Lessons Learned

How the Partnership for a Healthy North Carolina Avoids Kentucky's Medicaid Reform Mistakes

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Executive Summary

Governor Pat McCrory's Partnership for a Healthy North Carolina is an innovative approach to redesign the state's old Medicaid system into a safety net that improves patients' health and saves taxpayer dollars.

The Partnership builds upon powerful patient-centered reforms already working in other states. Key features of the Partnership—patient choice, competition among private plans, funding strategies that prioritize patient health, and streamlined billing systems—are succeeding in Florida, Kansas, and Louisiana.

The McCrory administration wisely embraced proven strategies to develop the Partnership. But it also paid close attention to why managed care reform efforts faltered elsewhere, particularly in Kentucky.

In 2011, Kentucky transitioned to a statewide Medicaid managed care program. Unfortunately, an ill-conceived implementation timeline and the absence of key provisions resulted in several complications for patients, providers, and policymakers. These include:

- Senseless administrative burdens afflicting providers' abilities to practice efficiently
- Lengthy payment delays to doctors and hospitals
- Poor implementation strategies resulting in failed development of provider networks

This report examines these and other mistakes that left Kentucky with a botched Medicaid reform. It also explains the strategies and provisions included in the Partnership for a Healthy North Carolina that help to ensure North Carolina's patient-centered Medicaid reform does not replicate Kentucky's failings.

Overview

North Carolina's Old Medicaid program is badly in need of reform. Costs are skyrocketing, patients lack choice and control over their health future, access is limited, and health outcomes are poor.[1]

In April 2013, Governor Pat McCrory put forth a plan to redesign North Carolina's broken Old Medicaid program.[2] McCrory's plan, the Partnership for a Healthy North Carolina, builds upon pro-patient, pro-taxpayer Medicaid reforms already succeeding in states such as Florida, Kansas and Louisiana.[3] In those states, these reforms have increased patients' access to quality care, improved patients' health outcomes, created greater budget predictability, and saved taxpayers' money.[4]

The Partnership for a Healthy North Carolina utilizes comprehensive care entities (CCEs) to deliver care to Medicaid patients more efficiently. Under the plan, public and private CCEs submit competing bids to the state to provide all Medicaid services available to patients. The state then contracts with several of these CCEs to buy fully-capitated health plans. Plans are selected based on cost, quality, and access to care, ensuring they will provide the highest level of service and benefits at the lowest cost to taxpayers.

The reform pays a flat monthly rate for each enrolled individual, which is risk-adjusted for that individual's specific health status. The fixed monthly rate is paid to the CCE, and in exchange the CCE provides all Medicaid-covered services for those individual patients.

This framework shifts the risk of waste, fraud, and abuse from the state and taxpayer back to the entities that are actually managing and coordinating patients' care. This payment arrangement also provides CCEs with financial incentives to prioritize all patients' health and to identify and treat health conditions earlier. Risk-adjusted rates prevent plans from cherry-picking healthy patients, instead creating a financial incentive for CCEs to compete for sicker patients and manage their care more effectively. The Partnership for a Healthy North Carolina adjusts rates for inflation to help ensure providers remain profitable and costs are predictable year after year.

Under the Governor's plan, the state awards contracts to multiple CCEs. These entities operate statewide, serving both rural and urban areas, and all use the same vendor to reimburse medical providers. Medicaid patients are empowered to choose a health plan from among these CCEs that best meets their specific health needs and concerns. The plans compete for patients based on value. If patients are unhappy with their plans, they can choose new plans that provide them with better value based on their individual circumstances.

According to the North Carolina Department of Health and Human Services, these reforms are expected to save the state upwards of 8 percent per year. That represents annual savings of more than $1 billion. Because these savings are achieved through capitated payments, they are immediately bankable, as the state is only at risk for enrollment changes once the capitated rates are set by contract.

Learning from other states

Some individuals have criticized the Partnership for a Healthy North Carolina since it was announced by Gov. McCrory. These criticisms have largely been based on the recent experience of Kentucky's attempt to move toward traditional Medicaid managed care.[5,6]

Kentucky's statewide Medicaid managed care program was launched in November 2011.[7] The state transitioned more than 560,000 Medicaid patients to managed care from the traditional fee-for-service Old Medicaid program.[8]

Risk-bearing managed care organizations serve most of Kentucky's Medicaid program, although some populations and benefits are carved out.[9] Kentucky contracts with three managed care organizations in seven of its eight Medicaid regions and with four managed care organizations in the remaining region.[10]

The Partnership differs dramatically from Kentucky's traditional Medicaid managed care experiment. The Partnership features protections and common sense strategies that help guard against many of the problems Kentucky faced in its implementation of traditional managed care. Patient-centered Medicaid reforms in Florida, Kansas, and Louisiana, which serve as models for the Partnership, incorporate relatively simple measures that safeguard against the kinds of challenges faced in Kentucky.

The Partnership for a Healthy North Carolina reduces administrative burdens afflicting Kentucky providers

One of the earliest reported problems with Kentucky's transition to traditional managed care was the complex administrative burden placed on providers. Providers reported confusion about processing claims, as each of Kentucky's Medicaid managed care plans had its own coding and billing system that differed substantially from the system previously used by the traditional Old Medicaid program.[11]

Providers accustomed to billing for each 15-minute increment of a visit soon discovered the health plans expected them to submit one single bill for the entire length of the patient visit.[12] There was also confusion about specific billing codes and modifiers, creating unnecessary frustration for providers and plans alike.[13] This confusion led to early problems, including initial reimbursement denials and reductions.[14]

The Partnership for a Healthy North Carolina addresses this potential problem in its outline of how the redesigned Medicaid system will operate. The Partnership requires all CCEs use the same financial vendor for reimbursement: North Carolina's Medicaid Management Information System (MMIS).[15] A consistent billing system alleviates much of the hassle providers experience as they bill different plans for the care they provide.

Kansas' patient-centered KanCare reform did something similar, giving providers the option to use Kansas's MMIS to submit claims to KanCare managed care organizations.[16] To further maximize providers' time and ability to practice, North Carolina may wish to follow Kansas's lead and give providers a choice of either the MMIS or the CCEs' billing systems, as some physicians may be more familiar with the commercial billing systems or find them more user-friendly.

North Carolina is also modernizing its MMIS with NCTracks, an improved claims processing system that launched in July 2013.[17] The improved system will provide 24/7 access to MMIS, enable electronic submission of all claim types, fully support electronic funds transfers of claims payments, and consolidate claims processing activities for multiple health plans.[18]

The NCTracks project began in 2008 and was originally scheduled to go live in August 2011.[19] Numerous implementation issues delayed the project and an auditor's report found that the Perdue administration lacked adequate controls to address those delays.[20] These delays have caused the project to cost twice what was originally expected.[21]

The current administration inherited the project when Gov. McCrory assumed office in January 2013. An audit of the system's readiness in February 2013 found that 285 of the 834 system tests that were deemed "critical" had not yet been performed.[22] The audit also found that of the 549 critical system tests that had been performed, NCTracks had failed 123 of them.[23]

The audit provided the North Carolina Department of Health and Human Services with a number of recommendations to ready the system by its revised July launch date.[24] Senior staff have been busy implementing those recommendations and performing other readiness activities in preparation for launch. According to the state auditor, the Department has mitigated several of the problems identified in February and has been working to mitigate the remaining issues before the July launch date.[25]

NCTracks should be fully operational well before implementation of the Partnership for a Healthy North Carolina. By allowing providers to use the improved MMIS system for reimbursement, the Partnership eliminates the frustration and confusion about claims processing that Kentucky providers endure.

The Partnership avoids the payment delays Kentucky providers face

Perhaps the single largest problem resulting from Kentucky's shift to traditional managed care was longer payment delays to doctors and hospitals, especially in the early months. In the first quarter of 2012, the Kentucky Department of Insurance cited two of the three health plans for failing to pay providers' claims promptly.[26] Some providers sued the health plans, claiming they had been waiting more than a month for the vast majority of their unpaid claims, and more than three months on many of those bills.[27]

These delays were largely caused by billing system issues and by the fact that, in some cases, the managed care organizations had not finalized contracts with providers before the open enrollment period.[28] One managed care organization also claimed the state provided it with false cost and utilization data during the bidding process, causing it to underbid and lose $120 million in the first year, leading to further payment delays.[29]

This led to a preliminary audit of the plans.[30] The auditor's report highlights how Kentucky failed to establish a proper Medicaid reform framework. For example, the state had not developed adequate metrics to measure the timeliness of provider reimbursements.[31] The auditor's report also criticized state officials for failing to establish procedures for reporting those metrics or resolving payment delays.[32]

Kentucky's Medicaid agency reports that payment delays have significantly improved since the transition period.[33] State officials report that approximately 78 percent of the 28 million claims filed during the first year of implementation had been approved and paid, with 99 percent of approved claims being paid within 30 days.[34] Many of the remaining payment denials or changes relate to improper billing codes.[35]

Nevertheless, the Kentucky governor's office has promised that the state's Department of Insurance will review payment disputes between providers and managed care organizations.[36] It has also promised to launch targeted audits of the managed care organizations for claims processing issues.[37]

States that have implemented reforms similar to the Partnership for a Healthy North Carolina have avoided this problem by instituting prompt payment requirements for all health plan providers. KanCare, for example, includes strict prompt payment requirements among its Year 1 performance measures.[38] KanCare's benchmark requires managed care organizations to process all clean claims within 20 days and 90 percent of all nursing facility claims within 14 days.[39] KanCare withholds 3 to 5 percent of the capitated rates each year.[40] Plans will not receive those funds if they do not meet payment and other performance benchmarks.[41]

Louisiana's Bayou Health requires managed care organizations to pay 90 percent of all clean claims within 15 business days and 99 percent of all clean claims within 30 calendar days.[42] If a claim is disputed, it must be sent to an independent third party for review.[43] As a result, between 99.8 percent and 99.99 percent of all clean claims are processed within 30 days, with average billing cycles ranging from 3.7 to 8.3 days.[44,45,46]

Louisiana's Bayou Health protects providers from payment delays

Plan	Share of claims processed within 30 days	Average billing cycle
Louisiana Healthcare Connections	99.83%	8.3 days
LaCare	99.99%	3.7 days
Amerigroup	99.80%	6.0 days

Source: Louisiana Department of Health and Hospitals

The Partnership develops strong provider networks through thoughtful implementation

Another major problem Kentucky experienced during its transition to traditional managed care related to the development of new provider networks.[47] A provider network is a group of physicians, specialists, hospitals, clinics and other providers that contract with a CCE or managed care organization to deliver services to the organization's members.

While the plans in Kentucky were able to secure letters of intent from providers, many doctors and hospitals were unable to agree on final contract terms before open enrollment.[48] In some cases, the letters of intent did not result in actual contracts, leaving managed care organizations' provider networks in flux.[49]

Most provider-network development problems stemmed from Kentucky's rapid transition. The legislation to transition Kentucky's Old Medicaid program to managed care was enacted March 25, 2011.[50] The state issued a request for proposals on April 7, 2011 and finalized the contracts with the three selected managed care organizations on July 8, 2011.[51,52] This gave managed care organizations just four months from the time contracts were signed until open enrollment began to establish operations in each of the regions of Kentucky they were contracted to serve.[53]

Kentucky's timeline did not guarantee network development problems, of course. In KanCare, for example, open enrollment began just four months after finalizing contracts with the selected managed care organizations.[54] The difference between Kentucky and Kansas was in planning. Prior to selecting managed care organizations, Kansas spent more than a year planning for the implementation of KanCare.[55]

Kansas created regular progress deadlines to help ensure provider networks would be ready in time for open enrollment. The contracts included deadlines for approving provider agreements, deadlines for meeting readiness benchmarks for contracting with the providers needed for each geographic region, deadlines for reporting all contracted providers and deadlines to fully establish networks prior to KanCare launching in January 2013.[56] Kansas also performed readiness reviews, document requests, on-site reviews and health plan audits in the period leading up to open enrollment.[57]

North Carolina can prepare for implementation of the Partnership the way Kansas prepared for KanCare. The Partnership's timetable helps ensure CCEs will have enough time to establish provider networks before open enrollment begins. The North Carolina Department of Health and Human Services can spend the time leading up to open enrollment holding multiple community and stakeholder meetings, as well as forming provider workgroups to prepare for implementation activities and hosting regular operational status meetings.

North Carolina's Department of Health and Human Services welcomes collaboration, having already scheduled numerous town hall events statewide to discuss Medicaid reform.[58] The reform process itself has been an exercise

in transparency and stakeholder input, beginning when the Department issued a request for ideas to improve the Medicaid program.[59] Indeed, the entire framework of the Partnership for a Healthy North Carolina was developed after months of working with more than 160 different providers, Medicaid patients and advocacy groups offering input in the reform process.[60]

The Partnership features leadership with the critical experience Kentucky lacked

Kentucky's rapid implementation was further complicated by a lack of experience with managed care throughout the state's Medicaid agency. Senior state officials responsible for overseeing the new managed care program had little exposure to managed care reforms and few received any training prior to implementation.[61] State officials lacked expertise in monitoring performance and utilizing tracked information to improve quality.

North Carolina has the benefit of senior staff with a wide range of experience with managed care programs and Medicaid reform. State officials have monitored quality and access for years. The state already tracks Medicaid performance through Healthcare Effectiveness Data and Information Set (HEDIS) measures.[62] These metrics are used by more than 90 percent of health plans in the United States to evaluate plan performance on cost-effectiveness and health outcomes.[63,64,65]

Dr. Aldona Wos, secretary of the North Carolina Department of Health and Human Services, previously experienced a difficult transition to managed care in New York State and is committed to ensuring North Carolina does not replicate those same mistakes. Her background as a physician is another asset as she oversees implementation of the Partnership.[66]

Carol Steckel, North Carolina's Medicaid director, has extensive state and national experience with Medicaid reform. Steckel previously served in the U.S. Department of Health and Human Services and spent more than a decade running Alabama's Medicaid program.[67]

Steckel has also served as the executive committee chairperson of the National Association of State Medicaid Directors, as president of the National Association of Medicaid Directors, and as a fellow in the Robert Wood Johnson Foundation's Medicaid Leadership Institute.[68]

She also previously directed the Center for Health Care Innovation and served as executive director of health care reform, both at the Louisiana Department of Health and Hospitals, during implementation of Bayou Health, Louisiana's innovative, patient-centered Medicaid reform plan.[69,70]

The experience of senior staff will assist in redesigning North Carolina's Medicaid program to increase access to needed care, improve patient health outcomes and make Medicaid budgeting more predictable.

The Partnership helps ensure managed care organizations cannot hold the state hostage like they can in Kentucky

Kentucky's managed care program gives contracted managed care organizations too much leverage over the state. Although the state received seven bids, it awarded just three statewide contracts.[71] One of these three plans is now threatening to drop out of the program.[72]

Federal rules require patients have a choice of at least two plans. A plan threatening to leave has much greater leverage over the state if that state only contracts with a total of two or three managed care organizations.[73]

Oklahoma experienced this in the mid-2000s. While operating the SoonerCare Plus program, Oklahoma contracted with just a few managed care organizations, barely meeting the federal requirement that patients be

given a choice of at least two plans.[74] Because Oklahoma did not maintain a robust marketplace of Medicaid plan options, the few managed care organizations that received contracts from the state had enormous leverage over taxpayers.

Oklahoma had to eventually cancel its managed care program altogether when one of the contracted managed care organizations demanded an 18 percent rate increase.[75] Because that managed care organization was necessary to meet the federal requirement that all patients be given at least two options, Oklahoma was forced to end the program.[76]

Florida and Louisiana have avoided this problem by creating a more robust Medicaid marketplace. Florida divides its Medicaid population into eleven geographic regions, ranging from 100,000 to 600,000 enrollees per region, with an average of four to six plans offered per region.[77,78] In Broward County, which has nearly 180,000 enrollees, Medicaid patients can choose from 13 different health plans.[79] Louisiana selected five statewide options for its 900,000 enrollees.[80]

The Partnership for a Healthy North Carolina calls for the state to contract with up to four comprehensive care entities.[81] Four are needed to ensure robust competition, but with 1.5 million Medicaid patients, North Carolina's Medicaid program has the economy of scale to attract significant interest from even more plans. If North Carolina can expand the number of CCEs, the state will have more leverage over the CCEs, rather than the other way around.

Conclusion

Governor Pat McCrory's innovative Partnership for a Healthy North Carolina is blazing a trail toward pro-patient, pro-taxpayer Medicaid reform. The proven strategies employed by the Partnership are likely to rein in skyrocketing Medicaid spending and empower patients with greater control over their health future, better access to specialists, and improved health outcomes.

These strategies have already worked in Florida, Kansas, and Louisiana, and are likely to work in North Carolina, too.

Not only has North Carolina learned what succeeds for patients and taxpayers in other states, it has also learned what simply doesn't work. Looking closely at Kentucky's attempts at Medicaid managed care reform, and the pitfalls that followed, the governor has taken common sense steps to avoid failure. The Partnership for a Healthy North Carolina is truly a well-thought-out, pro-patient, pro-taxpayer Medicaid reform.

Endnotes

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“To prejudge other men’s notions
before we have looked into them
is not to show their darkness
but to put out our own eyes.”

JOHN LOCKE (1632–1704)

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