



Managed Care Reform and Prospects for Medicaid Expansion in North Carolina

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Overview

North Carolina is poised to undertake significant reforms to its \$12.4 billion Medicaid program that serves two million of its residents, even as the political landscape has shifted in Raleigh and in Washington, D.C.¹ Divided government at the state level has jump-started reform in North Carolina as the newly elected Democratic Governor has invigorated the Medicaid managed care reform begun by Republicans. The lingering question is whether the state will also expand its Medicaid program. Using the key issues of rural health disparities, value-based payment arrangements, and behavioral health integration, which managed care reform aims to address, we consider how Medicaid expansion could impact the realization of managed care reform goals.

KEY TAKEAWAYS

In North Carolina, Medicaid expansion in combination with managed care reform would:

- Increase the number of beneficiaries in rural areas, supporting sustainable membership levels for robust competition among managed care plans, but could also strain existing provider networks and lead to patients seeking care in high-cost settings.
- Help providers achieve the scale required to participate and succeed in population-based payment models, but in the short term could make providers reluctant to enter into contracts that hold them accountable for managing the care of new and unfamiliar patients.
- Address the physical and behavioral health needs of the uninsured, helping to improve health and avoid future spending on comorbid conditions, but require short-term investment and could exacerbate problems with the state's behavioral health system.

Eighteen other states in addition to North Carolina have so far elected not to expand Medicaid, although many have participated in the trend towards managed care. Like North Carolina, the tradeoffs they face when weighing the decision to expand have likely shifted in the new political landscape. Examining North Carolina's experience may provide insights into whether and how expansion could help these states achieve their broader reform goals.

The State of Medicaid Reform in North Carolina

At present, the North Carolina Medicaid program remains largely fee-for-service, but there is broad agreement from policymakers and health system stakeholders that it can be reformed to better reward high-quality care and improve the value of care purchased by the state. To that end, in September 2015, a Republican majority legislature passed a bill mandating that the state's Medicaid program be reformed to a managed care model, and a Section 1115 waiver written for this purpose was submitted to the Centers for Medicare and Medicaid Services by the then-Republican Governor in June 2016.^{2,3} The administration of a newly elected Democratic Governor has undertaken a public comment period and proposed a program design for managed care that builds on the initial waiver request.⁴ Released in August 2017, the white paper outlining the program design makes clear that the new administration is fully committed to the successful implementation of managed care, regardless of whether the governor's top health policy priority—Medicaid expansion—wins approval from the Republican-majority legislature in Raleigh.

Prospects for Medicaid Expansion

With Congress unable to pass federal health reform this summer, Medicaid expansion under the provisions of the Affordable Care Act remains a possibility for the state. The new Governor campaigned for Medicaid expansion, and even attempted an administrative expansion during the brief overlap between his assuming office on January 6, 2017 and the conclusion of the Obama Administration. This effort was blocked by a lawsuit from leaders from the state legislature, which passed a bill in 2013 prohibiting any administrative attempt to expand Medicaid.⁵ Even if it had succeeded, the Republican controlled General Assembly would need to appropriate the state costs of Medicaid expansion. However, during the 2017 legislative session a group of House Republican leaders in health policy sponsored a bill that would create Carolina Cares, a new health insurance program that would extend coverage to approximately 375,000 low-income childless adults.^{6,7} The program would be administered by managed care plans and funded by a combination of federal contributions, hospital (and potentially other health care-related) assessments, and premium contributions from program participants. The bill includes a strict requirement that no funding come from state appropriations. The legislation also includes personal responsibility program requirements for employment activities, premium contributions and co-payments, and participation in preventive care and wellness activities that may have precluded approval by the previous federal administration, but could be reviewed more favorably by the new CMS administrators, who are signaling a more open and expansive approach to waiver

review that allows states greater flexibility. The NC House bill failed to pass during this year's legislative session but could be considered again, especially now that there is greater clarity on the prospect of federal health reform.

Medicaid Expansion's Impact on Managed Care Reform Goals

Much has been written about both managed care reform and Medicaid expansion, with analysts forecasting the potential impact of alternative proposals and advocates crafting arguments both for and against, including some made by the authors of this brief.⁸ However, because managed care reform and Medicaid expansion proposals have been developed on different timelines and would be approved and implemented through different legislative and administrative processes, they have typically been analyzed independently. **This brief considers them in concert and explores the ways in which Medicaid expansion would impact three critical health policy issues that the managed care reform plan aims to address: rural health disparities, value-based payment arrangements, and behavioral health integration.**

Rural Health Disparities: Competition and Consumer Choice

Although North Carolina is the ninth most populous state in the nation, it has large rural areas (80 of 100 counties) that are sparsely populated.⁹ Health disparities and the unique challenges facing rural areas in the state are well-documented,¹⁰ and North Carolina's initial waiver submission acknowledged them directly:

One in five North Carolinians, including over half a million Medicaid beneficiaries, live in a rural county. Rural populations are more likely to live in poverty, and have co-occurring chronic diseases and lower life expectancy than individuals living in non-rural areas. (2016 Waiver 2.3.3.6)

A key strategy for managed care reform is to implement a model in which multiple risk-based managed care plans compete for Medicaid beneficiaries who get to choose which plan is best for them. North Carolina will award prepaid health plan (PHP) managed care contracts to both commercial Medicaid managed care plans (CPs) and provider-led entities (PLEs), defined as plans owned and operated by providers and serving beneficiaries in their local region.¹¹ The revised program design proposes six regions that will define the contract areas for participating plans.¹² Three commercial plans would be required to offer coverage in all six regions, while provider-led entities would receive contracts to offer coverage in one or more contiguous regions.¹³ As explained in the initial waiver

submission, the state anticipates that “the presence of PLE’s competing and operating side-by-side with CPs will achieve key goals of consumer choice, provider choice, provider-led innovation and cost containment.”¹⁴

However, the number of plans that will be awarded contracts per region will be necessarily dependent on the number of eligible beneficiaries in the region. A Joint Legislative Oversight Committee (JLOC) report delivered in March 2016, shortly before the initial waiver submission, proposed a minimum of 50,000 beneficiaries per regional PLE, and 33,000 to 40,000 beneficiaries per region for each statewide commercial plan.¹⁵ Regardless of the levels at which the minimum thresholds are ultimately set, the limited number of beneficiaries located in rural regions means that they will not be able to support as many PLE options as regions with higher populations. For example, the region covering counties in the rural western portion of the state includes approximately 165,000 beneficiaries.¹⁶ In order to satisfy the minimum beneficiaries per region requirements proposed in the JLOC report, it could only support a maximum of one PLE in addition to the three commercial plans.

Furthermore, the state has no mechanism for guaranteeing that provider-led entities will form and choose to compete within contracting regions. Alabama offers a cautionary example.¹⁷ Although not an expansion state, Alabama received approval via a Section 1115 waiver to implement a Medicaid managed care model that would feature “Regional Care Organizations (RCO),” similar to North Carolina’s proposed provider-led entities.¹⁸ Alabama defined five contracting regions and developed plans to have at least two RCOs operating in each region.¹⁹ However, due to concerns about adequate funding, several entities that had planned to operate RCOs withdrew from participation, and implementation of Alabama’s managed care program was delayed.^{20,21} In July 2017, the state decided to abandon its RCO model entirely and draft a new reform plan, citing uncertainty over federal funding for Medicaid and new possibilities for waiver approval under the Trump Administration.²²

Expanding Medicaid in North Carolina would boost the number of beneficiaries in rural regions by offering Medicaid coverage to individuals who are currently uninsured. Many of the rural counties in the proposed managed care contracting regions with the fewest number of Medicaid beneficiaries also have the highest proportion of uninsured residents who might stand to gain coverage under Medicaid expansion.²³ A greater number of Medicaid beneficiaries within a predominantly rural contracting region could entice PLEs to form and enter the market, ensure sustainable member levels for robust competition among plans, and provide revenue and resources that attract providers and investments in health infrastructure.

However, rural regions are already struggling with provider shortages, and adding more patients could further strain the existing provider networks in rural areas in the short term.²⁴ This could be especially problematic under the Carolina Cares expansion plan and its requirements for members to participate in preventive care and wellness activities like routine physicals and screenings. In many of the rural counties in North Carolina, newly insured members may struggle with timely access to providers who can deliver services that satisfy the wellness activities, especially in the short run, as it would take some time for new providers or provider models to develop in response to the demand from the newly insured population.

Additionally, without adequate health provider infrastructure, newly insured patients may resort to seeking care in unnecessarily high-cost settings. In Oregon, researchers have found that newly insured Medicaid expansion beneficiaries often continue to seek care in Emergency Departments (ED).²⁵ Although not all states have experienced such an increase in ED visits in response to expansion, the potential for this pattern of utilization could be a concern for prospective provider-led entities that are considering forming in rural regions but must weigh the risk posed by a large previously uninsured population with unknown care needs that could incur high costs in the short term by seeking care in the most costly settings.²⁶

KEY TAKEAWAY

Medicaid expansion would increase the number of beneficiaries in rural areas, supporting sustainable membership levels for robust competition among managed care plans, but could also strain existing provider networks and lead to patients seeking care in high cost settings.

Support for Provider Transformation into Value-Based Payment Environment

A clear policy priority driving the shift to a managed care model is the desire to reform the Medicaid program so that “payments will reward value and outcomes rather than volume.”²⁷ North Carolina hopes to achieve this goal not only by contracting with risk-bearing managed care plans, but also by changing the way providers are paid by shifting them into value-based payment arrangements:

DHHS plans to encourage accelerated adoption of Value-Based Payment arrangements between PHPs and providers in Medicaid that tie to quality strategy

priorities. The goal of pursuing VBP is to ensure that payments to providers are increasingly focused on population health, appropriateness of care, and other measures of value, rather than on a fee-for-service basis. PHPs will be encouraged to develop and lead innovative strategies to increase the use of VBP arrangements over time... (Proposed Program Design White Paper VI.(A)(2))

However, the revised program design also acknowledges that North Carolina is “behind the curve on tying payments to value” and that the 65,000 providers currently enrolled in Medicaid vary in their readiness to enter into value-based payment arrangements.²⁸ Both the initial waiver and revised program design emphasize the importance of supporting providers through the transition to managed care and helping build their capacity for participating in value-based payment arrangements.

Population-based payments such as per-member per-month payments or global budgets provided either to individual providers, practices, or integrated health systems are one category of value-based payments that could be implemented between PHPs and providers in the new managed care system.²⁹ Given that many of the state’s primary care providers have experience in the state’s existing primary care case management program and that some large integrated health systems already operate accountable care organizations (ACOs), many providers already have experience with population-based payments. However, in order to participate in such population-based payment arrangements, providers need a large enough panel of Medicaid patients to achieve the scale required to both manage the risk of accountability for patient outcomes and to invest in the infrastructure required to successfully manage care. For example, In Massachusetts’ Primary Care Reform Initiative model, providers participate in a shared savings model in which they may also commit to shared risk, but only if their attributed population is large enough.³⁰ Expanding Medicaid would offer more patients for practices to bolster their panels to achieve the scale required to participate and succeed in population-based payments.

Yet as previously discussed, there are many health provider shortage areas (HPSAs) spread across the state, especially for primary care. In the short-term, Medicaid expansion could exacerbate the shortages and providers could be faced with attributed patients that they may not have the resources to manage adequately in the face of upside/downside risk. For example, the revised program design proposes that Medicaid beneficiaries will select both a PHP and a primary care provider upon enrollment.³¹ Beneficiaries who do not select a primary care provider will be assigned to one through an auto-assignment process that will favor advanced medical homes (AMH). Advanced medical homes are primary care practices that participate in a tiered system in which practices in higher

tiers take on additional care management responsibilities and become eligible for performance-based payments. If Medicaid expansion were implemented, practices may hesitate at first to participate in a higher AMH tier and other provider types may be reticent to enter into value-based contracts that make them responsible for patients they do not know and may not have the resources to care for adequately.

Once the expansion population is enrolled in Medicaid and providers have sufficient medical history and claims experience to review, they will likely be better prepared to enter into alternative payment models, but in the short term, expansion combined with managed care reform could slow the transition to value-based payments.

KEY TAKEAWAY

Medicaid expansion would help providers achieve the scale required to participate and succeed in population-based payment models, but in the short term providers may be reluctant to enter into contracts that hold them accountable for managing the care of new and unfamiliar patients.

Behavioral Health Integration

Behavioral health services in North Carolina Medicaid are currently coordinated by behavioral health managed care organizations (Local Management Entity-Managed Care Organizations, LME-MCOs) throughout the state under the authority of a Section 1915(b)(c) waiver. Under this model, the state makes capitated payments to LME-MCOs, which coordinate care and pay behavioral health providers for services rendered to Medicaid beneficiaries.

The problems with payment and delivery of behavioral health in North Carolina are myriad and acute. They include long wait times for care and a lack of community treatment options that result in reliance on emergency department visits and inpatient services, a fragmented funding system, and a lack of accountability by the LME-MCOs for health outcomes.^{32,33}

The initial waiver submission clearly acknowledged the importance of behavioral health and called for greater clinical integration of physical and behavioral health care.³⁴ Reflecting the urgency that the new Governor and DHHS Secretary ascribe to the state’s problems with behavioral health, the revised program design white paper includes an accelerated timeline for integration under PHPs and additional details for implementing the transition.³⁵

One reason for the fragmented funding for mental health is that the LME/MCOs receive capitated payments to coordinate and pay for behavioral health services for Medicaid beneficiaries and also receive “single stream” funding that is appropriated by the state each year, in part, to cover mental health and substance use services for the uninsured.³⁶ The LME/MCOs have some discretion over how they spend single stream funding, which has led to concerns about lack of oversight and subsequent decreases in budget allocation.³⁷ Furthermore, changes in the amount of single stream funds allocated from year to year can make it difficult for the LME/MCOs and the providers they pay to make decisions regarding investments in behavioral health infrastructure.³⁸ Medicaid expansion would not eliminate the need for single stream appropriations for uninsured individuals seeking behavioral health services entirely, but could reduce the amount required by reducing the number of uninsured individuals in the state. Furthermore, transferring this funding from the single stream annual appropriation to per-member per-month Medicaid payments made to PHPs would stabilize the funding by tying it to individual members and attach accountability for outcomes to the funds.

In addition, mental health conditions and substance use are frequently comorbid with chronic diseases.³⁹ Medicaid expansion is an opportunity to address the physical health needs of the uninsured, including chronic disease management, and thereby potentially mitigate or prevent behavioral health needs and substance use.

However, the challenges of mental health reform concurrent with Medicaid expansion are similar to those related to rural health and the move to value-based payment—a new and improved system of care that can be imagined downstream cannot be created overnight, and the infusion of hundreds of thousands of expansion beneficiaries into that system could present immediate challenges. A rapid increase in the number of beneficiaries seeking services could further strain the behavioral health system, potentially compounding problems like long waits for care. While expanded delivery of behavioral health care could yield significant cost savings over the long term by reducing the burden of comorbid chronic diseases, it would require increased and sustained investment in behavioral health services in the short term. Lastly, the behavioral health system in North Carolina has undergone constant changes over the last 15 years, and integration with physical health would be implementing another round of significant changes, potentially confusing and imposing an additional burden on providers and patients trying to navigate the system.^{40,41}

KEY TAKEAWAY

Medicaid expansion would address the physical and behavioral health needs of the uninsured, helping to improve health and avoid future spending on comorbid conditions, but would require short-term investment and could exacerbate current problems with the state’s behavioral health system.

Prospects for Bipartisan Reform Efforts

The reform proposals that have been put forth in North Carolina by policymakers, including the initial Section 1115 waiver, revised program design, and Carolina Cares draft legislation demonstrate that both parties are seeking to achieve the same big picture goals—better health for residents and better value for state dollars spent on care. As of the writing of this brief, not enough members of both parties have been able to agree that Medicaid expansion is a way to realize these goals, but the managed care reform set into motion by Republicans and being readied for implementation by the new Democratic administration could provide the window of opportunity for reconsideration.

This brief has identified some of the ways in which Medicaid expansion can help realize the objectives of managed care reform, but also identified some of the challenges that expansion could pose to the new model as it is implemented. The revised program design white paper specifies a more detailed and flexible approach to implementation, with features like a staggered rollout by region, a gradual phase-in of behavioral health integration, and tiered tracks for provider participation in the advanced medical home model. This flexibility could help the system more easily absorb the expansion population and enable policymakers to better capitalize on the opportunities offered by expansion while mitigating some of the short-term challenges.

The 2016 election has shifted the national political landscape, and may have opened new pathways for reform efforts that combine ideas from both parties to achieve mutual goals. North Carolina may prove an important case study in whether and how a divided state government can forge a path to better health and value for care in this new environment.

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