Community Care of North Carolina

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Community Care of North Carolina

Our Vision and Key Principles

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- Develop a better healthcare system for NC starting with public payers (Medicaid)
- Strong primary care is foundational to a high performing system
- Additional resources needed to help primary care manage populations
- Timely data is essential to success

Medicaid challenges

- Lowering reimbursement reduces access and increases ER usage/costs
- Reducing eligibility or benefits limited by federal "maintenance of effort"; raises burden of uninsured on community and providers
- The highest cost patients are also the hardest to manage (disabled, mentally ill, etc.) — CCNC has proven ability to address this challenge
- Utilization control and clinical management only successful strategy to reining in costs overall

CCNC Provides NC with:

- Statewide medical home and care management system in place to address quality, utilization and cost
- 100 percent of all Medicaid savings remain in state
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.

Key Tenets of CCNC

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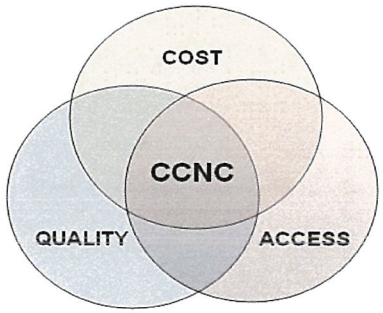
- Public-private partnership
- "Managed not regulated"
- CCNC is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs primarily by greater quality, efficiency
- Providers who are expected to improve care must have ownership of the improvement process



Primary Goals of CCNC

- Improve the care of Medicaid population while controlling costs
- A "medical home" for patients, emphasizing primary care
- Community-based networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings

CCNC: "How it works"

- Primary care medical home available to 1.4 million individuals in all 100 counties.
- Provides 4,500 local primary care physicians with resources to better manage Medicaid population
- Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery

CCNC: "How it works"

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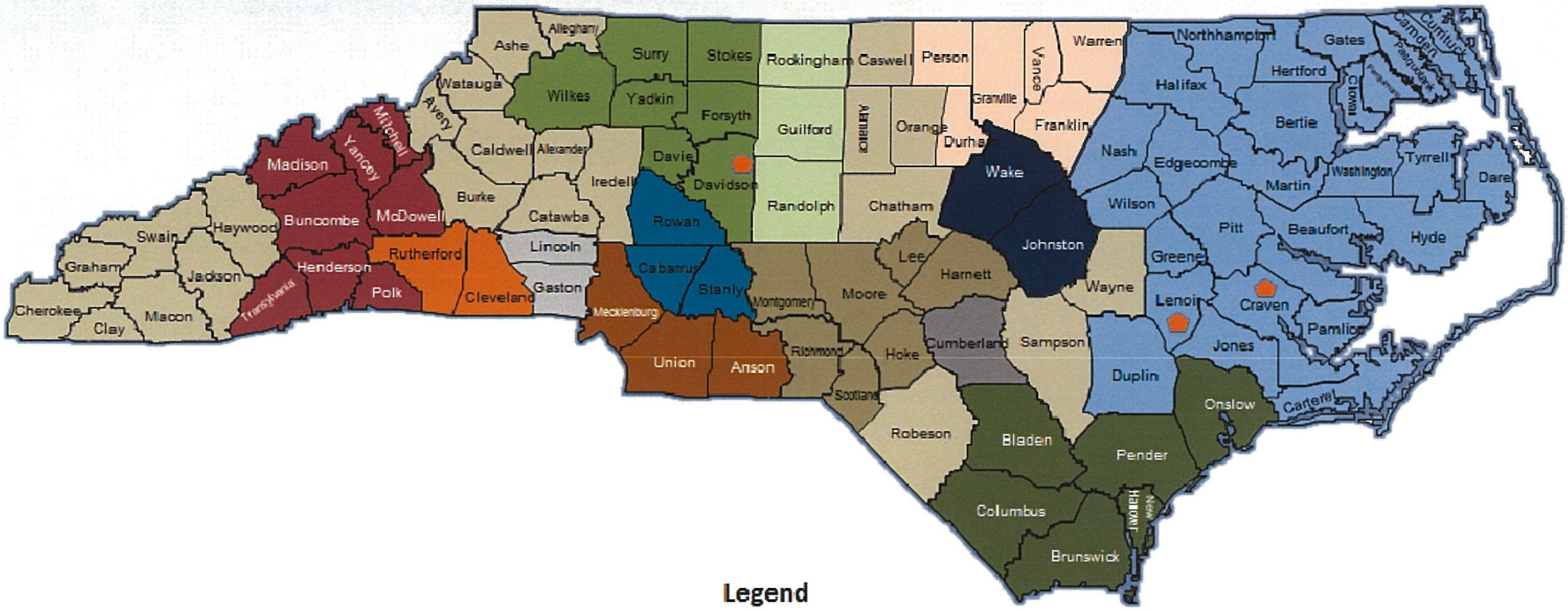
- The state identifies priorities and provides financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practices are spread to other networks
- The state provides the networks full access to claims data
- Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions).

Community Care Networks



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Source: CCNC August 2012

Community Care Networks

- Are non-profit organizations that receive a per-member, per-month (PMPM) payment from the state
- Primary care providers also receive a PMPM payment
- Provides resources needed to manage enrolled population, reducing costs
- Central office of CCNC is also a nonprofit 501(c)(3)
- Seek to incorporate all providers, including safety net providers
- Have Medical Management Committee oversight
- Hire care management staff

Each network has:

- Clinical Director
  - ✓ A physician who is well known in the community
  - ✓ Works with network physicians to build compliance with care improvement objectives
  - ✓ Provides oversight for quality improvement in practices
  - ✓ Serves on the Sate Clinical Directors Committee
- Network Director who manages daily operations
- Care Managers to help coordinate services for enrollees/practices
- PharmD to assist with Med management of high cost patients
- Psychiatrist to assist in mental health integration

Community Care's Informatics Center

Informatics Center — Medicaid claims data

- Utilization (ED, Hospitalizations)
- Providers (Primary Care, Mental Health, Specialists)
- Diagnoses – Medications – Labs
- Costs
- Individual and Population Level Care Alerts

Real-time data

- Hospitalizations, ED visits, provider referrals

Community Care's Informatics Center

- Care Management Information System (CMIS)
- Pharmacy Home
- Quality Measurement and Feedback Chart Review System
- Informatics Center Reports on prevalence, high-opportunity patients, ED use, performance indicators
- Provider Portal

Chronic Care Program Components

- Enrollment/Outreach
- Screening/Assessment/Care Plan
- Risk Stratification/ Identify Target Population
- Patient Centered Medical Home
- Transitional Support
- Pharmacy Home – Medication Reconciliation, Polypharmacy & PolyPrescribing
- Care Management
- Mental Health Integration
- Informatics Center
- Self Management of Chronic Disease

Major initiatives

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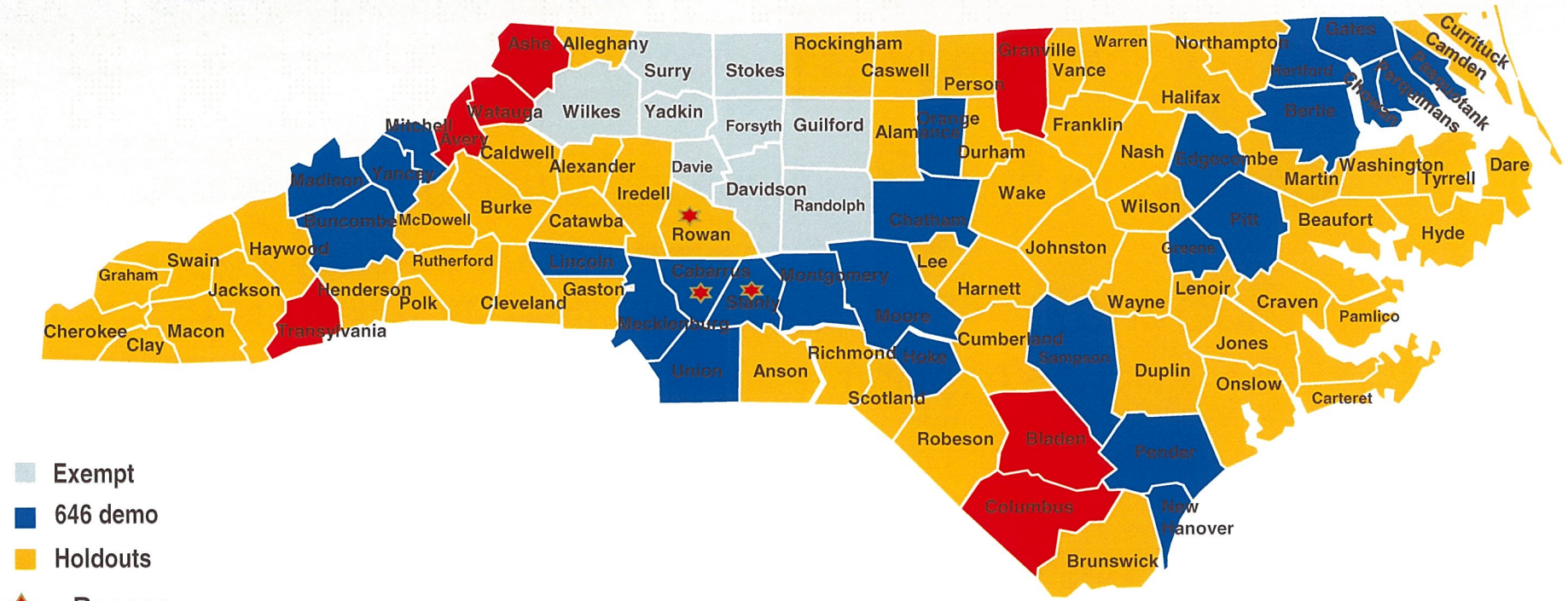
- Multi-payer Advanced Primary Care Practice Project (MAPCP - 7 rural counties)
- Pregnancy Medical Home
- Care Coordination for Children (CC4C)
- Child Health Accountable Care Coalition (CHACC) – CMMI Innovations Grant
- Medicare 646 demo (22 counties) caring for Medicare patients
- Beacon Community (3 counties), all payers
- Palliative Care
- Support for practices seeking PCMH recognition
- Chronic Pain Initiative

646 & Multi-payer Counties



NCQA-recognized PCMH practices in North Carolina

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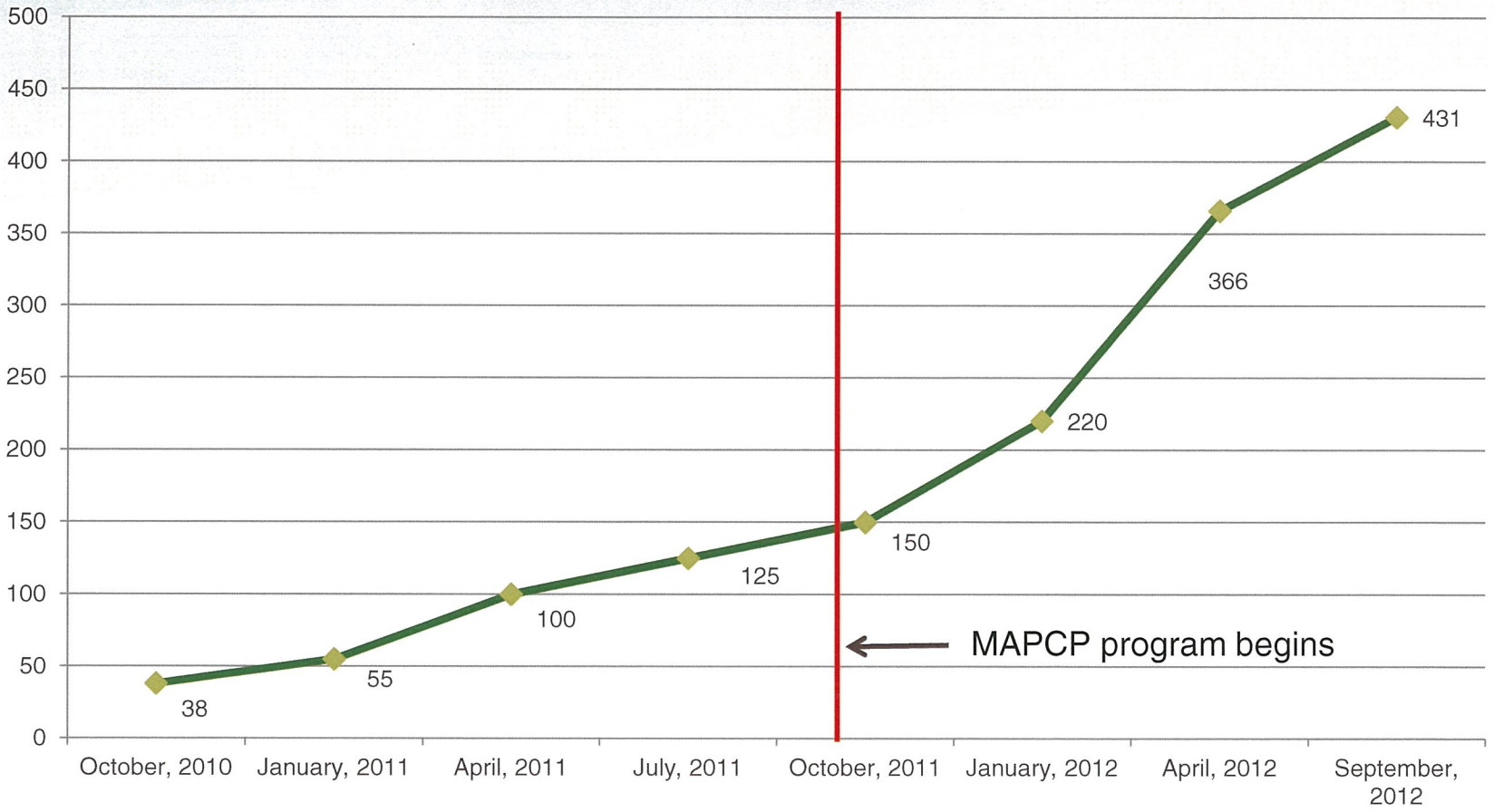

Quality comes first, savings ensue

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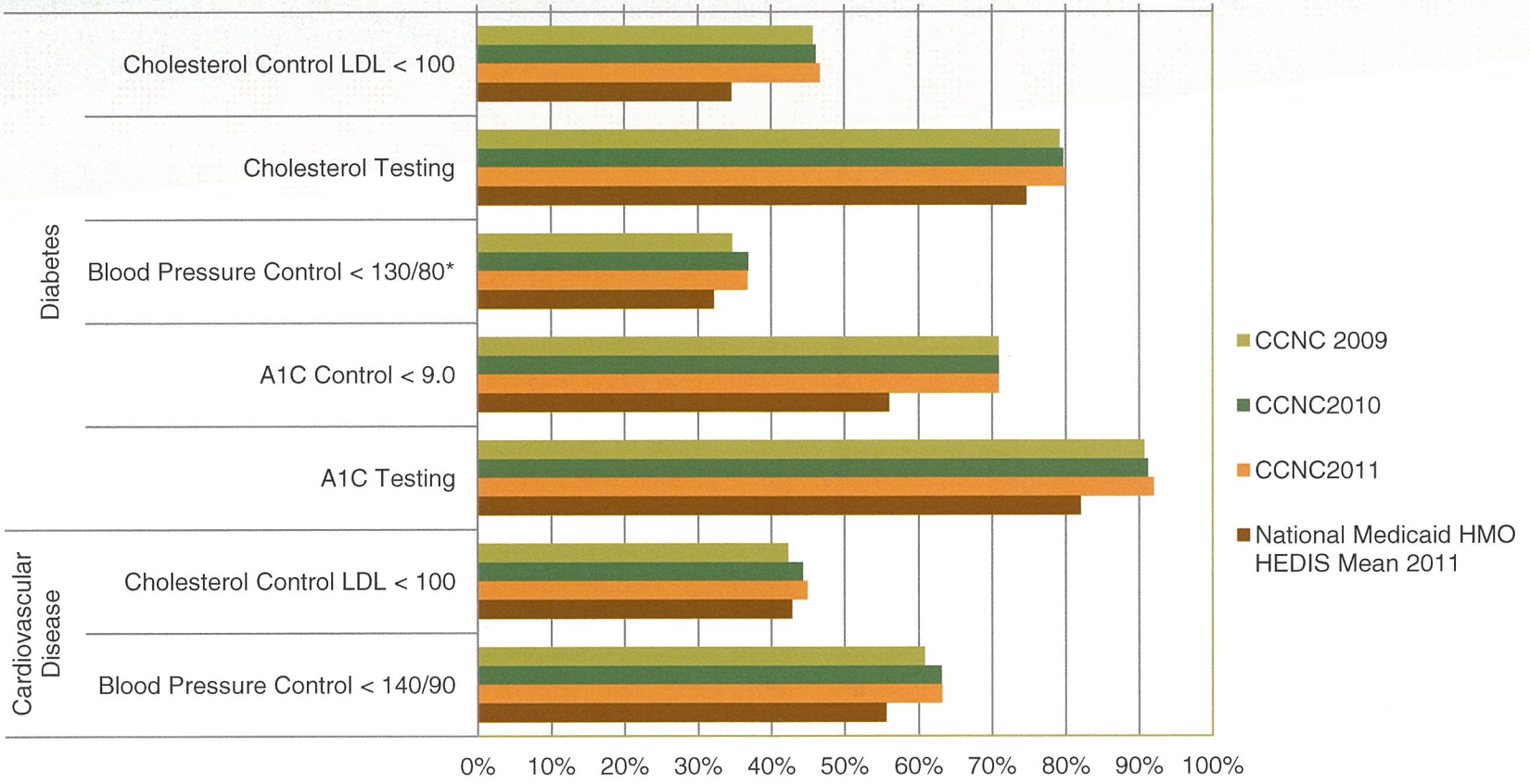

*Includes the benchmark for HEDIS Year 2010. As of HEDIS Year 2011, HEDIS is no longer reporting a benchmark for BP < 130/80.

Managing transitions

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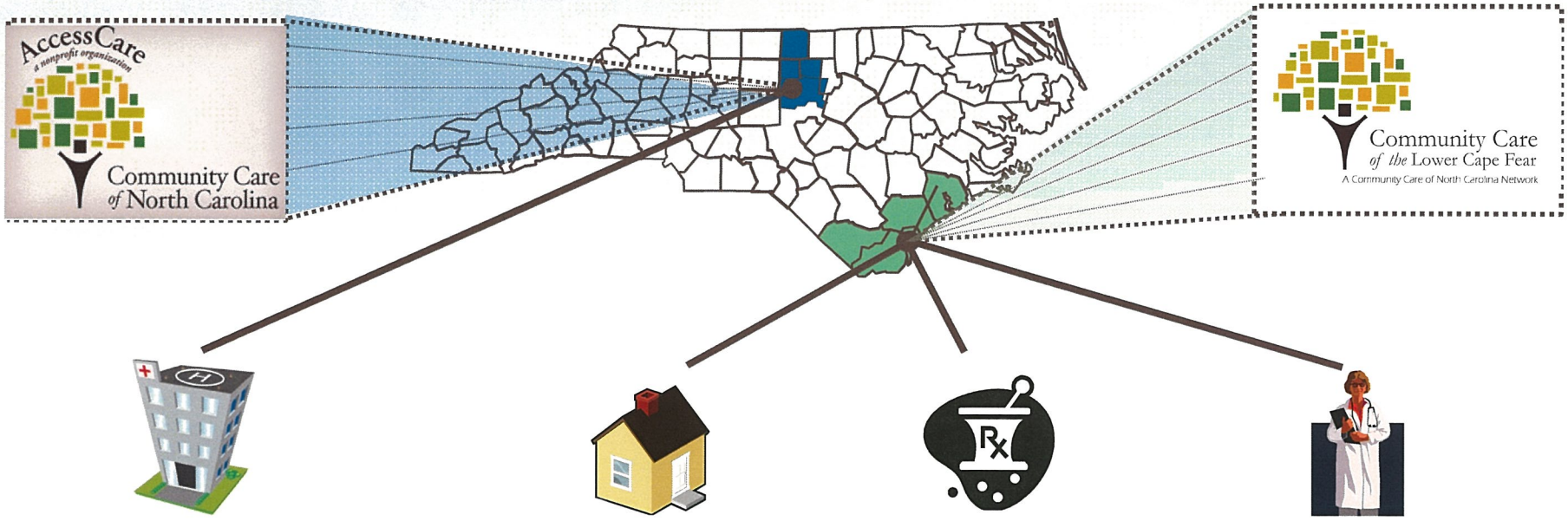
- 190,000 NC Medicaid recipients admitted to the hospital each year; 31,000 multiple hospital admissions.
- Nearly 1 in 10 admissions is readmission within 30 days of a previous discharge.
- ABD only 25% of NC Medicaid recipients, but 40% of all inpatient admissions, two-thirds of potentially preventable readmissions, and 80% of total costs.
- ABD – often multiple chronic physical and behavioral health conditions, polypharmacy, low health literacy, socioeconomic stress, and multiple physicians providing care.

Managing transitions

- Cross-hospital traffic common: 23% of readmissions within 30 days of discharge occur in a different facility.
- Cross-region traffic common: for large referral centers (e.g., Duke and UNC), half of all patients come from communities outside of the locally affiliated CCNC network of primary care medical homes.

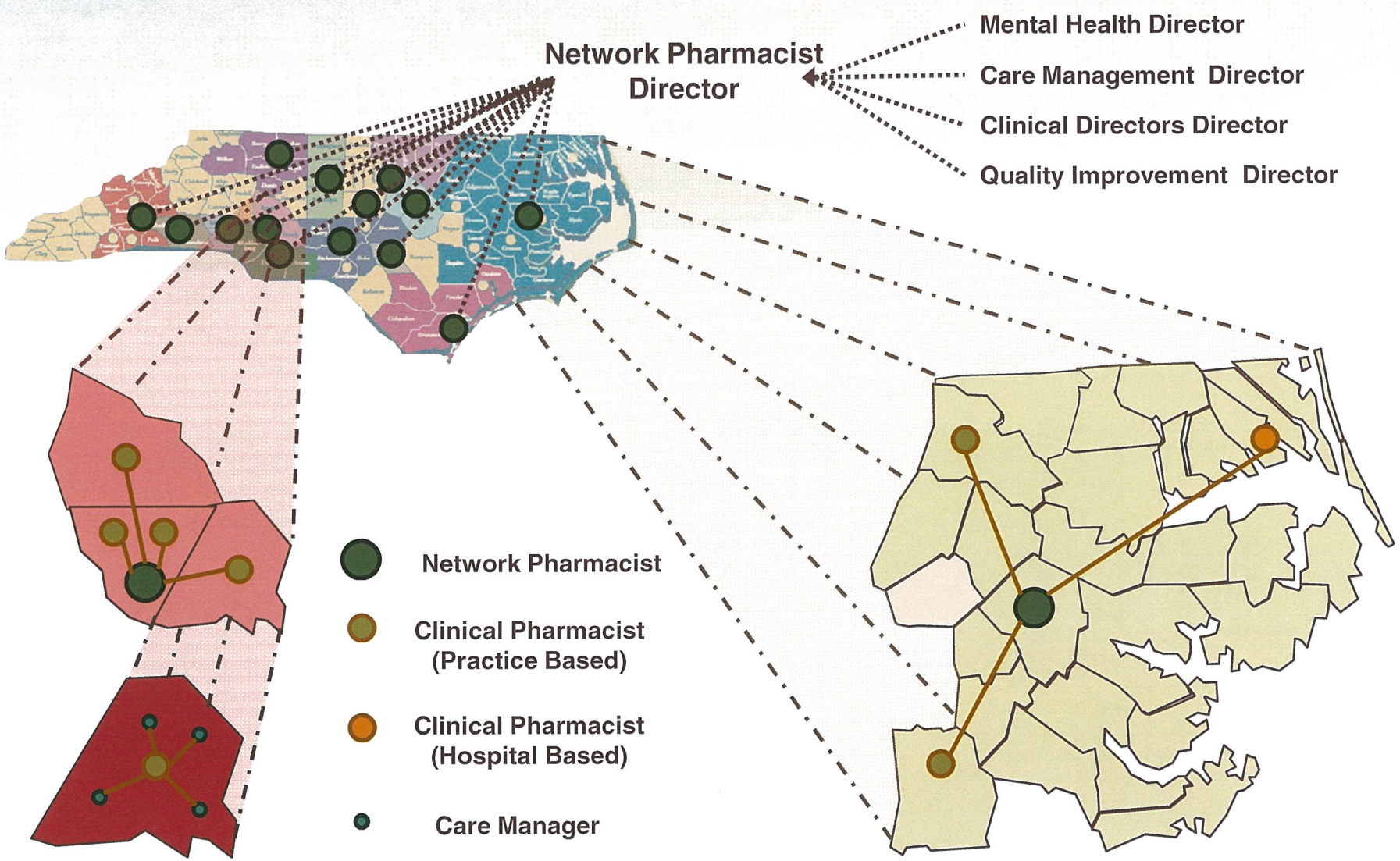
Collaboration Across Geography

(Patient Discharged from UNC, but lives in Onslow- Med Reconciliation Plus)



Hospital	Home	Network	Clinic
Transitional Care Manager (TCM)	Primary Care Manager (PCM)	Network Pharmacist (PharmD)	CCNC Physician (PCP)
Meets with Patient, Gathers Discharge instructions, Counsels and Refers to PCM →	**Meets with Patient at Home, Gathers Drug Use inventory, Assessment and Self-Management** →	**Reviews All Medication Lists (Discharge, Home, Claims) for Discrepancies** →	**Visit Scheduled, PCP Receives Problem List and Care Coordination Plan**

CCNC Pharmacy Programs Infrastructure



Scope and Reach of CCNC Transitional Care

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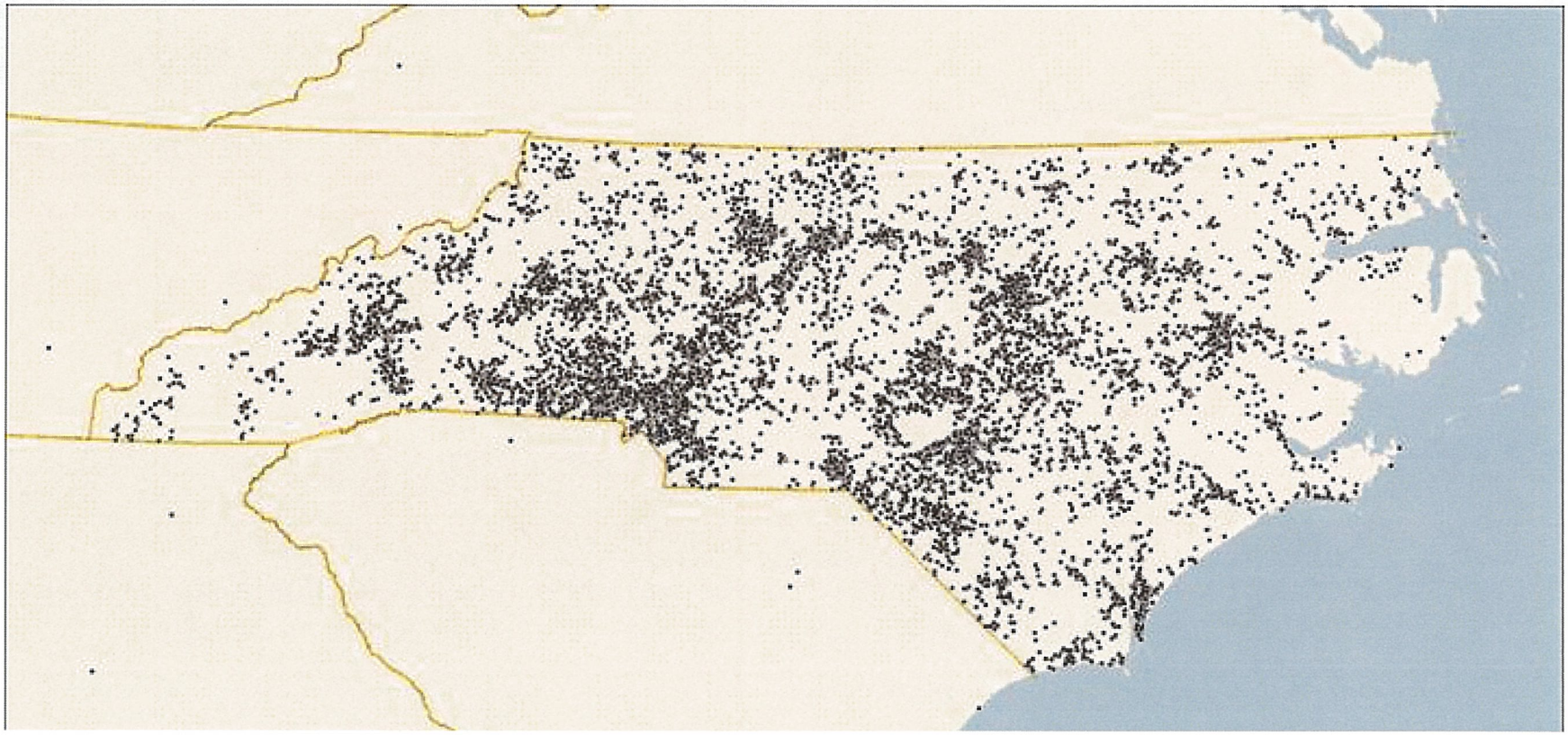

Each dot represents the location of a person who received transitional care during a 6-month period from May – October 2011.

Impact of Care Coordination

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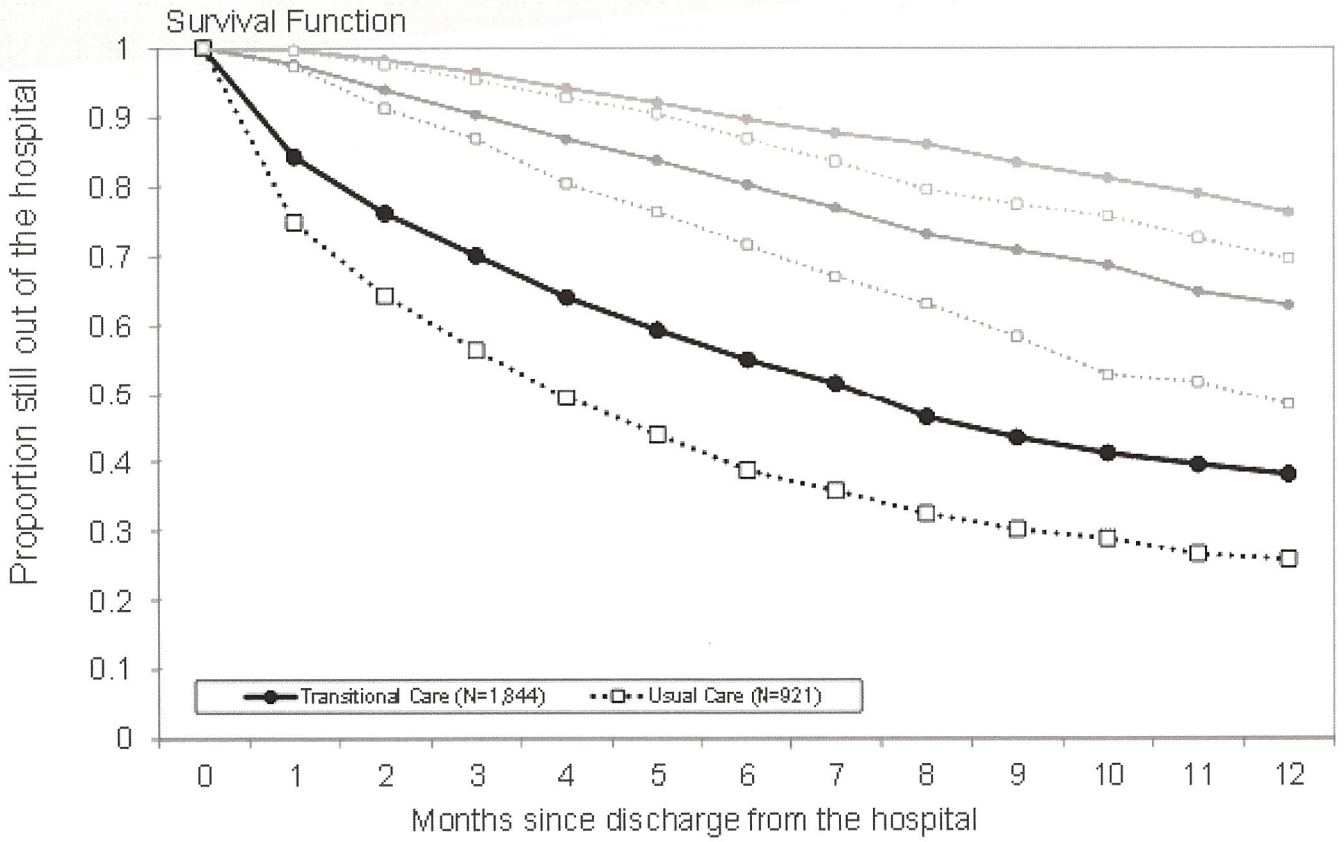
Time to First Readmission for Patients Receiving Transitional Care Versus Usual Care
Lighter shaded lines represent time from initial discharge to second and third readmissions
(Significant Chronic Disease in Multiple Organ Systems, Levels 5 & 6)



Transitional Care

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- Real Impact: Complex chronic patients who received transitional care experienced a 20% reduction in readmission rates compared to a similar cohort of Medicaid patients enrolled in a CCNC medical home who did not.
- Sustained Results: Differential still evident a year after discharge, with reduced likelihood of a second and third readmission during the year.
- High ROI: Providing transitional care to three of the highest-risk patients prevents one hospital admission in the year following discharge.
- Refined Process: We have refined our approach for targeting those patients most likely to benefit from transitional care.

Financial results: Milliman

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State Fiscal Year	Per-Member, Per-Month	Total Annual Savings
2007	$8.73	103,000,000
2008	$15.69	204,000,000
2009	$20.89	295,000,000
2010	$25.40	$382,000,000
		$984,000,000

Analysis of Community Care of North Carolina Savings, Milliman, Inc. December 2011

Medicaid Expenditures as Percent of Total State Expenditures: 2009 - 2011

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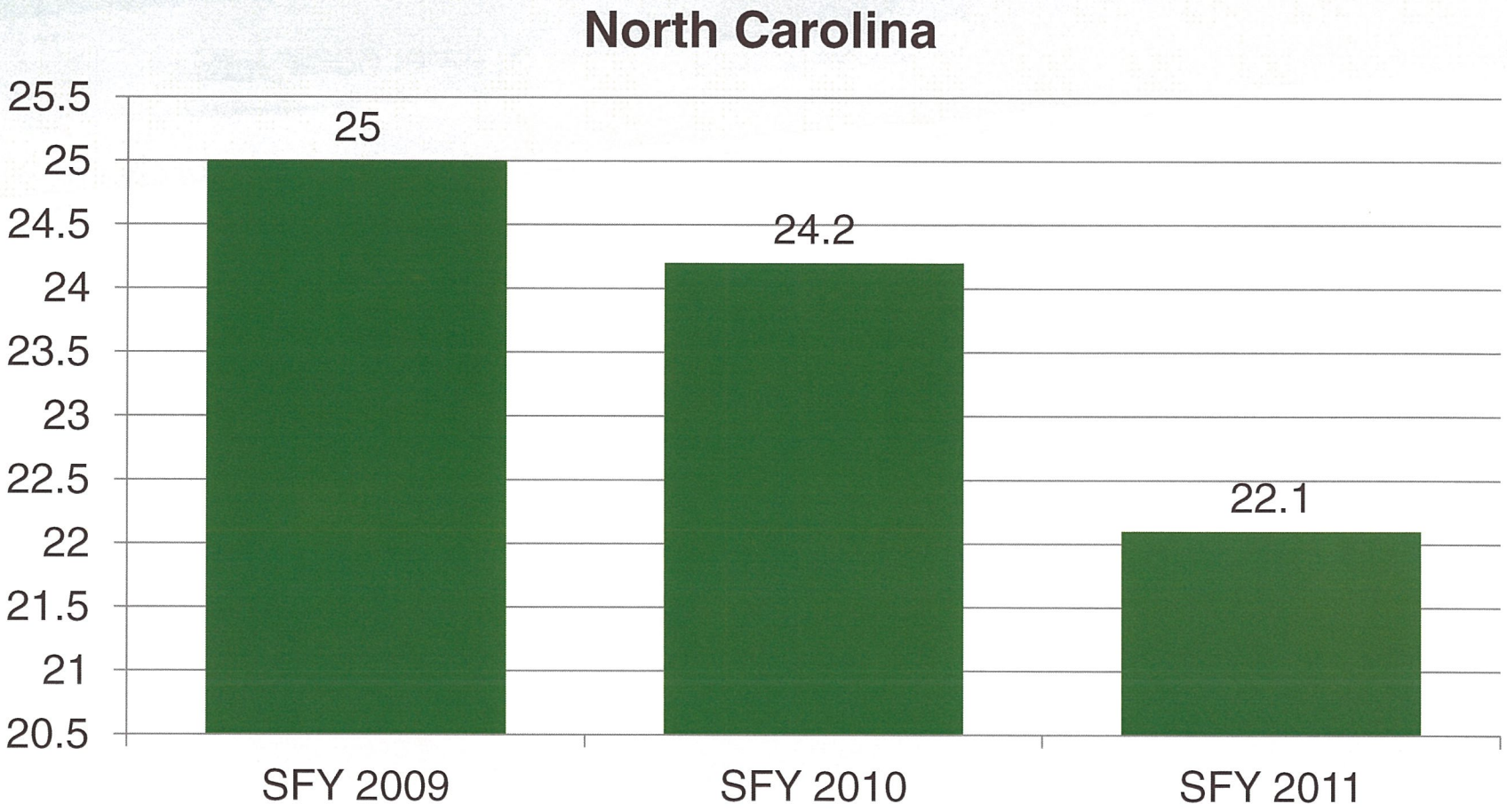

National Association of State Budget Officers, State Expenditure Report 2009-2011. www.nasbo.org

Annual Percentage Change in Medicaid Expenditures: 2009 - 2011

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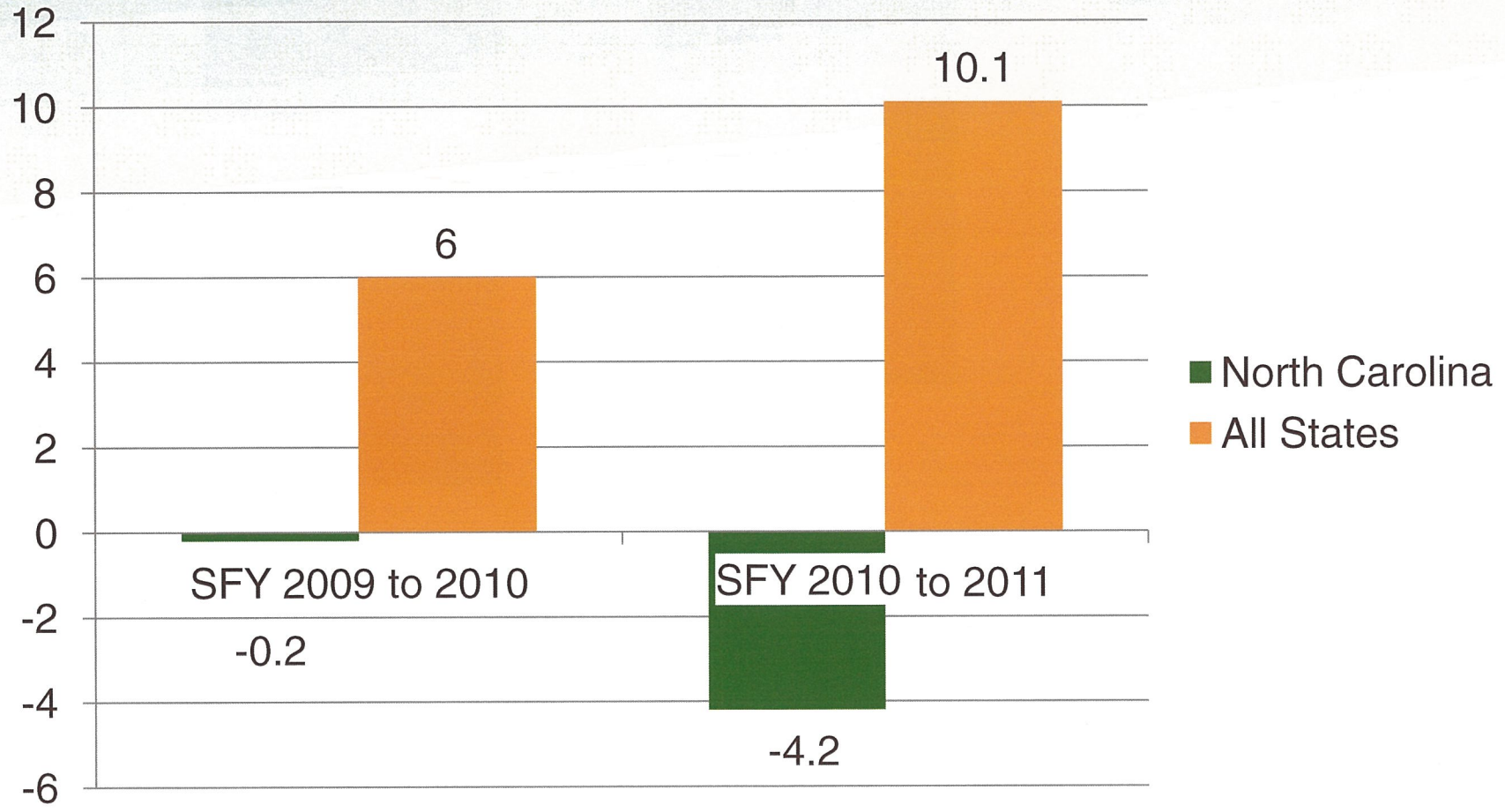

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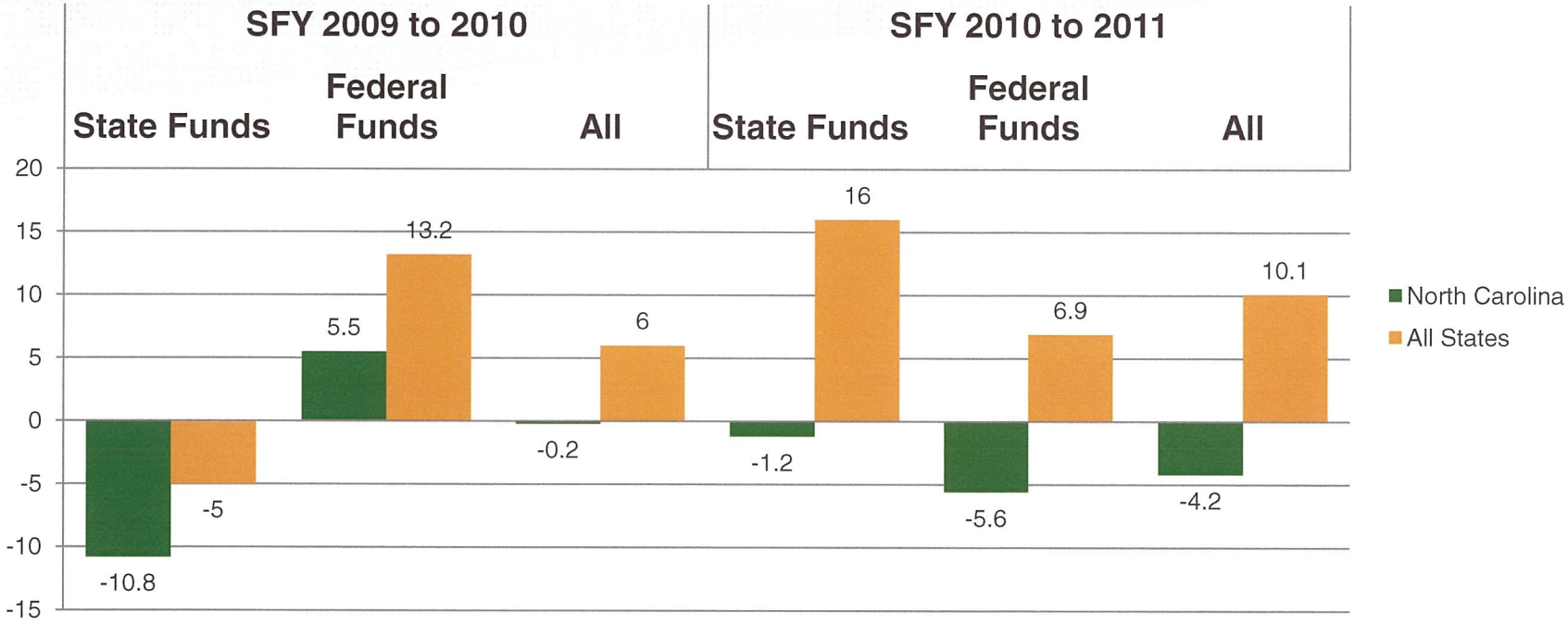
(State/ Federal / Total Components)



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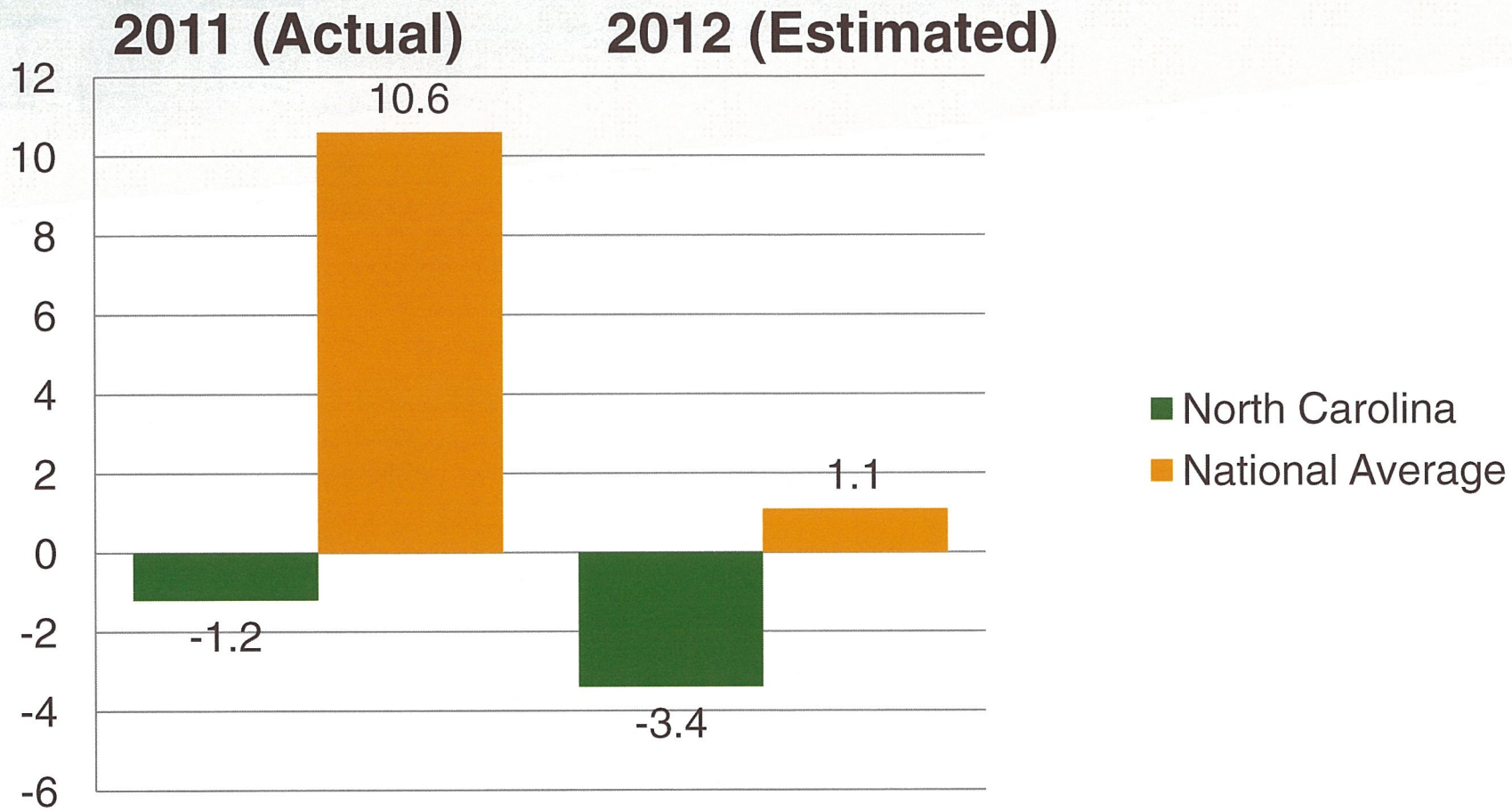
Annual Percentage Medicaid Growth Rate: 2011- 2012



National Association of State Budget Officers, Fiscal Survey of States, Spring 2012. www.nasbo.org

Annual Percentage Medicaid Growth Rate: 2011-2012

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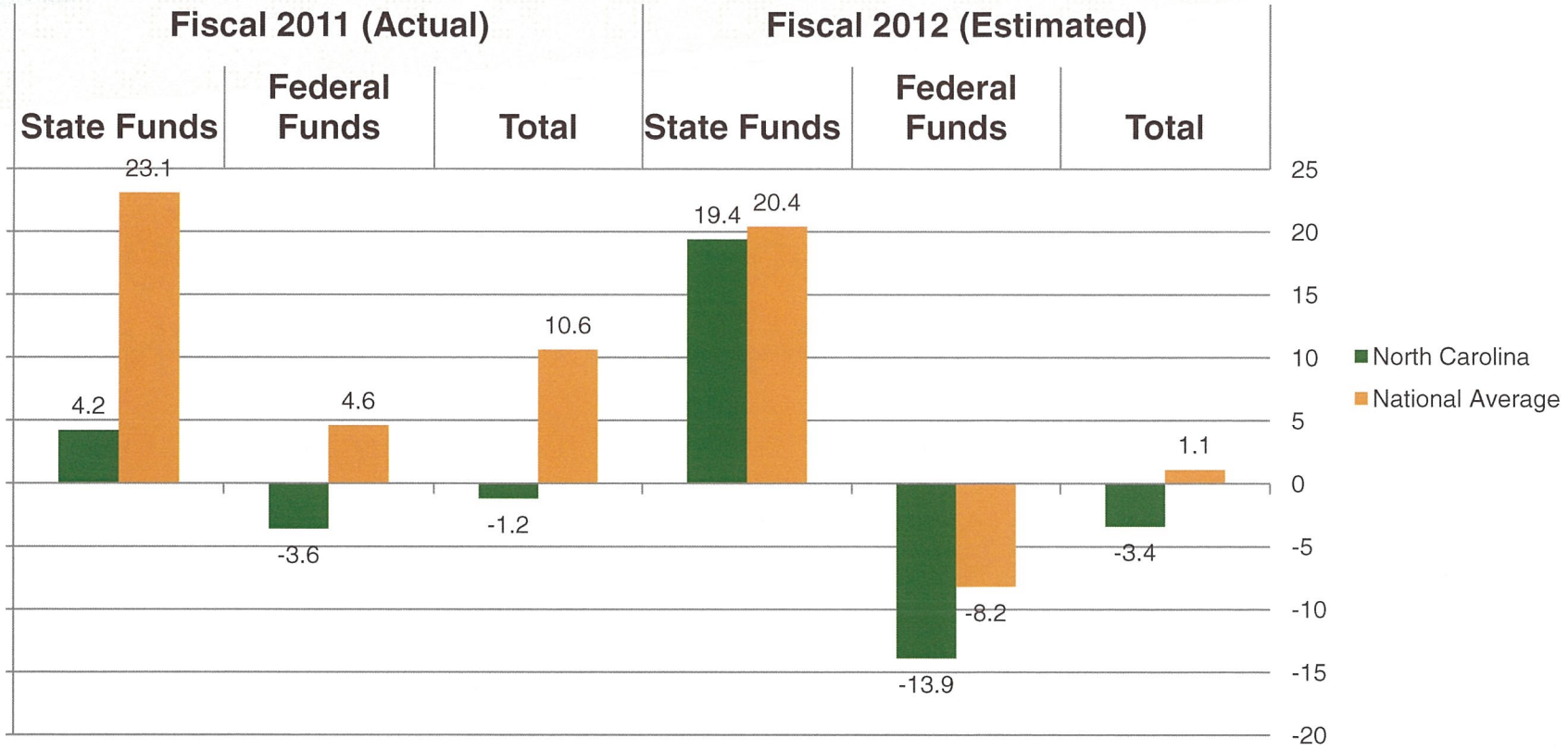
State / Federal / Total Components



National Association of State Budget Officers, Fiscal Survey of States, Spring 2012. www.nasbo.org

Building on Success

- Work with North Carolina's State Employee health plan
- New employer initiative with GlaxoSmithKline's North Carolina employees
- Improved governance through new 11-person board
- Continuing enhancements to Informatics Center and data analysis capabilities.

CCNC advantage

- Flexible structure that invests in the community (rural and urban) -- provides local jobs
- Fully implemented in all 100 counties
- All the savings are retained by the State of North Carolina
- Very low administrative costs
- Ability to manage the entire Medicaid population (even the most difficult) and other populations
- Proven, measurable results
- Team effort by NC providers that has broad support
- Collaborative

Lessons Learned

- Primary Care is foundational
- Data essential (timely and patient specific)
- Additional community based resources to help manage populations needed (best is located in practice)
- Collaborative local networks builds local accountability and collaboration among specialists and Primary care
- Physician leadership essential
- Must be flexible (healthcare is local) and incremental
- Make wise choices of initiatives (where you can make a difference - success breeds success)
- Risk taking not essential- shared accountability is!

Want to Know More?

www.communitycarenc.org