Primary Care and CCNC: The Experience of One US State

Thomas C. Ricketts, Ph.D., MPH

The University of North Carolina-Chapel Hill

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North Carolina

- North Carolina (NC) historically, a poor, southern state
- Since 1970s a "Sunbelt" Technology Center
  - **Population 8,970,000**
  - **48,710 sq miles (127,000 km²)**
  - **Poverty Rate 19% (US 17%)**
  - **Infant Death Rate 8.6/1000 (US 6.8)**
  - **113 hospitals, 19,100 physicians 85,000 registered nurses**
  - **8,200 primary care physicians**
  - **6 University Hospital Systems (CHUs)**
    - Duke, UNC, ECU, Wake Forest, Carolinas Medical, Mission.

Context: Primary Care Structure NC

Practitioners

- Family Physicians
  - **N=3,000**
- General Internists
  - **N=3,000**
- Pediatricians
  - **N=1,500**
- Nurse Practitioners
  - **N=1,300**
- Physician Assistants
  - **N=1,400**

Structures

- Small Practice Offices
  - **N=800**
- Clinics (multispecialty)
  - **N=400**
- Federal Clinics
  - **N=50**
- Rural Health Centers
  - **N=85**
- University Clinics
  - **N=10**
- Veterans Clinics
  - **N=8**

Populations

- Private Insured (incl state employees)
  - **N=4.5 million**
- Medicare
  - **N=1.25 million**
- Medicaid
  - **N=1.3 million**
- Uninsured
  - **N=1.4 million**
- Veterans
  - **N=200,000**

Context: CCNC Structures

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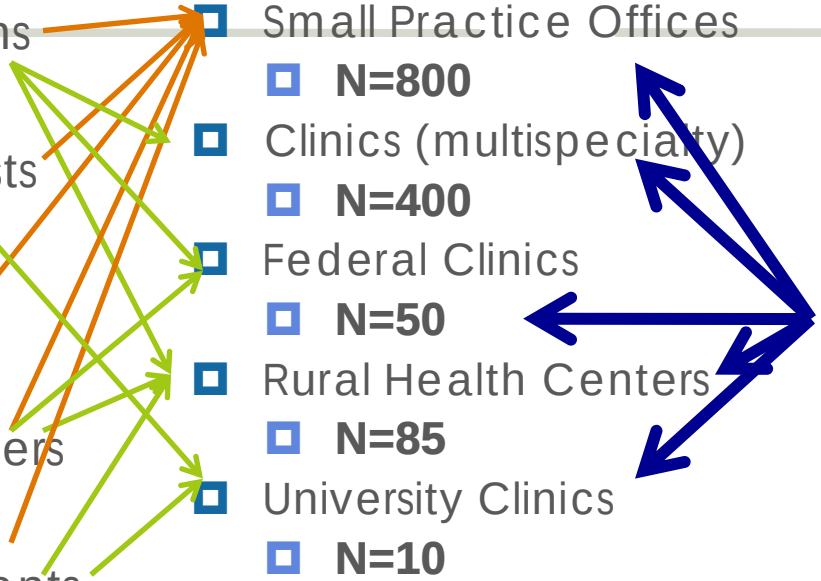


Medicaid in NC

- Funded by State of NC ***and*** US Federal Government
  - **Federal (National) law controls, pays states 50-80%**
  - **Center for Medicare and Medicaid Services (CMS applies rules)**
  - **States must cover some groups, have options for other**
  - **NC General Assembly chooses options, appropriates $9 BILLION (63% federal funds)**

Medicaid: Key Program for SPECIAL Populations

- State-Federal program to provide medical care for low income and CATEGORIES of people
  - **Women and children below 200% of poverty**
  - **Low income people qualified for Medicare (shared)**
  - **Blind and disabled**
  - **Recipients of cash assistance programs**

Medicaid Goals/Mechanisms

- To cover health care costs for certain low-income or disabled groups
- NOT an insurance system for poor people (CMU)
- Not a unified national system, but a state-federal "partnership"
- Costs are growing faster than Medicare

Community Care of NC: CCNC

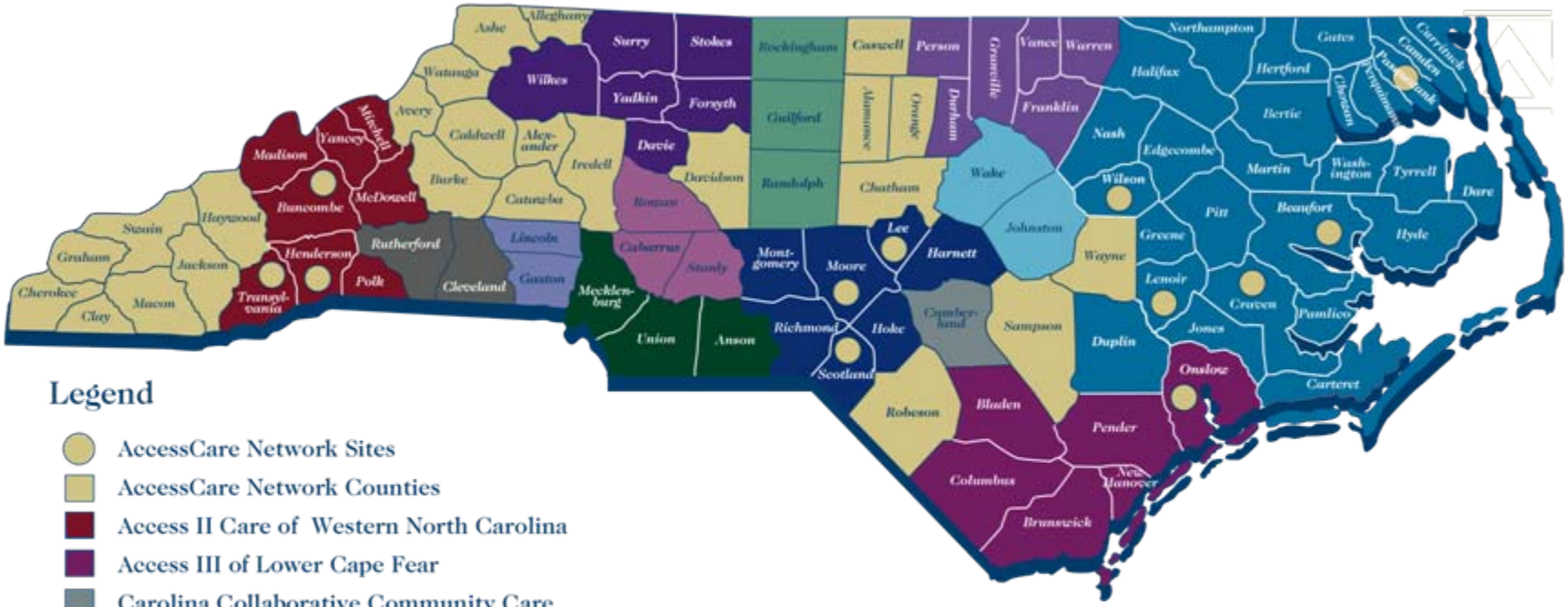
- Developed by **LOCAL** physicians in cooperation with entrepreneurial **STATE** bureaucrat (Jim Bernstein)
- Allowed by CMS as a “Waiver” program
- 77% of 1.4 million Medicaid **eligibles** are enrolled in CCNC

CCNC key features

- **Networks of physicians and**
- Per Member Per Month payment to Network
  - **$2.50 for case management**
  - **+$3.00 for population health activities for AFDC**
  - ***OR,* $5-$8 for intensive cases (disabled)**
- Program must demonstrate cost reductions
- 14 community networks, 3,500 physicians in 1,200 practices, 913,000 enrolled patients.

Community Care of North Carolina

Access II and III Networks

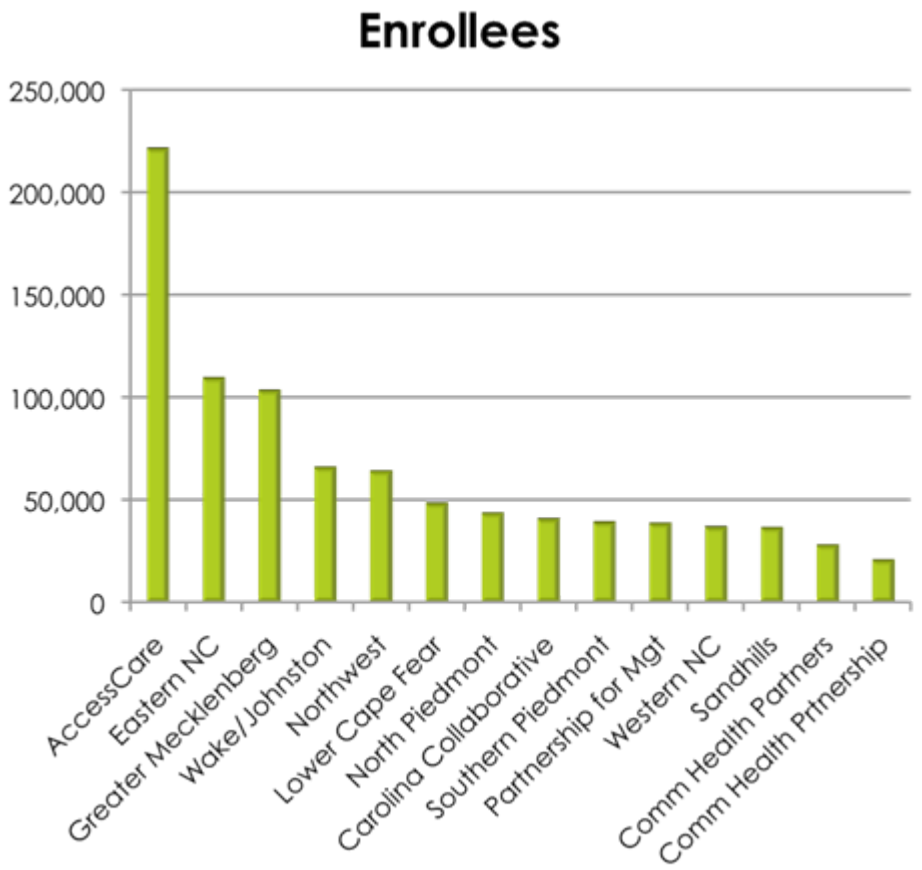


Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western North Carolina
- Access III of Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake / Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan

CCNC Networks

- Scope of Networks
  - **Smallest: 20,386 enrollees (2 rural counties)**
  - **Largest: 220,864 enrollees (Spread across the state in a loose network held together by an academic system, UNC Health)**
  - **Largest Local: 103,053 enrollees (focused on two urban counties and one adjacent rural county)**



What A Network Does

- Assumes responsibility for primary care of Medicaid recipients
- Identifies costly patients and services
- Develop and implement plans to manage utilization and cost (e.g., Emergency Department visit follow up, pharmacy use)
- Support chronic disease care (Disease Management overall, Asthma, congestive heart failure);
- Support ongoing quality improvement process

CCNC State/Central Infrastructure

- Care Management Information and resources
- Case Management Training for nurses/MDs
- Medical Director/Network Director meetings
- Population/Disease Management Support
- Statewide audits of quality of care
- Design and Support for new pilot programs

Schema for CCNC

I. *Clinical Directors Group STATEWIDE*

- Select targeted diseases/care processes
- Review evidenced-based practice guidelines
- Define the program
- Establish program measures

- ASTHMA
- DIABETES
- PHARMACY
- HIGH-RISK & -COST
- ED
- HEART FAILURE

II. *Local Medical Mgmt. Comm.*

- Implement state-level initiatives
- Develop local improvement initiatives

- GASTRO-ENTERITIS
- FEVER
- OTITIS MEDIA
- DEPRESSION
- CHILD DEVELOPMENT
- LOW BIRTH WEIGHT
- ADHD
- CAP-C
- CHRONIC CARE
- MENTAL HEALTH
- DIABETES DISPARITIES
- DENTAL VARNISHING
- OBESITY

III. *PRACTICE A* | *PRACTICE B* | *PRACTICE C*

Care Managers and CCNC quality improvement staff support clinical management activities

Process

- CCNC Clinical Directors
  - **Select targeted disease with evidence for effectiveness of interventions**
  - **Define PROGRAMS (diabetes, asthma, emergency room, pharmaceuticals, heart failure, other)**
  - **Establish criteria for measurement**
- Each network has Medical Director and Management team that determines implements **PROGRAM**
- Team determines priority for LOCAL network or PRACTICE

Impact on Family Medicine Practices (small physician offices)

- Average patient panel per physician—2400 patients
- Average % Medicare—20% (480 patients)
- **Average % Medicaid—9% (216 patients)**

Yearly impact of $2.50 pmpm, Medicaid—$6,480 per physician (average income per physician $170,000)

Other incentives may come in future:

Medicare Medical Home

Pay for Performance

Practice Profiles as Feedback

COMMUNITY CARE OF NORTH CAROLINA

IMPORTANT UPDATE

ACCESS II & III

YourProgram Profile

Community Care Peer Review Summary

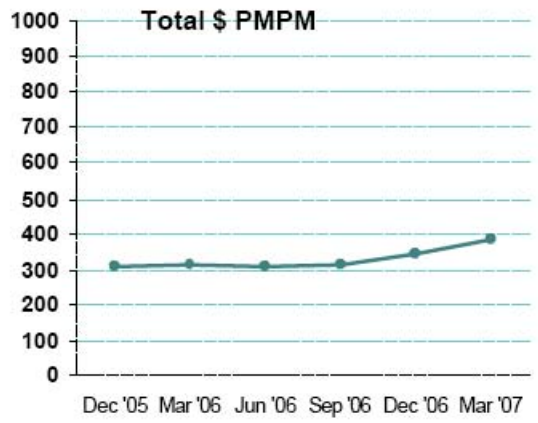
Time Period: Quarter ending Mar, 07

Managed Care Provider Type: Community Care of North Carolina

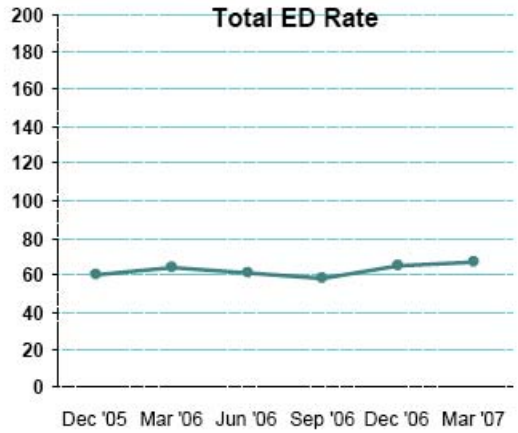
Avg. Monthly Enrollment: 743827

Eligibility 0 - 21: 576642

Eligibility > 21: 167185



CCNC ($) 310 313 310 312 344 386



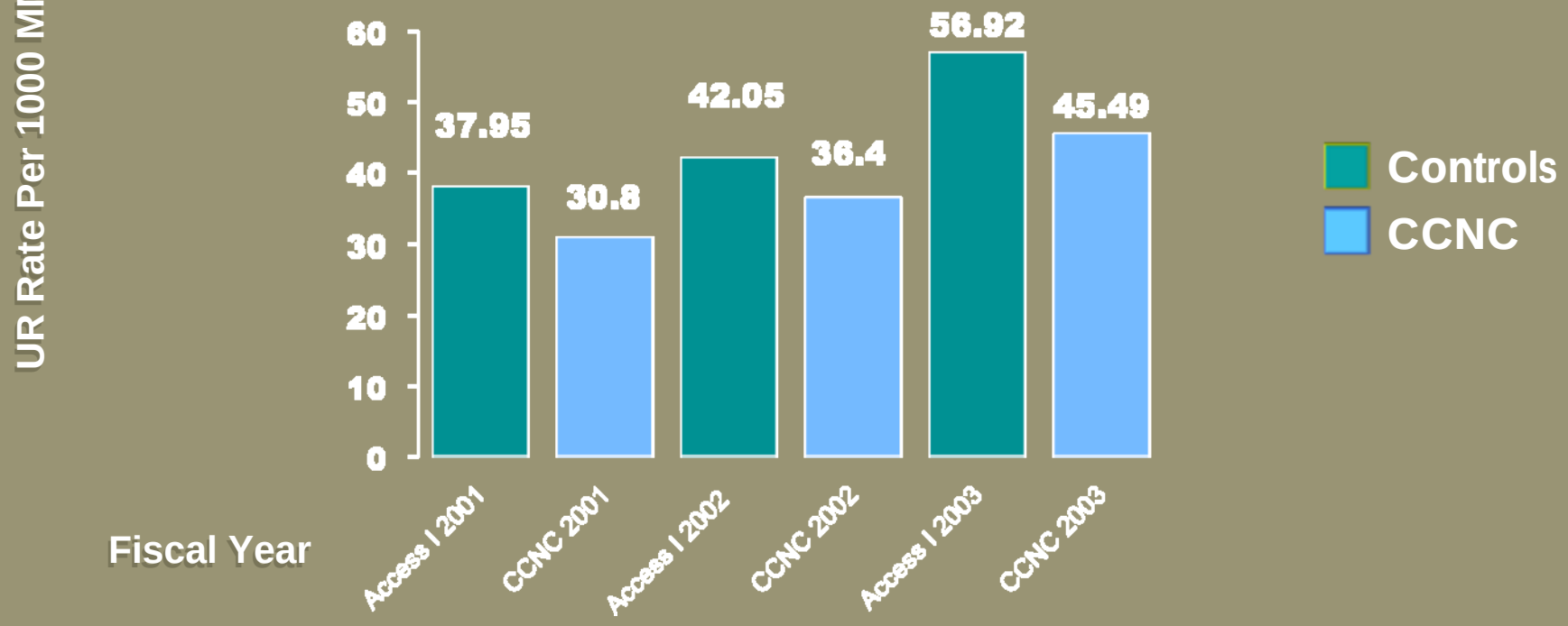
CCNC Rate 60 64 61 58 65 67

Utilization	CCNC Qtr End 9/06		CCNC Qtr End 12/06		CCNC Qtr End 3/07	
	Rate	PMPM	Rate	PMPM	Rate	PMPM
PCP	266	$18	314	$20	326	$21
Specialist	143	$20	150	$20	165	$22
Hospital Inpatient	6	$32	7	$32	7	$34
Hospital Outpatient	91	$31	92	$32	96	$28
Pharmacy	835	$60	949	$68	996	$72
ED Total	58	$18	65	$20	67	$20
ED Non emergent	33	$8	40	$9	43	$10
Labs	48	$2	46	$2	50	$2
X-Rays	4	$2	4	$2	4	$2
Out-patient Mental Health	62	$7	66	$7	200	$99

CCNC—Outcomes

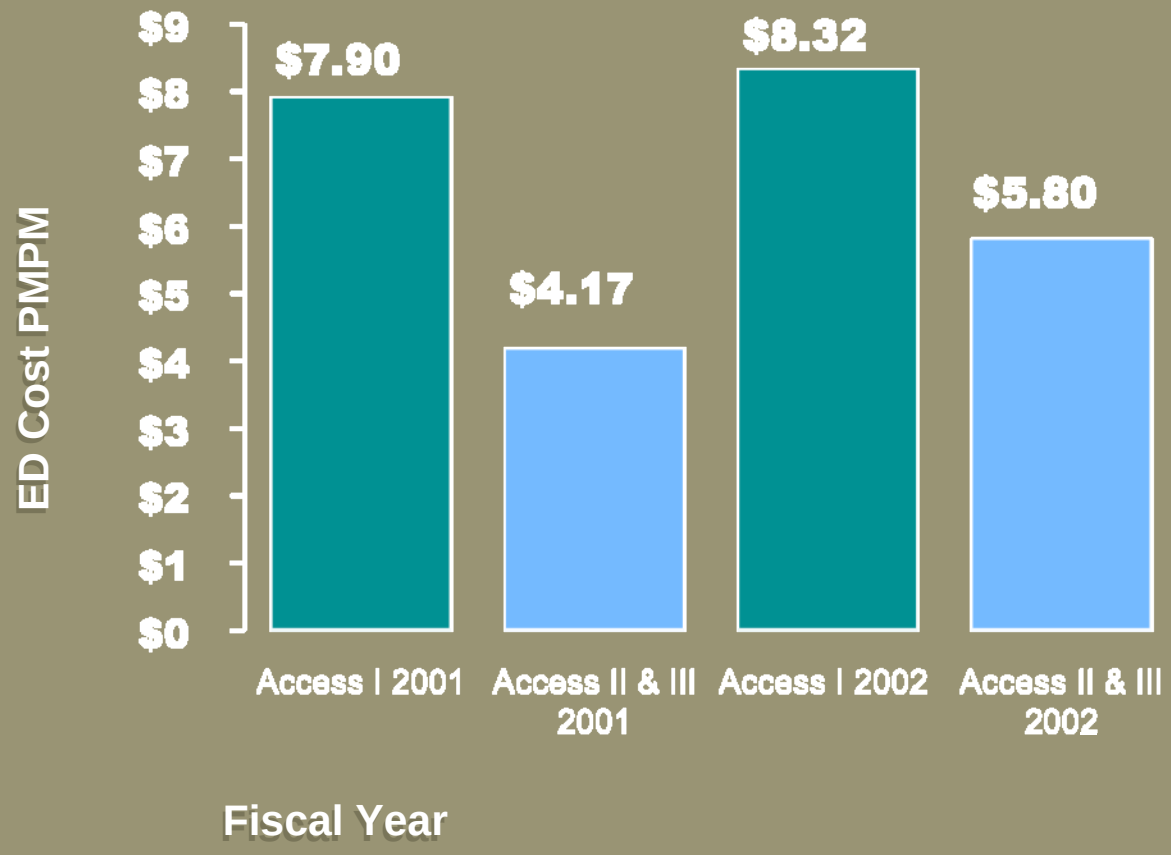
Emergency Department ED Use

ED Utilization Rate – 7/1/01 – 6/30/03 – Children < 21 years



ED Initiative

ED Cost PMPM – 7/1/01 – 6/30/02 – Children < 21 years



Savings Calculation

(Access I PMPM – Access II-III) x Access II-III Enrollment

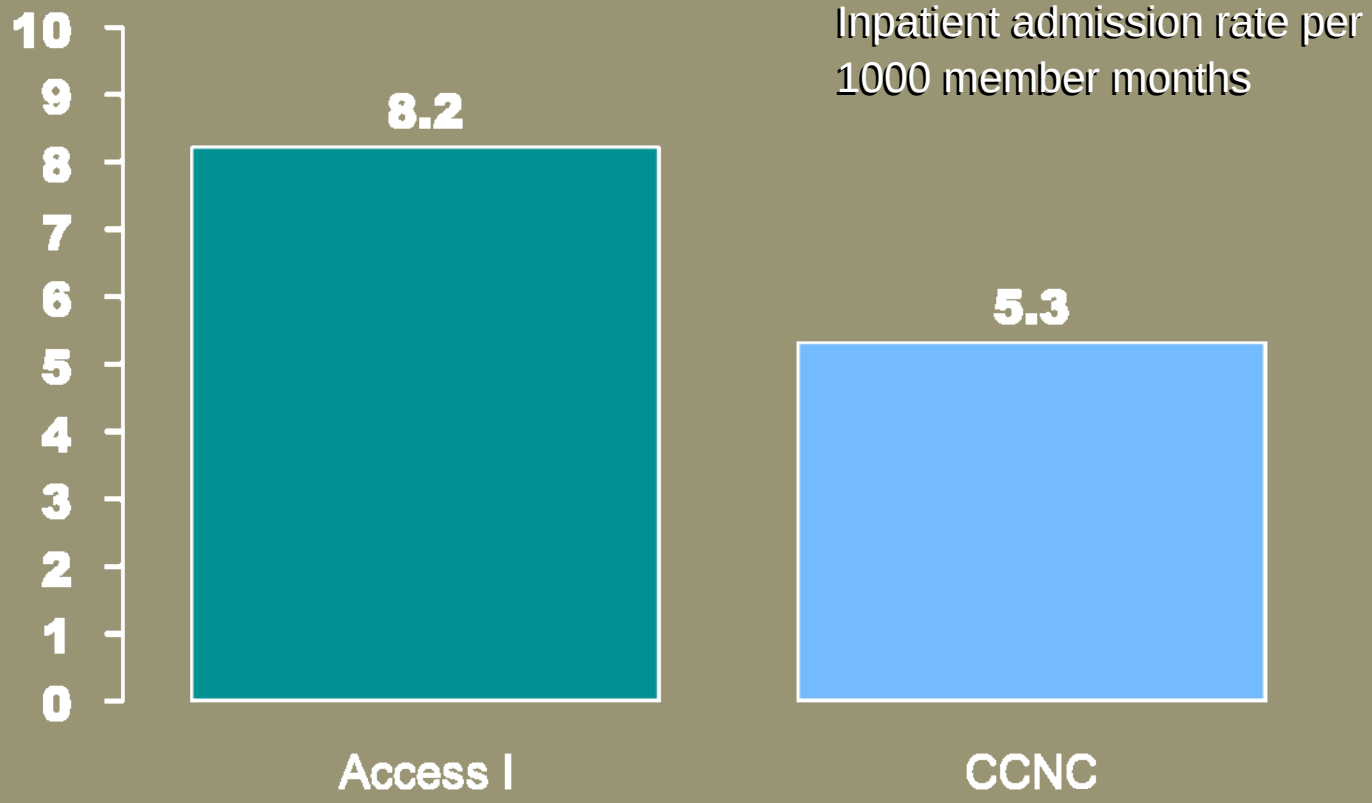
Total Savings – '01-'02
$10,362,190

Controls
CCNC

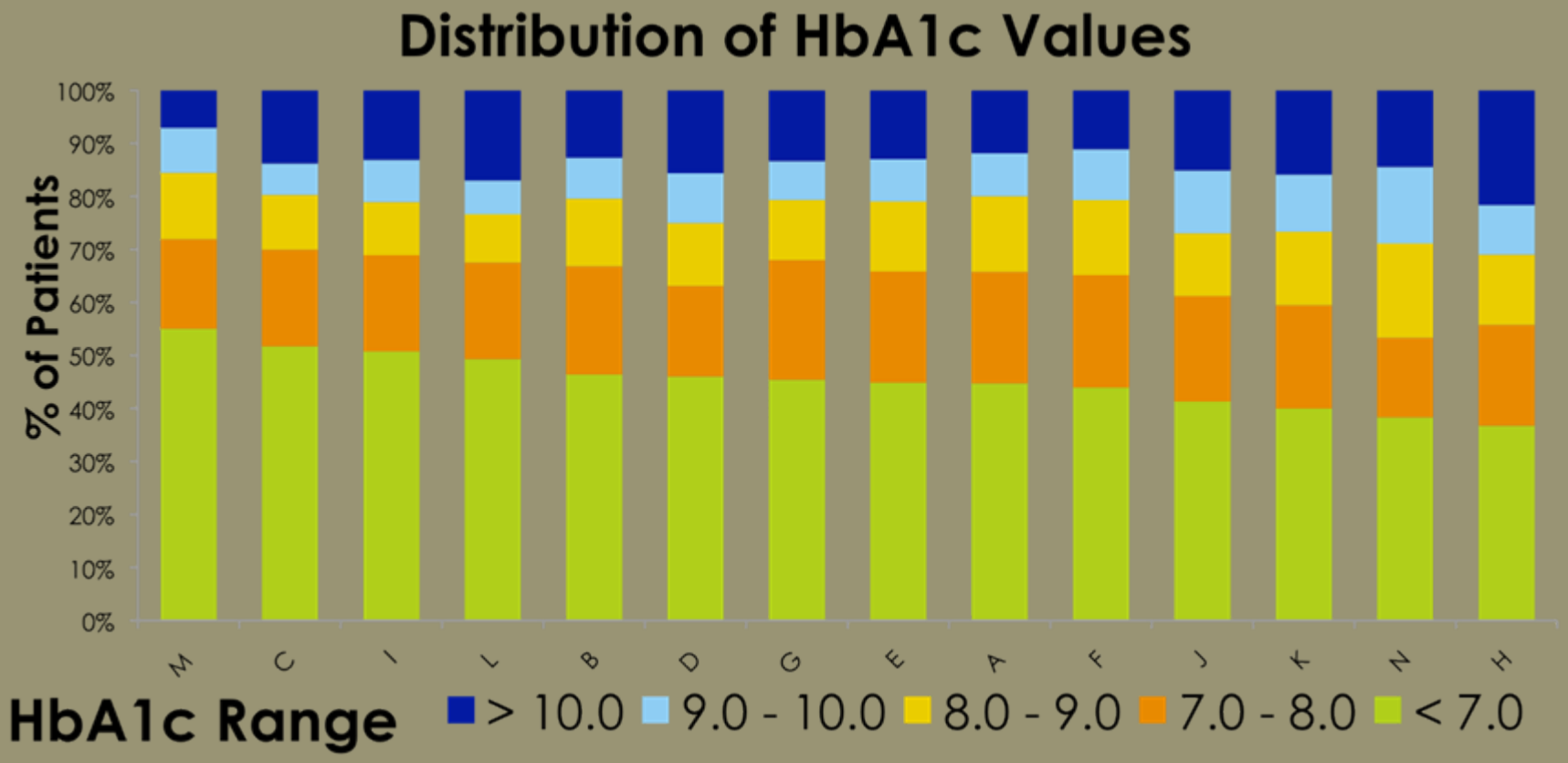
Asthma Initiative

Pediatric Asthma Hospitalization Rates

April 2000 - December 2002



Diabetes—Network Comparisons



Costs Savings: Controversy

- CCNC has an actuary estimate "savings" based on costs per member per month for patients.
- Mercer (private actuary) Extrapolates to all enrollees
  - **Estimates "Savings" of $240,000,000 (2006) on total program costs of $9,012,613,680 (2.67%)**
  - **Mercer estimates drop to $147,000,000 in 2007**
  - **Extrapolates experience of chronic care results to acute care**
  - **Other, case by case analysis estimates savings of perhaps $30,000,000 based on case-match methodology**

Summary

- CCNC shows how a FLEXIBLE structure based on primary care can reduce costs and improve outcomes
- It is an evolutionary program tied to one funding structure-Medicaid but affects practice structure for more patients

Primary Care and Health Reform

- Primary Care the '**Fundamental Building Block**' for Health Care Reform
- Its identity is now combined with the Patient Centered Primary Care **MEDICAL HOME** Concept
- CCNC considered national “Model”

Patient-Centered Primary Care COLLABORATIVE

AAFP

Carolina Public Health Solutions

Thomas C. Ricketts, Ph.D., MPH

The University of North Carolina-Chapel Hill

ricketts@schsr.unc.edu

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