

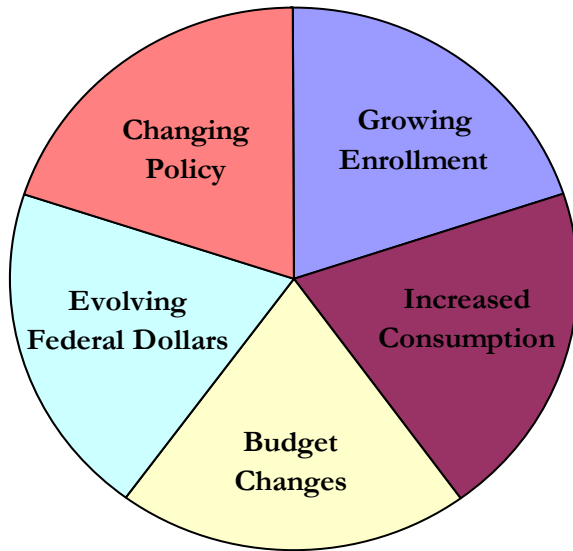
Understanding Medicaid Waivers in the Context of Demographic and Economic Realities

Division of Medical Assistance
February 24, 2010

History

- In 1996-1998, the conversation about waivers was happening in North Carolina
- Our dear friend, Richard Clark and myself were traveling around the State presenting on managed care for people with developmental disabilities and how self direction could be used within managed care
 - How the CAP-MR waiver could operate in a managed care environment
- Fast forward 12 years and....history starts to repeat itself

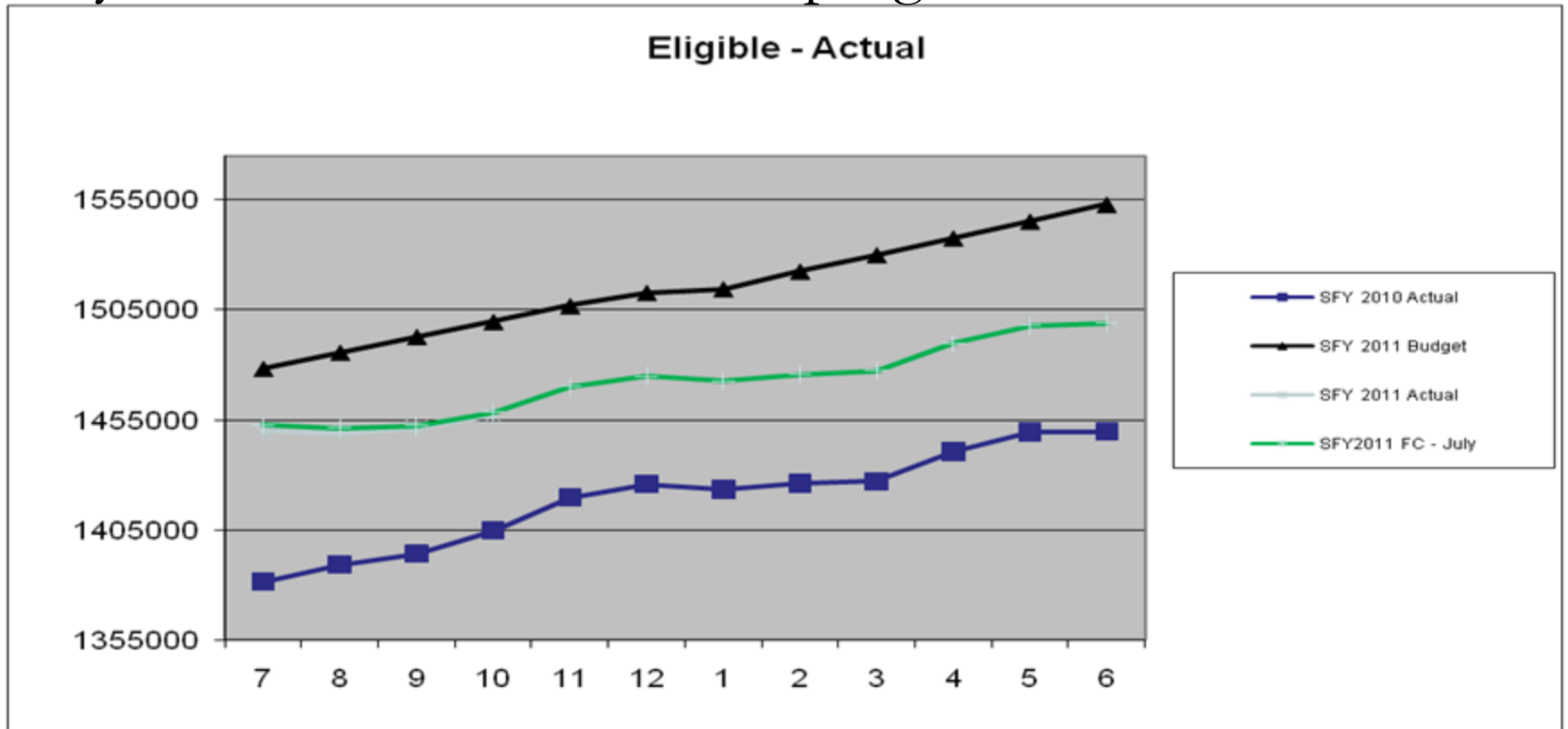
MEDICAID - YESTERDAY



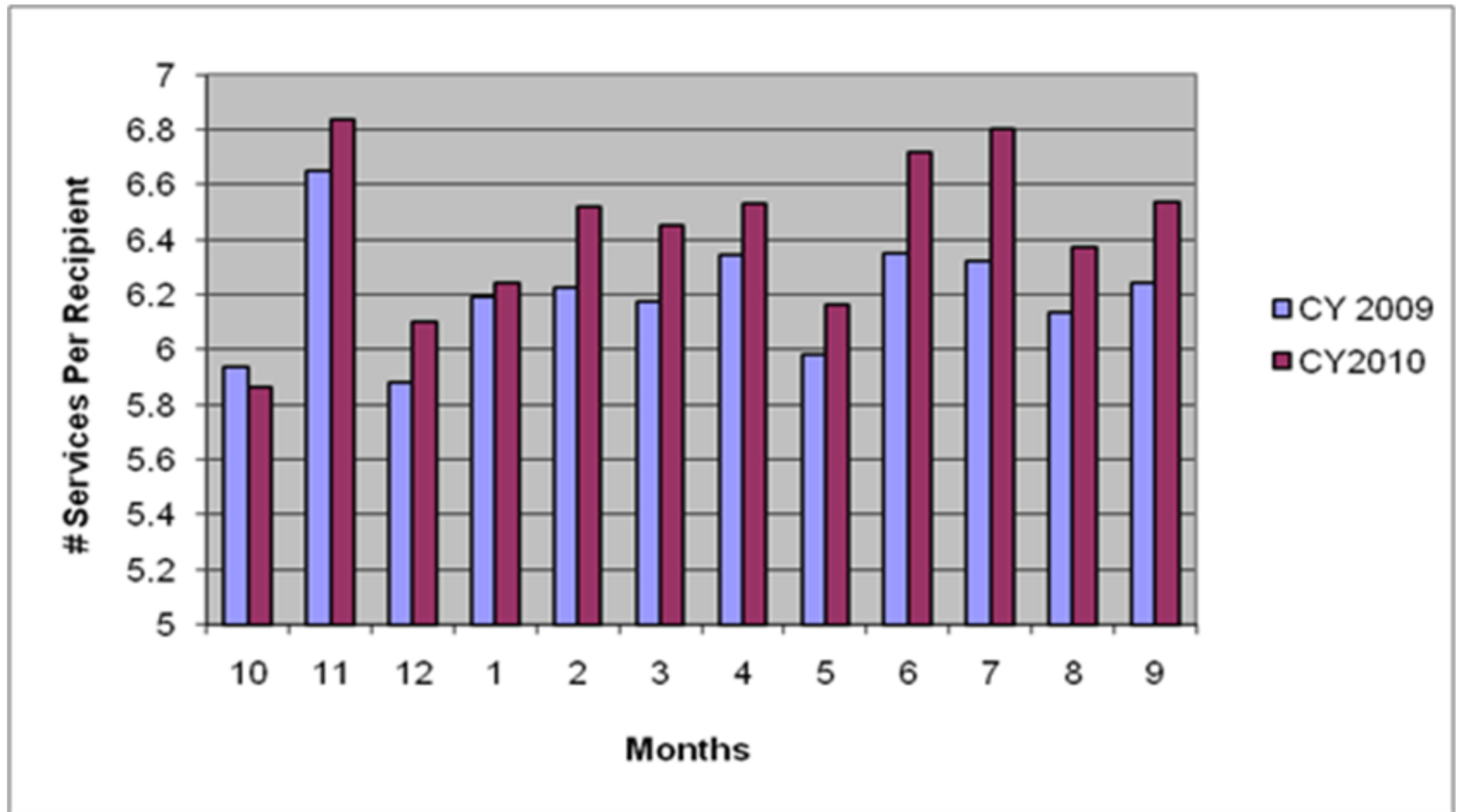
- Enrollment growth highest in 15 years
- Consumption increased by over 4%
- Policy changes to implement budget requirements

MEDICAID TODAY

- Key Medicaid Factors - \$10B program



More Services being used per recipient



MEDICAID OVERALL BUDGET

TOTAL EXPENDITURES IN SFY 2011 PROJECTED TO BE \$9,738,000,000

FOUNDATION SERVICES

- Prescribed Drugs
- Case Management
- Family Planning
- Health Department
- Dental
- Physician Services
- Transportation

SHORT TERM MEDICAL

- Inpatient Hospital
- Outpatient Hospital
- Emergency Service
- Lab & Xray
- Podiatry
- Chiropractic
- Ambulatory Surgery
- DME & Home Health
- Optical
- Hearing Aids
- Hospice

LONG TERM AND RESIDENTIAL

- Adult Care Homes
- Nursing Homes
- Personal Care Services
- CAP Disabled
- CAP Children

BEHAVIORAL HEALTH

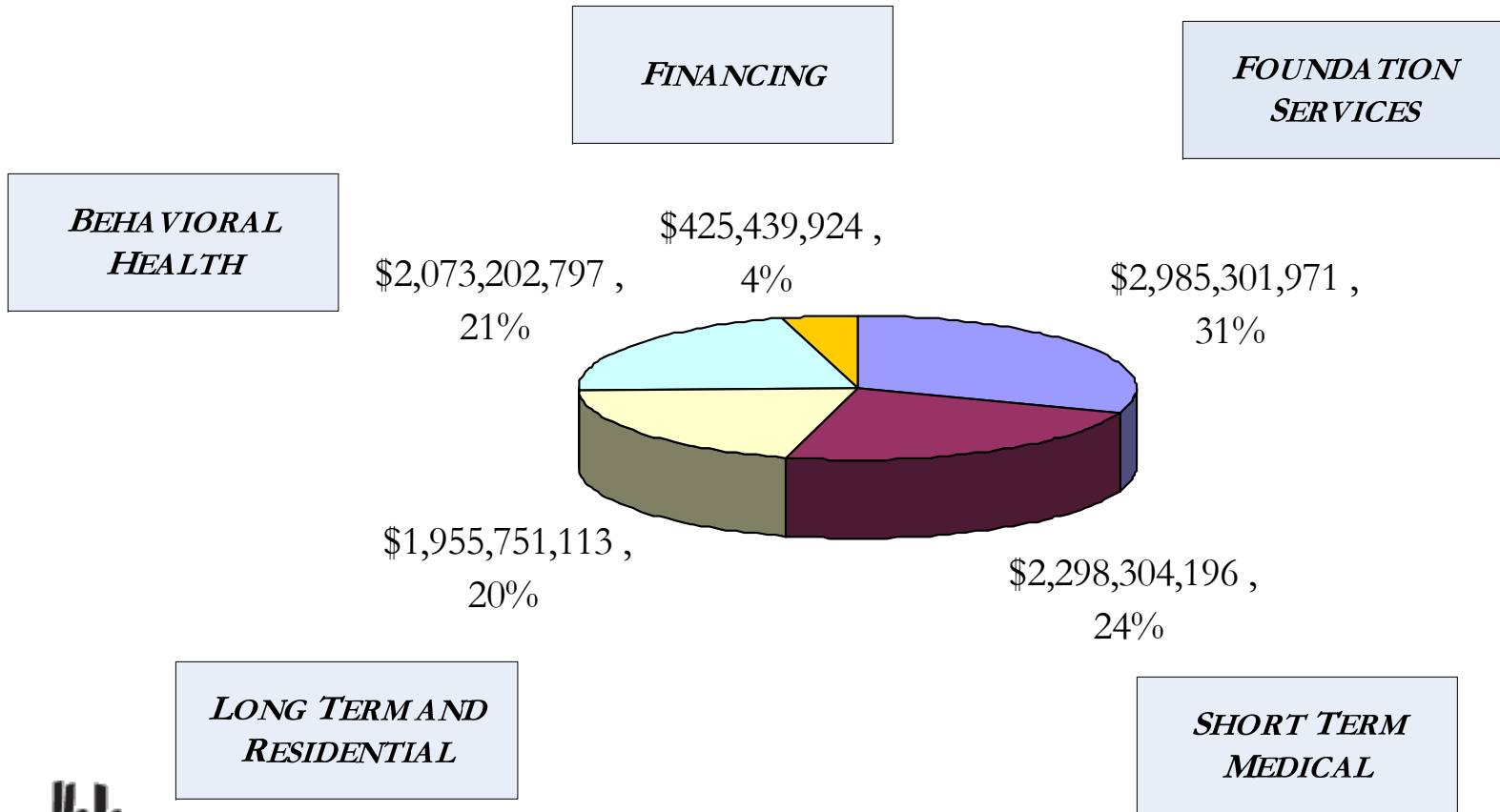
- ICF MR
- CAP MR/DA
- Inpatient MH Hospital
- Outpatient MH Hospital
- High Risk Intervention
- Practitioners NonPhys
- Mental Health Clinics

FINANCING

- Part B Premiums
- Part D Premiums
- Part A Patient Portion
- Group Health Premiums



DISTRIBUTION OF MEDICAID EXPENDITURES



BEHAVIORAL HEALTH

<i>BEHAVIORAL HEALTH</i>	PRACTITIONER NONPHYS	836,434,838
	CAP MR	475,997,457
	ICF MR	471,870,312
	INPATIENT HOSPITAL	107,477,750
	OTHER	181,422,441



But we don't think it is just about the money

- Although many states have considered managed care for long term care and supports as a means of controlling costs, most also are looking at managed care as a way for improving care coordination across typically existing fee for service (ffs) silos.
- In NC we also have taken the road of better care coordination
- Meanwhile, states have organized care for people needing long-term care services within the fee-for-service system. Mixed results

1) Disease management programs that seek to manage and improve care for certain individuals with chronic diseases

- Community Care of NC: 14 networks across the state with over 1.1 million of Medicaid recipients enrolled out of 1.5 million per month
- Started with Women and Children and added Age/Blind and Disabled categories two years ago
- Health Choice will be added next FY

2) Medicaid home and community-based waiver programs where care managers coordinate home and community based services (HCBS) and the programs ensure that, on average, the services cost no more than nursing home services or ICF-MR level of care

- CAP-MR/DD
 - It is a form of management of a program within budgets and limitations
 - Has been silo based as evidence by recent efforts to consolidate case management programs

3) PACE – Program of All Inclusive Care for the Elderly

- 3 operational and 8 more applicants
- Fully capitated

4) PBH 1915 b/c wavier

- additional LMEs/regions to join within the next year

Why do we like the approach?

- Medicaid-funded long-term care services are growing rapidly, and this growth will accelerate in the future.
- Attractive because can achieve budget stability over time through capitation. Not all managed care is capitated.
 - CCNC is Per member, per month for care management and care coordination with other contract performance requirements such as decreased hospital readmits, medication reconciliation, primary care and behavioral health integration,
- By paying a single, fixed fee per enrollee, states limit their financial risk, passing part or all of it on to contractors/vendors.
- Hold one entity accountable for both controlling costs and providing quality care.
- That kind of focused accountability is impossible in the traditional fee-for-service system, in which the state pays different providers for their respective components of care but has no single entity to hold accountable for consumer or system outcomes.

NC is Committed to a public approach to managed care in mh/dd/sa

- Different per member per month based upon categories of eligibles and type of historical utilization
 - There is differences between periodic care and long term care. Long term care proves to be more predictable
- Savings go back into the program and services

Health Homes

- NC is moving forward with Health Homes – an option allowed with the Affordable Care Act
 - Management of chronic conditions, including behavioral health
- CCNC (Community Care of NC) will be NC's Health Home Model
- Much work has been done to interface the data sharing and to clarify the roles/responsibilities of LMEs and CCNC
- Led by value....Driven by outcomes that result in better care and quality

MODEL

CASE MANAGEMENT SERVICES

DMA

- Finance
- Clinical Oversight
- Rate Setting
- Clinical Policy

**MEDICAL HOME
PCP & OBGYN**

Every Medicaid recipient will have a medical home.

FFS

NC CCN Inc.

- Practice Coordination
- Clinical Policy
- Quality Assurance
- Outcomes Metrics

Local PH Depts.

- High Risk OB
- Quality Assurance
- Outcome Metrics
- CSHN
- EI

At Risk CM

- Data Transfer
- Clinical Coordination
- Quality Metrics

CAP/C CM

- Data Transfer
- Clinical Coordination
- Quality Metrics

CAP/DA CM

- Data Transfer
- Clinical Coordination
- Quality Metrics

HIV CM

- Data Transfer
- Clinical Coordination
- Quality Metrics

Local CCNC Networks – health homes

- Health Check
- Case Management
- Care Management
- Data Transfer & Mgmt
- Quality Assurance
- Outcome Metrics
- 1st Level Program Integrity

LMEs

- STR
- Endorsements
- Care Coordination
- Monitoring
- Quality Assurance
- Outcome Metrics
- Program Integrity

CAP MRDD
Including CM

CABHA
Includes CM

DD CM

Case rate or PMPM

PMPM

CCNC pays PMPM

CCNC Pays PMPM

PMPM

No DMA \$\$

Case rate

Case rate

Case rate

Managed Care Capitated Rate

So, what is the Medicaid vision

- Value in Health Care
- Bringing learning to practice
- Full application of information technology
- Determining the value proposition for a particular intervention
- The right care, To the right patient, At the right time, For the right price
- Evidence based practice, driven by outcomes
- Supporting decisions and operations
- Begins with understanding an its safety, effectiveness, and cost in different populations and circumstances, relative to alternatives and its potential as a source of high-value innovation.

Using the power of the Medicaid program to improve the health care of North Carolina's people