



The Partnership for a Healthy North Carolina

Medicaid Reform that Works
for Patients, Providers, and Taxpayers Alike

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May 2013

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This is a joint publication of the Florida-based Foundation for Government Accountability and the North Carolina-based John Locke Foundation. It appears as Policy Brief #5 for the Foundation for Government Accountability's Medicaid Cure initiative, and as a Policy Report for the John Locke Foundation. The views expressed in this report are solely those of the author and do not necessarily reflect those of the staff or board of the John Locke Foundation. For more information, call 919-828-3876 or visit www.JohnLocke.org.

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Executive Summary

North Carolina's most vulnerable Medicaid patients deserve a health care safety net that meets their needs and moves them from sickness to health. North Carolina taxpayers deserve peace of mind their sacrifices to fund that safety net are not being squandered on a failing program that cannot meet its purpose. And North Carolina policymakers deserve budget certainty when it comes to Medicaid spending, so they can adequately fund the program and all other state priorities.

North Carolina's current Medicaid program does not meet a single one of these objectives:

- In 55 percent of the most widely-tracked patient health outcome measures, North Carolina scored worse in 2011 than it did in 2010.
- Total Medicaid spending in North Carolina has grown almost 90 percent in the last decade, from less than \$8 billion annually just a decade ago to more than \$14 billion annually in 2012.
- North Carolina spends more per-person on Medicaid than any of its seven state neighbors, as well as the U.S. average.
- In each of the last four fiscal years, North Carolina's Medicaid spending exceeded its appropriated budget by an average of 11 percent.

Recognizing North Carolina's Medicaid failures, Governor Pat McCrory has proposed the Partnership for a Healthy North Carolina, an innovative reform to redesign North Carolina Medicaid into a truly pro-patient, pro-taxpayer health care safety net.

The Partnership for a Healthy North Carolina infuses the Medicaid program with winning market-based strategies of competition, accountability, transparency and a common-sense funding structure. Key features of the plan include:

- Patient choice – patients can choose from among several competing private plans to find one that will serve them best.
- Smarter funding – plans receive a fixed amount of funding per patient—with sicker patients garnering greater funding—and receive additional compensation if they succeed in improving patients' health and quality of life. Funding is truly aligned with patient health.
- Streamlined reimbursements – consolidated payment systems ensure health care providers are reimbursed more quickly for the treatments they provide.
- Taxpayer savings – the patient-centered reforms are expected to save the state upwards of 8 percent per year—an annual savings of more than \$1 billion.

Although North Carolina policymakers should explore additional ways to make the Governor's proposal even stronger, the Partnership for a Healthy North Carolina represents a major step forward in transforming Medicaid into an affordable and successful health care safety net.

OVERVIEW

Medicaid is a joint state and federal program meant to provide medical care to poor and vulnerable citizens. In North Carolina, Medicaid primarily serves low-income families, the elderly, and individuals who are blind or disabled. Low-income families make up 71 percent of North Carolina’s total Medicaid program.¹

Each categorically eligible group has its own eligibility standards to qualify for Medicaid. Children under the age of five, for example, can live in households that earn up to 200 percent of the federal poverty level and still qualify for Medicaid.² Parents can earn up to 33 percent of the federal poverty level and still qualify, while individuals who are elderly, blind, or disabled can earn up to 100 percent of the federal poverty level and still qualify for Medicaid coverage.^{3,4}

A GROWING PROBLEM

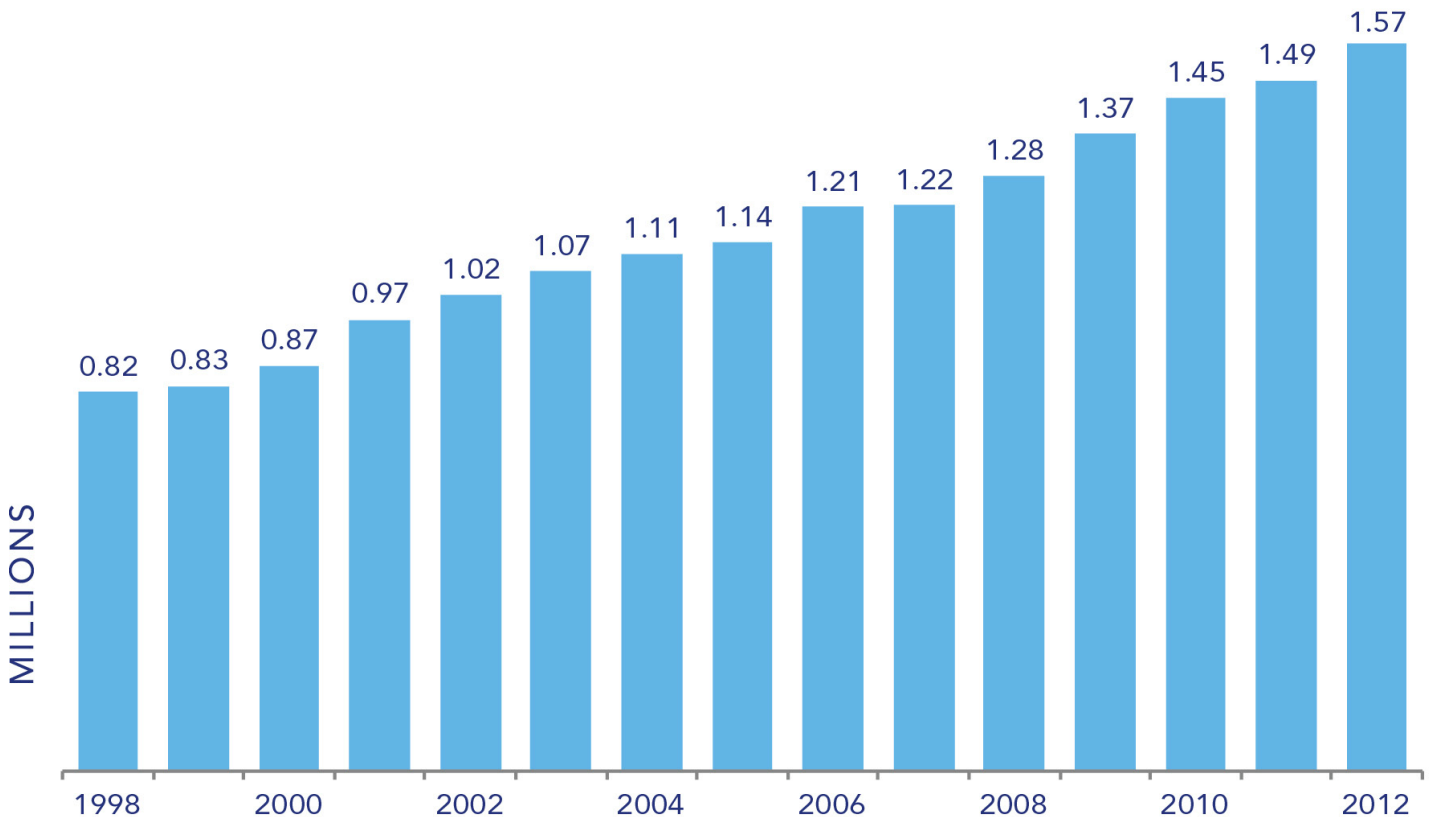
The number of people in North Carolina’s Medicaid program has skyrocketed in recent years. In 1998, 815,000 North Carolinians were enrolled in Medicaid.⁵ By 2012, 1.6 million were enrolled, nearly doubling during the last fifteen years.⁶ To put this in perspective, North Carolina’s total population has grown by just 25 percent since 1998, meaning that Medicaid enrollment is growing nearly four times as fast as the state population as a whole.⁷

North Carolina’s Medicaid eligibility levels, by category

Children (ages 0-5)	200% FPL
Children (ages 6-18)	100% FPL
Young adults (ages 19-20)	33% FPL
Parents	33% FPL
Pregnant women	185% FPL
Elderly, blind, disabled	100% FPL

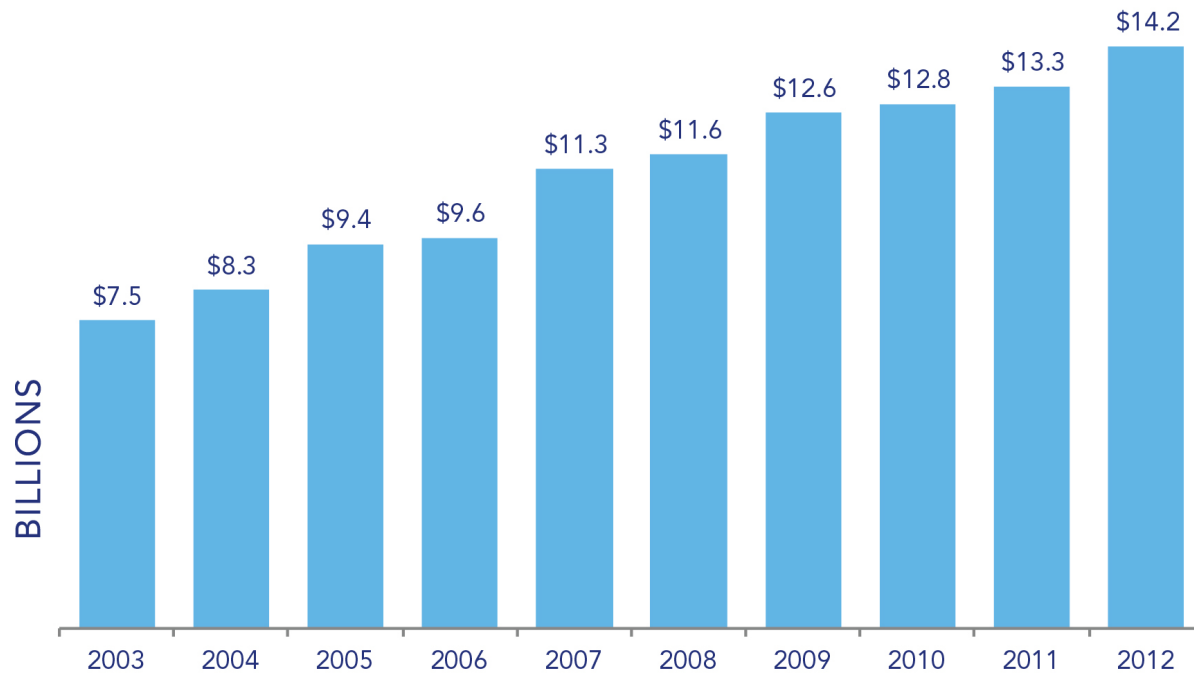
Source: North Carolina Department of Health and Human Services

North Carolina’s Medicaid enrollment has nearly doubled in the last fifteen years



Source: North Carolina Department of Health and Human Services

North Carolina's Medicaid spending has grown nearly 90 percent in the last decade



Source: North Carolina General Assembly Fiscal Research Division

Skyrocketing enrollment has led to uncontrollable costs. Medicaid spending has grown to more than \$14 billion per year, up from less than \$8 billion just a decade ago.⁸ While North Carolina's Medicaid spending has grown by nearly 90 percent during the last decade, the state's economy has grown by less than 50 percent.⁹ Even more troubling, Medicaid spending has grown more than twice as fast as state revenue.¹⁰

But enrollment is not the only cause of North Carolina's spiraling Medicaid costs. Indeed, per-person spending has grown for every category of Medicaid eligibility.¹¹ Not only is North Carolina's per-person spending growing, it is also the highest in the region and substantially higher than the national average.¹²

This exorbitant per-person spending has led to budget overruns year after year, requiring annual supplemental

North Carolina spends more per person on Medicaid than any other state in the region

North Carolina	\$6,098 per person
Kentucky	\$5,890 per person
South Carolina	\$5,181 per person
Mississippi	\$4,890 per person
Tennessee	\$4,742 per person
Florida	\$4,168 per person
Alabama	\$4,081 per person
Georgia	\$3,979 per person
U.S. Average	\$5,535 per person

Source: North Carolina Office of the State Auditor

appropriations to fill North Carolina's Medicaid budget deficit. In fact, Medicaid has exceeded its appropriated budget in each of the last four fiscal years by an average of 11 percent.^{13,14} Between fiscal years 2009 and 2012, Medicaid spending exceeded the approved budget by a combined \$5.4 billion.¹⁵ All this creates an annual cycle of appropriating supplemental funding for Medicaid in order to shore up its deficits.¹⁶

Not all of this skyrocketing spending has been paid for exclusively with state tax dollars. States' Medicaid programs are paid for with a combination of state and federal taxes. Each state receives federal reimbursement of Medicaid expenditures according to its Federal Medical Assistance Percentage (FMAP) rate. This rate can range from 50 percent to 83

percent of Medicaid expenditures, depending on the state's per capita personal income. Historically, two-thirds of all Medicaid spending in North Carolina has been paid for with federal money.¹⁷ North Carolina's FMAP rate is scheduled to be 65.8 percent in fiscal year 2014.¹⁸

Despite skyrocketing spending, Medicaid's performance is deteriorating

North Carolina's Medicaid woes go beyond the program's rapid enrollment and spending growth. A quarter of the state's physicians will not take any new Medicaid patients.¹⁹ For comparison, more than 84 percent of South Carolina physicians accept new Medicaid patients.²⁰ This is particularly troubling given that North Carolina has a smaller number of total physicians than most states.²¹ Its ranking for primary care physicians is especially concerning, as only 15 states have fewer primary care physicians per capita than North Carolina.²² According to federal data, North Carolina has a primary care doctor shortage in 78 of its 100 counties.²³

Nationwide, Medicaid is known for creating huge access barriers for patients.²⁴⁻²⁸ These large access barriers often result in worse health outcomes for patients in traditional Medicaid programs.²⁹⁻³³ Not only do patients enrolled in Medicaid frequently suffer worse health outcomes, Medicaid's performance is getting worse too.

North Carolina measures performance with the Healthcare Effectiveness Data and Information Set (HEDIS), a set of metrics used by more than 90 percent of health plans in the United States.³⁴ North Carolina tracked 53 performance measures in its Medicaid program during both 2010 and 2011.³⁵ Unfortunately, about 55 percent of the tracked measures were worse in 2011 than they were in 2010.³⁶ This is not a single-year anomaly. North Carolina's Medicaid performance has been on a downward spiral for the past several years.³⁷

North Carolina has experimented with care coordination through its Community Care of North Carolina (CCNC) model. CCNC is a non-profit collection of 14 regional networks that currently provide some care coordination services to Medicaid patients. The Medicaid program pays a small administrative fee on a per-member per-month basis for care coordination, but all medical services are billed fee-for-service.³⁸ The administrative fee ranges from \$3 to \$13 per member per month and varies by eligibility category, with higher management fees for elderly, blind, and disabled patients.³⁹ In 2010, 97 percent of North Carolina's Medicaid spending was billed fee-for-service.⁴⁰

The goal of CCNC is to connect Medicaid patients with a "medical home," with an assigned primary care provider coordinating each patient's care in order to reduce unnecessary utilization and manage medical conditions more efficiently. CCNC claims to have saved the state billions of dollars, although those calculations and claims have been subject to intense scrutiny by care management experts for severe methodological flaws.⁴¹⁻⁴³

Even with CCNC's alleged savings, North Carolina's Medicaid program remains unsustainable. Medicaid costs are higher than the national average and continue to grow faster than state revenues, jeopardizing all other state priorities. Moreover, despite the CCNC model's emphasis on improving health through comprehensive and continuous care, care remains fragmented, health outcomes are deteriorating, and navigating the Medicaid bureaucracy has become complex and burdensome for patients and providers alike.

A BETTER WAY FORWARD

Medicaid's one-size-fits-all approach is failing North Carolina patients, providers, and taxpayers. Fortunately, there is a proven way to increase access to needed care, improve health outcomes, and make Medicaid budgeting more predictable. Governor Pat McCrory's Partnership for a Healthy North Carolina is an innovative, patient-centered approach to improve the state's Medicaid program.⁴⁴

The Partnership for a Healthy North Carolina embraces comprehensive care entities to more efficiently deliver care to Medicaid patients. Under the Partnership, public and private comprehensive care entities would submit competing bids to North Carolina's Medicaid program to provide all Medicaid services. The state would then

Quality is declining in North Carolina's Medicaid program

	2008	2009	2010	2011	Gain or loss since 2008
Asthma					
Use of appropriate medications for asthma	90.12%	90.24%	89.79%	89.08%	(-)
Cancer screening					
Breast cancer screening	36.96%	36.45%	36.30%	35.09%	(-)
Cervical cancer screening	56.54%	54.98%	54.02%	52.83%	(-)
Colorectal cancer screening	22.53%	22.67%	23.46%	22.20%	(-)
Childhood Immunization					
Childhood immunization - Combinaton 2	79.39%	72.92%	71.55%	N/A	(-)
Childhood immunization - Combinaton 3	72.00%	66.15%	66.86%	N/A	(-)
Comprehensive Diabetes Care					
Hemoglobin A1c testing	73.79%	74.37%	74.61%	74.27%	(+)
LDL-C screening	64.49%	65.54%	66.70%	64.71%	(+)
Eye (retinal) exam	39.48%	39.11%	40.08%	38.54%	(-)
Dental					
Annual dental visit (no assigned primary care physician)	51.51%	53.35%	56.38%	57.29%	(+)
Annual dental visit (assigned primary care physician)	54.92%	57.36%	60.31%	61.09%	(+)
Mental Illness					
Follow-up after hospitalization for mental illness (7 days)	21.50%	19.42%	19.82%	17.75%	(-)
Follow-up after hospitalization for mental illness (30 days)	57.32%	48.06%	48.91%	40.23%	(-)
Preventative services					
Adolescent well-care visits	30.78%	32.50%	34.49%	37.10%	(+)
Adults' access to preventive services (20 - 44 years old)	78.57%	77.96%	77.06%	75.19%	(-)
Adults' access to preventive services (45 - 64 years old)	71.75%	70.74%	69.90%	68.22%	(-)
Well-child visits (ages 0-15 months) - 1 or more visits	98.95%	98.96%	98.93%	98.94%	(-)
Well-child visits (ages 0-15 months) - 6 or more visits	58.09%	57.49%	58.10%	60.02%	(+)
Well-child visits (ages 3-6) - 1 or more visits	66.37%	66.89%	67.93%	69.84%	(+)

Source: North Carolina Department of Health and Human Services

contract with these comprehensive care entities to buy fully-capitated health plans. Plans would be selected based on cost, quality, and access to care, ensuring that the plans will provide the most benefits to patients at the lowest cost to taxpayers.

These plans would be paid a flat monthly rate for each enrolled individual, which would be risk-adjusted for that individual's health status. The state pays the fixed monthly rate in exchange for the comprehensive care entity to provide all Medicaid-covered services for individual patients. This framework shifts the risk of waste, fraud, and abuse from the state and taxpayer back to the entities that are managing and coordinating patients' care. This payment arrangement also provides financial incentives for comprehensive care entities to diagnose and treat health conditions sooner. Risk-adjusting the capitated rates prevents plans from cherry-picking healthy patients and instead motivates comprehensive care entities to compete for sicker patients and manage their care more effectively. The Partnership for a Healthy North Carolina plan would adjust these rates for inflation to ensure that providers remain profitable and that costs are predictable year after year.

The Partnership is expected to save the state upwards of 8 percent per year.⁴⁵ That represents an 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.

Key Aspects of the Partnership for a Healthy North Carolina

- The state awards contracts to three or four comprehensive care entities.
- Comprehensive care entities operate statewide, ensuring fair and equal access for patients in both rural and urban areas.
- All comprehensive care entities use the same financial vendor to reimburse medical providers, increasing speed and efficiency of repayments.
- Patients can choose from among the several plans available and pick the one that best meets their individual health concerns.
- Plans compete for patients based on the value and quality of service they can provide.
- Patients unhappy with their plans can drop them and choose new ones that will better serve them.

LEARNING FROM OTHER STATES

The Partnership for a Healthy North Carolina was inspired by successful patient-centered Medicaid reforms enacted in Florida, Louisiana, and Kansas. North Carolina can build on those successes to customize a patient-centered reform plan that works best for the state's truly vulnerable Medicaid patients.

Florida

In 2005, Florida enacted a bipartisan plan to redesign its Medicaid program.^{46,47} Florida's Medicaid Reform Pilot covers five counties, with more than 317,000 patients participating in the Pilot.⁴⁸ The combined total population of Florida's five reform counties is nearly 3 million, ranging from 27,000 residents in Baker County to 1.8 million residents in Broward County.⁴⁹

In 2011, Florida lawmakers passed legislation to launch the reforms statewide, with implementation beginning in August 2013.^{50,51} When fully implemented, the reforms will cover more than 3.2 million Medicaid patients.⁵²

Like the Partnership for a Healthy North Carolina, Florida's Medicaid Reform Pilot empowers patients with meaningful choices for their health coverage. Patients can choose from up to 13 different health plans, including

plans offered by traditional managed care organizations as well as provider-led plans.⁵³ Florida also offers patients with very specific health needs the opportunity to enroll in a specialty plan uniquely customized to their needs.⁵⁴ In order to help patients make informed choices, Florida's Medicaid Reform Pilot provides an independent choice counseling program to assist in navigating the plan selection process, providing objective comparisons based on patients' specific needs and concerns.⁵⁵

The Florida Reform Pilot is not only delivering greater choice, it is delivering better results as well. Reform plans outperformed the traditional Old Medicaid program in 22 of 33 HEDIS health outcomes.⁵⁶ Better yet, 94 percent of the Reform Pilot's regularly-tracked health performance measures have improved since 2008.⁵⁷

Reform Pilot patients also seem more satisfied with their plan choices and quality of care. In 2012, the Florida agency overseeing the Medicaid Reform Pilot received just six complaints for every 10,000 patients.⁵⁸ The plans also successfully resolve these complaints, as no unresolved grievances were filed in all of 2012.⁵⁹ When surveyed, patients in the Reform Pilot reported high satisfaction and generally had no problems finding personal doctors whom they liked within their plan's networks.⁶⁰

Florida's reforms are also protecting taxpayers and creating greater budget certainty. By paying plans with capitated, risk-adjusted rates, Florida has reduced the same budget unpredictability of the traditional Old Medicaid program that results in annual Medicaid deficits in North Carolina. The capitated rates have been significantly lower than Florida's per-person spending on similar populations still enrolled in the traditional Old Medicaid program.⁶¹ Florida is expected to save approximately \$1 billion annually when the reforms are fully implemented statewide.⁶²

Louisiana

In 2012, Louisiana launched Bayou Health. Bayou Health empowers patients to choose from five different statewide health plans, all of which were selected through a competitive bidding process.⁶³ Like the Florida Medicaid Reform Pilot and the proposed Partnership for a Healthy North Carolina, Bayou Health patients have the power to choose a plan that best meets their individual needs and circumstances. If they are not satisfied with their selection, they may switch to a different plan that will provide them with better value. The available plans are split between fully-capitated health plans and provider-led plans that are expected to transition to fully-capitated plans in the future.⁶⁴

Provider-led plans provide coordinated care for patients and share cost savings with the state at the end of the year for the populations enrolled in these plans. Unlike CCNC in North Carolina, if the provider-led plans do not hit the state's savings targets, they must refund the plan fees to the state.⁶⁵ More than half of Bayou Health patients are enrolled in one of the three statewide fully-capitated health plans.⁶⁶

To create budget predictability and rein in costs, Bayou Health developed an actuarially sound capitated rate, which is then risk-adjusted for the health status of every patient.⁶⁷ The capitated rate built in an initial 3.5 percent savings, with those savings expected to increase over time.⁶⁸ Louisiana taxpayers saved approximately \$160 million during the first year of Bayou Health alone.^{69,70}

Kansas

In 2013, Kansas launched KanCare, which provides all Medicaid patients with services through a fully-capitated managed care program.⁷¹ Like the Partnership for a Healthy North Carolina, all services and populations are within KanCare, combining physical, mental, behavioral, and long-term care services into the program.⁷²

Medicaid patients are automatically enrolled in one of KanCare’s three health plans and, like in the reforms in Florida, Louisiana, and the Partnership proposed in North Carolina, can switch to a plan they decide best meets their needs.⁷³ Each plan is fully responsible for coordinating and managing the care of its Medicaid patients.

Like Louisiana, Kansas has approximately 5 percent savings built into its capitated rates.⁷⁴ These savings are expected to grow in later years, as the initial costs are reduced and then grow more slowly over time.⁷⁵

In all, KanCare is expected to save more than \$1 billion during the next five years.⁷⁶ It has already saved taxpayers an additional \$67 million above its initial savings target for year one, meaning the \$1 billion in savings is likely to grow even larger during the first five years and beyond.⁷⁷

AN EXCELLENT STARTING POINT

The Partnership for a Healthy North Carolina is an excellent starting point for patient-centered Medicaid reform. Four components of the plan are critical to its success:

1. Comprehensive care entities are full, risk-bearing plan providers

The risk-bearing capitated payment structure provides comprehensive care entities with a financial incentive to improve health and more effectively manage patients’ conditions. These entities will bear the risk if they coordinate care or manage health conditions poorly, but will also reap the rewards if they do so effectively. This payment structure also ensures taxpayers have more predictability from the Medicaid budget, knowing monthly capitated rates in advance, rather than waiting for provider reimbursement claims to be filed.

2. Capitated rates are risk-adjusted for health status

Risk-adjusting rates for health status prevents comprehensive care entities from crafting their plans in a way that encourages healthy patients to enroll while pushing sicker patients to go elsewhere. Risk-adjusting rates actually encourages comprehensive care entities to compete for sicker patients, rather than just the healthy, and manage their care more effectively. Plans are given a larger capitated rate for sicker patients and a smaller capitated rate for healthy patients, meaning that the biggest financial rewards will likely come from effectively coordinating the care of sicker patients. Risk-adjusting rates also prevents waste, fraud, and abuse and ensures resources are dedicated to those who need them most.

3. The reform does not carve out certain services, benefits, or populations

Keeping all services, benefits, and populations within the reform ensures the entire Medicaid population and all Medicaid services are delivered through the comprehensive care entity model. Carving specific services or populations out of the reform reduces its effectiveness, making it more difficult to accomplish patient-centered coordinated care. The absence of carve outs also tears down the walls between physical, behavioral, and mental health providers, encouraging better coordination and an increased focus on the holistic needs of each patient.

4. The Partnership for a Healthy North Carolina empowers Medicaid patients with meaningful choices for their health plans

Rather than corralling every patient into the same one or two health plans regardless of their individual circumstances, the Partnership gives each patient the ability to pick from multiple options a plan that best meets their needs. When given meaningful choices, patients are empowered to take more control over their health care decisions. Indeed, between 70 percent and 80 percent of patients in Florida’s Medicaid Reform Pilot actively choose their health plan, compared to the 20 percent to 30 percent who let the state automatically assign them to a plan.⁷⁸

NINE IDEAS TO UPGRADE THE PARTNERSHIP FOR A HEALTHY NORTH CAROLINA

The Partnership for a Healthy North Carolina can be tailored even further to the unique needs and individual circumstances of North Carolina's most vulnerable patients. There are a number of upgrades policymakers could pursue to ensure the reform works best for patients, providers, and taxpayers alike.

1. Expand the number of contracted comprehensive care entities beyond the three or four in the current proposal.

With 1.5 million Medicaid patients, North Carolina's Medicaid program has the economy of scale to attract significant private sector interest. Florida, for example, divided 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.⁷⁹ Louisiana received 14 bids for Bayou Health and selected five statewide options for its 900,000 enrollees.^{80,81} Kansas received five bids and contracted with three statewide options for its 400,000 enrollees.⁸² By expanding the number of plan providers, patients will be able to choose from even more plans competing for their enrollment. More competition also ensures that capitated rates will be more competitive, as the state will have more leverage over the comprehensive care entities, rather than the other way around.

2. Permit provider-led plans (physician practices, hospitals, federally qualified health centers, patient-centered medical homes, etc.) to also compete for patients.

Allowing provider-led plans to compete with other comprehensive care entities gives patients even more choices and further improves customer service and quality of care through more robust competition. In Florida, nearly half of the patients in the Medicaid Reform Pilot have chosen provider-led plans.⁸³ These provider-led options could be given statutorily-guaranteed slots, provided they are capitated within two years.

CCNC could be guaranteed one of those slots to compete alongside traditional managed care organizations, provided it is capitated within two years. This preserves and strengthens the CCNC model, but guarantees patients other options from which to choose.

3. Permit specialty plans to be offered alongside other comprehensive care entities.

Specialty plans could be offered to patients with very specific health challenges, including those with acute mental health needs, children in foster care, or patients with HIV/AIDS. Similar specialty plans are offered in Florida's Reform Pilot and allow patients to enroll in uniquely specialized plans customized to best address their special health needs. These plans should be offered in addition to the slots available for statewide contracts with other comprehensive care entities.

4. Implement a robust choice counseling program to help patients navigate the plan selection process.

Choice alone is not enough. Informed choice should be the gold standard. Florida's choice counseling program provides patients with comparisons of primary care and specialist networks, hospital networks, preferred drug lists, and extra benefits, among other things.⁸⁴ Surveys offered to all patients who use choice counseling during the enrollment and plan-switching process show that this counseling is very helpful to patients. More than 90 percent of patients found the counseling services helpful and 95 percent would recommend the counseling services to a friend.⁸⁵ Louisiana's Bayou Health features a similar choice counseling program. Choice counseling ensures patients are empowered not only with the ability to choose, but with the knowledge necessary to choose wisely. By having choice counselors operate under an independent contract, rather than be affiliated with the state or with the health plans themselves, North Carolina can ensure vulnerable patients receive truly objective information to help them pick the plan that provides the best value.

5. Include certain provider protections to ensure access improves and providers remain profitable.

Provider protections could include a statutorily-guaranteed provider rate floor for physicians and hospitals, based on current fee-for-service rates. This ensures savings are achieved through patient-centered reforms, rather than simple reimbursement rate cuts. Likewise, the state could insist on prompt payment requirements for all comprehensive care entities and could permit comprehensive care entities and medical providers to negotiate higher fees within their networks than in the traditional Medicaid program.

6. Add certain patient protections critical to ensuring the reforms work.

Patient protections could include strict plan penalties for contract breaches or patient abandonment. Just as the reforms are designed to prevent cherry-picking, they are also designed to make sure patients are treated fairly. These protections also include an open enrollment period during which patients can switch plans, empowering them to select the plans that provide them with the greatest value.

7. Allow comprehensive care entities to offer customized and extra benefit packages.

By allowing comprehensive care entities to offer customized and extra benefit packages, patients could receive benefits not typically covered by the traditional Medicaid program, including over-the-counter drugs, vision, preventative dental coverage, nutrition therapy, and respite care.⁸⁶ In 2012, plan providers in Florida's Reform Pilot offered 31 customized benefit packages from which to choose.⁸⁷ Customized and enhanced benefit packages ensure comprehensive care entities are able to compete on value by tailoring their benefits to best meet the needs and desires of their patients.

8. Build enhanced benefits rewards into capitated rates.

Florida's Medicaid Reform Pilot allows Medicaid patients to earn up to \$125 per year for receiving certain preventative services, complying with maintenance and disease management programs, and keeping appointments.⁸⁸ Individuals may then use these rewards to purchase over-the-counter items at participating pharmacies.⁸⁹ This wellness program encourages Medicaid patients to take control of their own health and promotes healthy behavior.

9. Allow working Medicaid patients to buy employer-sponsored or individual coverage when available and cost effective.

North Carolina could allow individuals to opt out of the Medicaid program and instead use the dollar value of their Medicaid benefits to pay the individual's share of the premium for private health insurance.

CONCLUSION

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

Governor McCrory's Partnership for a Healthy North Carolina is an innovative, patient-centered approach to tackle these challenges head on. It will improve the health of Medicaid patients and protect taxpayers from the Old Medicaid program's mismanagement. The strategy has already worked in Florida, Kansas, and Louisiana, and will work in North Carolina too.

To be sure, the Partnership for a Healthy North Carolina proposal could be further improved by implementing a few additional features to strengthen the reform and increase competition. But there is no question the proposal is a critical step forward to provide a Medicaid safety net that works for the patients who rely on it and the taxpayers who fund it.

Endnotes

1. Authors' calculations based on federal data from the Medicaid Statistical Information System covering fiscal year 2010, disaggregated by each basis of eligibility category. See, e.g., Medicaid Statistical Information System, "State summary datamart: FY 2010 quarterly cube," Centers for Medicare and Medicaid Services (2012), <http://msis.cms.hhs.gov>.
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3. Ibid.
4. Ibid.
5. Monthly enrollment in North Carolina's Medicaid program was 815,400 in June 1998. See, e.g., Eileen R. Ellis et al., "Medicaid enrollment in 50 states: June 2003 data update," Kaiser Family Foundation (2004), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-enrollment-in-50-states-june-2003-data-update-report.pdf>.
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8. Fiscal Research Division, "Health and Human Services Subcommittee: FY 2012-13 budget highlights," North Carolina General Assembly (2012), http://www.ncleg.net/FiscalResearch/fiscal_briefs/Budget_Fiscal_Briefs/2012_Session_Budget_Fiscal_Briefs/Final_HHS_2012_Fiscal_Brief-2012-09-06.pdf.
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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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