

# Community Care of North Carolina



“Improving Medicaid Chronic  
Disease Care and Controlling Costs”

*The Case for Medical Homes and  
Community Networks*

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# General Comments

- There is no “system” in the US healthcare system
- Healthcare does not respond to typical market driven forces
- We are inconsistent in our expectations (physician report cards, multiple new providers, transparency, self referral)
- HIT will not fix the problem alone
- We can not rebalance the system by taking money from one group and giving to another ( progress will be by controlling utilization, managing chronic disease, addressing MH/SA and improving prevention)
- The primary care system must be handled differently than the specialty/hospital system
- Role of government needs to be more directive!!

# The Cost Equation

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

- 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!!!*

***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 traditional managed care
- Successful Carolina Access program linked recipients with PCP in all 100 counties
- PCCM model alone not effective in cost control or quality improvement
- State was piloting Managed Care program in 2 metro areas- needed alternative for rural areas

# ISSUES IDENTIFIED:

- No real care coordination system at the local level
- Providers feel limited in their ability to manage care in current system- needed help
- 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 in partnership with the State*
- *Fully Develop the Medical Home Model ( enhanced PCCM)*



# 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

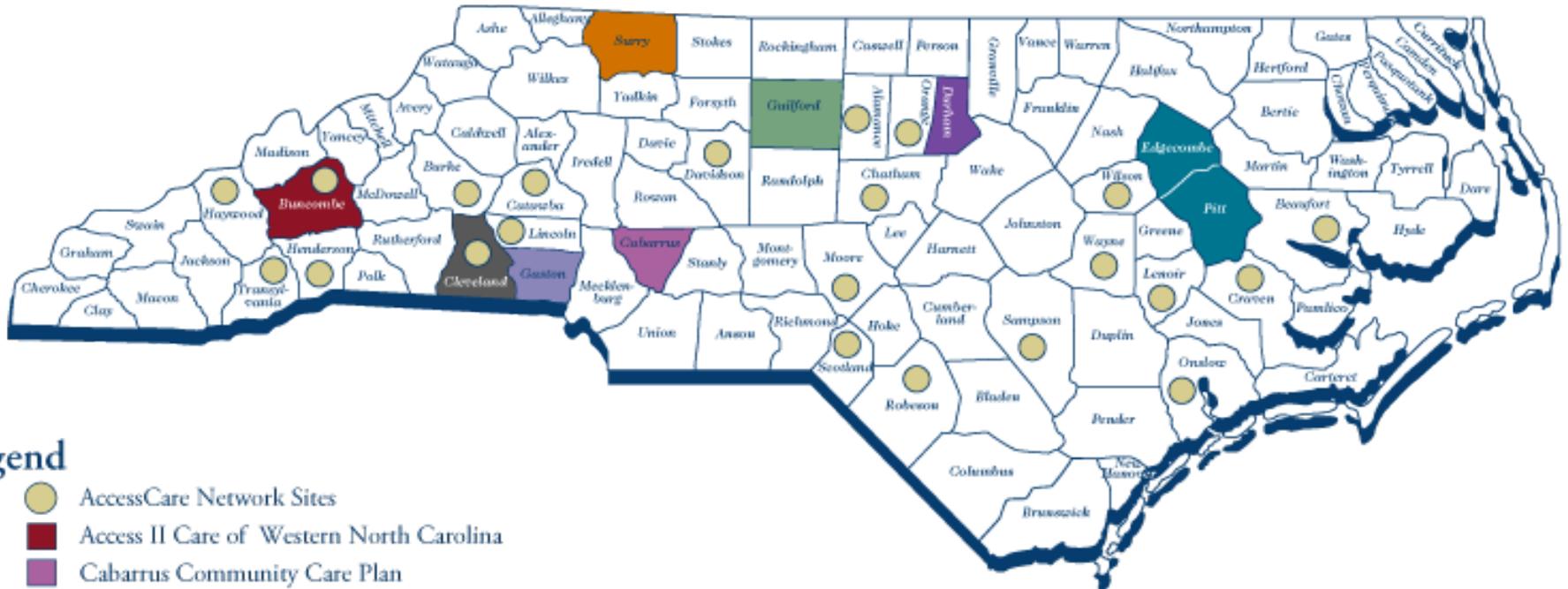




# Community Care of North Carolina (Access II and III Networks)

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

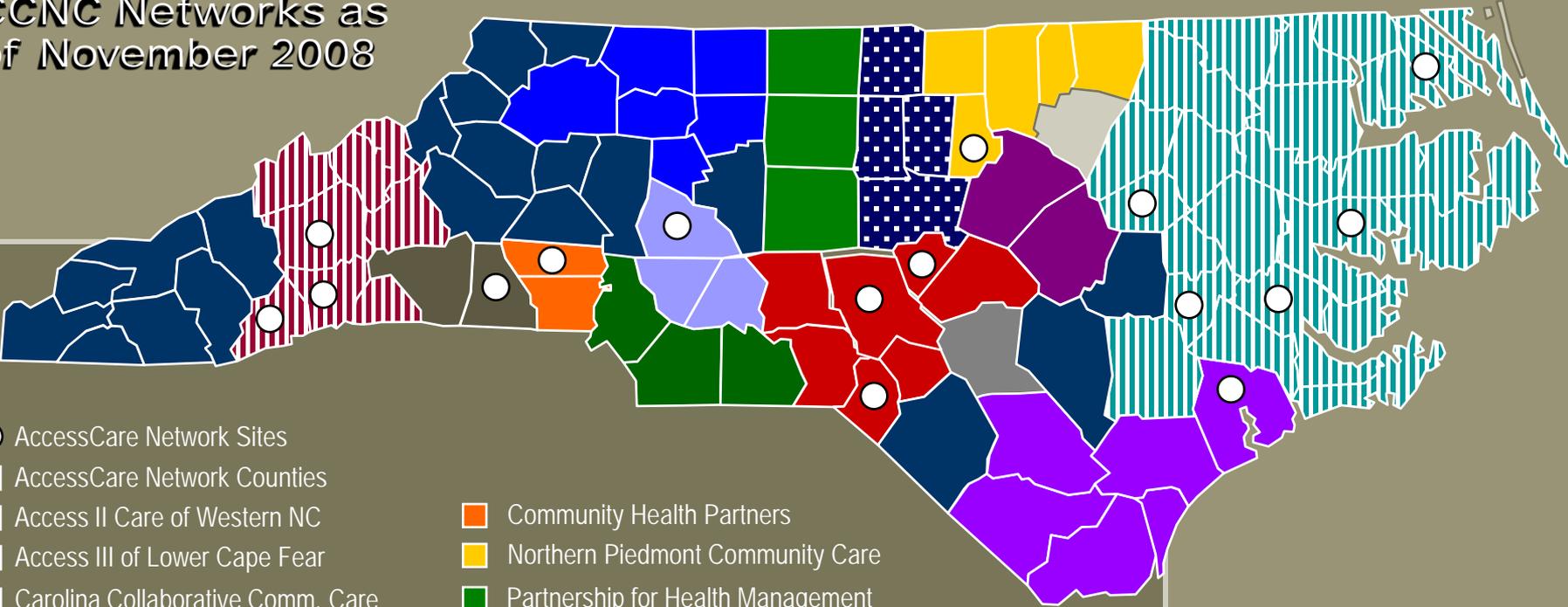
## *Now in 2008*

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care
- 15 Networks with more than 3500 Primary Care Physicians (1200 medical homes)
- over 950,000 enrollees
- Now mandated inclusion of Aged Blind and Disabled and SCHIP by General Assembly



# CCNC Spread: 15 networks, 3500 MDs, >950,000 patients

CCNC Networks as of November 2008



- 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
- Medical management committee
- Receive \$3.00 PM/PM from the State
- Hire care managers/medical management staff to work with PCPs
- PCP also get \$2.50 PMPM to serve as medical home and to participate in DM
- *NC Medicaid pay 95% of Medicare FFS*



## ***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

*“As we increase network activities we also increase the PMPM network payment”*

# **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

# Key Innovations

- Provider networks organized by local providers and are physician led
- Evidenced based guidelines are adapted by consensus rather than dictated by the state
- Medical Homes are given the resources for care coordination and get timely feedback on results
- Inclusion of other safety net providers and human service agencies

“We are about building local systems of care rather than changing how we pay for services”

# **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)**



# Network Specific Quality Improvement Initiatives

- “Assuring Better Child Development” (ABCD)
- ADD/ADHD
- NC HealthNet- 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

# What is Needed to Improve Chronic Illness Care

According to Ed Wagner, MD, author of the Chronic Care Model, fundamental system changes are needed to meet the needs of patients with chronic illnesses:

- A medical home that can provide a “continuous healing relationship”
- Use of care team
- Effective evidence-based treatment
- Support for patient self-management
- Systematic follow-up and planned encounters
- More intensive management for high risk patients and for those not meeting goals
- Coordination across settings and professionals
- Registries

# So *What* Makes **CCNC** *Work*?

- Focus on patient
- Helping physician improve care by providing additional resources
- Clinical best practice ( changes at the practice level is applied to all patients- not just Medicaid)
- Local community based management- physician led
- True public –private partnership

# Key Results

## Asthma

- 34% lower hospital admission rate
- 8% lower ED rate
- average episode cost for children enrolled in CCNC was 24% lower
- 93% received appropriate inhaled steroid

## Diabetes

- 15% increase in quality measures

# **Cost/Benefit Estimates**

# Community Care of North Carolina Cost Savings

- Cost - \$8-20 Million yearly (state)  
(Cost of Community Care Operations)

## Compared to Prior Yr

- Savings - \$ 60 million SFY03
- Savings - \$ 124 million SFY04
- Savings- \$ 81 million SFY05
- Savings- \$ 161 million SFY06
- Savings- \$157 million SFY 07

## ***NC Medicaid Administrative costs only 6%!***

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

# Chronic Care Pilot- ABD population

- 30,000 patients
- Take an average of 7.8 prescription medications per month
- 4,000 have Diabetes
- 2,400 have COPD
- 8,600 have Hypertension
- 900 have Congestive Heart Failure
- 7,900 have a co-morbid Mental Health Diagnosis
- 70% have co-morbidities (suffering with two or more chronic conditions)
- Congestive Heart Failure was the 2nd leading cause of hospitalization

\$ 53 million first year savings SFY 07

## “Community Care of North Carolina” *in the news...*

- October 3, 2007: Community Care of North Carolina wins the 2007 Annie E. Casey Innovations in American Government Award given by the Kennedy School of Government at Harvard University

## Next Steps

- Strengthen the ability of the CCNC medical home to manage chronic illness care
- Enhance the ability of practices/networks to support patient self-management
- Partner with other community providers- Home Health, SNF
- Integrate specialist expertise into care improvement process
- Strengthen communication and performance feedback to clinicians
- Investing in improved Clinical Information System/Registries
- Expand management to Medicare and other patients

# ***What's Next for Community Care of NC?***

Governor's Quality Initiative  
CCNC Medicare Demonstration  
Care+Share & NC HealthNet  
Others

# NC Healthcare Quality Alliance

- All-payor involvement
- BCBS, SEHP, Medicaid major collaborators
- 5 key diseases measured (asthma, diabetes hypertension, congestive heart failure and post MI treatment)
- State-wide effort using CCNC as foundation
- Focus on local expert assistance for practice redesign ( AHEC providing services to practices)

AHEC will provide direct assistance for practices to get to NCQA level 2 or 3

# **CCNC has applied for a 646 Medicare demonstration**

- Manage the duals
- Manage at risk elderly
- Voluntary
- Shared savings- non risk model
- Reinvestment of savings in ( quality, HIT, new services for elderly and community support for the uninsured)

# *Key Visions*

- “Managed not regulated”
- CCNC is a clinical program not a financing mechanism
- Public –private partnership
- Community-based, physician led
- Quality and system oriented
- Economizing through raising quality rather than lowering fees

# Take Home Thoughts

- Development of programs that work take time- often 18-24 months to see results
- Reinvestment of a portion of savings needed to sustain program and assure future results
- Investment in community programs will reduce overall medical cost for all patients
- Local physician leadership essential for success
- Maintaining adequate physician reimbursement (particularly for primary care) essential for adequate access to care for Medicaid and the uninsured

***Want to Know More?***

**[www.communitycarenc.com](http://www.communitycarenc.com)**

# Community Care of North Carolina



# Thank You



[HOME](#)