Community Care of NC

Building Accountable Care Using Public Programs - lessons learned

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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 multipayer 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
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
COMMUNITY CARE OF NORTH CAROLINA: MEDICAL HOME DESIGN

Our model

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

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

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

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

Networks
- Number involved: 14
- Pay for coordinator: Yes

Community
- Hospitals, DSS, Health Departments, Key Community Partners

Hospitals
- Member of Board / Steering Committee

Performance Evaluations
- Mercer Cost Analysis
- Frequency: Annually

Primary Care

Physician

Patient

Care Coordinator

Flexible Scheduling
- Open access in some practices
- Payment for expanded hrs

24/7 Access
- Yes
- Directly, local collaboration, or call center
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)
right Patient.
right Time.
right Setting.
right Intervention.
right Care Team.

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 Initiatives
  - 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

INFORMATICS CENTER

Case Manager Input (CMIS)
Pharmacy Claims
Medical Claims
Audit Data
Pharmacist Input (Pharmacy Home)
Real-time Pharmacy (Surescripts)
Real-time hospital/ED census
Labs
Practice and Hospital EHR
Then Technical, Analytical and Educational Support

- Predictive Models
- Reporting Services
- Analytics
- Applications

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

CCNC Care Team
Nurses, Pharmacists, Social Workers, Health Educators

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

Hospital
Home
Clinic
Other Settings
Informatics Center Architecture

Informatics Center Decision Support System (IC DSS)

Reports
- Ad-hoc reports built here
- Standard reports designed here

Applications
- CMIS
- Pharmacy Home
- Audit System
- IC Website

Tier 3 Databases
- Reports
- CMIS
- Pharmacy Home
- Audit System
- IC Website

Aggregated Data Warehouse (Tier 2)
- Calculated Measures
- Consolidate, Calculate, etc.

Data Warehouse (Tier 1)
- Medicare
- LabCorp
- Medicaid
- SureScripts
- Hospitals (ADT)
Data Analytics and Reporting Services
Data Analytics: Program Planning

Disease Prevalence among Elderly & Disabled NC Medicaid Recipients

### Chronic Care Disease Prevalence

- **Diabetes**: 22%
- **Hypertension**: 40%
- **Asthma**: 15%
- **COPD**: 12%
- **Mental Illness**: 42%

#### Complexities

- Heart Disease or Stroke: 11%
- 3 or more Comorbidities: 33%
- 8 or more prescriptions: 11%

#### Hospital Use

- At least one ED visit: 42%
- At least one hospitalization: 19%
### Ex: KBR-Funded Stroke Prevention Initiative

Number of non-dual patients with HTN

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<th>Condition</th>
<th>Count</th>
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<td>12,888</td>
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<tr>
<td>+ DM, CHD, or IVD</td>
<td>6,129</td>
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<td>non-dual HTN + CHD/IVD with poor medication adherence</td>
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The Pharmacy Home Medication Regimen Report

Patient Information
Name: Jane D Doe  DOB: 2/20/1944  Gender: Female  Medicaid ID: 123456789T  Medicaid Eligible: Yes
Allergies: Unknown  Medicare Eligible: No

Practice Information
PCP: UNC FAMILY PRACTICE CENTER  Network: AccessCare
PCP Phone:  Network AccessCare
PCP Fax:  Network AccessCare

Pharmacist/Case Manager Information
Most Recent Pharmacy: CARRBORO FAMILY PHARMACY INC  Pharm Phone: (919) 533-7629  Case Manager Status: 
Network RPh: Troy K Trygstad  Network RPh Phone: 919-269-5241  Network RPh Fax: 

Patient Criteria Information
8+ Rx: Yes  3+ Practices: Yes  Ave. PDC: Ave. Rx $/Mo: $646.61

Medication Regimen

<table>
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<tr>
<th>Drug Description</th>
<th>Prescriber*</th>
<th>Last Filled</th>
<th>Days Supply</th>
<th>Qty</th>
<th>Paid Amt</th>
<th>Al</th>
<th>Gap/DC</th>
<th>PML/PA</th>
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* The prescriber(s) listed above may occasionally be mistated due to pharmacy imputation errors when interpreting a prescriber's signature. In many cases the prescriber is unknown.

Al = Adherence Index
GAP = Gap in Therapy
DC = New Drug Filled in Same Class
### Quality Measurement and Feedback: Quarterly Claims-Derived Quality Measures

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

<table>
<thead>
<tr>
<th>Network</th>
<th>Asthma</th>
<th>ED Access</th>
<th>AIG Testing</th>
<th>Eye Exam Testing</th>
<th>Childhood Screening</th>
<th>Heart Failure</th>
<th>Cancer Screening</th>
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<td>Access II Care of Western NC</td>
<td>0.9</td>
<td>4.7</td>
<td>87%</td>
<td>50%</td>
<td>66%</td>
<td>79%</td>
<td>33%</td>
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<tr>
<td>Access III of Lower Cape Fear</td>
<td>1.5</td>
<td>8.5</td>
<td>87%</td>
<td>54%</td>
<td>79%</td>
<td>85%</td>
<td>42%</td>
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<td>AccessCare</td>
<td>0.9</td>
<td>7.5</td>
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<td>52%</td>
<td>72%</td>
<td>81%</td>
<td>38%</td>
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<tr>
<td>Carolina Collaborative Community Care</td>
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<td>20.1</td>
<td>88%</td>
<td>56%</td>
<td>81%</td>
<td>85%</td>
<td>45%</td>
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<td>Carolina Community Health Partnership</td>
<td>0.2</td>
<td>5.8</td>
<td>92%</td>
<td>57%</td>
<td>77%</td>
<td>81%</td>
<td>34%</td>
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<td>Community Care of Wake and Johnston Counties</td>
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<td>14.4</td>
<td>84%</td>
<td>48%</td>
<td>66%</td>
<td>82%</td>
<td>33%</td>
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<td>Community Care Partners of Greater Mocksville</td>
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<td>47%</td>
<td>76%</td>
<td>87%</td>
<td>36%</td>
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<td>Community Care Plan of Eastern Carolina</td>
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<td>13.3</td>
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<td>55%</td>
<td>73%</td>
<td>82%</td>
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<td>Community Health Partners</td>
<td>1.4</td>
<td>9.6</td>
<td>89%</td>
<td>48%</td>
<td>79%</td>
<td>86%</td>
<td>28%</td>
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<tr>
<td>Northern Piedmont Community Care</td>
<td>1.1</td>
<td>13.4</td>
<td>82%</td>
<td>52%</td>
<td>73%</td>
<td>84%</td>
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<td>Northwest Community Care</td>
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<td>Partnership for Health Management</td>
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<td>65%</td>
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<td>51%</td>
<td>82%</td>
<td>86%</td>
<td>33.3</td>
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<td>CCNC</td>
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<td>52%</td>
<td>73%</td>
<td>83%</td>
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**Report Date: 8/27/2009**
### Access III of Lower Cape Fear

**QMAF Claims Measure 2008Q4**

#### Asthma

<table>
<thead>
<tr>
<th>Network</th>
<th>Network County</th>
<th>Asthma Patient Count</th>
<th>Member Months</th>
<th>IF Asthma Visits</th>
<th>ED Asthma Visits</th>
<th>IF Asthma Ed Visits for 1000 Mem</th>
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<td>BLADEN</td>
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<td>1118</td>
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<td>128</td>
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<td>0</td>
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<td>262</td>
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<td>2175</td>
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</table>

**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

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**Quality Measurement and Feedback:** Drill Down Capabilities

**Community Care of North Carolina**

**Report Date:** 8/27/2009
### Program Evaluation and Accountability:

#### Quarterly Chronic Care Cost/Utilization Measures

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<th>Network Number</th>
<th>Network Name</th>
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<th>4QTR08</th>
<th>Utilization Rate (%)</th>
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<td>625.9</td>
<td>628.9</td>
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<td>628.9</td>
<td>0.36</td>
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<td>0107103</td>
<td>Community Health Partners</td>
<td>625.9</td>
<td>628.9</td>
<td>0.36</td>
</tr>
</tbody>
</table>

#### Example of Outcomes

- **Mar 2009**
  - State Total Cost: $1,199.19
  - Medicaid Cost: $1,351.17
  - Non-Medicaid Cost: $360.53
  - Number of Stays: 131.9
  - Readmission Count: 103.3
  - Readmissions as % of Total Admissions: 14.4%

### TOTAL PMPM COSTS

### PHARMACY PMPM COSTS

### INPATIENT RATE

### ED RATE

### NON-EMERGENT ED RATE

### READMISSION COUNT

### READMISSIONS AS % OF TOTAL ADMISSIONS
Diabetes: A1C <7.0

2009 CCNC Chart Review Results
Diabetes: A1C >9.0

(LOYER IS BETTER!)
Diabetes: BP <130/80

2009 CCNC Chart Review Results
Diabetes: BP >140/90

2009 CCNC Chart Review Results
Diabetes: LDL Cholesterol Control <100

2009 CCNC Chart Review Results
Diabetes: LDL Cholesterol Control

>130

(LOWER IS BETTER!)

Network rate

NCQA goal

2009 CCNC Chart Review Results
Cardiovascular: LDL Control < 100

2009 CCNC Chart Review Results
Heart Failure: LVEF Documented In PCP chart

2009 CCNC Chart Review Results
Heart Failure: ACE/ARB use

2009 CCNC Chart Review Results
Heart Failure: Beta Blocker use

[Bar chart showing percentage of beta blocker use across different categories.]
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 SFY07

- 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
“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 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.
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 STRATEGIES

- To use its networks of medical homes and community-based care management infrastructure to develop an 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
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