The North Carolina Medicaid program currently constitutes 32% of the state budget and provides insurance coverage to 18% of the state’s population. At the same time, 13% of North Carolinians remain uninsured, and even among the insured, significant health disparities persist across income, geography, education, and race. The Duke University Bass Connections Medicaid Reform project gathered to consider how North Carolina could use its limited Medicaid dollars more effectively to reduce the incidence of poor health, improve access to healthcare, and reduce budgetary pressures on the state’s taxpayers.

We submit the accompanying report to North Carolina’s policymakers, which include the following highlights:

- Federal Medicaid policy is likely to reduce future federal dollars, putting additional budgetary strains on North Carolina’s Medicaid program. Proposals to convert federal Medicaid funding to per capita block grants will translate into a disproportionately large reduction for North Carolina compared to other states because of the state’s recent reductions in per-enrollee spending, the state’s above-average spending trajectory for children and adults, and the projected growth in the state’s elderly population.

- As North Carolina ushers in Medicaid Managed Care (MMC), policymakers should ensure the market exhibits robust choice and competition. Lessons from other states’ experiences reveal that policymakers should:
  (a) develop a reasonable implementation timeline, including preparing for early losses from MCOs
  (b) reduce administrative burdens and assure timely payments to providers, to keep providers participating in Medicaid networks
  (c) endeavor to encourage MCO entry and sustained market participation, to foster MCO competition and ensure sufficient plan choice

- A transition to MMC should incorporate successful elements of the state’s Primary Care Case Management (PCCM) model with Community Care of North Carolina (CCNC): MCOs should rely on regional networks, which enabled local flexibility and allowed providers to tailor care to local communities. Moreover, MCOs should adopt CCNC’s data-driven patient management to navigate chronically ill patients and target interventions, which according to a 2015 audit reduced total spending by 9% and inpatient admissions by 25%.
Recent Medicaid reforms in Indiana, Michigan, and Iowa offer lessons for any reforms that rely on consumer-driven financial incentives, such as monthly premiums, lockout policies, and healthy behavior incentives. These states’ experiences suggest that any behavioral program should be within a simple, streamlined Medicaid design to reduce patient confusion and lower administrative costs to the state.

Because a small percentage of patients account for the majority of Medicaid’s costs, “super-utilizers” should be targeted within a hotspotting program. Hotspotting employs multidisciplinary teams to address patients’ medical needs and environmental factors that exacerbate poor health. Similar models in other states have led to 49% reductions in healthcare costs and a 44% reduction in hospitalizations. Medicaid should expand reimbursement policies to enable hotspotting strategies and should encourage shared savings programs so providers are financially incentivized to do so.

The Medicare and Medicaid dually eligible (duals) population are among the sickest and most expensive beneficiaries. In North Carolina, duals represent 17% of the Medicaid population but require over 30% of state Medicaid spending. North Carolina should continue efforts to reform care delivery and payment to address enrollment complexity and integrate delivery. In addition, hotspotting holds considerable potential to reduce expenditures among Medicaid dual-eligibles and improve health outcomes in rural populations.

Telemedicine provides a low-cost solution to rising healthcare prices, provider shortages in rural counties, and limited access to specialists. North Carolina currently follows a hub-and-spoke telemedicine model, in which provider hubs offer services to patient originating spoke sites, and limits telemedicine reimbursement to live video interactions with originating site location requirements. Policymakers should expand telemedicine coverage to include remote patient monitoring, and should relax originating site requirements.

Graduate Medical Education (GME) training should be updated to reflect and facilitate needed changes in the delivery system. Current GME programs do not focus on utilizing patient data and technology for efficient patient management. GME should develop hotspotting and telemedicine professionals for the future physician workforce.