thead>
<tr>
<th>Expanded Eligibility</th>
<th>Children Moving from Health Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>77,072</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>246,956</td>
</tr>
<tr>
<td>Parents</td>
<td>175,329</td>
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<tr>
<td>New Enrollees</td>
<td>499,357*</td>
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</tbody>
</table>

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) ~ 200,000

*Depending on the source, as high at 700,000 new eligibles. Currently NC Medicaid monthly averages 1.4 million active cases up to approx 1.8 million per year.
PROJECTED IMPACT IN 2014

• Number of non-elderly uninsured drops from 1,596,000 to 724,000

• Nonelderly Medicaid enrollment of 1.9 million
  – 632,000 adult nonparents
  – 298,000 adult parents
  – 971,000 children
  – 118,000 newly enrolled current eligibles (woodwork effect)
  – 474,000 newly enrolled eligibles
CHALLENGES
MEDICAID CHALLENGES TO INCREASING PROVIDER ACCESS

Given current historic budget shortfalls:

• Reducing eligibility or benefits limited by federal “maintenance of effort” – leads to reductions in what is paid for and how much is paid

• Lowering reimbursement reduces access and increases ER usage/costs

• Proposed federal rules on “Access to Covered Medicaid Services”
LOWER REIMBURSEMENT MAY RESULT IN LOWER PROVIDER PARTICIPATION

- Large anecdotal evidence of providers leaving; currently scrubbing internal data to see effect of last round of budget reductions

- 2004 national study published in *Health Affairs*:
  - Physicians in states with lowest Medicaid fees less willing to accept Medicaid patients
  - Large fee increases were associated with physicians’ greater willingness to accept new Medicaid patients

- Same rationale in ACA that requires payment of primary care providers 100% of the Medicare fee schedule starting in 2013

PROPOSED FEDERAL RULES ON ACCESS

• Proposed federal rules published May 6, 42 CFR Part 447 on “Access to Covered Medicaid Services” on fee-for-service payments

• Based upon the Medicaid and CHIP Payment and Access Commission (MACPAC) study, the framework for consideration of access to care would be:
  – Enrollee needs
  – Availability of care and providers
  – Utilization of services
PROPOSED FEDERAL RULES

• Requires reports on access to covered services
  – Whenever a rate reduction SPA is submitted, State must submit information from an access review conducted within the prior year to the SPA’s effective date
  – State must conduct access review for a subset of services each calendar year and release the results through public records or the State’s web site by January 1 annually
    • First of such reviews is due 12 months after the effective date of the final rule
    • States will decide which services will be reviewed, and each service is reviewed at least once every five years
PROPOSED FEDERAL RULES ON ACCESS

• Projected Cost:
  – Based upon the assumptions within the proposed rule, the cost per year for reviews: $1,313,160

  – Potential to slow down SPA approval process, decreasing anticipated savings in budget shortfall years
PROPOSED FEDERAL RULES ON ACCESS

- Total annual man-hours to complete reviews: 25,440
  - Already operating with limited staff

- Creates additional administrative burden

<table>
<thead>
<tr>
<th></th>
<th>Major NC Insurer</th>
<th>Division of Medical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Claims processed</td>
<td>47.2 million</td>
<td>88.0 million</td>
</tr>
<tr>
<td>Number of Employees</td>
<td>4,600</td>
<td>400</td>
</tr>
<tr>
<td>Number of Enrollees</td>
<td>3.7 million</td>
<td>1.8 million</td>
</tr>
<tr>
<td>Value of Claims</td>
<td>$11.3 billion</td>
<td>$9.7 billion</td>
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Using the power of the Medicaid program to improve the standard of care across the State of North Carolina
QUESTIONS?
Ensuring System Capacity as we Approach 2014: Health Resources and Services Administration Strategies

Rebecca T. Slifkin, PhD
Director, Office of Planning, Analysis, and Evaluation
Health Resources and Services Administration
Department of Health and Human Services

November 8, 2011
HRSA is acutely aware of need to ensure system capacity in 2014

Multiple strategies:
- Working to quantify primary care provider supply and identify ways to track moving forward
- Funding additional training capacity for primary care providers
- Implementing new strategies to improve the distribution of primary care providers
- Building the safety net capacity through our CHC program
- Supporting new models of care delivery that can improve quality and outcomes while decreasing costs and more efficiently using providers.
The ACA created the National Center for Health Workforce Analysis, located within HRSA’s Bureau of Health Professions. The Center is working to:

- Build on existing sources of data including from professional associations, states, and federal agencies
- Strengthen national and state capacity for data collection and analysis including within professional associations
- Develop and promote a national uniform minimum data set
- Support research to better understand current and future workforce needs and dynamics.
• The National Center for Health Workforce Analysis will provide data, tools, information and guidance on the health workforce trends and developments

• States are in the best position to identify their priority needs and understand their local resources

• The National Center and state stakeholders can build an effective partnership
New Programs to increase Primary Care Training

The ACA creates new opportunities to finance health professions training. The Department of Health and Human Services made available more than $455 million to support the training of new primary care providers by 2015:

• **Primary Care Residency Expansion Program:** 82 programs across the country are currently receiving funding to train more than 500 new primary care physicians.

• **Advanced Nursing Education Expansion Program:** 26 schools of nursing are currently funded to train nearly 600 new primary care nurse practitioners and nurse midwives.

• **Expansion of Physician Assistants Training Program:** 28 programs are receiving funding to train nearly 600 new physician assistants.
• **Teaching Health Center Graduate Medical Education Program:** 11 teaching health centers are funded to support community-based training of primary care physician residents.

• **Expanding Residency Slots for Primary Care:** the ACA redistributed unused residency positions and directs them for the training of primary care physicians. Priority is given, among other factors, to hospitals that have a rural training track or are located in a primary care health professional shortage area.
Since 1972, the National Health Service Corps has helped underserved areas gain access to health care

• The American Recovery and Reinvestment Act and the Affordable Care Act transformed this program

• In FY2008 the NHSC field strength was 3,601. For FY2011 it grew to 10,279

• In addition to growth in Corps strength, two strategies help with distribution
  – ACA allows HIS facilities serving only tribal members to qualify as sites
  – As part of the White House Rural Initiative, President Obama announced a pilot that includes critical access hospitals as eligible NHSC sites.
• For more than 40 years, health centers have delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay.

• Health centers are the essential primary care provider for America’s most vulnerable populations.

• Today, more than 1,100 health centers operate 8,100 service delivery sites that provide care to more than 19 million patients in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.
The ACA established the Community Health Center fund that provides $11 billion over a 5 year period for the operation, expansion, and construction of health centers.

- $9.5 billion is targeted to support ongoing operations, creating new sites in medically underserved areas, and expanding preventive and primary health care services.
- $1.5 billion will support major construction and renovation projects at community health centers nationwide.

In FY 2011, the Health Center Program announced and awarded more than $1.7 billion in ACA grants.

- $732 million for 144 Health Center Capital Development awards,
- $900 million to support ongoing health center operations
- $30 million to establish 67 new health center sites and 129 health center planning grants, and
- $40 million to support quality improvement activities in more than 900 health centers nationwide.
• Research indicates that health insurance does not guarantee a usual source of primary care.

• After passage of health insurance reform, between 2005 and 2010 Massachusetts health centers saw a 36% increase in patients—even while the overall percentage of uninsured patients decreased by over 22%.

• In 2014 there will continue to be uninsured individuals who will need health centers as their source of affordable preventive and primary care.

• Many of the services that health centers currently provide, that improve the accessibility and quality of care provided to low income, vulnerable patients, will not likely be covered under health insurance reform.
We are revisiting a number of our current programs to make sure they support new models of care delivery that can more efficiently use providers.

• FY 2012 Changes in HRSA’s Advanced Nursing Education program
  – ANE program invites applications that seek to develop enhanced training in health care technology and interprofessional team-based
  – Encouraging cross fertilization among professionals increases collaborative relationships in the practice environment and improve the quality of care being provided
  – Prepare nurses to provide health care in a technologically advanced interprofessional environment
FY 2012 Changes in Nurse Education Practice, Quality and Retention (NEPQR) Program

• NEPQR invites projects focused on development of interprofessional practice initiatives

• Seeking projects that create clinical practice environments comprised of nursing and at least one other discipline that:
  o foster increased communication and shared decision-making among disciplines;
  o promote increased mutual respect and dialogue among diverse health care professionals; and
  o create more efficient and integrated practices that lead to high quality patient-centered outcomes
New Programs under the ACA:

• Nurse Managed Health Clinics
  – Grants to develop and operate practice arrangement managed by advanced practice nurses that provide primary care and wellness services to underserved and vulnerable populations.
  – Complements and extends nurse-managed clinic program authorized under Title VIII (Nurse Education, Practice, Quality and Retention Program).
  – 10 nurse-managed clinics awarded 3-year grants.

• Personal and Home Care Aide State Training Program
  – Grants to states to develop, implement, and evaluate core competency-based curriculum and certification programs to train and certify qualified personal and home care aides.
  – 75 hour minimum training programs.
  – 6 states awarded 3-year grants.
• Encourages and supports health centers to transform their practices and participate in the PCMHH recognition process to:
  – improve the quality of care and outcomes for health center populations;
  – increase access; and
  – provide care in a cost effective manner.
• HRSA/BPHC will cover recognition process fees and provide technical assistance resources for practice transformation.
• Participation is strongly encouraged and provides an opportunity for health centers to achieve PCMH recognition.

For further information on the PCMHH Initiative:
• PCMHH Initiative PAL: http://www.bphc.hrsa.gov/policiesregulations/policies/pal201101.html
• BPHC Helpline: bphchelpline@hrsa.gov or 1-877-974-BPHC (2742)
• PCMHH email: PCMHHinitiative@hrsa.gov
Established by the Affordable Care Act, the Innovation Center's mission is to help transform Medicare, Medicaid, and CHIP through improvements in the health care system, thereby ensuring better health care, better health, and reduced costs for beneficiaries, and ultimately enhancing the health care system for all Americans.

The Innovation Center has the resources and flexibility to rapidly test innovative care and payment models and encourage widespread adoption of practices that deliver better health care at lower cost.

Many interesting initiatives on their website:
http://innovations.cms.gov/
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Capacity During Enrollment Surges

National Association of Medicaid Directors
November 8, 2011

Vincent D. Gordon
Deputy Secretary
Office of Medical Assistance Programs
Pennsylvania Department of Public Welfare
The Environment

- Current increase in Medicaid enrollments
- Reduced state revenues
- Future Medicaid enrollment increase under health care reform
Department of Public Welfare
Initiatives Related to Increased Eligibles

• Development of an Empowerment Model that is consistent with our mission

• Expansion of Medicaid managed care
Empowerment Model Development

- The Department of Public Welfare is developing a person-centered, participant-directed system that will:
  - Promote and encourage healthy choices
  - Encourage and empower consumers to work
  - Foster consumer choice and independence
  - Increase the information available to consumers about their health care and other human services expenses
HealthChoices

• 1.6 million - over 70 percent of MA consumers - served through one of our managed care programs

• Three HealthChoices Zones with mandatory managed care

• Program goals:
  - Improve access to health care services
  - Improve quality of care
  - Maximize opportunities to provide cost-effective healthcare

*HealthChoices MCOs play a critical role in providing high-quality, cost-effective care for MA consumers.*
ACCESS Plus

- 320,000 MA recipients served in 42 counties
- Non-capitated, managed fee-for-service program
- ACCESS Plus vendor provides:
  - Primary Care Case Management
  - Disease Management
  - High-Cost and High-Risk Case Management
Focus on the Future: *Proposed HealthChoices Expansion*
Focus on the Future

Comprehensive Review
• Comprehensively review entire framework of health care and public assistance programs and services

Reduce Expenditures
• Continue to ensure we can sustain our programs by reducing expenditures over the next 18 months

Encourage Independence
• Preserve essential aid to those truly in need while encouraging independence and self-sufficiency