Health Homes as a Vehicle for Cost Savings in Medicaid: The NC Experience

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Why Health Homes?

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- **Medicaid spending growth**
  - Need for budget predictability
- **Medicaid cost drivers**
  - 5% of population drives 50% of the cost
    - Individuals with multiple chronic conditions
    - Behavioral health conditions

Complex patients drive ER usage*

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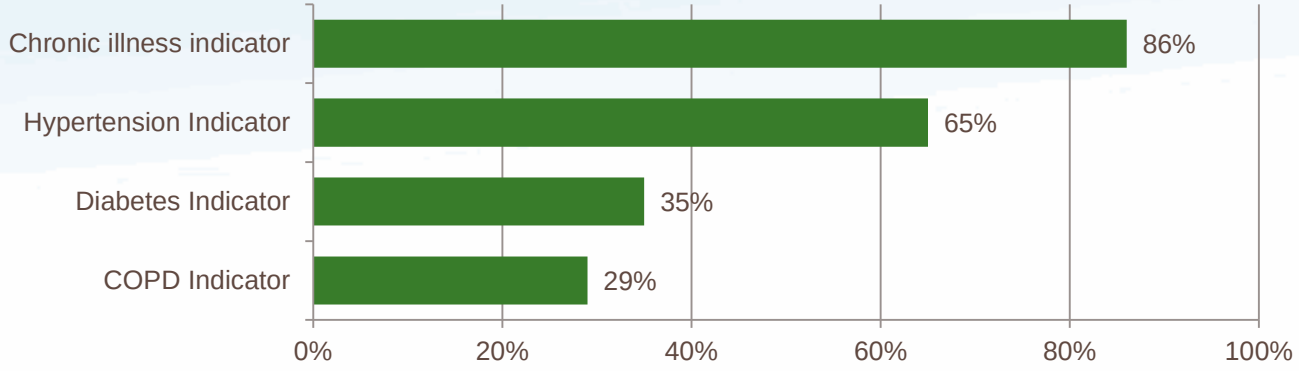
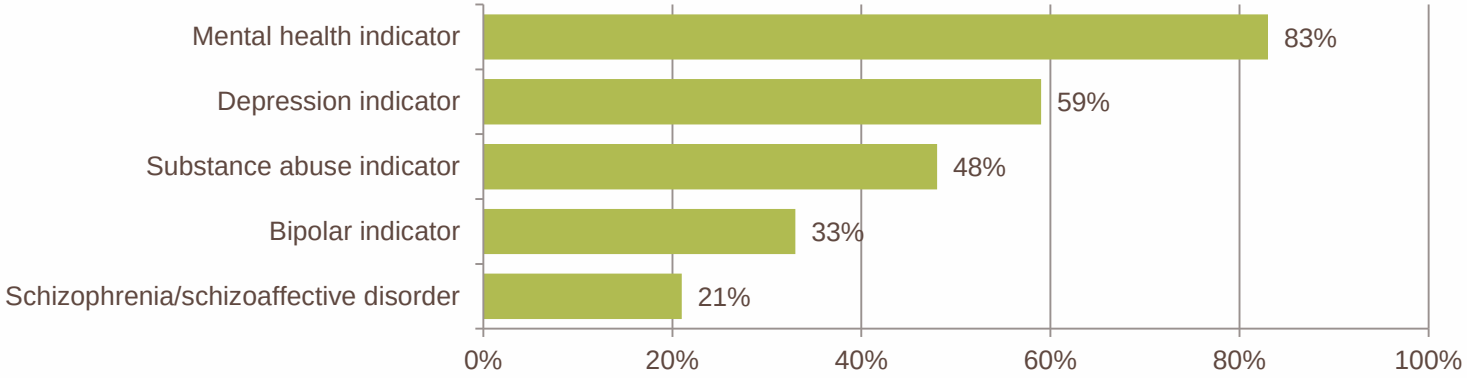
Prevalence of Chronic Illness



Prevalence of Mental Health Issues



***** Analysis of 1,394 NC Medicaid recipients with **20 or more ED visits** in State Fiscal Year 2011.

Why Health Homes?

- **Medicaid spending growth**
  - Need for budget predictability
- **Medicaid cost drivers**
  - 5% of population drives 50% of the cost
    - Individuals with multiple chronic conditions
    - Behavioral health conditions
- **Strong primary care infrastructure correlates with cost savings and quality care**
  - 15% reduction in emergency room visits
  - $10 PMPM total cost reduction
- **Behavioral health integration essential for Medicaid**

Health Home Basics

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Section 2703 of ACA

- State plan option
- Enhanced funding of HH services with 90%/ 10% match
- Funding for 2 years

Beneficiaries

- 2 or more chronic conditions
- Serious or persistent mental illness

Health Home Services

- Care management
- Transitional care
- Patient and family support
- Community resources

Patient Centered Medical Homes

- “Whole Person Care”
- Use of Health Information Technology

Health Home Landscape

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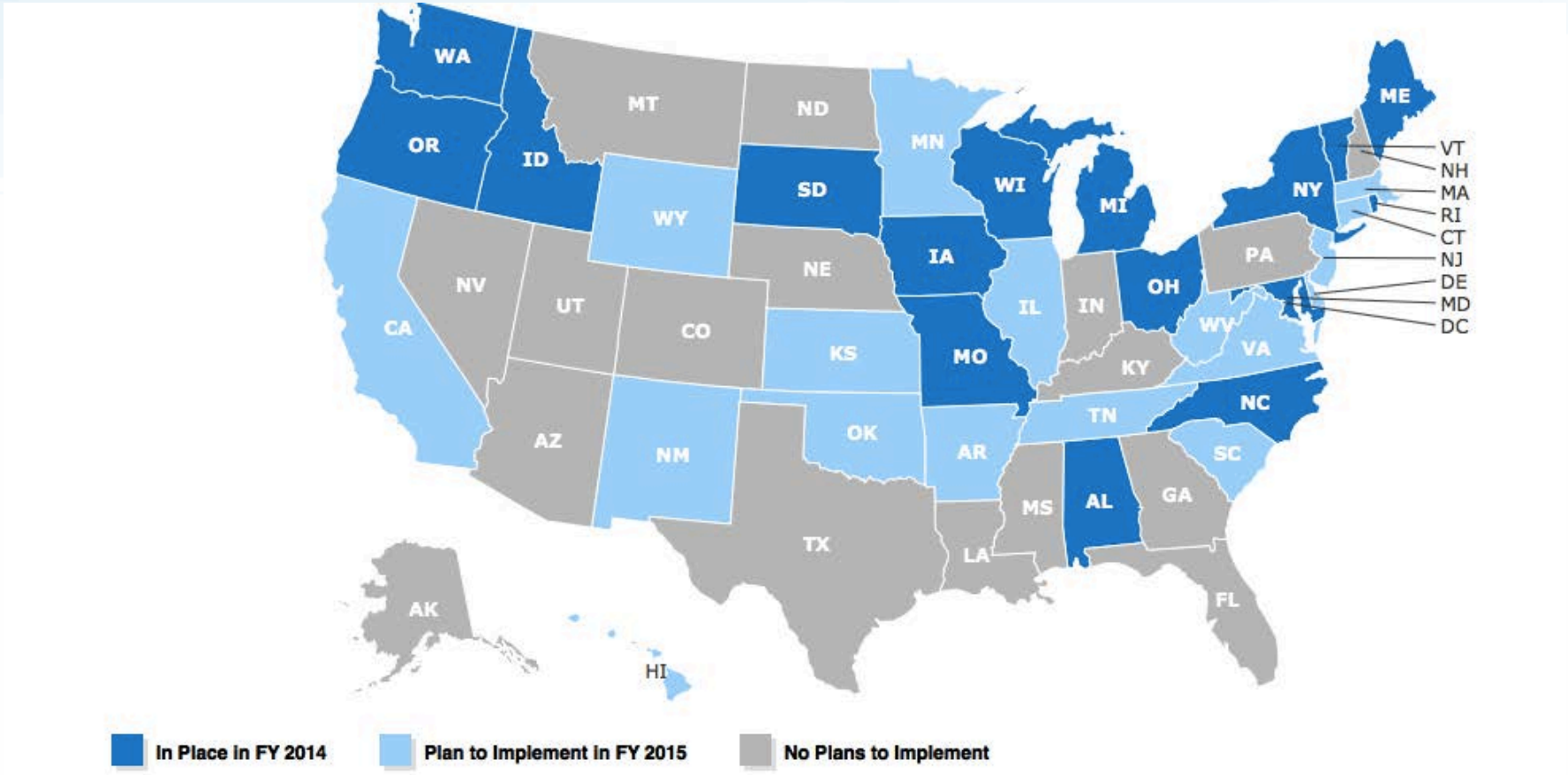

NC's Health Home Approach

- **Use CCNC primary care case management infrastructure**
  - 1800 medical homes
  - 530,000 beneficiaries
  - Care management services
  - Informatics Center
- **Financing:**
  - Primary care case management program (PCCM)
  - PMPM payment to practices: $5 or $2.50
  - PMPM to 14 regional networks for 7 different sub populations
  - PMPM to central office for informatics center, training, leadership

CCNC Regional Networks

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 Community Care
- Community Care of the Sandhills
- Community Care of Southern Piedmont

CCNC Manages Cost and Quality for Enrolled Beneficiaries

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Key Tools Include:

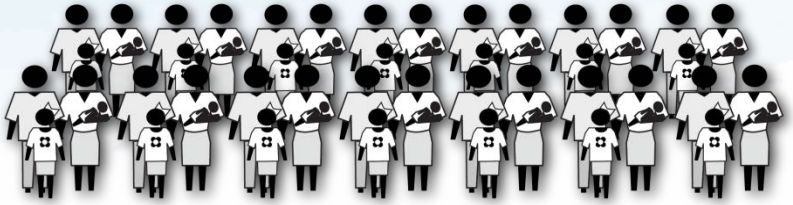
- **Informatics with analytics, reporting, clinical applications, and shared care management platform**
- **Care management model that uses analytics to target highest need beneficiaries in the appropriate settings**
- **Practice support model that provides resources to medical homes that serve Medicaid beneficiaries to provide higher value care**
- **Assist DHHS/DMA in effectively deploying programs (e.g. pharmacy initiatives, clinical policy changes)**

Each CCNC Network has:

- A **Clinical Director**
  - A physician who is well known in the community and works with network physicians on care improvement strategies and goals
  - Provides oversight for quality and performance 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 **Pharmacist** to assist with Medication Management of high cost patients
- A **Psychiatrist** to assist in behavioral health integration
- An **Obstetrician** to assist with promoting best practices with PMHs
- Palliative Care, Chronic Pain, and OB Coordinators

CCNC Footprint Statewide

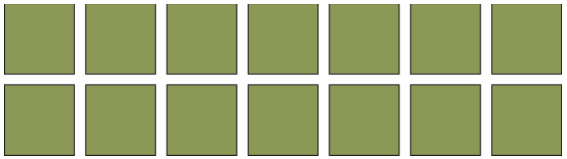
- 5,000 primary care providers
- 1,800 Practices
- 90% of PCPs in NC



- 1.3 million Medicaid Patients
- 300,000 Aged, Blind, Disabled
- 150,000 Dually Eligible

All 100 NC Counties

14 Networks



Each network averages:

- 1.4 Medical Directors
- 42.8 Local Case Managers
- 1.8 Pharmacists
- 1.0 Psychiatrist

Local Network: Wake & Johnston

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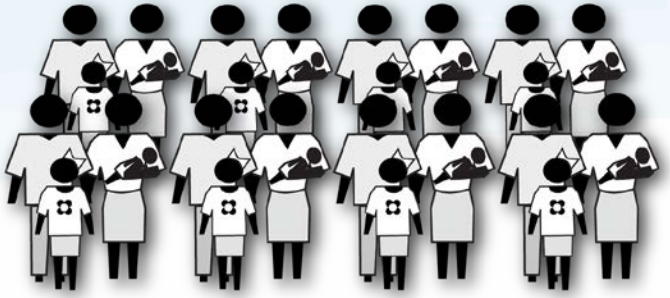
- 155 primary care sites
- Wake Faculty Practices



- 103,000 Medicaid
- 5th largest network in population served

Wake & Johnston Numbers

- 2 Medical Directors
- 39 Local Case Managers
- 3 PharmDs
- 2 Psychiatrists
- 1 Obstetrician

At:

WakeMed

- 11 FTEs dedicated to WakeMed
- 9 Registered Nurses/SW
- 2 Patient Coordinators

Population Health Management: A Step-by-Step Approach

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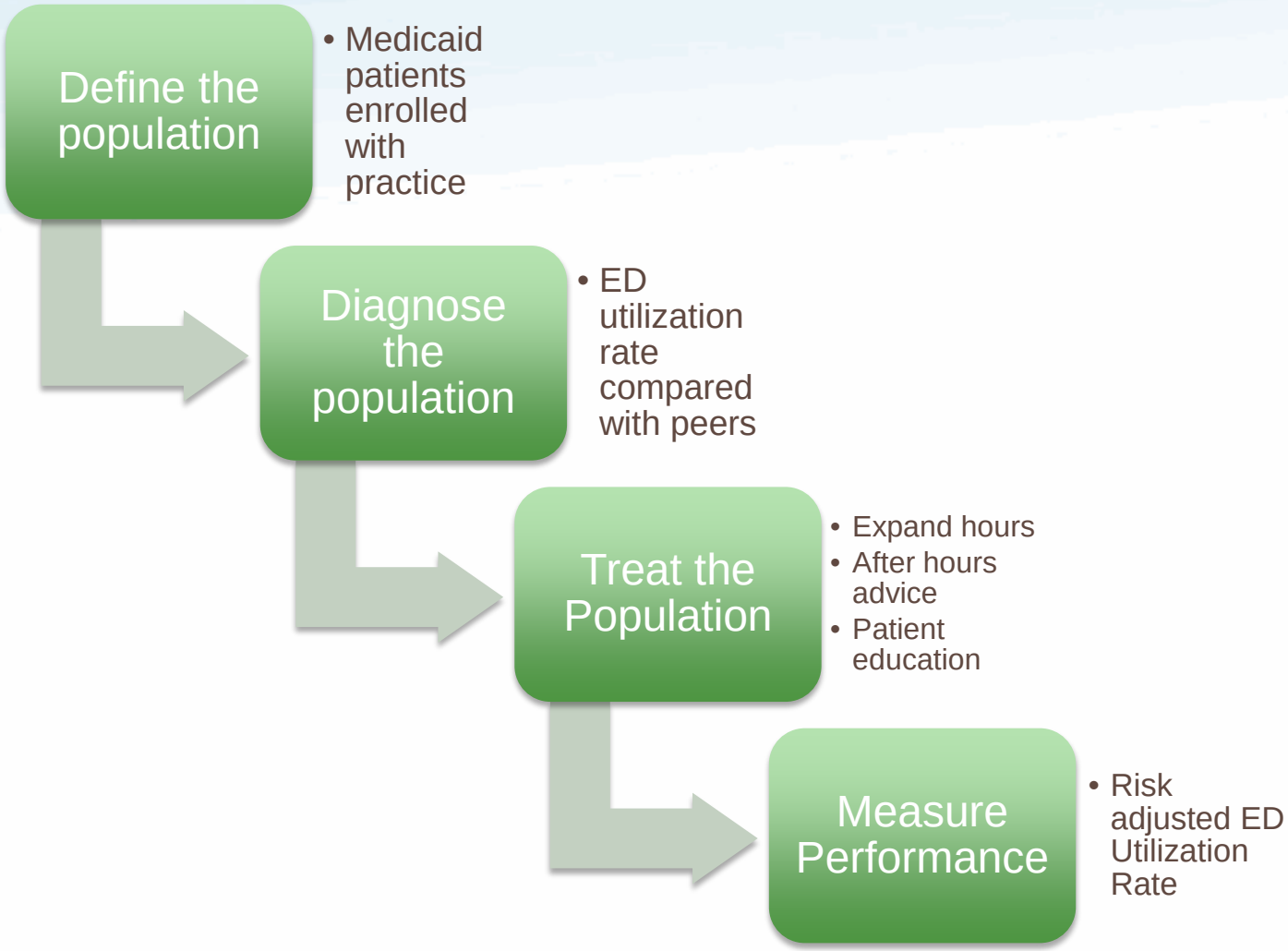

CCNC Impact and Results

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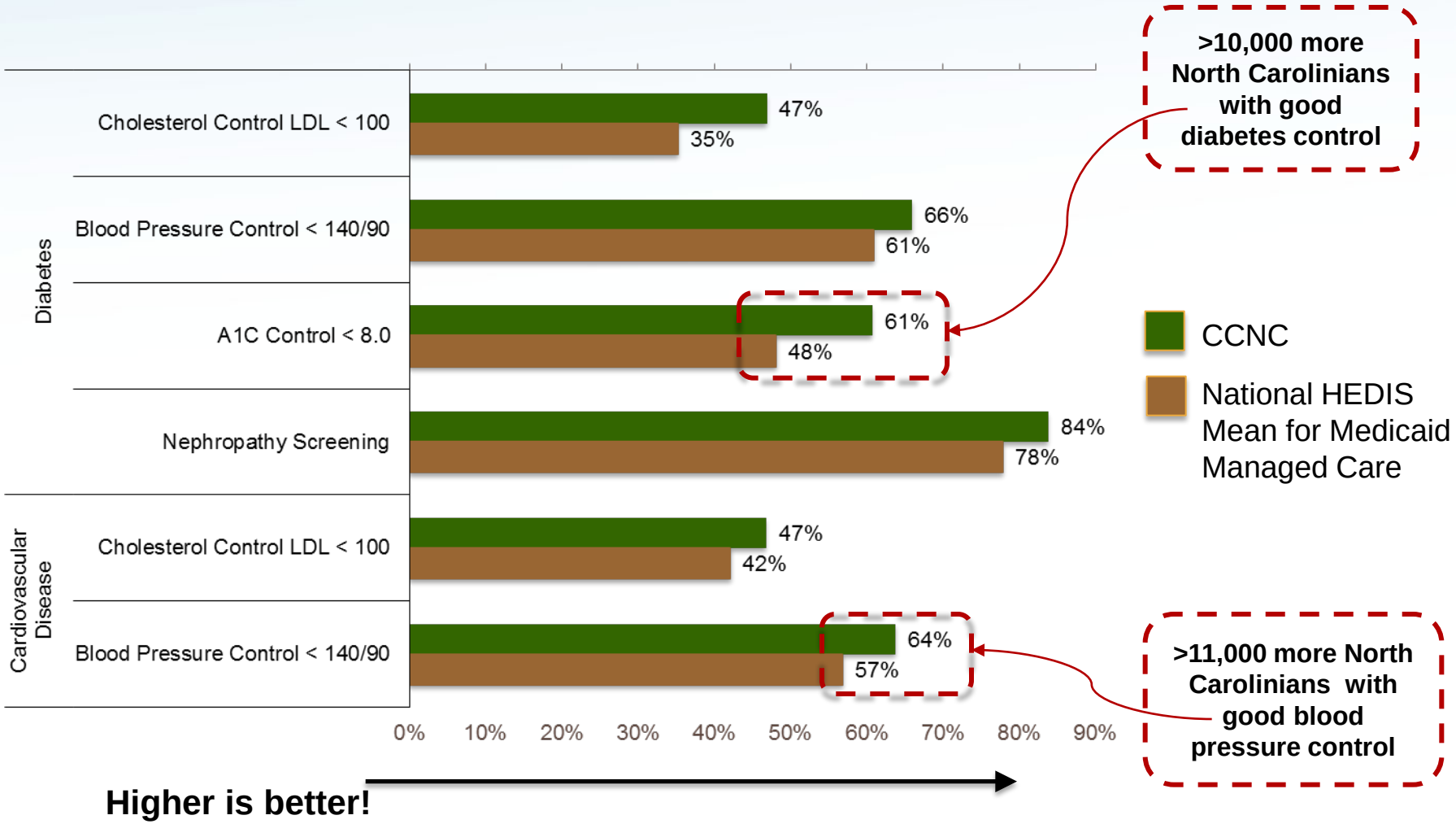
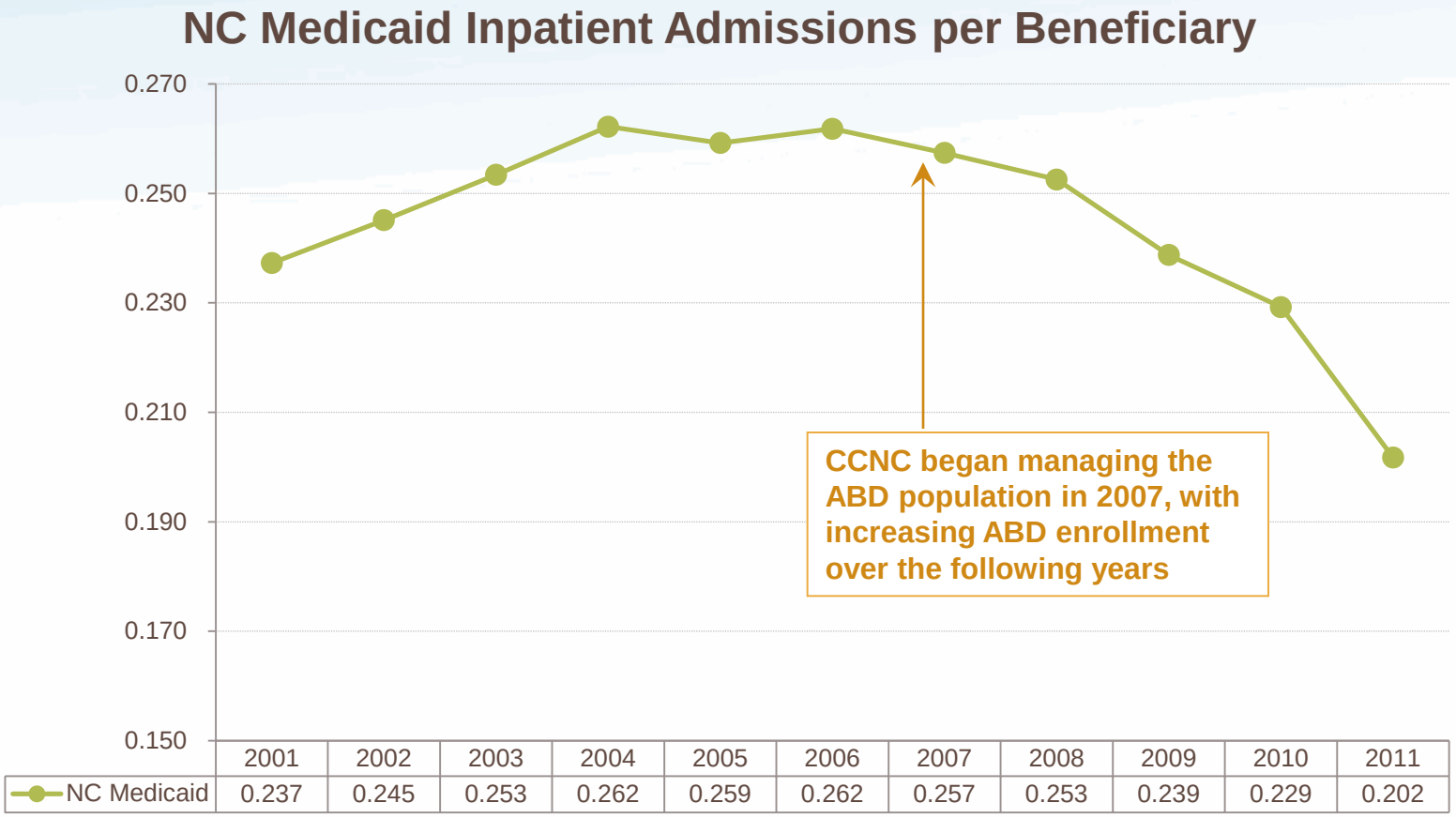
- **Analysis of complex care management and medical home model demonstrates:**
  - Cost savings with beneficiaries with multiple chronic conditions
  - Cost savings with beneficiaries with behavioral health and chronic conditions
  - Costs savings with ED super utilizers
  - 20% decreased readmission rates
- **Reach or exceed HEDIS Medicaid MCO benchmarks in Asthma, Hypertension and Diabetes**

CCNC HEDIS Performance Compared to Medicaid Managed Care Benchmarks



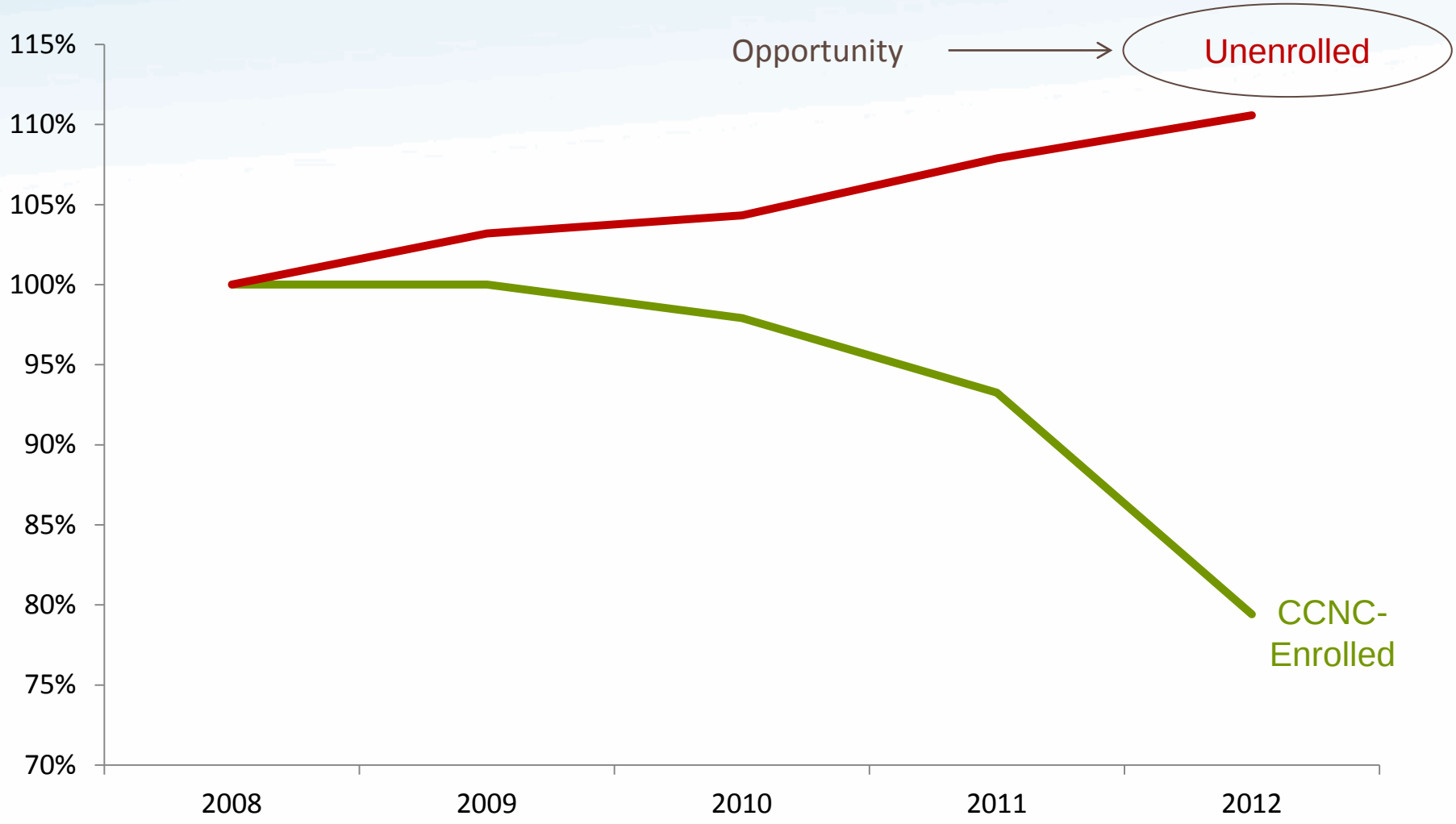
Long Term Trends in NC Medicaid Inpatient Admission Rates



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NC Medicaid	0.237	0.245	0.253	0.262	0.259	0.262	0.257	0.253	0.239	0.229	0.202

Number of Inpatient Admissions per Medicaid Beneficiary, including Dual Eligibles
Inpatient data obtained from AHRQ Healthcare Cost and Utilization Project (HCUP), hcupnet.ahrq.gov. Enrollment from Kaiser Family Foundation website, kff.org.

Potentially Preventable Inpatient Costs, PMPM Spending Trends



Peer-reviewed research

Cutting Hospital Readmissions

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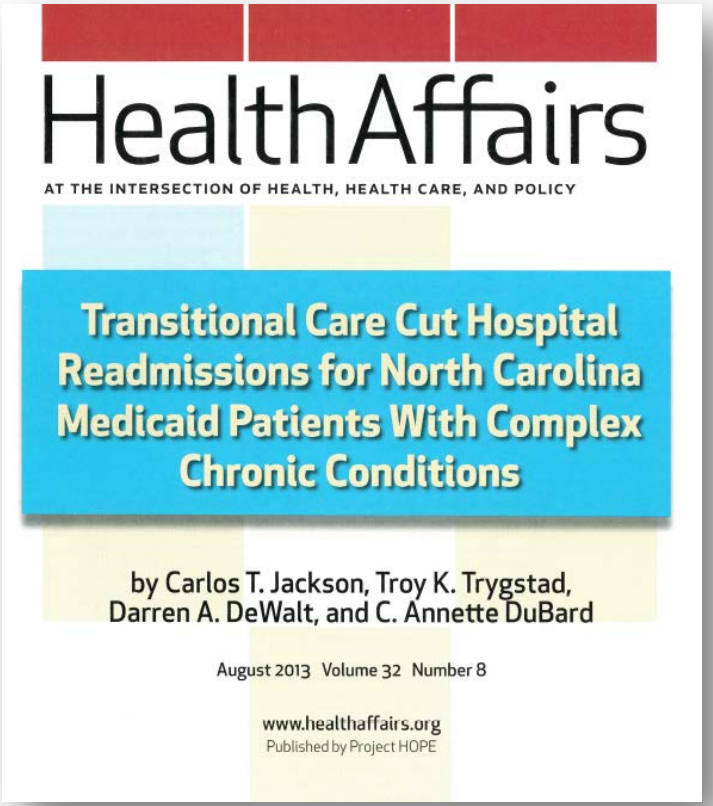
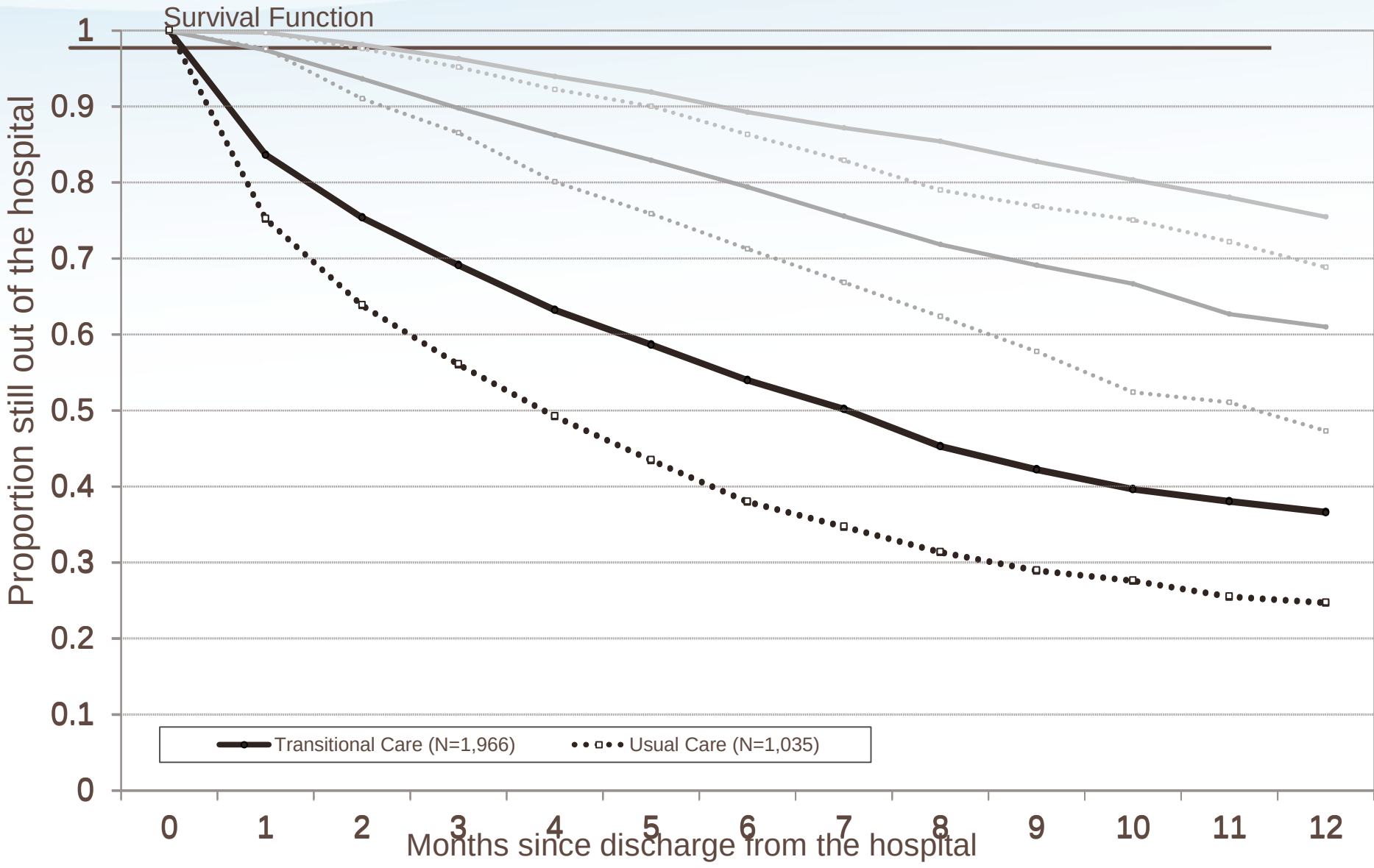
- 20% reduction in readmissions for patients in the transitional care program.
- 12-month readmission rates consistently lower for participants within each level of clinical severity.
- For every six interventions, one hospital readmission avoided – strong ROI



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)



Peer-reviewed research

Cutting Costs for Highest Risk Recipients

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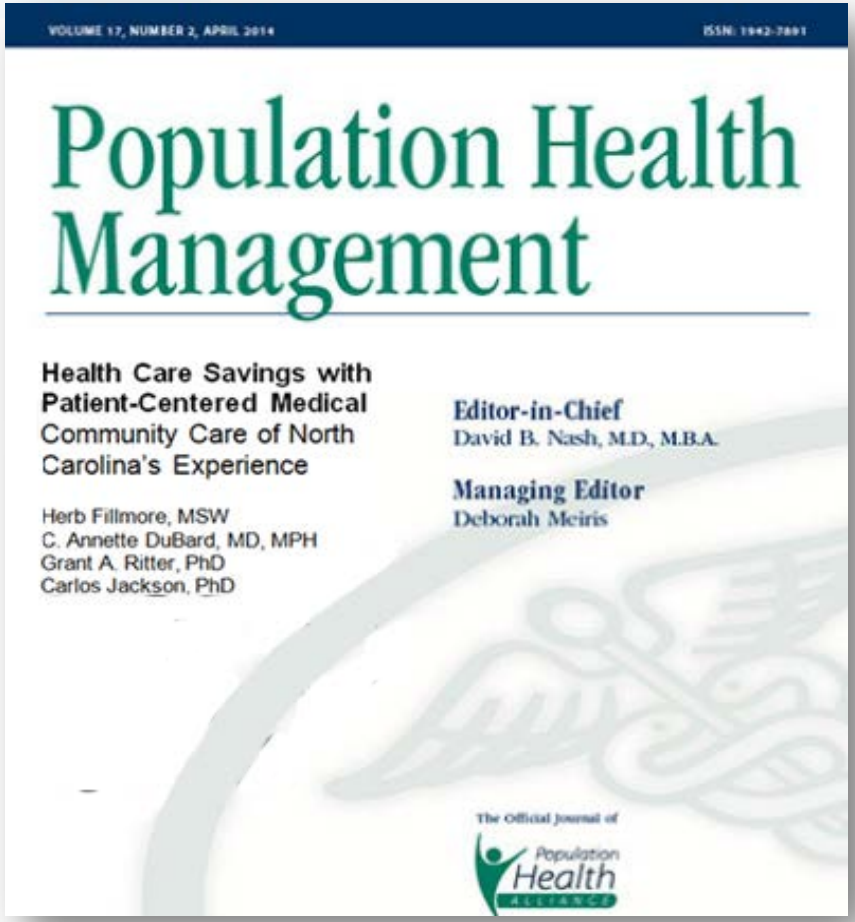
- Significant savings for 169,667 non-elderly, disabled Medicaid recipients
- $184 million savings in about 5 years
- Higher per-person savings for patients with multiple chronic conditions.



Lessons Learned from NC

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- **Building capacity in primary care can yield cost savings and improved quality**
  - Regional structure to convene practices and deploy practice support staff
  - Support practices with care management team for complex patients
  - Provide meaningful data to primary care practices
- **IT Infrastructure is Key**
  - Targeted analytics drives efficient care management
- **Healthcare is Local**
  - Regional collaborations between PCPs, hospitals, behavioral health, and community providers
- **HHs are an opportunity to test new payment models**

NC: Where Are We Going?

- **Shifting from Fee for Service to risk based payments**
- **Medicaid Reform legislation**
  - House and Governor
    - Regional ‘Provider Led Entities’
    - Capitation
    - Build on primary care infrastructure
  - Senate
    - Commercial Managed Care Organizations
- **CCNC:**
  - Stay in place during transition and support system change
  - Collaborate with PLEs and MCOs