Medicaid Reform

Presentation to the NC Medical Care Commission

Brown Building, Dorothea Dix Campus

Raleigh

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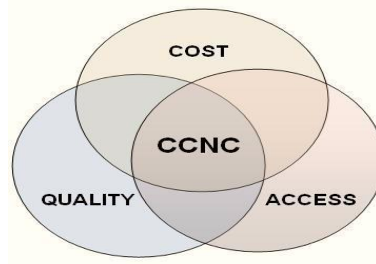
Disclaimers

- *I do not work for the Division of Medicaid Assistance (DMA) and can not speak on its behalf.*
- *My employer, Community Care, is a contractor to DMA.*
- *Between my time at DMA and Community Care, I spent 5 ½ years at a national, non-partisan health foundation – working with state health policymakers.*

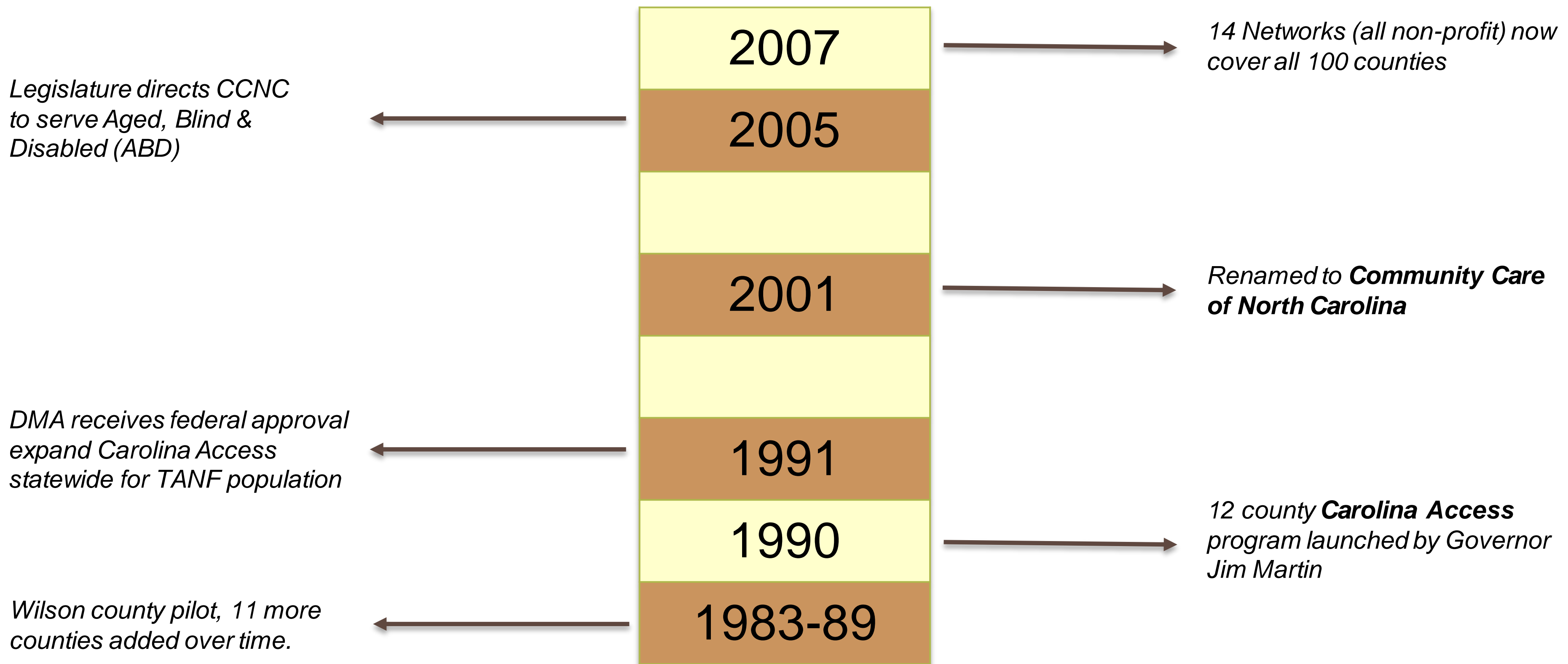
What is Community Care?

- Federal regulations identify two types of “managed care” for Medicaid: Primary Care Case Management (PCCM) and capitated managed care.
- NC’s contract with the federal government identifies us as their PCCM provider.
- We are a community-based, physician-led medical home model that coordinates care, ensures patients receive optimal care and avoids unnecessary services (e.g., ED visits, hospitalizations, Rx).

- We use health informatics to target the most at-risk (impactable) patients.
- Medicaid savings are achieved in LOCAL partnership with doctors, hospitals and other health providers.
- <u>100 percent of all savings remain in the state.</u>
- It is a national award-winning, best-practice model.



Key Dates: *From a Pilot to Carolina Access to Community Care of North Carolina (CCNC)*



A North Carolina-based Solution

What Do We Influence?

Community Care

primary care

hospitals & emergency departments

referrals to specialists

medications

< 45% of total Medicaid claims spending

We have minimal influence over the utilization of these services:

personal care services

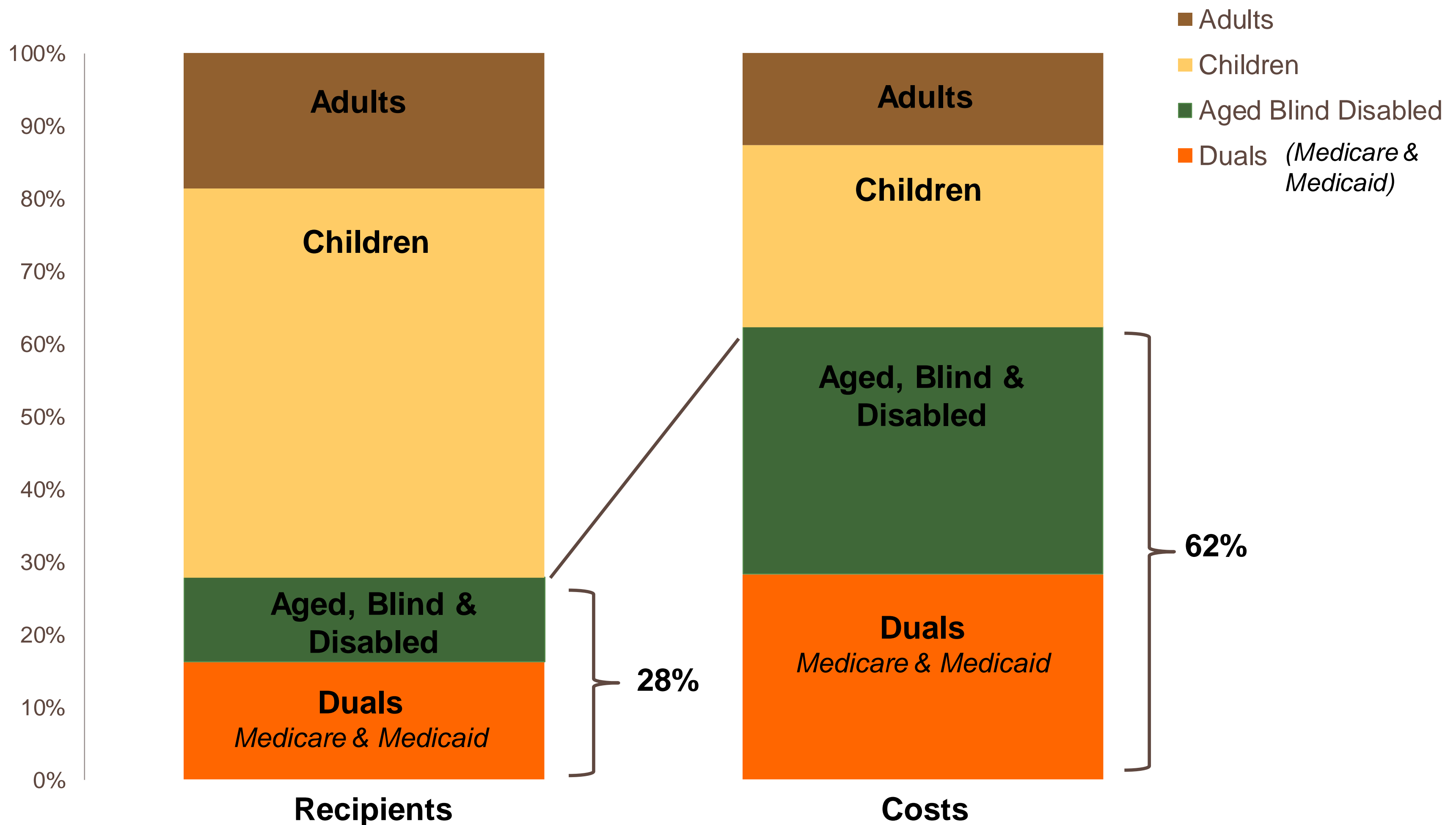
nursing homes & other LTC settings

diagnostic testing

behavioral health care

medical equipment

A Small Number of Medicaid Recipients Are Responsible for a Disproportionate Share of Costs



Source: CCNC Informatics Center

Who Do We Serve?

- **1.4 million Medicaid enrollees (~80% of Medicaid population)**
  - Nearly all Infants and Children
  - Nearly all Moms/Parents
  - Most, but not all, Aged, Blind & Disabled (ABD)

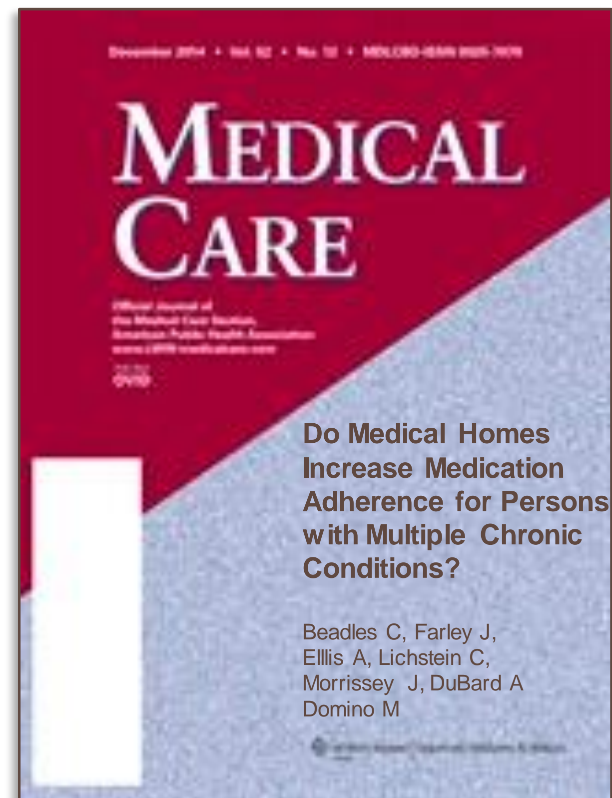
- **Groups NOT covered:**
  - Skilled Nursing Facility (SNF) residents
  - Approximately 195K “duals” and 66K ABD

What Have Been Our Results?

Improved Medication Adherence for Chronic Conditions

Compared to non-enrollees, CCNC medical home enrollees have better medication adherence for **depression, hypertension, diabetes and hyperlipidemia**

- Proportion of Days Covered higher by **4.7, 6.0, 4.8, and 5.1 percentage points** respectively (p <0.001)
- Percentage of patients with good adherence (PDC >80%) consistently higher among CCNC enrollees



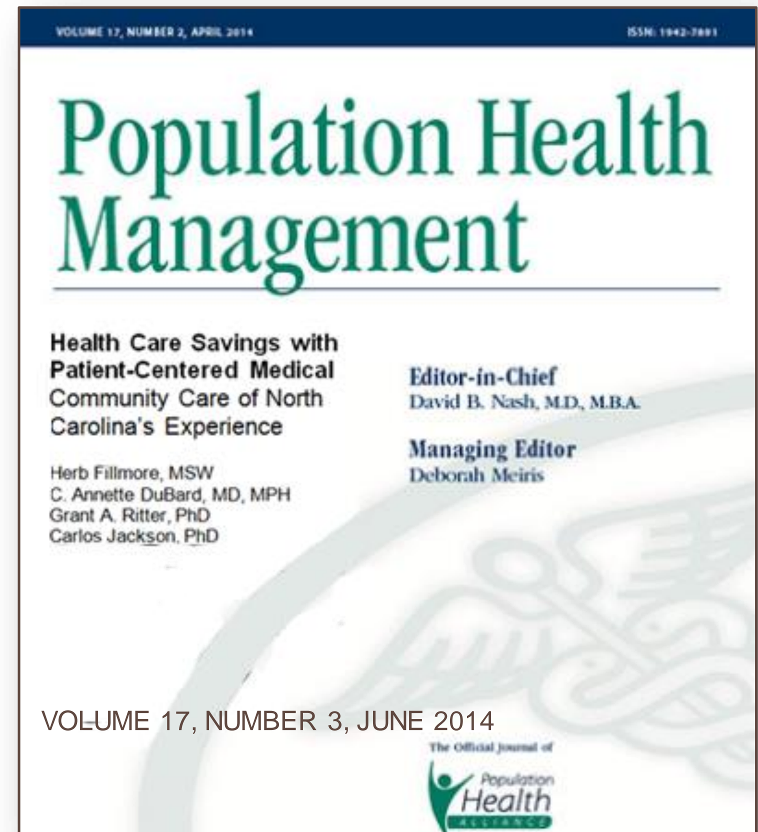
Peer-reviewed research

Cutting Costs for Highest Risk Recipients

- Significant savings for 169,667 non-elderly, disabled Medicaid recipients

- $184 million savings over 5 years

- Higher per-person savings for patients with multiple chronic conditions.



Outpatient Follow-up After Hospital Discharge

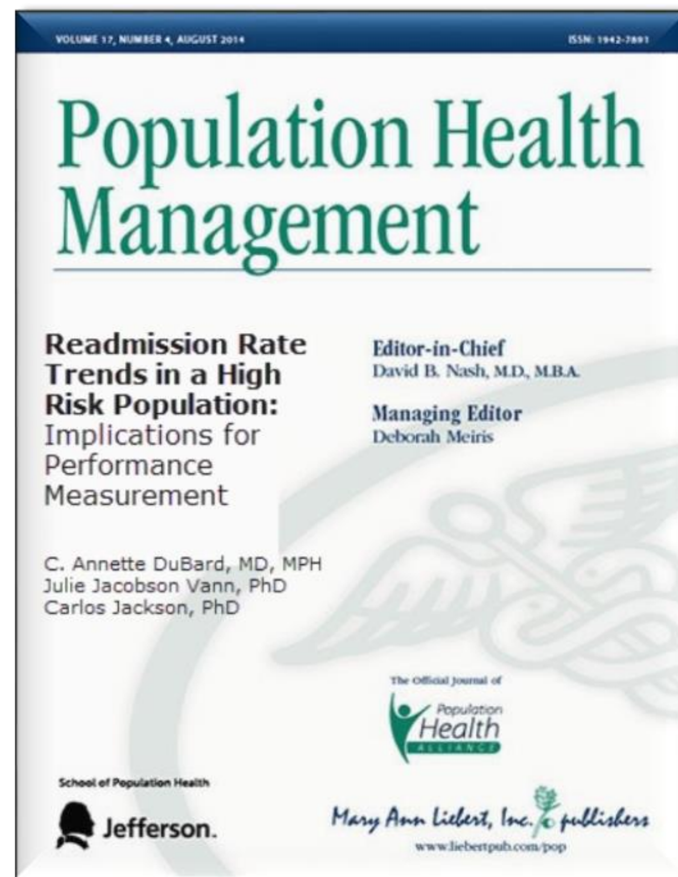
- Novel approach to using risk segmentation strategies to inform optimal timing of outpatient follow-up after hospital discharge
- Efforts should focus on assuring that highest risk patients receive follow-up within 7 days

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



Peer-reviewed report

Improving Quality of Care for Medicaid Recipients

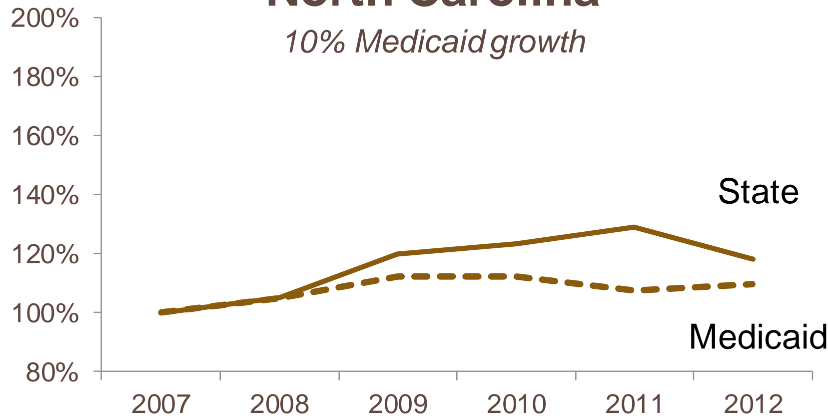
CCNC-enrolled Medicaid recipients **do better** than Medicaid recipients in managed care plans nationally in the care of:

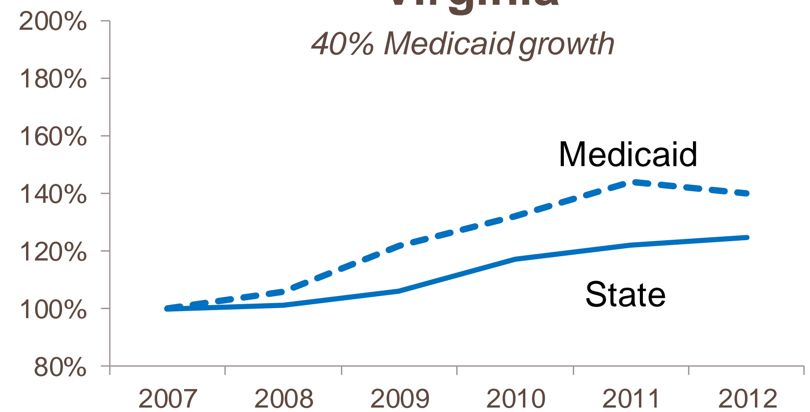
- Diabetes
  - ✓ A1C control (61% vs. 48%)
  - ✓ Blood pressure control (66% vs. 61%)
  - ✓ Cholesterol control (47% vs. 35%)
  - ✓ Attention to nephropathy (84% vs. 78%)
- Asthma
  - ✓ Appropriate medications (96% vs. 85%)
- Hypertension
  - ✓ Blood pressure control (64% vs 57%)
- Cardiovascular Disease
  - ✓ Cholesterol control (47% vs. 42%)

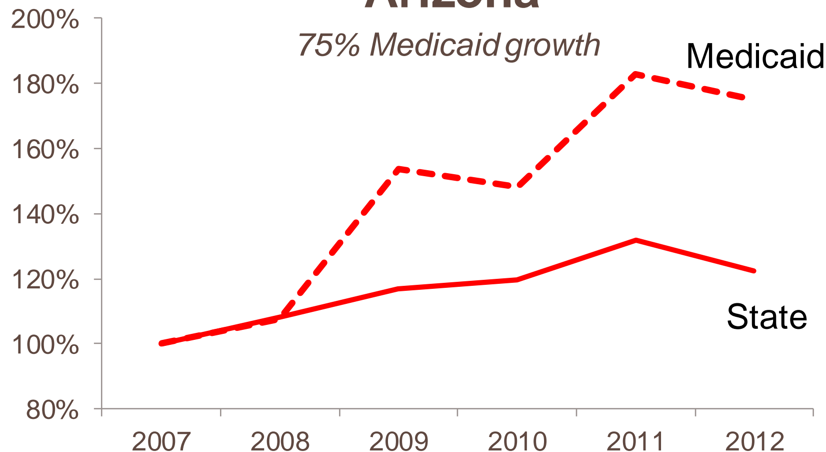
DuBard, CA. 2013 March-April; 74(2):142

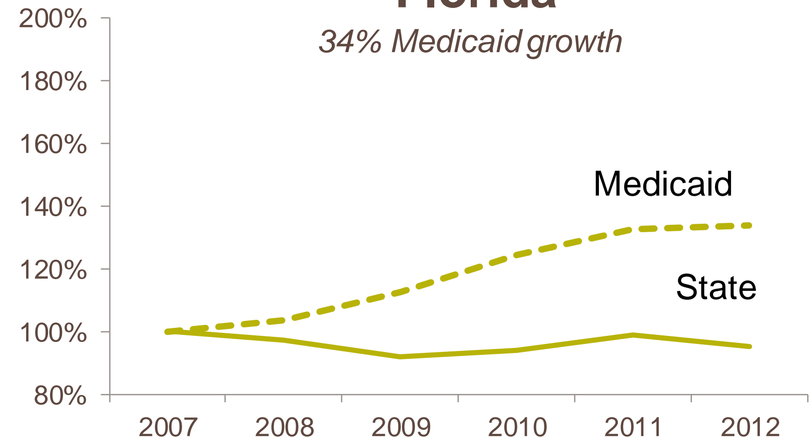
Comparison of Yearly Growth in Medicaid Expenditures from 2007

National Association of State Budget Officers (NASBO)





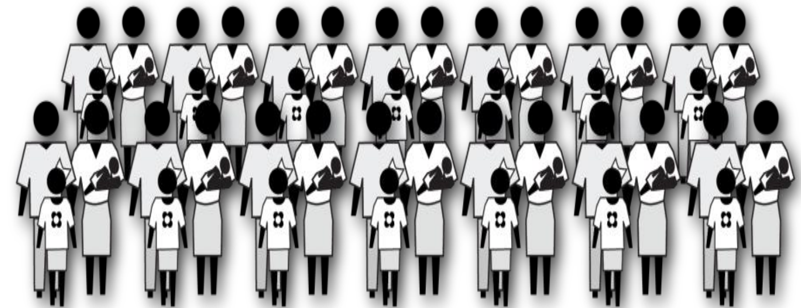




Source: NASBO "State Expenditure Report," released November 2013

The CCNC Statewide Footprint

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



- 1.4 million Medicaid patients

All 100 Counties

14 Networks

Each network averages:

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

Each Community Care Network Has:

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

Some Ideas/Suggestions

- Improve on what works (e.g., locally-grown medical homes/care coordination teams; use of health informatics)
- Fix what's broken (e.g., volume, not value-based payments; are there services needing more attention)
- Put the patient first
- Make sure any reform efforts are transformative, not disruptive

Thank You