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

Tom Wroth, MD, MPH

Community Care of North Carolina
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
Complex patients drive ER usage*

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

Prevalence of Chronic Illness

- Chronic illness indicator: 86%
- Hypertension Indicator: 65%
- Diabetes Indicator: 35%
- COPD Indicator: 29%

Prevalence of Mental Health Issues

- Mental health indicator: 83%
- Depression indicator: 59%
- Substance abuse indicator: 48%
- Bipolar indicator: 33%
- Schizophrenia/schizoaffective disorder: 21%

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- 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

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
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
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

All 100 NC Counties

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

14 Networks

Each network averages:
- 1.4 Medical Directors
- 42.8 Local Case Managers
- 1.8 Pharmacists
- 1.0 Psychiatrist
Local Network: Wake & Johnston

- 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:

- 11 FTEs dedicated to WakeMed
- 9 Registered Nurses/SW
- 2 Patient Coordinators
Population Health Management: A Step-by-Step Approach

Define the population
- Medicaid patients enrolled with practice

Diagnose the population
- ED utilization rate compared with peers

Treat the Population
- Expand hours
- After hours advice
- Patient education

Measure Performance
- Risk adjusted ED Utilization Rate
CCNC Impact and Results

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

Higher is better!

- **Cholesterol Control LDL < 100**
  - CCNC: 35%
  - National: 47%

- **Blood Pressure Control < 140/90**
  - CCNC: 66%
  - National: 61%

- **A1C Control < 8.0**
  - CCNC: 48%
  - National: 61%

- **Nephropathy Screening**
  - CCNC: 84%
  - National: 78%

- **Cholesterol Control LDL < 100**
  - CCNC: 47%
  - National: 42%

- **Blood Pressure Control < 140/90**
  - CCNC: 57%
  - National: 64%

>10,000 more North Carolinians with good diabetes control

>11,000 more North Carolinians with good blood pressure control
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

 OPPORTUNITY

CCNC-Enrolled

Unenrolled

2008 2009 2010 2011 2012
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
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

- 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.

Population Health Management
Health Care Savings with Patient-Centered Medical Community Care of North Carolina’s Experience

Editor-in-Chief
David B. Nash, M.D., M.B.A.
Managing Editor
Deborah Meiris

The Official Journal of Population Health Alliance
Lessons Learned from NC

- 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