PRESENTATION:
NC Medicaid Reform
“Improving Quality While Controlling Cost”
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Hey, we're broke!

Medicaid
Roads
Education
Objectives

- General problems facing State Medicaid Programs
- Community Care of NC- our experience and what led us to our current program
- Discussion of ongoing initiatives and results
- A few take home thoughts
“States Struggle with Medicaid budgets”

Policy Tools Utilized by States

- PA, PDL, Supplemental rebates
- Reimbursement cuts
- Eligibility cuts
- Fixed rate contracts - managed care organizations
- Disease Management??
- New-Recipient self purchased plan with fixed $ amount - Fla
Figure 3
Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2004

State Tax Revenue

<table>
<thead>
<tr>
<th>Year</th>
<th>State Tax Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>3.5%</td>
</tr>
<tr>
<td>1998</td>
<td>6.8%</td>
</tr>
<tr>
<td>1999</td>
<td>7.1%</td>
</tr>
<tr>
<td>2000</td>
<td>8.5%</td>
</tr>
<tr>
<td>2001</td>
<td>10.9%</td>
</tr>
<tr>
<td>2002</td>
<td>12.9%</td>
</tr>
<tr>
<td>2003</td>
<td>9.4%</td>
</tr>
<tr>
<td>2004</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

Medical care complexity and state budget complexities are being swallowed by the 'Medicaid' tiger.
The Cost Equation

- Eligibility and benefit - who you cover and for what
- Reimbursement - what you pay
- Utilization - how much services are provided

We just have not figured out how to manage utilization!!!
Figure 7

Medicaid Enrollees and Expenditures by Enrollment Group, 2003

- Enrollees:
  - Total = 52.4 million

- Expenditures:
  - Total = $235 billion

- Elderly: 9%
- Disabled: 16%
- Adults: 27%
- Children: 48%

Expenditure distribution based on CBO data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.

North Carolina Medicaid

- PCCM (Access I) started in 1992
- HMO contracted in 3 metro area 1997
- First (7) community networks (Access II/III) piloted 1998
- Most HMOs did not renew- 2001
- CCNC (Access II/III) became single Medicaid strategy 2002
Current NC Medicaid Facts

- 1.2 million covered (15.2% of population)
- 686,000 children covered
- 45% of all babies born covered
- 30.5% of recipients consume 74.5% resources
- Drug cost now equals hospital cost was increasing at double digit rate yearly
- Inpatient care (hosp, NH, MRC) consumes 40.7%
- Physicians account for only 9-10% of costs!!!
ISSUES:

- No real care coordination system at the local level
- PCPs feel limited in their ability to manage care in the current system
- Local public health departments and area mental health programs are not coordinated into the medical care management process
- Duplication of services at the local level
- State “Silo Funding”
Issues (continued..)

- Only 1/3 of Medicaid budget is women and children. 2/3 disabled and elderly which is less suitable for typical commercial managed care approach
- Large portion of the state’s Medicaid population is in rural counties where there is minimal managed care activity
Silos Within Silos

Division of Social Services

Carolina Access MCR
(Managed Care Representative)
* Gathers & processes local enrollment data
* Interprets Access roles for the state
* Gathers local Medicaid statistics
* Patients & doctors representative

Medicaid Intake
Transportation
Work First/Job Placement
Child Protection Services
Adult Protection Services
Day Care
Child Support
Emergency Assistance
Food Stamps

Division of Public Health

Child Services Coordination
Maternity Care Coordination
Maternal Outreach Program
Health Check
Postpartum Newborn/ Nurse Home Visiting Program
Intensive Home Visitor Program
Immunization Program
Family Planning
WIC/Breast Feeding Promotion
Communicable Disease
Environmental Health
Health Promotions
Carolina Access I (10+ yr experience)
The statewide PCCM has resulted in:

- Medicaid patients linked with a primary care provider increasing access to services across the state

- Primary care providers willing to serve as a gatekeepers and assist patients with appropriate utilization of the health care system (2.50pmpm)

IMPROVED ACCESS

*The problem was that it did not address the population that consumed the most resources!!*
Options consider for NC Medicaid

- State Operated
- Contracted Out
- Locally Run
Primary Goals

- Improve the care of the Medicaid population while controlling costs
- Develop Community based networks capable of managing populations
Basic Operating Premise

- Regardless of who manages Medicaid, the hospitals, physicians and safety net providers in NC serving patients remain the same and must be engaged.
- We need to transform Medicaid management from a regulatory function to a health management function.
- We must carefully balance cost containment with quality improvement efforts.
- Decision making must be driven by data & outcomes monitored.
- We must help transform healthcare system from acute care model to chronic illness model.
“Management rather than Regulation”
Goals Achieved By:

- Making Sure People Get Care When They Need It
- Increasing local provider collaboration
- Obtaining Quality Care
- Implementing Best Practice Guidelines
- Managing Medicaid Costs
Community Care of North Carolina

Build on ACCESS I

- Joins other community providers (hospitals, health departments and departments of social services) with physicians

- Creates community networks that assume responsibility for managing recipient care
Community Care of North Carolina

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care
- 15 Networks with more than 3000 physicians
- 595,000 enrollees
Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Steering/Governance committee
- Medical management committee
- Receive $2.50 PM/PM from the State
- Hire care managers/medical management staff
What Networks Do

- Assume responsibility for Medicaid recipients
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care & reduce variability
- Implement improved care management and disease management systems
Key Program Areas in Managing Clinical Care:

- Implementing quality improvement — Best practice processes
- Implementing disease management
- Managing high-risk patients
- Managing high-cost services
- Building accountability through monitoring & reporting
Managing Clinical Care

Clinical Directors Group
- Select targeted diseases/care processes
- Review evidenced-based practice guidelines
- Define the program
- Establish program measures

Local Medical Mgmt. Comm.
- Implement state-level initiatives
- Develop local improvement initiatives

PRACTICE A
PRACTICE B
PRACTICE C

Care Managers and Access II and III quality improvement staff support clinical management activities

ASTHMA
DIABETES
PHARMACY
HIGH-RISK & -COST
ED
GASTRO-ENTERITIS
OTITIS MEDIA
CHILD DEVELOPMENT
ADHD
FEVER
DEPRESSION
LOW BIRTH WEIGHT
ANCILLARY SERVICES

BEST PRACTICES
Improving Quality
“Disease Management”
Current Disease Management Initiatives

- Asthma
- Diabetes
- Pilots in Depression, ADHD, Special Needs, Children, Gastroenteritis, Otitis Media and Low Birth Weight
Asthma Initiative

- First program initiative – began Jan. 1999
- Adopted best practice guidelines (NIH)
- Implemented continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback
**Asthma Initiative**

**Process Measures**

**Key**

1. No. with asthma who had documentation of staging
2. No. staged II – IV on inhaled corticosteroids
3. No. staged II – IV who have an AAP

<table>
<thead>
<tr>
<th>Year</th>
<th>No. with Asthma</th>
<th>Staging on Inhaled Corticosteroids</th>
<th>Having an AAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>'99</td>
<td>47%</td>
<td>64%</td>
<td>78%</td>
</tr>
<tr>
<td>'00</td>
<td>56%</td>
<td>64%</td>
<td>75%</td>
</tr>
<tr>
<td>'01</td>
<td>49%</td>
<td>93%</td>
<td>75%</td>
</tr>
<tr>
<td>'02</td>
<td></td>
<td>95%</td>
<td>73%</td>
</tr>
</tbody>
</table>

- **Graph:** Percentage of patients with asthma who met the specified measures for each year from '99 to '02.
Asthma Initiative
Pediatric Asthma Hospitalization Rates
April 2000 - December 2002

Key
In patient admission rate
per 1000 member months
Asthma Pilot DM Findings from Sheps:

- CY 2000 Annual Savings $290,000
- CY 2001 Annual Savings $1,470,000
- CY 2002 Annual Savings $1,580,000
Diabetes Initiative

- Second program-wide initiative – began July 2000
- Adopted best practice guidelines (ADA)
- Implement continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback
Diabetes Initiative
ACCESS II-III Diabetes Chart Audit Results

- BP
- Referral for Dial. Eye exam
- Foot Exam
- HbA1c every 6 mo.
- Lipid Profile
- Album. Screening
- Flu Vaccine
- Pneumococcal Vaccine

Comparison:
- Baseline (July – Dec. ’00)
- July – Dec. ‘01
- Jan. – June ’02
- July – Dec. ’02

Percentage

0 10 20 30 40 50 60 70 80 90 100
SOURCE: February 20, 2004
Sheps Center Report

Diabetes Disease Management Findings:

- Overall pmpm costs for CCNC diabetes lower than Access
- 9% lower hospital admissions
Diabetes DM Findings from Sheps:

- Cost savings for diabetes care for 3 year period approximately $2.1 million

- Potential > $11.3 million total savings in 2003 if CCNC were statewide with asthma and diabetes DM
Managing Costs
“Targeted Approach”
Managing High-Cost Services:

- Pharmacy
  - Nursing home polypharmacy
  - PAL
  - Ambulatory polypharmacy
- Emergency Department
- Ancillary Services
- In-home Care
ED Initiative

- Target enrollees with 3 or more ED visits in 6 month time period
- Care managers perform outreach, education & follow-up
- Special mailings target top 3 reasons for ED visits (otitis media, fever, upper respiratory infections)
- Reinforce “medical home” concept
ED Initiative
ED Utilization Rate – 7/1/01 – 6/30/03 – Children < 21 years

Fiscal Year | 2001 | 2002 | 2003
--- | --- | --- | ---
Access I | 37.95 | 42.05 | 56.92
CCNC | 30.8 | 36.4 | 45.49

UR Rate Per 1000 MM
ED Initiative
ED Cost PMPM – 7/1/01 – 6/30/02 – Children < 21 years

Savings Calculation

(Access I PMPM – Access II-III) x Access II-III Enrollment

Total Savings – ’01-’02
$10,362,190
Cost Effective Prescribing 2003

“How to make a difference in rising prescription drug costs!”
NC Medicaid Expenditures: Prescription Drugs

- **FY99**: $557,772,670
- **FY00**: $754,505,194
- **FY01**: $927,240,693
- **FY02**: $1,056,158,750

The graph shows the increase in Medicaid expenditures for prescription drugs from FY99 to FY02.
Process – PAL

- Pharmacy committee defines drug classes and unit doses
- Medicaid calculates relative drug cost and rank (net costs- includes rebates)
- Inform Access II and III physicians
- Measure changes in prescribing patterns
- State-wide rollout began Nov 2003
# PAL — Prescription Advantage List

## Access II and III Prescription Advantage List

### ACE Inhibitors

<table>
<thead>
<tr>
<th>Drug name</th>
<th>PAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>lisinopril</td>
<td>1</td>
</tr>
<tr>
<td>enalapril</td>
<td>1</td>
</tr>
<tr>
<td>benazepril</td>
<td>2</td>
</tr>
<tr>
<td>captopril</td>
<td>2</td>
</tr>
<tr>
<td>ramipril</td>
<td>2</td>
</tr>
</tbody>
</table>

### Macrolides

<table>
<thead>
<tr>
<th>Drug name</th>
<th>PAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>erythromycin</td>
<td>1</td>
</tr>
<tr>
<td>clarithromycin</td>
<td>1</td>
</tr>
<tr>
<td>azithromycin</td>
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</table>

### Fluoroquinolones

<table>
<thead>
<tr>
<th>Drug name</th>
<th>PAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>moxifloxacin</td>
<td>1</td>
</tr>
<tr>
<td>levofloxacin</td>
<td>1</td>
</tr>
</tbody>
</table>

### HMG-CoA Reductase Inhibitors (Statins)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>PAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>simvastatin</td>
<td>1</td>
</tr>
<tr>
<td>atorvastatin</td>
<td>1</td>
</tr>
<tr>
<td>pravastatin</td>
<td>2</td>
</tr>
</tbody>
</table>

### Proton Pump Inhibitors

<table>
<thead>
<tr>
<th>Drug name</th>
<th>PAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>pantoprazole</td>
<td>1</td>
</tr>
<tr>
<td>omeprazole</td>
<td>2</td>
</tr>
<tr>
<td>esomeprazole</td>
<td>2</td>
</tr>
</tbody>
</table>

### H₂ Antagonists

<table>
<thead>
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<th>Drug name</th>
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</thead>
<tbody>
<tr>
<td>ranitidine</td>
<td>1</td>
</tr>
<tr>
<td>famotidine</td>
<td>1</td>
</tr>
<tr>
<td>nizatidine</td>
<td>2</td>
</tr>
<tr>
<td>cimetidine</td>
<td>3</td>
</tr>
</tbody>
</table>

### Non-sedating Antihistamines

<table>
<thead>
<tr>
<th>Drug name</th>
<th>PAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>loratadine</td>
<td>1</td>
</tr>
<tr>
<td>cetirizine</td>
<td>2</td>
</tr>
<tr>
<td>diphenhydramine</td>
<td>3</td>
</tr>
</tbody>
</table>

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The information also includes details on inhaler agents and combinations, but the specific names are not visible in the provided image.
Anticipated Savings

- PAL - $30 - $40 million annual savings expected
- Other Pharmacy Management/Policy Initiatives:
  - Selected Prior Approval
  - Specialty Disease Registry
  - Active Intervention
  - Selected OTC coverage
Nursing Home Polypharmacy Initiative ("Active Intervention")
Community Care of North Carolina
Intervention

Pharmacist / Physician Teams

- Review drug profiles / medical records of Medicaid patients in nursing homes
- Determine if a drug therapy problem exists
- Recommend a change
- Perform follow-up to determine if change was made
Screening Criteria

- Nursing home residents with...
  - >18 drugs used in a 90 day period
- 9208 residents met this criteria
- Medicaid database uses criteria to flag charts
Flagging Criteria

- Inappropriate Rx for the elderly “Beers drugs”
- Drugs used beyond usual time limit
- Drug Use Warnings & precautions
- Prescription Advantage List “PAL”
- Potential Therapeutic Duplication
Preliminary Findings

- Patients reviewed: 9208
- Recommendations made: 8559
  - Unnecessary therapy – 19%
  - More cost effective drug – 56%
  - Wrong dose – 7%
  - Potential adverse reaction – 9%
  - Needs additional therapy – 3%
  - Other – 6%
- Recommendations implemented: 6359 (74%)
Potential Cumulative Savings from Interventions

Dollars in Millions
Cost/Benefit Estimates
Community Care of North Carolina

July 1, 2002 – Jun 30, 2003

- Cost - $8.1 Million
  (Cost of Community Care operation)

- **Savings - $60,182,128** compared to FY02

- **Savings - $203,423,814** compared to FFS
  (Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)
NC Medicaid Expenditures

The graph shows the trend of North Carolina Medicaid expenditures from 1996 to 2003, where the expenditures have increased over time.
Pilot Initiatives

- Therapy services
- Low birth weight
- Disparities
- Mental health integration
- Poly-pharmacy in outpatient settings
- Sickle cell
- Community Access programs (uninsured)
- Special needs population
Big Lessons & Challenges

- There are no easy $100 million decisions, but there may be 50 $2 million decisions (you just have to find them).
- Providers must be engaged, but a challenge to keep their attention.
- Must make policy decisions consistent with program goals and vision.
- Savings are additive (the total sum of savings seems to be greater than the sum of individual initiatives).
Other Lessons Learned

1. Top down approach is not effective in N.C.
2. Community ownership a must
3. Can’t do it alone - must partner
4. Incentives must be aligned
5. Must develop systems that change behavior at the practice and community level
6. Have to be able to measure outcomes (data and feedback important- “you get what you inspect…”)
7. Lasting change takes time and reinforcement
8. There are indirect quality and cost benefits to the community
Community Care of North Carolina

Thank You