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## Replication of North Carolina Community Care is Not the Best Option for Louisiana

The Louisiana Department of Health and Hospitals (DHH) has conducted a thorough review of promising practices in Medicaid managed care in other states, including “the North Carolina model,” which several groups have asked Louisiana to consider implementing. Following intense research of best practices in dozens of states, including North Carolina, DHH has determined that replication of the North Carolina Community Care program toward managing care for Louisiana Medicaid and CHIP recipients would not best serve the needs of our enrollees, would not address the state’s most critical health issues, would leave too much risk and financial burden on the taxpayers of the state, and would not create a sustainable system the state could implement in 2014 when an estimated 600,000 new Medicaid eligibles come online. The department’s position is based on the following:

**A North Carolina-like model would require too much time to implement and would delay better health results for recipients.** It has taken a 12-year period (since 1998), for the enhanced “North Carolina model” of primary care case management to become what it is today. Louisiana currently has poor health rankings, particularly for the children and pregnant women/infants treated through Medicaid, and a lack of access to specialty care. Our state does not have the luxury of years to build its own managed care program from the ground up, particularly since more recipients will need Medicaid care with expanded eligibility in 2014. Given these time constraints and the current poor state of health for our citizens, it is more responsible for the state to buy a proven model that has demonstrated to work effectively and immediately in other states. A prepaid Coordinated Care Network (CCN) could be fully operational statewide, with benchmarks to improve patients’ health in place, within 13 months of implementation. The other proposed CCN type, a shared-savings network, would be provider owned, would include cared management and would result in shared savings among providers and the state, accomplishing what Louisiana needs.

**The North Carolina model does not address Louisiana’s most critical health conditions needing improvement, particularly for pregnant women and children.** The North Carolina model only focuses on managed care for high-risk, high-cost Medicaid enrollees. Given Louisiana’s poor health outcomes, the state wants to implement a program that manages care for all Medicaid and CHIP recipients. The state has not seen any evidence that the North Carolina model provides managed care for pregnant women covered by Medicaid, and none of the health quality measures North Carolina’s networks currently report relate to birth outcomes. In Louisiana, Medicaid provides prenatal care and labor and delivery services for 70 percent of pregnancies, so this is a crucial health area any program implemented in this state must address. Louisiana’s high number of low-birth weight babies and infant mortality rankings are areas the state hopes to improve through an effective managed care solution that focuses on better monitoring of high-risk pregnancies, coordinating prenatal care and improving birth outcomes.

**The North Carolina model does not give providers flexibility to negotiate higher rates, and does not assume the responsibility of coordinating care to ensure access to specialists.** The “North Carolina model” uses fee-for-service reimbursement methodology. Because of this, providers are not able to negotiate higher rates to ensure access. Prepaid models can offer higher rates as incentives to providers. If Louisiana implemented a similar model, the state still would be responsible for ensuring recipients have access to specialty care, which is an area of the current Louisiana Medicaid program needing improvement. In a prepaid model, organizations can offer provider incentives to ensure specialty care access by rebalancing health care dollars and paying specialists a higher rate that encourages them to better comply with the terms of their contracts with the state. **Furthermore, the North Carolina model does not allow room for the care networks to provide incentives to patients to encourage healthy behaviors, and does not have the tools or experience to control hospital and ER use.** Louisiana ranks first for unnecessary hospitalizations and third for ER use. The state needs a

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coordinated care network that addresses these issues and better coordinates care so recipients do not have to use hospitals for non-emergency health issues.

**The North Carolina model would require a significant investment of state dollars up front to implement and would not generate the greatest cost savings for taxpayers.** – Actuarial analysis of both Medicaid managed care models the state is proposing, shared savings and prepaid, indicated that gross savings will be less under the shared savings model than the prepaid model of managed care.

In addition, North Carolina received considerable startup funding from the state and private foundations such as the Commonwealth Fund and Center for Health Care Strategies to create and implement their managed care model. Louisiana does not have this funding in place, and does not have time to apply for grant or foundation funding that might not come through, which would further delay managing care for enrollees.

**North Carolina has significantly more state and county (parish) staff members who oversee their managed care model than Louisiana could provide.**

Community Care of North Carolina has a significant number of state and county (parish) employees who work full-time to manage the program. In Louisiana, which already has fewer Medicaid employees working on managing care, the state’s workforce has experienced a staffing reduction, and state budget plans call for an additional 5 percent state workforce reduction in the next three years. It is unlikely, given the administration’s and legislative priority to reduce the size of state government, Louisiana could obtain the necessary workforce to oversee and manage a

Louisiana replication of North Carolina Community Care from the state level. It is more financially responsible for the state to allow health organizations to implement managed care with their own full-time workforces, particularly since managing care is not a core competency for Louisiana, and it would take the state years to develop the necessary expertise already available through these organizations.

**CONCLUSION: The health department has determined that North Carolina’s model would not provide better, more effective health care for Louisiana’s Medicaid enrollees than the models being proposed by DHH.** The CCN “shared savings model” developed is an enhanced Primary Care Case Management (ePCCM) model that builds on and enhances the North Carolina model, giving providers an opportunity to participate in an enhanced case management plan that meets the necessary standards to improve health for Louisiana citizens. By implementing this model simultaneously with the proposed prepaid CCN model, Louisiana would be uniquely positioned to determine the degree of variation in the two models—if any—relative to quality measures, enrollee satisfaction, savings generated, reductions in ER utilization, hospitalization and costs for members with chronic conditions in advance of the major Medicaid expansion in 2014. Also, this gives Louisiana Medicaid providers and enrollees a wider variety of choices in how they participate in a managed care program. Providers would be allowed to enroll in both the prepaid and shared-savings networks, and patients could pick among different health plans to find ones that best suit their families’ needs.