

Community Care of North Carolina



“Improving Medicaid Quality and Controlling Costs by Building Community Systems of Care”

**Greetings from Governor Mike
Easley, Secretary Carmen Hooker-
Odom and your colleagues in NC**

Major Department Goals

- Medicaid Reform (CCNC)
- Mental Health Reform
- Improving Healthcare Quality
- MMIS change- NC Leads

Vision: Innovation and Collaboration

2004 The Cost Equation

$$\text{Eligibility/Benefits} + \text{Reimbursement Rate} + \text{Utilization} = \text{Cost}$$

- Eligibility and Benefits – how many you cover and what you cover
- Reimbursement - what you pay
- Utilization - how many services are provided

We just have to figure out how to manage utilization!!!

Current NC Medicaid Facts

- ❖ 1.6 million unduplicated eligibles covered (15.2% of population)
- ❖ 810,000 children covered
- ❖ 45% of all babies born covered
- ❖ 30 % of recipients consume 74.5% resources
- ❖ Inpatient care (hosp,NH,MRC) consumes 40%
- ❖ Physicians account for only 9-10% of costs!!!
- ❖ Over \$1.5 billion spend on mental health services
- ❖ Total budget over \$ 8.5 billion

Improving Quality & Controlling Medicaid Costs

**Developing Community Care of NC
Why It Was Needed?**

Why We Started CCNC as Pilot

- NC is a mainly rural state not well suited for and with little managed care
- Successful Carolina Access program linked recipients with PCP in all 100 counties
- PCCM model alone not effective in cost control
- State was piloting Managed Care program in 2 metro areas- needed alternative

ISSUES:

- No real care coordination system at the local level
- Providers feel limited in their ability to manage care in current system
- Local public health departments and area mental health services are not coordinated with the medical care system
- Duplication of services at the local level
- State “Silo Funding”

Primary Goals

- *Improve the care of the Medicaid population while controlling costs*
- *Develop Community based networks capable of managing populations*
- *Fully Develop the Medical Home Model*



Community Care of North Carolina

*Build on ACCESS I (PCCM) 1998-99 as
pilot program*

- Joins other community providers (hospitals, health departments and departments of social services) with physicians
- Designated primary care medical home
- Creates community networks that assume responsibility for managing recipient care

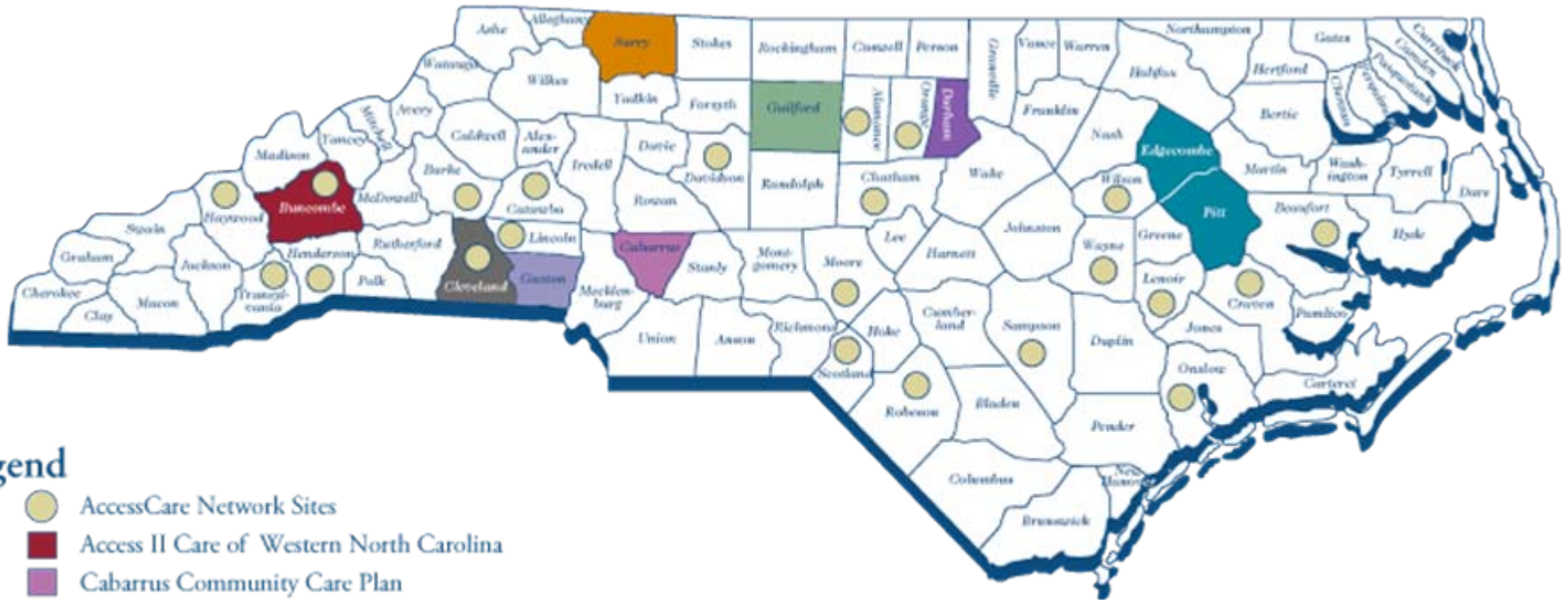




Community Care of North Carolina (Access II and III Networks)

1999

Then



Legend

- AccessCare Network Sites
- Access II Care of Western North Carolina
- Cabarrus Community Care Plan
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Durham Community Health Network
- Partnership for Health Management
- Surry County Health Network

Community Care of North Carolina

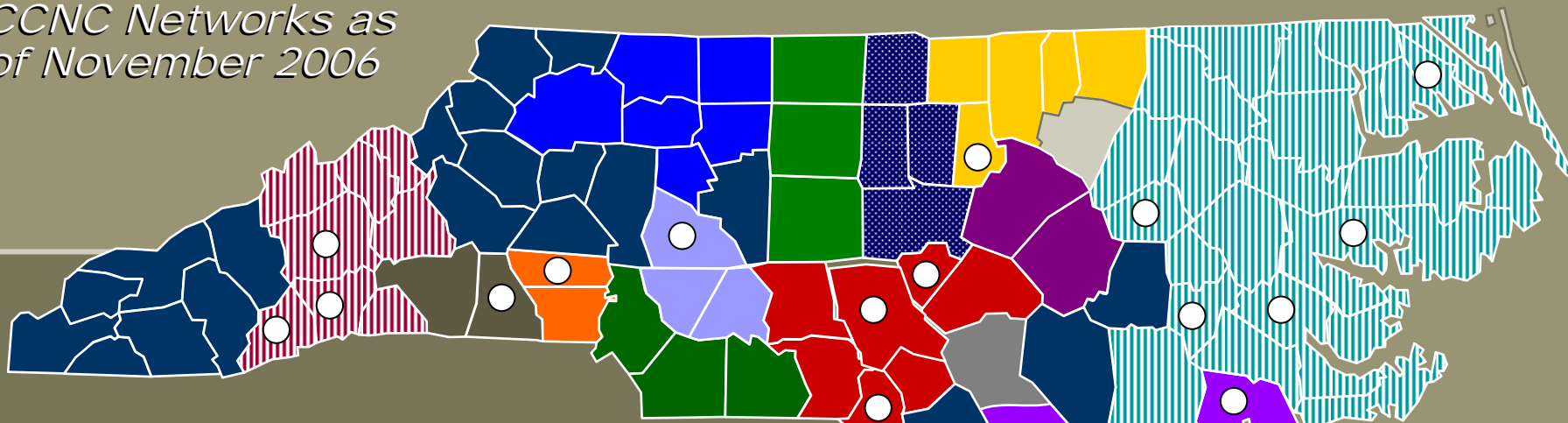
Now in 2007

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care
- 15 Networks with more than 3500 Primary Care Physicians (1000 medical homes)
- over 775,000 enrollees



CCNC Spread: 15 networks, 3500 MDs, >750,000 patients

CCNC Networks as of November 2006



- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western NC
- Access III of Lower Cape Fear
- Carolina Collaborative Comm. Care
- Carolina Community Health Partnership
- Northwest Community Care Network
- Comm. Care Partners of Gtr. Mecklenburg
- Community Care Plan of Eastern NC
- Community Health Partners
- Northern Piedmont Community Care
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan
- Community Care of Wake and Johnston Counties
- Central Care Health Network

Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Steering/Governance committee
- Medical management committee
- Receive \$2.50 PM/PM from the State
- Hire care managers/medical management staff
- PCP also get \$2.50 PMPM to serve as medical home and to participate in DM



Each Network Now Have:

- Part-time paid Medical Director- role is oversight of quality efforts, meets with practices and serves on State Clinical Directors Committee
- Clinical Coordinator- oversees the overall network operations
- Care Managers- small practices share/large practices may have their own assigned
- Now all networks have a PharmD to assist with medication management of high cost patients

How We Financed the Start-up

- Initial CCNC PCP PMPM was converted from PCCM payment (those who didn't join had their rate reduced to \$1 PMPM)
- Initial network PMPM financed by grants (foundation & industry unrestricted grants)
- State financed full PMPM after year 2
- Foundation for Advanced Health Programs fund new projects and chart audits

Key Attributes of our Medicaid Medical Home

- Provide 24 hr access
- Provide or arrange for hospitalization
- Coordinated and facilitate care for patients
- Collaborate with other community providers
- Participate in disease management/prevention/quality projects
- Serve as single access point for patients

What Networks Do

- Assume responsibility for Medicaid recipients
- **Implement improved care management and disease management systems**
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care & reduce variability



Keys to Success

- Medical and administrative committees that provide direction on local care management activities.
- Dedicated case managers to carry out such population management activities as risk assessment, case management, and disease management.
- Care management processes that apply both new and existing resources, such as health department support services, in meeting the needs of enrollees.
- Regular reporting and profiling of target initiatives that allow networks to monitor their progress in achieving target goals.

Guidelines for Selecting a Quality Improvement Initiative

- There are enough Medicaid enrollees with the disease to obtain a "return on investment."
- Evidence exists that best practices lead to predictable and improved outcomes.
- Appropriate evidence-based practice guidelines are available.
- Best practices and outcomes are measurable, reliable, and relevant.
- There is room for improvement - a gap exists between best practice and everyday practice.
- There is a measurable baseline and thus an ability to measure improvement.

Physicians must be supportive

Current State-wide Disease and Care Management Initiatives

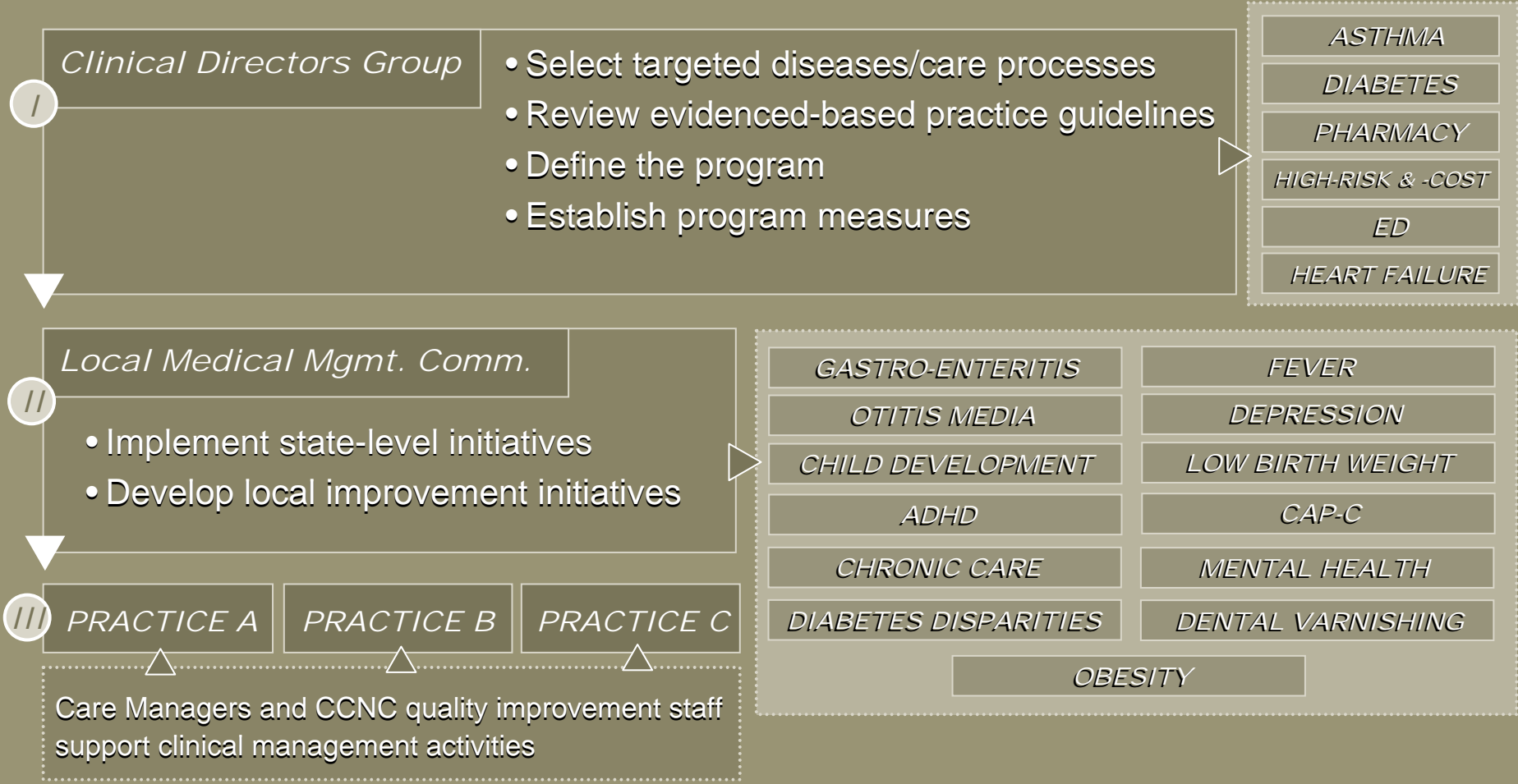
- Asthma
- Diabetes
- Pharmacy Management (PAL, NH poly-pharmacy)
- Dental Screening and Fluoride Varnish
- Emergency Department Utilization Management
- Case Management of High Cost – High Risk
- Congestive Heart Failure (CHF) (2006)



CCNC State Infrastructure

- Care Management Information
- Case Management Training
- Medical Director/Network Director meetings
- Population/Disease Management Support (ED, DM, Asthma, now CHF)
- Statewide audits of quality of care
- Support for new pilot programs

Managing Clinical Care



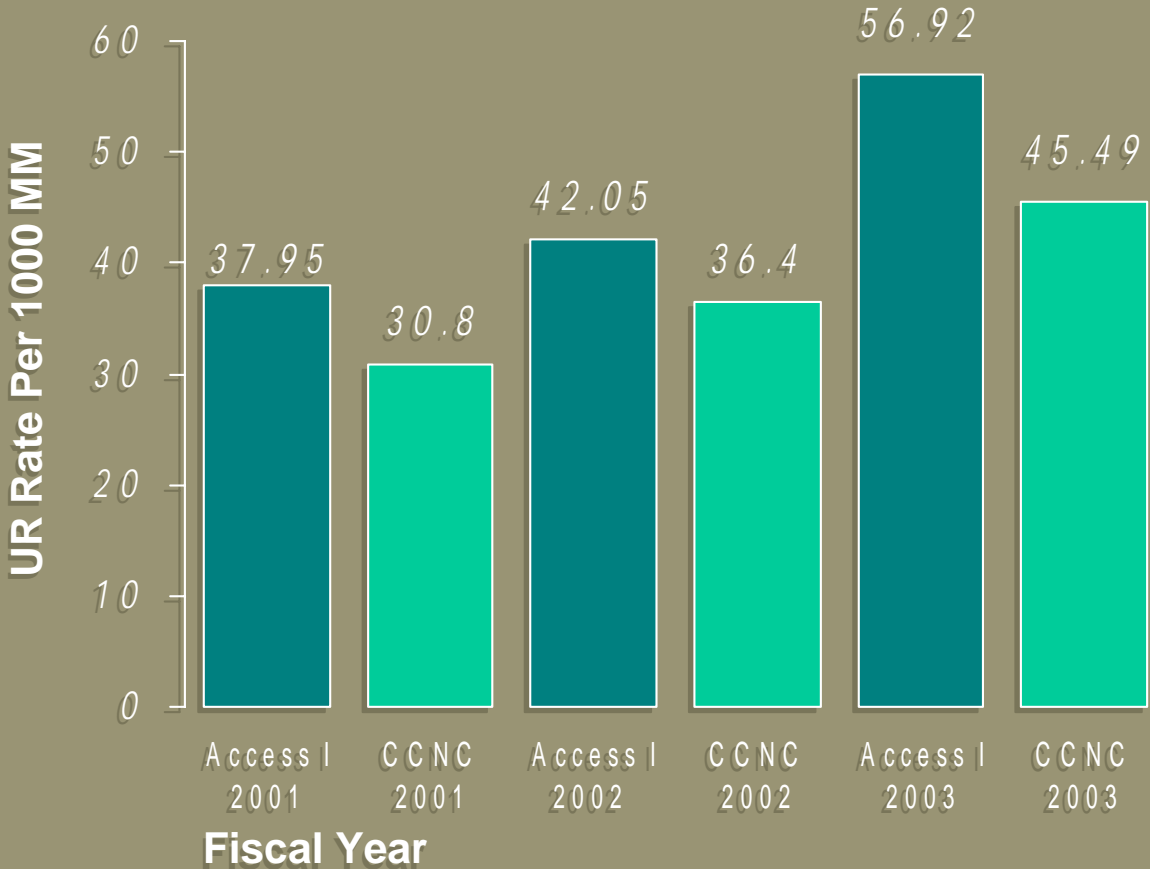
High cost/high risk patient: ED Initiative

- Target enrollees with 3 or more ED visits in 6 month time period
- Care managers perform outreach, education & follow-up
- Special mailings target top 3 reasons for ED visits (otitis media, fever, upper respiratory infections)
- Reinforce “medical home” concept



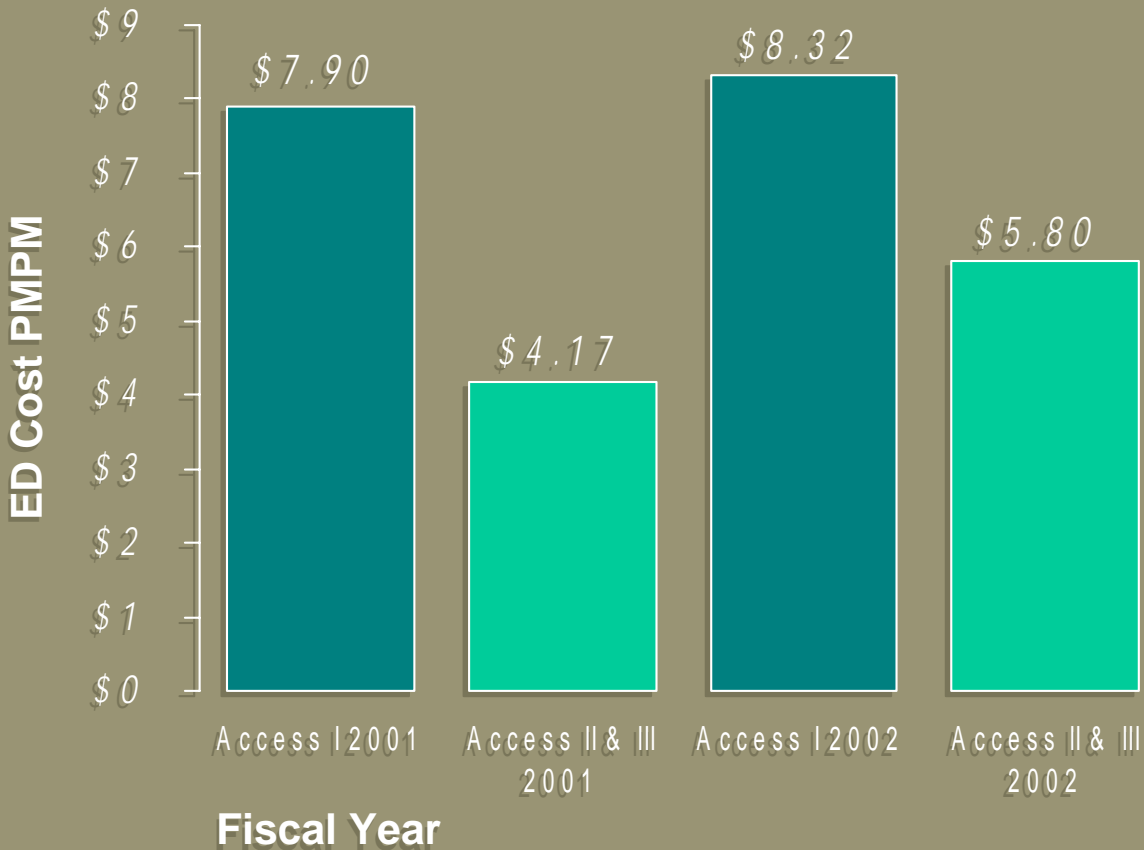
ED Initiative

ED Utilization Rate – 7/1/01 – 6/30/03 – Children < 21 years



ED Initiative

ED Cost PMPM – 7/1/01 – 6/30/02 – Children < 21 years



Savings Calculation

(Access I PMPM –
Access II-III) x
Access II-III Enrollment

Total Savings – '01-'02
\$10,362,190

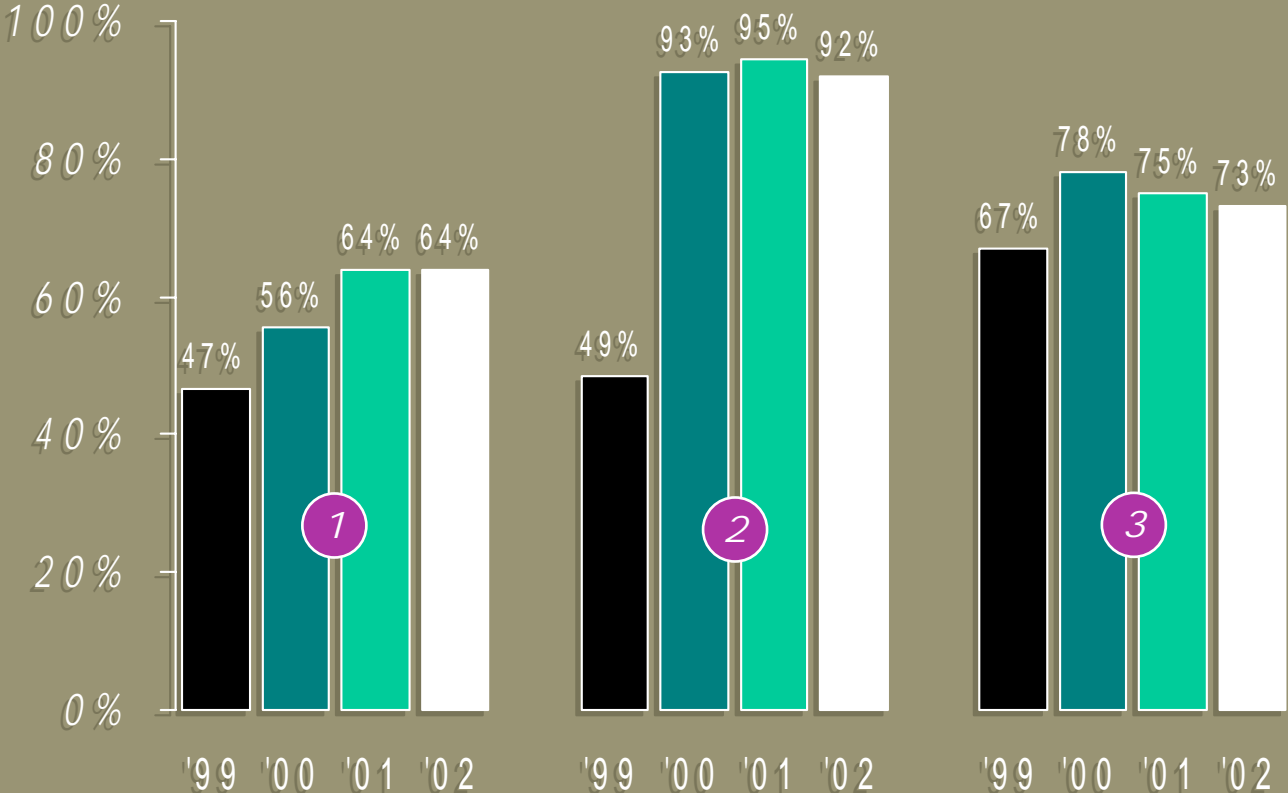
Asthma Initiative

- First disease initiative – began Jan. 1999
- Adopted best practice guidelines (NHLBI)
- Provided “tool box” for asthma care at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback



Asthma Initiative

Process Measures



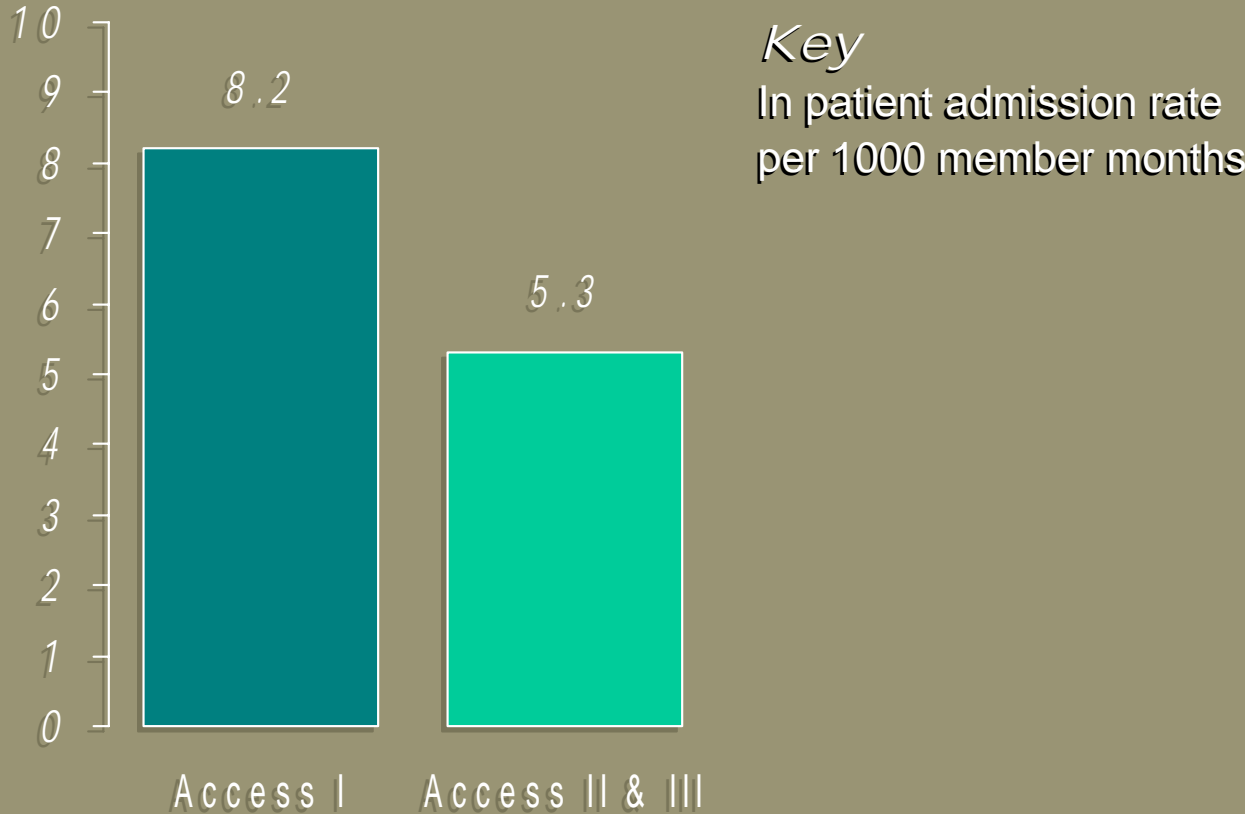
Key

- 1 No. with asthma who had documentation of staging
- 2 No. staged II – IV on inhaled corticosteroids
- 3 No. staged II – IV who have an AAP

Asthma Initiative

Pediatric Asthma Hospitalization Rates

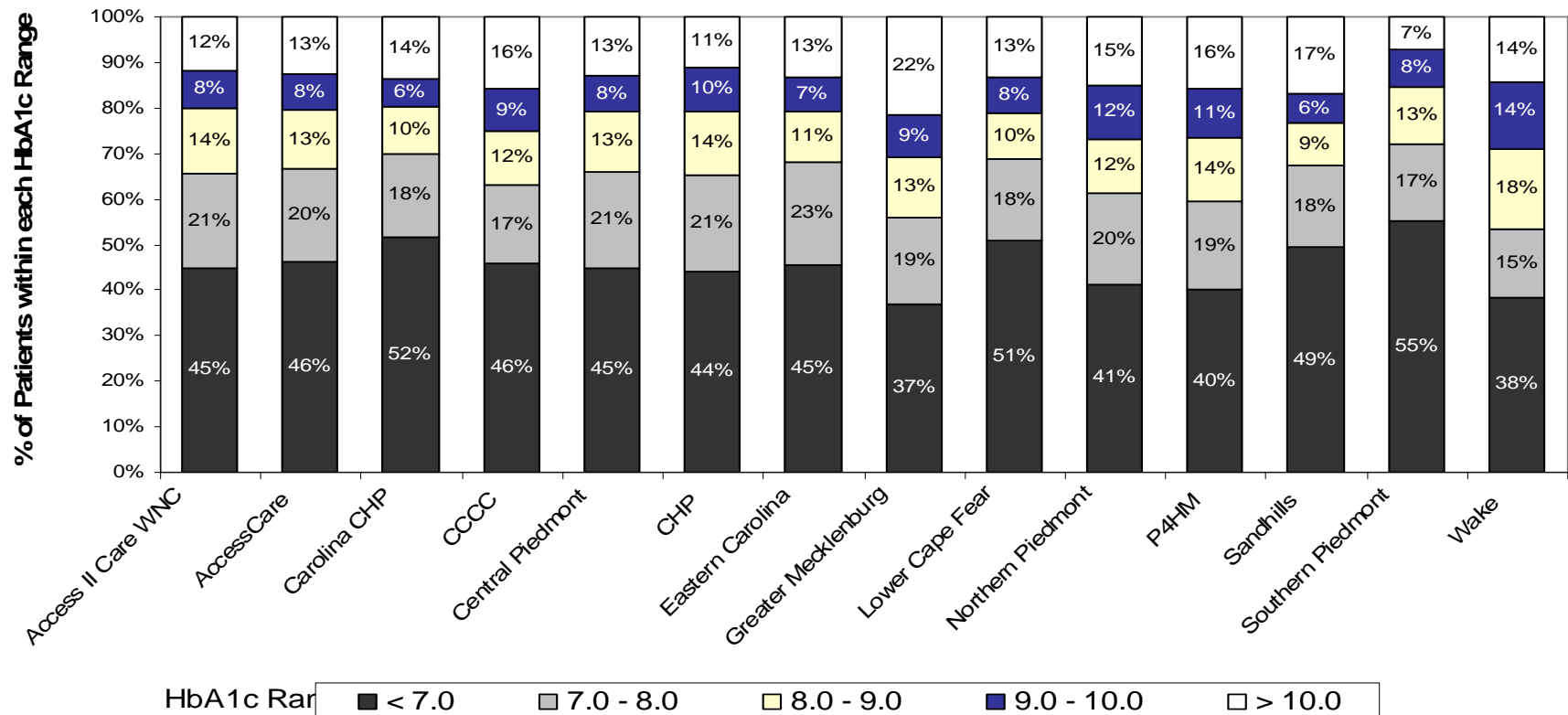
April 2000 - December 2002



Diabetes—Network Comparisons

Community Care of North Carolina Diabetes Disease Management Quality Initiative Round 5 2005

Distribution of HbA1c Values



Network Specific Quality Improvement Initiatives

- “Assuring Better Child Development” (ABCD)
- ADD/ADHD
- HCAP/Coordinated care for the uninsured
- Gastroenteritis (GE)
- Otitis Media (OM)
- Projects with Public Health (Low Birth Weight, open access & diabetes self management)
- Diabetes Disparities
- Medical Home/ED Communications

New Network Pilots

- Aged, Blind and Disabled (ABD)
- Depression Screening and Treatment
- Mental Health Integration
- Mental Health Provider Co-location
- E- Rx
- Medical Group Visits
- Dually Eligible Recipients

Cost/Benefit Estimates



Community Care of North Carolina

July 1, 2002 – Jun 30, 2003

- Cost - \$8.1 Million

(Cost of Community Care operation)

- **Savings - \$60,182,128 compared to FY02**

- **Savings- \$203,423,814 compared to FFS**

(Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)



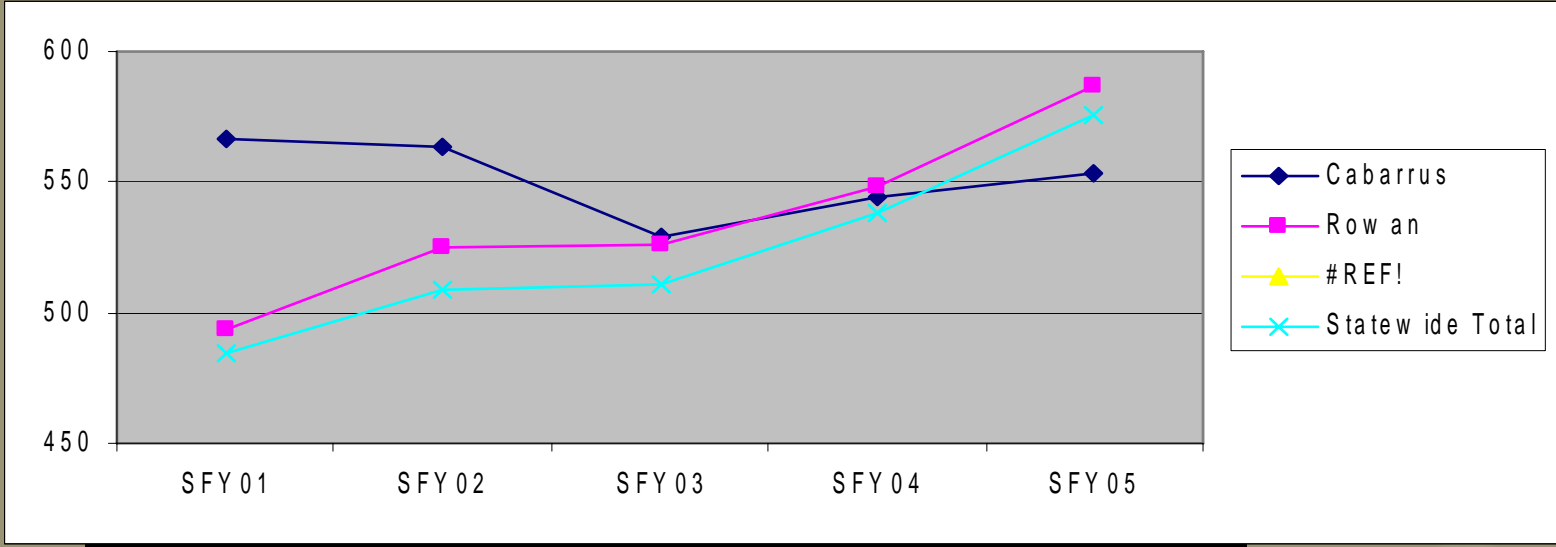
Cost Savings for SFY 2004

July 1, 2003- June 30, 2004

- Cost - \$10.2 million
(cost of CCNC operations)
- Savings- \$124 million compared to SFY 03
- Savings \$225 million compared to FFS

SFY 2005 and 2006 final results pending but similar results

Cabarrus County- 4 Year Results



	% Change				
	SF02	SF03	SF04	SF05	4 yr
Cabarrus	-1%	-7%	2.90%	1.67%	-3%
Rowan	6%	0%	4.30%	7.00%	17%
State	5%	0%	5.30%	7.00%	17%

Big Lessons & Challenges

- There are no easy \$ 100 million decisions- but there may be 50 \$ 2million decisions (you just have to find them and be patient)
- Providers must be engaged and supported
- A primary care based medical home is essential
- Must have data to support policy and program
- Establish & support collaborative systems of care
- Eliminate unneeded administrative costs
- Opportunities to align multiple resources around quality (IPIP/GQI)

How Are Physicians Paid?

- FFS @ 95% of Medicare
- \$ 2.50 PMPM to medical home (pay to participate in DM)
- Planned P4P – additional PMPM based on last years performance- essential for success

Problem with using Medicaid funds to further pay for needed practice reform and HIT (this funding is critical)

Challenges

- Legislature has mandated aged blind and disabled into CCNC (most difficult to manage)
- Networks now have to reach out to new providers
- Data hard to get due to MMIS issues
- Legislature diverts savings into other non-medical programs (NC Medicaid came in \$350 million under budget last year)
- Performance slows without more intense practice change (need more resources)

Our Plan for Further System Change

- Governor's Quality Initiative (BCBC, SEHP, Medicaid & ? Medicare)- over 65% of NC insured
- NC Health Net (coordinated free care)
- Mental Health Transformation/Integration
- **Medicare 646 Redesign Waiver**

646 Medicare Redesign Demonstration Waiver

**North Carolina's Proposal for
System Redesign
“Community Care of NC”**

Our Proposal to CMS

- **Proposal Basics:** North Carolina would like CMS to partner with NC to develop a statewide pilot utilizing CCNC to manage those recipients eligible for both Medicare and Medicaid and to allow selected networks to manage the entire Medicare population. CCNC has applied for a Medicare 646 Demonstration waiver for this proposal.

Basics of the proposal

- Joint agreement between CMS and NC Community Care Networks, Inc (a not for profit organization representing all CCNC networks) and supported by NC DHHS.
- Medicare fee for service payments unchanged
- CCNC plans & implements disease management, care coordination and utilization management programs for the target population. Enrollment will be voluntary with an opt-out provision. Project is phased in over the pilot demonstration period.

- Budget model is developed with agreement for shared savings between CMS and NC-CCN (CCNC networks). Budget neutrality maintained.
- Savings retained by NC-CCN will be utilized for 1) additional services for the elderly, 2) health information technology development & practice redesign that will improve healthcare quality, 3) quality incentives for participating providers, 4) Medicaid relief by shifting some Medicaid benefits to the Demonstration 5) premium assistance for the uninsured and 6) basic administration costs for operating the demonstration.

- Network and Medical Home receive PMPM payment
- Medicare data coordinated with Medicaid data.
- The proposal is a “pay as you go” shared savings approach. New benefits will be implemented after savings realized. (prior years savings utilized)

Potential Savings: Mercer was engaged to estimate the conservative 5 year savings under this proposal. Anticipated total Medicare savings exceeds \$1.4 billion.

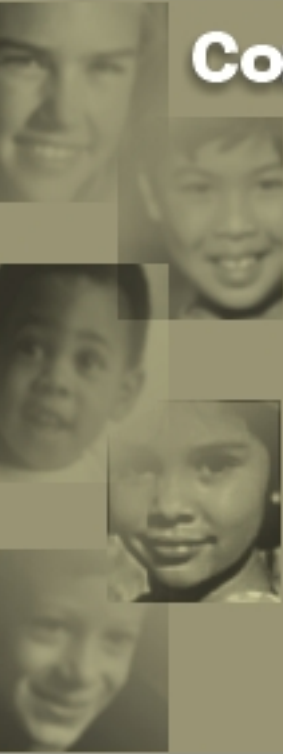
How Saving Will Be Used

1. P4P
2. Practice redesign
3. HIT
4. New services for Medicare recipients
5. Medicaid relief to allow expansion of Medicaid to more uninsured
6. Premium assistance for the uninsured

Want to Know More?

www.communitycarenc.com

Community Care of North Carolina



Thank You



[HOME](#)