Enhanced Primary Care Case Management System

Legislative Report

North Carolina Community Care Networks, Inc.

Quarterly Report

As of April 1, 2011

Table of Contents

Reporting Requirement (Section 10.36(h))

"NCCCN, Inc. shall report quarterly to the Department and to the Office of State Budget and Management (OSBM) on the development of the statewide Enhanced Primary Care Case Management System and its defined goals and deliverables as agreed upon in the contract. Beginning July 1, 2010, NCCCN, Inc., shall submit a quarterly report to the Secretary of Health and Human Services, OSBM, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the progress and results of implementing the quantitative, analytical, utilization, quality, cost containment, and access goals and deliverables set out in the contract. NCCCN, Inc., shall conduct its own analysis of the Community Care system to identify any variations from the development plan for the Enhanced Primary Care Case Management System and its defined goals and deliverables set out in the contract between DMA and NCCCN, Inc. Upon identifying any variations, NCCCN shall report the plan to DMA within 30 days after taking any action to implement the plan."

First Quarter 2011 Highlights

The first quarter of 2011 witnessed a continuation of trends manifested in previous quarters regarding development of the Enhanced Primary Care Case Management System as well as evidence that NCCCN and its fourteen Networks continue to make progress in achieving savings for North Carolina's Medicaid Program. This is the case despite the increased medical complexity and fragility of the patients served by Community Care of North Carolina.

Highlights include:

- Community Care enrollment of Total as well as Aged, Blind & Disabled (ABD) continued to grow
- Despite this increase in ABD enrollment, monthly cost per member per month (PMPM) continues to run substantially below the experience seen in prior years
    - For the first six months of SFY 2011 PMPM for non-Dual ABDs was $1,261, a 10.5% decrease from the prior year
    - SFY 2011 PMPM is running 6.7% below the pre-Enhanced Primary Care levels of SFY 2009
- Rates for Inpatient Admissions and Emergency Department usage are below SFY 2011 total year performance targets while usage of lower cost generic medications continues to exceed performance targets
- Community Care, in concert with the Division of Medical Assistance and the Division of Public Health, successfully launched the Pregnancy Medical Home Initiative

Introduction

NCCCN Inc. is a not-for-profit administrative entity designed to work with Community Care Networks in establishing, supporting, and maintaining a statewide medical home / primary care provider delivery system. Networks have developed an organized health care delivery system for Medicaid enrollees that coordinates a full continuum of care and develops processes and formal programs to promote population health management principles, community development, quality improvement, cost containment efficiencies, service utilization, budget analytics and forecasting. These tools are needed to address the challenges of providing high quality health services to the Medicaid population in the state of North Carolina, including all rural and underserved areas.

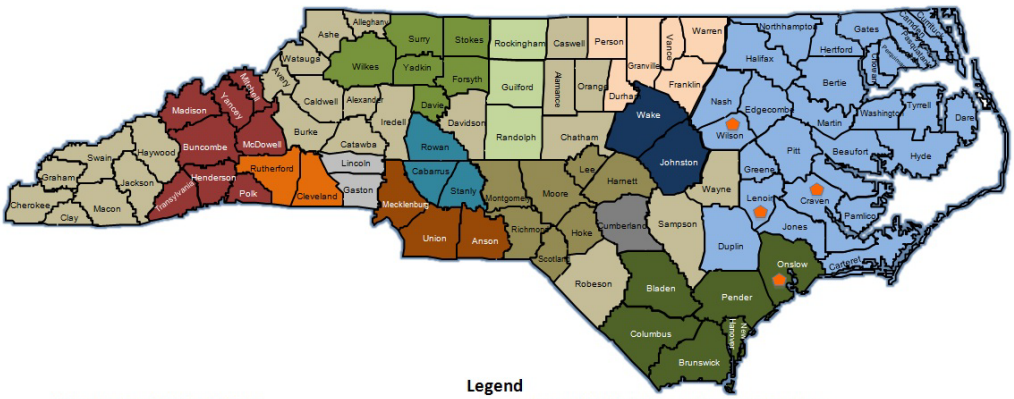
Under the Community Care population management approach to health care delivery, certain clinical, disease and care management services and support systems are established for enrollees in concert with their medical home / primary care provider. This population management model has demonstrated success in improving the quality and containing the costs of health care. The approach is based on a fee-for-service model with an enhanced services case management fee. Community Care Networks coordinate health care services with the Primary Care Providers (PCPs) who function as the enrollees' Medical Homes while achieving budget performance goals and benchmarks.

Pursuant to Session Law 2010-31 §10.36(h) North Carolina Community Care Networks Inc. is submitting this quarterly report to document implementation of a statewide Enhanced Primary Care Case Management System and associated goals and objectives. Contractual deliberations between NCCCN, Inc. and the Division of Medical Assistance are being conducted currently and this report includes information with regard to chart review and claims based performance measurements which NCCCN believes will be set forth in the contract when it is executed between DMA and NCCCN, Inc.

Enrollment and Demographics

The first quarter of 2011 witnessed further growth in enrollment, for both the Total as well as Aged, Blind, and Disabled (ABD) categories, a continuation of the trend in prior quarters. Total and the ABD member enrollment in the Community Care Networks as of April 1, 2011 was 1,072,355 and 199,516, respectively. This is an increase of 1.16% and 2.14% from the December, 2010 amounts. The total number of provider practices enrolled in Community Care was 1,485, a 2.1%% increase from December, 2010.

The geographic profile of the Community Care system and its fourteen (14) networks as of April, 2011 is as follows:



Community Care of North Carolina Networks

Access Care: Alamance, Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Caswell, Catawba, Chatham, Cherokee, Clay, Davidson, Graham, Haywood, Iredell, Jackson, Macon, Orange, Robeson, Sampson, Swain, Watauga, and Wayne.

Community Care of Western North Carolina: Buncombe, Henderson, Madison, Mitchell, McDowell, Polk, Transylvania and Yancey

Community Care of Lower Cape Fear: Bladen, Brunswick, Columbus, New Hanover, Onslow and Pender

Carolina Collaborative Community Care: Cumberland

Carolina Community Health Partnership: Cleveland and Rutherford

Community Care Partners of Greater Mecklenburg: Anson, Mecklenburg, Union

Community Care of Wake and Johnston Counties: Wake, Johnston

Community Care Plan of Eastern Carolina: Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington and Wilson

Community Health Partners: Gaston and Lincoln

Northern Piedmont Community Care: Durham, Franklin, Granville, Person, Vance and Warren

Northwest Community Care Network: Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin

Partnership for Health Management: Guilford, Randolph and Rockingham

Community Care of the Sandhills: Harnett, Hoke, Lee, Montgomery, Moore, Richmond and Scotland

Southern Piedmont Community Care Plan: Cabarrus, Rowan and Stanly

ABD as a percentage of Total enrollment has increased to 18.6% on April 1, 2011. As a result, CCNC continues to see a relatively greater influx of ABD patients who have more complex and chronic medical needs which impacts the health acuity levels of the enrolled membership as discussed later in this report. As mentioned in previous reports, ABDs are enrolled into the CCNC program through the efforts of DMA and county social service agencies, and the rate of ABD enrollment was impacted during 2010 as a result of CMS' (Center for Medicare and Medicaid Services) temporary order to DMA to cease automatically enrolling dual eligibles into the CCNC program. However, DMA has worked with CMS and the cease and desist order was lifted during the latter part of April, 2011 per the Division of Medical Assistance. A demographic profile as of April 1, 2011 and growth by quarter during the past several years follows:

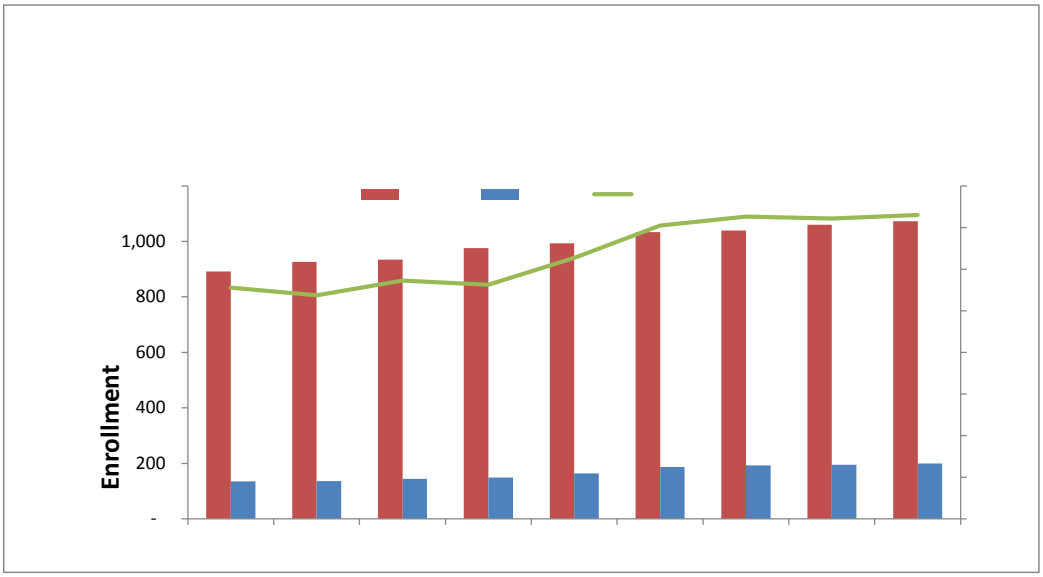
Demographic Profile as of 04-01-2011

CCNC Enrolled

Network	Number of Enrollees			ABD		Medicaid Program -a)		Per cent of Medicaid Program Enrolled -b)		Number of CCNC Practices	
	Total	ABD	Percent	Dual	non-Dual	Total	ABD	Total	ABD	Total	Percent
Access Care	227,188	36,932	16.3%	15,058	21,874	276,495	70,710	82.17%	52.23%	283	19.1%
Community Care of Western North Carolina	53,916	11,077	20.5%	5,500	5,577	76,446	21,078	70.53%	52.55%	70	4.7%
Community Care of Lower Cape Fear	57,888	14,439	24.9%	6,579	7,860	89,495	24,666	64.68%	58.54%	136	9.2%
Carolina Collaborative Community Care	47,657	9,755	20.5%	3,693	6,062	55,304	13,661	86.17%	71.41%	86	5.8%
Carolina Community Health Partnership	24,111	4,046	16.8%	1,479	2,567	35,009	9,382	68.87%	43.13%	21	1.4%
Community Care Partners of Greater Mecklenburg	120,270	17,960	14.9%	7,817	10,143	152,362	30,997	78.94%	57.94%	160	10.8%
Community Care of Wake and Johnston Counties	81,165	11,372	14.0%	3,908	7,464	110,140	24,511	73.69%	46.40%	104	7.0%
Community Care Plan of Eastern Carolina	134,694	36,655	27.2%	17,305	19,350	205,807	63,770	65.45%	57.48%	208	14.0%
Community Health Partners	33,645	5,753	17.1%	2,302	3,451	49,317	12,216	68.22%	47.09%	46	3.1%
Northern Piedmont Community Care	49,879	9,796	19.6%	4,101	5,695	81,287	21,025	61.36%	46.59%	41	2.8%
Northwest Community Care Network	78,555	15,471	19.7%	7,004	8,467	97,916	24,118	80.23%	64.15%	110	7.4%
Partnership for Health Management	61,099	7,665	12.5%	2,937	4,728	110,479	27,705	55.30%	27.67%	63	4.2%
Community Care of the Sandhills	55,681	10,805	19.4%	4,780	6,025	77,327	19,341	72.01%	55.87%	93	6.3%
Southern Piedmont Community Care Plan	46,607	7,790	16.7%	3,317	4,473	58,116	12,869	80.20%	60.53%	64	4.3%
Total	1,072,355	199,516	18.6%	85,780	113,736	1,475,500	376,049	72.68%	53.06%	1,485	100.0%

(a- Based on DMA Medicaid Enrollees by County as of 03-30-2011

(b- Note that percentages do not reflect Medicaid enrollees who are ineligible for CCNC enrollment because of Program Aid classification or living arrangement codes.
For example there are approximately 30,000 ABDs residing in nursing facilities and ICF/MRs who are not eligible for enrollment in CCNC.


Enrollment
1,000
800
600
400
200
-

Quarterly Reported Measures and Improvement Targets

Quality of Care Measures – Patient Chart Reviews

Since its beginning in 1998, the Community Care system has used performance measurement and feedback to help meet its goals of improving the quality of care for Medicaid recipients while controlling costs. Quality measurement is intended to facilitate quality improvement efforts in Community Care practices and local Networks as well as to evaluate the performance of the program as a whole. Under the direction of Network Clinical Directors, this measurement and feedback process has evolved over time to meet the changing needs of the Community Care program and it is expected that this evolutionary process will continue to address issues such as:

- Continued expansion of the Community Care system's enrolled population and increasing focus on the ABD population who suffer frequently from multiple chronic conditions,
- Development of additional quality initiatives,
- Changes in evidence based clinical practice guidelines,
- Decisions rendered by the Community Care system's Quality Measurement and Performance workgroup whose Network representatives meet periodically to review and improve performance measures. The workgroup's goals are to develop performance measures with:
    - clinical importance based on disease prevalence and potential for improvement,
    - scientific soundness (the strength of the evidence underlying the clinical practice recommendation and evidence the measure improves care based on its reliability, validity and comprehensibility), and
    - feasibility of implementing the performance measure

Chart reviews are performed on an annual cycle for patients with medical conditions involving diabetes, asthma, cardiovascular disease and heart failure. Chart reviews are used when the desired performance metrics cannot be obtained from administrative claims data. The Community Care system continues to contract with Area Health Education Centers to perform independent and random chart reviews using an electronic data abstraction tool. Chart review measures pertain to:

- Asthma management (assessment of symptoms and continued care)
- Diabetes (foot-care, and control of glycemia, blood pressure and cholesterol)
- Management of blood pressure, cholesterol, appropriate use of aspirin and tobacco use
- Assessment of LV function in heart failure

As reported in the January 1, 2011 Quarterly Report, the chart review activity for the SFY 2010 cycle was completed during December, 2010. For the sake of completeness, that same information (network level results and a comparison of 2010 metrics with 2009) is included in this report as Attachment A. However, CCNC's performance during 2010 versus 2009 as well as its performance versus HEDIS benchmark measures bears repeating here.

- CCNC achieved state-wide improvements in Medicaid Recipient quality of care with improvement in 14 of 15 chart review measures in 2010 compared with 2009
- CCNC's performance exceeds Medicaid managed care performance nationally in six out of six measures for which HEDSIS benchmarking is available

This last point needs to be put into context. If CCNC's recipients were to receive the same quality of care as Medicaid HMO enrollees nationally, they would have poorer health and health outcomes as well as a poorer quality of life and North Carolina would experience:

-3,000 more recipients with poor diabetes control
-2,500 more recipients with poor diabetes and cholesterol control
-1,670 more recipients with cardiovascular disease and poor blood pressure control.

A chart comparing CCNC's 2010 performance versus 2009 and HEDIS benchmarks is included in Attachment A.

As chart reviews for the practices are completed during 2011, practice-level results with patient-level details will be available to the Networks via a **secure** internet reporting service on a next day basis. Providing credible and provider friendly reports, accompanied with benchmarks and peer comparisons is crucial in motivating providers to provide "best" health care in a cost effective manner. These quality metrics are critical to the ability to implement locally the systemic changes needed to improve quality and care outcomes in practices. Network Clinical Directors are instrumental in engaging community providers and motivating them to implement Community Care quality initiatives.

Operational Measures - Medicaid Claims Review

Medicaid claims data is analyzed and claims derived performance metrics are developed which generally are reported monthly at the Network and practice levels as well as by County. These performance metrics have associated performance targets[1] and are classified as:

Per Member Per Month Metrics which originated with efforts during 2008 to enroll ABD recipients into the CCNC program to provide them with a medical home. Per contract with DMA, the baseline for these metrics is SFY 2009-2010 and these metrics involve performance targets to:

1. Decrease Inpatient Admissions per 1000 Member Months (non-Dual ABD)
2. Decrease ED Rate per 1000 Member Months (non-Dual ABD)

Enhanced Plan Metrics which relate to the Enhanced Plan for which the Networks began receiving an enhanced PMPM fee during April, 2010. Per agreement with DMA, the baseline for these metrics is SFY 2009-2010 and these metrics performance targets aim to:

1. Reduce Preventable Readmissions (within 30 days) as Percent of Total Admissions (non-Dual)
2. Reduce Readmissions (within 30 days) – Psychiatric Diagnoses (non-Dual)
3. Decrease Program-level PMPM inpatient costs - (last three months of life reported on a rolling 12 month basis) (non-Dual ABD)
4. Increase Percentage of Practices with Co-located Behavioral Health Providers (**reported annually**)
5. Generic Medications as Percent of all Fills (non-Dual)
6. Report on Clinical Integrity Efforts (**reported quarterly**)
7. Decrease ABD per member per month costs (alternative to metrics 1, 2 and 3)

[1] Performance targets are identified for each metric as appropriate below.

Although contract deliberations with the Division of Medical Assistance are on-going, NCCCN has developed methodological specifications for several Enhanced Plan metrics for which it is assumed agreement will be reached. These include programming and quality assurance testing for measures #2 Reduce Readmissions (within 30 days) – Psychiatric Diagnoses (non-Dual), and #3 Decrease Program Level PMPM Inpatient Costs (last three months of life) – non-Dual ABD . NCCCN had hoped to be able to report on these metrics in this report, but programming efforts have not yet been completed. Information regarding metric #4, Co-Located Behavioral Health Providers utilizes an annual survey and is included in this report.

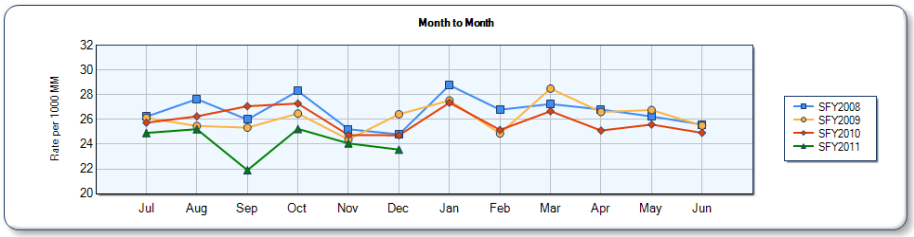
Non risk-adjusted reporting for the remainder of the Enhanced Plan and PMPM measures is ongoing. The following tables show unadjusted, program-level, results for these measures from July 2008 through December 2010. Dates refer to date of service, and a three-month lag time is allowed for claims processing before measures are calculated. SFY 2011 rates for inpatient admissions and emergency department utilization continue to track well below the SFY2010 experience. The preventable readmission rate remains stable, near 15%. This measure reflects what proportion of all hospital admissions represented a preventable readmission which occurred within 30 days of a prior discharge. The metric can be misleading when the total number of admissions is declining which continues to be the case with the overall CCNC population. It is difficult to simultaneously reduce both inpatient rates and readmission rates.

The preferred use of generic prescriptions instead of more costly alternatives continues to rise, and is now at 73.5% for the overall program. The success of CCNC's generic prescription initiative has been quite remarkable, with an overall increase from 60% to 73.5% during the past three years, exceeding the Enhanced Plan target rate.

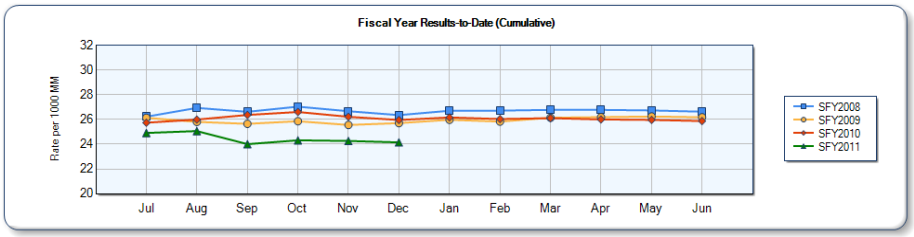
Most importantly, we are achieving the overarching aim of the Enhanced Plan: to reduce unnecessary spending for the Aged, Blind and Disabled Medicaid population. Monthly PMPM costs in SFY 2011 continue to track well below the SFY2010 experience.

PMPM Metrics

Inpatient Admissions per 1000 Member Months – Enrolled non-Dual ABD



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	26.2	27.6	26.0	28.3	25.2	24.8	28.8	26.8	27.2	26.8	26.2	25.6
SFY2009	26.1	25.5	25.3	26.5	24.4	26.4	27.5	24.9	28.5	26.6	26.8	25.5
SFY2010	25.7	26.3	27.1	27.3	24.7	24.7	27.4	25.2	26.7	25.1	25.6	24.9
SFY2011	24.9	25.2	21.9	25.2	24.1	23.6	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	26.2	26.9	26.6	27.0	26.7	26.4	26.7	26.7	26.8	26.8	26.7	26.6
SFY2009	26.1	25.8	25.7	25.9	25.6	25.7	26.0	25.8	26.1	26.2	26.2	26.2
SFY2010	25.7	26.0	26.4	26.6	26.2	26.0	26.2	26.0	26.1	26.0	26.0	25.9
SFY2011	24.9	25.1	24.0	24.3	24.3	24.2	-	-	-	-	-	-

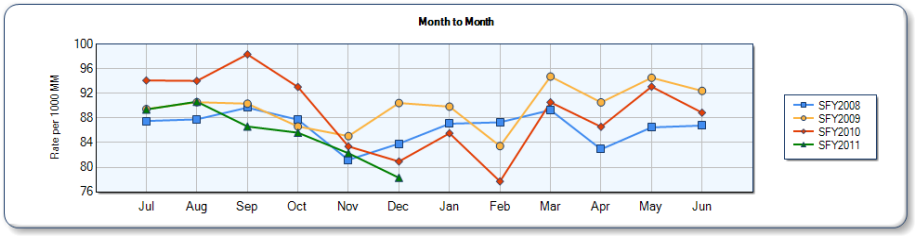
Inpatient Admissions per Thousand Member Months - Enrolled non-Dual ABD

	Historical			Actual SFY 11 (Year - to - Date)												
Network	SFY 08	SFY 09	SFY 10 Baseline	Target*	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of WC	26.7	26.6	25.8	25.3	27.8	28.0	26.8	25.3	24.8	24.5						
Community Care of Lower Cape Fear	25.9	25.3	26.3	25.8	26.8	27.0	27.1	27.1	26.3	25.8						
Access Care	25.6	24.7	23.3	22.8	22.7	22.6	21.7	22.2	22.4	22.5						
Carolina Collaborative Community Care	25.0	22.9	23.7	23.2	24.3	24.8	23.6	24.3	24.7	24.7						
Carolina Community Health Partnership	25.5	25.9	24.0	23.5	28.5	27.4	26.0	25.7	24.0	23.5						
Community Care - Wake/Johnston	22.8	22.8	23.2	22.7	18.0	19.3	19.8	20.5	20.6	20.3						
Community Care of Greater Mecklenburg	28.5	27.9	28.5	27.9	27.7	29.3	27.2	27.3	26.7	26.8						
Community Care of Eastern Carolina	25.7	25.6	25.8	25.3	24.1	23.7	22.5	23.0	23.5	23.6						
Community Health Partners	33.9	31.8	32.1	31.5	30.4	30.6	28.1	27.8	27.7	27.0						
Northern Piedmont Community Care	25.5	24.1	24.4	23.9	23.0	22.9	22.0	22.7	22.2	22.5						
Northwest Community Care	33.1	30.2	30.2	29.6	28.1	27.8	27.9	27.8	27.7	27.5						
Partnership for Health Management	26.6	30.2	29.3	28.7	27.3	25.9	23.8	23.3	23.9	23.6						
Community Care of the Sandhills	32.5	33.9	29.1	28.5	27.4	28.6	26.7	28.6	28.3	27.7						
Southern Piedmont Community Care	21.8	24.4	22.4	22.0	23.1	22.3	20.4	21.1	20.9	20.5						
CCNC Total	26.6	26.2	25.9	25.4	24.9	25.1	24.0	24.3	24.3	24.2						

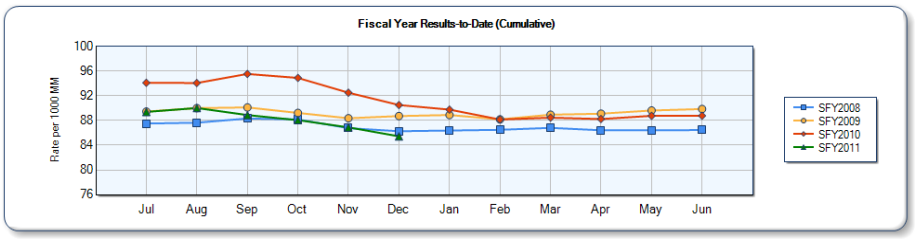
* Target is a 2% Reduction from 2010 Baseline Rate

Note that 13 Networks as well as the total CCNC program are meeting their SFY 2011 target on a YTD basis.

ED Rate per 1000 Member Months – Enrolled ABD



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	87.5	87.8	89.7	87.7	81.2	83.8	87.1	87.3	89.3	82.9	86.5	86.8
SFY2009	89.4	90.6	90.3	86.6	85.1	90.4	89.8	83.4	94.7	90.5	94.5	92.4
SFY2010	94.1	94.0	98.3	93.0	83.4	80.9	85.5	77.7	90.5	86.6	93.1	88.9
SFY2011	89.4	90.6	86.6	85.6	82.3	78.3	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	87.5	87.6	88.3	88.2	86.8	86.3	86.4	86.5	86.8	86.4	86.4	86.5
SFY2009	89.4	90.0	90.1	89.2	88.4	88.7	88.9	88.2	88.9	89.1	89.6	89.9
SFY2010	94.1	94.1	95.5	94.9	92.5	90.5	89.8	88.2	88.5	88.2	88.8	88.8
SFY2011	89.4	90.0	88.9	88.1	86.9	85.4	-	-	-	-	-	-

Note that 11 Networks as well as the total CCNC program are meeting their SFY 2011 target on a YTD basis.

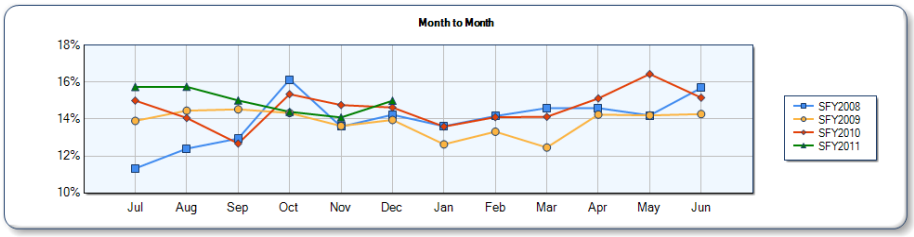
ED Rate per 1000 Member Months - Enrolled ABD

	Historical			Actual SFY 11 (Year - to - Date)												
Network	SFY 08	SFY 09	SFY 10 Baseline	Target*	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of WC	81.9	81.2	81.5	79.9	84.1	86.2	88.5	83.2	81.5	79.4						
Community Care of Lower Cape Fear	96.8	99.6	91.7	89.9	89.7	90.6	88.3	88.4	87.0	.85.6						
Access Care	83.2	86.1	85.8	84.1	88.5	88.9	89.1	88.0	86.9	85.0						
Carolina Collaborative Community Care	58.6	52.0	55.2	54.1	49.0	45.6	47.0	48.3	49.3	48.6						
Carolina Community Health Partnership	108.8	127.7	124.1	121.6	127.4	129.7	129.8	129.9	128.2	125.0						
Community Care - Wake/Johnston	83.2	86.7	80.5	78.9	72.0	76.4	76.6	76.3	76.3	74.7						
Community Care of Greater Mecklenburg	100.4	100.6	95.1	93.2	95.9	95.2	94.3	92.7	91.9	91.3						
Community Care of Eastern Carolina	81.6	83.7	85.4	83.7	89.9	89.5	87.7	87.4	85.9	84.8						
Community Health Partners	96.4	114.3	107.8	105.6	103.2	107.4	101.9	97.0	94.3	94.7						
Northern Piedmont Community Care	85.6	92.1	93.0	91.1	92.6	95.0	92.7	91.2	89.4	88.7						
Northwest Community Care	97.9	100.2	99.1	97.1	103.5	102.2	100.6	98.3	97.2	95.2						
Partnership for Health Management	78.4	85.0	87.0	85.3	86.6	84.5	84.7	84.6	83.7	81.2						
Community Care of the Sandhills	90.7	97.0	95.9	94.0	93.4	96.5	93.8	94.0	92.2	90.6						
Southern Piedmont Community Care	91.3	100.2	98.0	96.0	94.8	99.0	96.6	97.6	95.9	94.1						
CCNC Total	86.5	89.8	88.8	87.0	89.4	90.0	88.9	88.1	86.9	85.4						

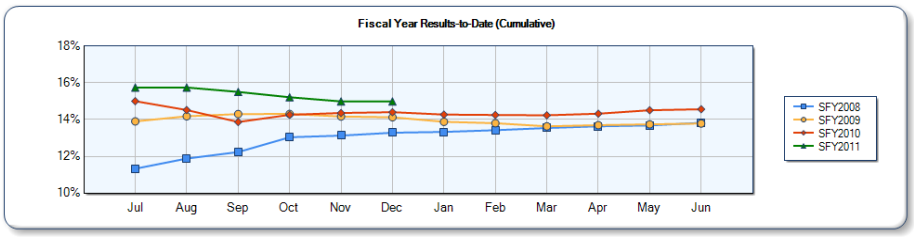
* Target is a 2% reduction from 2010 Baseline Rate

Enhanced Plan Metrics

Preventable Readmissions – Enrolled non-Duals



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	12.4%	12.9%	16.1%	13.6%	14.2%	13.6%	14.2%	14.6%	14.6%	14.2%	15.7%
SFY2009	13.9%	14.4%	14.5%	14.3%	13.6%	13.9%	12.6%	13.3%	12.5%	14.2%	14.2%	14.3%
SFY2010	15.0%	14.1%	12.7%	15.3%	14.8%	14.6%	13.6%	14.1%	14.1%	15.1%	16.4%	15.2%
SFY2011	15.7%	15.7%	15.0%	14.4%	14.1%	15.0%	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	11.9%	12.2%	13.0%	13.1%	13.3%	13.3%	13.4%	13.5%	13.6%	13.7%	13.8%
SFY2009	13.9%	14.2%	14.3%	14.3%	14.2%	14.1%	13.9%	13.8%	13.6%	13.7%	13.7%	13.8%
SFY2010	15.0%	14.5%	13.9%	14.3%	14.4%	14.4%	14.3%	14.2%	14.2%	14.3%	14.5%	14.6%
SFY2011	15.7%	15.7%	15.5%	15.2%	15.0%	15.0%	-	-	-	-	-	-

Preventable Readmissions - Enrolled non-Duals

Network	Historical SFY 08	Historical SFY 09	SFY 10 Baseline	Actual SFY 11 (Year - to - Date) Target*	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of WC	12.0%	13.0%	12.8%	12.3%	14.2%	15.6%	15.7%	15.3%	14.8%	14.6%						
Community Care of Lower Cape Fear	12.7%	12.2%	13.9%	13.3%	13.4%	13.8%	14.6%	14.4%	13.7%	13.5%						
Access Care	13.5%	12.3%	12.9%	12.4%	14.6%	13.6%	12.6%	12.5%	12.4%	12.7%						
Carolina Collaborative Community Care	13.4%	15.4%	19.7%	18.9%	20.2%	20.0%	19.7%	19.4%	19.7%	20.3%						
Carolina Community Health Partnership	11.6%	11.6%	12.3%	11.8%	9.4%	10.9%	10.7%	10.9%	11.9%	11.4%						
Community Care - Wake/Johnston	13.5%	12.9%	13.2%	12.7%	13.9%	14.5%	14.5%	14.1%	13.6%	13.3%						
Community Care of Greater Mecklenburg	13.2%	14.9%	15.0%	14.4%	16.8%	16.2%	15.3%	15.3%	15.0%	14.5%						
Community Care of Eastern Carolina	14.9%	14.5%	15.6%	15.0%	16.4%	15.8%	16.5%	15.9%	15.8%	16.2%						
Community Health Partners	12.5%	13.6%	13.7%	13.2%	15.1%	15.0%	13.2%	14.0%	14.6%	15.1%						
Northern Piedmont Community Care	14.4%	13.2%	16.9%	16.2%	13.5%	15.8%	16.5%	16.5%	16.6%	17.0%						
Northwest Community Care	18.0%	16.3%	17.3%	16.6%	19.9%	20.6%	19.9%	19.0%	18.0%	18.0%						
Partnership for Health Management	14.8%	13.9%	15.2%	14.6%	21.2%	19.9%	20.0%	18.9%	17.8%	17.0%						
Community Care of the Sandhills	14.5%	14.5%	13.1%	12.6%	14.4%	14.9%	15.4%	15.2%	15.1%	15.1%						
Southern Piedmont Community Care	11.2%	12.4%	13.3%	12.8%	13.3%	16.5%	15.9%	15.5%	14.9%	14.0%						
CCNC Total	13.8%	13.8%	14.6%	14.0%	15.7%	15.7%	15.5%	15.2%	15.0%	15.0%						

* Target is a 4% Reduction from 2010 Baseline Rate

Note that 1 Networks is meeting its SFY 2011 target on a YTD basis. While total program performance continues to exceed prior year activity, there has been an improvement as SFY 2011 has progressed.

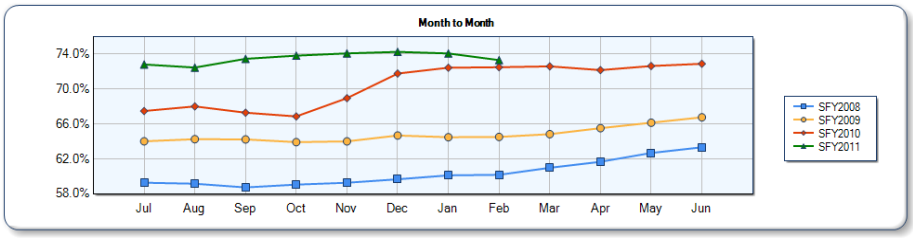
Increase in Percent of Network Practices with Co-located Behavioral Health Specialists

Network	Number of Practices -a), -b) Total	BH Specialist	BH Specialist as % of Total	Calendar Year 2011 Target
AccessCare	281	11	3.91%	
Community Care of Western Carolina	69	12	17.39%	
Community Care of Lower Cape Fear	135	12	8.89%	
Carolina Collaborative Community Care	82	1	1.22%	
Carolina Community Health Partnership	21	3	14.29%	
Community Care of Wake and Johnston Counties	97	5	5.15%	
Community Care Partners of Greater Meclenburg	157	4	2.55%	
Community Care Plan of Eastern Carolina	213	3	1.41%	
Community Health Partners	46	4	8.70%	
Northern Piedmont Community Care	38	14	36.84%	
Northwest Community Care	109	5	4.59%	
Partnership for Health Management	60	8	13.33%	
Sandhills Community Care Network	89	3	3.37%	
Southern Piedmont Community Care Plan	65	7	10.77%	
Total	1,462	92	6.29%	105

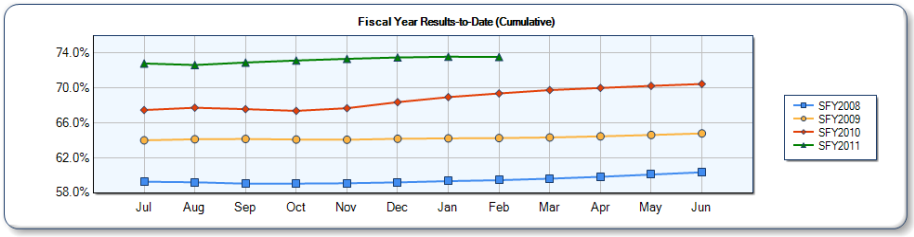
(a- Survey of Network practices conducted December 2010 - January 2011

(b - Networks identified practices with a licensed behavioral health specialist

Generic Medications as Percent of All Fills – All Medicaid non-Duals



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	59.3%	59.2%	58.7%	59.1%	59.3%	59.7%	60.1%	60.2%	61.0%	61.7%	62.7%	63.3%
SFY2009	64.0%	64.3%	64.2%	63.9%	64.0%	64.7%	64.5%	64.5%	64.8%	65.5%	66.1%	66.8%
SFY2010	67.5%	68.0%	67.3%	66.9%	68.9%	71.8%	72.4%	72.5%	72.6%	72.2%	72.6%	72.9%
SFY2011	72.8%	72.4%	73.4%	73.8%	74.1%	74.2%	74.1%	73.3%	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	59.3%	59.2%	59.1%	59.1%	59.1%	59.2%	59.3%	59.5%	59.6%	59.8%	60.1%	60.3%
SFY2009	64.0%	64.1%	64.2%	64.1%	64.1%	64.2%	64.2%	64.3%	64.3%	64.5%	64.6%	64.8%
SFY2010	67.5%	67.7%	67.6%	67.4%	67.7%	68.4%	68.9%	69.4%	69.8%	70.0%	70.2%	70.5%
SFY2011	72.8%	72.6%	72.9%	73.1%	73.3%	73.5%	73.6%	73.5%	-	-	-	-

Generic Medications as Percent of All Fills

Network	Historical SFY 08	Historical SFY 09	SFY 10 Baseline	Target*	Actual SFY 11 (Year - to - Date) Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
No Network	61.5%	66.0%	71.1%		73.5%	73.4%	73.6%	73.8%	74.0%	74.1%	74.2%	74.2%				
Community Care of WC	60.8%	65.4%	70.4%	71.8%	72.1%	72.1%	72.5%	72.8%	73.0%	73.2%	73.3%	73.2%				
Community Care of Lower Cape Fear	59.8%	64.3%	70.8%	72.2%	73.3%	73.0%	73.2%	73.4%	73.6%	73.8%	73.9%	73.9%				
Access Care	59.2%	64.0%	70.3%	71.7%	72.6%	72.4%	72.8%	73.1%	73.5%	73.7%	73.8%	73.8%				
Carolina Collaborative Community Care	57.8%	62.4%	68.9%	70.3%	71.0%	70.5%	71.1%	71.4%	71.6%	71.8%	72.0%	72.0%				
Carolina Community Health Partnership	58.6%	64.0%	70.7%	72.1%	72.6%	72.3%	73.0%	73.2%	73.6%	73.9%	74.1%	74.2%				
Community Care - Wake/Johnston	59.4%	63.1%	68.8%	70.2%	70.5%	70.4%	70.6%	70.9%	71.0%	71.2%	71.3%	71.3%				
Community Care of Greater Mecklenburg	59.6%	63.0%	69.3%	70.7%	72.5%	72.3%	72.6%	72.8%	72.9%	73.0%	73.1%	73.0%				
Community Care of Eastern Carolina	60.4%	65.2%	71.2%	72.6%	73.4%	73.1%	73.3%	73.5%	73.7%	73.9%	74.0%	74.0%				
Community Health Partners	58.1%	62.8%	69.6%	71.0%	72.2%	72.2%	72.4%	72.7%	73.0%	73.2%	73.2%	73.1%				
Northern Piedmont Community Care	62.6%	66.1%	71.1%	72.5%	73.7%	73.7%	73.8%	73.9%	74.1%	74.3%	74.3%	74.2%				
Northwest Community Care	61.6%	65.9%	70.4%	71.8%	72.5%	72.4%	72.7%	72.8%	72.9%	73.1%	73.2%	73.1%				
Partnership for Health Management	59.3%	64.7%	70.5%	71.9%	72.3%	71.9%	72.3%	72.3%	72.5%	72.7%	72.8%	72.8%				
Community Care of the Sandhills	59.6%	64.3%	70.4%	71.8%	73.5%	73.0%	73.3%	73.5%	73.6%	73.7%	73.8%	73.6%				
Southern Piedmont Community Care	59.6%	64.5%	69.7%	71.1%	72.0%	71.7%	72.0%	72.2%	72.4%	72.6%	72.6%	72.5%				
CCNC Total	60.3%	64.8%	70.5%	71.9%	72.8%	72.6%	72.9%	73.1%	73.3%	73.5%	73.6%	73.5%				

* Target is a 2% increase above 2010 Baseline

Note that all 14 Networks are meeting their SFY 2011 target on a YTD basis and that the CCNC program is running 3.0% above SFY 2010 on a YTD basis.

Clinical Integrity Efforts

Meetings are held between DMA's Program Integrity organization and NCCCN every 2 – 3 weeks to review the results of NCCCN efforts in identifying questionable billing practices based on information NCCCN has received from Network personnel as well as review of claim billing details by two of NCCCN's physician consultants. A tabulation of results identified during the first quarter of 2011 (claims primarily from the last quarter of 2010) is as follows:

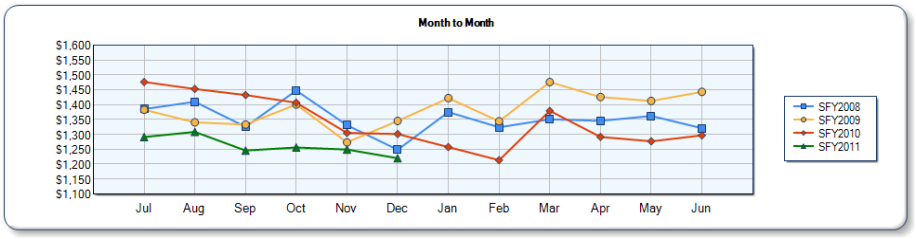
Provider Type	Issue	Referral Source	Amount	Comments / Status
Oncologist	Duplicate billing	Claim review	$8,451	Recoupment letter sent by PI
Chiropractor (ages 0 – 5)	Concerns regarding safety and efficacy of spinal manipulation in children under 5; some billing not related to musculoskeletal issues.	Claim review	$28,633 – not covered per policy $5,600 – inappropriate care	Meetings held with DMA's medical director and Program Integrity (PI). Suggested NC PAG be enlisted to set a lower age limit for Chiropractic services. NC Legislature is discussing elimination of all Chiropractic services
Chiropractor (ages 6 – 21)	Paid $103,000 over 2 years for non-covered diagnoses such as "general medical exam", eye disorder and non-musculoskeletal conditions	Claim review	$103,000	PI has agreed to "work" this payment process with DMA's Clinical Policy group
Chiropractor (age > 21)	DMA policy implies coverage is for subluxation only. $412,000 paid in 2009 – 2010 for non-subluxation services including $151K for non musculoskeletal services and $149K related to pregnancy ($136K from a single provider)	Claim review	$412,000	PI to pursue $136,000 apparent erroneous payment to one provider and send for a sample of records for all providers performing adjustments for Scoliosis (specifically contra-indicated by existing policy)
Neurologist	$1.2 million in billing for nerve conduction studies performed by unqualified providers ($277,000 from one provider)and $35,000 billed for diagnoses not clinically supportable, eg. asthma, cervical cancer screening	Claim review	$1,200,000	Medicare and private insurers not "paying well" for this service since hand-held devices became available. Clinical Integrity team working with NC PAG and Medicaid's medical director to tighten up its payment policy
PCP – mid-level practitioners	Identified a practice where mid-levels appeared to be practicing without a valid NC physician overseeing the practice	Claim review		Practice provided copy of fax it had sent establishing the overseeing MD. Case closed
BH provider	Practitioner identified who bills identically for all patients ,ie. bills 32 units for 8 hours of counseling	Claim review	$12,144	PI has requested records
BH provider	Provider billed for hours of individual counseling for 3 family members on the	Claims review	$2,587	PI has requested records

Provider Type	Issue	Referral Source	Amount	Comments / Status
	same day			
Hospital	Four instances of billing for bili-lights where billing did not match dates of service or clinical situation	Claim review	$7,414	PI has requested records
DME - diapers	Policy states Medicaid will not pay for diapers for children under age 3 but claims paid erroneously because they were billed on an unexpected code	Claim review	$23,848	Checked to see that proper edits were in place and functioning in the MMIS. Have been informed that problem has been corrected. Recoupment letters sent. Bulk of the $24K recovered
DME – glucose test strips	DMA policy since 02/2010 to only pay for Prodigy test strips (monthly cost - $74) but provider billed at $298 per month from 02/2010 thru 12/2010 ($7,877 should have been $2,300)	Claim review	$5,577	Case to be opened by PI as work-load permits. Edits need to be put in MMIS to prevent re-occurrence
Parenteral Nurition	Provider billing for specialized type of total parenteral nutrition ($29,000 for 2 patients for 3 months)	Claim review	$41,868	Clinical Integrity working with CCNC pharmacist to determine type/brand of TPN to educate providers. Will suggest to PI that it work with DMA rate setting to establish maximum TPN payment amounts or Prior Auth for certain TPNs
PCP	Large number of units billed for injections into small joint in neck. Two providers frequently bill 80 units instead of usual 2 to 8 units	Claim review	$14,868	Determined there was no MMIS edit to limit number of joint injections. PI worked with Clinical Policy to get edit in place which mirrors maximum number of units Medicare uses for this type of service. Recoupment letters sent
Recipient	Parent appears to have succeeded in having child categorized as disabled under false pretenses. Child takes no medications and has not had an outpatient visit in 4+ years	Network – Care Manager	$69,422 (assumes undetected thru child's 19th birthday)	Disability determinations are outside the purview of CCNC's scope. PI referred issue to Recipient Fraud unit
BH provider	Child seen in crisis by Network psychologist who noted more than 80 claims for counseling sessions although this was denied by family who said they	Network – Psychologist and Care Managers	$10,185 in claims for specific child $19,288 in claims for four other patients	Determined that provider has billed $5.6 million in similar situations. Subsequent to CCNC supplying information to PI, a PI team paid a site-visit to the provider and has

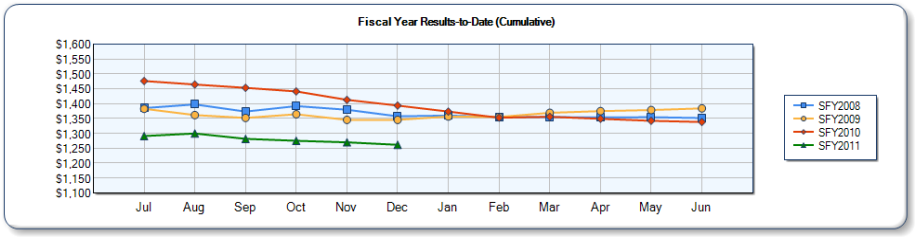
Provider Type	Issue	Referral Source	Amount	Comments / Status
	were seen twice. Two other similar cases from Care Managers			initiated a case
BH provider	Care manager noted billing for daily counseling for child living 4 hours away in boarding school. Provider billing under two provider numbers for care reportedly not provided. Care Manager determined 6 other patients where services billed were not provided	Network – Care Managers	$123,263	Uncertain as to whether this provider had come to PI's attention before Care Manager's involvement. Further investigation as determined that provider bills under multiple numbers and a PI case has been opened and total amount involved approximates $1.2 million
BH provider	Two care managers noted a provider billing for 15 counseling sessions while patient was incarcerated. Four other patients denied receiving services which were billed by the provider	Network – Care Manager	$74,569	Determined that LME and PI were well aware of provider activities and a case had been initiated already with a total amount involved of approximately $1.6 million. This info added to on-going case
BH provider	Care Manager noted 2 BH providers who bill for services that patient claims were never received	Network – Care Manager	$4,433	PI case apparently initiated against providers already. Total amount involved approximates $300,000
PCP	Director concerned clinic may not be providing adequate primary care. No one onsite at visits and patients receiving care in ED	Network – Director		Practice closed medical office during April, 2011
Home Care Agencies	Twelve home care agencies have been reported by networks where providers billed for services not rendered involving more than 50 recipients	Network – Care Managers	Large amount but undetermined	Recouped $7,214 from one provider, PI unable to locate one provider and ten other providers subject to on-going investigation (total of these cases is in the $ millions)
PCP	Provider's staff reported that unnecessary services are provided. Determined that approximately $56,63 involved duplicate billing	DMA – Director	$28,500	$28,500 should be recouped. Pursuant to discussion with DMA Medical Director, CI staff will discuss with CCNC management taking this case to the NC Medical Board

Another on-going issue involves high use of CT scans. Many patients have been identified who received more than 10 CT scans in a 12 month period, usually in the ED setting but many times for non-emergent and chronic pain type issues. Many of the patients with the highest number of CT scans have received multiple narcotic prescriptions from multiple providers. A project has been initiated that involves DMA and the UNC Radiology and Emergency Departments to inform providers and patients as to the scope of the problem and risks associated with this level of CT utilization as well as suggest that patients be linked to a primary care medical home. Primary care providers, radiologists and ED physicians across the state will be informed about this initiative and the scope of the problem in North Carolina. The CCNC team will send letters to patients who had more than 10 scans in 12 months and attempt to contact patients by phone call when the patient has had more than 4 times the legal exposure limit for radiation workers. In 12 months, a follow-up claims review will made to determine if a difference is noted in CT scan use by these patients.

PMPM Cost – Enrolled (non-Dual) ABD



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,410	$1,325	$1,447	$1,331	$1,248	$1,375	$1,324	$1,351	$1,345	$1,362	$1,321
SFY2009	$1,383	$1,340	$1,333	$1,400	$1,273	$1,345	$1,422	$1,344	$1,476	$1,426	$1,412	$1,443
SFY2010	$1,476	$1,453	$1,432	$1,406	$1,305	$1,301	$1,257	$1,213	$1,379	$1,291	$1,277	$1,297
SFY2011	$1,291	$1,308	$1,246	$1,256	$1,249	$1,220	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,398	$1,373	$1,392	$1,379	$1,357	$1,360	$1,355	$1,355	$1,354	$1,355	$1,352
SFY2009	$1,383	$1,361	$1,352	$1,364	$1,345	$1,345	$1,356	$1,355	$1,369	$1,375	$1,379	$1,385
SFY2010	$1,476	$1,464	$1,453	$1,441	$1,413	$1,394	$1,374	$1,353	$1,356	$1,350	$1,343	$1,339
SFY2011	$1,291	$1,300	$1,281	$1,274	$1,269	$1,261	-	-	-	-	-	-

Note the 10.5% pmpm under run in SFY 2011 versus SFY 2010 thru December YTD.

Risk Adjusted Analyses

The preceding metrics and graphs report clinical and financial results on a "raw" basis since the metrics ignore the acuity level of the Networks' enrolled populations. To address this deficiency, NCCCN has contracted with a data analytics firm, Treo Incorporated, which specializes in the analysis of health care delivery organizations and their enrolled populations, particularly state Medicaid populations. Treo has assisted NCCCN in understanding the acuity level (risk score) of its enrolled population (excluding dual eligibles), cost trends and the results of both Network operations and the CCNC enrolled population as well as the Medicaid un-enrolled population receiving services on a fee-for-service basis. The January 1, 2011 Quarterly Analysis included an analysis which focused on trends between 2007 and 2009 and explored the differences in performance between CCNC and the un-enrolled, fee for service, Medicaid populations. Additionally, that report focused on child and adult cohorts.

CCNC has been engaged with Treo to examine Network performance on a risk adjusted basis. However, the results of this analysis have not been completed. It is hoped that the results of the analysis will be available in the next quarterly report. At this point however, efforts between NCCCN and Treo are focused on developing a set of analytical tools and reports to respond to a budgeted reduction in Medicaid expenditures with which NCCCN and CCNC have been tasked by the NC General Assembly.

Status of Enhanced Primary Care Case Management Initiatives

The Enhanced Primary Care Case Management Program, launched in April of 2010, directed NCCCN and the Networks to undertake a set of eight initiatives which are funded through an increase in the per member per month amounts paid to Community Care by the Division of Medical Assistance.

Initiative	Status as of 04-01-2011
Transitional Support and Intensive Care Management A multi- project initiative which focuses on the ABD population to effect comprehensive care management. Workgroups involving Network personnel include Screening Assessment and Care Planning, Polypharmacy, Pediatric Chronic Care, Hypertension/Coronary Artery Disease, Mental Health, Data and Evaluation, the Care Management Information System (CMIS), and Self Management of Chronic Illnesses. Networks aim to reorganize delivery of care in ways that enhance appropriate access, increase service delivery options, improve efficiencies in the identification, assessment and care planning processes, reduce the rate of institutionalization and reduce unnecessary inefficiencies and expenses inherent in the current system. Specific targets include: Embed chronic care support staff in large ABD practices Embed chronic care support staff in large hospitals Develop a central call center to support network activities Hire additional care managers	All networks have implemented the following care management initiatives and processes in the chronic care program: Transitional support – 50+ care managers have been embedded in practices with high volume Medicaid members and 43+ care managers have been embedded in hospitals with high volume Medicaid admissions. The hospital based care managers are working as part of the discharge planning team and beginning to assess, educate and support the patients in their transition out of the hospital setting 60 new care management positions have been filled Medication reconciliation – is being performed in the homes of high risk patients within 5 business days from hospital discharge. Health Care Team – practices are implementing patient centered care planning as part of a health care team when managing the highest risk and cost patients. The Call Center work group meets regularly to make recommendations and has visited with potential call center vendors. A RFP has been developed and was distributed to potential vendors in May 2011. The CCNC Call Center will focus initially on contacting patients who present at EDs for non-emergent conditions, to reinforce the importance of the medical home. It is anticipated that a contract will be let in the September, 2011 timeframe.
Behavioral Health Integration / Coordination	

Initiative	Status as of 04-01-2011
This initiative supports the integration of behavioral health services, including mental health and substance abuse, into the 1,400+ primary care practices of the fourteen Networks across North Carolina. The initiative aims at integrating care to consumers in their medical homes across the state. Specific targets include: • Hire Lead psychiatrist at NCCCN • Hire Network psychiatrists & behavioral health specialists • Adopt evidence-based treatment protocols in practices	Accomplishments include: • A lead psychiatrist has been hired at NCCCN as well as a part time pharmacist. • All Networks have hired psychiatrists & behavioral health specialists • Standardized processes and expectations in behavioral health care have been developed across the 14 networks, including evidence based treatment guidelines for depression, ADHD and substance abuse • Providers have been educated as to resources available to support integrated care and training has been conducted for all psychiatrists, coordinators and care managers in Motivational Interviewing • Standardized processes and expectations in behavioral health care have been developed across the 14 networks, including evidence based treatment guidelines for depression, ADHD and substance abuse
Palliative Care This focuses on addressing the needs of patients and their families involved in end-of-life care. Specific targets include: • Hire part-time physician at NCCCN and 5 additional FTEs to lead a statewide initiative across the 14 CCNC Networks	• A physician lead was hired at NCCCN; all Networks have identified part-time palliative care coordinators • Networks have identified physician palliative care "champions" • Palliative care training sessions were conducted across the state through February 2011 • Palliative care "champions" and coordinators will meet regularly to define medical home expectations and PCP engagement and training
Enhance Existing Management of Pharmacy This expands upon existing infrastructure to advance the number of practices engaged in e-prescribing and continues efforts to increase generic prescriptions as a percentage of total prescriptions filled. Specific targets include: Hire 1 FTE pharmacist at NCCCN and 9 pharmacist FTEs across the 14 CCNC Networks	• 9 FTE's (18 pharmacists) hired to cover the 14 Networks • Enhanced pharmacy program efforts utilizing MD easy, medication reconciliation and e-prescribing • Implemented a contract with SureScripts to secure fill history and fill gaps in pharmacy data

Initiative	Status as of 04-01-2011
National benchmarking with Medicaid generic	
Clinical Integrity (analysis of potential Medicaid outliers) NCCCN is assisting DMA's Program Integrity to identify potential outliers involving Medicaid services and providers. Specific targets include: • NCCCN, Inc to hire clinical staff to support IBM Software to identify outliers • Each Network to hire a part-time local physician to assist effort	• NCCCN opted to use data analytics tools from Ingenix Inc. rather than IBM to review claims data. • Bi-monthly meetings are held with a dedicated team at DMA Program Integrity to review the results of claims data reviews and PI has begun pursuing potential outliers identified by NCCCN clinicians. • NCCCN has developed a tracking tool to document and monitor follow-up efforts. • A part time physician was hired at NCCCN.
Informatics Center (IC) Enhancements The NCCCN IC is expanding its efforts to integrate data from various sources and provide clinically relevant information to networks, providers and care management partners at the point of care. Specific targets include: • NCCCN to hire 12 FTEs in 2010 and an additional 4 FTEs in 2011 • Develop infrastructure to integrate data and provide clinical information to Networks	• More than 12 FTEs have been brought onboard since inception of the Enhanced initiative to support network infrastructure, data integration and analysis, as well as expand the CMIS and Provider Portal capabilities. Additional hires are scheduled for 2011. • IC has contracted with SureScripts, Lab Corp and TREO to improve and increase data available for population management activities • Integrated enhancement to the Care Management Information System • Launched and upgraded the Provider Portal application to support meaningful information exchange across providers and delivery settings • 34 hospitals are now sending real time data on admissions, discharges and transfer data to NCCCN, to alert the care management team to the status of Medicaid recipients in the emergency department or inpatient unit on a twice daily basis.
Privacy Officers and Network Administrators This involves expanding the CCNC Networks' infrastructure to expand the reach of IC capabilities by securing data-use agreements, the creation of IC data user profiles, and the training and support of users. Specific targets include: 16 FTEs to be hired across 14 Networks	• A privacy officer was hired at NCCCN • 12 of the 14 Networks have hired privacy officers • All Networks have hired network administrators • Networks are in the process of signing new data use agreements with external providers. To date, agreements signed with 21 LMEs (local management entities), 270 PCPs (primary care providers) and 21 HDs (health departments)

Comment [DL1]: Is that number correct? I thought it was in the 40s

Comment [CAD2]: Tom, you could attach the list of participating hospitals if you'd like

Initiative	Status as of 04-01-2011
Care Management Collaboration with PCPs Efforts focus on achieving a higher level of clinical integration by having private providers coordinate their clinical case management services with the Networks so that on a case by case basis, patient profiles and key clinical data can be exchanged thereby effecting a more comprehensive plan of care for the individual. Specific targets include: • 12 FTEs to be hired across 14 CCNC Networks to decrease duplication of effort and improve integration of services	• Clinical and data analysis staff have been hired to support the implementation of the pregnancy medical home and coordinated care for children initiatives. See additional comments below regarding the Pregnancy Medical Home initiative

Informatics Center- Update

The Informatics Center collects and reports valuable health information to improve the quality and to control the costs for NC Medicaid. Use of the web-based Care Management Information System, Provider Portal, and Pharmacy Home medication management platform continue to grow as indicated in the tables below. Patient care information is accessed for over 70,000 Medicaid patients every month through these applications.

Case Management Information System (CMIS) – A web-based, secure, care management application which contains demographic and claims data on more than 2 million Medicaid recipients (more than 1 million enrolled currently). The application's components reflect a care management model such that care managers and Network staff maintain a single patient-centered care plan that stays with the recipient when the recipient changes location within the state. The CMIS includes standardized health assessments and screening tools, disease management and coaching modules as well as workflow management features.

A major expansion of the CMIS has been launched which will take place during the first and second quarters of calendar year 2011. This expansion will make CMIS access available to public health case managers involved in care management for pregnant women, the Pregnancy Medical Home, and Child Coordination for Children (CC4C), programs. This will generate more than 500 new CMIS users during the coming year who will have a shared, secure, web-based patient record for care management documentation and coordination of care management activities.

Operational statistics for the quarter are as follows:

Time Period	January 2011	February 2011	March 2011
Number of unique user log-ins	732	754	778
Total successful log-ins	16,418	16,593	19,211
Number of unique patients accessed	71,984	71,186	75,998
Average duration of visit	259 minutes	245 minutes	255 minutes
Total pages viewed	2.4 million	2.4 million	2.9 million

Provider Portal – Providers treating patients in various settings can utilize a web-portal to access a Medicaid patient's health record, Medicaid claims history and clinical care alerts, including information generated outside of the provider's local clinic or health system to obtain a "total" perspective. Contact information for the patient's case manager, pharmacist, mental health therapy provider, durable equipment supplier, home-health or personal care service provider is readily available. The roll-out of this application to primary care practices and hospitals is on-going and has been very

successful to date. In addition to medical providers, all Local Management Entities (LMEs) now have access to the Portal to enable care coordination and quality improvement in the care of Medicaid recipients with mental health needs.

The rollout of the Community Care Provider Portal to primary care practices and hospitals is ongoing, and has been very successful to date. In addition to primary care and hospital providers, Local Management Entities (LMEs) and local health departments now have access to the Portal, enabling care coordination and quality improvement in the care of Medicaid clients with mental health needs.

Operational statistics for the quarter are as follows:

Time Period	January 2011	February 2011	March 2011
Number of unique user log-ins	548	554	873
Total successful log-ins	4,062	5,190	7,194
Number of unique patients accessed	5,749	7,545	9,945
Average duration of visit	9 minutes	8 minutes	8 minutes
Total pages viewed	48,868	60,330	79,603

Pharmacy Home Application - This medication management platform uses a process of gathering and organizing drug use information from multiple sources (patient medical chart, prescription history, discharge instructions) and sharing this information with providers to identify and resolve urgent and emergent prescription drug duplications, interactions, possible adverse events, poor adherence or other suboptimal drug-taking behaviors. A significant upgrade to the medication information available in Provider Portal and Pharmacy Home was successfully executed this quarter, with the inclusion of medication history information for dually eligible recipients participating in the 646 demonstration project, through the Surescripts data source.

Operational statistics for the quarter are as follows:

Time Period	January 2011	February 2010	March 2010
Number of unique user log-ins	284	286	306
Total successful log-ins	2,634	2,767	2,959
Number of unique patients accessed	3,871	4,480	4,855

Time Period	January 2011	February 2010	March 2010
Average duration of visit	9 minutes	9 minutes	8 minutes
Total pages viewed	21,293	23,042	24,820

A “Meducation” module available to providers, pharmacists, and care managers through the above applications has gained traction over the past several months. This is a hosted medication instruction and counseling resource for healthcare professionals, with video and print educational materials designed to address low health literacy, improve the readability of documents for the elderly and visually impaired, and better serve non-English speaking patients. Since its release in August 2010, medication counseling materials for Medicaid recipients have been generated in English, Spanish, Arabic, French, Russian, Cantonese, Mandarin, Haitian Creole, Italian, Korean, and Bengali.

New Informatics Center Projects

ONC Challenge Grant: NCCCN will be a sub-awardee of a Challenge Grant from the Office of the National Coordinator for Information Technology to build on NCCCN’s existing “Pharmacy Home” application, a model web-based medication management application currently in use with 1.2 million CCNC Medical Home Medicaid enrollees. Under this grant, the North Carolina Health Information Exchange will charge NCCCN with enhancing the existing “Pharmacy Home” application to connect it to the NCHIE as a value added service to encompass all payers and providers. By project completion, the NCHIE will be the primary inbound source of the disparate medication lists from multiple settings and systems to the application, as well as the conduit for outbound communication with NCHIE participants, including a provider’s own electronic system of record. The Pharmacy Home will then act as a node on the NCHIE to provide a “common view” of all available medication lists. This enhanced set of aggregated information will greatly enable medication reconciliation efforts and also enable more valid decision support.

Carolina Data Warehouse Project (funded by Duke Endowment): The UNC School of Medicine has been awarded a Duke Endowment grant to establish an electronic health information exchange of data from the Carolina Data Warehouse to the Community Care Informatics Center, to improve both NCCCN’s and UNC’s efforts in quality improvement and cost containment. For example, data from the UNC hospital discharge summary, with key information related to post hospital discharge patient follow-up needs will be sent automatically and in near real time to the NCCCN informatics platform. Such electronic data transfer will enable more timely, efficient, and effective care management efforts at the time of care transitions, and will reduce the need for phone calls and manual chart abstractions by CCNC care managers. Additionally, NCCCN has specific patient laboratory needs to augment their quality measurement tools. UNC will send diabetes, renal, and lipid blood test results important for the quality improvement efforts of Community Care networks.

Pregnancy Home Initiative– Update

In March 2011, CCNC, in conjunction with the Divisions of Medical Assistance (DMA) and Public Health (DPH), launched the Pregnancy Home Initiative aimed at improving birth outcomes in the Medicaid population. One of the main Pregnancy Medical Home (PMH) goal is to decrease the rate of low birth weight babies (less than 5 ½ pounds) born in North Carolina. This is to be accomplished by utilizing standardized risk screenings and assessments of all pregnant patients at their first prenatal visit and ensuring patients at risk for poor birth outcomes are connected to a pregnancy care manager. Other key focus areas of the Initiative include a reduction in the rate of primary cesarean -sections and elective deliveries which occur before 39 weeks of gestation as well as an increase in the use of 17P (17-alpha hydroxyprogesterone), a weekly injection which prevents recurrent preterm birth.

Prenatal care providers are encouraged to contract with their local CCNC Network to become a Pregnancy Medical Home (PMH). The PMH identifies pregnant patients identified as having "priority" risk factors at the initial prenatal screening. Priority risk factors include both medical risk, such as a history of preterm birth, a chronic disease that complicates pregnancy, multiple gestation, and/or psychosocial issues, including smoking, the use of alcohol or drugs, or the presence of domestic violence. Each PMH practice has a designatied OB Care Manager. Formerly known as the Maternity Care Coordination Program, OB care management is provided by local health departments in partnership with Community Care and the initiative is being held accountable to specified performance metrics. The OB care manager assesses each patient with priority risk factors and develops an individualized care plan to address her needs.

Pregnant Medicaid patients can be referred for OB care management by any prenatal care provider or community agency when a priority risk factor is identified or suspected, so that the care manager can assess the patient's needs and work with her to provide support and set goals for her pregnancy.

Each CCNC network now has an OB nurse coordinator and an OB physician champion to support this Initiative. PMH practices are eligible to receive incentive payments for completing the initial risk screening and for performing a postpartum visit that involves depression screening, reproductive life planning, and a referral for ongoing care. In addition, the payment to the provider for a vaginal delivery now has been set equal to that for a cesarean section. This eliminates any potential financial incentive to perform cesarean sections.

As a part of the contractual arrangement with the local Network, PMH practices must agree to work on improving quality and performance metrics in the key focus areas of the Initiative and to working closely with Pregnancy Care Managers.

As of early May 2011, approximately 185 practices had contracted with local CCNC Networks to become Pregnancy Medical Homes; about one-third of these are local health department maternal health clinics while two-thirds represent private OB/GYN or family medicine practices. Federally-qualified health centers, rural health clinics, and other providers of prenatal care to pregnant Medicaid patients are eligible to become PMH practices. CCNC Networks are working closely with all stakeholders in their communities to ensure needed deliverysystems redesign and community relationships are in place so that the Pregnancy Home Initiative will achieve its goals.

At the state level, this Initiative is the culmination of a year of planning by an OB Workgroup comprised of representatives from CCNC, DMA and DPH as well as local health departments, private OB providers, maternal-fetal medicine specialists, midwives and care managers. Currently, the CCNC network OB nurse coordinators meet monthly to promote program consistency across the state, and the OB physician champions will have their first in-person meeting in June. CCNC and DPH are co-sponsoring several webinars in June focusing on Smoking Cessation for Pregnant and Postpartum Women, given by a perinatal tobacco use expert from "You Quit Two Quit", a Health and Wellness Trust Fund pilot program. Regular meetings continue to occur among stakeholders from CCNC, DMA and DPH so that efforts are well-coordinated and address implementation issues as they arise.