

Chapter 14 looks at what alternatives and approaches are likely to work, given current U.S. political processes. Chapter 15 addresses the leadership options open to professionals and the skills that they need to develop to perform them appropriately. Chapter 16, the concluding chapter, sums up some of the issues raised in earlier chapters and sends you on your way, hopefully as an effective future participant in the policy process.

Double-Checking for Contextual Change

Even when a specific policy had been thoroughly analyzed, it still has to be checked against a scenario about what is likely to happen to the system as a whole. Alternative visions, which we call *scenarios*, need to be considered. For example, a concern about moves that take us closer to universal coverage—whether that means the Affordable Care Act (ACA) as it is more fully implemented or future efforts (such as, potentially, a single-payer system)—is that we could be worse off unless there are concurrent system changes that reduce waste, expand primary care services, and address the impact on prices of treatment access for additional millions of low- and middle-income people. Various provisions of the ACA attempt to address each of these areas, but critics often say it does not do enough to control costs.

A comparison of two offsetting effects of an alternative decision is a trade-off analysis. That is one step in comparing outcomes, but it is still a very narrow picture in terms of the transparency of unintended consequences and secondary and tertiary effects. Trade-offs should be considered throughout the analysis. After the trade-offs have been evaluated and the alternatives narrowed down, the relevant scenarios will become apparent.

In the field of health policy, consensus is hard to come by, and even harder to sustain. There are certain conclusions, however, that seem to be inescapable:

- Without major interventions, health care will be near or at 20% of GDP over the next decade. No government is likely to risk too radical a change in that large a portion of the economy, especially while contending with other issues, such as international competition, immigration, terrorism, and government deficits.
- The moves of employers away from responsibility for paying health insurance premiums for workers, workers' families, and pensioners will continue despite the mandates in the ACA. The availability of an alternative path to coverage for employees of small businesses—namely the exchanges—is likely to accelerate this trend. Some larger employers may also choose to pay the penalty rather than provide “shared responsibility” coverage for all full-time employees.
- Insurance companies will come up with less expensive products for individuals (with lesser coverage) to adapt to the changing market. The risk has always been that these basic packages and new exclusions create another class of underinsured individuals and possibly drive up the premiums for the chronically ill and others who require more comprehensive coverage. This process will be shaped by the “minimum value” and “minimal essential coverage” provisions of the ACA.
- The unique aspects of health care in terms of uncertainty, agency conflict, and market failure will constrain the degree to which free-market solutions will take hold.
- Consolidation will increase the possibilities for better coordination of care but risk further increase in the market power of providers.
- Communicable disease events in other countries will affect the United States much more rapidly because of global transfers of people, foodstuffs, money, and information.
- The flow of physicians into the United States for training and their subsequent experiences practicing here will set up the potential for a competent workforce elsewhere, as we now see returnees performing hip and heart valve replacements in a number of countries at a third of the cost, with international middlemen brokering such services.
- Similarly, but more darkly, the illicit market in transplantable organs is growing rapidly, again through middlemen. There is also the international trade in prescription drugs, which is primarily attributed to Canada but is really wider and has great growth potential. Unfortunately, it opens up an entryway for counterfeit drugs as well.
- The perceived future insolvency of the Medicare “insurance” system will put pressure on the federal government, but that reckoning will likely be postponed because it will be beyond the reelection time horizons of most politicians. States will continue to deal with the burden of the working poor under the ACA and Medicaid. Even

states not participating in Medicaid expansion are expected to see increased enrollment and a rise in associated costs as a result of the ACA, and those participating in the expansion will pay 10% of related costs after 2016. That and the problems of local disasters, especially if a pandemic occurs, will lead to pressures on the federal government to provide more leadership. If the states are generally successful, the federal government will not seek a comprehensive solution. If the states fail, and that, in turn, threatens their fiscal integrity, Congress will be more likely to act.

- The states will continue to be a laboratory for implementing health policies, either through waivers or policies that are not directly related to Medicaid. The ACA allows each state to set up its own coverage system within the framework of federal law. In the wake of the ACA's passage, for example, Vermont began to develop its own system for universal coverage.

The greatest uncertainties, therefore, are not on the financing side, but on the cost-control side. Many cost-oriented measures that seem to work over time have been described previously. They could involve the following:

1. Removing provider incentives and opportunities for overutilization
2. Reducing contribution margins and incomes of providers and suppliers to levels comparable for other professional services through administered pricing or competition
3. Reducing the costs of malpractice coverage and the need for defensive medicine
4. Allowing more international competition to drive down prices
5. Constraining treatment choices to those that are most effective and efficient
6. Encouraging labor substitution for those process steps that can be made routine
7. Empowering primary care providers to control utilization and self-referral
8. Increasing the supply of providers to levels available in other countries
9. Allowing some longer waiting periods for elective procedures to slow consumption
10. Increasing use of information technology to avoid waste and medical error, but also trying to avoid the implementation of these systems in ways that are anticompetitive at both the provider and equipment supplier levels

If the states find they must demand more stringent measures from

to see further implementation of measures with more impact. Such measures could include the following:

- Full transparency in health care pricing, including bundled prices for all stages of a specific medical condition
- Legislation to amend the Employee Retirement Income Security Act (ERISA) to allow states to regulate self-insured plans
- Regionalization of care for complex or rare medical conditions, which would require greater patient travel but produce much less waste and better outcomes
- Stronger control of the referral process by primary care providers
- Other aspects of value-based competition (Porter & Teisberg, 2006) in the marketplace, including the following:
 - Integrated IT systems reporting bundled prices and quality performance for many more procedures and diagnoses.
 - Attention to the total process of care, making it better coordinated and more effective.
 - Shifting research budget priorities from developing and evaluating new treatments to evaluating methods already in use and innovating more in process improvement rather than in new product development (Chin et al., 2013).
 - Limitations on allowable price discrimination, perhaps along the lines of the Robinson-Patman antitrust law, but applied to individuals.
 - Phasing out of laws governing corporate practice of medicine, as well as other restrictive regulations, in order to open up competition on price and results. This needs to be accompanied by licensure procedures that are more closely linked to performance.

Are we saying that the future of our health care depends more on the willingness of others to underwrite our debt—factors that if they change significantly could precipitate an economic breakdown—than on our own democratic processes? That is possible. Noted health economist Victor Fuchs (2002) has suggested that major health system change, such as national health insurance, will come only after the “kind of change that often accompanies a war, a depression or large scale civil unrest” (p. 1824).

TRADE-OFFS

It is popular to talk about a country, if not a world, divided over values, but that is not the entire story. This book illustrates that there are many trade-offs—trade-offs everywhere one turns. **Table 14-1** lists a number of these,

Table 14-1 Illustrative List of Trade-offs, Impacts, and Some of the Proposed Solutions

Trade-off	Versus	Current Impact	Proposed Solutions
First-dollar coverage	Catastrophic insurance	Many see payouts, motivating participation, but not enough money for both	Major medical option Means testing (spend-downs and Medicaid) Risk pools for high-risk patients
Selective underwriting	Community rating	Adverse selection Lifetime limits Prevention disincentives	Minimum coverage for all, with add-ons allowed
New drug safety and efficacy	Rapid deployment of effective technology	Current focus on drugs for continued use A lack of new drugs to fight acute illnesses	Sponsored development Reduced approval cycles Stronger postmarketing surveillance
Direct-to-consumer advertising	Health education campaigns	Higher drug costs Overutilization Misallocated research funds Disease mongering	Constraints on proportion of costs in advertising Redefining health Health education (counter detailing)
Liability for vaccines' effects	Vaccine development and production capacity	Inability to respond to surges in demand Failure to develop new vaccines and production methods	Limited liability Support for nonprofit producers Subsidies for standby capacity
Linked electronic medical records	Consumer privacy	Medical errors Duplicate tests Slow responses to acute problems	Designing in privacy safeguards Firewalls
Need to train new health professionals	Desire to increase faculty incomes and cross-subsidize research	Overstressed learners Decreased quality of care	Better funding of supervision Reduced charges for learner-produced services
Investment driven by utilization growth	Certificate of need	Efforts to increase demand Duplication of services Reduced competition	Wider disease-specific catchment areas Capital rationing Global budgeting

showing the two sides, the impacts of the current status quo, and some possibilities for responding to them. The fact that these trade-offs have been issues for as long as they have shows that they are currently at an equilibrium position (or an impasse). Some would argue that having a less than rational system with unresolved conflicts and continuing inefficiencies is not all bad because it provides high-income employment. It does that, but one might also question how productive much of that employment is.

We expect that managing trade-offs, rather than implementing radical changes, will be grist for health policy analysts' mill for some years to come. Each time a new program or regulation is proposed to deal with one aspect of health care access, cost, and quality, the policy analyst must present to the interested parties the trade-offs that have to be made, their magnitude, and their consequences, intended and otherwise. The policy analyst will have to look at the desired impact, the unintended consequences, the distributional effects, the ethical issues, the technological impact, the financial feasibility, the political feasibility, and the best way to implement the proposal, and from that come up with a justified recommendation to the parties involved, the politicians, and the public. Such analyses do not necessarily lead to earthshaking decisions because there is no one answer. However, they are necessary if we are to make things better rather than worse. If they succeed, it will be a product of leadership as much as anything else; however, those who would lead, especially from a professional position, must participate both in effective analysis and in rational leadership.

WORKING OUT YOUR OWN SCENARIOS

Someone could push the policy envelope by considering extreme scenarios against the status quo and seeing what kind of health care system might result; however, getting single-event estimates is only one step in the process. An event may be acceptable on its own, but its interaction with other events may result in an overall outcome that is totally unacceptable. For example, encouraging kidney transplants for end-stage renal disease patients is one thing, but if the supply is totally inadequate and promotes a sizable international traffic in involuntarily harvested human kidneys, would that be acceptable? We have set up an illustrative example with multiple scenarios to compare. We have provided five scenarios, three of which are extreme:

- A. Extrapolating current trends
- B. Extreme reliance on free market
- C. Extreme industrialization

Table 14-2 Building Some Scenarios for Cost Reduction

Change Scenario	A	B	C	D	E
1. Remove provider incentives to overutilize.	N	N	N	Y	
2. Major changes in staffing requirements.	N	Y	Y	Y	
3. Major reductions in provider and staff incomes and contribution margins.	?	Y	N	Y	
4. Reduced costs of malpractice coverage.	Y	?	Y	Y	
5. International competition reducing prices.	Y	Y	?	?	
6. Constraining treatment choices to those most effective and efficient.	N	N	Y	Y	
7. Encouraging labor substitution where process can be industrialized.	N	Y	Y	Y	
8. Empowering primary care providers to control utilization and self-referrals.	N	N	Y	Y	
9. Increasing supply of providers to levels in other countries.	N	Y	N	?	
10. Increased waiting periods and other devices to increase competition.	N	N	Y	Y	
11. Increasing use of IT to reduce waste and medical error without constraining competition.	Y	Y	N	?	
12. Global budgeting of hospitals and other institutions to ration capital, perhaps on a regional basis.	N	N	Y	Y	
13. Stripping away less essential services or covering outside health insurance system.	?	?	Y	Y	
14. Return of more voluntarism in the health sector.	N	Y	N	N	

Y = likely, N = not likely, and ? = not predicted

Scenario A is the extrapolation of the current trends in the current system.

Scenario B is the case of an extremely strong move toward a free-market health care system.

Scenario C is the case of an extremely strong move in the direction of industrialization and corporate governance of health care.

Scenario D is the case of a major economic crisis that leads the country to a major overhaul of government programs, including health care, and major changes in the tax code, such as a shift from the income tax to a value-added or some other form of consumption tax.

Scenario E provides all citizens a voucher for basic health coverage, replacing current insurance and Medicaid and ultimately Medicare. It would be financed with a value-added tax and add administrative systems to oversee coverage, technology assessment, and quality measurement and to replace the current tort system for malpractice with administrative law.

- D. National economic crisis resulting in major tax code reform
E. The Emanuel-Fuchs proposal

In **Table 14-2**, we have provided, by way of illustration, event predictions for 15 changes that fit the first four of these scenarios. A rational person can certainly come up with others, and thus we have included **Table 14-3**, which encourages you to build your own predictions, redefining the scenarios and then assessing the impact of a set of events that you are free to augment.

Scenario A: The Status Quo Extrapolated

As you look down column A of **Table 14-2**, you see that not much new is happening to reduce costs. We might expect to see some responses as volume increases due to access improvements under the ACA, reductions in malpractice insurance costs, and international competition to reduce the prices of some procedures. There are also possibilities that as consumers and insurers find it harder and harder to pay their bills provider incomes will fall further, along with institutional contribution margins. Health information technology (IT) will move into place, but it may still be subject to the complaint that despite increased deployment of health IT the motivation to share information is still lacking. Thus, one might see some internal waste and medical error reduced, but very high investment costs with relatively little immediate impact on operating costs. Some major changes might occur on the funding side, however; thus, you might want to repeat the exercise with an added set of rows representing programmatic changes on the funding side.

Scenario B: Extreme Reliance on the Free Market

Here we would be likely to see little or no action to reduce costs, except to increase the competitive pressures from foreign competition and to increase the supply of providers. The primary argument for consumer-centered health care—that consumers will make choices to lower their own costs of care—is not addressed in this listing. Again, you might want to repeat the exercise with some events related to consumer-driven health care as an additional set of rows; however, with the lower resulting profit margins and professional incomes, more providers are likely to improve efficiency to compete on cost, resulting in staffing changes, better use of information technology for scheduling and coordination, and more use of volunteers.

Table 14-3 Your Exercise on Building Cost-Reduction Scenarios

Change Scenario	A	B	C	D
Remove provider incentives to overutilize.	N			
Major reductions in provider and staff incomes.	?			
Reduced costs of malpractice coverage.	Y			
Constraining treatment choices to those most effective and efficient.	?			
Encouraging labor substitution where process can be industrialized.				
Empowering primary care providers to control utilization and self-referrals.				
Rationing capital available to institutions.				
Increased waiting periods and other devices to increase competition.				
Increasing use of IT to reduce waste and medical error without constraining competition.				
Global budgeting of hospitals and other institutions, perhaps on a regional basis.				
No-fault health insurance, perhaps with tiered premiums				

Y = likely, N = not likely, and ? = not predicted

Scenario A is the extrapolation of the current trends in the current system.

Scenario B is _____

Scenario C is _____

Scenario D is _____

Scenario C: Extreme Industrialization

Under the corporate, industrializing scenario, the resulting oligopolistic firms will likely try to resist and/or seek protection from a number of cost-reduction pressures, such as foreign competition and increasing the supply of providers. At the same time, they will likely make a number of

internal policy choices that limit provider options, restrict capital investment, constrain institutional budgets, and break jobs down into repetitive tasks doable by lower-level, lower-paid personnel. They will also be likely to resist and lobby against measures to limit overutilization, as long as those limits affect their revenues.

Scenario D: National Economic Crisis Resulting in Major Tax Code Reform

In this scenario, the nation is in severe economic difficulties, and radical change is in the air. There is near universal coverage. At the same time, there is a much higher level of regulation affecting choices of treatments, capital availability, and staffing coupled with a defined minimum acceptable coverage. Resources will be very tight; thus, waiting lines will lengthen, and there will be pressures to put hospitals on fixed budgets, reduce services that are not absolutely necessary, and concentrate specialized treatment capacities to increase throughput and effectiveness.

Scenario E: The Emanuel-Fuchs Proposal

In a one-page article in *Fortune*, Emanuel and Fuchs (2006) offered a suggestion on "How to cure U.S. health care." They offered a comprehensive five-part program, the centerpiece of which would be a health care voucher for every citizen currently younger than age 65. It would cover currently accepted levels of care with existing or new health plans. Each individual would then have a choice of 5 to 10 plans that would have to accept all comers.

The vouchers would be paid for by an earmarked 10% value-added tax that would be offset by replacing current employment-based insurance premiums, Medicaid expenditures, and individual and corporate tax deductions for health care premiums. Medicare recipients would be grandfathered (so to speak) under the current system, but those in the new program would stay with it past age 65, and Medicare would gradually be phased out.

To administer it, there would be a new system of federal and regional boards, much like the Federal Reserve System, to provide accountability, specify and modify the benefit package, and oversee technology assessment and quality evaluations. Malpractice cases would be assigned to a separate administrative system that would adjudicate and pay claims and oversee linkages to quality measurement and the licensure process. We have left column E of Table 14-2 blank for you and your colleagues to assess and fill in.

Interpreting the Cost-Reduction Scenarios

As you can see, virtually every scenario in Table 14-2 has elements to which U.S. patients would strongly object, and each is likely to generate strong opposition from one or more interest groups. That is why the most radical departures from current trends of more intramarket competition and more industrialization are likely to occur only if there is a continuing economic crisis or a more serious meltdown of the economic system, forcing a return to bipartisanship and evoking new, strong domestic leadership with the will to take the government in a very different direction; however, it is apparent that each of the first three scenarios is weak in terms of its likely effects on health care costs, and, ultimately, draconian measures may be taken. In other words, nothing in these scenarios is likely to work until the society either runs out of money or reaches some consensus as to when enough health care is enough. Economists differ on whether that will be 10, 20, or 25 years from now (Hall & Jones, 2007).

TRY YOUR OWN SCENARIOS

We purposely offered scenarios that omitted some key policy possibilities (such as consumer-oriented health care) in hopes that you and your associates would undertake your own evaluative process and (1) flesh out your own list of changes to be tried, (2) match them against your own list of scenarios, (3) debate the effects of each change on the outcome of each scenario, and (4) come up with your own concepts of what would or would not work in the United States under various conditions. There are no pat answers. Most alternatives have been tried elsewhere in the world with mixed results. What would you want the United States to try next, perhaps on a small scale, to see how it works here?

CONCLUSION

This chapter emphasized the importance of putting event forecasts into scenarios to highlight how events and measures will interact. The initial step is to outline and evaluate the trade-offs involved with each alternative. A number of examples of health care trade-offs are provided. Possible outcome scenarios can be developed from your own lists of trade-offs. Four illustrative outcome scenarios were considered dealing with the status quo ante, more industrialization, more governmental involvement, and more of a free market; however, even these were not examined exhaustively, and further examination would be warranted on your part.

Case 14 Partnership for a Healthy North Carolina

In early February 2013, the administration of newly elected Republican governor Pat McCrory began the process of Medicaid reform with a request for information (RFI). Based on those responses, the newly appointed leaders of the state Department of Health and Human Services, Aldona Wos, MD (secretary), and Carol Steckel, MPH (Medicaid director), held a number of information-gathering meetings around the state. On April 3, 2013, the governor and the heads of both legislative houses held a press conference to announce that they would seek legislative approval of a Medicaid waiver request to Washington to substantially change the state's Medicaid system.

The governor and the secretary had referred to this effort as a "Partnership for a Healthy North Carolina." This was also the title of a report published by the John Locke Foundations and the Foundation for Government Accountability (Ingram & Restropo, 2013). Art Pope, a significant contributor to the John Locke Foundation and other libertarian causes and Republican candidates, was the governor's newly appointed associate budget director.

That report viewed as positive recent reforms in Florida, Louisiana, and Kansas. It suggested that North Carolina could save \$1 billion annually, or 8% of its Medicaid costs, using the design cited in the report, as follows:

- The state awards contracts to three or four comprehensive care entities (CCE).
- CCEs operate statewide, ensuring fair and equal access for patients in both rural and urban areas.
- All CCEs 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 the service they can provide.

KEY ASPECTS OF THE PARTNERSHIP FOR A HEALTHY NORTH CAROLINA

- Patients unhappy with their plans can drop them and choose new ones that will better serve them.
- These plans would be paid on a risk-adjusted, capitated basis. (Ingram & Restropo, 2013)

Many of North Carolina's Medicaid patients had already been enrolled in a medical home program that was fee-for-service with a per-member-per-month (PMPM) management fee. This nonprofit system of local networks, organized and operated by community physicians, named Community Care of North Carolina, has been credited with saving the state close to a billion dollars over a 4-year period. It has also been recognized as a national leader in improving Medicaid quality and cost and has been expanding to serve other populations as well.

THE GOVERNOR'S POINT OF VIEW

The governor had frequently stated that Medicaid was "broken" and that he envisioned a system "to provide care for the whole person by uniting physical and behavior health, increase administrative ease and efficiency for providers, create a predictable and a sustainable Medicaid program for taxpayers" (Office of the Governor, 2013). House Speaker Tom Tillis (R-Mecklenburg) was quoted as saying, "We cannot continue to have frequent unplanned Medicaid shortfalls that wreak havoc on the budgeting process. Medicaid must stop being a budgetary time bomb."

Senate President Pro Tempore Phil Berger (R-Rockingham) was quoted as saying, "Medicaid's out-of-control costs are undermining our ability to fund core constitutional obligations like education, transportation and our judicial system. The budget we introduce next week must include over \$1 billion in additional funding for out-of-control Medicaid costs."

The governor's administration could also point to an audit of the Medicaid program conducted by State Auditor Beth Wood (D). It had been commissioned by his predecessor, Governor Bev Perdue (D), but the report was not issued until January 17, 2013. The audit discovered that there had been major overruns in the Medicaid entitlement program and that administrative costs paid directly were high compared to other states. North Carolina's population was growing and had been hard hit by the Great Recession, thus enrollment had increased rapidly. The Kaiser Family Foundation credited North Carolina with

Case 14 (continued)

the smallest per capita costs in the Southeast and the nation's slowest growth in program costs (Hoban, 2013a). Assertions about the relative level of administrative cost varied greatly. Some states contracted out administrative functions that others produced directly with budgeted resources. Some state health and human services departments loaded allowable collateral costs into the Medicaid budget to maximize the inflow of federal dollars. For example, North Carolina was charging half of the cost of the Medicaid-eligibility specialists in county social services departments back to Medicaid.

The disastrous 2013 rollout of a new computerized Medicaid payment system was also cited as a symbol of the need for change. In the interest of full disclosure, we must note that one author of this text served as chair of the North Carolina Medicaid Medical Care committee some 30 years ago, and the department had severe problems using its data for systematic analysis then, as now. It could not compete effectively in the IT labor market and had trouble even administering its IT contracts to get necessary management information out of what was essentially a transactional system.

There were also widely acknowledged problems with the state's mental health system, which depended largely on Medicaid. For example, mental health provider agencies, called local management entities (LMEs), had for the past 2 years been bearing the risk of providing mental health care services using a set amount of money each month. However, given the financial problems that many of these LMEs suffered, as evidenced by the failure of the Asheville-based Western Highlands Network, Steckel decided that this was not the most effective way of managing financial resources that had been set aside for mental health (Hoban, 2013b).

Critics of the governor were quick to suggest that he was using the "Medicaid is broken" issue as a cover for his refusal to develop a state insurance exchange under the ACA.

MANAGED MEDICAID IN NORTH CAROLINA

The last state health maintenance organization (HMO) contract for Medicaid recipients, serving only Mecklenburg County, including

Charlotte, ended in 2006. A number of other HMO contracts, mostly serving urban areas, had been in operation between 1986 and 2002.

Community Care North Carolina (CCNC) and its earlier version, called ACCESS, has been credited with increasing the number of physicians accepting Medicaid patients. According to the Kaiser Family Foundation (2009), "CCNC was adopted as an alternative to capitated managed care that was embraced by physicians and was able to successfully operate in both urban and rural areas."

Since 1991, a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS) has been in effect for primary care case management programs. The state launched a successful pilot program that was then expanded statewide. The participating providers were paid a PMPM management fee for coordinating care and compensated fee-for-service for treatment. This system evolved and expanded and was spun off from state government into CCNC. This system of 14 primary care provider (PCP) networks serves as the medical home for more than half of the state's Medicaid enrollees. The networks are nonprofit and managed locally but fall under the umbrella of the nonprofit, statewide CCNC organization, which develops procedures and standards and provides information services, education, and evaluation. The system also had a Section 646 waiver to serve dual eligibles and high-risk uninsured.

As of 2013, the state Department of Health and Human Services requirements for a Medicaid PCP to participate included the following:

A candidate for participation must meet the criteria below:

- Perform primary care that includes certain preventative services;
- The ability to create and maintain a patient/doctor relationship for the purpose of providing continuity of care;
- Establish hours of operation for treating patients at least 30 hours per week;
- Provide access to medical advice/services 24/7;
- Maintain hospital admitting privileges or have a formal agreement with another doctor based on ages of the members accepted;
- Refer or authorize services to other providers when the service cannot be provided by the PCP;
- Use reports provided by the DMA managed care section as guides in maintaining the level of care that meets the goals of CCNC and patient needs. Reports are available via the web and paper copies that are mailed. (NC DHHS, 2013, p. 9)

Case 14 (continued)

North Carolina had resources that could be leveraged, including CCNC and the LMEs currently delivering mental health services. The number of entities would probably be reduced. The medical care managers would probably number five to seven, and physical and mental health would be integrated. The legislature would likely act in May 2014 and waivers submitted to Washington soon after so that requests for proposals could go out in time to put the system in place in late 2015 or early 2016 (Dihoff, 2013).

Discussion Questions

1. What are the apparent strengths and weaknesses of the current Medicaid care management system in North Carolina?
2. How does one separate out the effects of IT failures, budget overruns, and exogenous changes in enrollment?
3. What would be the governor's likely proposal to the legislature? Why?
4. What should CCNC do to prepare for the changes that seem to be in the wind?
5. How does one best integrate physical and mental health services?

Chapter 15

Health Professional Leadership

Normal is getting narrower and narrower.

—Personal observation by an experienced nurse practitioner

Health professionals can be important participants in health policy processes. They bring their experiences, their knowledge of both science and art, their ability to distinguish between the two, and their commitment to the patient. Typically, they also bring a commitment to lifelong learning. The power of the professions, especially physicians, has been waning of late, but that has a lot to do with the height of their dominance in the past. In an open, market-driven, information-rich society, the old monopoly power described by Starr (1982) is not sustainable. Health professionals now need to undertake new leadership roles or else their status will be further undermined by those actively seeking a greater share of the pie. Those new roles will have to focus more on collaboration and coordination of care.

DISINTERESTEDNESS

Much of the diminished respect for health professionals stems from the public's perception of reduced disinterestedness. Current fashion in economics seems to deny the concept of disinterestedness—the concept of lack

Case 14 (continued)

The responsibility of managing care rested with the network. Physician leaders had been developing evidence-based tools for the networks, including implementing best practices and disease management for

- Asthma
- Congestive heart failure
- Diabetes
- Hypertension
- Ischemic vascular/cardiovascular disease

Physicians also sought to develop case management procedures for high-risk/high-cost patients.

Process performance measures were in place for all of these, and almost 30,000 chart reviews supporting quality improvement were conducted among the 1.3 million (out of 1.8 million) Medicaid enrollees and 1,350 PCP practices in a recent year. CCNC had had a streamlined electronic medical record system available since 2009. Reviews were conducted randomly within diagnosis, and several registries were supported.

The PCPs had a limited gate-keeping role:

... the PCP is contractually obligated to refer patients and authorize treatment for patients when unable to provide the necessary service. It is the domain of the PCP to refer/authorize treatment and define the scope... which includes the number of visits being authorized and the extent of the diagnostic evaluation. The PCP should be informed if a secondary referral... should be made. A provider who has received a referral should consult the PCP before referring to a secondary provider for situations not related to the diagnosis of the first referral. The PCP may authorize care retroactively; however, it is at the discretion of the PCP. (NC DHHS, 2013, p. 9-10)

The document then proceeds with a page-long list of "Exempt from Authorization by the PCP"; the list includes emergency departments, hospital-owned urgent care centers, hospices, hospital-based lab and diagnostic procedures, and health departments.

WHERE DOES NORTH CAROLINA GO NEXT?

The governor's announcement created considerable concern, especially in the medical community. For example, one letter from a physician in the *Raleigh News & Observer* read:

I appreciate the governor's desire to control Medicaid spending. I know of few physicians who would argue against reining in medical costs or making improvements. But the governor's proposal runs counter to what North Carolina has been doing with its award-winning approach to Medicaid.

The national Kaiser Family Foundation even recently reported that North Carolina had the lowest rate of growth in Medicare spending in the nation.

So why change direction now? And why use private managed care companies that have been shown to be more costly and less effective in many cases? (George, 2013)

The *Triangle Business Journal* commented:

... health care providers say Medicaid reimbursements barely cover costs as it is, so it's difficult to see where a potential CCE could find real savings. ... The state has a history of making health care demands that private companies find unachievable. Last year, the state put out requests to outsource inmate health care, but abandoned the idea when Corizon Inc., one of the largest providers of such services, said that the state's requests "contain several provisions that are either completely unattainable or add significant and unnecessary cost that will likely mitigate any savings that can be achieved." (deBruyn, 2013)

Later in the year, Secretary Wos was involved in other controversies, and in October, Medicaid Director Steckel resigned to go into the private sector. On November 6, 2013, the governor invited 30 state health care leaders to the governor's mansion to discuss Medicaid reform. The governor reported that there was a new advisory group working on a proposal. It would hold public hearings and recommend a waiver request to the legislature on March 17, 2014. One participant reported that the governor felt that no one state had all the answers and that