Community Care of North Carolina

2011-2012 Cost Savings Strategy

Community Care of North Carolina

Our Vision and Key Principles

Community Care of North Carolina

- Develop a better healthcare system for NC starting with public payers (Medicaid)
- Strong primary care is foundational to a high performing system
- Additional resources needed to help primary care manage populations
- Timely data is essential to success
- Build better local healthcare systems (public-private partnership)
- Physician leadership is critical
- Improve the quality of the care provided and cost will come down
- A risk model is not essential to success- shared accountability is!

Primary Goals of CCNC

- Improve the care of the enrolled Medicaid population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings

Medicaid challenges

- Lowering reimbursement reduces access and increases ER use
- Reducing eligibility or benefits limited by federal “maintenance of effort”; raises burden of uninsured on community and providers
- The highest cost patients are hardest to manage (disabled, mentally ill, etc.) — Community Care has proven ability to address this challenge
- Utilization control and clinical management only successful strategies to reining in costs overall
- Designing systems that work in urban and rural communities.

CCNC provides NC with:

- Statewide medical home & care management system to address quality, utilization and cost
- 100% of all Medicaid savings remain in state
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.

Community Care Networks

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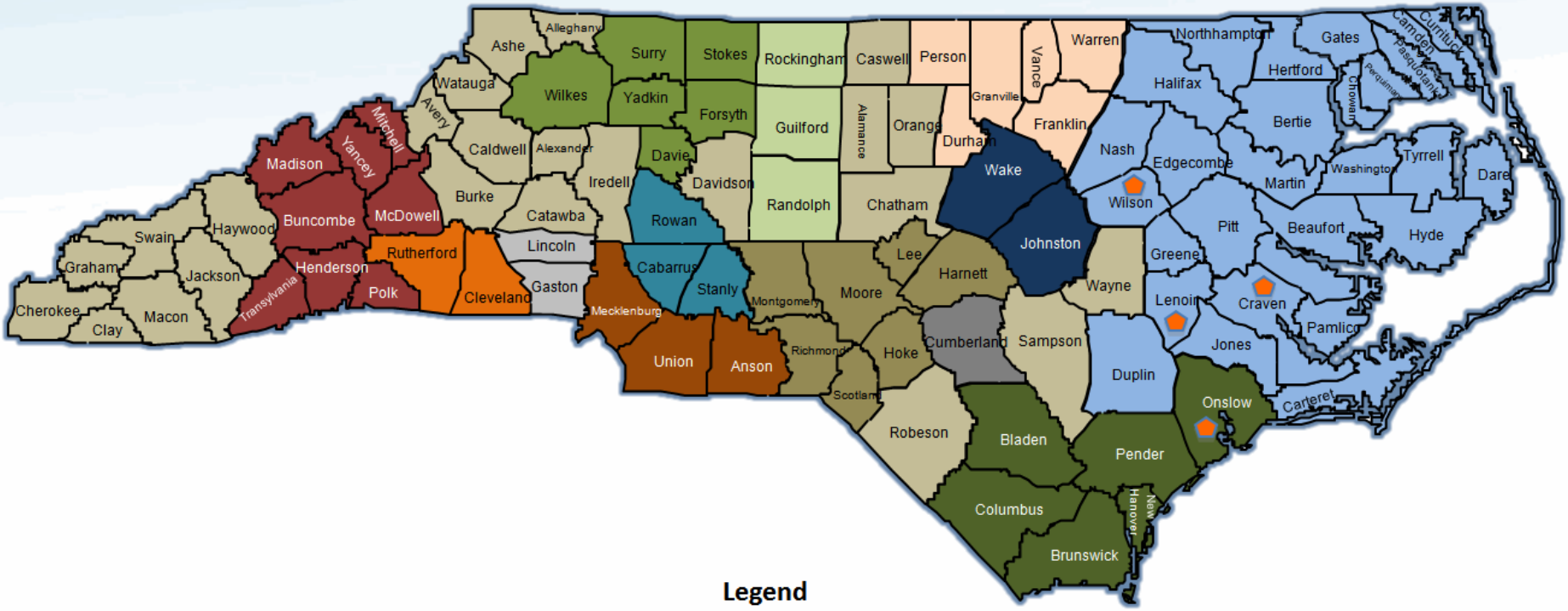


- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership

Legend

- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Community Care Networks

- Are non-profit organizations
- Seek to incorporate all providers, including safety net providers
- Have Medical Management Committee oversight
- Receive a pm/pm from the State for most enrollees
- Hire care management staff to work with enrollees and PCPs
- Participating PCPs receive a pm/pm to provide a medical home and participate in Disease Management and Quality Improvement

Community Care of NC – *Now in 2011*

- Focused on improved quality, utilization and cost effectiveness of chronic illness care
- 14 Networks with more than 4500 Primary Care Physicians (1360 medical homes – representing 94% of primary care providers)
- Serving 1.3 million Medicaid enrollees

Community Care of NC – *Now in 2011*

- **Actively engaging other payers and providers**
  - ✓ 646 quality demonstration ~ 44,000 duals (1/3 of the state)
  - ✓ Multi-payer demonstration in 4 networks (includes Medicaid, Medicare, BCBS and State Health Plan)
  - ✓ Commercial and self-insured employers
- **CHIPRA and Beacon Grant recipients**

Each CCNC Network Has:

- **A Clinical Director**
  - ✓ A physician well known in the community
  - ✓ Works with network physicians to build compliance with CCNC care improvement objectives
  - ✓ Provides oversight for quality improvement in practices
  - ✓ Serves on the State Clinical Directors Committee
- **A Network Director who manages daily operations**
- **Care Managers to help coordinate services for enrollees/practices**
- **A PharmD to assist with Medication Management of high cost patients**
- **Psychiatrist to assist in mental health integration**
- **Palliative Care and Pregnancy Home Coordinators**

Current Statewide Disease & Care Management Initiatives

- **Asthma (1998 – 1st Initiative)**
- **Diabetes (began in 2000)**
- **Dental Screening and Fluoride Varnish (piloted for the state in 2000)**
- **Pharmacy Management**
  - Prescription Advantage List (PAL) - 2003
  - Nursing Home Poly-pharmacy (piloted for the state 2002 - 2003)
  - Pharmacy Home (2007)
  - E-prescribing (2008)
  - Medication Reconciliation (July 2009)
- Emergency Department Utilization Management **(began with Pediatrics 2004 / Adults 2006)**
- Case Management of High Cost-High Risk **(2004 in concert with rollout of initiatives)**
- Congestive Heart Failure **(pilot 2005; roll-out 2007)**
- Chronic Care Program – including Aged, Blind and Disabled
  - Pilot in 9 networks 2005 – 2007
  - Began statewide implementation 2008 - 2009
- Behavioral Health Integration **(began fall 2010)**
- Palliative Care **(began fall 2010)**
- Pregnancy Home and Care Coordination for Children with Special Needs **(began April 2011)**

Community Care's Advantages

- Flexible structure that invests in the community (rural and urban) -- provides local jobs
- Fully implemented in all 100 counties
- All the savings are retained by the State of North Carolina
- Very low administrative costs
- Ability to manage the entire Medicaid population (even the most difficult)
- Proven, measurable results
- Team effort and collaborative approach by NC providers that has broad support

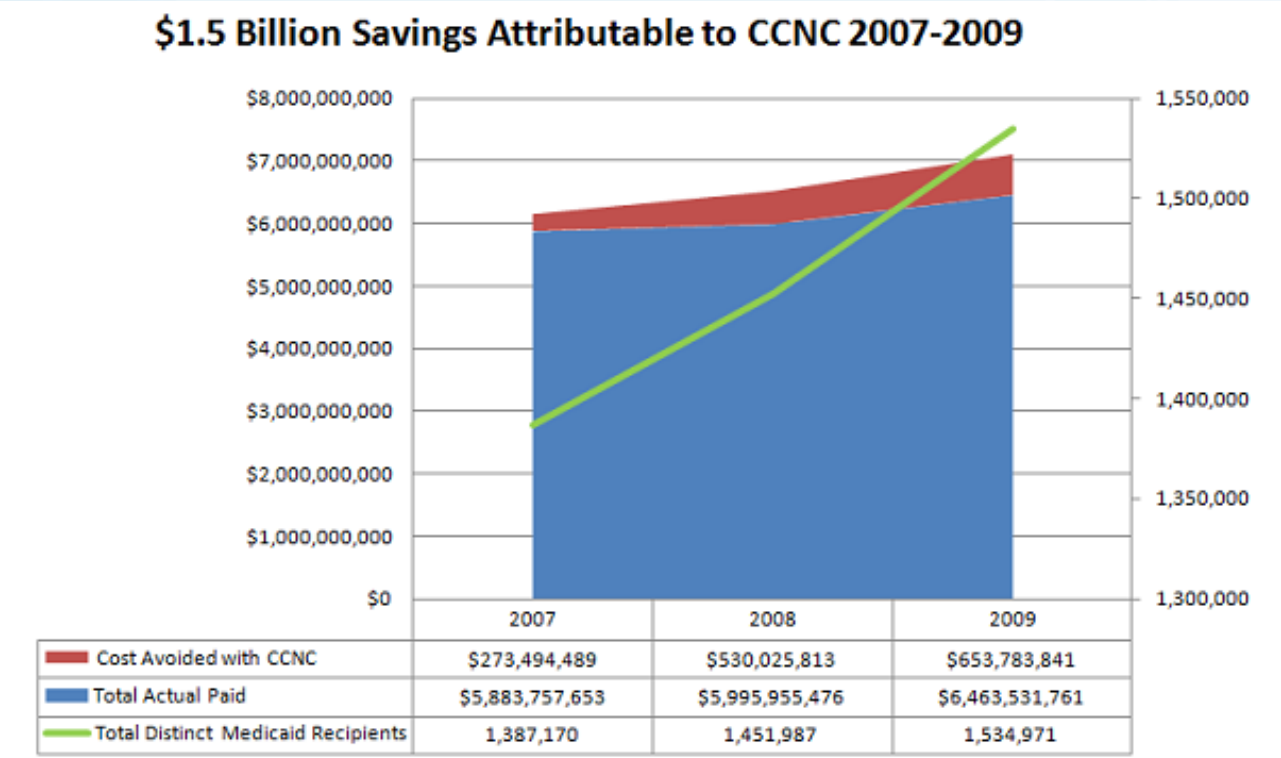
Population Management Components

- Outreach / Education / Enrollment / Communication
- Screening / Assessment / Care Plan
- Risk Stratification / Identify Target Population
- Patient Centered Medical Home – Evidence-based best practices and team based care
- Targeted Disease and Care Management Interventions and Best Practices
- Pharmacy Management
- Behavioral Health Integration
- Transitional Care
- Self Management of Chronic Conditions

CCNC's Cost Impact

- **Separate analysis by Treo Solutions, a health care business intelligence company**
  - Contracted by CCNC to analyze and report Medicaid data on a risk-adjusted basis.
  - Estimated three-year savings (2007-2009): **nearly $1.5 billion dollars** – all directly back to the state

Treo's savings estimate



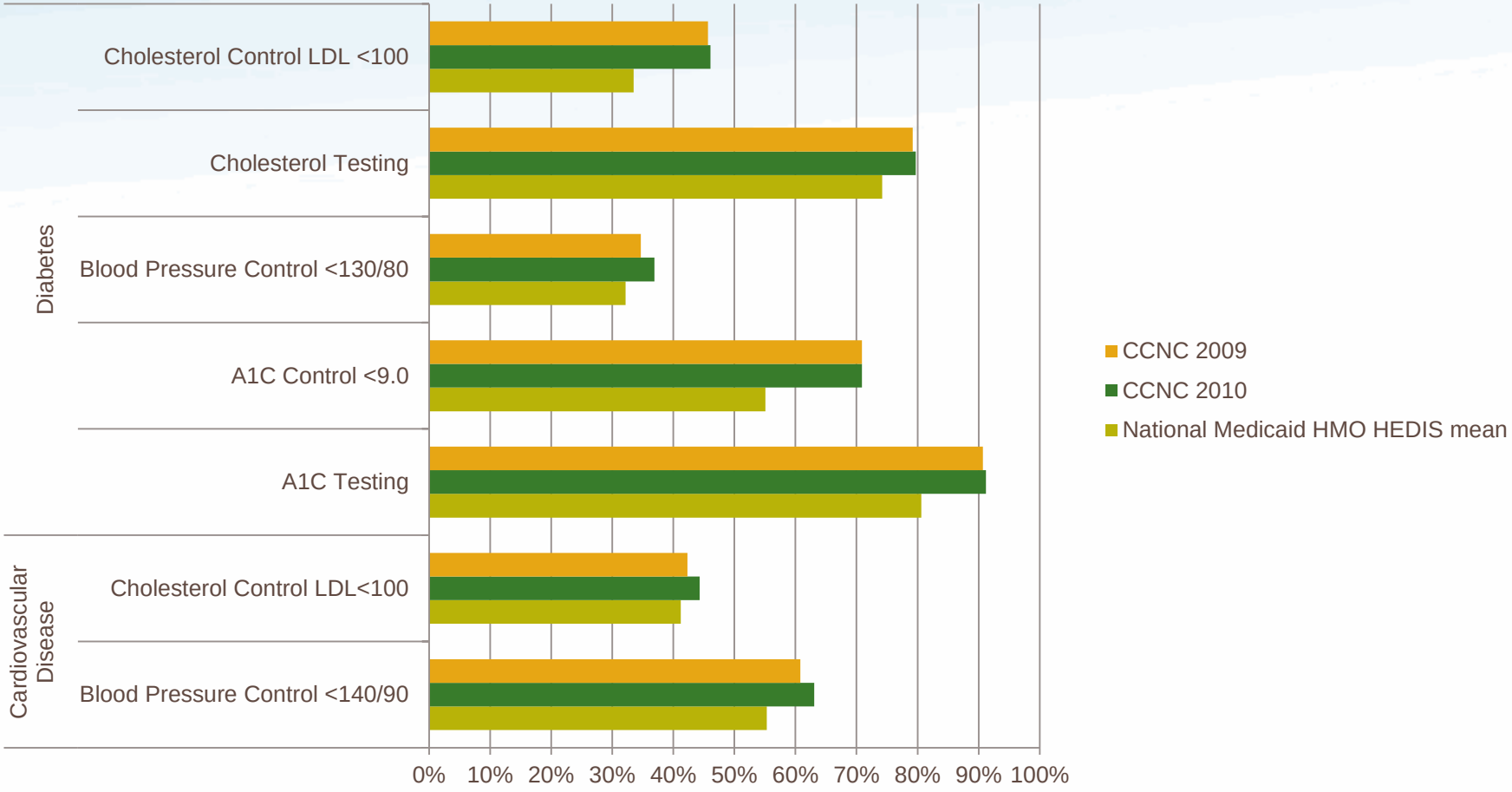
Using the unenrolled fee-for-service population, risk adjustments were made by creating a total cost of care (PMPM) set of weights by Clinical Risk Group (CRG), with age and gender adjustments. This weight set was then applied to the entire NC Medicaid Population. Using the FFS weight set and base PMPM, expected costs were calculated. This FFS expected amount was compared to the actual Medicaid spend for 2007, 2008, 2009. The difference between actual and expected spend was considered savings attributable to CCNC. Treo Solutions, Inc., June 2011.

CCNC's Impact

- **Independent analysis of data by Milliman, one of world's largest consulting practices**
  - Contracted by DMA to calculate Medicaid savings attributable to CCNC initiatives and actions
  - **2010 estimated total savings:**

    $383 million

No compromise on quality (in fact top 10% nationally)



What HEDIS scores mean

- **If CCNC recipients received the same quality of care as an average Medicaid HMO member nationally, NC would be dealing with:**
  - 3,000 more recipients with poorly controlled diabetes
  - 2,500 more recipients with poorly controlled diabetes AND cholesterol levels
  - 1,670 recipients with cardiovascular disease and poorly controlled blood pressure.

Building on Success

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Other payers and major employers seeking the benefits of CCNC's approach

- Medicare 646 demo (22 counties) caring for Medicare patients
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- Beacon Community (3 counties), all payers
- Multi-payer primary care demo (7 rural counties) Medicare, Medicaid, Blue Cross and Blue Shield of North Carolina, State Employees Health Plan
- First in Health employer initiative

New Budget Challenge

- **CCNC's significant savings have come from pilots that were tested, then expanded statewide – a process that takes time.**
- **In addition to ongoing efforts, NCGA directed CCNC to find <u>additional</u> savings of *$270 million*** *(90 million in state dollars SFY 2012 and 2013)*

Savings Plan

- Original savings plan based on enrolling approximately 180,000 unenrolled Medicaid recipients into CCNC.
- CCNC enrollees costs are 15% lower than non-enrolled
- Currently project that savings from enrollment will be $30 million in SFY2012.
- Community Care and DHHS are working to identify additional savings to make up the difference

New implemented initiatives/ estimated state savings

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- **Enhanced analytics to identify potentially preventable expenses = $3.0 million FY2012**
  - Treo Solutions risk-adjusted analysis
  - Stratify the population to identify “most impactable” patients
  - Provide network-level priority lists for outreach
  - Network “SWAT team” approach
  - Work with partners to manage these patients

New implemented initiatives/ estimated state savings

- **Emergency department initiative**
  = $1.0 million – ID highest ED users; call center outreach; behavioral management
- **Chronic pain initiative**
  = $7.1 million – Enroll ED physicians in CSRS, best practices in pain meds; embed staff in EDs
- **Adult care homes**
  = $0.8 million – Bring medical home model to residents in facilities

New implemented initiatives/ estimated state savings

- **Mental health specialty prescriptions**
  = $5.6 million – Partner with academic programs to promote best practices, monitor and coordinate services
- **Prescription drug utilization**
  = $3.4 million – Maximize preferred and non-restricted drug usage through education, point-of-sale web applications and pre-policy switching assistance

Current estimate of state savings from enrollment/ special initiatives = $51 million (SFY2012) & $150 million (SFY2013)

Other planned efforts to reduce costs

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- **Radiology best practices**
  – engage providers in savings target, best practices; pilot decision support system
- **Work with DMA to find additional cost-saving opportunities**
  - Enhanced clinical integrity efforts
  - Potential edits for MMIS
  - Establishing “medical necessity” process for key services

Other planned efforts to reduce costs

- **Partner with LMEs**
  – Partner with LMEs to focus on SMPI population, register children on atypical anti-psychotics
- **Centers of Excellence/Best Practices**
  – Engage oncologists, nephrologists, cardiologists, psychiatrists and other specialists in quality/cost projects
- **Collaboration with home /hospice providers**
  – Work with providers to identify most complex home/hospice patients and connect them to medical homes

Bending the cost curve

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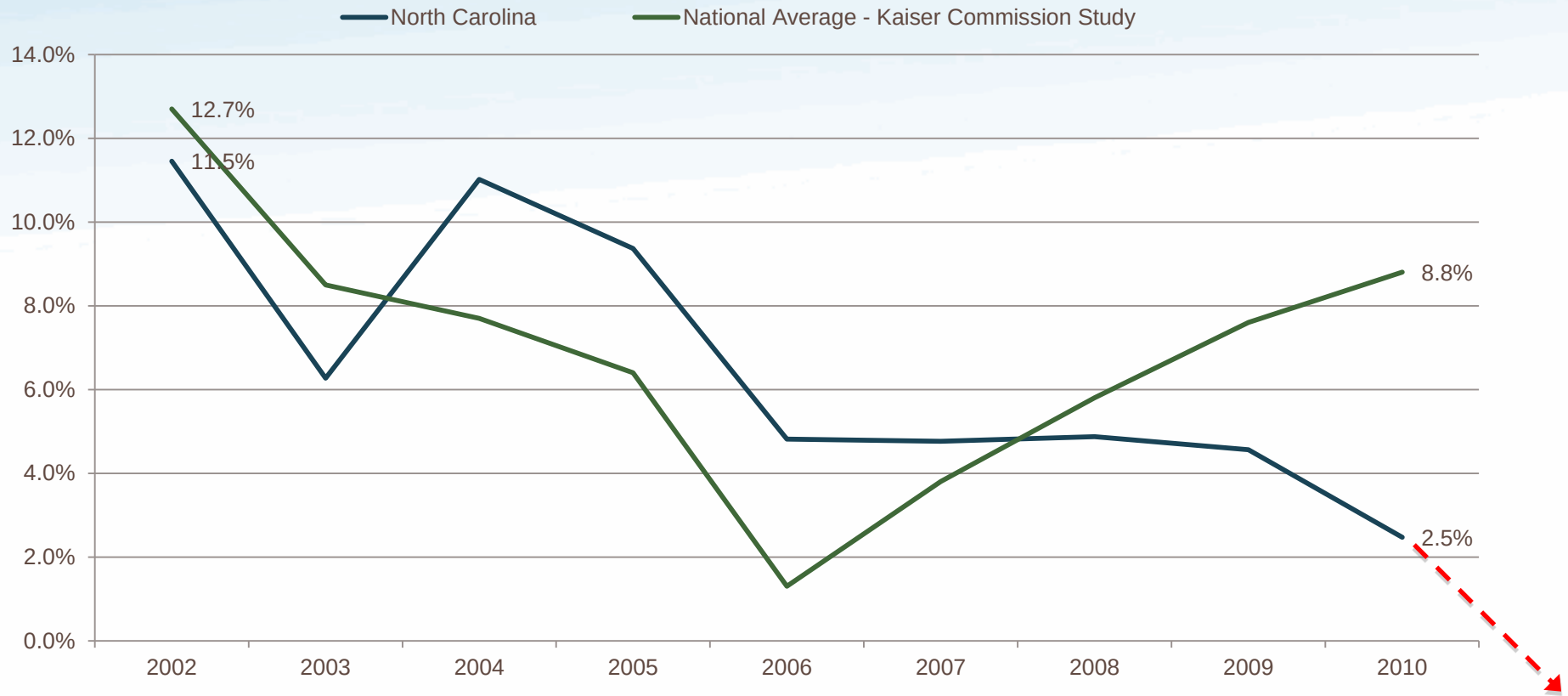
- 2010: Saved $383 million total (Milliman)
- 2011: Milliman to complete analysis for DHHS
- 2012: Expect to maintain savings trend plus add $51 million in state savings
- 2013: Maintain prior savings plus an additional $150 million in state savings

Annual Percent Change in Medicaid Expenditures: 2002 - 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 organization.

CCNC Implements ABD Program

Next Steps

- Build out Informatics Center, Provider Portal, decision support and advanced analytics as a shared resource for all communities
- Expand physician enrollment to specialty providers
- Implement additional multi-payer projects

Next Steps

- **Strengthen partnerships**
  - Collaborate with NC Hospital Association on best practices for reducing readmissions
  - Work with NC Medical Society on best practices, decision support systems
  - Support NC Academy of Family Physicians in promoting patient-centered medical home (PCMH) recognition.

Next Steps

Build new partnership opportunities with provider and service organizations

- Home care and hospice agencies
- Nursing homes
- Adult care homes
- ED physicians
- Radiologists
- Psychiatrists and mental health providers/LMEs
- Other provider groups and community organizations