An Update on Community Care of North Carolina's Medicare Demonstrations

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To enhance the impact of Community Care of North Carolina (CCNC)'s population health initiatives, CCNC partnered with the US Centers for Medicare and Medicaid Services to bring persons who are dually eligible for both Medicaid and Medicare, as well as Medicare beneficiaries, into CCNC's system of medical homes and community-based care management supports.

Community Care of North Carolina (CCNC) was established in 1998 to improve the quality, use, and cost-effectiveness of care for Medicaid recipients in North Carolina. CCNC's 14 networks and 1,400 primary care medical homes now serve more than 1 million Medicaid recipients. In 2006, the decision was made to add new populations to CCNC's system of medical homes and community-based care management supports. The primary reason for the expansion was simple: if CCNC could achieve measureable improvements in care for Medicaid recipients, how much greater impact was possible if the CCNC population-management system was adopted by other payers?

Physicians and other health care providers typically deal with myriad insurance and health plans, each with their own set of guidelines, utilization management requirements, incentives, supports, and reports. Rarely does a plan have a sufficient number of a practice's patients to achieve the impact intended or even to capture the physician's attention. On the other hand, if a majority of a practice's patients could come under a common set of guidelines, expectations, incentives, and supports, better attention would be paid and, potentially, greater improvements in care could be achieved.

To begin to test this enhancement approach, CCNC sought to partner with the US Centers for Medicare and Medicaid Services (CMS) to bring North Carolina individuals who are dually eligible for Medicare and Medicaid (hereafter, "dual-eligible individuals") and North Carolina Medicare beneficiaries into CCNC. An initial partnership began in 2006, with the Medicare Health Care Quality Demonstration, commonly known as the 646 Demonstration; a second began in 2010, with the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration; and a third began in 2011, with the Affordable Care Act Initiative–State Demonstration to Integrate Care for Dual Eligible Individuals. What follows is a brief update on these 3 initiatives.

646 Demonstration

The 646 Demonstration, which takes its common name from the section of the Medicare Prescription Drug, Improvement, and Modernization Act from which it derived its statutory authority, was designed to improve the quality and efficiency of care for Medicare beneficiaries by means of health care system redesign. Because the CMS required that the organizations participating in the demonstration be nongovernmental, the 14 community care networks of CCNC established a new nonprofit entity, North Carolina Community Care Network, to represent them in the application process. North Carolina Community Care Network applied in the second round of requests for proposals issued by the CMS on September 29, 2006. North Carolina Community Care Network received final approval of its demonstration agreement and protocol in November 2009. On January 1, 2010, North Carolina Community Care Network began participation in the 5-year demonstration.

During years 1 and 2 of the demonstration, CCNC is to manage approximately 42,000 dual-eligible beneficiaries who receive care at 196 CCNC practices in 26 counties. It is estimated that 170,000 Medicare-only beneficiaries who receive care from the 196 practices will be added to the demonstration at the beginning of year 3. During years 3-5, CCNC will manage approximately 212,000 Medicare-only and dual-eligible beneficiaries. The exempt, intervention, and holdout counties are shown in Figure 1. Exempt counties were excluded from participation in the 646 Demonstration because they were part of another demonstration. Counties that were not in the demonstration nor exempt from participation were labeled "holdout" counties.

The demonstration has an out-of-state comparison group composed of beneficiaries receiving a qualifying service from a primary care practice in a comparison county. For comparison purposes, 78 counties, in the following 5 states, that matched the characteristics of North Carolina's 26 intervention counties were selected: Georgia (18 coun-

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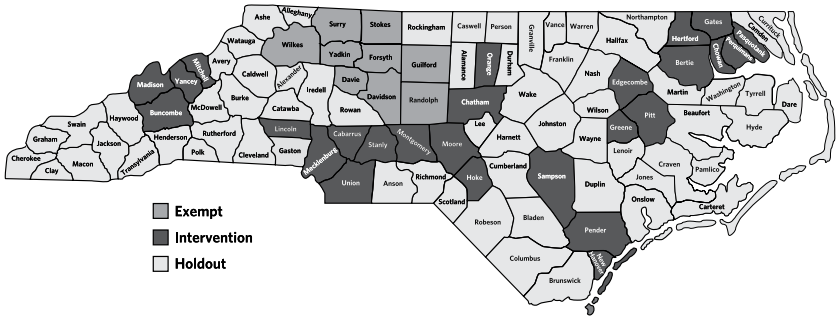
FIGURE 1.
Participation in the Medicare Health Care Quality Demonstration Among North Carolina Counties



Note. Exempt, counties excluded from participation because of involvement in another demonstration; holdout, counties other than exempt or intervention counties; intervention, counties participating in the demonstration.

ties), Kentucky (19 counties), South Carolina (12 counties), Tennessee (19 counties), and Virginia (20 counties).

The size and complexity of the dual-eligible population, in terms of physical health, mental health, and socioeconomic needs, necessitate special mechanisms for identifying patients most appropriate for care management interventions. The use of historical claims data to screen patients for care management intervention can greatly improve the efficiency of the care team. North Carolina Community Care Network received the first Medicare A and B data files from the CMS in November 2010. These data are being used to identify the dual-eligible individuals managed in the 646 Demonstration, to track claims-derived performance measures, and to determine quality improvement outcomes. We are also able to identify patients who meet specified criteria for further screening by a care manager, according to patterns of service use (such as multiple emergency department and in-patient visits, multiple medications, lack of primary care physician contact, target medical conditions, and high cost) during the previous 12 months. Approximately 8% of the target population was identified as highest priority for care management (as of March 1, 2011).

Quality measures are aligned with CCNC's Chronic Care Program, such as measures for diabetes, hypertension, and congestive heart failure. In year 1, 50% of the savings are contingent on meeting quality-of-care objectives. Each subsequent year, the percentage of savings contingent on meeting quality-of-care objectives increases by 10%, until year 4, when it caps at 80%.

The quality improvement performance measures for years 1 and 2 of the demonstration are shown in Table 1. Some performance measures are collected from claims data, whereas others are collected through on-site annual chart reviews. In 2010, North Carolina Community Care Network contracted with North Carolina Area Health Education Centers to perform chart reviews on a sample of the individuals managed in the 646 Demonstration, and chart reviews will continue to be performed for samples of individuals in subsequent years of the demonstration.

We have already seen several best-practice models emerge from the network's early work with the demonstration population. The first model involves home visits to patients by care managers. Many of the care managers perform home visits after a patient is discharged from the hospital, to promote self-management skills, such as assisting patients in making needed follow-up medical appointments, as well as performing medication reconciliation in consultation with the network pharmacist. Consultations with the primary care provider, hospital, and network pharmacist take place when potential medication errors are identified.

The second model addresses care management in adult care homes. One large, multisite federally qualified health center has developed an integrated care management service to help manage the dual-eligible individuals in the 646 Demonstration and the chronic care populations residing in adult care homes. The program is designed to facilitate, in partnership with the participating adult care homes, improved care management for these patients through better assessment, communication, and follow-up in the homes.

In a third model, some large-volume 646 Demonstration practices are performing group medical visits for selected chronic care patients.

A fourth model consists of a nursing home initiative. Five percent of the dual-eligible individuals in the 646 Demonstration reside in nursing homes. One network has embedded care managers in nursing homes. These managers review hospital admission data and work with the nursing homes to reduce preventable readmissions (eg, for falls and dehydration).

A fifth model involves training in palliative care. Along with symptom management, palliative care emphasizes open communication and emotional and spiritual support for the patient and their family. In this way, palliative care offers patients increased autonomy and the best-possible

TABLE 1.
Quality Improvement Performance Measures for Years 1 and 2 of the Medicare Health Care Quality Demonstration

Source, variable/condition, measure	Year 1 measure	Year 2 measure
Claims data		
Diabetes care		
Hemoglobin A_{1C} testing	Yes	Yes
Lipid profile	Yes	Yes
Retinal examination[a]	Yes	Yes
Foot examination	Yes	Yes
Smoking status	Yes	Yes
CHF		
Left-ventricular failure assessment	Yes	Yes
ACE inhibitor and/or ARB therapy[b]	Yes	Yes
Beta-blocker therapy	Yes	Yes
Smoking status	Yes	Yes
Blood pressure control	Yes	Yes
Ischemic vascular disease		
Lipid measurement	Yes	Yes
Blood pressure control	Yes	Yes
Aspirin use	Yes	Yes
Smoking status	Yes	Yes
Hypertension		
Blood pressure control	Yes	Yes
Smoking status	Yes	Yes
Onsite annual chart review		
Transitional care		
Readmission rate	Yes	Yes
Percentage of patients hospitalized for CHF who have an outpatient visit ≤30 days after discharge	Yes	Yes
Patient safety		
Medication reconciliation[c]	No	Yes
Percentage of discharged patients receiving transitional care	No	Yes
Congestive heart failure		
Body weight during most recent clinic visit	No	Yes
Diabetes care		
Nephropathy status	No	Yes
Hemoglobin A_{1C} level <8%	No	Yes
Diabetes and hypertension		
ACE inhibitor and/or ARB therapy	No	Yes
Chronic obstructive pulmonary disease		
Smoking-cessation counseling	No	Yes
Total measures, no.	18	25

Note. ACE, angiotensin converting enzyme; ARB, angiotensin receptor blockers; CHF, congestive heart failure.
[a]Including dilation of the eyes.
[b]The measure evaluates the percentage of patients with an ejection fraction of <40% who are prescribed ACE inhibitors or ARBs.
[c]Formally referred as "pharmaceutical therapy management improvement, noninstitutional."

quality of life during serious illness. CCNC is providing palliative care training to the providers and care managers identified in all networks.

Since the implementation of the demonstration and the receipt of the Medicare data, CCNC has had the opportunity to learn more about the health status of dual-eligible individuals and to test different improvement strategies. CCNC expects to receive preliminary quality and cost-savings findings from the CMS by the end of 2011.

MAPCP Demonstration

The Division of Medical Assistance of the North Carolina Department of Health and Human Services, in partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC), the State Health Plan for Teachers and State Employees, and CCNC, has been selected to participate in the CMS-sponsored MAPCP Demonstration. North Carolina is one of 8 states selected to receive this competitive award. The duration of the MAPCP Demonstration is 3 years. North Carolina will launch the demonstration in October 2011. This initiative provides an opportunity to bring the CCNC primary care medical homes and community-based care management system to Medicare recipients and individuals in 7 rural counties across North Carolina (ie, Ashe, Avery, Bladen, Columbus, Granville, Transylvania, and Watauga) who are privately insured by BCBSNC and the State Health Plan.

The primary goals of the demonstration are to improve quality and bend the cost curve by reducing the growth of spending and decreasing costs, through effective care management and coordination, while supporting a robust health information system. This demonstration will also provide an opportunity to examine the drivers of practice transformation necessary to successfully achieve a patient-centric system of care management delivery to improve population health. Emphasis is being placed on participating practices achieving National Committee for Quality Assurance patient-centered medical home (PCMH) recognition. Each of the payers in the demonstration has agreed to infuse resources to participating practices and networks, to expand and build the required capacity, and to develop a shared set of expectations. In exchange for the additional payer resources, participating practices and networks are expected to ensure that every patient has a primary care physician who assumes responsibility for the patient's care; to provide services for high-risk patients, such as care coordination, transitional support, disease management, and medication reconciliation; to work with key community partners, such as hospitals, who can provide data on admissions and emergency department visits and can collaborate in patient management to reduce emergency department visits and prevent inappropriate admissions and readmissions; to work together with physicians and other health providers to develop quality and care improvement initiatives, monitor performance, and measure goal attainment; to review performance from claims analysis and other available data

sources to drive practice improvement; to apply for National Committee for Quality Assurance PCMH recognition; and to participate in surveys, interviews, and focus groups for the purpose of evaluating the demonstration.

The CMS will contract with an outside evaluator to measure outcomes across all 8 of the participating states. The CMS evaluation will focus only on the public payers (ie, Medicare and Medicaid). The participating payers in the North Carolina demonstration will perform a joint program evaluation that addresses outcomes across all of the payers (ie, BCBSNC, the State Health Plan for Teachers and State Employees, Medicaid, and Medicare). The focus of the evaluation is to determine whether the medical home, when supported by Medicare, Medicaid, and private health plans, will (1) reduce unjustified variation in health care use and expenditures; (2) improve the safety, effectiveness, timeliness, and efficiency of health care; (3) increase the ability of beneficiaries to participate in decisions concerning their care; and (4) increase the availability and delivery of care that is consistent with evidenced-based guidelines.

State Demonstration to Integrate Care for Dually Eligible Individuals

On April 14, 2011, the CMS announced that 15 states would receive federal funding to "develop better ways to coordinate care for people with Medicare and Medicaid coverage, also known as dual eligibles, who often have complex and costly health care needs" [1]. North Carolina (through the North Carolina Division of Medicaid Assistance) is 1 of the 15 states. Under this demonstration, which will be administered by the new Federal Coordinated Health Care Office, participating states are expected to develop new ways to meet the complex and costly medical needs of dual-eligible individuals. The goal of this initiative is to eliminate duplication of care through improved coordination of Medicare and Medicaid services and to expand access to needed services while lowering costs. North Carolina's approach during the 12-month planning process is to build on the CCNC statewide infrastructure by partnering with long-term care providers, home and community-based providers, area agencies on aging, and other stakeholders to design, in concert with dual-eligible individuals and their families, health care delivery systems for dual-eligible individuals that can provide the right care at the right time; improve the health of the dual-eligible population; improve the quality, access, and reliability of care; and reduce the costs of care.

The complexity of the dual-eligible population, combined with the variety of living arrangements, requires targeted approaches to achieve lasting improvements in care and outcomes. North Carolina will build its integration strategy around the dual-eligible individuals' living arrangements—the home, the nursing home, and the adult care home. While there will be common approaches that cross living arrangements, particularly in the identification and management of chronic illnesses, each setting will have unique challenges requiring special strategies and partnerships. Subject to the availability of funds, successful planning efforts will be eligible for implementation funds. NCMJ

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