Community Care of North Carolina
Dual Innovation Proposal

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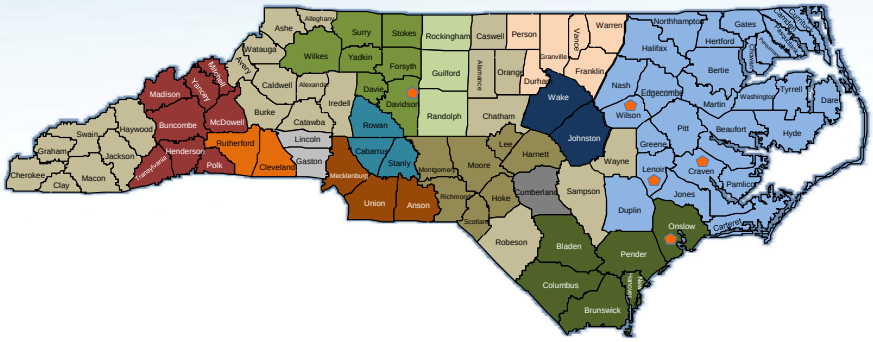
Community Care of North Carolina

What is CCNC?

- Private nonprofit corporation created as umbrella organization for 14 local nonprofit networks.
- Builds & supports medical homes in all 100 NC counties.
- Created to support and enhance the delivery of primary care – “ground up” population management that is physician led
- Coordinates care and manages transitions, e.g., hospital patient discharged into the community.
- Informatics Center brings data to point of care, provides physicians, care managers and health team members with actionable information.

Community Care Networks



- 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
- 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

Source: CCNC 2012

Community Care Provides

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- Statewide medical home and population management system in place to address quality, utilization and cost
- 100 percent 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.

Vision and Key Principles

- 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
- Physician leadership is critical
- Improve the quality of the care provided and cost will come down

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CCNC Today

- 100 NC counties
- 1,500 primary care practices,5,000 health care professionals and 600 care managers
- Many behavioral professionals, pharmacists
- Serve 1.2 million Medicaid, Health Choice and private sector members
- > 100,000 duals already participating in CCNC

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NC's Dual Eligibles

Dual Eligible Beneficiaries: 284,160

Living at Home	234,589 (82.6%)
In Nursing Homes	30,164 (10.6%)
In Adult Care Homes	19,118 (6.7%)

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NC's Dual Eligibles

Estimated Percent of NC Dual Eligible Beneficiaries With

Hypertension	73%
Three or more chronic diseases	54%
Diabetes	39%
Mental Health Condition	32%
Ischemic Vascular Disease	24%
COPD	19%

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NC's Dual Eligibles

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Percent of Dual Eligible Beneficiaries Using Services (Annually)

- At Least One Hospital Stay 26%
- Emergency Department 40%

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CCNC's first Duals effort: 646 Quality Demonstration Waiver

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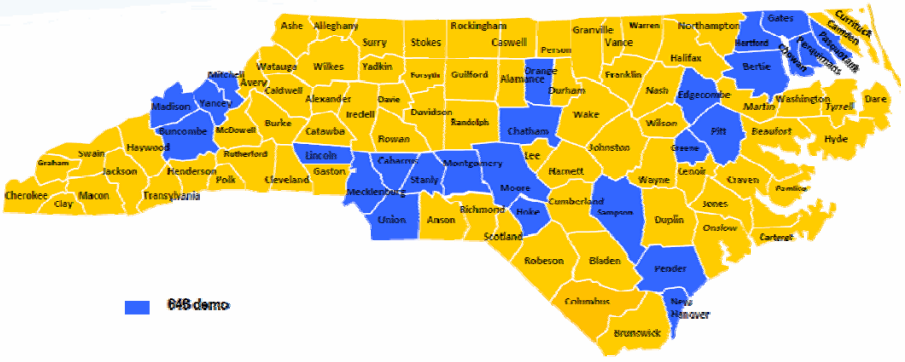
North Carolina's 646 Counties



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646 Initiative – CCNC Infrastructure

- Physician-directed care management
- Community based care coordination
- Health information technology (HIT)
- Key aims:
  - ✓ Connect providers
  - ✓ Support care management and delivery
  - ✓ Measure performance
  - ✓ Implement pay-for-performance financial incentives in a medical home.
  - ✓ Team based care

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646 Initiative

- Adding new Medicare data to our very robust Informatics System gave us valuable information that we did not have in our non-646 counties.
- For Year 1, we showed improvement in 17 out of 18 performance measures.
- We're not yet seeing cost savings, which is expected in the first year of implementing a new program (improved access/prevention has initial costs)
- Lack of specific savings means we don't yet have resources to expand to the Medicare-only population at this time.

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646 Initiative

- Turnaround time for Medicare data was a significant problem in the first two years of the 646 project.
- First Medicare data file not in hand until November 2010, meaning CCNC operated for most of Year 1 without claims data.
- Couldn't identify and manage the highest risk and cost patients in the first year – another factor in savings results.

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646 Initiative

- For Year 2, we do know that we showed improvement in 16 of our 25 performance measures.
- The cost analysis and remaining 9 measures require paid claims data that we expect to receive in August 2012.
- We have learned a great deal through participation in the 646 Demonstration – good preparation for our proposal for a new approach to working with Duals.
- We recognize the need to help Duals navigate the health care system and ensure the right information can follow them across providers and settings.

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Dual Eligible Planning Grant

- NC one of 15 states awarded planning grants from federal Centers for Medicare and Medicaid (CMS) Innovation Center in partnership with the Federal Coordinated Health Care Office
- Primary deliverable – strategic framework and detailed plan for how to structure & implement integrated model of care
- CMS expected to award additional federal grant funding for implementation in multiple states

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Dual Eligible Planning Grant

- Broad input from more than 180 stakeholders:

Division of Medical Assistance
Division of Aging and Adult Services
Division of Vocational Rehabilitation
American Association of Retired Persons
SHIIP/NC Dept of Insurance
Association for Home and Hospice Care of NC
North Carolina Association on Aging
North Carolina Adult Day Services Association
Friends of Residents in Long Term Care
Governor's Advisory Council on Aging
North Carolina Academy of Family Physicians
North Carolina Consumer Advocacy, Networking and Support Organization
North Carolina Hospital Association
North Carolina Healthcare Facilities Association
Forsyth Community Resource Connection
Chatham-Orange Community Resource Connection
North Carolina Statewide Independent Living Council
North Carolina Association of Area Agencies on Aging
National Alliance on Mental Illness
North Carolina Providers Council Association
North Carolina Association of Long Term Care Facilities
North Carolina Assisted Living Association
North Carolina PACE Association
Community Care Partners of Greater Mecklenburg
Easter Seals UCP North Carolina and Virginia
Carolinas Center for Hospice and End of Life Care
North Carolina Baptist Aging Ministry
The Arc of North Carolina
North Carolina Alliance of Public Health Agencies
North Carolina Association of County Commissioners
NC Division of Medical Assistance
US Department of Health and Human Services (HHS)
Centers for Medicare and Medicaid Services (CMS)

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Dual Planning Grant Integrated Care Model

- "State Demonstration to Integrate Care for Dual Eligible Individuals" submitted to CMS on May 1, 2012
- Model integrates primary care, acute care, behavioral health care and long term services and supports
- Managed fee-for-service model
- Brings the medical home model to nursing facilities and adult care homes / assisted living

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Dual Planning Grant Integrated Care Model

- State-wide medical home infrastructure and comprehensive provider network
- Population management activities, including disease and care management, pharmacy management, transitional care, acute and preventive care, care coordination, etc.
- Screenings and assessments
- Beneficiary-centered plans of care
- Health Care Teams

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Dual Planning Grant Integrated Care Model

- Team based care with the Primary Care Provider (PCP) of the patient's medical home leading the multi-disciplinary team
- Patient and family caregiver involvement, including self-management
- Behavioral health integration
- Strong home and community based options and supports

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Dual Planning Grant Integrated Care Model

- Robust data-sharing and communication system
- Consumer protection and advocacy
- Aligned financial incentives for high quality, cost effective care

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Potential for shared savings

- Strategic priorities will be based on Medicare data analysis
- Promising areas for savings:
  - ✓ Medication therapy management
  - ✓ 24/7 call coverage to reduce unnecessary emergency department use
  - ✓ Increase access to primary care supports to reduce avoidable hospital admissions
  - ✓ Transitional Care – ensuring the right information, right providers / team members, right time – across delivery settings

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Path Forward for NC Duals

- Implementation to begin January 2013 (pending successful review and negotiations).
- Reviewing 2010 Medicare data and awaiting 2011 data to guide care coordination and targeting.
- Early work suggests opportunities in preventable hospitalizations, non-urgent use of emergency departments and medications management.
- Seeking a State Plan Amendment to allow the Nursing Facility residents to be enrolled into medical homes.

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Updates will be posted on our website:

www.communitycarenc.org

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