United States House of Representatives
Energy and Commerce Subcommittee on Health

Testimony of Denise Levis Hewson
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Community Care of North Carolina

June 21, 2011

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

Good afternoon Chairman Pitts, Ranking Member Pallone and distinguished members of the Subcommittee. I am Denise Levis Hewson, Director of Clinical Programs and Quality Improvement Community Care of North Carolina. Thank you for the opportunity to discuss our work with citizens dually eligible for Medicare and Medicaid in North Carolina enrolled in the Community Care Program.

What is Community Care of North Carolina (CCNC)?

Community Care is a collaborative organization comprised of regional networks of health care providers, physicians, hospitals, health departments, social service agencies and other community organizations. Each network is a nonprofit organization and CCNC is a separate nonprofit that serves as a “central office” coordinating efforts statewide and providing economies of scale for mutually-beneficial efforts like building robust data systems and supporting clinical and quality program implementation .

We create medical homes, matching each patient with a primary care provider who leads an interdisciplinary care team — professionals who coordinate seamless medical services aimed at producing better outcomes.

Our challenge is to cut costs without slashing fees or benefits – as limiting access to preventive and primary care can often have the opposite effect on cost as what is intended. We have found that you simply don't save money by moving more people's care into the ER setting.

Sustainable savings come only from learning to deliver care in a smarter, more coordinated way. In the last ten years, we have learned how to do that in North Carolina. We're always adapting and refining our model, but we've had some success in changing how care is delivered for the highest risk and cost patients.

What is different about CCNC?

CCNC is led by the physicians who are charged with changing the face of health care. This bottom-up governance is key to getting buy-in at the practice level. With this buy-in, we have begun to make significant changes in how the community-based health care delivery system functions.

CCNC is built on a model in which every patient has a "medical home." This approach identifies a primary care physician who assumes responsibility for an enrolled patient population over the long term. We have built more than 1,400 medical homes across North Carolina.

In our 14 networks across the state, we wrap support around the primary care physicians / medical homes with: approximately 600 care managers, 30 medical directors, 14 network directors, 18 clinical pharmacists and 10 local psychiatrists. These are local people managing local patients – and driving improvements in the system. The physicians are engaged and participate in creating standardized expectations around implementing evidence based best practices – they lead the local

teams deciding how to collaborate to get the best results. CCNC's partners are accountable and empowered.

Efforts to improve care and save money are owned by those who directly care for patients. CCNC Care managers know their patients, the community and the resources that are available locally. Care managers "on the ground" connect the dots between patient, physician, specialist, hospital, home health, and other community resources. We believe that all health care is local and that community support for individuals with multiple, chronic conditions can significantly improve health outcomes.

The state and CCNC identify clinical priorities based on incidence, cost and amenability to specific health interventions. CCNC's informatics Center provides quality and care management data to networks and practices. Physicians get regular performance feedback that helps drive improvement in the care they deliver. They are held accountable for improving care and containing costs. We believe it is critically important to stratify your population to focus on patient who will benefit the most from your population management interventions.

Who works together for CCNC enrollees?

Serving CCNC's over 1 Million Medicaid and NC Health Choice enrollees — some of our state's most vulnerable citizens – is a big job. This population includes citizens from all 100 North Carolina counties. This includes about 80,000 dual-eligible beneficiaries and about 180,000 beneficiaries in the Aged, Blind and Disabled (ABD) category.

Hospitals provide data and collaborate in patient management. Health departments, departments of social services, local hospitals, mental health organizations and area health educations centers

are also key partners. For dually-eligible patients, our networks and practices are also connecting with long-term care support providers.

We hope this committee will look hard at better aligning Medicare and Medicaid services at the patient and community level. Allowing for shared savings and/or per-member, per-month management fees that would provide better patient management without capitation, risk models, new provider organizations or additional silos. The delivery system must be patient centered. The important thing to remember is that patients' needs change over time so a system must follow the patient across settings and providers and engage patients early in their chronic disease process. Our community based medical home and network infrastructure can focus on population management strategies and achieve the "triple aims" – of improving the health care of the dual population; improving the quality, access and reliability of care; and reducing the costs of care.

Financial impact

The total annual budget for Community Care and its 14 networks is just one percent of total Medicaid costs in North Carolina, yet CCNC's performance metrics have met or exceeded HEDIS measures attained by managed care organizations managing other state Medicaid populations.

Our commitment to quality doesn't just mean better care. It has also lead to significant program savings. We asked an analytics company Treo Solutions to help us estimate CCNC's impact on cost. Looking at data from just 2007 through 2009, Treo estimated CCNC to have saved nearly 1.5 billion dollars in health care costs in North Carolina. When we have all of the data for 2010, we think this number will rise considerably.

Our trend data is also significant. What we're seeing is that when figures are adjusted for risk, actual costs for CCNC enrollees are consistently below expectations. Conversely, costs for the un-enrolled Medicaid population are significant *higher* than expected – comparable to the cost creep most states are seeing.

For example, on a per-member, per-month (PMPM) basis, costs for CCNC enrollees dropped from $397 to $391 between 2007 and 2009. Costs for non-enrolled Medicaid patients were 15 and 16 percent higher in than expected in 2008 and 2009, respectively.

Private sector interest grows

Seeing what we've done in North Carolina with Medicaid, other payers have gotten interested in utilizing CCNC's approach. This includes Medicare, through the 646 demonstration project in 22 NC counties and a Beacon community, for all payers, in three counties. There is a separate multi-payer demonstration through the CMS Innovations Program in 7 rural counties in our state. Finally, we are about to launch a new initiative with private sector employers and insurers in the Triangle area (Raleigh-Durham-Chapel Hill area around the capital).

Mr. Chairman, I would like to thank you and the members of your Subcommittee for the opportunity to be here today to discuss these important issues. I hope that Community Care can be a resource to this Subcommittee as you move forward.

U.S. House of Representatives, Energy and Commerce Subcommittee on Health

Summary of Testimony Denise Levis Hewson
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June 21, 2010

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

Community Care is a collaborative organization of nonprofit regional networks of primary care physicians, hospitals, health departments, other community organizations.

There is no corporate headquarters or government bureaucracy telling physicians how to practice – just committed, local teams that are accountable for results.

Our system is built on 1400 “medical homes,” each lead by a primary care physician who takes responsibility for the managing the health of enrolled beneficiaries.

Physicians get support from 14 CCNC networks, including approximately 600 care managers, 30 medical directors, clinical pharmacists and 10 local psychiatrists.

Cost savings under this model have been significant – estimated at 1.5 billion dollars for the three years from 2007 through 2009.

CCNC’s success with the Medicaid population has lead to growing interest from other payers, including Medicare, North Carolina employers, the State Health Plan and private-sector insurers.