Community Care of North Carolina

Advancing Accountable Care in NC

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

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“The second kick of a mule is no education!”

Bill Pully

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"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"

McKethan

- 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

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- 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

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- 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 yesteday 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?

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- 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

Network Design Revisited

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- 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

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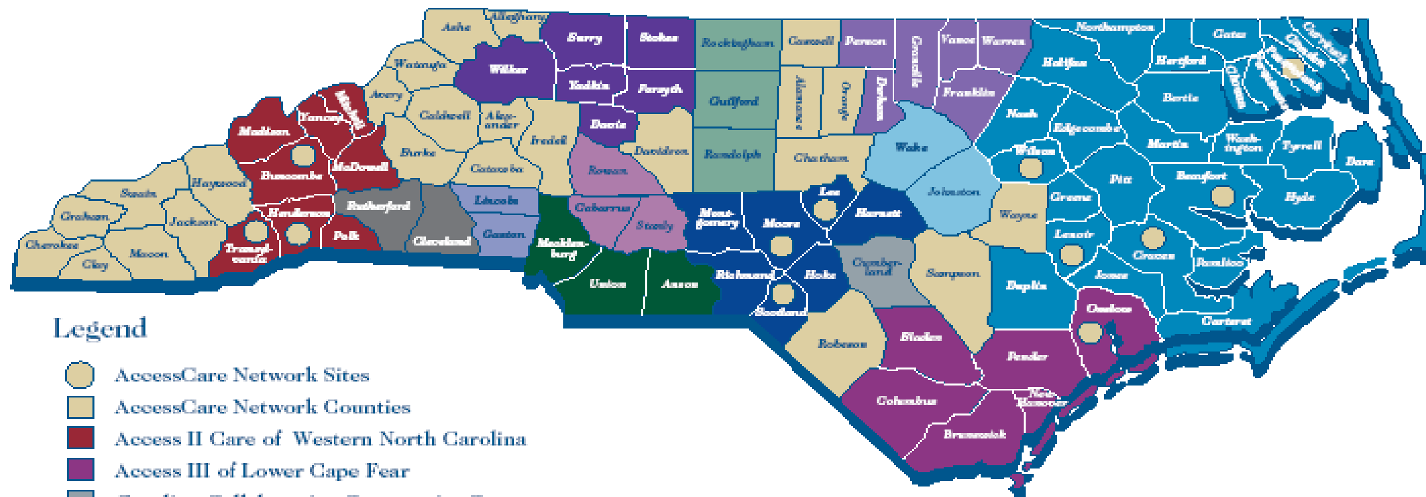
Access II and III Networks



Legend

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

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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

646 & Multi-payer Counties

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Ashe
Alleghany
Surry
Stokes
Rockingham
Caswell
Person
Granville
Vance
Warren
Northampton
Gates
Currituck
Camden
Pasquotank
Perquimans
Chowan
Hertford
Bertie
Halifax
Watauga
Wilkes
Yadkin
Forsyth
Guilford
Alamance
Orange
Durham
Franklin
Nash
Edgecombe
Martin
Washington
Tyrrell
Dare
Mitchell
Avery
Caldwell
Alexander
Davie
Davidson
Randolph
Madison
Yancey
Burke
Iredell
Wake
Wilson
Pitt
Beaufort
Hyde
Buncombe
McDowell
Catawba
Rowan
Chatham
Johnston
Greene
Haywood
Swain
Graham
Rutherford
Lincoln
Cabarrus
Montgomery
Lee
Harnett
Wayne
Lenoir
Craven
Pamlico
Jackson
Henderson
Polk
Cleveland
Gaston
Mecklenburg
Stanly
Moore
Cumberland
Sampson
Duplin
Jones
Cherokee
Clay
Macon
Transylvania
Union
Anson
Richmond
Hoke
Scotland
Onslow
Carteret
Robeson
Bladen
Pender
Columbus
New Hanover
Brunswick

Exempt
Intervention
Holdouts

Our Results

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

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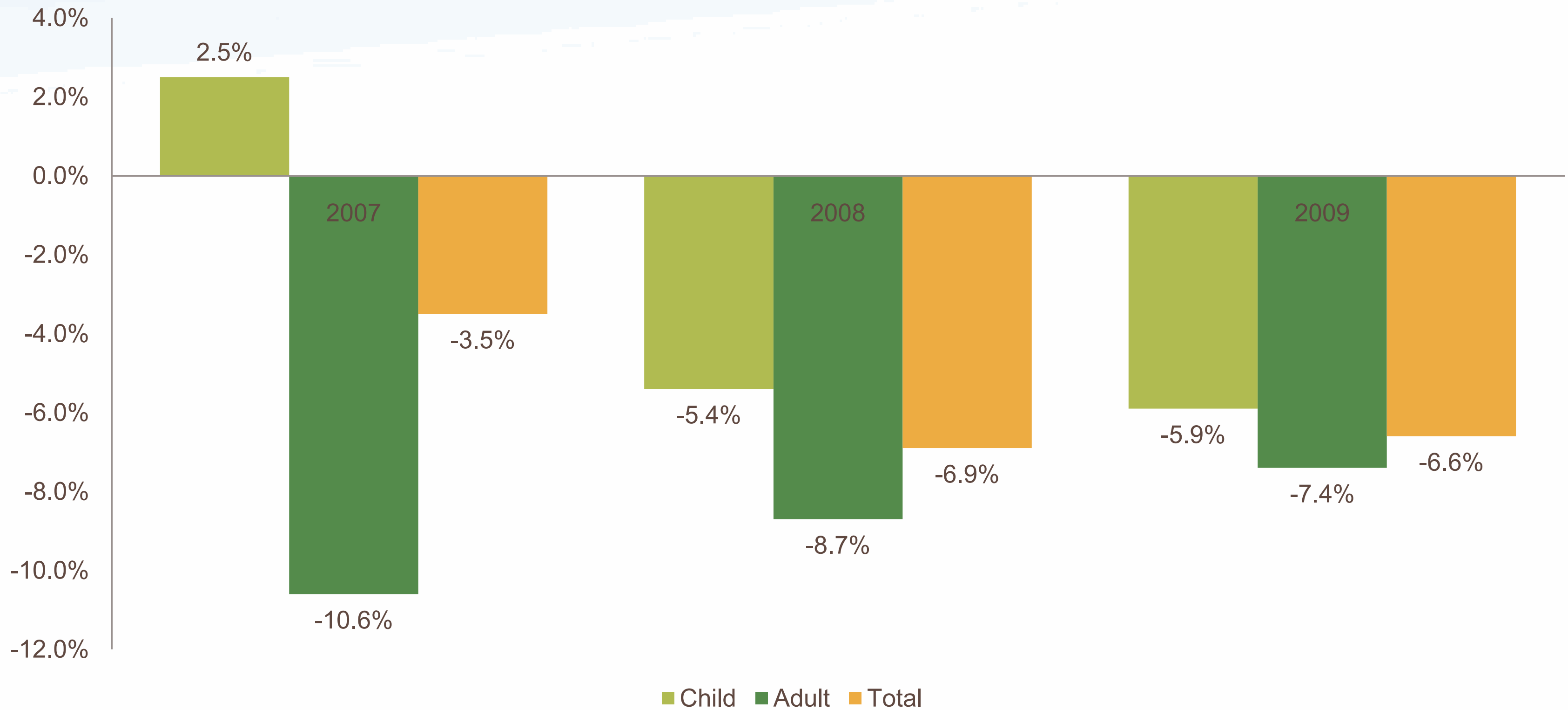
Variance from Expected Spending

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

DHHS Performance Measures for CCNC

Enrolled ABD Cost PMPM

Month to Month

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,138	$1,153	$1,084	$1,187	$1,088	$1,028	$1,137	$1,089	$1,114	$1,103	$1,117	$1,087
SFY2009	$1,129	$1,095	$1,097	$1,143	$1,044	$1,105	$1,168	$1,102	$1,210	$1,166	$1,154	$1,184
SFY2010	$1,205	$1,191	$1,177	$1,159	$1,081	$1,069	$1,041	$983	$1,089	$998	$968	$959
SFY2011	$946	$962	$911	$918	-	-	-	-	-	-	-	-

Fiscal Year Results-to-Date (Cumulative)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,138	$1,145	$1,125	$1,140	$1,130	$1,112	$1,116	$1,113	$1,113	$1,112	$1,112	$1,110
SFY2009	$1,129	$1,112	$1,107	$1,116	$1,101	$1,102	$1,112	$1,111	$1,122	$1,127	$1,130	$1,135
SFY2010	$1,205	$1,198	$1,191	$1,182	$1,161	$1,145	$1,129	$1,110	$1,107	$1,095	$1,081	$1,069
SFY2011	$946	$954	$939	$934	-	-	-	-	-	-	-	-

Annual Percent Change in Medicaid Expenditures 2002 - 2010

North Carolina — Georgia — National Average - Kaiser Commission Study

18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

17.0%
12.7%
11.5%
8.8%
3.7%
2.5%

2002 2003 2004 2005 2006 2007 2008 2009 2010

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

Georgia implements

CCNC Implements ABD Program

Next steps for CCNC

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- 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 initiaitve**
- **Radiology: decision support initiaitve**

- **How to join:**

1) Quality and cost project 2) simple three way network agreement (practice, network, CCNC) 3) data use agreements and 4) physician leadership

CCNC Informatics Center

Providing Meaningful Data to
Drive Local Quality Improvement

CCNC informatics center

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Informatics Center – Medicaid claims data

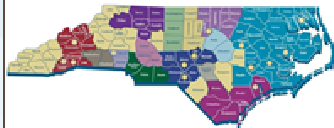
- Utilization (ED, Hospitalizations)
- Providers (Primary Care, Mental Health, Specialists)
- Diagnoses – Medications – Labs
- Costs
- Individual and Population Level Care Alerts

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



Welcome: Annette Dubard

Provider Portal

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Logout

Patient Search:

Medicaid ID | Clear All
Last Name Exact | Birth Date mm/dd/yyyy
Last Name Partial | First Name Partial | Birth Year yyyy

Search

My Practices | Patient List | Patient Profile | Report Site | Meducation | CCNC Info and Patient Mgmt Tools

Patient Care Team Summary | Medication Regimen | Medication History | Visit History

Patient: | Medicaid ID: | Birth Date: | CA PCP: Charles Drew CHC

Medications listed reflect filled prescriptions paid by Medicaid. Recent fills may not appear, if claim has not yet been processed. Prescriptions paid out-of-pocket or under a Medicare Part D plan do not appear. If patient is dually eligible for Medicaid and Medicare, medication history is likely incomplete.

The prescriber(s) listed below may occasionally be misstated due to pharmacy imputation errors when interpreting a prescriber's signature. In many cases the prescriber is unknown.

Medication Regimen - 8 prescriptions

Medication Regimen Report | Pocket Medication List Report

Fill Date	Drug Description	Qty	Days	Paid	Gap In Therapy	Adherence Index	Prescriber	Pharmacy	Source
2/3/2010	RAMIPRIL 5 MG CAPSULE	90	30	$10.43		0.70	SALLY PATEL	CVS PHARMACY 7559	Claims
1/31/2010	VENTOLIN HFA 90 MCG INHALER	18	30	$33.21			SALLY PATEL	CVS PHARMACY 7559	Claims
1/31/2010	HYDROCHLOROTHIAZIDE 25 MG TB	30	30	$3.03		0.62	SALLY PATEL	CVS PHARMACY 7559	Claims
1/31/2010	LORATADINE 10MG OTC	30	30	$5.30			SALLY PATEL	CVS PHARMACY 7559	Claims
1/31/2010	METFORMIN HCL ER 500 MG TAB	60	30	$6.74		0.71	SALLY PATEL	CVS PHARMACY 7559	Claims
12/1/2009	MELOXICAM 7.5 MG TABLET	60	30	$4.75			SALLY PATEL	CVS PHARMACY 7559	Claims
12/1/2009	OMEPRAZOLE 20 MG CAPSULE DR	30	30	$15.84		0.71	SALLY PATEL	CVS PHARMACY 7559	Claims
12/1/2009	ADVAIR 500/50 DISKUS	60	30	$268.94	49*	0.76	SALLY PATEL	CVS PHARMACY 7559	Claims

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What the Future Could Look Like

1. New Investments in Best Care

Employers (SAS, GSK, IBM, Others)	Private Insurers (BCBS, Others)	State Health Plan	Medicaid	Medicare

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

Hospitals

Primary Care Physicians

Specialty Physicians

Other Providers

Multiple Regional or Specialty ACOs (CCNC)

Multiple Regional or Specialty ACOs

Payers (see previous slide)

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

Claims Data

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

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- 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"