North Carolina Coalition on Aging Legislative Priority:

Preserving Medicaid Benefits and Eligibility for 1.8 Million Beneficiaries

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June 2015

Medicaid is a health insurance program jointly-financed by the state and federal government but the state administers the program. Currently the federal government pays for 2/3 of the cost and the state is responsible for 1/3 of the cost in North Carolina. Medicaid represents the second largest expenditure in the state budget behind Education, composing 17.5% ("NC House," 2015). The North Carolina General Assembly is debating Medicaid reform, but the House of Representatives and the Senate have reached an impasse regarding the structure of the program. Reform involves change from the current fee-for service structure where reimbursement to doctors and hospitals is based on the number of office visits and procedures for a beneficiary. The North Carolina General Assembly (NCGA) favors reimbursement based on capitation to provider-led organizations or insurance companies that are responsible for coordinating all medical services for Medicaid beneficiaries. These companies or groups will be penalized for exceeding the funding or given financial incentives for positive health outcomes for its patients while staying within the budget (Bonner, 2015).

Medicaid provides a safety net to the most vulnerable individuals. According to White and Dennis (2015) of the North Carolina Academy of Family Physicians, nearly 65% of Medicaid beneficiaries are children from low-income families, 2% are low-income pregnant women (but then coverage stops after the birth). Approximately 15% of beneficiaries are blind or disabled and about 7% are elderly (over age 65). It is essential for the General Assembly to pass Medicaid Reform that maintains benefits for beneficiaries while controlling Medicaid's costs especially since Medicaid pays for long term services and supports (LTSS); the number of Medicaid beneficiaries has risen in recent decades and states throughout the U.S. are struggling with decreased revenues since the 2008 Economic Recession and the slow recovery. Based on 1999-2000 statistics from the NC Division of Medical Assistance (DMA), there were over 1.22 million

beneficiaries and in 2009 it had risen to over 1.81 million beneficiaries. The main reason for this increase was the decline in personal income due to economic downturns and an increase in the state's population. Between 1999 through 2009, the state's population rose from 7.949 million to 9.435 million (as cited in Cansler, 2013). Another factor contributing to Medicaid's cost is that North Carolina's population is aging. The North Carolina's Division of Aging and Adult Services finds that since 2011 individuals over age 65 comprise 13.3% of the population but that proportion will increase to 19.6% by 2031. By 2025, 86 of North Carolina's 100 counties will have a higher proportion of people over age 60 than people under age 18. The significance of these demographics is the impact of the aged (over age 65) population on Medicaid's budget for LTSS, which includes assistance with Activities of Daily Living (ADLs) (as cited in Cansler, 2013). ADLs are defined as personal care tasks such as bathing, eating, dressing, and using the toilet. Although individuals over age 65 qualify for Medicare, Part A only offers benefits for a limited number of days in a skilled nursing facility (SNF) or in the home following an in-patient hospital stay for rehabilitative purposes and does not offer coverage if the individual's needs are only for personal care (Centers for Medicare and Medicaid Services, n.d.). Therefore, LTSS will continue to be a major component of Medicaid's budget with more aged beneficiaries in the next several decades.

In the NCGA Senate's version for Medicaid Reform, senators claim that commercial managed care organizations (MCOs) will be able to give the Medicaid budget "predictability" because the state will grant a set amount of funding annually to manage the care for a specific number of beneficiaries. The MCOs will be required to stay within that budget. According to Bob Atlas, a consultant hired by the North Carolina Department of Health and Human Services (DHHS), the savings to the state for MCOs may be minimal. MCOs are currently required under

the Affordable Care Act (ACA) of 2010 to contribute to federally- distributed subsidies to offer means-tested financial assistance to aid people when purchasing a health insurance policy, so MCOs ask the state to pay them an additional 2.5% to partially cover this expense in their contracts. Moreover, according to Hugh Tilson, Vice President of the North Carolina Hospital Association, budget predictability in Medicaid under the management of MCOs may remain unachievable because of fluctuations in the number of enrollees and the share of the cost the federal government will pay ("Medicaid Plan," 2014). Of greater concern is that Medicaid beneficiaries may have diminished access to healthcare because MCOs will pay healthcare providers a set amount every month with no financial incentives for delivering quality care. Therefore, the providers may refuse to give services to Medicaid patients altogether ("How do you solve a problem like Medicaid," 2014).

On June 23, 2015 the NC Senate released its budget proposal and its components are: 1. Eliminate the state's contract with Community Care of North Carolina (CCNC) to manage care for Medicaid beneficiaries. 2. Disperse networks such as Northern Piedmont Community Care. 3. Utilize MCOS or Provider-led Entities (PLEs) to coordinate care for all beneficiaries, which is why Senator Ralph Hise (R-Spruce Pine) states there is no need for CCNC because these companies will manage patients' care so that they avoid paying for costly care and maintain a profit. All profits will be shared among the managed care companies and its shareholders since they assume total financial risk for its beneficiaries ("Uncertainty hangs over providers," 2015). Most significant is that Medicaid will be under the administration authority of an 8-member Health Benefits Authority Board appointed by the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Secretary of Health and Human

Services. The Health Benefits Authority will be a separate entity from the Department of Health and Human Services (DHHS) (Zachary, 2015).

On June 23, 2015 the NC House of Representatives passed HB-372: 2015 Medicaid Modernization, which calls for healthcare providers to form "provider-led entities" (PLEs) across the state. These entities will assume full financial risk after being paid a set rate for case management and administration responsibilities for a minimum of 30,0000 beneficiaries. Beneficiaries can select or be assigned to a PLE and a primary care physician to manage their healthcare with the goal of decreasing preventable hospitalizations by promoting preventative care. DHHS maintains oversight over the program which will complete its transition from a fee-for-service program to the PLE-based structure over the course of 5 years. During the transition period, DHHS will also need to attain a federal waiver from the Center for Medicare and Medicaid Services (CMS) so that the state can implement HB-372. Moreover, a committee of experts in healthcare will be established in an advisory role to DHHS to develop the federal waiver application and to implement performance measures ("NC House," 2015). These provider-led entities will be given financial incentives for meeting the goals of quality health care delivery without exceeding the budget or penalized for failing to meet the benchmarks for performance and quality care. The House plan will affect 90% of all Medicaid beneficiaries. The 10% who will remain unaffected are dually eligible for Medicare and Medicaid, so they are the responsibility of the state and federal government (Hoban, 2015). Medicare is an entitlement program for individuals over age 65, but younger adults between age 18 and 64 qualify if they have been determined to be incapable of returning to the workforce and have received Social Security Disability benefits for the past 2 years, or diagnosed with End Stage Renal Disease, or kidney failure (My Medicare Matters: National Council on Aging, n.d.).

Thus, the House and Senate bills on Medicaid reform are similar in that they will utilize PLEs to coordinate all health services for beneficiaries but differ in all other aspects. For example, while the Senate will utilize PLEs to coordinate patient care, it also utilizes MCOs to perform this task. The Medicaid reform bill from the Senate will apply to all beneficiaries since there are no exclusions for dual eligible beneficiaries like the House bill. In addition, the Senate bill entirely excludes any involvement from the state government. In contrast, the House does maintain oversight from the DHHS and says nothing regarding changes to the state's contract with CCNC or disbanding any regional networks. Under the House Bill, the PLEs can continue to utilize CCNC's expertise during the Medicaid transition (Zachary, 2015).

The state currently spends over $13 billion on Medicaid and Governor McCrory supports Medicaid reform that creates Comprehensive Care Entities (CCEs) throughout the state that will function to coordinate health care services for Medicaid beneficiaries. The CCEs will be contracted to perform a Functional Needs Assessment that will serve as the framework for collaboration among networks of healthcare providers to improve health outcomes. In addition, there will be a free-market element to providing health services to Medicaid recipients because CCEs will compete to sign contracts with the state government (Office of the Governor, n.d.). The CCEs will serve as the "entry point" to the entire healthcare services system that will coordinate seamlessly to provide services in mental health, substance abuse, and physical health. Reimbursement will also be a streamlined process because all CCEs will utilize the Medicaid Management Information System (MMIS) as its financial vendor which will decrease administrative costs. To prevent "cherry picking" (being selective about which Medicaid recipients it will cover in order to save money), the CCEs need to rely on Per Member per Month (PMPM) payment with "risk stratification" that grants a higher level of funding to cover patients

with high medical needs. Moreover, CCEs are required to cover beneficiaries in both urban and rural areas of the state without changes in Medicaid eligibility. Incremental implementation of this plan for reform was scheduled to begin July 2015 ("Partnership for a healthy North Carolina," 2013). In sum, the Governor's approach to Medicaid reform is most similar to the House's Bill because of its focus on networks of healthcare providers receiving capitation to coordinate all medical services for beneficiaries throughout the state.

Mark Benton, Director of CCNC, does not support the Senate's plan to utilize private for-profit MCOs because any savings attained from coordinating services for Medicaid beneficiaries are added to the company's profits and among its stakeholders. In contrast, savings attained from CCNC's regional networks automatically are returned to the state and taxpayers ("Uncertainty hangs over providers," 2015). The Senate plans to eliminate the state's contract with CCNC, although the organization has been determined to save Medicaid dollars based on independent review. CCNC's approach to saving money in addition to improving health outcomes is based on being comprised of 14 regionally-based, non-profit healthcare provider-led networks that include physicians, clinicians, behavioral health specialists, care managers, and pharmacists. These provider-led networks utilize Health Information Technology (IT) to facilitate collaboration among multiple providers to facilitate making decisions regarding healthcare. The significance of these regionally-based networks is that they serve all 100 North Carolina counties and are focused on developing community-based solutions to its population's health concerns (Community Care of North Carolina, n.d.). Thus, non-profit management of health care services is needed to cover all beneficiaries in Medicaid Reform so the state's taxpayers will benefit from effective case management.

It was discussed on June 26, 2015 at a meeting among the North Carolina Coalition on Aging members of the concern that the Senate approach to Medicaid reform has the inadvertent consequence of eliminating the Program of All-Inclusive Care of the Elderly (PACE) in North Carolina. PACE is a federal program that is optional for states to offer it under Medicaid. Its goal is to prevent premature admission to a nursing home if the participant is able to live safely in his or her community with the assistance of services offered from the community and an interdisciplinary team that consists of geriatrics-trained primary-care physicians, nurses, social workers, dieticians, in-home aids to assist with activities of daily living (ADLs), pharmacists, and Occupational/Physical Therapists from the PACE Center serving the participant's area. The interdisciplinary team develops and implements a personalized plan for the participant of services they can offer either directly or able to contract with another party within the community. Dental care, adult day health center services, and medically necessary transportation are also included. Participants need to be at least 55-years-old and certified by their state as qualifying for nursing home care ("Program of all-inclusive care of the elderly," n.d.). The program is funded by Medicare, Medicaid, and private pay. The amount of payment charged to participants depends on income level. If the participant qualifies for Medicaid, LTSS and prescription drug coverage are offered without any premiums or co-payments if authorized by the interdisciplinary team. Individuals who do not qualify for Medicaid are charged a monthly premium for LTSS and Medicare, Part D for Prescription Drug coverage. PACE is highly effective in saving money for the state because only 7% of all PACE participants in the U.S. live in a nursing home ("PACE," n.d.). Moreover, independent evaluations have found that PACE's model decreases hospitalizations and improves the health outcomes of participants (as cited in "Program of all inclusive care," n.d.). However, the Senate plan on Medicaid reform eliminates

the state's role in administering Medicaid, so the effect will be that PACE will no longer be able to be offered in North Carolina's Medicaid program and LTSS is a major contributing factor to budget unpredictability in Medicaid.

To comprehend how much of a factor LTSS services are to budget unpredictability, let us consider the fact that PACE offers Adult Day Health Care Services to offer respite to family caregivers and that nationally only 7% of all PACE participants require the 24-hour monitoring offered by nursing homes. According to a Genworth's (2015) survey of Adult Day Health Centers in North Carolina, the minimum daily rate is $21 and the maximum is $125. The median annual rate is $13,260 with 1% compound inflation, meaning the following year's cost increase will generally be 1% greater than the preceding year. In contrast, the daily rate of a semi-private room in a nursing home (double-occupancy) is $102 at a minimum and a maximum of $316. The median annual rate is $75,190 with compound inflation of 3% annually. Therefore, delaying or preventing permanent residence in a nursing home is beneficial to the state because it saves on Medicaid's budget for LTSS.

What is needed in North Carolina to facilitate more budget predictability in Medicaid is higher utilization of interdisciplinary networks of providers that are non-profit and will cover all regions of the state. Therefore the networks manage the care, but can remain under the state's oversight. These networks will assess a beneficiary's needs, manage the authorized services, and then utilize health IT to measure health status then make changes to the personalized plan of care as needed. Health IT has been utilized by Home and Community-Based Services under Medicaid and has been effective in improving quality of care for beneficiaries while decreasing costs to the healthcare system because electronic information is shared among health care providers and hospitals on procedures conducted, diagnostic tests results, and information about all prescription

drugs (Mandl, McMullen, Yusauskas, 2014). To be of practical use by healthcare providers, Health IT requires a common language and expectations so that the information can be communicated and easily understood using interoperable computer systems and software. Beginning in March 2014, the Centers for Medicare and Medicaid Services (CMS) awarded grants for Demonstration and Planning Projects intended to measure the performance of health IT as a component of a state's Medicaid community-based LTSS for up to $42 million in 3 years. Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, and Minnesota have participated in CMS' Testing Experience and Functional Tools (TEFT) program (Angeles, 2014).

Although health IT is currently in the demonstration and planning phases, Medicaid must remain under the state's oversight in order for the state to receive any federal funding for developing and implementing a health IT system. Placing Medicaid under the oversight of a new Health Benefits Authority makes the state ineligible to receive additional federal funding since it is a separate entity from DHHS. Under Provision 2701 of the Affordable Care Act (ACA), the Secretary of the state's DHHS has broad authority to identify initial core set of health care quality measures for adults eligible for Medicaid and then establish a Quality Measurement Program. Afterward, the DHHS Secretary will update the initial core set of adult health quality measures based on feedback regarding performance from healthcare providers. Based on the feedback, CMS develops national standards for health IT across all state Medicaid programs (Centers for Medicare and Medicaid Services and Center for Medicaid and CHIP Services, 2013).

Senator Hise claims that establishing a separate entity from DHHS that is not subject to The State Personnel Act allows for the members of the Health Benefits Authority greater flexibility to

make adjustments to Medicaid to prevent budget overruns in the $14 billion budget, in contrast to waiting until Medicaid is already exceeding its budget before making changes (Henkel, 2015). Although Senator Hise's argument sounds plausible, measures that would genuinely decrease the probability of Medicaid budget overruns while maintaining eligibility and benefits for current and future beneficiaries must include greater investment into home-and community-based services for aged/or disabled adults in order to adequately fund the care management needs so nursing home care can be prevented or delayed at a minimum. Examples of what Berry and Woody (2013) view as indicators of institutional/facility-based care in North Carolina are that in Fiscal Year 2011-2012, the DMA paid $1,068,105,297 for nursing home care for 38,428 people ($27,795 per person on average). In contrast, home/community based services had much less resources. Home-delivered meal services were provided for 18,689 people daily at a cost of $14,226,679 ($761 per person). In-home aids provided care for 7,559 beneficiaries on varying days for $20,076,820 ($2,642 per person).

Greater investment in home and community-based services requires a distribution of state funds to local agencies from North Carolina's Division of Aging and Adult Services and the Division of Social Services. According to a Health Services Research Study (2012, as cited in Berry & Woody, 2013), adequately funded community-based service networks are effective in decreasing the proportion of nursing home residents in the state. The key to these efforts lies in the framework of the state's 16 Area Agencies on Aging (AAA) that receive federal funding from the Older Americans Act (OAA) of 1965 to implement and facilitate supportive services to meet the needs of adults over age 60 (North Carolina Division of Aging and Adult Services, 2015). The AAAs can collaborate with CCNC to improve the coordination of beneficiary care needs for both medical care and community-based services. Greater investment in these services

will result in more support for family caregivers so there is less need for paid assistance in caregiving or monitoring the beneficiary (Berry and Woody, 2013). Thus, greater investment in community and home-based services and maintaining PACE in North Carolina will remove the bias toward facility care in Medicaid, and the quality of life for North Carolina residents will improve as a consequence of more family caregiver supportive services in addition to the better health status facilitated by health IT utilized by healthcare professionals.