Community Care
OF NORTH CAROLINA

Rhode Island CHT Oversight Committee

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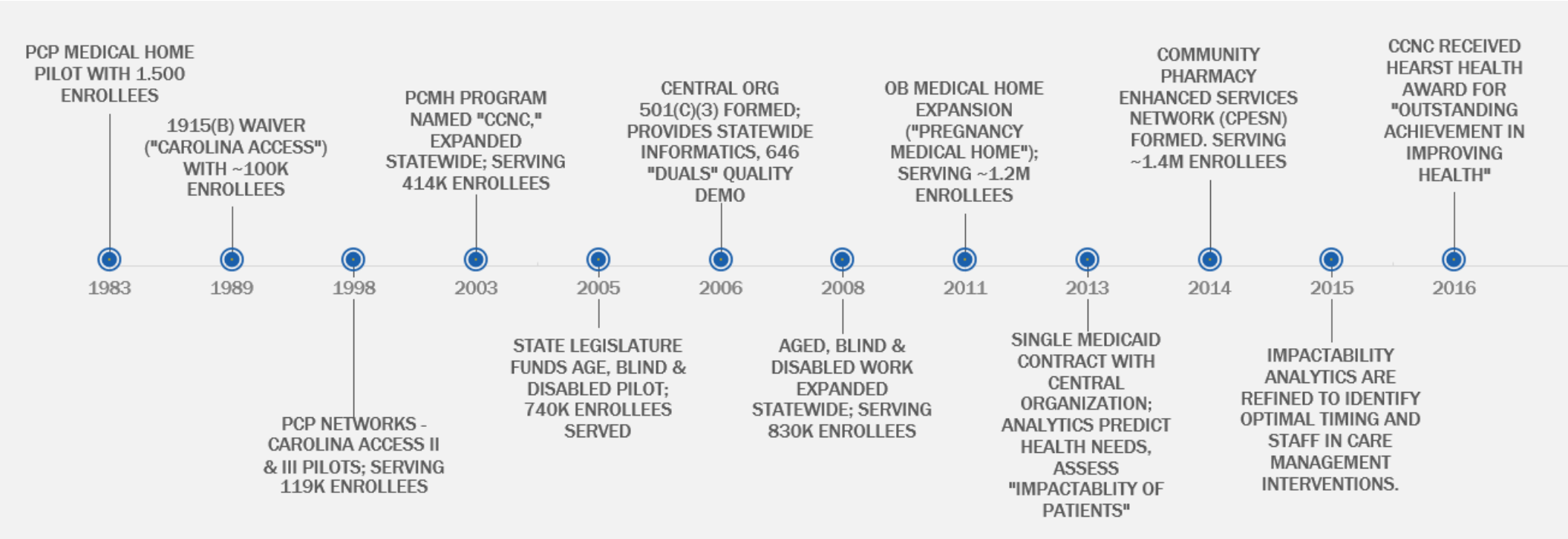
March 26, 2021

NC & CCNC Public Private Partnership

- **CCNC then (1998)program and now (2021) public–private partnership**
- **Key Design elements:**
  - State-wide cross provider/patient resources and program management supporting local care teams (networks)
  - Variable PCP support (some need more than others)
  - Physician leadership central to success
  - Predictive analytics to drive resource allocation
  - Funding options: multi-payer but public payers represent the biggest opportunity for impact

CCNC's History Over Almost 30 Years



Building Community Care Networks

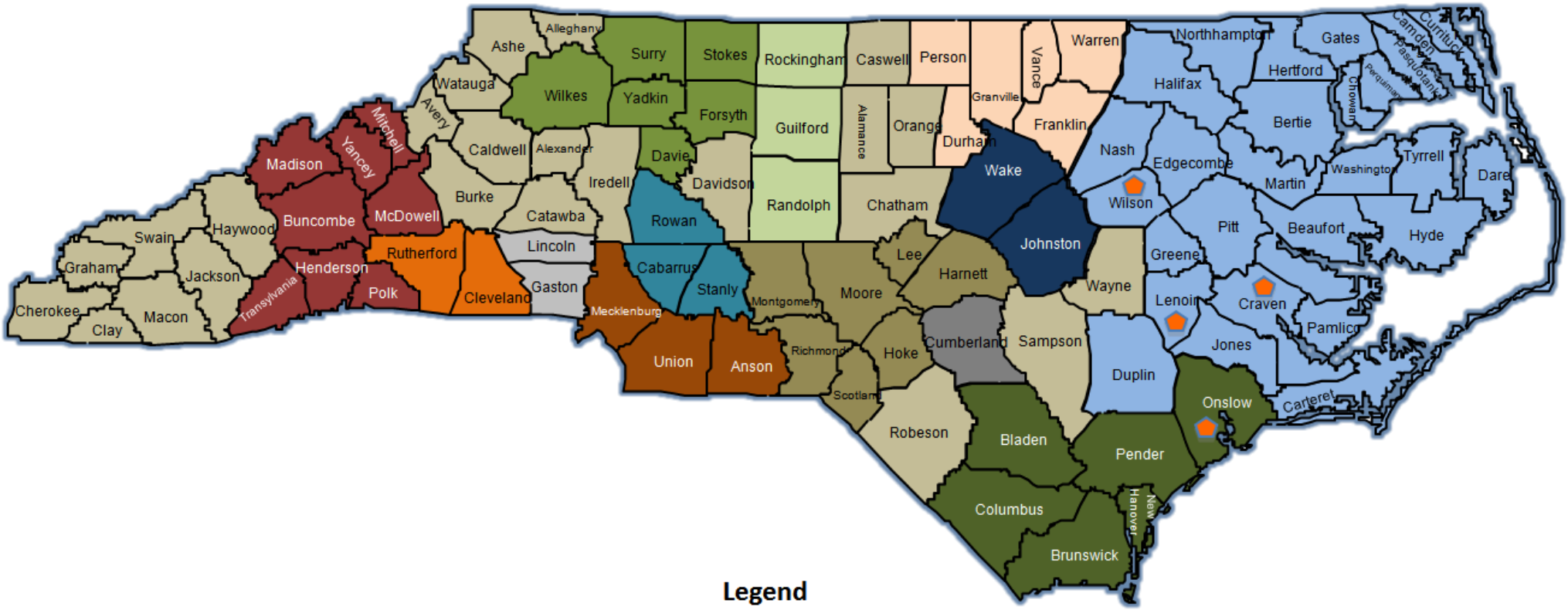
State required of communities as they built their networks

- Must be not for profit
- Governance of program must include

Majority of primary care physicians, hospital, health department and social services

- May be sponsored by an administrative entity such as a hospital, FQHC, Health Department, existing not for profit
- Must be able to contract with the State
- Must accept responsibility for the entire community patients

Community Care Networks- then



Legend

- 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

Statewide PCMH Network Infrastructure Footprint

5,000 primary care providers

- 1,800 Practices
- 90+% of PCPs in NC

1.5 million Medicaid Patients

- 1 million children
- 500,000 adults
- 300,000 Aged, Blind, Disabled
- 150,000 Dually Eligible

All 100 NC Counties

Each region averages:

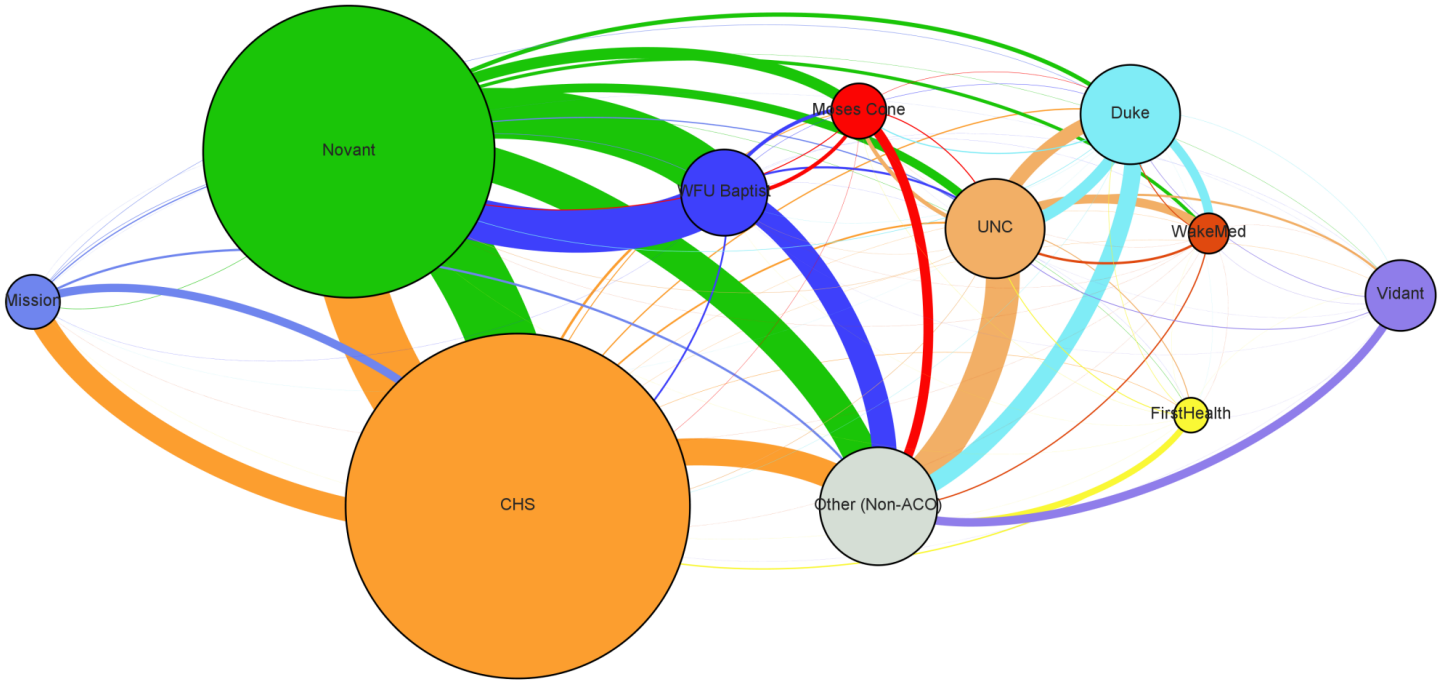
- 1.4 Medical Directors, 1.0 Psychiatrist
- 42.8 Local Care Managers
- 1.8 Pharmacists
- Multiple disciplines: RN, LCSW, RD, …

Why State-wide and Cross Provider Resources?

- Although there has been more consolidation of health systems and development of ACOs, patients still move between providers and regions
- There is still a lack of coordination with social support resources and providers who remain are outside integrated systems
- Most complex patients need more resources but represent the largest opportunity
- Shared resources are effective for complex patients and in rural areas

Cross-system Traffic

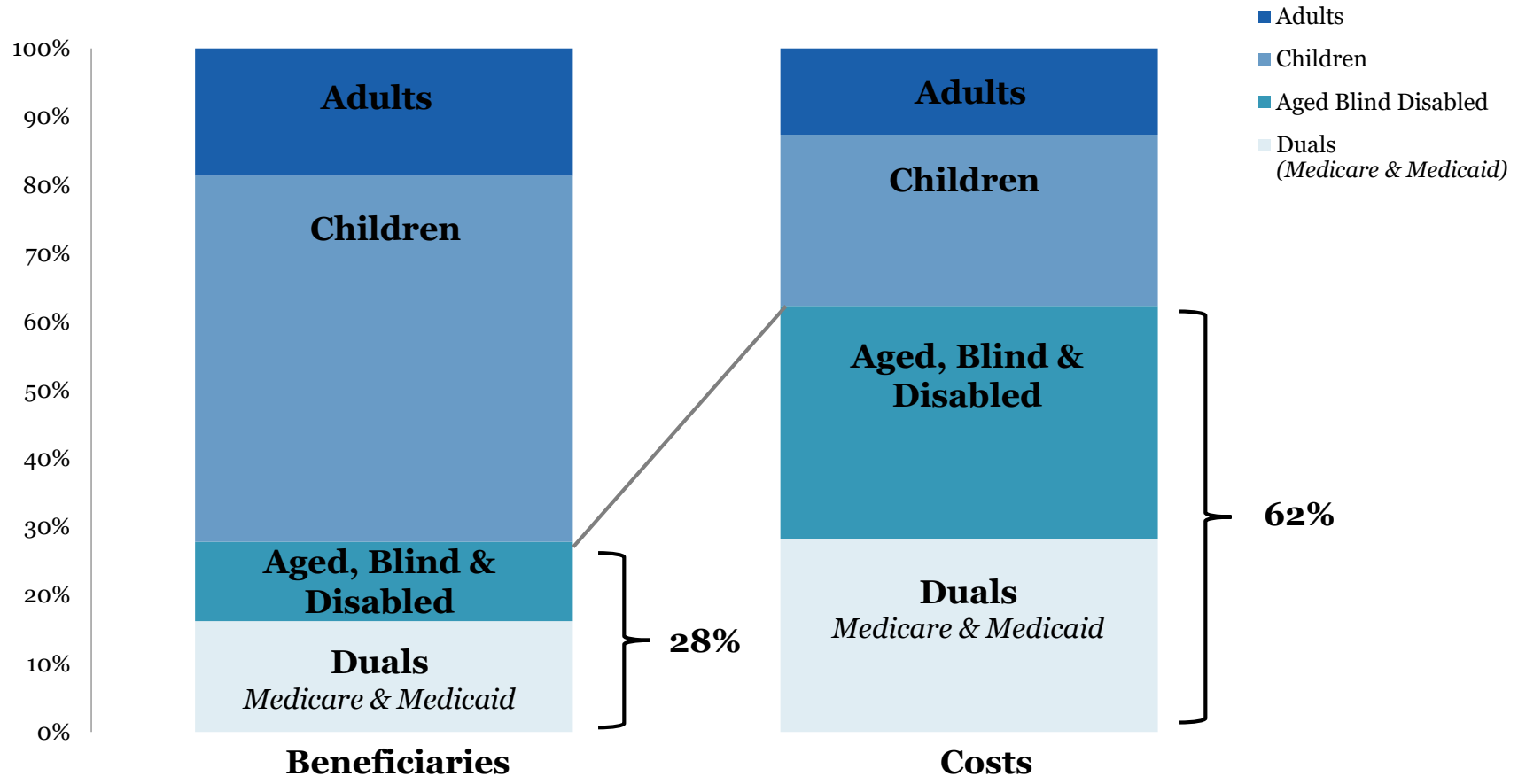
Among patients enrolled in a hospital-owned practice:



- Bubble size represents number of inpatient admissions
- Thickness of the lines represents the number of inpatient admissions **outside** of the respective healthcare systems

Bending Cost Curve and Improving Clinical Outcomes: Leverage Existing CCNC Cost-Savings Infrastructure

A Small Portion of Beneficiaries Are Responsible for a Disproportionate Share of Costs



Analytics- Impactibility

- Predictive analytics drive resource allocation and ROI
- Helps tell you who will benefit from intervention (but maybe as helpful, who will not)
- Helps define funding need
- State-wide coordination but local resources
- Can operate on claims alone
- Important to drive intervention for highest need patients
- Should be transparent and shared resource

Impactability and Social Determinants

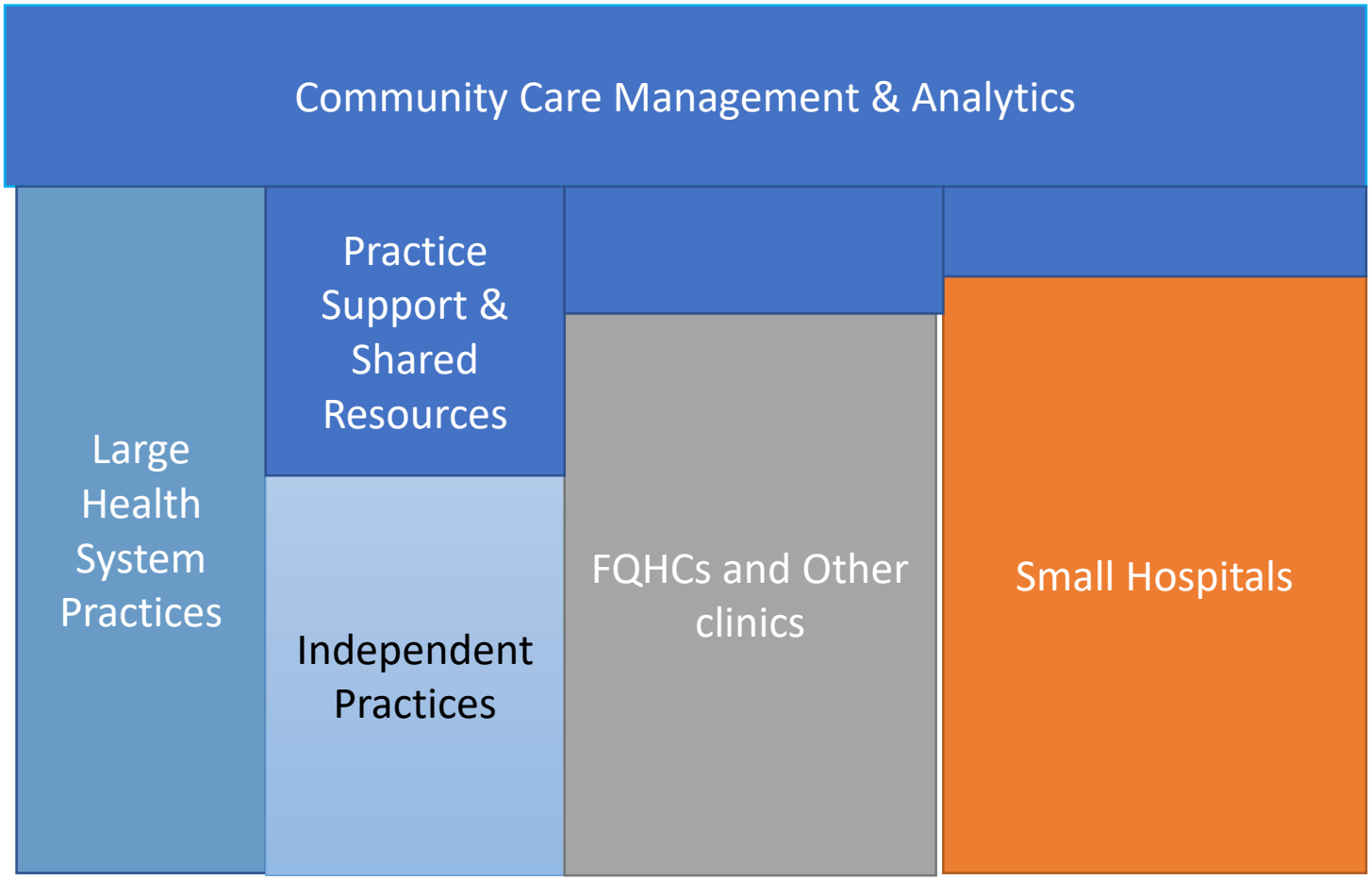
88% of impactable patients have at least one of the following social risk factors in addition to their medical conditions:

- 77% have mental illness
- 30% lack adequate support system
- 29% lack adequate transportation
- 18% have unstable housing
- 17% have experienced trauma or abuse
- 17% have substance abuse problems
- 16% have unmet nutritional needs.
- 14% are illiterate

58% have more than one of these

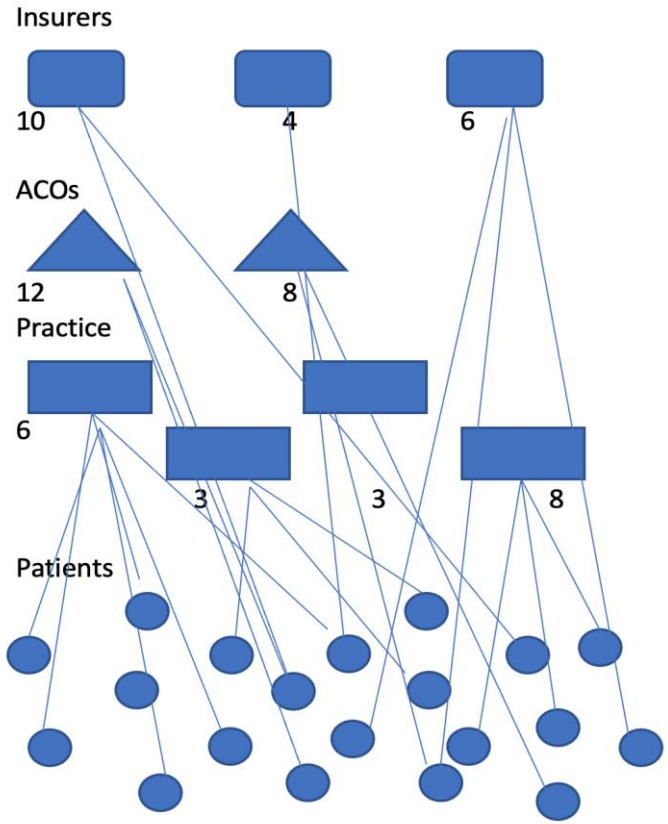
21% have at least 4 of these

Not all providers need the same care management support but all need some

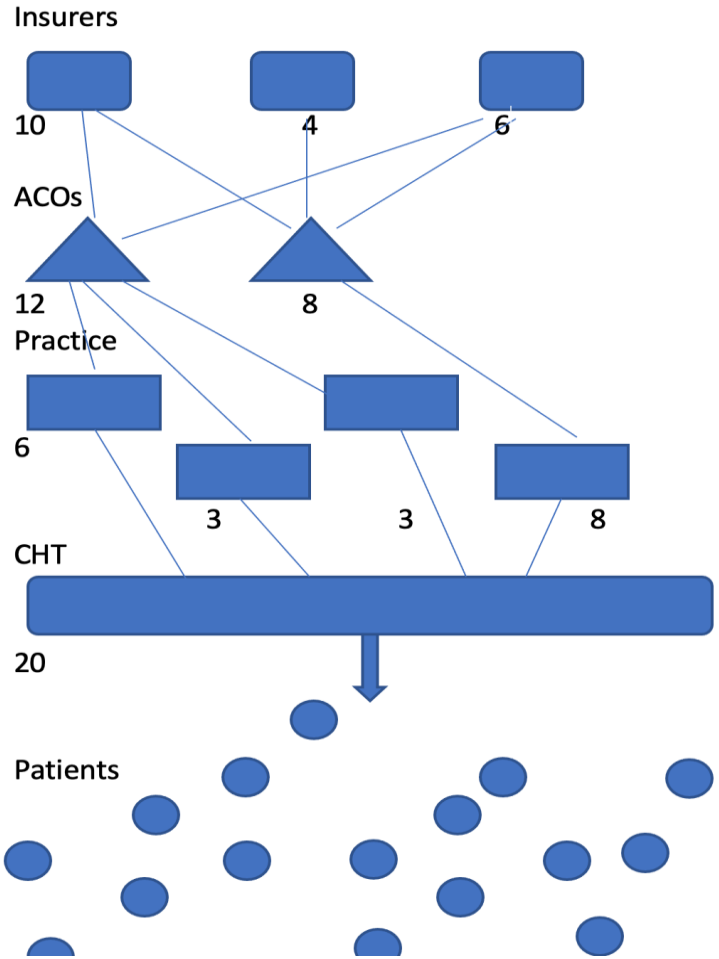


The efficiency of a shared resource

- If every insurer or ACO does their own



- If there is a shared resource



Funding Then - Mainly Medicaid

- Grants
- FFS to providers
- Provider PMPM (PCMH) $3.00 pmpm for children & $5.00 ABD
- CCNC (for CM and PS) $2.50 pmpm children $ 5.00-8.00 pmpm ABD
- PMPM for Medicaid can be accomplished by SPA -no waiver needed (was originally a waiver program)

Our Customers

Funding Now

Medicaid

- Same funding for all patients not enrolled in PHP- managed Medicaid
- Participate with CCPN with all managed care plans (PMPM plus quality and shared savings payments) Wellcare, United, BCBS, Carolina Complete
- Still unclear how state will handle care management related to social determinates in their waiver – will CCNC still do it or will another NFP?

Medicare Advantage with CCPN (United, Wellcare, Humana, Aetna)

- PMPM for care management and network support
- Administration of quality and shared savings

Commercial with CCPN (Blue Premier and State employees Health Plan, Cielostar, several exchange plans)

- Most have a pmpm network fee and some quality bonus

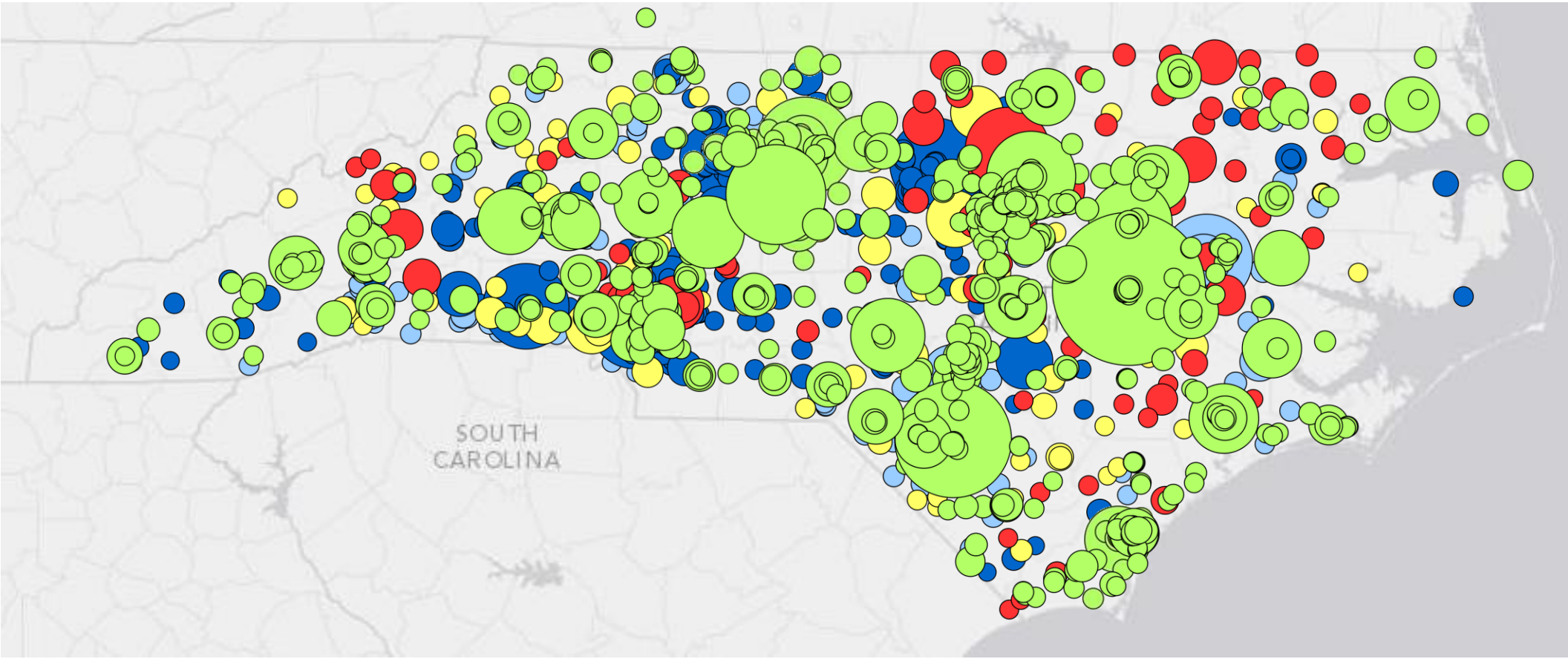
Thoughts on Funding and Contracting

- Insurers and Health systems will usually prefer to do their own care management- hard to contract with unless State pushes
- ACOs have their own resources or want to build them but are sometimes approachable to subcontract
- Medicare, Medicaid and Commercial patients often require very different approaches to type and amount of care management support- must be flexible in how you contract
- The role of the State in pushing for a coordinated approach is important
- Organizing independent PCPs and safety net providers into value-based contracts is an important option to assure infrastructure is used and funded
- You must prove you ROI to be successful long term

Primary Care System

- Independent primary care is often overlooked and invisible to policy makers but a significant part of the infrastructure
- Primary care needs variable levels of support based on size , location and patients served
- Physician leadership is critical for direction, engagement and advocacy to sustain any program across multiple administrations

CCNC Primary Care Landscape



Large Health System Owned Practices (25%)

Other Hospital Owned Practices (9%)

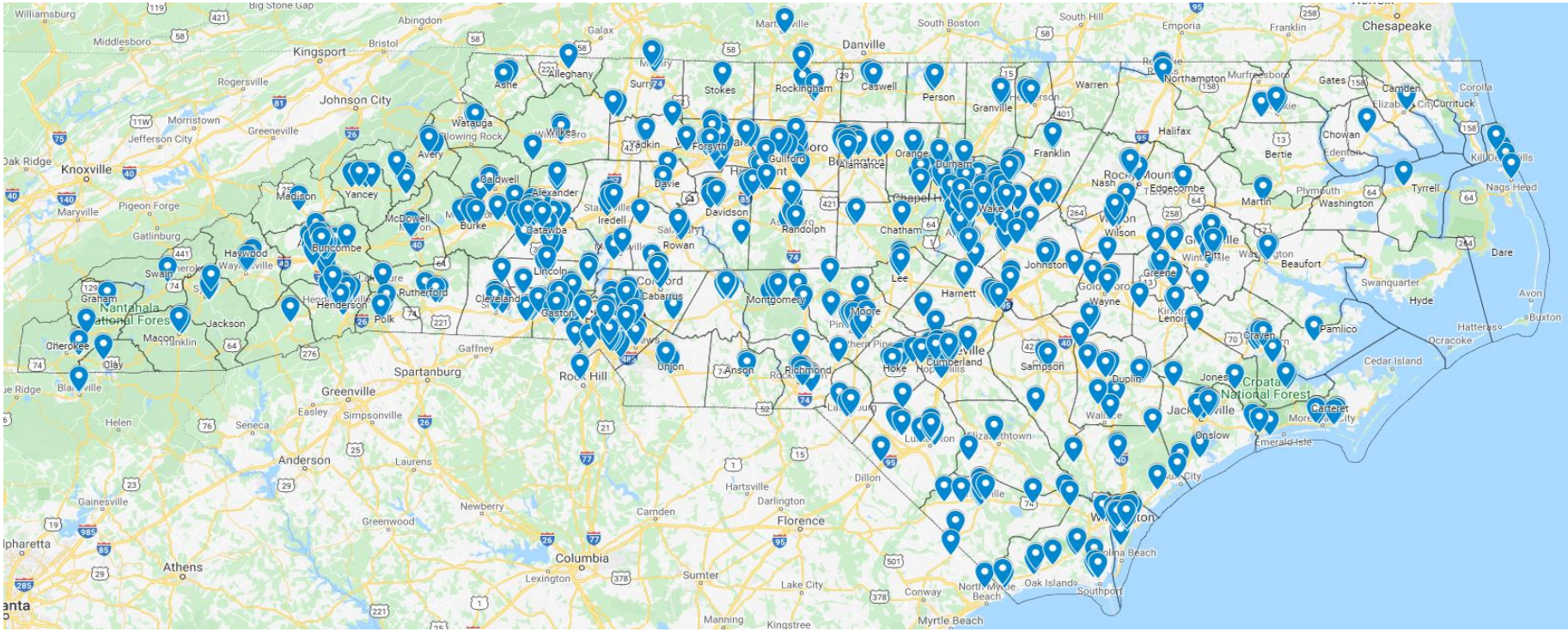
Federally Qualified Community Health Centers (7%)

Other Safety Net (RHC, LHD, other) (7%)

Independents (52%)

CCPN is our state-wide clinically integrated PCP network (as of March 1, 2021)

Number of Practices	Number of Clinicians
1,016	3,516



Appendix

CCPN Participation

Clinician Specialties	%
Family Medicine	32%
Pediatrics	23%
Internal Medicine	10%
OB/GYN	4%
Psychiatry / Behavioral Health	27%

Practice Type/ Specialty	%
Pediatrics	19%
FQHC	14%
Family Medicine	31%
Internal Medicine	14%
Health Department	5%
Psychiatry / Behavioral Health	23%
OB/GYN	2%

CCPN Practices

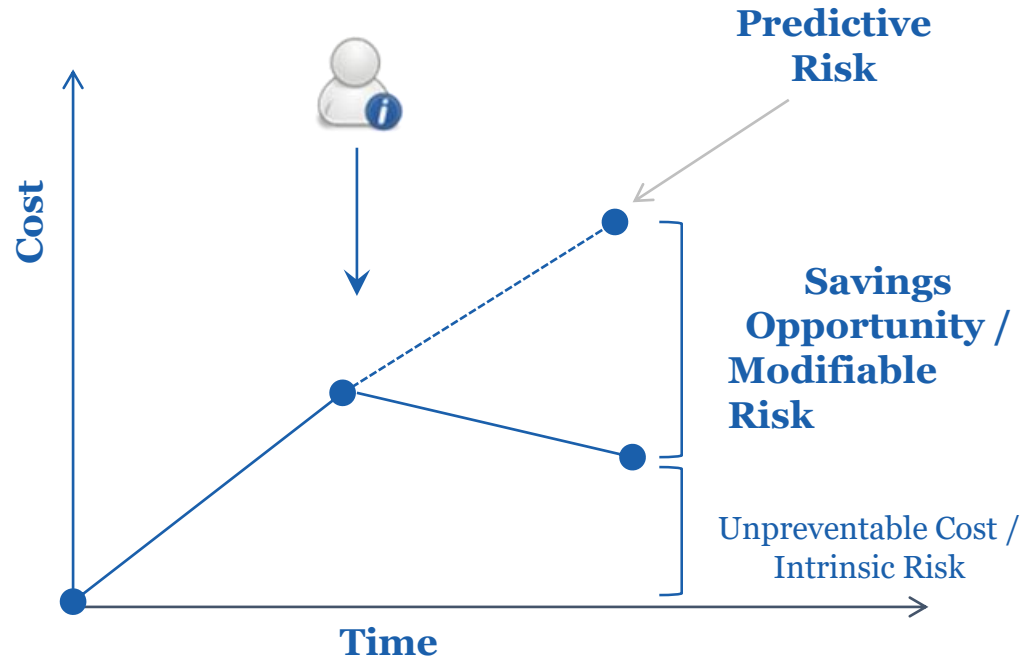
County Designation	%
Urban/Suburban	53%
Rural	47%

Practice Size	Medical %	BH %
Solo Practice	32%	35%
5 or fewer clinicians	83%	75%
6 or more clinicians	17%	23%

Population	Count	%
Total Medicaid	650,428	
Children <21	513,374	78.92%
Adults	137,054	21.07%
ABD	101,624	15.62%
Duals	44,923	6.69%

Population Profiling: Risk and Opportunity

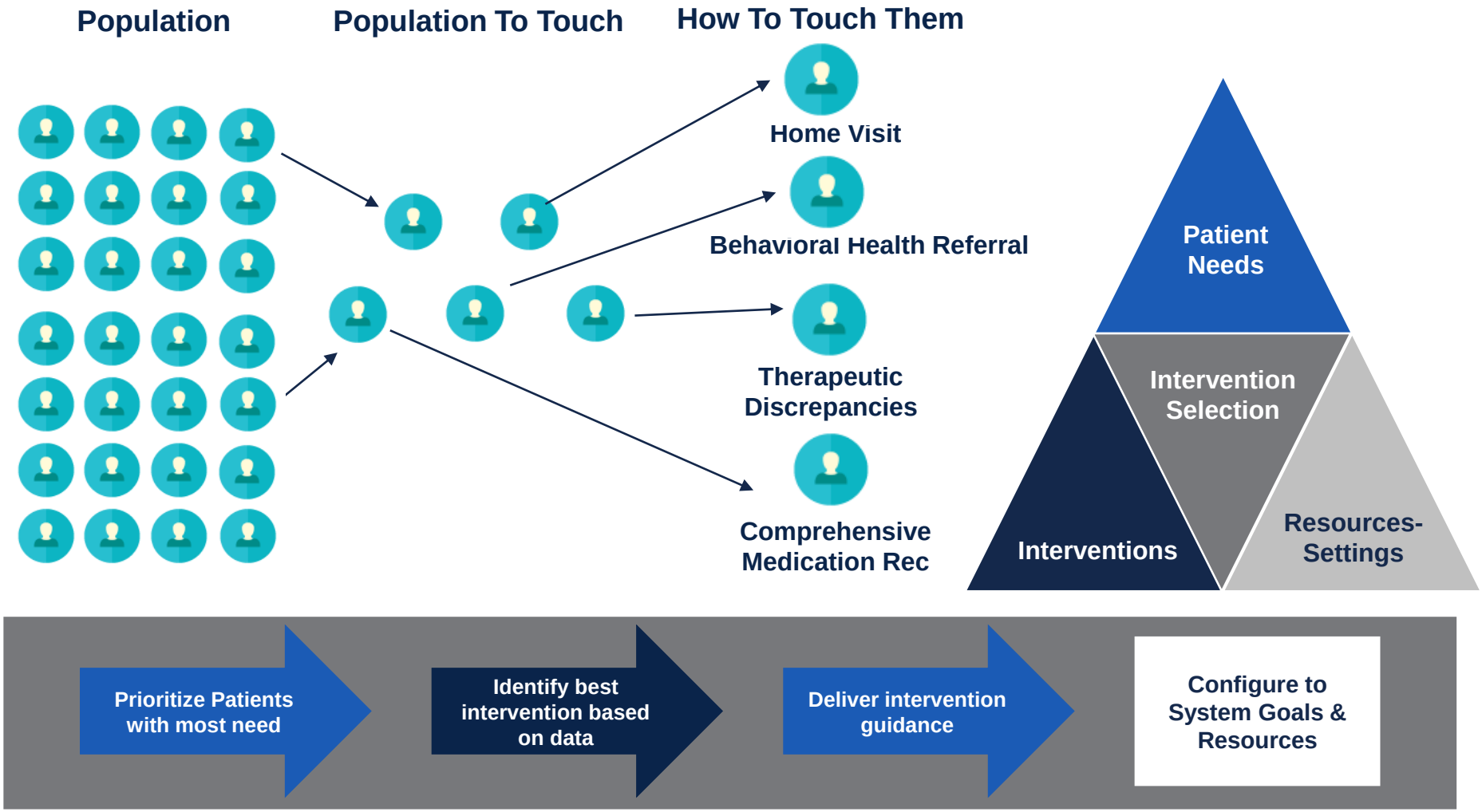
By focusing on modifiable risk, care providers can focus interventions on patients that have the largest change in cost trajectory.



Opportunity Examples:

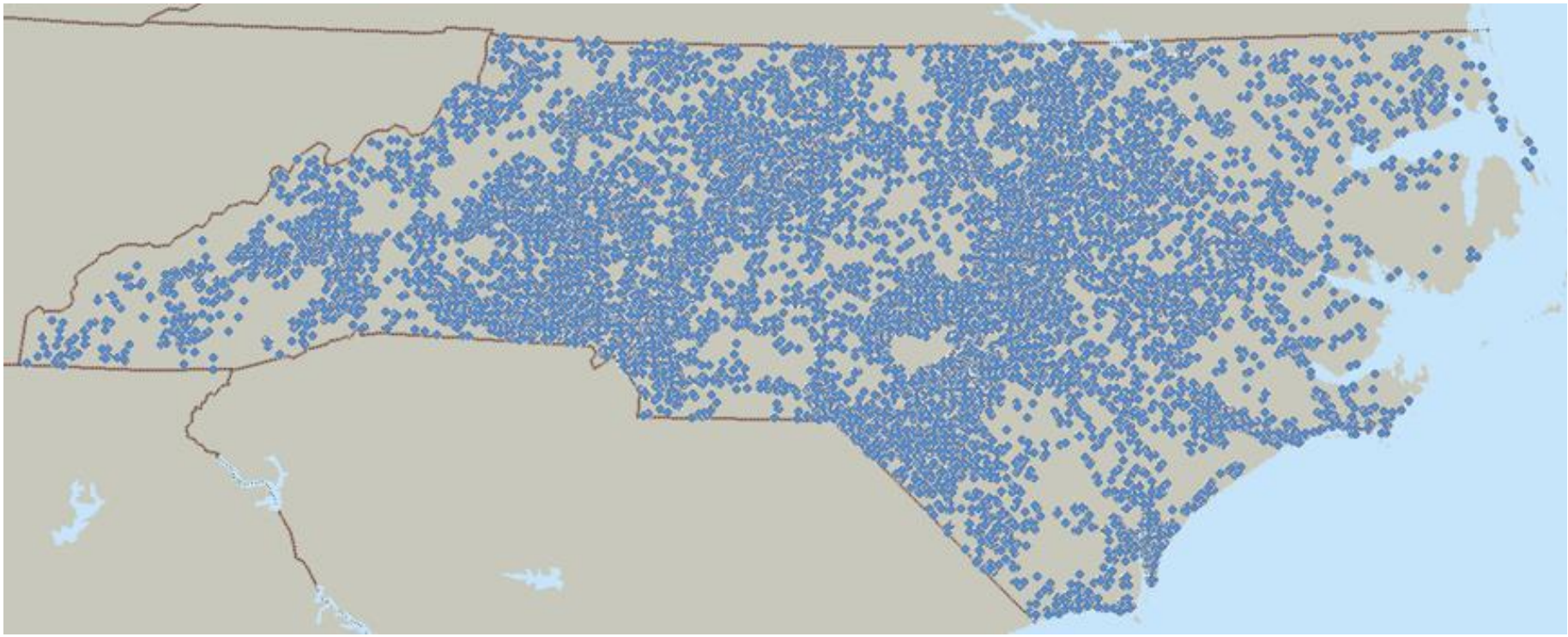
- Transitional Care
- Complex Care Management
- Med Adherence
- Palliative Care
- Behavioral Health
- ED Utilization

Population Profiling: Targeting Patients Who Will and Will Not Benefit From Intervention



Opportunity in the Context of Transitional Care

>32,000 Individuals received CCNC Transitional Care Support in 2015

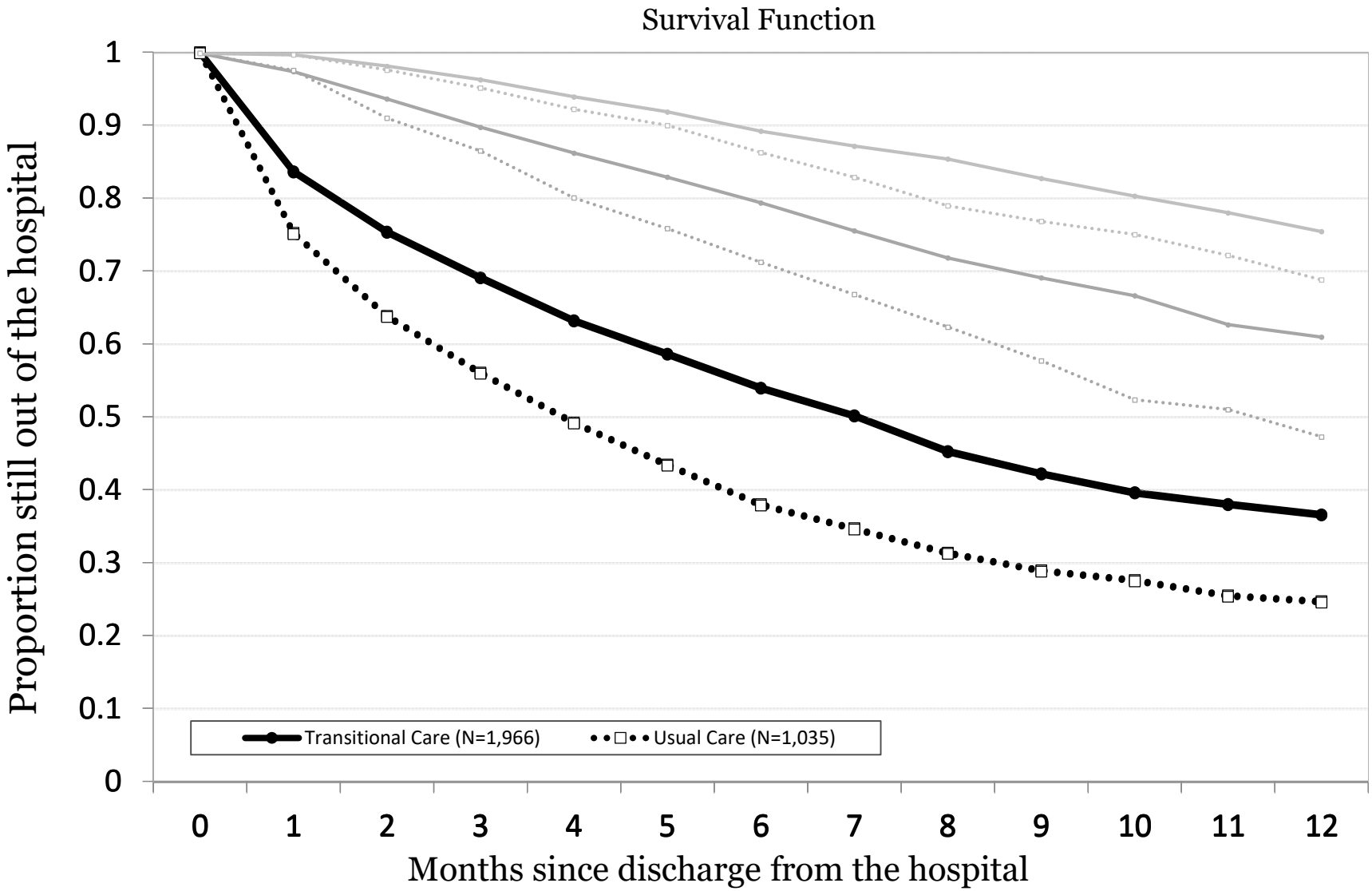


This targeting strategy yields nearly twice the savings of common risk-base or diagnosis-based strategies.

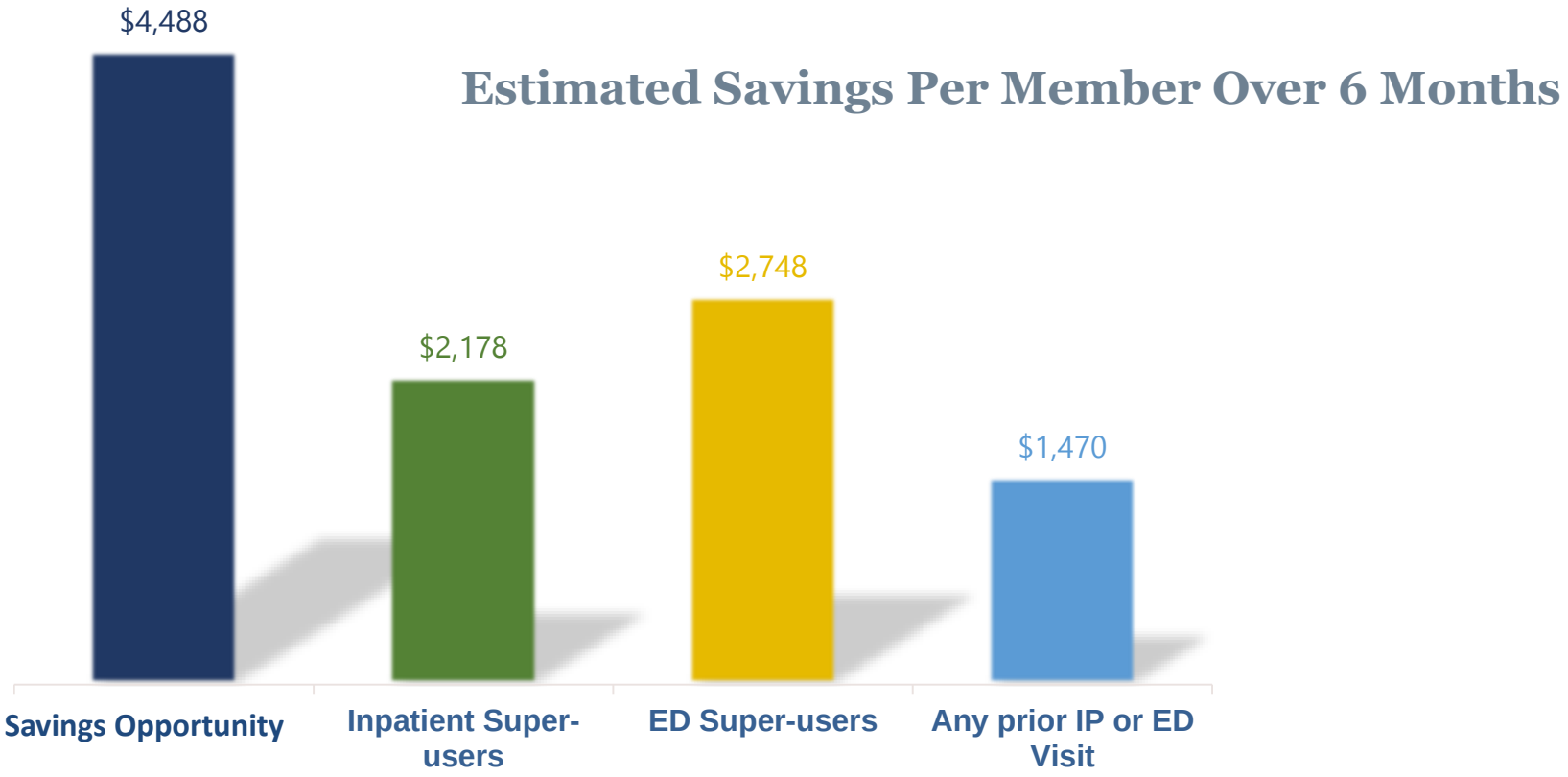
Impact through Scale, Efficiency, Community-Based Infrastructure

Time to First Readmission for Patients Receiving Transitional Care Vs. Usual Care

Lighter shaded lines represent time from initial discharge to second and third readmissions (Significant Chronic Disease in Multiple Organ Systems, Levels 5 & 6; ACRG3 = 65-66)



Results - Complex Care Management Savings Opportunity Model

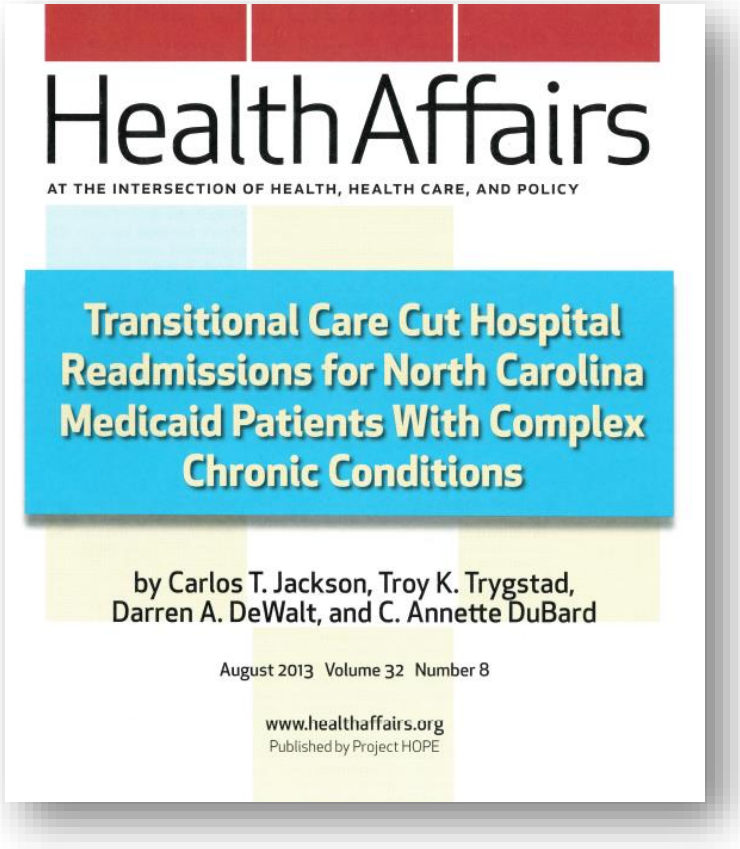


Take-away point

The same investment in care managing 5,000 patients yields VERY different results depending on who you choose to manage.

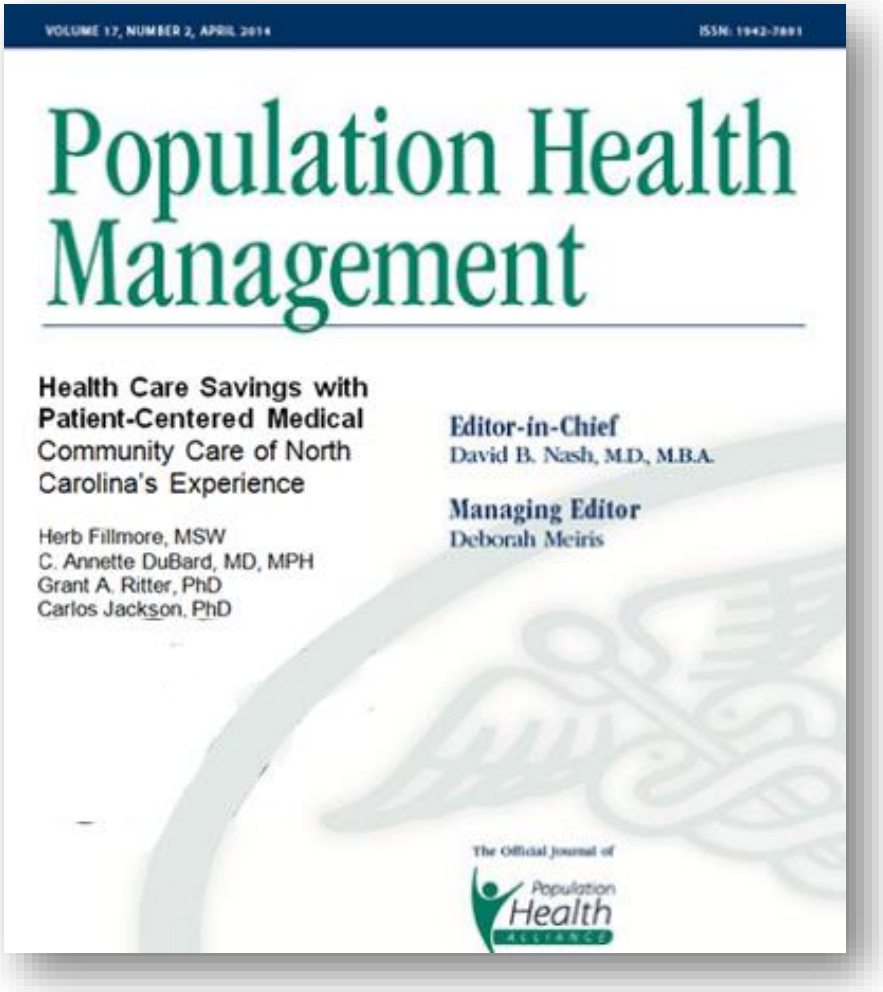
Peer-reviewed Research: Cutting Hospital Readmissions

- 20% reduction in readmissions for patients in the transitional care program
- 12-month readmission rates consistently lower for participants within each level of clinical severity
- For every six interventions, one hospital readmission avoided – strong ROI



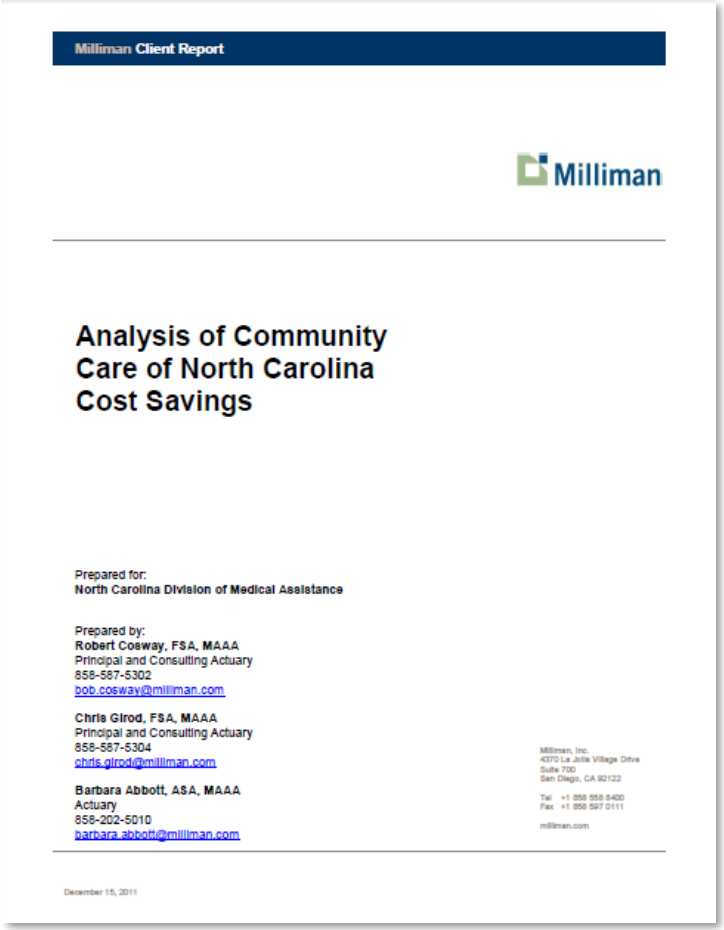
Peer-reviewed Research: Cutting Costs for Highest Risk Recipients

- Significant savings for 169,667 non-elderly, disabled Medicaid recipients
- $184 million savings in about 5 years
- Higher per-person savings for patients
  with multiple chronic conditions
  one hospital readmission
  avoided – strong ROI



External Evaluation: Bending the Cost Curve

- Analysis of Medicaid data by actuarial firm Milliman, Inc.
- CCNC saved North Carolina **nearly a billion dollars** over a four-year period from 2007 through 2010, validating CCNC's "quality first" approach



Milliman Client Report

Milliman

Analysis of Community Care of North Carolina Cost Savings

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December 15, 2011

Peer-reviewed Research: Readmission Trends Among High-Risk Beneficiaries

Among statewide NC Medicaid recipients with Multiple Chronic Conditions, 2008-2012:

- **10.5% reduction** in inpatient utilization
- **10.2% reduction** in 30-day readmissions
- Establishes that population-based performance measurement preferable to discharge-based readmission rates for accountable care framework