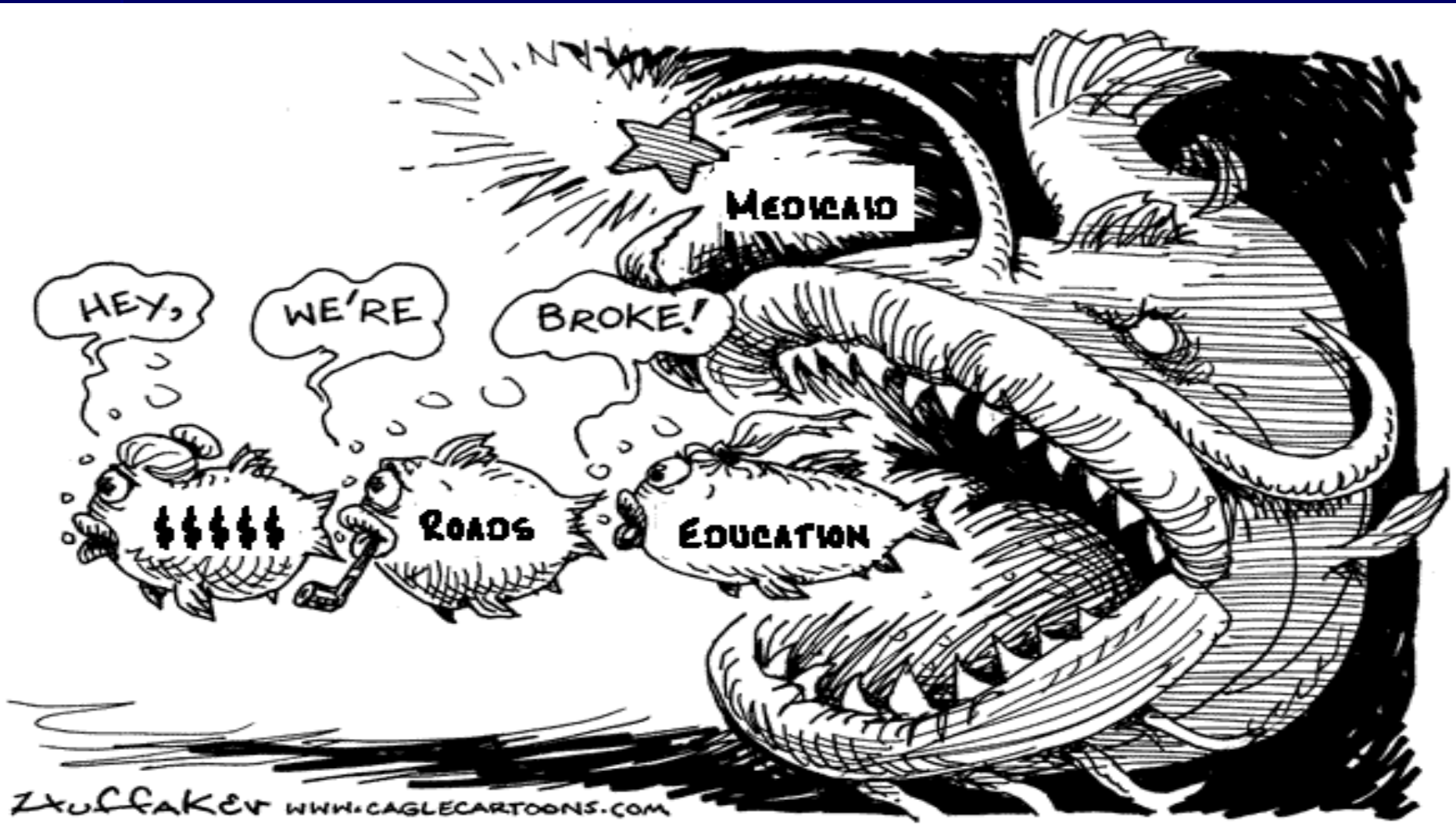
Community Care of NC

Building Accountable Care Using Public Programs- lessons learned”

ACCESS II & III

L. Allen Dobson ,Jr. MD FAAFP
President
NC Community Care Networks, Inc
Vice President
Carolinas Healthcare System



State Budgets in Crisis !!

The Cost Equation

Eligibility/Benefits + Reimbursement Rate + Utilization = Cost

- Eligibility and Benefits – how many you cover and what you cover (ARRA limits this option)
- Reimbursement - what you pay (a double edged sword)
- Utilization - how many services are provided

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

A Move Toward Accountable Care- what's needed?

- An Imperative to Act (sometimes a crisis is good)
- Uniformity of Effort and Standard Measures of Success
- An Open Process and Structure (new partnerships)
- Build an advanced primary care system
- New collaborative community organizations-"virtual health systems"
- Willingness to Share best practice and share data (transparency)
- Must balance cost efforts with quality efforts
- Align incentives (new payment options)
- A multipayor effort (whether you start with public or private)

Primary Goals in Developing CCNC

- *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)*

"CCNC is a clinical program and delivery system innovation. Its principles should work for commercial as well as public payors"

Community Care of North Carolina
Now in 2010

- Focuses on improved quality, utilization and cost effectiveness
- 15 Networks with more than 4200 Primary Care Physicians (1350 medical homes) + all NC Hospitals
- over 975,000 Medicaid enrollees
- Now mandated inclusion of Aged Blind and Disabled and SCHIP by General Assembly
- Major Medicare 646 demo
- New Partnership for SEHP

COMMUNITY CARE OF NORTH CAROLINA:

Under the Community Care program (CCNC), North Carolina is building community health networks that are organized and operated by community physicians, hospitals, health departments and departments of social services. By establishing primary care based provider networks, the program is putting in place the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.

CCNC is a statewide program.

- 934,489 Medicaid Recipients, 104,703 Health Choice Recipients, 1,360 practices, and approx. 4,500 primary care providers
- Patient population: Medicaid & Health Choice
- Duration: 1998 - present

Timeline

COMMUNITY CARE OF NORTH CAROLINA : MEDICAL HOME DESIGN

Our model

Networks

- Number involved:14
- Pay for coordinator: Yes

Government

- Legislation passed: Yes
- Medicaid / Health Choice
- Medicare Healthcare Demonstration

Community

- Hospitals, DSS, Health Departments, Key Community Partners

Payment

- PMPM: PCP-$2.50 AFDC, $5 ABD, $2.50 HC
  Network - $3 AFDC, $8 ABD, $2.50 HC

Primary Care

- Physician
- Patient
- Care Coordinator

Hospitals

- Member of Board / Steering Committee

Care Coordination

- Dedicated coordinator: Yes
- # patients / coordinator: 1/10,000 AFDC - 1/2,500 ABD

Performance Evaluations

- Mercer Cost Analysis
- Frequency: Annually

Health IT

- Medicaid Claims
- Case Management Information System
- Hospital Real-Time Data

Flexible Scheduling

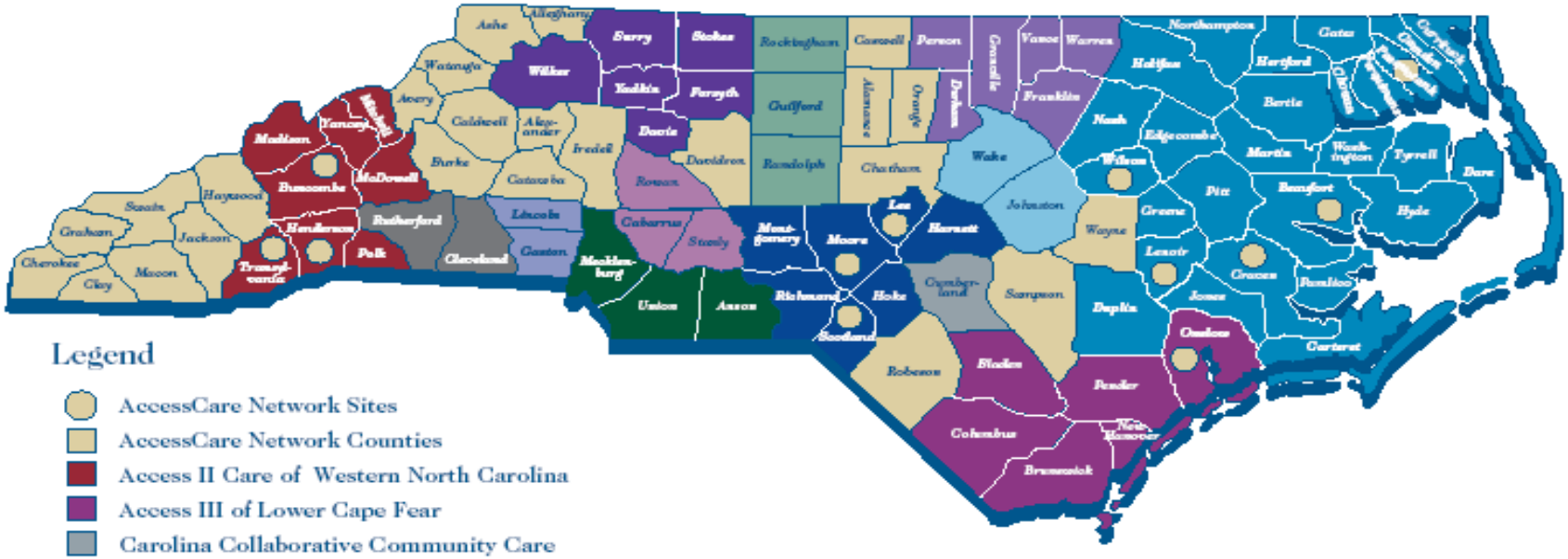
- Open access in some practices
- Payment for expanded hrs

24/7 Access

- Yes
- Directly, local collaboration, or call center

Community Care of North Carolina

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

Community Care Networks:

- Non-profit organizations
- Includes all providers(medical homes) including safety net providers
- Medical management committee
- Receive $3.00/$8.00 PM/PM from the State
- Hire/pay for care managers/medical management staff to work with PCPs
- PCP also get $2.50/$5.00 PMPM to serve as medical home and to participate in DM
- *NC Medicaid pay 95% of Medicare FFS for PC and 85% others*

How it Works Now

- The state identifies priorities and provides additional financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation
- Networks voluntarily share best practice solutions and best practice is gradually spread to other networks
- The State provides the networks access to data
- The State does an every 2 yr retrospective evaluation of the cost savings and effectiveness of the program (Mercer Eval).

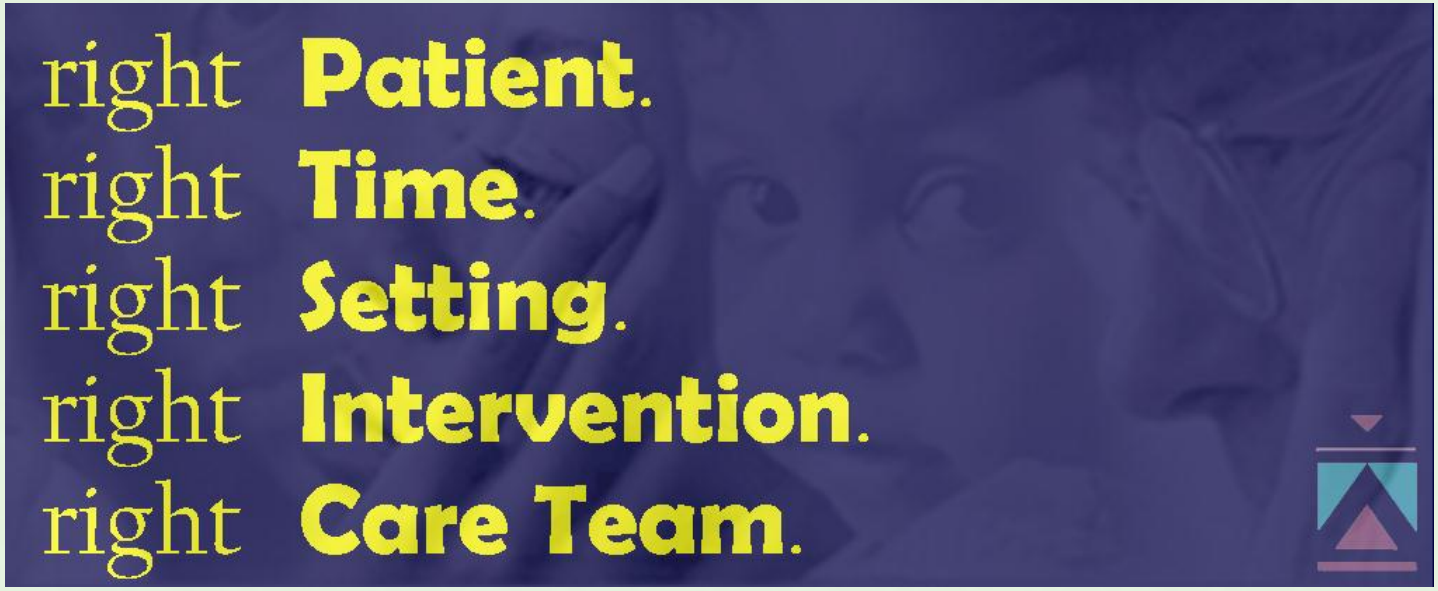
Each Network Now Have:

- 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 increase the network payment

A Move to Population Health

- Data will drive quality and costs (Informatics Center)
- Integration of basic Mental Health and Dental (ICARE)
- Use CCNC as a framework for uninsured (CareShare/HealthNet)
- Align AHEC
- Public Reporting and Multipayor (NCHQA)



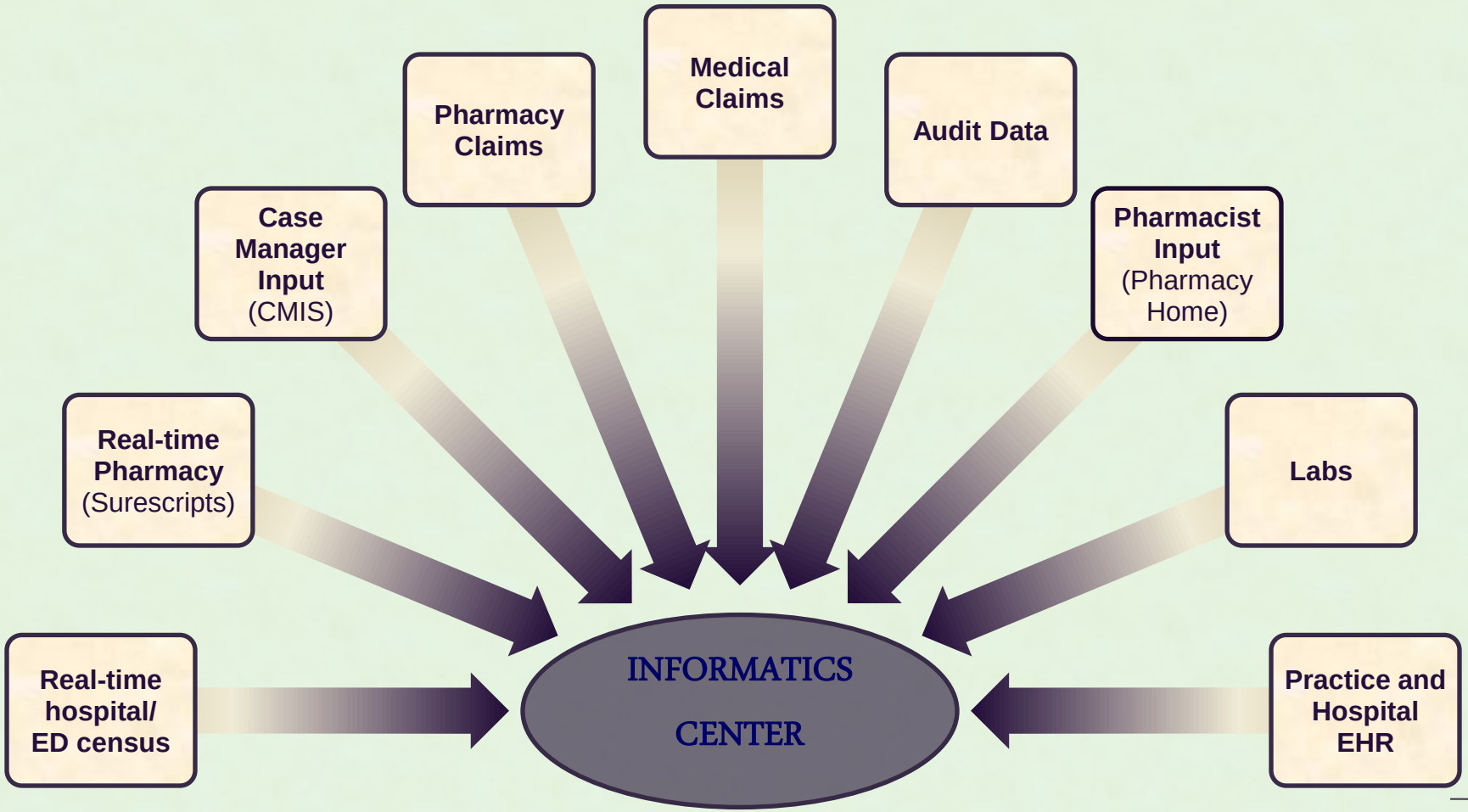
NCCCN Informatics Center

Information Support for Patient-Centered Care

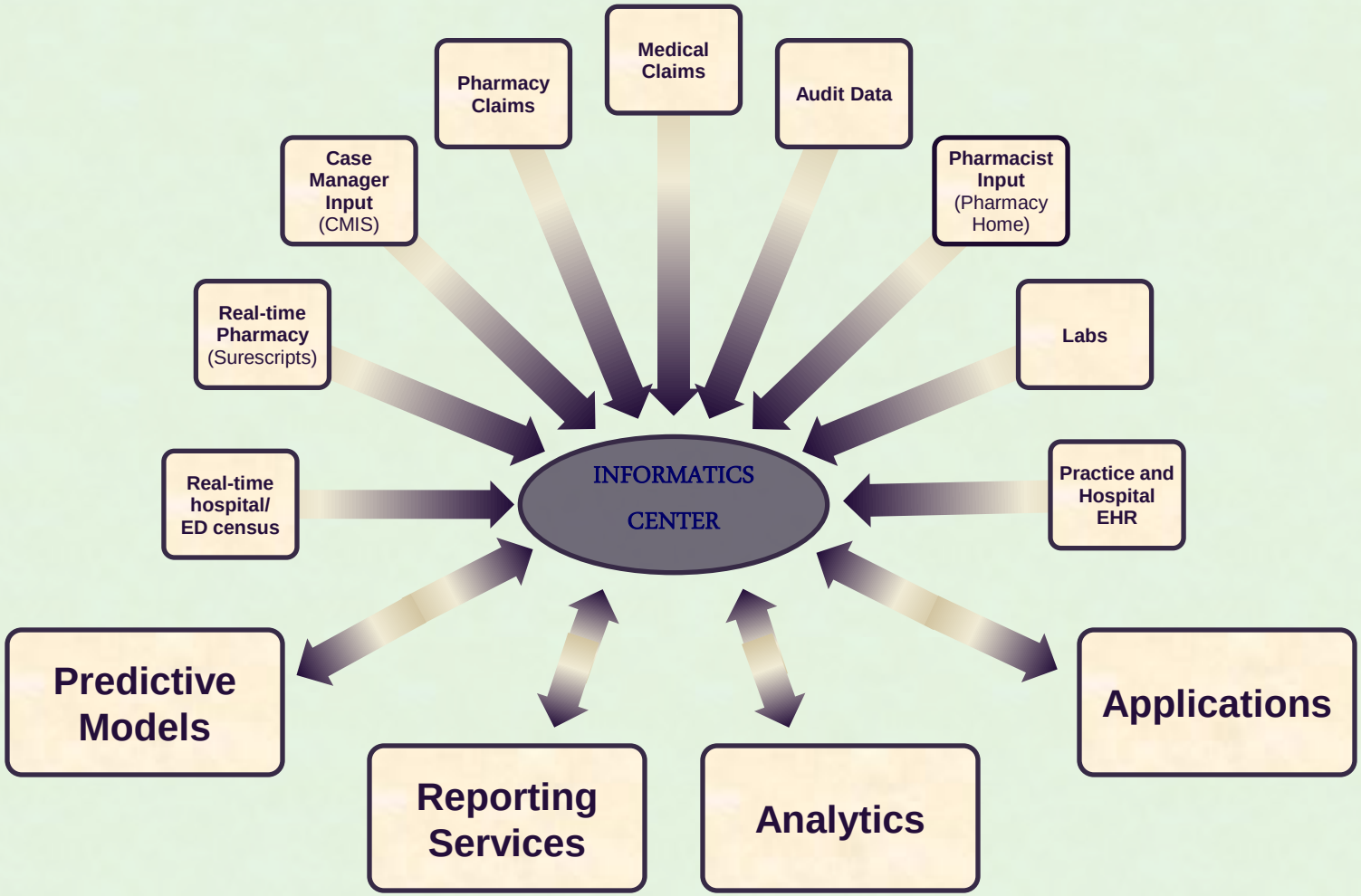
Informatics Center Functions

- **Patient Care and Care Coordination**
  - Intervention Planning
  - Population Management
  - Risk Stratification for Targeted Care Initiaitves
  - Workflow management and Care Team Communications
    - CMIS Case Management Information System
    - Pharmacy Home
    - Provider Portal
- **Practice- and Community-Based Quality Improvement**
- **Program Evaluation**

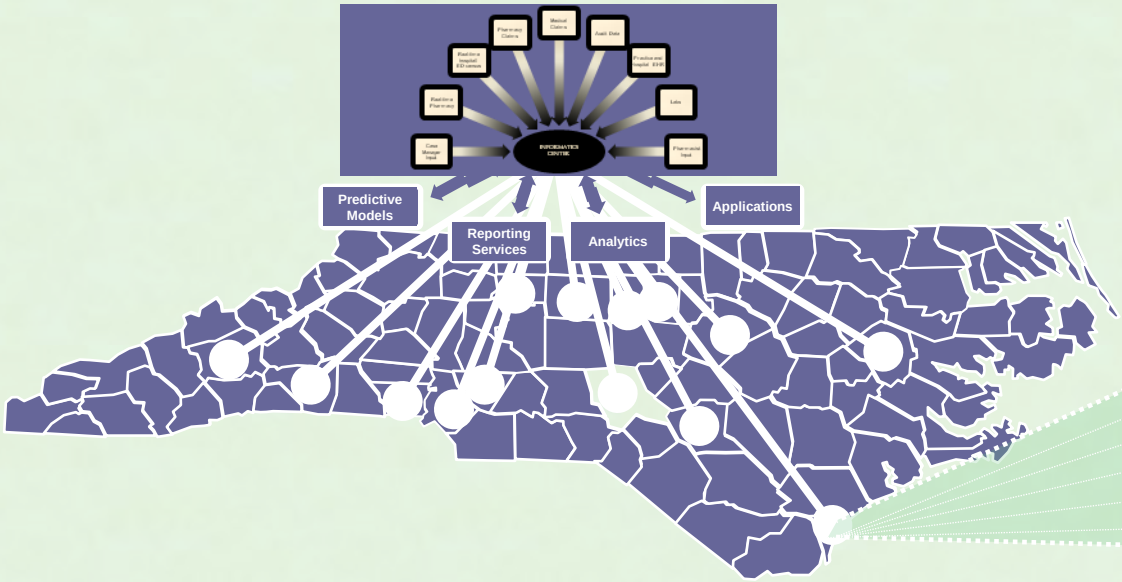
The Big Picture: It all Starts with Data



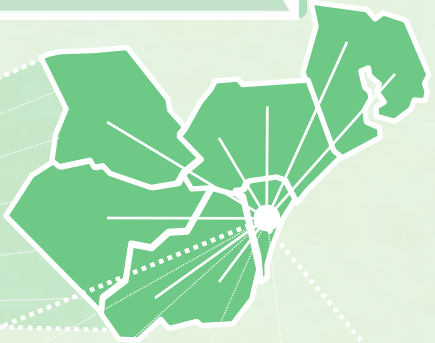
Then Organization and Dissemination



Then Technical, Analytical and Educational Support

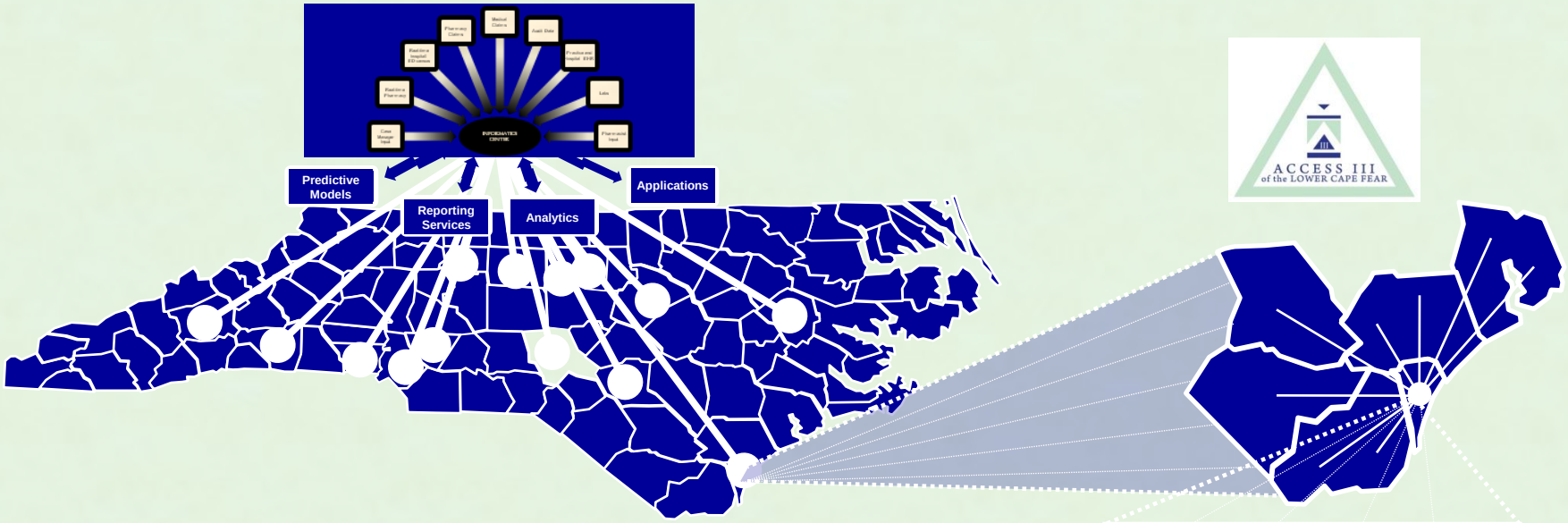


ACCESS III
of the LOWER CAPE FEAR



- Network Area Administrator **(NAM)**
- Quality Improvement Coordinator **(QI)**
- E-prescribing/HIT Facilitator **(eRx)**
- Expert Users **(EU)**

Then Caregivers



❖ Network Area Administrator **(NAM)**
❖Quality Improvement Coordinator **(QI)**
❖E-prescribing/HIT Facilitator **(eRx)**
❖Expert Users **(EU)**

CCNC Care Team

Nurses, Pharmacists, Social Workers, Health Educators

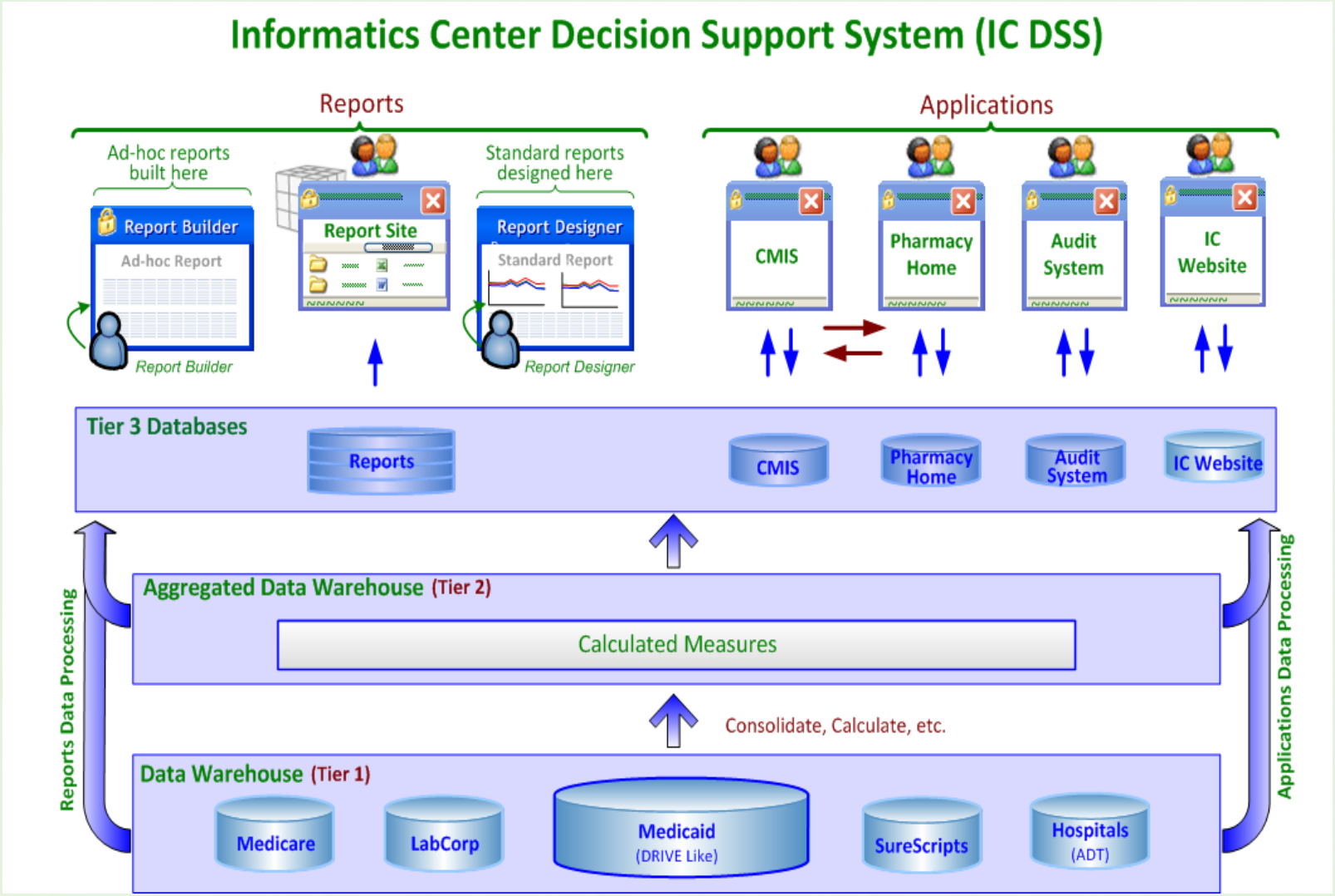

Hospital


Home


Clinic


Other Settings

Informatics Center Architecture



Data Analytics and Reporting Services

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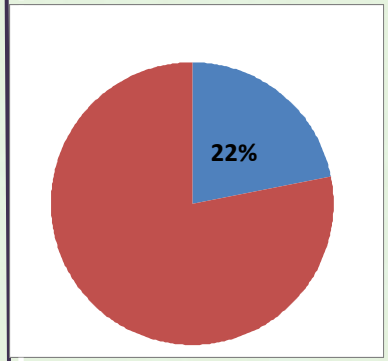
Data Analytics: Program Planning

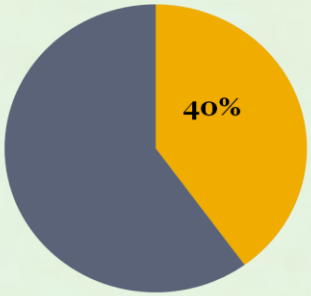
Disease Prevalence among Elderly & Disabled NC Medicaid Recipients

Chronic Care Disease Prevalence

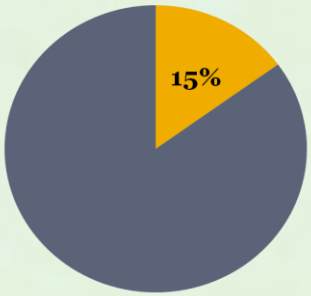
Diabetes



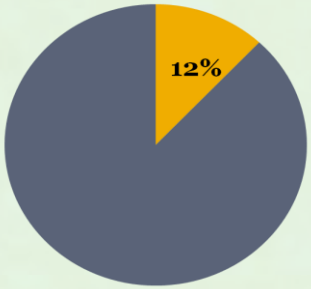
Hypertension



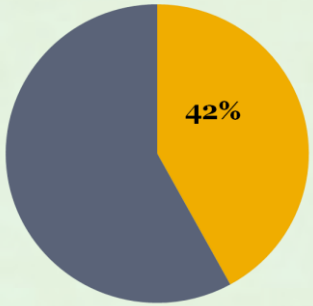
Asthma



COPD

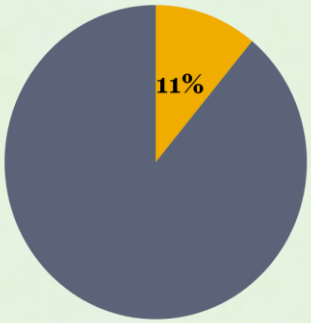


Mental Illness

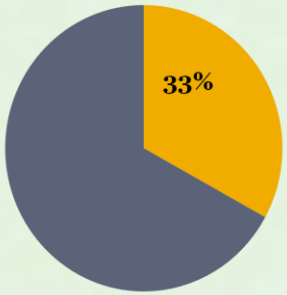


Complexities

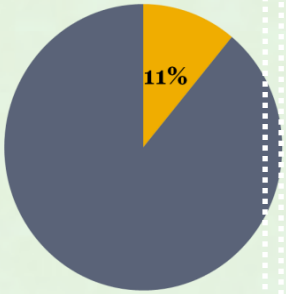
Heart Disease or Stroke



3 or more Comorbidities

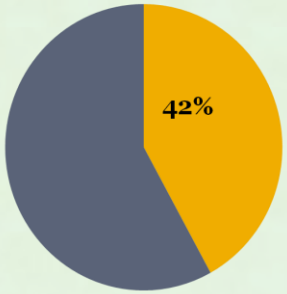


8 or more prescriptions

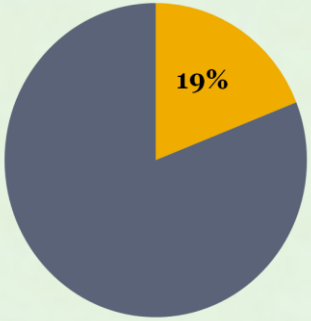


Hospital Use

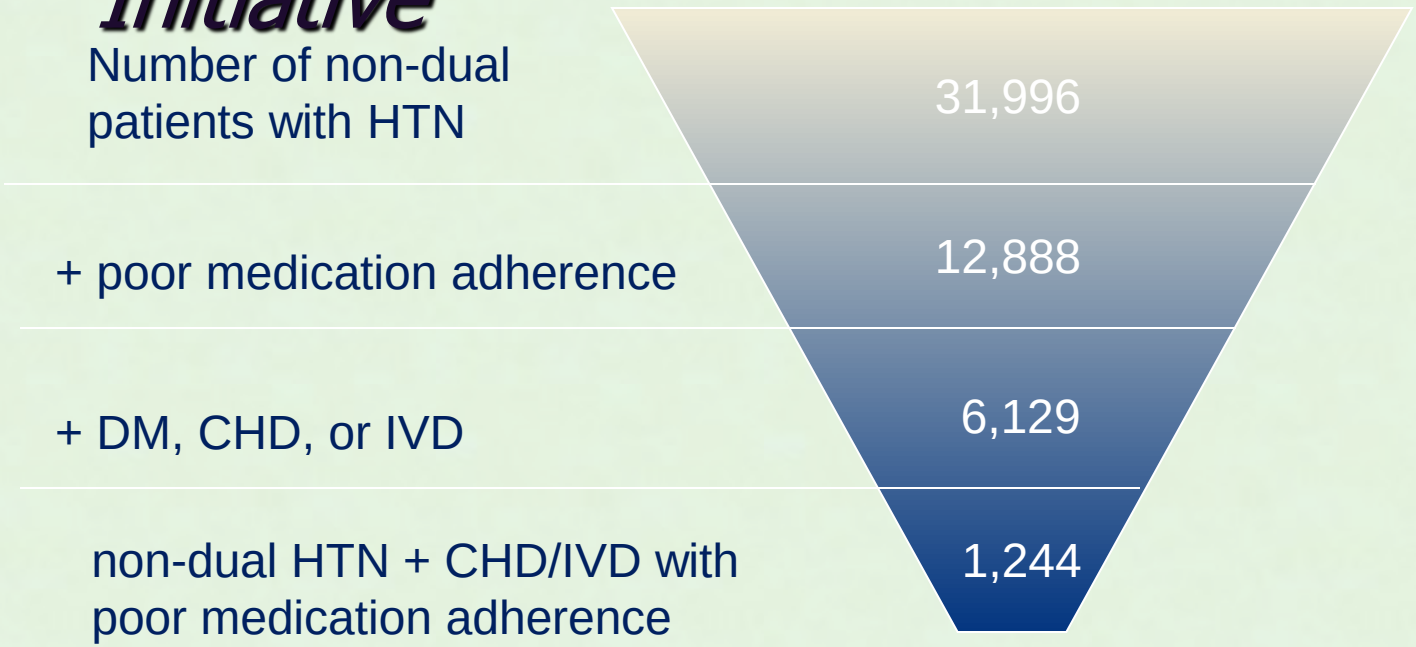
At least one ED visit



At least one hospitalization



Ex: KBR-Funded Stroke Prevention Initiative



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Chronic Care Reports:

(e.g.) 30-Day Readmission Report

S4- ABD PATIENTS WITH A 30 DAY READMISSION ENROLLED IN NETWORKS AS OF MARCH 1, 2009
CLAIMS WITH DATES OF SERVICE APRIL 1, 2008 TO MARCH 31, 2009

DATE OF BIRTH	CA PCP COUNTY	CA PCP NAME	ADMIT DATE	DISCHARGE DATE	BILLING PROVIDER	PRIMARY DIAGNOSIS
	WAKE	RALEIGH ASSOCIATED MEDICAL	10/10/2008	12/22/2008	WAKEMED	ACUTE RESPIRATORY FAILURE
	WAKE	RALEIGH ASSOCIATED MEDICAL	1/19/2009	1/22/2009	REX HOSPITAL	POST TRAUM PULM INSUFFIC
	WAKE	RALEIGH ASSOCIATED MEDICAL	2/2/2009	2/3/2009	REX HOSPITAL	UNSPECIFIED VIRAL INFECTIONS
	WAKE	RALEIGH ASSOCIATED MEDICAL	2/6/2009	2/8/2009	REX HOSPITAL	GASTROINTEST HEMORR NOS
	WAKE	HORIZON HEALTH CENTER	4/4/2008	4/8/2008	REX HOSPITAL	ADVERSE EFFECT ATICOAGULANTS
	WAKE	HORIZON HEALTH CENTER	4/29/2008	4/30/2008	WAKEMED	CHEST PAIN NEC
	WAKE	HORIZON HEALTH CENTER	11/1/2008	11/3/2008	WAKEMED	AMI ANT WALL INT EPI EAR
	WAKE	HORIZON HEALTH CENTER	2/26/2009	3/5/2009	REX HOSPITAL	ATRIAL FIBRILLATION
	WAKE	HORIZON HEALTH CENTER	3/16/2009	3/17/2009	REX HOSPITAL	ATRIAL FIBRILLATION
	WAKE	HORIZON HEALTH CENTER	3/26/2009	3/28/2009	REX HOSPITAL	UNSPECIFIED SYSTOLIC HEART FAILURE
	JOHNSTON	BENSON AREA MEDICAL CENTER	7/5/2008	7/8/2008	JOHNSTON MEMORIAL I	CHEST PAIN NEC
	JOHNSTON	BENSON AREA MEDICAL CENTER	10/7/2008	10/17/2008	JOHNSTON MEMORIAL I	CHRONIC OBSTRUTIVE ASTHMA - WITH (ACUTE) EXACERBATION
	JOHNSTON	BENSON AREA MEDICAL CENTER	2/10/2009	2/12/2009	JOHNSTON MEMORIAL I	CHEST PAIN NEC
	JOHNSTON	BENSON AREA MEDICAL CENTER	2/12/2009	3/4/2009	WAKEMED	ATRIOVENT BLOCK COMPLETE
	JOHNSTON	BENSON AREA MEDICAL CENTER	3/23/2009	3/28/2009	WAKEMED	OTHER CHRONIC POSTOPERATIVE PAIN
	WAKE	ROCK QUARRY ROAD FAMILY ME	6/3/2008	6/6/2008	WAKEMED	ASTHMA W STATUS ASTHMAT
	WAKE	ROCK QUARRY ROAD FAMILY ME	11/16/2008	11/19/2008	WAKEMED	CHRONIC OBSTRUTIVE ASTHMA - WITH (ACUTE) EXACERBATION
	WAKE	ROCK QUARRY ROAD FAMILY ME	3/1/2009	3/4/2009	WAKEMED	ACUTE RESPIRATORY FAILURE
	WAKE	ROCK QUARRY ROAD FAMILY ME	3/16/2009	3/18/2009	WAKEMED	ASTHMA W STATUS ASTHMAT
	WAKE	ROCK QUARRY ROAD FAMILY ME	6/17/2008	6/23/2008	REX HOSPITAL	ACUTE ON CHRONIC SYSTOLIC HEART FAILURE
	WAKE	ROCK QUARRY ROAD FAMILY ME	8/5/2008	8/9/2008	WAKEMED	ACUTE SYSTOLIC HEART FAILURE
	WAKE	ROCK QUARRY ROAD FAMILY ME	12/27/2008	12/28/2008	DUKE RALEIGH HOSPIT	DIABETES MELLITIS W/O COMPLICATION, TYPE II, UNCONTROLLED
	WAKE	ROCK QUARRY ROAD FAMILY ME	1/5/2009	1/19/2009	NASH GENERAL HOSPI	RECUR DEPR PSYCH-SEVERE
	WAKE	ROCK QUARRY ROAD FAMILY ME	2/11/2009	2/13/2009	WAKEMED	CONGESTIVE HEART FAILURE
	WAKE	ROCK QUARRY ROAD FAMILY ME	3/15/2009	3/17/2009	REX HOSPITAL	ACUTE SYSTOLIC HEART FAILURE

Printable Drug Use Profile

The Pharmacy Home
Medication Regimen Report

Rx claims through: 2/21/2008
Report Print Date: 04/04/2008

Patient Information

Name	Jane D Doe	**DOB**	2/20/1944	**Gender**	Female	**MedicaidID**	123456789T	**Medicaid Eligibile**	Yes
Allergies	Unknown							**Medicare Eligible**	No

Practice Information

PCP		PCP Phone		PCP Fax
Practice	UNC FAMILY PRACTICE CENTER	**Network**	AccessCare	

Pharmacist/Case Manager Information

Most Recent Pharmacy	CARRBORO FAMILY PHARMACY INC	**Pharm Phone**	(919) 933-7629	**Case Manager Status**	
Network RPh	Troy K Trygstad	**Network RPh Phone**	919-260-5241	**Network RPh Fax**	

Patient Criteria Information

8+ Rx	Yes	**3+ Practices**	Yes	**Ave. PDC**		**Ave. Rx $/Mo**	$646.01

Medication Regimen

Drug Description	Prescriber*	Last Filled	Days Supply	Qty	Paid Amt	AI	Gap/DC	PAL/PA
GLYCOLAX POWDER	UNC HOSPITALS	11/13/07	29	510	$22.75			
CITALOPRAM HBR 20 MG TABLET	UNC HOSPITALS	11/13/07	30	30	$4.91	0.26	DC?	
FUROSEMIDE 20 MG TABLET		05/03/07	31	31	$3.49	0.41	263*	
POTASSIUM CL 10 MEQ TABLET E		02/21/08	32	32	$6.90			
EFFEXOR XR 75 MG CAPSULE SA	UNC HOSPITALS	02/21/08	34	34	$136.32			
CITALOPRAM HBR 10 MG TABLET	UNC HOSPITALS	02/21/08	3	3	$2.83	0.28		
LANTUS 100 UNITS/ML VIAL	UNC HOSPITALS	02/14/08	25	10	$87.14			
DIOVAN 80 MG TABLET		02/14/08	30	30	$64.74			
LIPITOR 20 MG TABLET		02/14/08	30	30	$123.69			
METOCLOPRAMIDE 10 MG TABLET		02/09/08	30	90	$8.45			
RISPERDAL 1 MG TABLET	UNC HOSPITALS	02/01/08	30	30	$137.55			
OMEPRAZOLE 20 MG CAPSULE DR	UNC HOSPITALS	01/22/08	30	60	$40.68			
WARFARIN SODIUM 5 MG TABLET		01/22/08	31	31	$7.38			
RISPERDAL 0.5 MG TABLET	Prescriber Unknown	01/14/08	30	30	$129.44		DC?	
CLONAZEPAM 0.5 MG TABLET	Prescriber Unknown	01/10/08	25	100	$5.65			
WARFARIN SODIUM 1 MG TABLET	Prescriber Unknown	01/10/08	30	30	$6.80			

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

AI = Adherence Index
GAP = Gap in Therapy
DC = New Drug Filled in Same Class

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Quality Measurement and Feedback: Quarterly Claims-Derived Quality Measures

Community Care of North Carolina
QMAF Claims Measure 2008Q4
Non-Dual Patients

	ASTHMA		DIABETES				HEART FAILURE			CANCER SCREENING				
Network	IP Asthma Per 1000 MM	ED Asthma Per 1000 MM	A1C Testing	Eye Exam Testing	Cholesterol Screening	Nephropathy Screening	IP CHF Rate Per 1000 MM	IP CHF 30 Day Readmission Percent	LVF Percent	Colon Cancer	Cervical Cancer	Breast Cancer Ages 42-51	Breast Cancer Ages 52-69	Breast Cancer Ages 42-69
Access II Care of Western NC	0.9	4.7	87%	50%	66%	79%	19.3	7%	92%	33%	59%	47%	50%	49%
Access III of Lower Cape Fear	1.5	8.5	87%	54%	79%	85%	21.8	13%	91%	42%	60%	46%	54%	50%
AccessCare	0.9	7.5	88%	52%	72%	81%	40.2	44%	96%	38%	59%	44%	50%	47%
Carolina Collaborative Community Care	2.1	20.1	88%	56%	81%	85%	34.1	19%	95%	45%	65%	38%	48%	43%
Carolina Community Health Partnership	0.2	5.8	92%	57%	77%	81%	39.2	25%	93%	34%	53%	34%	34%	34%
Community Care of Wake and Johnston Counties	2.7	14.4	84%	48%	66%	82%	33.1	28%	99%	35%	60%	38%	49%	43%
Community Care Partners of Greater Mecklenburg	2.0	12.6	85%	47%	76%	87%	37.0	15%	97%	36%	62%	39%	44%	41%
Community Care Plan of Eastern Carolina	1.1	13.3	87%	55%	73%	82%	35.8	25%	96%	40%	59%	46%	56%	51%
Community Health Partners	1.4	9.6	89%	48%	79%	86%	28.8	29%	100%	38%	57%	43%	48%	46%
Northern Piedmont Community Care	1.1	13.4	82%	52%	73%	84%	42.2	20%	94%	36%	62%	43%	51%	47%
Northwest Community Care	1.6	12.6	80%	52%	68%	84%	56.1	36%	96%	37%	62%	43%	52%	48%
Partnership for Health Management	1.9	9.6	83%	48%	65%	82%	31.3	13%	95%	37%	62%	54%	60%	56%
Sandhills Community Care Network	1.6	11.0	84%	58%	70%	83%	38.4	23%	91%	41%	59%	45%	50%	47%
Southern Piedmont Community Care Plan	1.9	9.8	89%	51%	82%	86%	33.3	19%	96%	38%	59%	47%	52%	50%
CCNC	1.4	10.6	86%	52%	73%	83%	36.1	27%	95%	38%	60%	44%	51%	47%

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Quality Measurement and Feedback: Drill Down Capabilities

Access III of Lower Cape Fear
QMAF Claims Measure 2008Q4
Asthma

						Results	
Network	Network County	Asthma Patient Count	Member Months	IP Asthma Visits	ED Asthma Visits	IP Asthma Per 1000 MM	ED Asthma Per 1000 MM
Access III of Lower Cape Fear	BLADEN	98	1118	1	12	0.9	10.7
Access III of Lower Cape Fear	BRUNSWICK	128	1494	0	9	0.0	6.0
Access III of Lower Cape Fear	COLUMBUS	262	2876	10	18	3.5	6.3
Access III of Lower Cape Fear	NEW HANOVER	400	4589	6	51	1.3	11.1
Access III of Lower Cape Fear	ONSLOW	46	545	0	3	0.0	5.5
Access III of Lower Cape Fear	PENDER	54	616	0	2	0.0	3.2
Access III of Lower Cape Fear	Network Results	988	11238	17	95	1.5	8.5
CCNC	CCNC Results	17725	205689	286	2175	1.4	10.6

Definitions

Patients: Identified as having asthma during CY2008 (1/1/2008 to 12/31/2008

Non-Dual status: Medicaid only patients during CY2008 (1/1/2008 to 12/31/2008)

Enrollment Eligibility: 10+ months enrollment with Carolina Access during CY2008

Anchor Date: CCNC enrolled December 2008

Excluded: Recipients with third party major medical insurance

Member Months: Carolina Access II (CCNC) during CY2008

Asthma IP Visits: Hospital admissions with asthma primary diagnosis while enrolled with CCNC during CY2008. Claims paid date prior to 4/1/2009

Asthma ED Visits: Emergency Dept. visits with asthma primary diagnosis while enrolled with CCNC during CY2008. Claims paid date prior to 4/1/2009

Community Care of North Carolina **Report Date: 8/27/2009**

IC Report Site
Home

Program Evaluation and Accountability: Example of Outcomes

Reporting: Quarterly Chronic Care Cost/Utilizaiton Measures

TOTAL PMPM COSTS

PHARMACY PMPM COSTS

INPATIENT RATE

ED RATE

NON-EMERGENT ED RATE

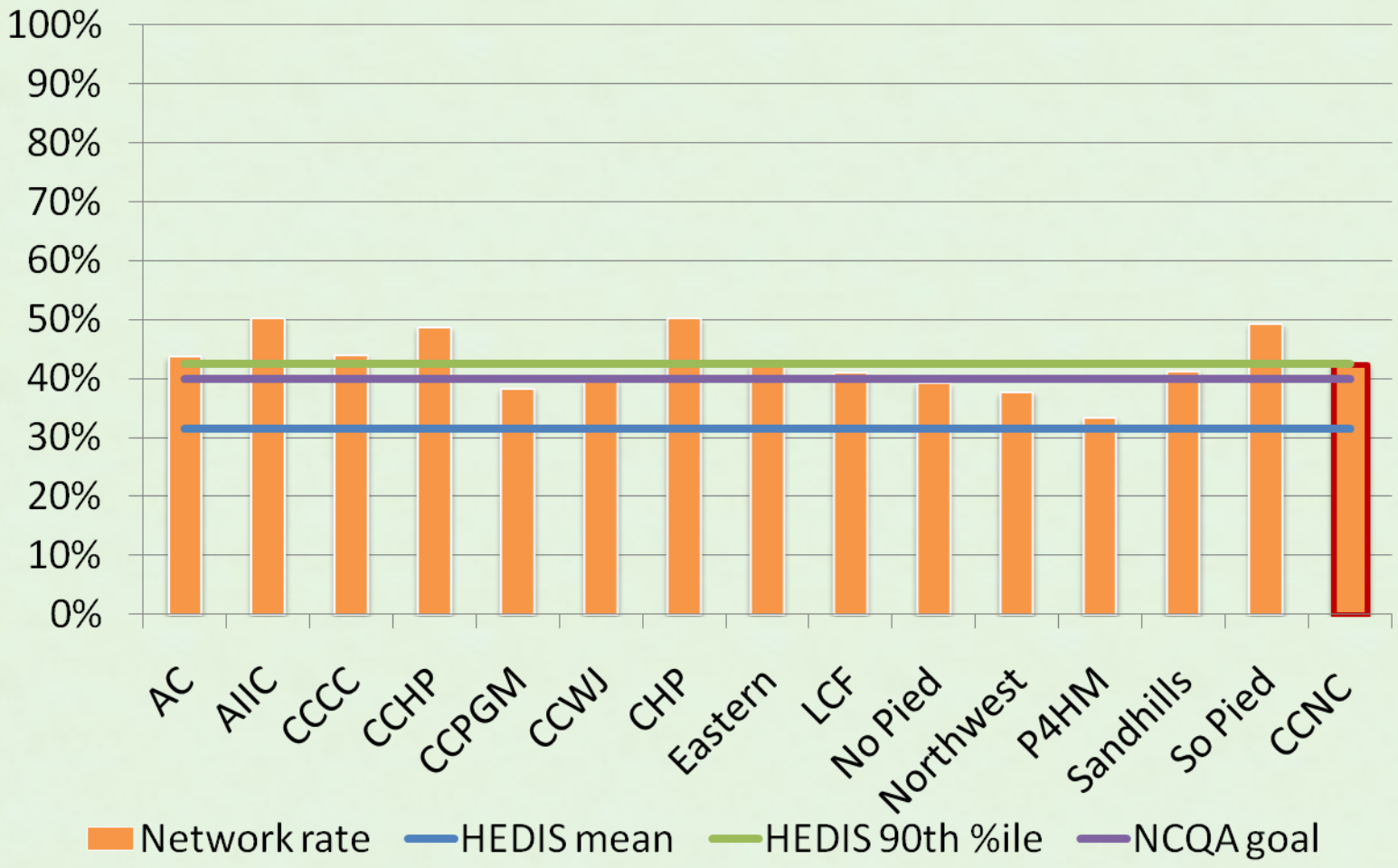
READMISSION COUNT

READMISSIONS AS % OF TOTAL ADMISSIONS

S3- QUARTERLY UTILIZATION/COST MEASURES
CLAIMS WITH DATES OF SERVICE JULY 1, 2008 TO MARCH 31, 2009
NON-DUAL ABD PATIENTS BY PCP COUNTY
PAID DATE LESS THAN JULY 15, 2009
SOURCE: DOWNLOADED FROM DRIVE JULY 20, 2009
1QTR09: JAN-MAR 2009
4QTR08: OCT-DEC 2008
3QTR08: JUL-AUG 2008

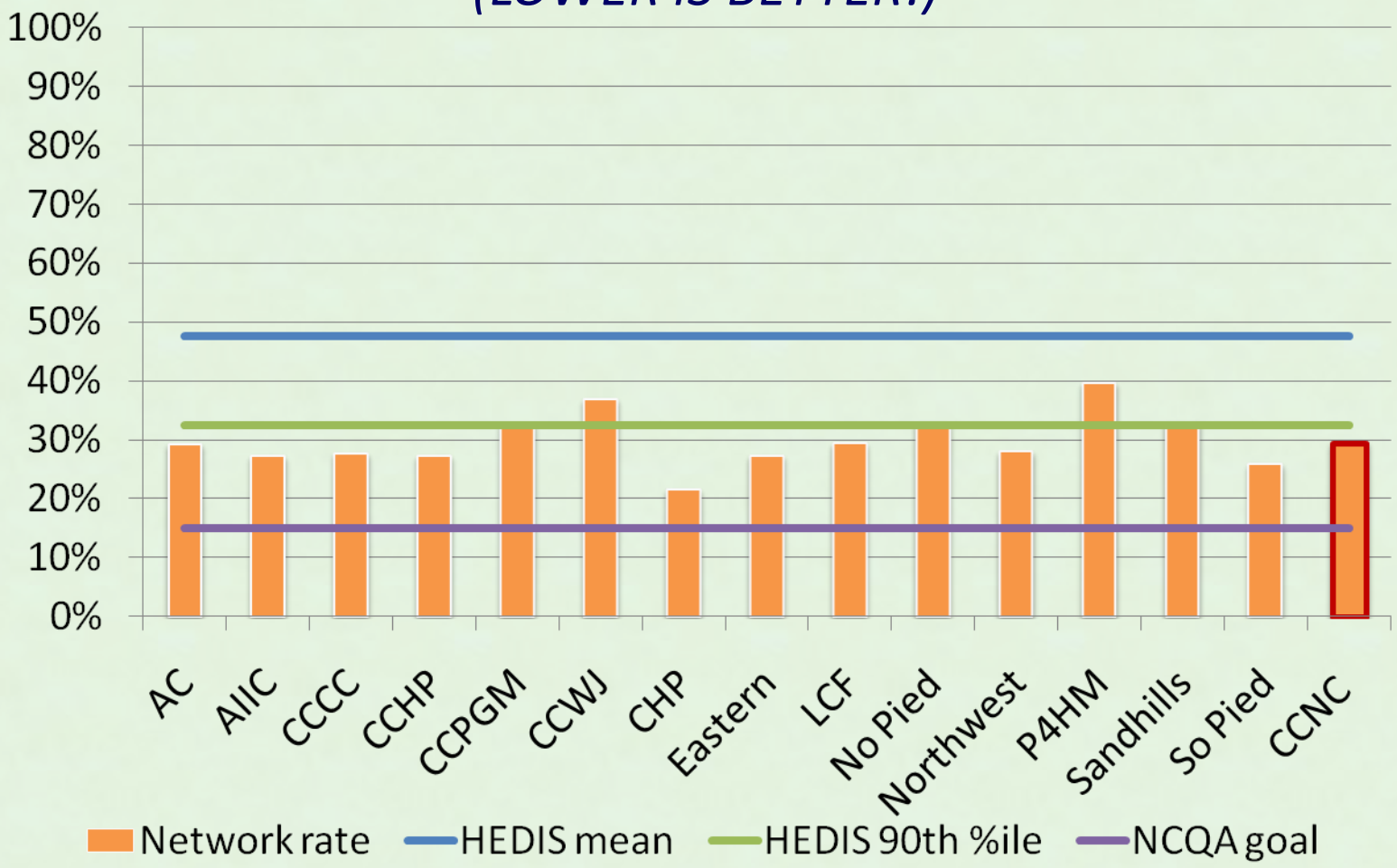
NETWORK NUMBER	NETWORK	QUARTER	TOTAL MEDICAID PMPM COST	PHARMACY PMPM COST	INPATIENT RATE PER 1000 MM	ED RATE PER 1000 MM	NON-EMERGENT ED RATE PER 1000 MM	HOSPITAL 30 DAY READMISSIONS	HOSPITAL STAYS	HOSPITAL 30 DAY READMISSIONS % OF STAYS
6701003	COMMUNITY HEALTH PARTNERS	1QTR09	$ 1,599.89	$ 423.54	34.0	126.8	75.0	42	264	15.9%
6701003	COMMUNITY HEALTH PARTNERS	4QTR08	$ 1,512.78	$ 422.67	27.9	123.3	67.4	31	211	14.7%
6701003	COMMUNITY HEALTH PARTNERS	3QTR08	$ 1,313.34	$ 340.32	24.8	114.0	59.6	33	179	18.4%
6701006	ACCESSCARE	1QTR09	$ 1,432.85	$ 367.40	25.4	91.2	51.2	202	1,462	13.8%
6701006	ACCESSCARE	4QTR08	$ 1,394.76	$ 345.76	23.3	87.7	47.3	183	1,312	13.9%
6701006	ACCESSCARE	3QTR08	$ 1,344.03	$ 314.46	22.7	87.5	45.0	162	1,246	13.0%
6701007	ACCESS II CARE OF WESTERN NORTH CAROLINA	1QTR09	$ 1,501.31	$ 419.27	30.0	93.7	50.9	40	365	11.0%
6701007	ACCESS II CARE OF WESTERN NORTH CAROLINA	4QTR08	$ 1,417.36	$ 415.27	24.4	86.8	48.5	35	281	12.5%
6701007	ACCESS II CARE OF WESTERN NORTH CAROLINA	3QTR08	$ 1,472.72	$ 416.14	26.0	113.8	65.2	64	283	22.6%
6701011	COMMUNITY CARE OF WAKE AND JOHNSTON	1QTR09	$ 1,303.30	$ 291.85	22.4	96.0	56.3	43	392	11.0%
6701011	COMMUNITY CARE OF WAKE AND JOHNSTON	4QTR08	$ 1,278.20	$ 283.10	22.7	91.3	51.4	46	377	12.2%
6701011	COMMUNITY CARE OF WAKE AND JOHNSTON	3QTR08	$ 1,198.90	$ 297.82	19.5	101.0	58.5	52	317	16.4%
6701012	PARTNERSHIP FOR HEALTH MANAGEMENT	1QTR09	$ 1,333.45	$ 278.80	34.1	89.3	50.6	53	290	18.3%
6701012	PARTNERSHIP FOR HEALTH MANAGEMENT	4QTR08	$ 1,224.07	$ 274.10	26.6	99.7	57.9	29	209	13.9%
6701012	PARTNERSHIP FOR HEALTH MANAGEMENT	3QTR08	$ 1,234.91	$ 271.56	27.1	98.3	55.6	36	215	16.7%
6701013	CAROLINA COLLABORATIVE COMMUNITY CARE	1QTR09	$ 1,249.66	$ 286.41	22.5	82.8	32.7	56	371	15.1%
6701013	CAROLINA COLLABORATIVE COMMUNITY CARE	4QTR08	$ 1,207.99	$ 271.41	24.0	59.3	31.9	46	382	12.0%
6701013	CAROLINA COLLABORATIVE COMMUNITY CARE	3QTR08	$ 1,199.19	$ 283.59	24.1	53.9	26.9	39	335	11.6%
6702000	COMMUNITY CARE PLAN OF EASTERN CAROLINA	1QTR09	$ 1,254.73	$ 267.60	26.7	96.8	56.0	150	1,255	12.0%
6702000	COMMUNITY CARE PLAN OF EASTERN CAROLINA	4QTR08	$ 1,204.03	$ 263.10	26.1	93.3	53.4	179	1,204	14.9%
6702000	COMMUNITY CARE PLAN OF EASTERN CAROLINA	3QTR08	$ 1,163.85	$ 264.34	23.3	91.1	50.6	140	1,042	13.4%
6702003	SOUTHERN PIEDMONT COMMUNITY CARE PLAN	1QTR09	$ 1,561.53	$ 348.19	28.5	111.6	60.9	43	304	14.1%
6702003	SOUTHERN PIEDMONT COMMUNITY CARE PLAN	4QTR08	$ 1,510.70	$ 348.76	23.1	100.6	53.0	28	259	10.8%
6702003	SOUTHERN PIEDMONT COMMUNITY CARE PLAN	3QTR08	$ 1,535.76	$ 347.59	22.6	116.6	70.8	43	252	17.1%
6702004	ACCESS III OF LOWER CAPE FEAR	1QTR09	$ 1,393.84	$ 347.43	25.4	113.2	62.9	49	519	9.4%
6702004	ACCESS III OF LOWER CAPE FEAR	4QTR08	$ 1,351.17	$ 335.55	24.6	108.4	59.4	50	482	10.4%
6702004	ACCESS III OF LOWER CAPE FEAR	3QTR08	$ 1,296.74	$ 346.20	23.8	105.3	55.1	59	444	13.3%
6702005	SANDHILLS COMMUNITY CARE NETWORK	1QTR09	$ 1,415.16	$ 327.07	33.7	108.8	32.7	59	391	15.1%
6702005	SANDHILLS COMMUNITY CARE NETWORK	4QTR08	$ 1,350.15	$ 321.92	33.0	105.1	57.4	43	367	11.7%
6702005	SANDHILLS COMMUNITY CARE NETWORK	3QTR08	$ 1,364.35	$ 325.85	29.7	110.9	57.3	59	321	18.4%
6702006	NORTHWEST COMMUNITY CARE	1QTR09	$ 1,527.99	$ 340.17	31.4	112.4	61.3	116	598	19.4%
6702006	NORTHWEST COMMUNITY CARE	4QTR08	$ 1,428.95	$ 329.88	28.6	104.4	57.1	111	525	21.1%
6702006	NORTHWEST COMMUNITY CARE	3QTR08	$ 1,511.48	$ 380.01	32.2	136.4	76.7	143	574	24.9%
6702007	NORTHERN PIEDMONT COMMUNITY CARE	1QTR09	$ 1,378.49	$ 271.27	24.3	102.3	51.8	31	343	9.0%
6702007	NORTHERN PIEDMONT COMMUNITY CARE	4QTR08	$ 1,297.90	$ 255.99	23.6	98.5	49.1	47	323	14.6%
6702007	NORTHERN PIEDMONT COMMUNITY CARE	3QTR08	$ 1,371.59	$ 284.93	23.4	100.9	50.8	30	321	18.7%
	STATE TOTAL	1QTR09	$ 1,410.28	$ 325.13	26.9	99.5	55.7	1,024	7,500	13.7%
	STATE TOTAL	4QTR08	$ 1,359.36	$ 315.22	25.5	96.1	52.7	982	6,875	14.3%
	STATE TOTAL	3QTR08	$ 1,324.78	$ 313.23	24.2	99.0	53.1	1,007	6,397	15.7%

Diabetes: A1C <7.0

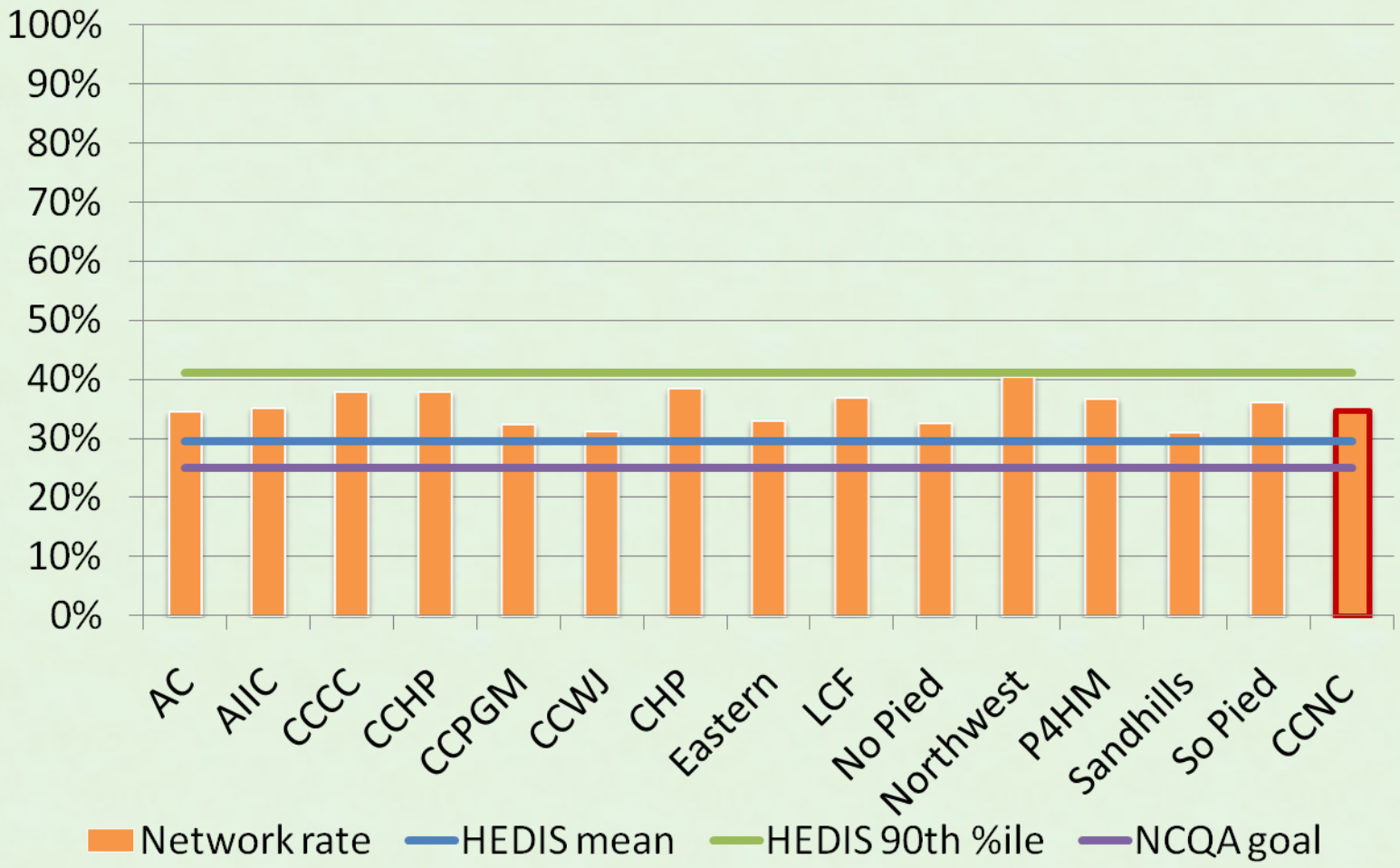


Diabetes: A1C >9.0

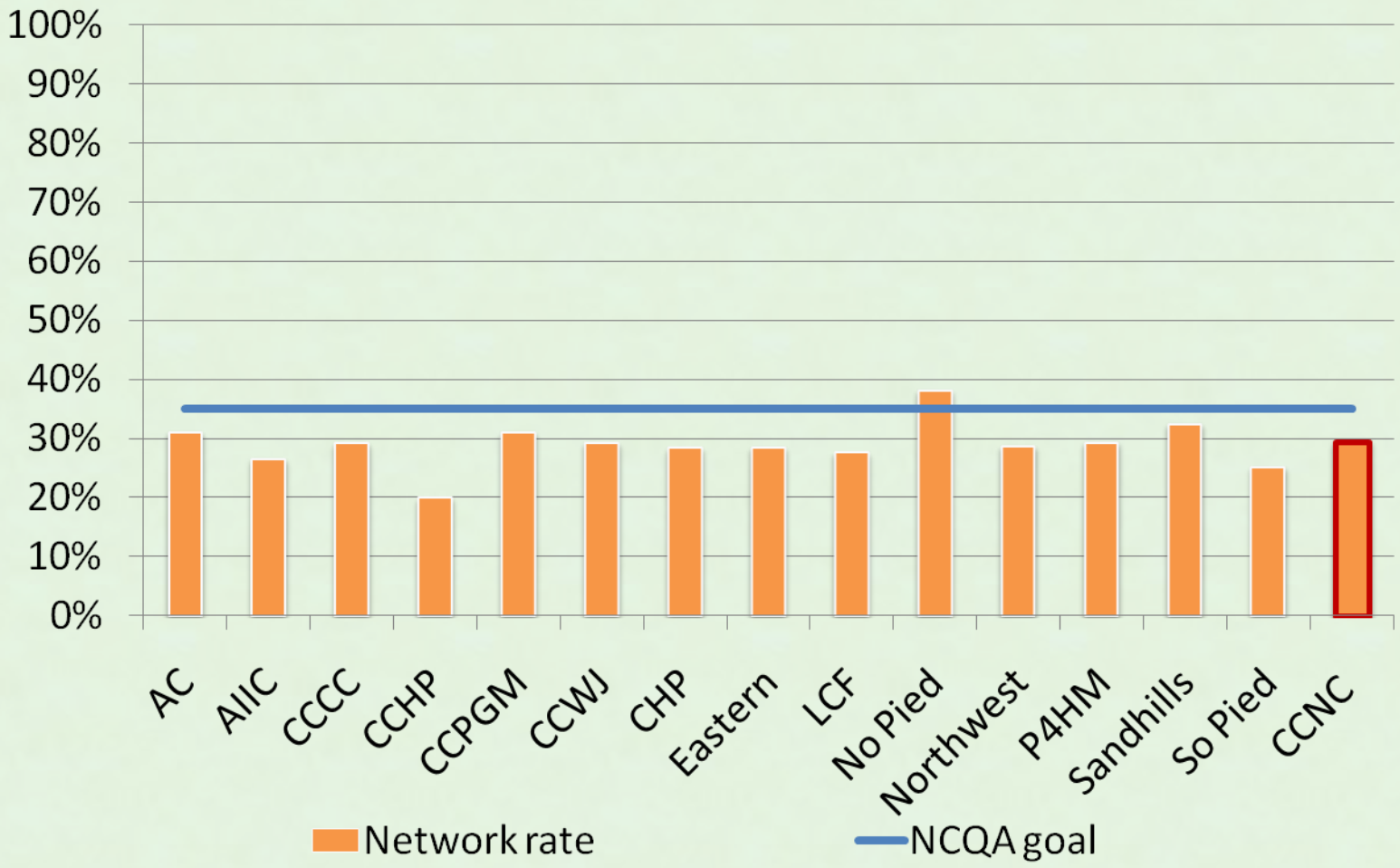
(LOWER IS BETTER!)



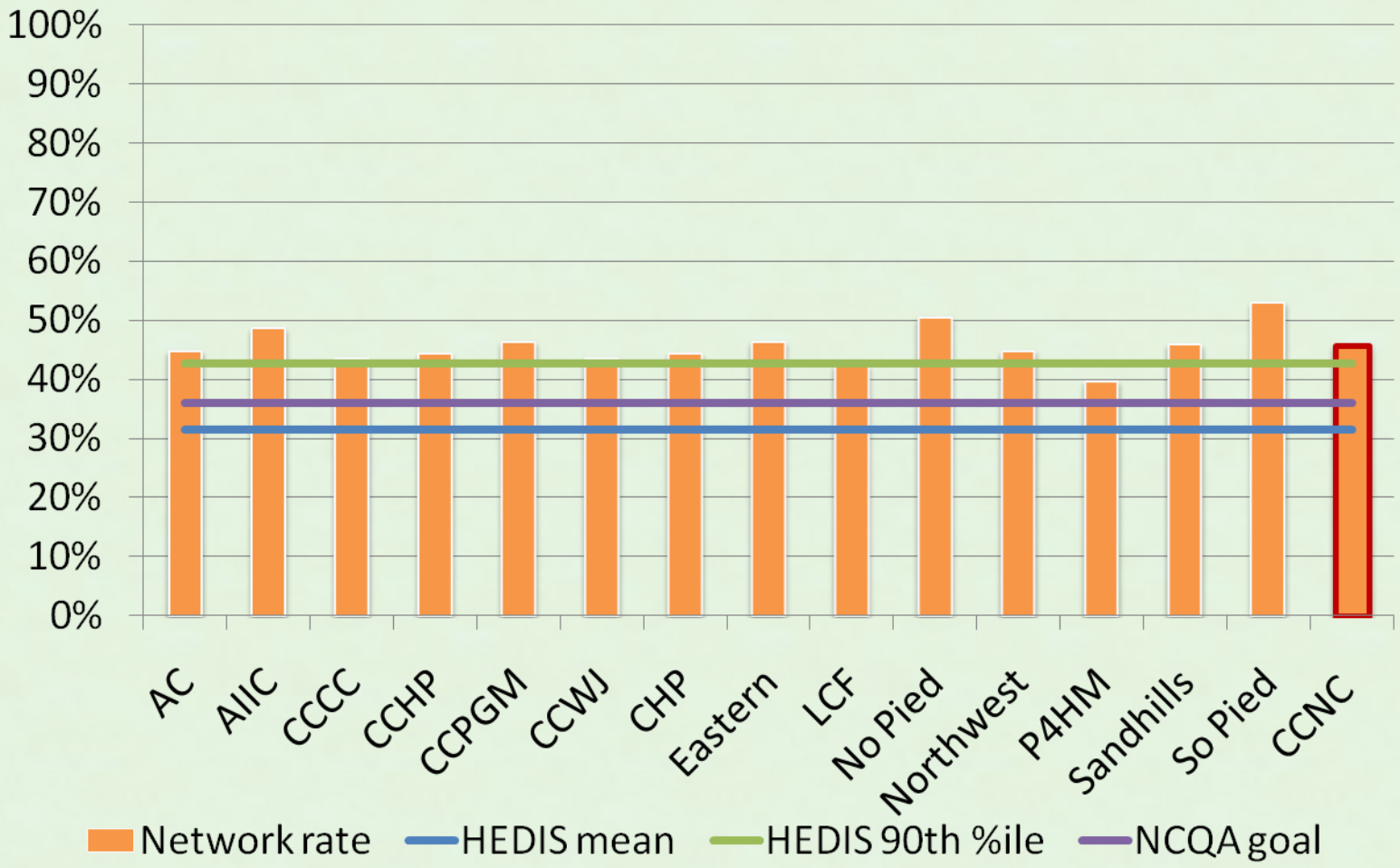
Diabetes: BP <130/80



Diabetes: BP >140/90

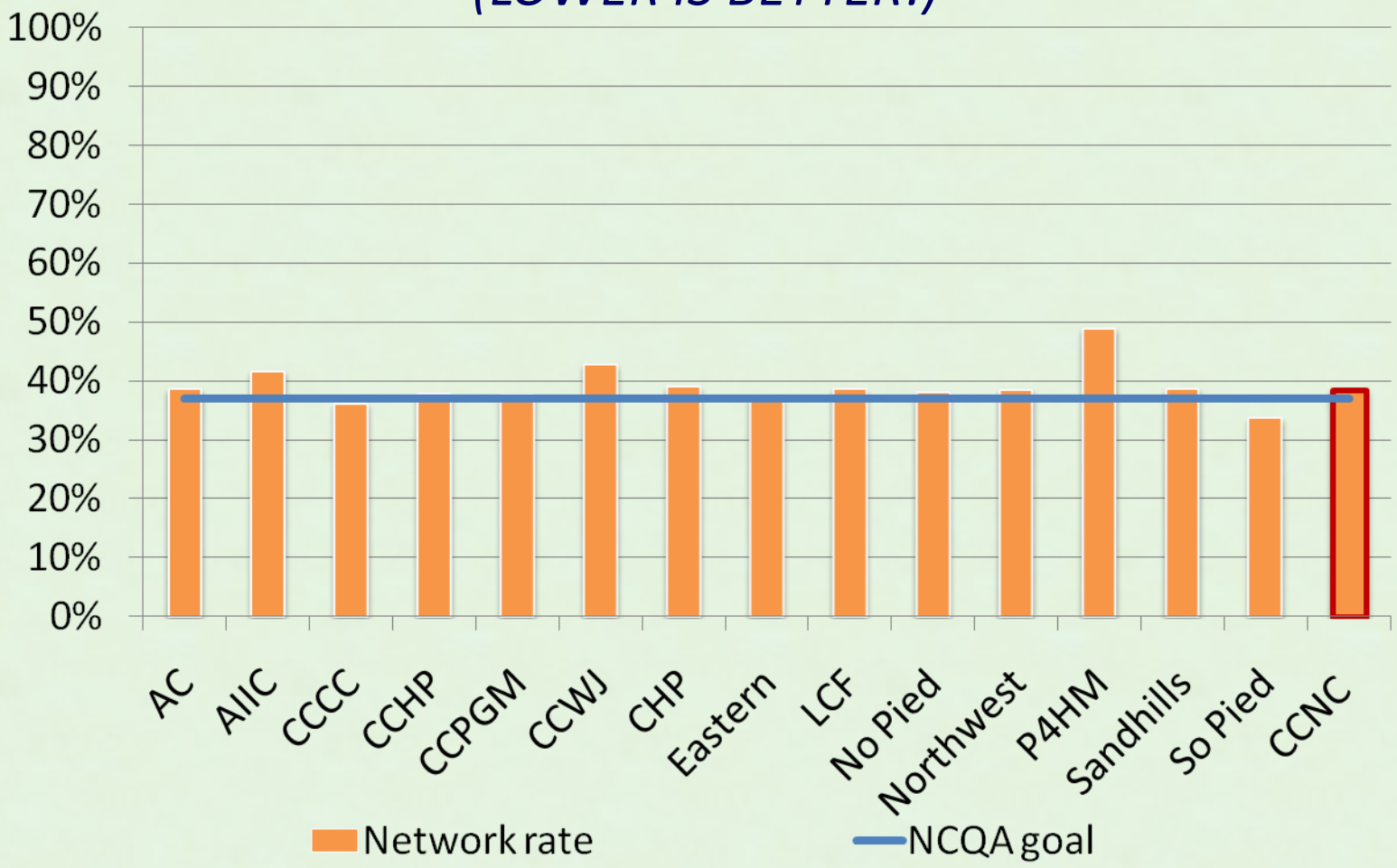


Diabetes: LDL Cholesterol Control <100

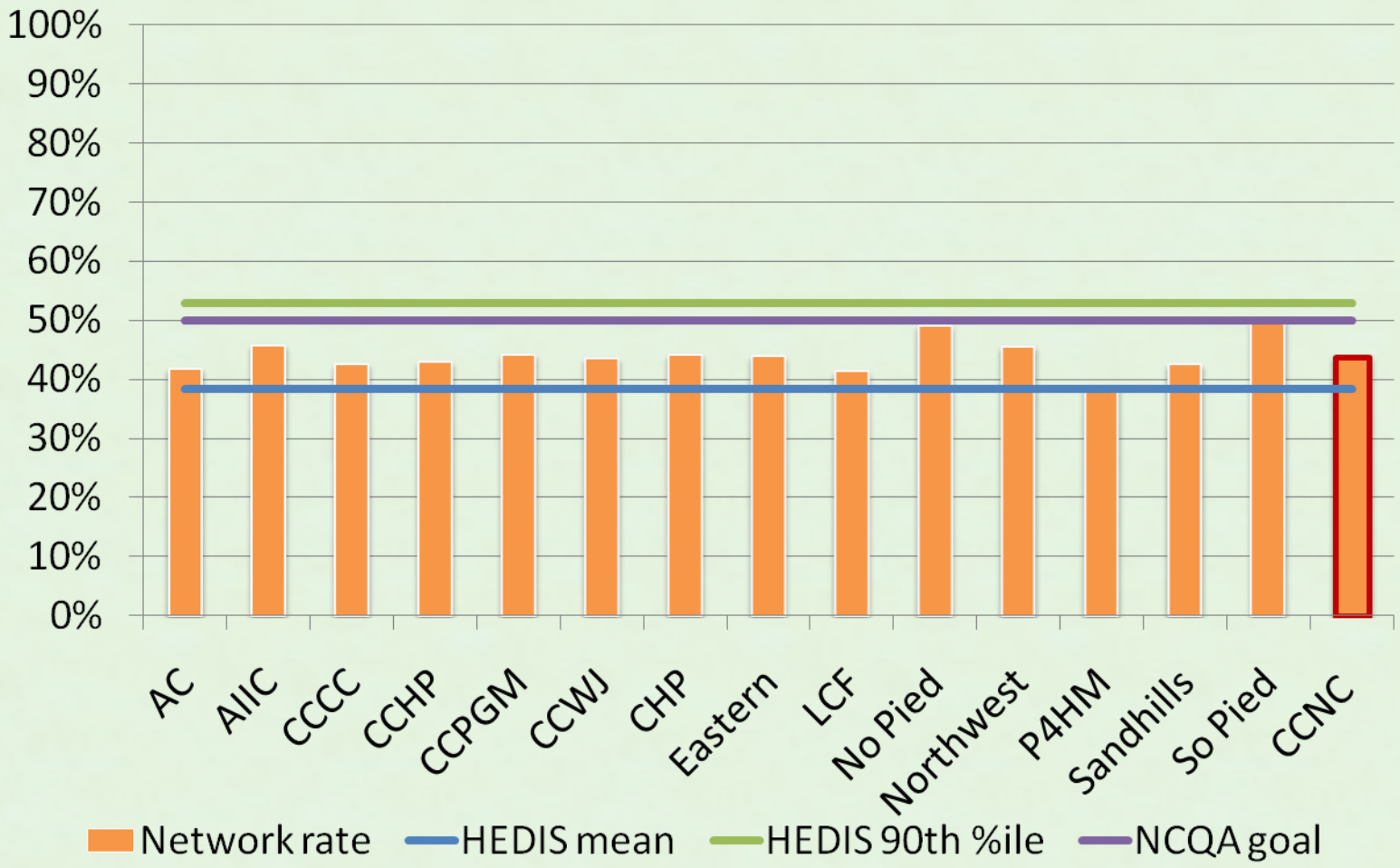


Diabetes: LDL Cholesterol Control >130

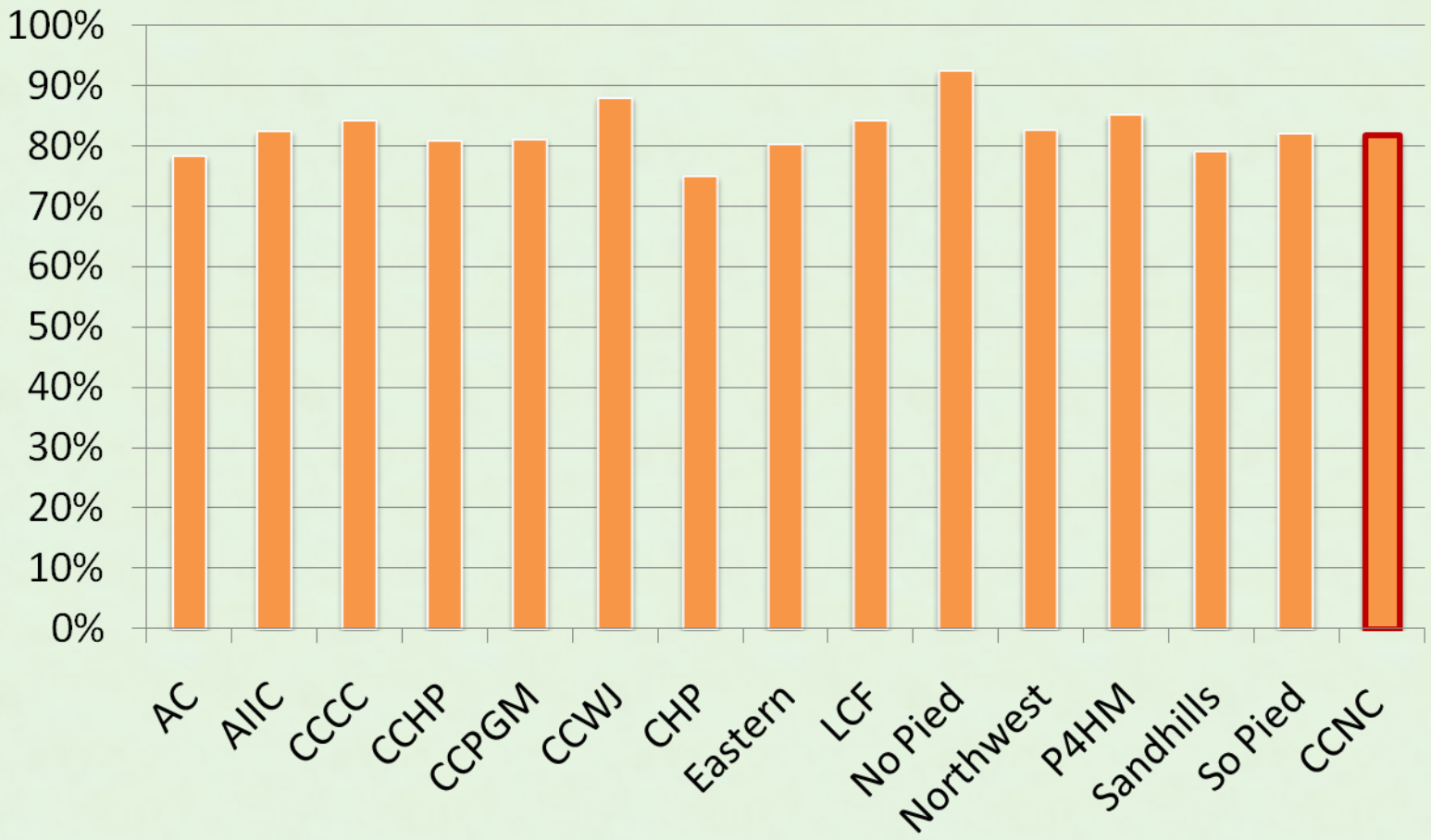
(LOWER IS BETTER!)



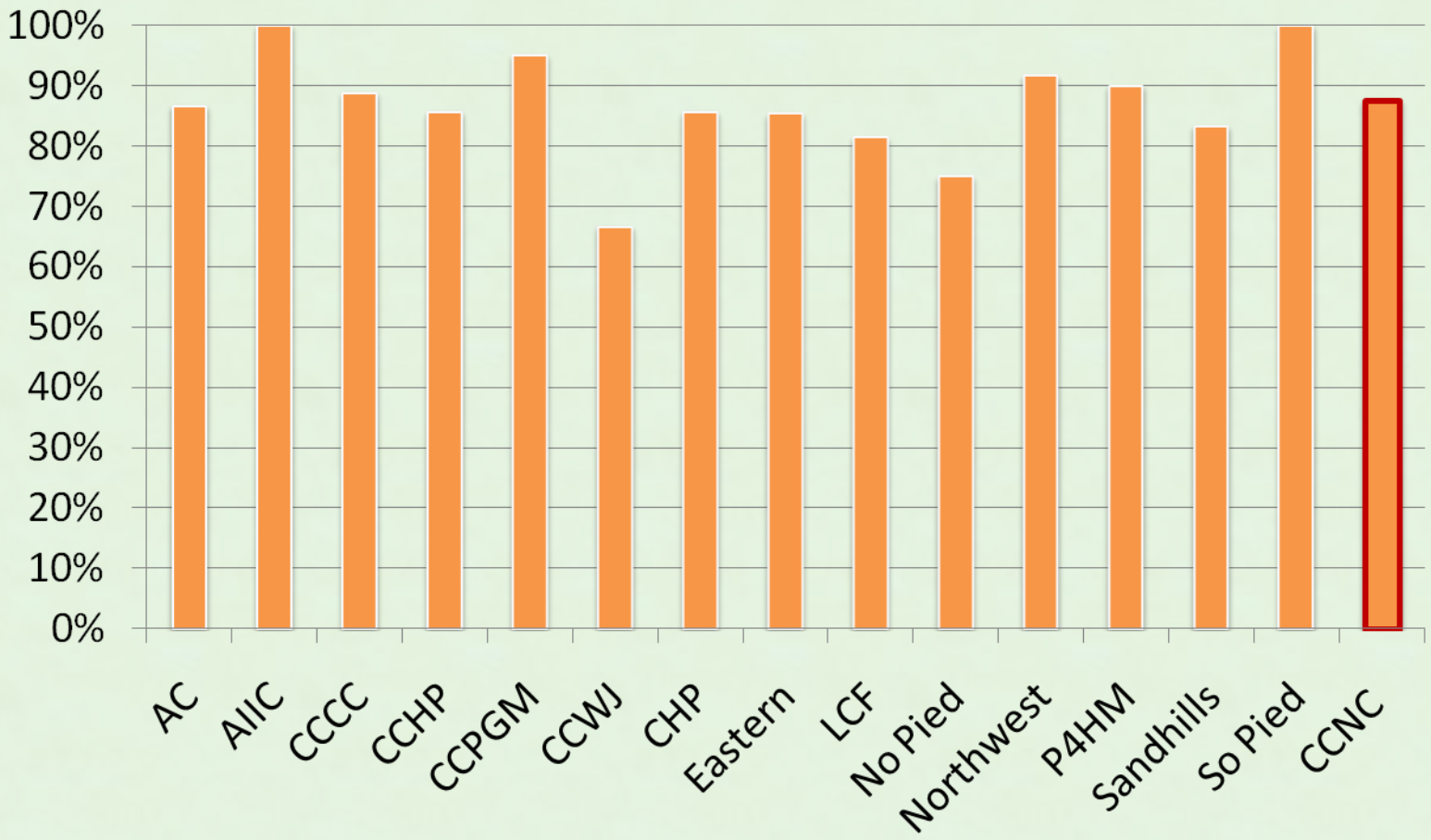
Cardiovascular: LDL Control < 100



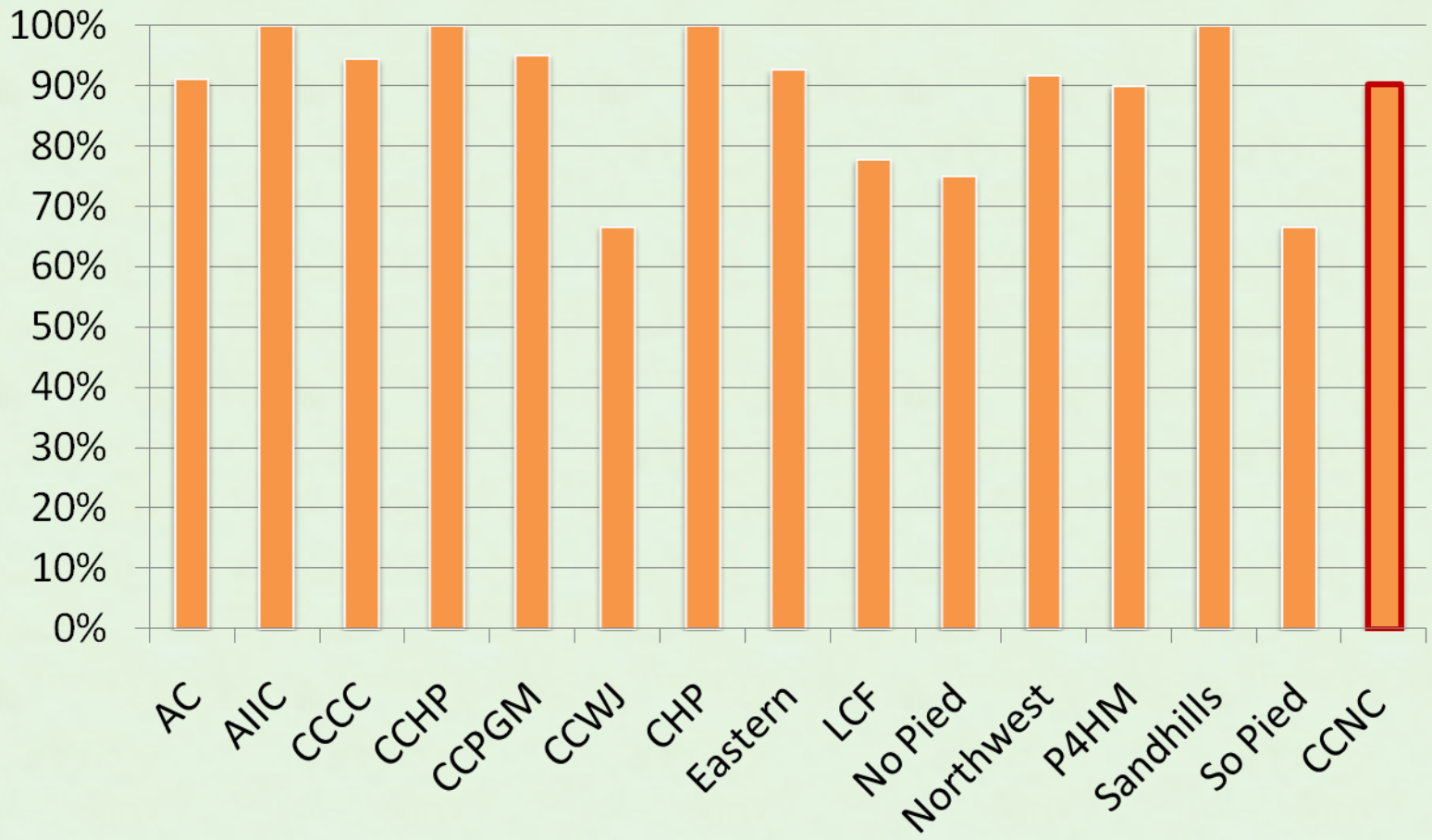
Heart Failure: LVEF Documented In PCP chart



Heart Failure: ACE/ARB use



Heart Failure: Beta Blocker use



Key Innovations

- "Virtual Provider Networks" organized locally and physician led
- Advanced primary care system supported by additional funding
- Evidenced based guidelines are adapted by consensus rather than dictated by the state (bottom up)
- 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 just changing how much we pay for services"

Community Care of North Carolina Cost Savings

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

Compared to Prior Yr (net of costs)

- Savings - $ 60 million SFY03
- Savings - $ 124 million SFY04
- Savings- $ 81 million SFY05
- Savings- $ 161 million SFY06
- Savings- $142 million SFY 07

- **Total AFDC 03-07: $ 568 Million**

NC Medicaid Administrative costs only 6%!
(Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)

ABD Savings SFY 05-07 additional $ 400 million- Mercer

New Populations

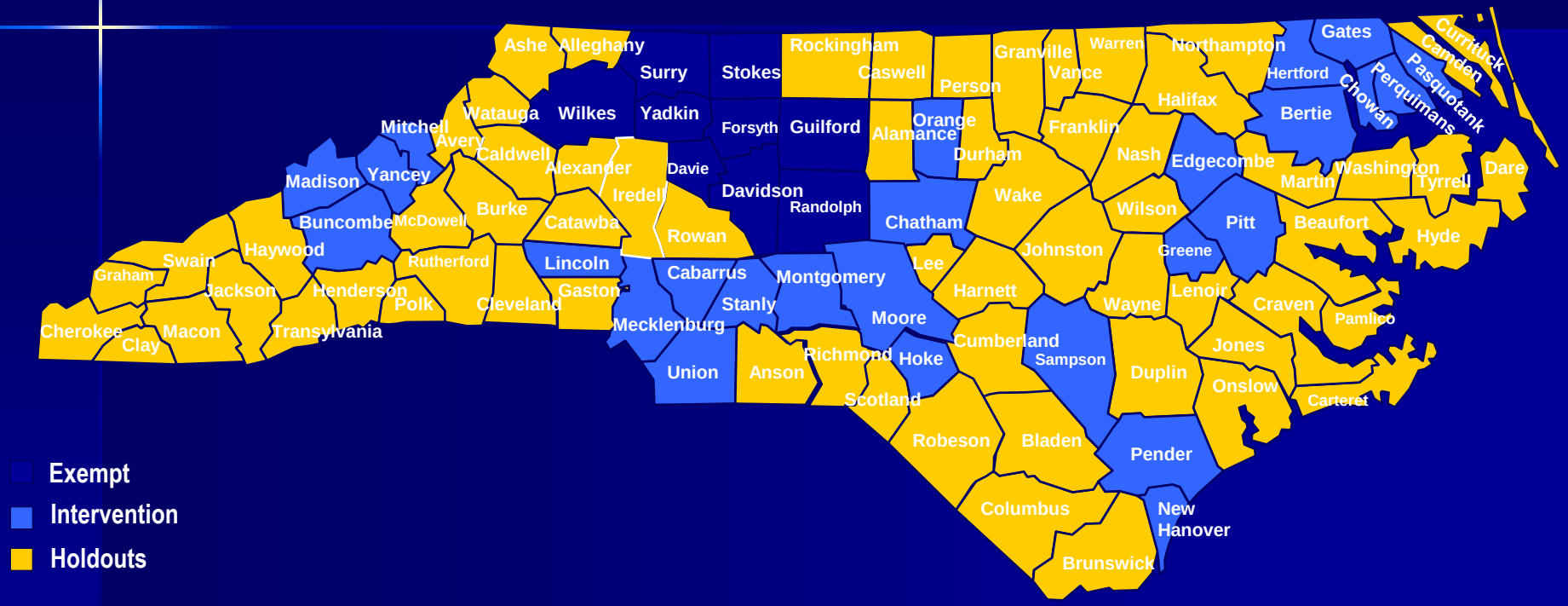
"646" DEMONSTRATION PROGRAM

Section 646 of the Medicare Modernization Act (2003) established a five year demonstration to "improve the quality of care and service delivered to Medicare beneficiaries through major system re-design". Program administered by the Centers for Medicare and Medicaid Services (CMS)

NORTH CAROLINA'S APPLICANT

- North Carolina Community Care Networks, Inc. (NCCCN), an umbrella organization representing the 14 Community Care Networks, was the applicant. NCCCN applied in September 2006.
- Demonstration Agreement was executed in December 2009
- The first demonstration year began January 1, 2010

646 Counties



Updated: October 1, 2009

KEY ELEMENTS OF NCCCN's DEMONSTRATION

- During years one and two, NCCCN will manage approximately 30,000 dually-eligible beneficiaries who receive care from 150 practices in 26 counties.
- At the beginning of year three, an estimated 150,000 Medicare-only beneficiaries who will receive care from those 150 practices will be added to the demonstration.
- During years three to five, NCCCN will manage an estimated 180,000 Medicare and dually-eligible beneficiaries.

COMPARISON GROUP

- A Medicare beneficiary receiving a qualifying service from a primary care practice in a comparison county.
- For comparison purposes, RTI selected 78 counties in 5 states that matched the characteristics of North Carolina's 26 intervention counties:
  - Georgia (18 counties)
  - Kentucky (19 counties)
  - South Carolina (12 counties)
  - Tennessee (19 counties)
  - Virginia (20 counties)

CHARACTERISTICS OF THE 646 POPULATION

- 50% will have 3 or more chronic conditions
- 75% will have hypertension
- 33% will have a mental health condition
- 40% will have diabetes
- 25% will have heart disease
- 20% will have chronic obstructive pulmonary disease
- 40% will have gone to the emergency room at least once during the year
- 25% will have been hospitalized at least once during the year
- Each dual will have an average of 7.8 prescriptions per month

ELIGIBLE BENEFICIARIES

- Be alive at beginning of the demonstration year
- Have at least one month of Part A and Part B enrollment
- Reside in North Carolina during the entire demonstration year
- Have not been enrolled in a Medicare Advantage plan during the demonstration year
- Not have coverage under an employer-sponsored group health plan during the demonstration year.

ASSIGNMENT OF BENEFICIARIES

- Beneficiaries will be assigned to intervention practices based on a retrospective analysis of claims data.
- Did a beneficiary receive a qualifying service from a participating physician during the assignment period.
- The assignment period is 3 months before the start of the demonstration year and ends 3 months before the close of the demonstration year.

PARTICIPATING PHYSICIANS

- Participating Practice/Physician must:
  - Be in an Intervention County
  - Be a primary care provider
  - Be enrolled in Carolina Access
  - Have participation agreement with Community Care

COMMUNITY CARE STRATIGIES

- To use its networks of medical homes and community-based care management infrastructure to develop effective system of chronic care management for 646 participants.
- Build on the Chronic Care Program being implemented in all 14 Community Care Networks to improve the care of Aged, Blind and Disabled Medicaid enrollees.
- Complete a major re-design in how care management is organized and delivered locally.

COMMUNITY CARE INTERVENTIONS

- Assist patients in transition
- Assist patients with complex conditions
- Reduce medication problems
- Strengthen the link between community providers
- Support the physician's ability to manage chronic care patients
- Develop nursing home and palliative care initiatives

COMMUNITY CARE PRIORITY PATIENTS

- Three or more chronic conditions within the past 12 months
- One or more inpatients admissions within the past 6 months
- Two or more ED visits within the past 6 months
- No PCP visit within the past year

STRATEGIES

- The long-range vision of CCNC is to use its community based networks to develop an effective system of chronic care statewide for Medicaid and Medicare recipients. This approach requires focused re-design efforts at the:
  - Central program office level
  - Network level
  - Practice/Medical Home level

CENTRAL PROGRAM OFFICE REDESIGN COMPONENTS

- Develop informatics center to provide timely and meaningful data
- Integrate Medicare and other payor data
- Provide aggregated reports to networks/practices
- Give scheduled updates on best practices
- Centralize patient education materials
- Provide consultation to networks as needed

NETWORK REDESIGN COMPONENTS

- Build team of case managers using holistic (whole-patient) approach
- Develop strong links with practices, community providers (e.g., hospitals, LMEs), and selected specialty practices
- Identify and enroll additional practices
- Designate informatics “champion” within each network to serve as point of contact and informal consultant

MEDICAL HOME REDESIGN COMPONENTS

- Designate 1-2 key people to be network liaisons
- Refer complex patients to network case manager as needed
- Expedite appointments for patients with acute needs or in transition (e.g., at discharge from hospital)
- Build additional capacity to proactively manage chronic illnesses and preventive care
- Embed supports in medical homes as needed

HOW WILL SUCCESS BE DETERMINED?

- CMS will establish expenditure and quality targets that will have to be met or exceeded to achieve success.
- The quality benchmarks will primarily be the benchmarks used by CCNC for their disease management initiatives (diabetes, COPD, and CHF).

SHARED SAVINGS

- Savings will be determined by comparing the actual expenditure incurred by the demonstration group to the expenditure target.
- Gross savings will be the difference between the expenditure target and actual expenditure.
- Net savings will be the difference between the savings and the minimum savings threshold. (2.9%-year1)
- Maximum payment to NCCCN will be the lesser of three amounts:
  - 80% of net savings
  - 50% of gross savings
  - 8% of the expenditure target

HOW CAN SAVINGS BE USED?

- Shared savings plan has to be approved by CMS
- Approved uses of savings
  - Support on-going operations
  - Reimburse NCCCN for administrative expenses
  - Physician incentives for achieving quality objectives
  - Pay for services provided to Medicare beneficiaries not covered by Parts A and B
- At the conclusion of the demonstration, all shared savings funds held in reserve will be disbursed to participating networks.

What's Next for CCNC?

- Medicaid (budget responsibility)
- Medicare 646 (Shared Savings)
- SEHP (DM/CM and Medical Home)
- Other insurers
- Full transparency on quality and utilization data (NCHQA)
- Alternative payment pilots

Key Visions

- "Managed not regulated"
- CCNC is a clinical program not a financing mechanism
- Public –private partnership
- Community-based, advanced primary care
- Quality and system oriented (investing in local communities and jobs)
- Economizing through raising quality rather than lowering fees
- Efforts have positive effect on all patients

Take Home Thoughts

- Development of local programs that work take time- often 18-24 months to see results
- Reinvestment of a portion of savings needed to sustain and grow program to 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, Medicare and the uninsured
- Medicaid (CCNC) and healthcare is a local economic development strategy