Overview

- Progress means not repeating past mistakes
- ACOs, Center for Medicare and Medicaid Innovation and practical options
- State of the State (the budget, hospitals, docs and CCNC)
- How CCNC can help NC “do it better”
- Outlook and how specialists can benefit
“The second kick of a mule is no education!”

Bill Pully
“The current trend in market consolidation is a ‘medical arms race’ that may outweigh savings from better management and delivery system improvements.”

“This is the path to price control and onerous regulation.”

-Dobson
“Uniting the Tribes”

- Quality tribe
- Payment Reform tribe
- HIT tribe
- Consumerism tribe

*What about the provider tribes?*
NC Has Significant New Federal Funding

- In these difficult financial times, North Carolina must maximize the benefit of this funding.
- Collaboration can create synergy between organizations with different, but overlapping goals.
ARRA in NC

- Health Information Exchange (HIE) – HWTF, new NC HIE ($12.9 million)
- Regional Extension Center – NC AHEC ($13.6 million)
- Beacon Community – Southern Piedmont Community Care Plan/CCNC ($15.9 million)
- Broadband Capacity – MCNC ($28.2 million in Phase 1, $75.75 million in Phase 2)
ARRA in NC (con’t)

- Workforce Development
- Training – Pitt Community College ($20 million)
- Curriculum Development – Duke ($4 million)
- CHIPRA (CCNC) ($9.3 million)
- NC Telehealth Network ($6.1 million)
- Comparative Effectiveness Research ($16 million)
- EHR Loan Program ($750,000 HWTF)
- ONC Challenge grant (NCHIE/CCNC- $1.7 million)

- New opportunities in CMI and ACOs
Accountable Care

- Not just a new form of capitation or full risk
- Not a return of managed care
- More than just integrated health systems

- “It must not be the second kick of the mule”

New regs just released yesterday for comment!
A Very Challenging Time Ahead for States!

- 3+ billion revenue deficit facing next session of the NC General Assembly
- Expiration of enhanced FMAP for Medicaid
- Continued growth in Medicaid rolls due to economy
- New Republican General Assembly who will be looking for solutions without raising taxes
- Major push by commercial Medicaid MCOs to do business in NC (will mean 15+% cut to hospitals)
- A panic on how to pay for 2014 Medicaid expansion
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
Best Path to Success?

- Build upon current resources in North Carolina to create a shared statewide infrastructure?

  or

- Continue market consolidation that’s creating individual, multiple, competing regional/local entities?
Building on CCNC’s Statewide System

Critical mass from NC’s 10-year investment

- Capacity: 14 not-for-profit regional networks + 4200 primary care physicians (1,350 medical homes) = 94% of PCPs + all NC hospitals and other providers

- Population: More than 1 million Medicaid enrollees + SCHIP+ new multi-payer initiatives

- Local resources: 400 care coordinators, 25 pharmacists, 15 psychiatrists, 22 medical directors
Not-for-profit collaborative community organizations, including the majority of PCPs, the hospital(s), the health department, and other providers

Shared responsibility for the improving quality and controlling costs for Medicaid recipients in the community (network of medical homes)

Physician leadership

State provides data and resources to enhance local systems of care
Existing, shared infrastructure

- Informatics center and center office program support

Growing multi-payer capacity

- Major Medicare 646 demo (22 counties — 30,000 duals and 180,000 Medicare)
- Primary care demo (7 counties — 150,000 patients)
- State Health Plan Medical Home Initiative
- Beacon Community (3 county)

Measurable results

- Better quality, utilization, cost effectiveness
Our Results

- Quality: CCNC performance in the top 10 percent nationally in HEDIS measures for diabetes, asthma, heart disease compared to MCOs
- Cost savings: More than $1 billion dollars from 2003 to 2007 — $568 million for AFDC and $400 million for ABD (Mercer Evaluations)
Variance from Expected Spending

Adjusting for the severity of illness of the population, total spending for CCNC enrollees has been lower than expected each of the past 3 years.
Quality HEDIS Measures

Diabetes
- Cholesterol Control LDL <100
- Cholesterol Testing
- Blood Pressure Control <130/80
- A1C Control <9.0
- A1C Testing

Cardiovascular Disease
- Cholesterol Control LDL<100
- Blood Pressure Control <140/90

CCNC 2009
CCNC 2010
National Medicaid HMO HEDIS mean
CCNC expands across North Carolina starting in 1998. Between 2002 and 2005 expansion increased from 17 to 93 counties. By 2007, all 100 counties were under the CCNC umbrella.
Next steps for CCNC

- Enhance the Informatics Center and Provider Portal as a shared resource for all communities
- Invite specialists to join CCNC
- Implement multipayer projects
- Work with NCHA, IHI on new best practices (e.g., reducing readmissions)
- Build infrastructure to facilitate ACO development
- Strive to give North Carolina the best health care system in the country
First Specialists Engaged

- Ob-Gyn: pregnancy home initiative
- Radiology: decision support initiative

How to join:
1) Quality and cost project
2) simple three way network agreement (practice, network, CCNC)
3) data use agreements
4) physician leadership
Providing Meaningful Data to Drive Local Quality Improvement
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
CCNC 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
## Patient Search:

- Medicaid ID 
- Last Name Exact 
- Last Name Partial 

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**Search**

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### Patient Care Team Summary

- **Patient:**
  - Medicaid ID: 
  - Birth Date: 
  - CA PCP: Charles Drew CCH

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### Medication Regimen

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What the Future Could Look Like
1. New Investments in Best Care

Existing Multi-payer Initiatives to Build On:
- Medicare 646 demo
- Beacon Community
- Advanced Primary Care Demo
- State Health Plan Medical Home

Statewide payment reform/consistent policies across payers

Revised payment structure and new investments to fund:
- Per member per month fee to support care coordination and medical home
- Waived/reduced co-pays for patients to support prevention and primary care
- Shared savings models
- Bundled Payments for selected services
- Other payment changes....
2. Shared Data and Health Information Technology Infrastructure

Multi-payer and multi-provider clinical and claims data available to providers for:
• Decision support
• Care coordination
• Care management
• Utilization information
• Support from REC, AHEC, NCHQA, Med Society, Hospital Association to help providers leverage data in practice

Clinical Data

Payers (see previous slide)

NCHIE & CCNC Informatics Center
CCNC could facilitate ACO development

Potential Roles:

- A CCNC Network as an ACO
- A CCNC Network providing services to several ACOs (care management and medical home)
- CCNC Informatics Center & Central Office supporting multiple overlapping specialty or IDS ACOs
- CCNC providing the framework and state-wide agreement with CMS for ongoing ACO development (Medicaid and FFS Medicare) in NC
CCNC advantage

- Flexible structure that invests in the community (rural and urban) – and is locally run
- Fully implemented in all 100 counties
- Very low administrative costs because of shared infrastructure
- Ability to manage the entire Medicaid population (even the most difficult) Medicare and other populations
- Proven, measurable results
- Team effort by NC providers that has broad support
- Open and transparent
- Built with physician leadership
Recommendation

- Continue to build on the CCNC local platforms
- Recruit our specialist to join their primary care colleagues in CCNC
- Establish CCNC Informatics Center as the trusted data source for state wide multi-payer data and analytics (CMS, BCBS and others) enriched with clinical information from the HIE
- Work together to design a proposal to provide a short and long term solution for NC Medicaid
- Agree on a standard set of quality and efficiency measures
- Establish a set of principles and a platform for ACO development and other innovations in NC
- Use CCNC to develop an NC agreement with CMS to support ACO development and a standard shared savings methodology that is transparent and sound.
- Be the premiere state in the United States for health care innovation

“Unite the Tribes”