

Executive Summary

This overview outlines key findings from Mercer's analysis of cost savings generated under North Carolina's CCNC/ACCESS Medicaid Program. Mercer limited this study to cost savings achieved for the Aged, Blind and Disabled participants during State Fiscal Year 2008 (SFY 2008). Our full report includes important details and some caveats concerning the findings and should be referenced for a more complete understanding of the results and related issues.

Savings were estimated by comparing costs for individuals enrolled in the CCNC/ACCESS program to costs for individuals not enrolled in the CCNC/ACCESS program, i.e., "Fee for Service" (FFS) program individuals. The two key financial findings were:

- Changes in care management for SFY 2008 versus SFY 2007 appear to have increased SFY 2008 costs under the CCNC/ACCESS program by a relatively modest \$6 million
- All care management initiatives to date, including the changes referenced above, appear to have reduced SFY 2008 costs under the CCNC/ACCESS program by approximately \$400 million

For our analysis, CCNC/ACCESS recipients were compared to FFS recipients by bucketing every individual into health risk score buckets, referred to as Resource Utilization Bands (RUBs), using Johns Hopkins Adjusted Clinical Groups (ACG) case mix system. Our first finding, that there was a relatively inconsequential increase in costs resulting from changes in care management between SFY 2007 and SFY 2008 is based on a comparison of increases or decreases in cost for each category of service (COS) within each RUB. The calculation was done separately for dually eligible Medicare recipients and for those not dually eligible. If costs for a given COS within a RUB increased less rapidly under the CCNC/ACCESS program than it did for FFS, then the difference was attributed to incrementally better care management.

Our study found incremental savings for Inpatient Hospital, Outpatient Hospital, Emergency room, Physician, and "other" miscellaneous service categories, suggesting the CCNC program is increasing its ability to manage costs in these broad areas. However, our analysis showed significant reductions between SFY 2007 and SFY 2008 for pharmacy costs within the FFS program. The CCNC/ACCESS program did not show similar significant reductions between the SFY 2007 and SFY 2008 period of analysis. Our more complete analysis notes that this finding is counter-intuitive, and may be a short term anomaly. We suggest a number of possible explanations, for example, that the FFS environment may be catching up to best practices in pharmacy management developed in the CCNC program prior to SFY 2008. We also note that several new CCNC initiatives may not yet have had an opportunity to produce savings.

Our second finding is that costs in the CCNC/ACCESS program are significantly less than those for apparently comparable recipients in the FFS program – that is, FFS members with comparable expected resource utilization according to the Johns Hopkins risk model and adjusted for Medicare status (i.e., whether or not the recipients are also eligible for Medicare), and for their different mix of services. Having adjusted for risk scores and service mix, our hypothesis is that these remaining cost differences may be due to the CCNC care management initiatives over the years. We caveat that there may be other unrecognized influences that could over- or under-state the savings estimates. Again, lower costs within the CCNC/ACCESS program are observed for Inpatient Hospital, Outpatient Hospital, Emergency room and Physician Services. These savings are partially mitigated by increases in cost for prescription drugs and for the Home Health care component of “other” services, which are exactly the services that care management seeks to emphasize in order to reduce higher intensity hospital and physician services.

In summary, subject to the necessary limitations of study methodology and data, the CCNC/ACCESS program appears to be doing an effective job of managing costs in the Aged Blind and Disabled segment of North Carolina’s Medicaid population and to be generating significant savings.

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