Enhanced Primary Care Case Management System

Legislative Report

North Carolina Community Care Networks, Inc.

Quarterly Report

As of July 1, 2011

Reporting Requirement (Section 10.28(c))

"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. NCCCN, Inc., shall submit biannual reports 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 develop and implement a plan to address the variations. NCCCN, Inc., shall report the plan to DMA within 30 days after taking any action to implement the plan."

Second Quarter 2011 Highlights

A number of positive trends continued during the second quarter of 2011 compared with prior quarters regarding development of the Enhanced Primary Care Case Management System. NCCCN and the fourteen networks which comprise Community Care of North Carolina (CCNC) continue to make progress in achieving savings for North Carolina's Medicaid Program. Savings are considerable despite the increased medical complexity and fragility of the patients served by CCNC. Highlights include:

- PMPM costs for non-Dual ABD are **2.9% and 9.7% below the 2010 and 2009 experience**, respectively.
- Overall SFY 2011 PMPM costs are **down 8.1 percent** from SFY 2009
- Through the first nine months of SFY 2011:
  - SFY2011 ABD PMPM (total) is **down 16.9 percent** from prior year
  - SFY2011 Non-Dual ABD PMPM is **down 6.8 percent** from prior year. The March YTD PMPM of $1264 is $252/month lower than the non-enrolled ABD per DMA as of July, 2011.
- SFY 2011 rates for **inpatient admissions and emergency department utilization are reduced** from SFY2001 levels. **Inpatient stays** per 1,000 members have **decreased 4.1 percent**.
- The generic **prescriptions fill rate has reached 73.9 percent** for the overall program. This is a significant increase from the 60 percent rate of three years ago, and exceeds the Enhanced Plan target rate for SFY 2011 of 71.9 percent.
- Rates for **Preventable Re-admittances improved at ten of fourteen CCNC networks**, and the overall program showed improvement during the quarter.
- Rates for **Inpatient Admissions and Emergency Department usage have already hit performance targets** for SFY 2011
- CCNC, in concert with the Division of Public Health and the Division of Medical Assistance, successfully launched the **Care Co-ordination for Children (CC4C) Initiative** during April, 2011, and an overview of this initiative is included in this report.
- The **Pregnancy Medical Home Initiative** was launched in April of 2011 and more than 240 practices and clinics are now participating in the effort to improve prenatal care and reduce pre-term births.
- CCNC is working with the **North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services** (MH/DD/SAS) to identify high-risk, high-cost individuals. This information is shared with Local Management Entities (LMEs) and Critical Access Behavioral Health Agencies (CABHAs) to facilitate outreach and intervention.
- CCNC networks partnered with the Governor's Institute on Alcohol and Substance Abuse and with NC DHHS's MH/DD/SAS in obtaining an $8.3 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to support training and tools necessary to implement the Screening, Brief intervention and Referral to Treatment (SBIRT) program in two CCNC pilot networks - Northwest Community Care Network and Community Care of the Sandhills.
- CCNC has been tasked to assist the Division of Medical Assistance in identifying and acting on opportunities to **reduce Medicaid expenditures by $90 million during SFY 2011**. The first step in accomplishing this objective is enrolling approximately 100,000 additional Medicaid recipients in CCNC. Enrollment efforts are already underway and CCNC will be provide additional details on the effort in its October 1, 2011 Legislative Report.

Introduction

North Carolina Community Care Networks, Inc., commonly known as Community Care of North Carolina (CCNC), is a not-for-profit administrative entity that works with local Community Networks to:

(a) Establish, support, and maintain a provider network of primary care medical homes that can implement population-based strategies for CCNC-enrolled Medicaid recipients.

(b) Hire and supervise care managers who work with local providers and patients to provide the wrap around support that is needed to ensure that health care services are coordinated across the full continuum of care; and

(c) Develop processes and formal programs that promote population health management, community development, quality improvement, cost containment efficiencies, appropriate service utilization, budget analytics and forecasting. These efforts allow the North Carolina to meet the challenges of providing health services to the Medicaid population throughout the state, including rural and underserved areas.

Under CCNC's approach to health care delivery, select clinical, disease and case management services are purchased for enrollees. Disease and care management support systems are also established to implement quality improvement initiatives and test new approaches to population management. The approach is based on a fee-for-service model augmented by an enhanced services case management fee. Community Care networks coordinate health care services through Primary Care Providers (PCPs) who provide CCNC enrollees' with "Medical Homes." These efforts allow the State to meet budget performance goals and quality benchmarks.

Pursuant to Session Law 2011-145 §10.28(c), North Carolina Community Care Networks, Inc. is submitting this quarterly report to document the results the implementation of a statewide Enhanced Primary Care Case Management System and associated goals and objectives. While contractual deliberations between NCCCN, Inc. and the Division of Medical Assistance are ongoing, this report includes information with regard to chart review and claims-based performance metrics which we believe will be required by the contract when finalized and executed between DMA and CCNC.

Enrollment and Demographics

The second quarter of 2011 witnessed further growth in enrollment for CCNC's total population and for the Aged, Blind, and Disabled (ABD) category, a continuation of the trend in prior quarters. Total and ABD member enrollment in the Community Care Networks as of July 1, 2011 was 1,085,583 and 203,987, respectively. This is an increase of 1.23% and 2.24% from the December, 2010 amounts. The total number of provider practices enrolled in CCNC is 1,500, a 1.0% increase from April, 2011.

The geographic profile of the Community Care system and its fourteen (14) networks as of April, 2010 is as follows:

Community Care of North Carolina

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 the 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 enrollment as a percentage of total enrollment has increased to 18.8% as of July 1, 2011. As a result, CCNC continues to see a greater influx of ABD patients with more complex and chronic medical needs. This impacts the health acuity levels of the enrolled membership as discussed later in this report.

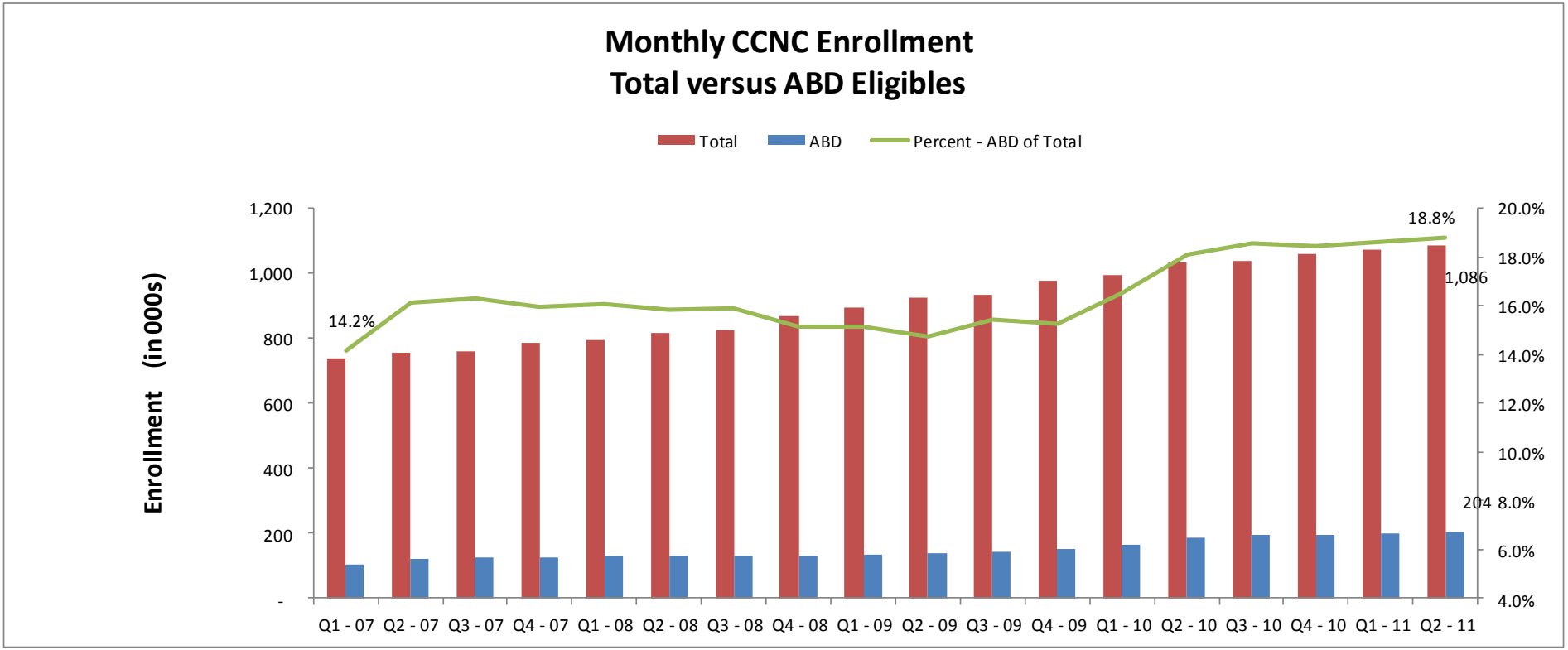
As mentioned in previous reports, the ABD population is enrolled into the CCNC program by DMA and county social service agencies. The rate of ABD enrollment was slowed during 2010 as a result of an order from the Centers for Medicare and Medicaid Services (CMS) to cease automatically enrolling dual eligibles into the CCNC program through an "opt-out" enrollment process. However, DMA has worked with CMS and the cease and desist order was lifted during the latter part of April, 2011. A demographic profile as of July 1, 2011 and growth by quarter during the past several years follows:

Demographic Profile as of July 2011

	CCNC Enrolled									Non - Enrolled -a)				Per cent of Medicaid Program Enrolled -b)		
	ABD			non- ABD			Total			ABD		non- ABD				
Network	Dual	non-Dual	Total	Dual	non-Dual	Total	Dual	non-Dual	Total	Dual	non-Dual	Dual	non-Dual	Total	ABD	non-ABD
Access Care	**15,386**	**22,041**	**37,427**	**64**	**191,943**	**192,007**	15,450	213,984	229,434	**28,023**	**8,245**	**14,032**	**34,622**	73%	51%	80%
Community Care of Western North Car	**5,608**	**5,620**	**11,228**	**24**	**42,801**	**42,825**	5,632	48,421	54,053	**7,963**	**2,160**	**4,071**	**8,116**	71%	53%	78%
Community Care of Lower Cape Fear	**6,522**	**7,808**	**14,330**	**24**	**44,048**	**44,072**	6,546	51,856	58,402	**7,321**	**2,174**	**3,765**	**8,284**	73%	60%	79%
Carolina Collaborative Community Car	**3,674**	**6,004**	**9,678**	**16**	**38,536**	**38,552**	3,690	44,540	48,230	**3,338**	**1,389**	**1,355**	**5,956**	80%	67%	84%
Carolina Community Health Partnersh	**1,455**	**2,547**	**4,002**	**4**	**19,924**	**19,928**	1,459	22,471	23,930	**4,212**	**1,234**	**2,057**	**3,650**	68%	42%	78%
Community Care Partners of Greater M	**8,809**	**11,147**	**19,956**	**25**	**103,945**	**103,970**	8,834	115,092	123,926	**7,919**	**3,689**	**4,193**	**14,913**	80%	63%	84%
Community Care of Wake and Johnstor	**3,952**	**7,796**	**11,748**	**23**	**70,819**	**70,842**	3,975	78,615	82,590	**9,623**	**3,050**	**3,278**	**13,100**	74%	48%	81%
Community Care Plan of Eastern Caroli	**17,348**	**19,504**	**36,852**	**58**	**97,625**	**97,683**	17,406	117,129	134,535	**20,449**	**6,134**	**8,995**	**18,856**	71%	58%	78%
Community Health Partners	**2,316**	**3,492**	**5,808**	**11**	**27,907**	**27,918**	2,327	31,399	33,726	**4,749**	**1,578**	**2,764**	**5,631**	70%	48%	77%
Northern Piedmont Community Care	**4,376**	**5,885**	**10,261**	**17**	**40,781**	**40,798**	4,393	46,666	51,059	**6,769**	**2,436**	**2,825**	**8,093**	72%	53%	79%
Northwest Community Care Network	**7,424**	**8,482**	**15,906**	**21**	**63,670**	**63,691**	7,445	72,152	79,597	**7,845**	**1,270**	**5,104**	**8,114**	78%	64%	83%
Partnership for Health Management	**3,066**	**4,828**	**7,894**	**12**	**54,676**	**54,688**	3,078	59,504	62,582	**12,880**	**6,715**	**5,301**	**20,580**	58%	29%	68%
Community Care of the Sandhills	**4,806**	**6,224**	**11,030**	**24**	**45,257**	**45,281**	4,830	51,481	56,311	**6,379**	**2,071**	**3,533**	**7,025**	75%	57%	81%
Southern Piedmont Community Care P	**3,387**	**4,518**	**7,905**	**10**	**39,375**	**39,385**	**3,397**	**43,893**	**47,290**	**4,381**	**960**	**2,745**	**5,299**	78%	60%	83%
Total	88,129	115,896	**204,025**	333	881,307	**881,640**	88,462	997,203	**1,085,665**	131,851	43,105	64,018	162,239	73%	54%	80%

(a- Unenrolled attributed to Network based on county of residence

(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 who are not eligible for enrollment in CCNC.


Monthly CCNC Enrollment
Total versus ABD Eligibles
Total
ABD
Percent - ABD of Total
Enrollment (in 000s)
1,200
1,000
800
600
400
200
-
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
14.2%
18.8%
1,086
204
Q1 - 07
Q2 - 07
Q3 - 07
Q4 - 07
Q1 - 08
Q2 - 08
Q3 - 08
Q4 - 08
Q1 - 09
Q2 - 09
Q3 - 09
Q4 - 09
Q1 - 10
Q2 - 10
Q3 - 10
Q4 - 10
Q1 - 11
Q2 - 11

Quarterly Reported Measures and Improvement Targets

Quality of Care Measures – Patient Chart Reviews

Since its inception in 1998, CCNC has used performance measurement and feedback to help meet the goal of improving quality of care for Medicaid recipients while controlling costs. Quality measurement is intended to facilitate quality improvement efforts in participating practices and local networks and 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 state's changing needs. It is expected that this evolution will continue through:

- Continued expansion of the Community Care system's enrolled population and increasing focus on the ABD population whose members frequently suffer from multiple chronic conditions;
- Development of additional quality initiatives;
  Changes in evidence-based clinical practice guidelines;
  Decisions rendered by Community Care's Quality Measurement and Performance workgroup whose representatives meet periodically to review and improve performance measures. The workgroup's goal is to develop performance measures with:
  - Clear prioritization 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 implementation.

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. Community Care continues to contract with Area Health Education Centers to perform independent, 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 left ventricular (LV) function in heart failure

As reported in the January 1, 2011 Quarterly Report, chart reviews for the SFY 2010 cycle were completed in 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.*

Risk Adjusted Analyses

The majority of CCNC's metrics report clinical and financial results on a "raw" basis since the acuity level of the networks' enrolled populations is not considered. It is important that some metrics adjust for varying acuity so we can measure the effectiveness of our initiatives apart from the differences in health status of subgroups in our population. As noted in previous quarterly reports, Community Care has contracted with a data analytics firm, Treo Solutions, LLC which specializes in the analysis of health care delivery organizations and their enrolled populations, including state Medicaid populations.

At Community Care's request, Treo has analyzed North Carolina's ABD non-dual population enrolled in CCNC and compared it to ABD non-duals who have not been enrolled into a CCNC network. The analysis examined claims from 2007 thru June of 2010, and the full report is attached to this legislative report as *Attachment C*. Highlights of Treo's findings include:

- CCNC has consistently **demonstrated an ability to restrain system costs** relative to trends experienced in North Carolina's unenrolled population. CCNC's costs are 1.5% lower than expected compared with an unenrolled spend exceeding expectations by 10.1%
- During the period analyzed, **CCNC enrolled a greater proportion of patients with complex, expensive health needs**. The ABD non-dual enrolled population increased by 33%. Accounting for only 10% of non-dual enrollment, the adult ABD population consumes 36% of Medicaid's spend
- The overall risk score for the enrolled ABD non-dual population is now higher than that of the unenrolled population, 3.50 versus 3.35. This means that **81% of the CCNC enrollees have either a dominant or moderate chronic condition, a malignancy or a catastrophic health condition** as compared with 68% of the unenrolled population.
- There is a strong indication that **CCNC is providing better access to health care** with only 4.1% of enrollees not using the health care system at all versus 13.5% of the unenrolled population.
- CCNC has had a **favorable impact on the cost of treating mental illness**. Nearly one-third of the enrolled ABD non-dual members has a serious and chronic mental illness. Yet spending for this population has declined by 0.2% while increasing 3.1% outside of CCNC.

Operational Measures - Medicaid Claims Review

Medicaid claims data is analyzed and performance metrics are developed and reported monthly at the network, practice and county levels. The performance targets[1] associated with these metrics are classified as:

Per Member per Month Metrics developed as part of 2008 efforts to enroll ABD recipients into CCNC medical homes. Per contract with DMA, the baseline for these metrics is SFY 2009-2010 with performance targets for:

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

Enhanced Plan Metrics that evaluate performance under the Enhanced Plan for which CCNC networks began receiving an enhanced PMPM fee in April, 2010. Per agreement with DMA, the baseline for these metrics is SFY 2009-2010. These metrics measure performance in:

1. Reducing Preventable Readmissions (within 30 days) as a percent of total non-Dual admissions.
2. Reducing readmissions (within 30 days) for non-dual behavioral health patients
3. Decreasing Program-level PMPM inpatient costs - (last three months of life reported on a rolling 12 month basis) for the non-Dual ABD population (reported quarterly)
4. Increasing the percentage of practices with co-located behavioral health providers (reported annually)
5. Increasing non-Dual use of generic medications as a percent of all fills
6. Clinical Integrity Efforts (reported quarterly)
7. Decreasing ABD per member per month costs (alternative to metrics 1, 2 and 3)

Community Care and the Division of Medical Assistance continue to develop methodological specifications for several Enhanced Plan metrics for which it is expected that agreement will be reached. These include programming and quality assurance testing for measure number 2 above (reducing readmissions for non-Dual psychiatric diagnoses and the development of metrics for number 3 above (decreasing program-wide inpatient costs for non-Dual ABD beneficiaries in the last three months of life). Measure number 3 involves palliative care, a dimension on which CCNC is reporting for the first time. While there is no change in metric number 4 (co-located behavioral health providers) from the April 2011 report, information on this annual measure is included for the sake of completeness.

Non-risk-adjusted reporting for the remaining elements of the Enhanced Plan and PMPM measures is ongoing. Where relevant, the following tables provide 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.

[1] Performance targets are identified for each metric as appropriate. Unless stated otherwise, all analyses are based on dates of service.

Topline Operational Results

ABD costs down

The overarching goal of the Enhanced Plan, to reduce unnecessary spending for the Aged, Blind and Disabled Medicaid population, is being achieved. Monthly PMPM costs in SFY 2011 continue to track well below the SFY 2010 experience and the PMPM results through March 2011. See the graphs on page 24 for details.

Inpatient and ED use down

SFY 2011 rates for inpatient admissions and emergency department utilization continue to track well below the SFY2010 experience. The preventable readmission rate continues to hover slightly below 15%. This measure reflects the proportion of preventable hospital admissions that represent a preventable readmission occurring within 30 days of a prior discharge. Community Care's experience suggests that it is difficult to significantly reduce preventable readmissions while the total number of admissions is declining. See the graphs on paged 13 and 15.

Generic use high

The preferred use of generic prescriptions instead of more costly alternatives continues to rise, and is now at 73.9 percent for the overall program. The success of CCNC's generic prescription initiative has been quite remarkable, with an overall increase from 60 percent to 73.9 percent during the past three years, exceeding the Enhanced Plan target rate for SFY 2011 of 71.9 percent. See chart on page 21 for details.

Palliative care metrics mixed

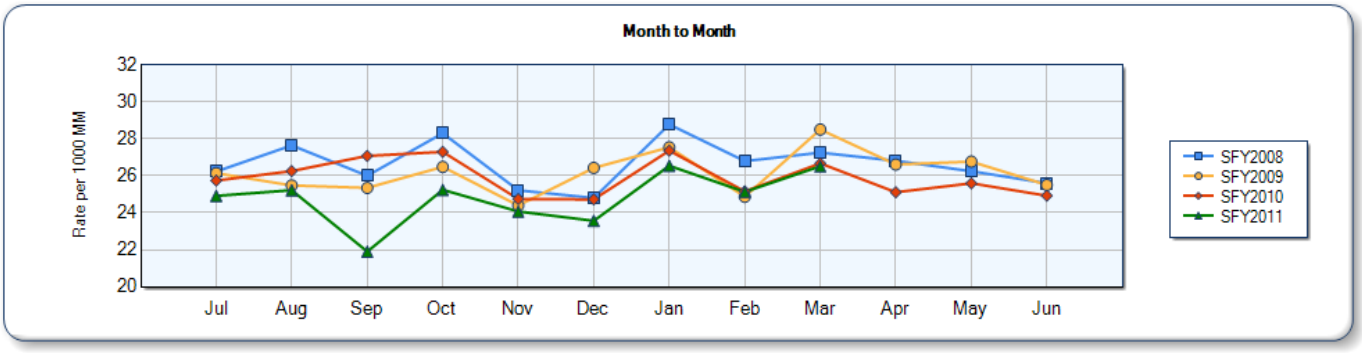
Average inpatient costs incurred during the 90 day period immediately preceding death increased by 1.8 percent on a rolling twelve month basis (to $4,908 from $4,820, March 31, 2011 versus March 31, 2010). Inpatient stays per 1,000 member months have decreased from 412 to 395 during the three month period, a decrease of 4.1 percent. See the charts on page 18 for details.

Fraud-recovery opportunities identified

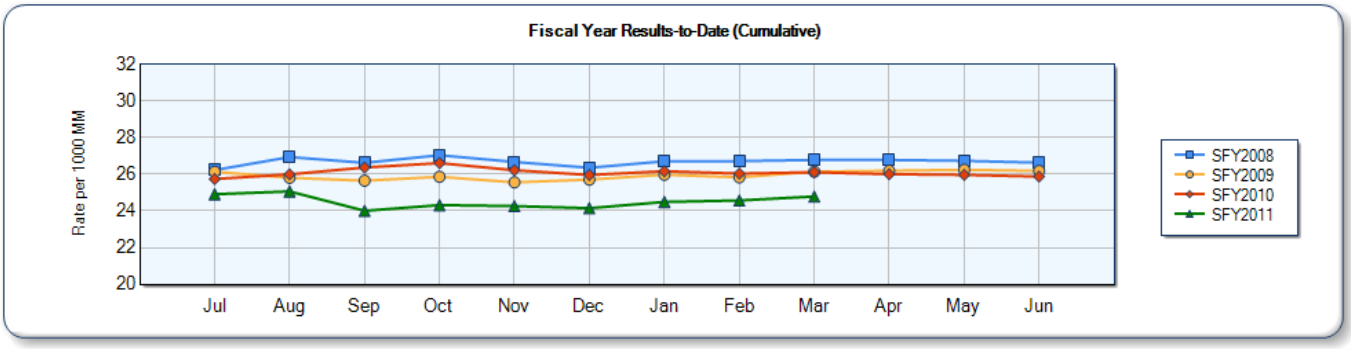
With respect to clinical integrity, the report summarizes the results of efforts to identify "low-hanging fruit" where pursuit of recoveries or cost avoidance might be achieved more easily. Specific recommendations are detailed on page 23.

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	26.5	25.1	26.5	-	-	-

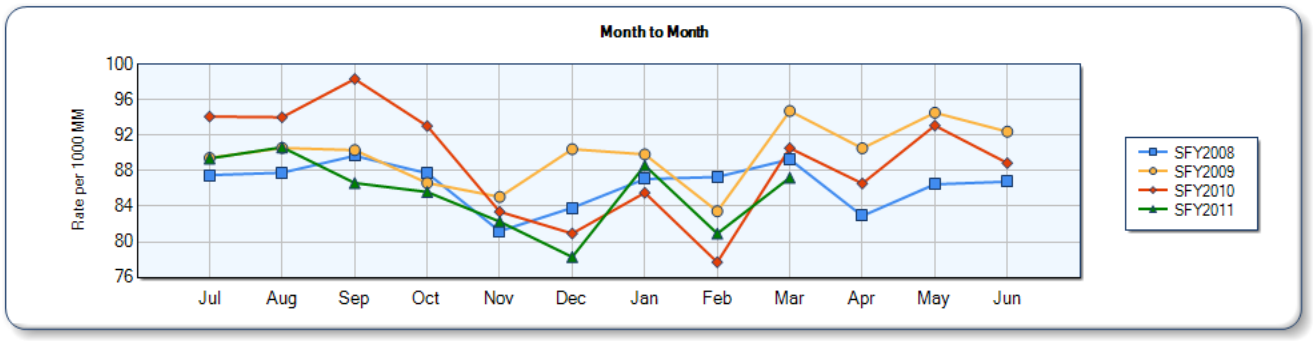


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	26.2	26.9	26.6	27.0	26.7	26.4	26.7	26.7	26.8	26.8	26.7	26.6
SFY2009	26.1	25.8	25.7	25.9	25.6	25.7	26.0	25.8	26.1	26.2	26.2	26.2
SFY2010	25.7	26.0	26.4	26.6	26.2	26.0	26.2	26.0	26.1	26.0	26.0	25.9
SFY2011	24.9	25.1	24.0	24.3	24.3	24.2	24.5	24.6	24.8	-	-	-

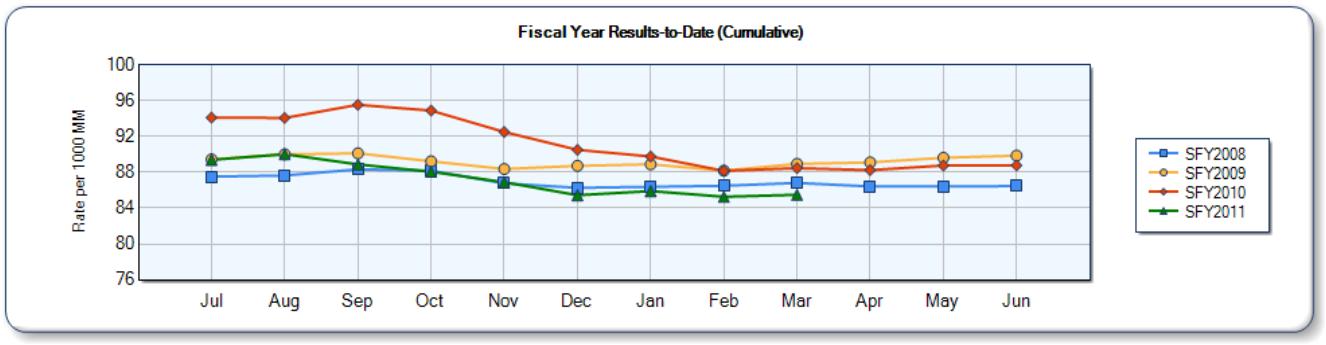
	Historical															
			SFY 10	Actual SFY 11 (Year - to - Date)												
Network	SFY 08	SFY 09	Baseline	Target*	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of WC	26.7	26.6	25.8	25.3	27.8	28.0	26.8	25.3	24.8	24.5	25.0	25.1	25.0			
Community Care of Lower Cape Fear	25.9	25.3	26.3	25.8	26.8	27.0	27.1	27.1	26.3	25.8	25.5	25.3	25.2			
Access Care	25.6	24.7	23.3	22.8	22.7	22.6	21.7	22.2	22.4	22.5	22.8	22.9	23.1			
Carolina Collaborative Community Care	25.0	22.9	23.7	23.2	24.3	24.8	23.6	24.3	24.7	24.7	25.1	25.0	25.2			
Carolina Community Health Partnership	25.5	25.9	24.0	23.5	28.5	27.4	26.0	25.7	24.0	23.5	23.4	24.2	24.7			
Community Care - Wake/Johnston	22.8	22.8	23.2	22.7	18.0	19.3	19.8	20.5	20.6	20.3	20.8	20.8	21.1			
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	27.0	26.9	27.1			
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	24.3	24.3	24.7			
Community Health Partners	33.9	31.8	32.1	31.5	30.4	30.6	28.1	27.8	27.7	27.0	27.8	27.8	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	22.8	22.7	22.9			
Northwest Community Care	33.1	30.2	30.2	29.6	28.1	27.8	27.9	27.8	27.7	27.5	27.5	27.6	27.8			
Partnership for Health Management	26.6	30.2	29.3	28.7	27.3	25.9	23.8	23.3	23.9	23.6	24.3	24.7	25.3			
Sandhills Community Care Network	32.5	33.9	29.1	28.5	27.4	28.6	26.7	28.6	28.3	27.7	28.2	28.4	28.5			
Southern Piedmont Community Care	21.8	24.4	22.4	22.0	23.1	22.3	20.4	21.1	20.9	20.5	20.9	21.4	21.7			
CCNC Total	26.6	26.2	25.9	25.4	24.9	25.1	24.0	24.3	24.3	24.2	24.5	24.6	24.8			
* Target is a 2% Reduction from 2010 Baseline Rate																

Ten of the fourteen networks as well as CCNC in total continue to meet the 2011 targets.

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	88.6	80.9	87.2	-	-	-



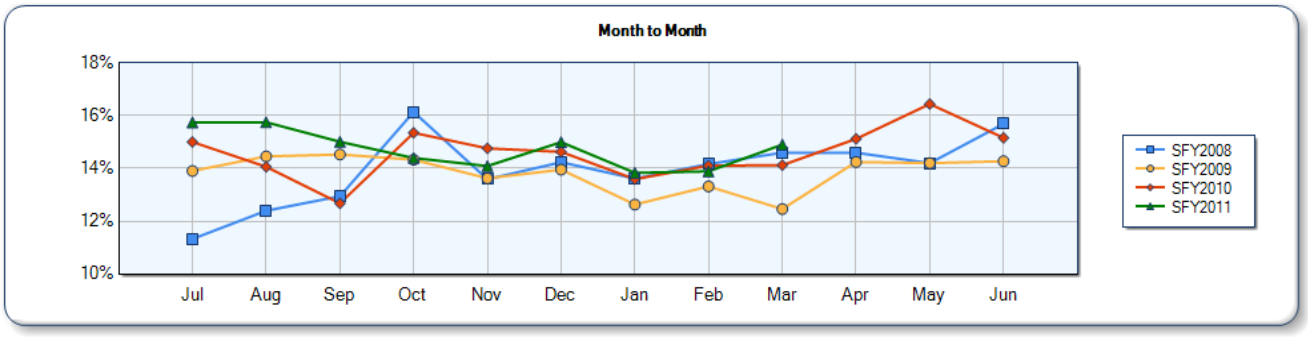
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	87.5	87.6	88.3	88.2	86.8	86.3	86.4	86.5	86.8	86.4	86.4	86.5
SFY2009	89.4	90.0	90.1	89.2	88.4	88.7	88.9	88.2	88.9	89.1	89.6	89.9
SFY2010	94.1	94.1	95.5	94.9	92.5	90.5	89.8	88.2	88.5	88.2	88.8	88.8
SFY2011	89.4	90.0	88.9	88.1	86.9	85.4	85.9	85.3	85.5	-	-	-

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	79.4	79.0	79.9			
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	86.2	85.6	85.6			
Access Care	83.2	86.1	85.8	84.1	88.5	88.9	89.1	88.0	86.9	85.0	85.3	84.7	84.8			
Carolina Collaborative Community Care	58.6	52.0	55.2	54.1	49.0	45.6	47.0	48.3	49.3	48.6	49.4	49.5	49.3			
Carolina Community Health Partnership	108.8	127.7	124.1	121.6	127.4	129.7	129.8	129.9	128.2	125.0	126.4	125.9	126.8			
Community Care - Wake/Johnston	83.2	86.7	80.5	78.9	72.0	76.4	76.6	76.3	76.3	74.7	74.9	74.0	74.2			
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	91.7	91.3	91.8			
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	85.5	84.6	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	97.7	98.8	100.4			
Northern Piedmont Community Care	85.6	92.1	93.0	91.1	92.6	95.0	92.7	91.2	89.4	88.7	89.8	89.0	89.3			
Northwest Community Care	97.9	100.2	99.1	97.1	103.5	102.2	100.6	98.3	97.2	95.2	95.5	95.1	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	80.6	79.1	79.1			
Sandhills Community Care Network	90.7	97.0	95.9	94.0	93.4	96.5	93.8	94.0	92.2	90.6	90.7	90.0	90.5			
Southern Piedmont Community Care	91.3	100.2	98.0	96.0	94.8	99.0	96.6	97.6	95.9	94.1	93.1	91.5	90.4			
CCNC Total	86.5	89.8	88.8	87.0	89.4	90.0	88.9	88.1	86.9	85.4	85.9	85.3	85.5			
* Target is a 2% reduction from 2010 Baseline Rate																

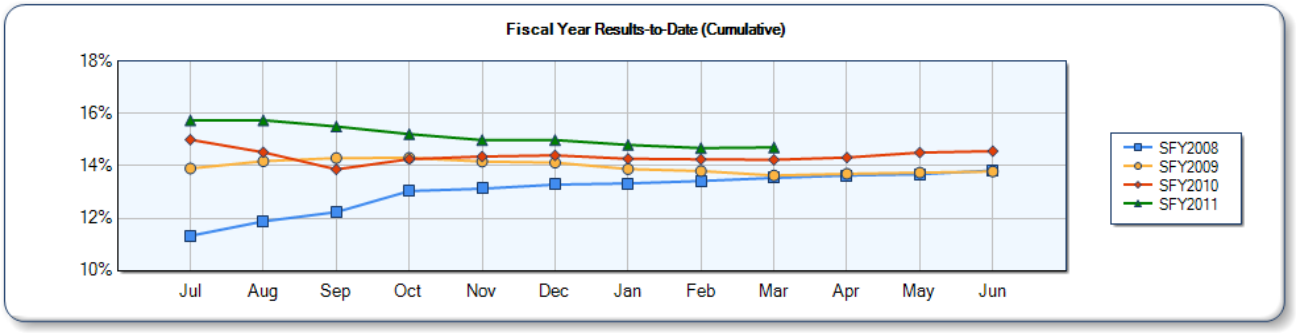
Eleven of the fourteen networks as well as CCNC in total continue to meet the 2011 targets.

Enhanced Plan Metrics

Preventable Readmissions – Enrolled ABD - 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%	13.8%	13.9%	14.9%	-	-	-

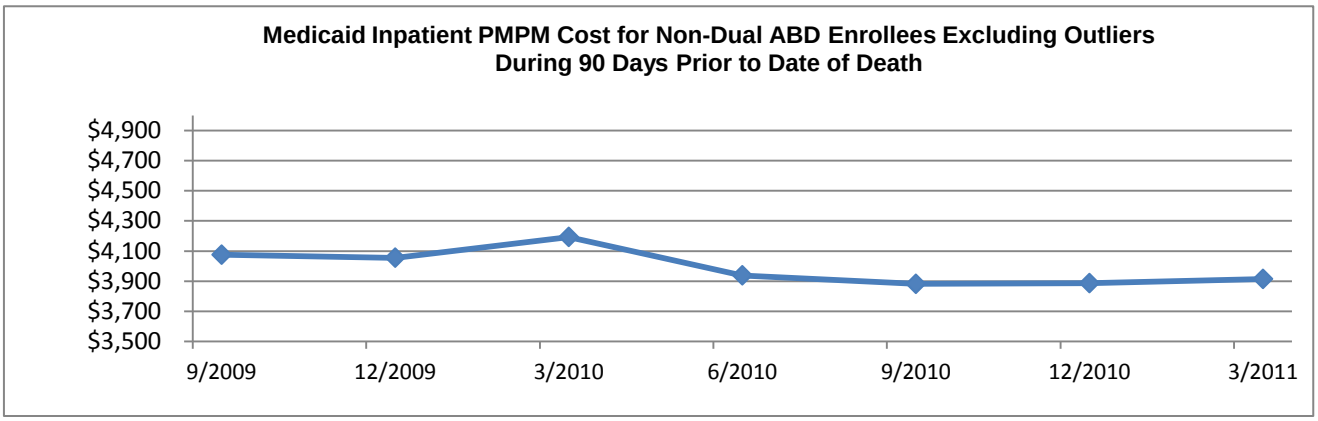


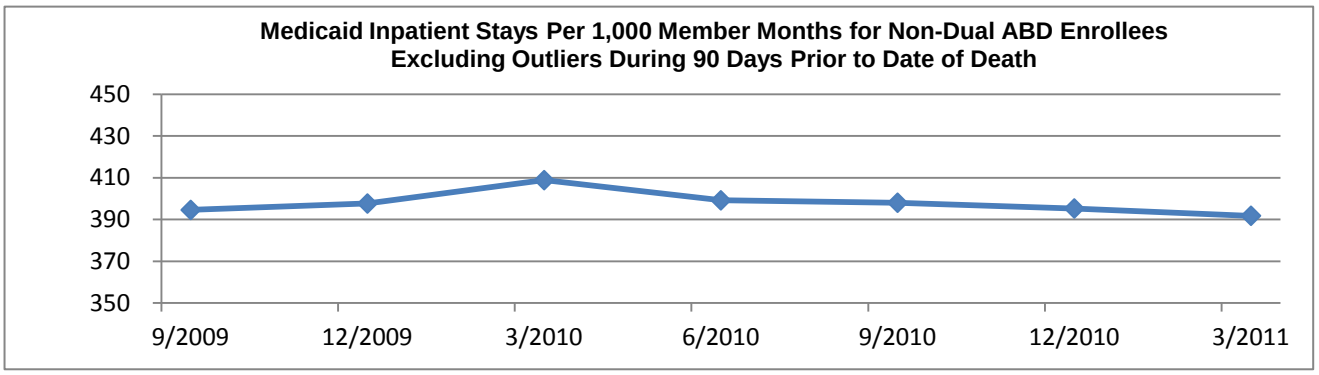
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	11.9%	12.2%	13.0%	13.1%	13.3%	13.3%	13.4%	13.5%	13.6%	13.7%	13.8%
SFY2009	13.9%	14.2%	14.3%	14.3%	14.2%	14.1%	13.9%	13.8%	13.6%	13.7%	13.7%	13.8%
SFY2010	15.0%	14.5%	13.9%	14.3%	14.4%	14.4%	14.3%	14.2%	14.2%	14.3%	14.5%	14.6%
SFY2011	15.7%	15.7%	15.5%	15.2%	15.0%	15.0%	14.8%	14.7%	14.7%	-	-	-

Network	SFY 08	SFY 09	Baseline	**Target***	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Access II of WC	12.0%	13.0%	12.8%	12.3%	14.2%	15.6%	15.7%	15.3%	14.8%	14.6%	14.2%	14.0%	13.7%			
Access III of Lower Cape Fear	12.7%	12.2%	13.9%	13.3%	13.4%	13.8%	14.6%	14.4%	13.7%	13.5%	13.2%	12.8%	12.6%			
Access Care	13.5%	12.3%	12.9%	12.4%	14.6%	13.6%	12.6%	12.5%	12.4%	12.7%	12.6%	12.7%	12.8%			
Carolina Collaborative Community Care	13.4%	15.4%	19.7%	18.9%	20.2%	20.0%	19.7%	19.4%	19.7%	20.3%	20.4%	20.2%	19.9%			
Carolina Community Health Partnership	11.6%	11.6%	12.3%	11.8%	9.4%	10.9%	10.7%	10.9%	11.9%	11.4%	11.2%	11.1%	11.8%			
Community Care - Wake/Johnston	13.5%	12.9%	13.2%	12.7%	13.9%	14.5%	14.5%	14.1%	13.6%	13.3%	13.1%	12.8%	12.9%			
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%	14.5%	14.6%	14.6%			
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%	15.9%	15.9%	15.9%			
Community Health Partners	12.5%	13.6%	13.7%	13.2%	15.1%	15.0%	13.2%	14.0%	14.6%	15.1%	14.7%	14.8%	14.7%			
Northern Piedmont Community Care	14.4%	13.2%	16.9%	16.2%	13.5%	15.8%	16.5%	16.5%	16.6%	17.0%	16.9%	16.3%	16.1%			
Northwest Community Care	18.0%	16.3%	17.3%	16.6%	19.9%	20.6%	19.9%	19.0%	18.0%	18.0%	18.1%	17.6%	17.9%			
Partnership for Health Management	14.8%	13.9%	15.2%	14.6%	21.2%	19.9%	20.0%	18.9%	17.8%	17.0%	16.0%	16.0%	16.5%			
Sandhills Community Care Network	14.5%	14.5%	13.1%	12.6%	14.4%	14.9%	15.4%	15.2%	15.1%	15.1%	15.1%	14.5%	14.4%			
Southern Piedmont Community Care	11.2%	12.4%	13.3%	12.8%	13.3%	16.5%	15.9%	15.5%	14.9%	14.0%	13.6%	13.9%	14.0%			
CCNC Total	13.8%	13.8%	14.6%	**14.0%**	15.7%	15.7%	15.5%	15.2%	15.0%	15.0%	14.8%	14.7%	14.7%			
* Target is a 4% Reduction from 2010 Baseline Rate																

Two of the fourteen networks currently are meeting the 2011 performance target.

Inpatient PMPM (90 Days – Enrolled ABD - Non-Duals, excluding outliers)[2]





The Enhanced Plan uses the inpatient cost PMPM metric to evaluate the efficacy of CCNC's palliative care efforts. The original presumption was that PMPM costs should decrease as palliative care efforts become more effective. While current measures for this metric are favorable, we expect that there is a limit to the cost-cutting impact of palliative care since some patient situations are unresponsive to these interventions and the availability of palliative care resources in inpatient and community settings varies considerably from one region to another. Also, this metric appears to fluctuate significantly for reasons unrelated to performance in palliative care. Given our concerns about cost as a measure of palliative care performance, we have included data on the number of inpatient stays in the last 90 days of life for comparison.

For example, one three-month period witnessed a 6.8 percent increase in deaths, a 7.1 percent increase in member months and an 8.7 percent increase in costs reported such that costs on a PMPM basis increased by 1.5 percent, all compared to the previous three months. On the other hand, inpatient stays per death and stays per member month both decreased by approximately 1 percent. It is apparent that there is significant variability with respect to deaths, stays, and member months. In particular, costs fluctuate markedly across networks and at the programmatic level as well, probably driven by the specifics of each end-of-life situation. As a result, this metric may need to be revisited.

[2] Because the average cost can be skewed by a small handful of unusually high cost outliers, we report the data excluding the top 1 percent of cases based on inpatient costs during that quarter.

Behavioral Health Integration

Behavioral health integration (BHI) is a long-term plan to build capacity at the primary care level to identify behavioral needs and provide evidence-based treatment. In many areas, the PCP is the only behavioral treatment provider/prescriber for mental health, often with little detailed training in the field.

The integration of behavioral health and primary care is aimed at breaking a "silo" system of care that fails to consider that patients frequently possess mental and physical co-morbidities. BHI recognizes our commitment to move beyond a health care delivery system that splits the mind and body by providing the resources and expertise needed to align the efforts of primary care and behavioral health care professionals.

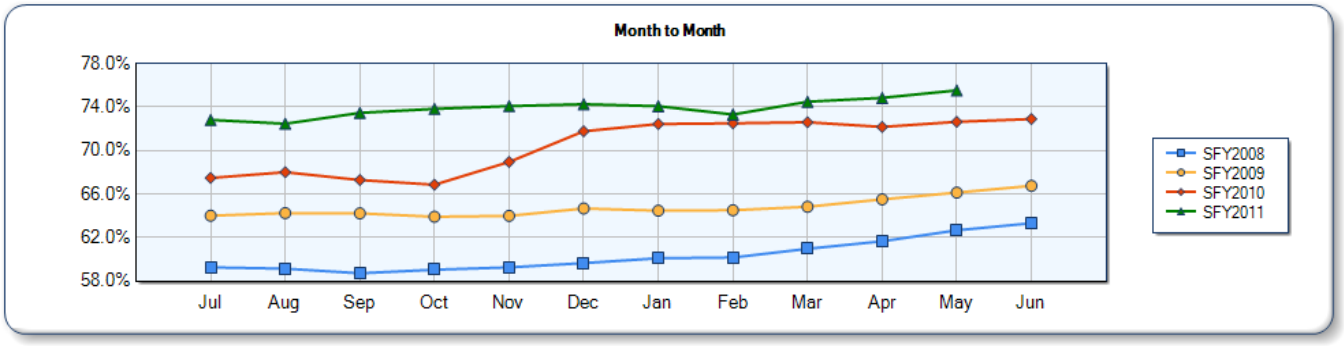
CCNC's behavioral health programs include A+Kids, an effort to promote the safe and efficacious use of anti-psychotic medications, and the Chronic Pain Initiative, a model successfully demonstrated in Wilkes County now being implemented across the state

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

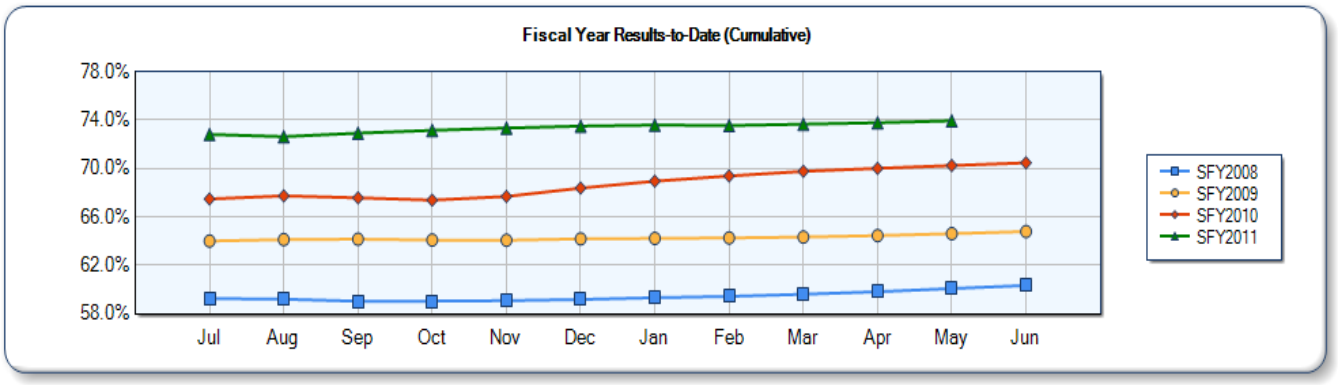
Network	Number of Practices -a), -b) Total	BH Specialist	BH Specialist as % of Total	Calendar Year 2011 Target
AccessCare	281	11	3.91%	
Community Care of Western Carolina	69	12	17.39%	
Community Care of Lower Cape Fear	135	12	8.89%	
Carolina Collaborative Community Care	82	1	1.22%	
Carolina Community 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%	74.5%	74.8%	75.5%	-



	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%	73.7%	73.8%	73.9%	-

Generic Medications as Percent of All Fills																	
	Historical																
			SFY 10	Actual SFY 11 (Year - to - Date)													
Network	SFY 08	SFY 09	Baseline	Target*	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%	74.3%	74.4%	74.5%		
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%	73.4%	73.5%	73.7%		
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%	74.0%	74.2%	74.3%		
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%	73.9%	74.1%	74.2%		
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%	72.1%	72.3%	72.5%		
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%	74.3%	74.5%	74.7%		
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%	71.4%	71.6%	71.9%		
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%	73.0%	73.1%	73.3%		
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%	74.1%	74.3%	74.4%		
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%	73.2%	73.3%	73.5%		
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%	74.3%	74.4%	74.7%		
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%	73.2%	73.3%	73.4%		
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%	72.9%	72.9%	73.1%		
Sandhills Community Care Network	59.6%	64.3%	70.4%	71.8%	73.5%	73.0%	73.3%	73.5%	73.6%	73.7%	73.8%	73.6%	73.7%	73.9%	74.1%		
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%	72.5%	72.6%	72.7%		
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%	73.7%	73.8%	73.9%		
* 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 4.8% above SFY 2010 on a YTD basis.

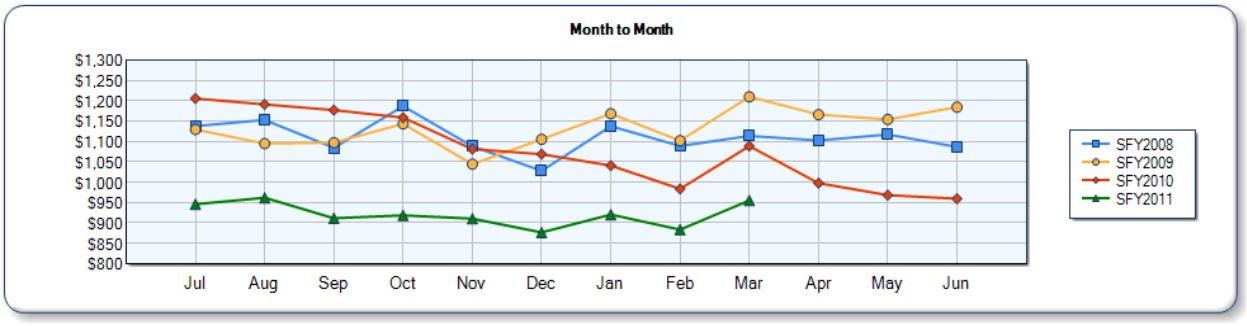
Clinical Integrity Efforts

CCNC continues to meet with DMA's Program Integrity organization frequently to review the results of efforts to identify questionable billing practices. The group reviews information received from network personnel and analyses of claims made by CCNC physician consultants. In addition, a meeting was held with DMA senior management to provide them with a sense of where to find "low-hanging fruit" – areas of concentration likely to result in more rapid recoveries while conserving Program Integrity resources. The details of discussions with DMA can be found in *Attachment B* to this quarterly report. A summary of areas where the state could potentially save upwards of $20 million is listed below. One of our recommendations is that DMA consider modifying its clinical policies to more closely align with Medicare policies in areas such as drug and allergy testing. Currently Medicare reimburses providers for fewer units than North Carolina's Medicaid program on many common procedure codes.

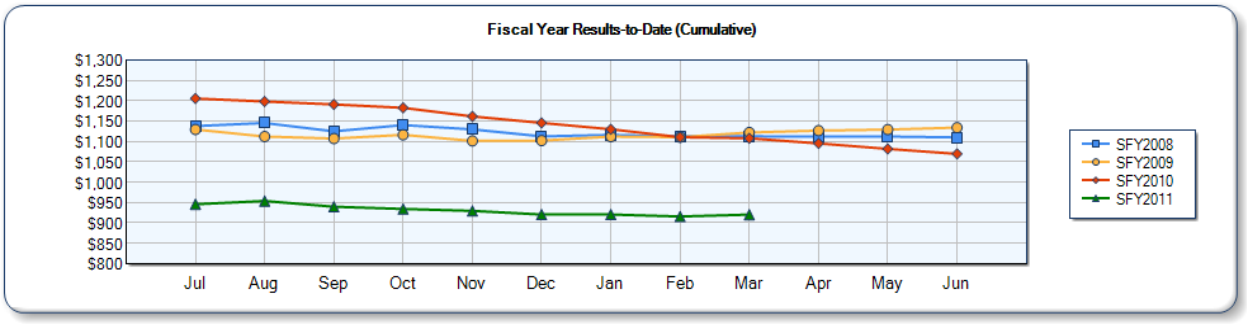
Low-hanging fruit – ESTIMATES BASED ON PAID CLAIMS

Service	**Potential savings**	**Ease (from CCNC's reviewer's perspective)**
Urine Drug Screens	$16Million	Might not be able to recoup, but avert future$
Allergy testing	$614K	Easy
Unbundling of Inpatient services	Likely $500K +	Difficult, would need more integration at PI
Glucose Test Strips	$101K	Easy, need edit to work
J-codes (injected medicines)	$300K	Labor intensive
HIV Case management	$300K	May be done, but implications elsewhere
Prostate Biopsies	$260K	Easy, may need to justify
Chiropractic – MPWs and children	$175K	Easy policy-wise, maybe tough politically
Bili lights	$100K	Easy, need edit to work
Supplies and Parenteral Nutrition	$50K	Labor intensive

PMPM Cost – Enrolled ABD



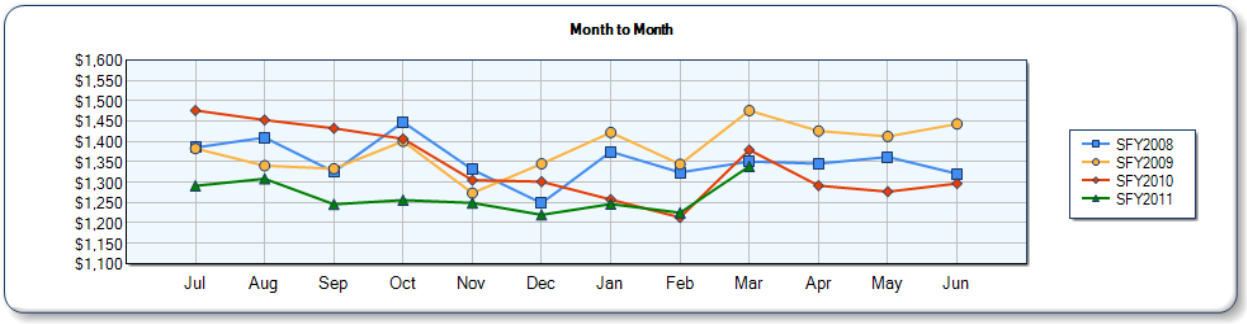
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,138	$1,153	$1,084	$1,187	$1,088	$1,028	$1,137	$1,089	$1,114	$1,103	$1,117	$1,087
SFY2009	$1,129	$1,095	$1,097	$1,143	$1,044	$1,105	$1,168	$1,102	$1,210	$1,166	$1,154	$1,184
SFY2010	$1,205	$1,191	$1,177	$1,159	$1,081	$1,069	$1,041	$983	$1,089	$998	$968	$959
SFY2011	$946	$962	$911	$918	$910	$876	$920	$883	$955	-	-	-



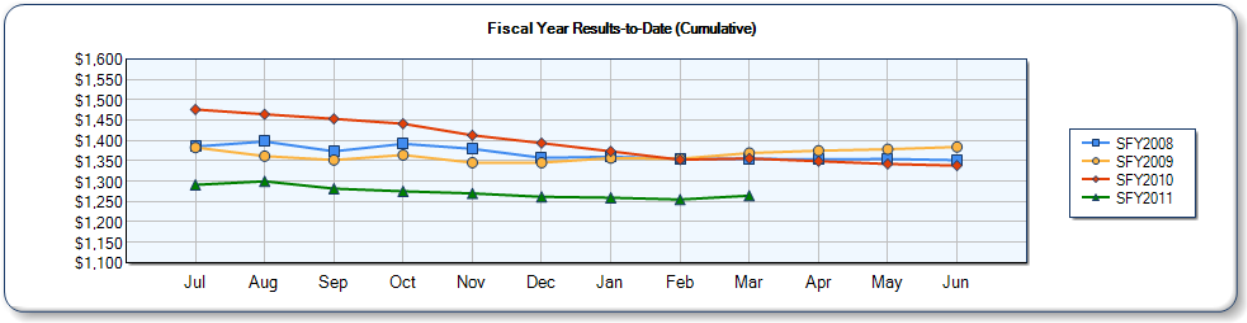
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,138	$1,145	$1,125	$1,140	$1,130	$1,112	$1,116	$1,113	$1,113	$1,112	$1,112	$1,110
SFY2009	$1,129	$1,112	$1,107	$1,116	$1,101	$1,102	$1,112	$1,111	$1,122	$1,127	$1,130	$1,135
SFY2010	$1,205	$1,198	$1,191	$1,182	$1,161	$1,145	$1,129	$1,110	$1,107	$1,095	$1,081	$1,069
SFY2011	$946	$954	$939	$934	$929	$920	$920	$915	$920	-	-	-

Note the 16.9% PMPM under-run in SFY 2011 versus SFY 2010 thru March YTD when all ABD (dual and non-dual) are compared.

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	$1,246	$1,225	$1,339	-	-	-

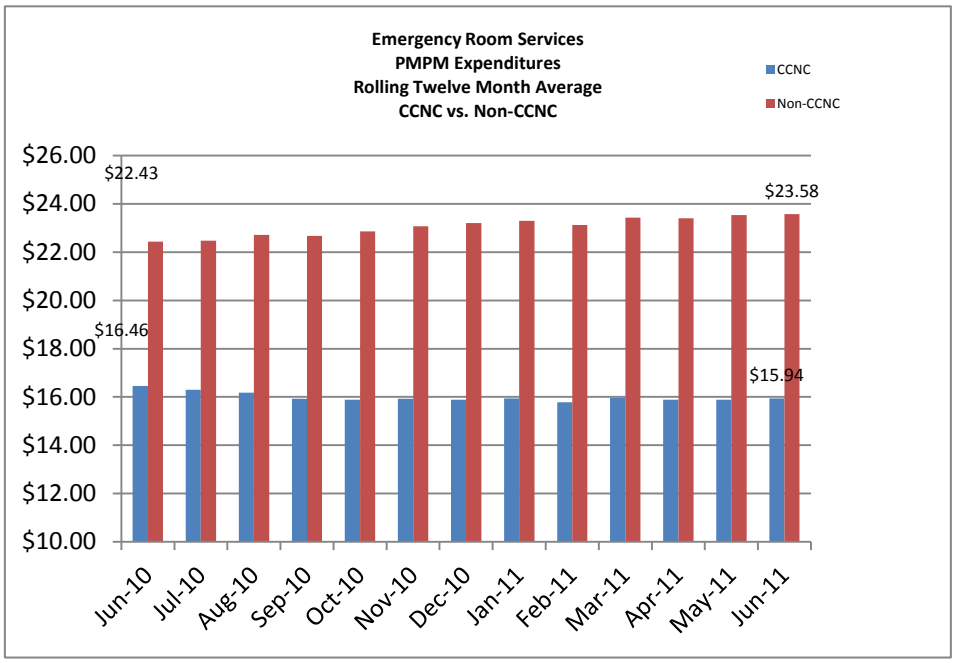


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,398	$1,373	$1,392	$1,379	$1,357	$1,360	$1,355	$1,355	$1,354	$1,355	$1,352
SFY2009	$1,383	$1,361	$1,352	$1,364	$1,345	$1,345	$1,356	$1,355	$1,369	$1,375	$1,379	$1,385
SFY2010	$1,476	$1,464	$1,453	$1,441	$1,413	$1,394	$1,374	$1,353	$1,356	$1,350	$1,343	$1,339
SFY2011	$1,291	$1,300	$1,281	$1,274	$1,269	$1,261	$1,259	$1,254	$1,264	-	-	-

Note the 9.4% PMPM under run in SFY 2011 versus SFY 2010 thru March YTD.

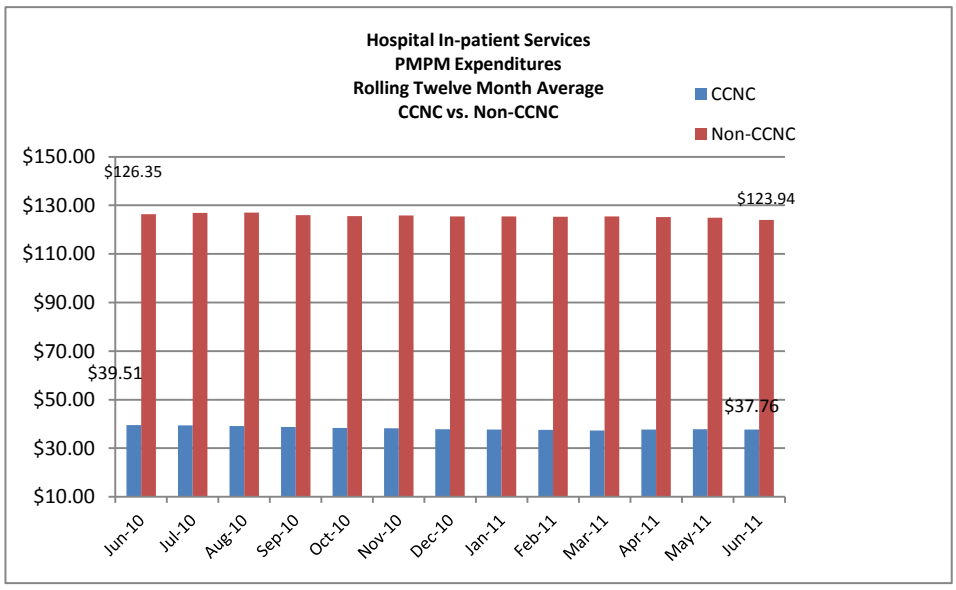
Performance on Categories of Service (COS) Reported by DMA

The Division of Medical Assistance (DMA) publishes dashboard metrics monthly to monitor expenditure levels and trends evident in various categories of service (COS) within the Medicaid program. The impact of CCNC on the Medicaid program can be evaluated by comparing CCNC performance versus non-CCNC experience in utilization of emergency room, hospital in-patient, hospital out-patient and physician services, although it should be noted that this comparison does not recognize differences between CCNC and non-CCNC performance due to differences in patient demographics. As an example, the relative proportion of adults and children in CCNC versus non-CCNC is different. The following graphs compare PMPM information for these services by examining the underlying DMA data and presenting it on a rolling twelve month PMPM average basis.

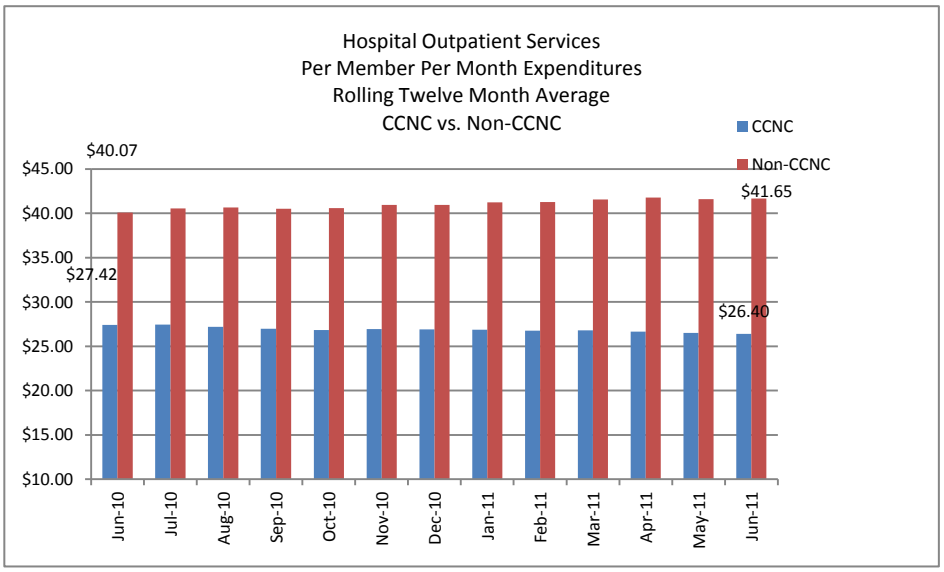


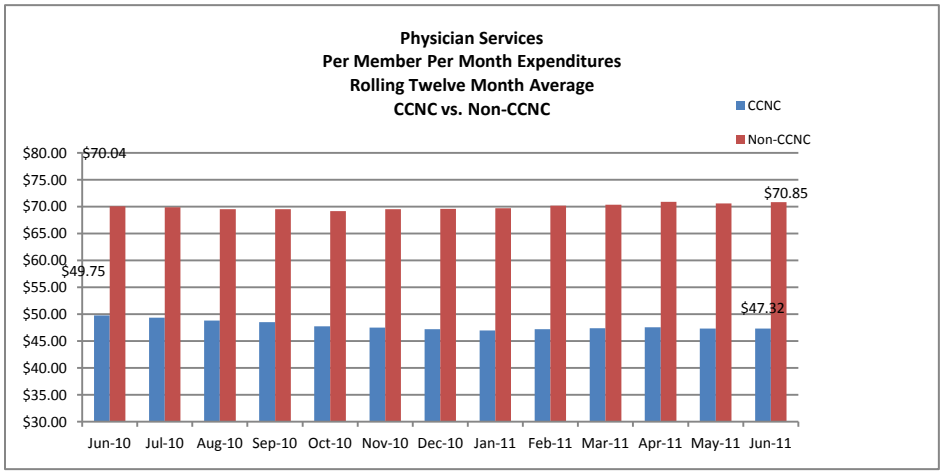
After recognizing the significant difference in PMPM experience between CCNC and non-CCNC populations, it should be noted that CCNC has managed a 3.1% decrease in PMPM expenditures on a rolling twelve-month basis (despite inflation associated with medical expenditures) – a significant headwind - while the non-CCNC experience demonstrates an 5.1% increase in PMPM, again the average on a rolling-twelve month basis.

The monthly average PMPM expenditures for both CCNC and non-CCNC in-patient activity have decreased over the past thirteen months. CCNC believes that the non-CCNC improvement is due at least in part to the continued enrollment of relatively sicker patients into the CCNC system.



Besides the significant dollar level difference in the PMPM averages, the CCNC program has managed to reduce the average monthly PMPM by 3.7% from $27.42 to $26.40 versus a 3.9% increase in non-CCNC PMPM.





Again, besides the significant dollar level difference in the PMPM averages, the CCNC program has managed to reduce the average monthly PMPM by 4.9% from $49.75 to $47.32 versus a 1.1% increase in the non-CCNC PMPM.

Again, while the differences between the CCNC-enrolled and non-enrolled populations is to some degree a reflection of demographic differences between the two groups, these comparisons still illustrate a meaningful difference in cost trends.

Status of Enhanced Primary Care Case Management Initiatives

The Enhanced Primary Care Case Management Program, launched in April of 2010, directed CCNC and the networks to undertake eight initiatives funded through an increase in the per member per month (PMPM) amounts paid to CCNC by the Division of Medical Assistance. The aim of the Enhanced Plan is to direct additional resources to activities likely to generate a strong return-on-investment, including transitional care, behavioral integration, palliative care, pharmacy management, clinical integrity and enhanced health care IT.

Initiative	Status as of 07-01-2011
Transitional Support and Intensive Care Management A multi-project initiative which focuses on the ABD population and 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 – More than 100 care managers have been embedded in practices with high-volume Medicaid membership and 50 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 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. • The Call Center work group met regularly to make recommendations on call center operations and has visited several call center vendors. • A draft RFP was distributed to potential vendors. Responses from the vendors were cost-prohibitive and it was decided that building in-house capacity would be more cost-effective. • Currently in early hiring phase of development.

Initiative	Status as of 07-01-2011
Behavioral Health Integration / Coordination In February 2010, the Division of Medical Assistance (DMA) approved the Behavioral Health Integration Initiative (BHI), a greater integration of behavioral health services into CCNC's approach. The plan supports the integration of behavioral health services, including mental health and substance abuse, into medical homes operated by 1,400 primary care practices in CCNC networks across North Carolina. Specific targets include: • Hire lead psychiatrist at CCNC • Hire network psychiatrists and behavioral health specialists • Adopt evidence-based treatment protocols in practices • Coordinate efforts with LMEs and CAHBAs	Accomplishments include: • A lead psychiatrist has been hired at CCNC as well as a part time pharmacist. • All networks have hired psychiatrists and behavioral health specialists. Some care managers have been co-located at LMEs to facilitate patient to community providers for treatment. • 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 • Executed data sharing agreement with LMEs to provide link to CCNC Informatics Center. Network behavioral health coordinates meet monthly with LMEs to discuss data, treatment issues. • 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 are being developed across the 14 networks, including evidence based treatment guidelines for depression, ADHD and substance abuse • Initial day long Motivational Interviewing training completed for network care managers with monthly TA and follow-up scheduled for the next year • Completed 17 trainings across the networks with Pharmacy staff in order to facilitate medication reconciliation for patients on behavioral health medications
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 CCNC and 5 additional FTEs to lead a	• A physician lead was hired at CCNC; all networks have identified part-time palliative care coordinators • Palliative care training sessions were conducted across the state through February 2011 • Palliative care questions have been added to the comprehensive

Initiative	Status as of 07-01-2011
statewide initiative across the 14 CCNC networks	health assessment tool in CMIS. • Care managers are beginning to identify patients that may benefit from palliative care and "starting the conversation."
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 CCNC and 9 pharmacist FTEs across the 14 CCNC networks • National benchmarking with Medicaid generic	• 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 • See update below regarding progress on eprescribing efforts
Clinical Integrity (analysis of potential Medicaid outliers) CCNC is assisting DMA's Program Integrity to identify potential outlier situations involving Medicaid services and providers. Specific targets include: • CCNC to hire clinical staff to run software identifying outliers. • Each network to hire a part-time local physician to assist effort.	• CCNC utilized analytical data mining software to determine findings. • 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. • CCNC has developed a tracking tool to document and monitor follow-up efforts. • A part time physician was hired at CCNC.
Informatics Center (IC) Enhancements CCNC's 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: • CCNC to hire 12 FTEs in 2010 and an additional 4 FTEs in 2011 • Develop infrastructure to integrate data and provide clinical information to networks • Improve data analysis capabilities by contracting with Treo Solutions for risk adjustment and predictive modeling.	• More than 16 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 • Providing real time data on admissions, discharges and transfers

Initiative	Status as of 07-01-2011
	from 38 hospitals • See update below regarding Informatics Center activities and progress
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. All 16 networks have a designated policy officer.	• A privacy officer was hired at CCNC • All networks have hired a designated privacy officer • All networks have hired network administrators • Networks are in the process of signing new data use agreements with external providers. Active users include 21 LMEs (local management entities) and 450 PCPs (primary care providers). Agreements for use have been signed by 99 LHDs (local health departments).
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 has 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

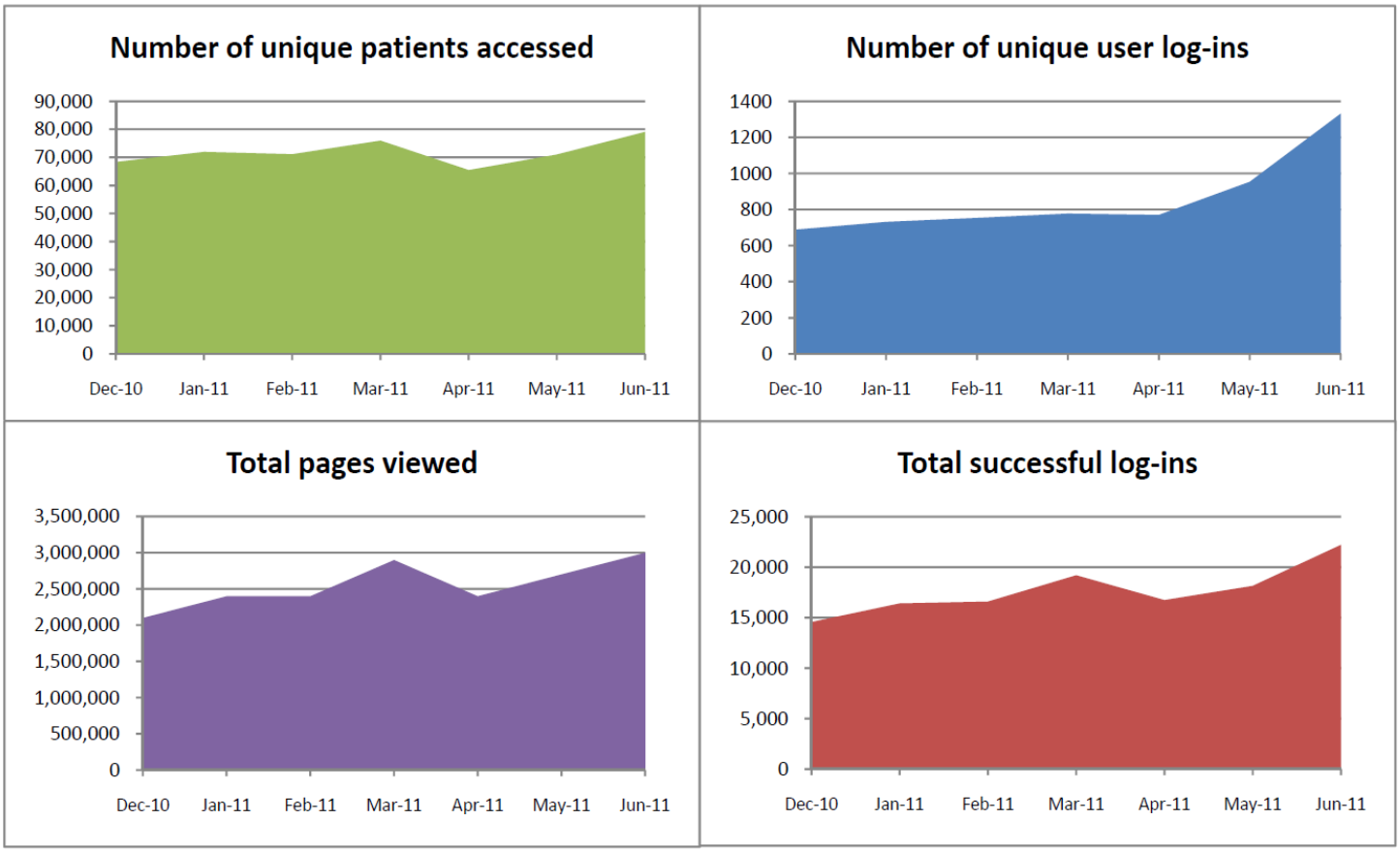
Informatics Center- Update

The Community Care of North Carolina Informatics Center continues to expand. The user base for both our Care Management Information and Provider Portal Systems is growing rapidly, as indicated in the updated usage statistics below. Access to patient information and a shared, coordinated patient record through these two applications is improving the care of over 80,000 Medicaid recipients every month.

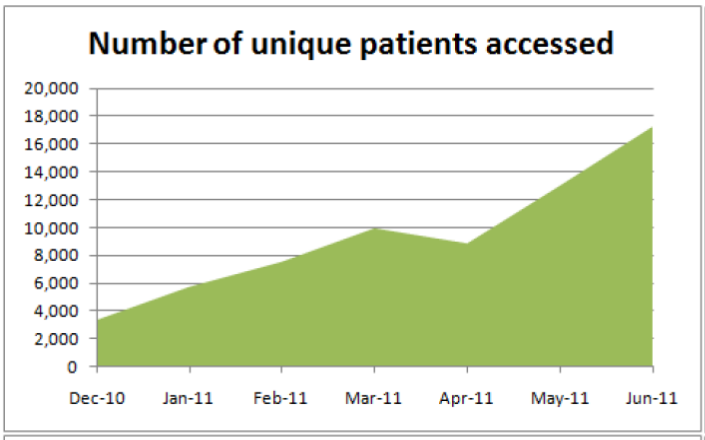
CMIS Enhancements: A major expansion of our Care Management Information System is underway incorporating new functionalities and open access to public health case managers involved in care management for pregnant women and children with special healthcare needs. We have trained over 500 new CMIS users in local health departments, providing them with a shared, secure, web-based patient record for case management documentation and coordination of care management activities for children with special health care needs (CC4C initiative) and women with high-risk pregnancies (Pregnancy Home initiative).

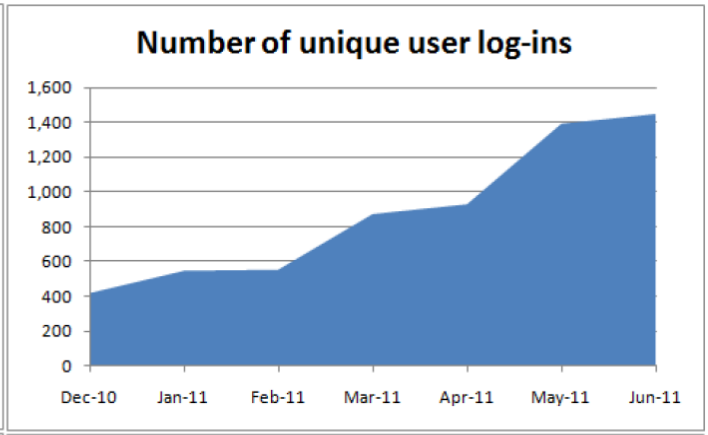
Specific new customized screening assessment and data collection fields have been added to CMIS for the Pregnancy Home Initiative. Additional new screening and intervention tools for the CC4C and Behavioral Health Integration projects are in final stages of development.

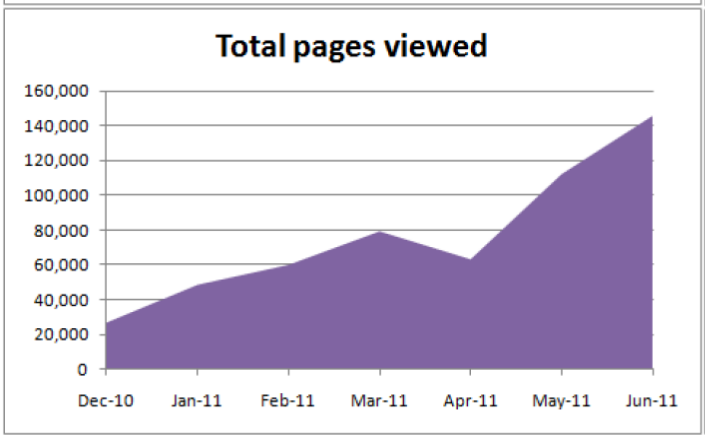
CASE MANAGEMENT INFORMATION SYSTEM (CMIS)
Usage Metrics –December 2010 through June 2011

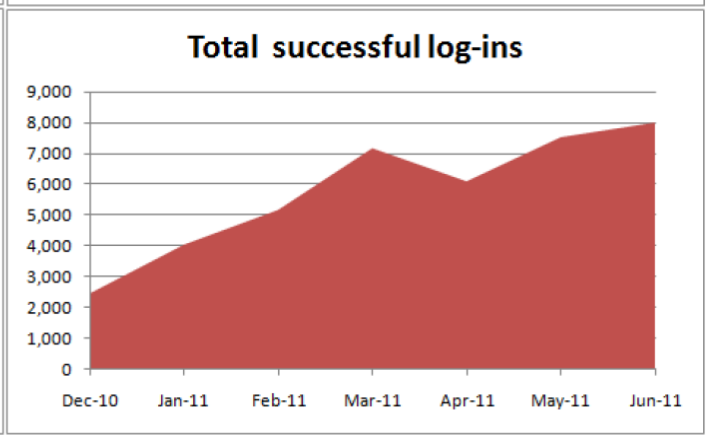


PROVIDER PORTAL
Usage Metrics –December 2010 through June 2011









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 CCNC'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 CCNC informatics platform. Such electronic data transfer will enable timelier, 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. UNC will also send blood pressure values and laboratory values such as diabetes, kidney, and cholesterol blood test results important for the quality measurement and quality improvement efforts of CCNC. We are currently in the testing phase and anticipate going live with this daily data feed within the next quarter.

Real-time Hospital Admission, Discharge, Transfer Data

Through the combined efforts of CCNC, NC DHHS, and the NC Hospital Association, the Informatics Center is now receiving twice-daily notifications of Medicaid inpatient and ED visits from 38 NC hospitals, with additional hospitals in development. Real-time notification greatly facilitates the identification of patients in need of care management support as they transition from hospital to home, including pharmacist review of medications and follow-up in the

primary care medical home. The following hospitals are currently sending real-time data to the CCNC Informatics Center. These hospital process 45% of all CCNC patient discharges.

Hospitals	Hospital Network
Alamance Regional Medical Center	AccessCare
Annie Penn Hospital	Partnership for Health Management
Bertie Memorial	Community Care Plan of Eastern Carolina
Cape Fear Valley Medical Center	Carolina Collaborative Community Care
CarolinaEast Medical Center	Community Care Plan of Eastern Carolina
Carolinas Medical Center	Community Care-Greater Mecklenburg
Carolinas Medical Center - Lincoln	Community Health Partners
Carolinas Medical Center - Mercy	Community Care-Greater Mecklenburg
Carolinas Medical Center - Northeast	Southern Piedmont Community Care Plan
Carolinas Medical Center - Pineville	Community Care-Greater Mecklenburg
Carolinas Medical Center - Union	Community Care-Greater Mecklenburg
Carolinas Medical Center - University	Community Care-Greater Mecklenburg
Catawba	AccessCare
Chowan Hospital	Community Care Plan of Eastern Carolina
Cleveland Regional Medical Center	Carolina Community Health Partnership
Duke Medical Center	Northern Piedmont Community Care
Durham Regional Hospital	Northern Piedmont Community Care
FirstHealth Montgomery Memorial Hospital	Sandhills Community Care Network
FirstHealth Moore Regional Hospital	Sandhills Community Care
FirstHealth Richmond Memorial Hospital	Sandhills Community Care
Grace Hospital	AccessCare
Heritage Hospital	Community Care Plan of Eastern Carolina
Kings Mountain Hospital	Carolina Community Health Partnership
Moses Cone Behavioral Health Center	Partnership for Health Management
Moses Cone MedCenter High Point	Partnership for Health Management
Moses H Cone Memorial Hospital	Partnership for Health Management
Pitt County Memorial	Community Care Plan of Eastern Carolina
Roanoke Chowan Hospital	Community Care Plan of Eastern Carolina
Southeastern Regional Medical Center	AccessCare
Stanly Regional Medical Center	Southern Piedmont Community Care
The Outer Banks Hospital	Community Care Plan of Eastern Carolina
Valdese General Hospital	AccessCare

Hospitals	Hospital Network
WakeMed	Community Care of Wake/Johnston
WakeMed Cary Hospital	Community Care of Wake/Johnston
Wesley Long Community Hospital	Partnership for Health Management
Wilson	Community Care Plan of Eastern Carolina
Womens Hospital of Greensboro	Partnership for Health Management

Care Co-ordination for Children – Overview

The Care Coordination for Children (CC4C) initiative is a **Population Management Program for At-Risk Children from Birth to 5 Years of Age.** The program**,** which began on March 1, 2011, transitions North Carolina's Child Service Coordination efforts – a public health targeted case management program – into a high-risk population management model. The CC4C Program is administered as a partnership between CCNC, the NC Division of Public Health (DPH) and the NC Division of Medical Assistance (DMA). The main goals of the program are to improve health outcomes and reduce costs for enrolled children.

Referrals into the program originate from medical homes, hospitals, community organizations, CCNC care management staff or families. These referrals can be submitted on paper or taken by phone by CC4C staff. Referred patients are children birth to 5 years of age who meet the following priority risk factors:

- **Children with Special Health Care Needs [Maternal Child Health Bureau definition]:**
  - Chronic physical, developmental, behavioral or emotional condition
  - Expected to last at least 12 months
  - Requires health and related services of a type and amount beyond that required by children generally

- **Children exposed to toxic stress in early childhood including, but not limited to:**
  - Extreme poverty in conjunction with continuous family chaos
  - Recurrent physical or emotional abuse
  - Chronic neglect
  - Severe and enduring maternal depression
  - Persistent parental substance abuse
  - Repeated exposure to violence in the community or within the family

- **Children in the foster care system who need to be linked to a Medical Home**

- **Children in the Neonatal Intensive Care Unit who need assistance in transition back to the community and a Medical Home**

- **Children who are high cost / high users of services**

- **CCNC-identified, Medicaid claims trigger referrals.**

CC4C services are being provided based on patient-need and according to risk stratification guidelines. A comprehensive health assessment, including the Life Skills Progression[3], assists the care manager in identifying the child's needs, plan of

[3] *The Life Skills Progression is a tool that measures a parent's life skills (the abilities, behaviors and attitudes) that help a family achieve a healthy and self-sufficient level of functioning. The tool assesses 35 dimensions including relationships/support systems; education and employment; health and medical care, mental health and substance use/abuse and access to basic essentials. The LSP also assesses the child's developmental progress. When completed sequentially in 6-month increments, the LSP makes progress visible and measurable.*

care and frequency of contacts required to effectively meet desired outcomes. Contacts occur in multiple settings including the medical home, hospital, community, child's home, and by phone. All documentation for CC4C services will be completed online in the CCNC Case Management Information System (CMIS).

Each Medical Home serving children birth to 5 years of age has a specific CC4C Care Manager(s) assigned to work with its high-risk clients. This stable relationship will support effective and complete communication between the Medical Home and the CC4C Care Manager.

Each CC4C agency will work in collaboration with its local CCNC network. It is anticipated that quarterly network meetings will be held for CC4C Care Managers to review performance metrics and share best practices. The network will review reports based on data from CMIS, Medicaid claims, vital records and other administrative sources for quality improvement purposes and to identify the extent to which the program is achieving its goals.

The CC4C program will be evaluated based on the following outcome measures:

- Increase in NICU graduates who have their first PCP/medical home visit within one month of discharge.
- Reduce the rate of hospital admissions for Medicaid children birth to <5 years of age.
- Reduce the rate of readmissions for Medicaid children birth to <5 years of age.
- Reduce the rate of ED visits for Medicaid children birth to <5 years of age.
- Increase the percent of comprehensive (health) assessments (CHAs) completed for CC4C patients identified as having a "priority."
- Increase the percent of children with special health care needs who are enrolled in a medical home.
- Increase the percent of children in foster care who are enrolled in a medical home.
- Increase the Life Skills Progression (LSP) Assessments on children receiving care coordination through CC4C on entry into the system, every six (6) months thereafter and/or upon deferral.

A CC4C Workgroup has been convened to advise and guide CCNC's work. Its members are actively involved in CC4C program development and the group's members meet monthly. The group includes representatives from DPH (CC4C and Early Intervention Staff), DMA, CCNC's Central Office, the Physician Community; Local CCNC Networks, Local Health Departments and members of the DPH, and the Children and Youth Family Council.

E – Prescribing Activity – Update

An objective of the primary care case management system is to facilitate the use of electronic prescribing within the CCNC Networks. The increase in e-prescribing as a percentage of total prescription activity by network for SFY 2009 through SFY 2010 is as follows:

Community Care of North Carolina
Network Level E - Prescribing Activity

	Quarter Ending											
Network	**Sep-08**	**Dec-08**	**Mar-09**	**Jun-09**	**Sep-09**	**Dec-09**	**Mar-10**	**Jun-10**	**Sep-10**	**Dec-10**	**Mar-11**	**Jun-11**
AccessCare	24%	32%	35%	40%	42%	46%	50%	52%	52%	52%	55%	62%
Carolina Collaborative Community Care	12%	29%	34%	46%	40%	41%	53%	53%	55%	55%	60%	66%
Carolina Community Health Partnership	5%	10%	38%	38%	38%	57%	52%	52%	52%	52%	62%	57%
Community Care Partners of Greater Mecklenburg	13%	16%	20%	22%	24%	27%	33%	33%	33%	38%	49%	58%
Community Care Plan of Eastern Carolina	18%	26%	28%	30%	35%	37%	44%	46%	45%	52%	54%	66%
Community Care of Wake and Johnston Counties	15%	25%	25%	29%	31%	31%	41%	41%	41%	43%	50%	55%
Community Care of Western North Carolina	24%	34%	35%	45%	44%	45%	45%	45%	45%	49%	58%	68%
Community Care of the Lower Cape Fear	14%	22%	23%	26%	27%	29%	37%	37%	37%	41%	44%	53%
Community Health Partners	15%	24%	28%	30%	37%	30%	39%	39%	39%	39%	48%	54%
Northern Piedmont Community Care	38%	49%	56%	58%	58%	64%	64%	69%	69%	73%	82%	87%
Northwest Community Care	7%	23%	22%	21%	29%	33%	42%	46%	48%	49%	57%	64%
Partnership for Health Management	21%	36%	36%	37%	45%	55%	61%	64%	67%	67%	70%	75%
Sandhills Community Care Network	22%	29%	34%	38%	44%	44%	59%	61%	57%	60%	62%	76%
Southern Piedmont Community Care Plan	50%	55%	59%	69%	70%	75%	77%	73%	75%	80%	83%	89%
Total Program	**19%**	**28%**	**31%**	**35%**	**38%**	**41%**	**47%**	**48%**	**48%**	**51%**	**57%**	**64%**

CCNC's efforts in this regard have helped North Carolina to become one of the leading states in the nation in e-prescribing efforts.

The level of e-prescribing activity in each state and the District of Columbia is measured annually by SureScripts LLC which operates the nation's largest e-prescription network and supports a rapidly expanding ecosystem of health care organizations nationwide.

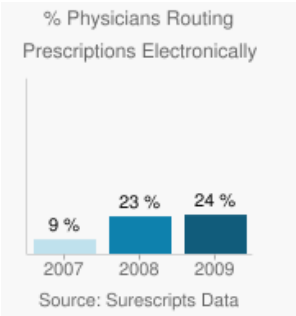
Based on the year 2009, the most recent year for which results are available, North Carolina ranked fifth overall. SureScripts rankings are calculated to account for three critical steps in the electronic prescribing process. These steps include:

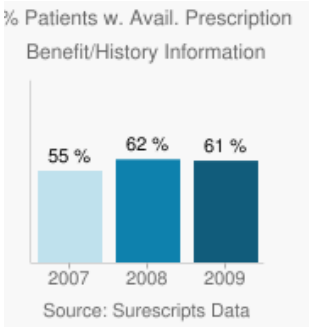
- Total prescription benefit requests and responses as a percent of the total number of patient visits
- Total medication history requests and responses as a percent of the total number of patient visits
- Number of prescriptions routed electronically

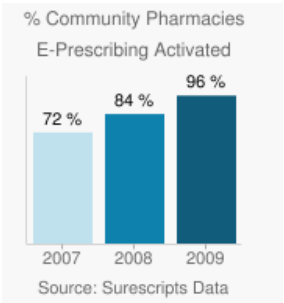
According to SureScripts, E-prescribing adoption metrics in the state show the same pattern of growth as follows:

	2007	2008	2009
Physicians Routing Prescriptions at Year-End	1,275	3,282	3,432
Community Pharmacies Activated for E-Prescribing at Year-End	1,288	1568	1777

The following graphs provide insight as to the relative level of e-prescribing versus total prescribing for the entire state.







Attachment A - CCNC Quality and Performance "Scorecard" Measures

Annual Quality Measures CY2010

Diabetes

	QMAF Chart Review															QMAF Claims*		
	HbA1c testing			Lipid Profile			Diabetes A1C Control <9.0			Diabetes LDL Cholesterol Control <130			Diabetes Foot Exam			Diabetes Eye Exam		
Network	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**
Access II Care of Western NC	255	277	92.1%	190	265	71.7%	200	265	75.5%	165	265	62.3%	210	265	79.3%			
Access III of Lower Cape Fear	498	545	91.4%	435	530	82.1%	390	530	73.6%	346	530	65.3%	409	530	77.2%			
AccessCare	1,096	1,226	89.4%	897	1163	77.1%	800	1,163	68.8%	717	1,163	61.7%	863	1,163	74.2%			
Carolina Collaborative Community Care	245	290	84.5%	211	278	75.9%	180	278	64.8%	176	278	63.3%	207	278	74.5%			
Carolina Community Health Partnership	159	176	90.3%	148	168	88.1%	114	168	67.9%	116	168	69.1%	138	168	82.1%			
Community Care of Wake / Johnston Counties	252	271	93.0%	204	252	81.0%	173	252	68.7%	156	252	61.9%	184	252	73.0%			
Community Care Partners of Gr. Mecklenburg	574	628	91.4%	487	605	80.5%	412	605	68.1%	379	605	62.6%	455	605	75.2%			
Community Care Plan of Eastern Carolina	1,381	1,478	93.4%	1150	1444	79.6%	1,077	1,444	74.6%	937	1,444	64.9%	1,009	1,444	69.9%			
Community Health Partners	188	203	92.6%	158	192	82.3%	142	192	74.0%	119	192	62.0%	157	192	81.8%			
Northern Piedmont Community Care	288	323	89.2%	242	307	78.8%	205	307	66.8%	186	307	60.6%	249	307	81.1%			
Northwest Community Care	455	495	91.9%	374	480	77.9%	343	480	71.5%	309	480	64.4%	414	480	86.3%			
Partnership for Health Management	135	163	82.8%	123	155	79.4%	99	155	63.9%	90	155	58.1%	145	155	93.6%			
Sandhills Community Care Network	322	340	94.7%	269	324	83.0%	230	324	71.0%	212	324	65.4%	250	324	77.2%			
Southern Piedmont Community Care Plan	271	293	92.5%	242	274	88.3%	201	274	73.4%	193	274	70.4%	219	274	79.9%			
CCNC	**6,119**	**6,708**	**91.2%**	**5130**	**6437**	**79.7%**	4,566	6,437	**70.9%**	4,101	6,437	**63.7%**	4,909	6,437	**76.3%**			
Hedis Mean			**80.6%**			**74.2%**			**55.1%**									
Hedis 90th percentile			**90.2%**			**84.0%**			**72.3%**									
NCQA DRP Goal									**≥85%**			**≥63%**			**≥80%**			

* 2010 results for claims-derived measures will be available April 2011

Attachment B

Low-hanging fruit – PLEASE NOTE THESE ARE ESTIMATES BASED ON PAID CLAIMS

SUMMARY TABLE:

Service	Potential savings	Ease (from CCNC's reviewer's perspective)
Urine Drug Screens	$16Million	Might not be able to recoup, but avert future$
Allergy testing	$614K	Easy
Unbundling of Inpatient services	Likely $500K +	Difficult, would need more integration at PI
Glucose Test Strips	$101K	Easy, need edit to work
J-codes (injected medicines)	$300K	Labor intensive
HIV Case management	$300K	May be done, but implications elsewhere….
Prostate Biopsies	$260K	Easy, may need to justify
Chiropractic – MPWs and children	$175K	Easy policy-wise, maybe tough politically
Bili lights	$100K	Easy, need edit to work
Supplies and Parenteral Nutrition	$50K	Labor intensive

1. Urine Drug Screens

It would be good to have the input of an anesthesiologist on this high dollar and at times confusing issue. After noting a few exorbitant claims for G0431 (for definition see below) reading reveals there is so much confusion over which drug test to bill—80101 or 80100 that CMS abandoned those 2 codes all together and created 2 NEW codes, which still do not seem to be well understood by billing providers. The short story is that on April 1, 2010 Medicare adopted the new codes and limited the units on each to ONE. The closing statement of the online article, "CMS explains drug testing codes G0431 and G0430" written by Attorney David Vaughn indicates that Medicare Part B carriers can and may recoup all units >1 back to April 1, 2010. These tests can run $660-700 per when docs bill for 60 units. (See: http://www.flsipp.org/MedicareAlerts/040910-URINE%20DRUG%20TESTING,%20MEDICARE%20CLARIFICATION%20OF%20CODING%20Vaughn.pdf)

"Old codes" =80100 - Drug screen, qualitative; multiple drug classes chromatographic method, each procedure and **80101** - Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class

New HCPCS codes are as follows:

G0430 - DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE

G0431 - DRUG SCREEN, QUALITATIVE; SINGLE DRUG CLASS METHOD (E.G., IMMUNOASSAY, ENZYME ASSAY), EACH DRUG CLASS

NC Medicaid paid **$ 10,472,972.81** for codes 80101 and 80100 between April 1, 2010 and April 1, 2011, and **69,498** or **$9,992,490.20** of these paid claims were for >1 unit**.**

If we capped the 80101 codes at 1 units, we would save $ 8,863,889.20

If we capped the 80100 codes at 1 units, we would save $ 315,108.52

NC Medicaid paid **$ 8,177,891.55** for codes **G0431 and G0430 that were for more than 1 unit** between April 1, 2010 and April 1, 2011.

If we capped G0431 code at 1 unit, we would save $ 7,617,719.68

If we capped G0430 code at 1 unit, we would save $ 69,005.41

http://www.aapc.com/memberarea/forums/showthread.php?t=28608

2. **Allergy testing:**

The issue: There is such variability in practice and technique in the Preparation and Provision of Allergens (CPT 95165) that CMS did a special report and study of the issue in 2001. (http://oig.hhs.gov/oei/reports/oei-09-00-00530.pdf) We find that this variability continues, with the lion's share of providers charging for 28 units (1 test "Board" set comes with 28 doses of various allergens) but some providers charge up to 300 units on a given date of service. (For 300units the amount billed to Medicaid is $6300, the amount paid is $2784)

Oregon Dental Services has a limit set at 56units (http://www.odscompanies.com/medical/pre_auth_95165.shtml) meaning limit per date of service of 2 sets/boards with 28 allergens apiece. Anything more than that requires prior auth. We recommend adopting this policy as well.

In 2010, if we had capped 95165 at 56units we could have saved $613,644.68

3. **Unbundling of hospital services**

See link below—if it is this big a problem for Medicare, chances are it's a problem for Medicaid as well….

http://www.ama-assn.org/amednews/2011/05/16/gvsb0516.htm

Also see letter from 1996 mentioning overpayment of about $2Million in NC in past. http://oig.hhs.gov/oas/reports/region4/49501113.pdf

Program Integrity has folks who deal with hospitals, given how much money is likely at stake it would be nice to have Dr. Gray give CCNC an entrée into this area to see if we can assist in identifying more potential waste.

4. **Glucose testing strips**

NC Medicaid contracted exclusively with Prodigy beginning Nov 2009 with all (except Duals) required to change over by Feb 2010 in an attempt to curb the cost of these supplies. However, there does not appear to be any upper limit on the number of strips a person can have each month. For a diabetic taking 5 shots per day of insulin (the exception, but it does still happen, of course) they might be expected to check sugars up to 5 times per day. This would mean they would need 150 strips per month, or 3 units (50strips per unit) per month at a cost of about $28 per 50 strips.

In the 1st quarter of 2011 alone there were 110 claims for more than 100 units (more than 5000 strips per month) and many for more than 300 units. For these 110 claims we paid $29,000 when we should have paid no more than $12,000 (with cap of 4 units).

In CY2010 there were 1,521 claims just for recipients (over $257K paid, and more than $101K OVERpaid for those if cap were enforced) for more than 4 units**. If we had capped A4253 (Glc strips) at 4 units (200 strips) for adults we would have saved $101,240 in 2010.**

J codes (injections of medications)

Units here are confusing. In some cases the number of units equals the number of milligrams of medication, and in some cases one unit is equal to the average dose of the medication.

This leads to errant billing and difficulty reining it in on the payer side, especially when some of these medications can be used in "megadoses" for chemotherapy. There was **$6.4 Million** spent on the J-code claims (J0129-J9395) that were 20% above the average units

In reviewing each quarter's claims (see blue and yellow pages titled J-codes 1st Qtr 2011) we find a few cases in which the amount of units billed would have likely proven fatal, but this is often when milligrams and units are confused by the biller. Medicare has limits on many of these J-codes and we are working to try to mimic those edits in our system.

There were more than $21,000 of claims for medication injections in which the provider billed for more than 5 times the average number of units billed for a medication, and $330,000 worth of claims where the provider billed for more than twice the average number of units. It would be helpful to have someone go through the 180-or-so J-codes and check to see which ones have limits on the Medicare MUE (Medically Unlikely Edits) list. Perhaps someone at IBM or using the IBM software could do this. CMS's MUE list was created in 2007 and was just updated 7/1/11 (http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp)

5. **HIV Case Management**

Recently an astute care manager was reviewing one of his patient's claims and was surprised to find billing for HIV case management. He was unaware she had HIV and knew her well. He asked the patient about this and she denied having HIV or receiving HIV case management services. We dug a little further and found that in calendar year 2009 and 2010 there were 152 recipients who received HIV case management who had no diagnosis of HIV (all HIV diagnosis codes checked) on 6 years of available claims.

Upon reviewing the list I found that though there were 25 providers, one provider was responsible for 100 of the 152 recipient's cases, and $341K of the $466K billed. We have turned this over to the Special Projects unit for investigation of that and one other provider on the list, but felt that this brought up a larger issue for NC Medicaid. Why do we allow ancillary providers to assign diagnoses to a patient? It seems that a lot of the waste, fraud, and abuse that comes through from the Mental Health side is from diagnoses assigned to patients by people who do not have the proper training to make diagnoses.

Likely annual savings if NC Medicaid required an MD to verify the HIV diagnosis prior to HIV Care management: about $300,000. New policies may require CCNC enrollment for these patients, which should solve the problem. We also have these providers under investigation at this time. **The larger issue, of disallowing anyone without proper training from assigning diagnoses to recipients might save millions in averting the types of fraud we currently see.**

6. **Prostate Biopsies**

A few years ago it was standard practice to do 4-8 biopsies of the prostate to determine the existence, location and severity of suspected prostate cancer. More recently 12+ (and even up to 60) "needle saturation biopsies" are being performed. This results in large bills for prostate biopsies. For instance, one 15 unit biopsy session yielded a bill for over $2300 and paid $1262 in November 2010. **NC Medicaid spent $7.4 Million on Prostate Biopsies in 2010.**

CMS noted, "separate billing for transperineal PSB samples resulted in significant overpayments for the amount of work involved in performing these services." (I believe that is what WE are seeing as well.) Thus, in Jan 2009 they made up totally separate codes to appropriately pay for the large volume of samples now taken at once. See the link below.

http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%2011%20Part%20B~Browse%20by%20Topic~Lab~8EEM4T3853?open&navmenu=Browse%5Eby%5ETopic%7C%7C%7C%7C

Link at the bottom of the page it points to the Federal Register Vol 173, No 130 (July 7, 2008), page 38520 where this point is discussed. It is discussed again in the Nov 2008 Fed Register (2nd link) and essentially no data or research studies are given, only reiterations of the comment above that "reimbursing $102 for each biopsy is a gross overpayment of the true work value" consistent with common sense given the lack of available evidence.

Palmetto, our new Medicare Part B carrier, was queried and we were told the following, "If >12 prostate biopsies are submitted, the edit is set up to pay the equivalent of the lowest saturation biopsy code from CMS. It [payment] is equivalent to 7 88305s…CMS has never sanctioned an MUE for 88305…. Palmetto set up an edit to pay all biopsies > 12 at the lowest saturation code rate. Appeals upholds our payment rate." We would advise that DMA try this as well.

If NC Medicaid had instituted a max of 7 units for 2010 we would have saved approximately $259,195.

http://www.psapath.com/NewsAndInformation/NewHCPCSProstateSaturationBiopsies/tabid/139/Default.aspx

7. **Chiropractic Services for Pregnant Women and Children**

We have worked with Clinical Policy on the matter of Chiropractic care and they have worked hard to make the policy line up with what is clinically appropriate. However, there are 2 categories of recipients which appear to be untouchable due to other policies: children and pregnant women.

Children: For children under age 5, there were $28,633 of chiropractic claims paid from 2009-2010, $5,600 not even related to musculoskeletal issues. Supporting diagnoses include: fussy baby, neck sprain, kyphosis, ankle derangement, vomiting, etc. For children age 6-21, there were $103,000 of chiropractic claims paid from 2009-2010 for noncovered diagnoses like "General medical exam", eye disorder, skin disorder, heart valve d/o, etc. Due to concerns of safety (especially manipulating prior to skeletal maturity) and lack of evidence of efficacy, we would suggest working with the Physicians Advisory Group (PAG) to set a lower age limit beyond which Medicaid will not cover chiropractic services. **If we restricted/limited chiropractic services in the Pediatric population, NC Medicaid could save about $75,000 per year.**

Pregnant women: Due to the fact that the Visit Limit contains many pregnancy diagnoses as exclusions, this population is not limited in terms of chiropractic services. **If we limited chiropractic services in Pregnant women, NC Medicaid could save about $100,000 per year.**

Due to Clinical policy's recent changes, there will be new limits on what Chiropractors can bill for—mainly requiring that they only treat patient for subluxations and "nonallopathic lesions of the spine" at each level, as is commensurate with their training. The care will be limited to the 8 visits already listed in policy. However, as mentioned, these limits will not exists for many pregnant women. We would recommend continuing the visit limit for chiropractic even during pregnancy. We did not look into the risks of chiropractic in pregnancy. It may make more sense to stop covering this all together. (I do not have info about

8. **Bili lights**

There was a policy written in 1997 for E0202 to cap the # of continuous days of bili lights to 7 AND it is supposed to only be used during the first 30 days of life…but I find in our outlier files several instances of more than 7 days. Dr. Biola & Bilbro spoke recently to Beth Osborne in Medical Policy and they were under the impression that this limit was still in place. Checking the July 1, 2011 update shows that it IS still as above. (http://www.ncdhhs.gov/dma/mp/dmepdf.pdf page 43)

There is specific mention of E0202 made in a "NCAMES"(?) blog and the fact that in Feb 2010 "Prior auth is no longer required." It would be good to find out the status of this and how it might be affecting this issue.

If the policy since 1997 has been that no more than 7 days, or no more than 7 units is allowable (that should pay $434.91), then 2 of the claims in outlier files were underpaid and 69 were overpaid for a total overpayment of **$24,430.52** in 1st quarter 2011 alone. It could be more than that in the cases

where the child was more than 30 days old. The edits need to be fixed so they are in concordance with existing policy.

If we fixed the edits to reflect existing policy, estimated $100,000 in savings per year (extrapolated from most recent quarter).

9. **Supplies and Total Parenteral Nutrition (TPN)**

In our Outlier files, the amount paid for some supplies ($1100 for an inner trach cannula for instance) and the number of units allowable in a given month (400 boxes of gloves, 700 suction catheters, 20,000 lancets) seems like we could save some with limits or edits here…but it is possible the individuals for whom I am seeing claims have some special exemptions.

The same is true for TPN with a few patients with tube feeds that cost $3000-5000 per month. One of our pharmacists is helping to study this issue currently. It may make to contract with one or more of the large teaching hospitals to make these feeds instead of allowing the private companies to mark this up so much.

Treo Solutions

125 DeFreest Drive
Troy, NY 12180
Phone: (800) 455-7338
Fax: (518) 426-4316

Treo Solutions, LLC.
125 DeFreest Drive
Troy, NY 12180

The analytics provided in this document is based on claims data and information provided to Treo Solutions, LLC (Treo) by Community Care of North Carolina (CCNC). CCNC provides Treo with claims and enrollment data on a quarterly basis. Treo Solutions has completed processing for two quarterly feeds representing calendar years 2007 through the middle of fiscal year 2010. Treo has been working closely with CCNC to develop a mutual understanding of their data through application of the proprietary Treo data discovery processes. These processes include checks for data integrity, completeness and reasonableness. The results are reviewed with the client before data is used for analytical purposes. The aggregated data and charts in this report have been reviewed by Treo, in conjunction with CCNC staff, to ensure that the data are in line with what CCNC would expect based on their knowledge of their population. As Treo's relationship continues with CCNC our understanding of their data and the population they serve will continue to mature.

Highlights of Treo Solutions Report

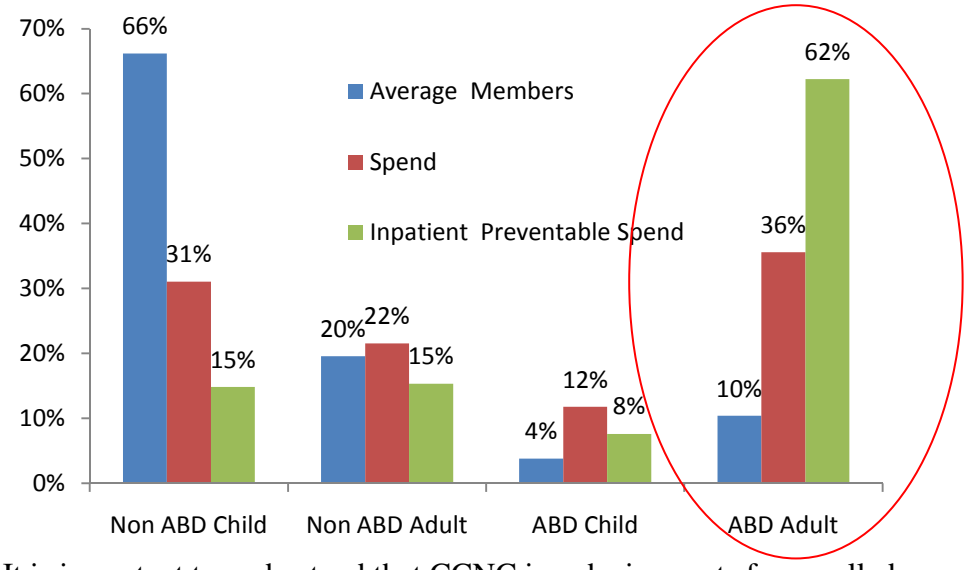
Community Care of North Carolina: results for the ABD non-dual population

CCNC has consistently demonstrated an ability to restrain system costs relative to trends evident in North Carolina's unenrolled (non-CCNC) Medicaid population. The following analyses examine CCNC impacts on the adult ABD (non-dual) Medicaid population, a good proxy for the Medicare population for which CMS is charged with reducing costs. Analyses were conducted by Treo Solutions, an independent healthcare analytics company, using industry standard methodologies for risk adjustment and identification of potentially preventable hospital utilization developed by 3M. CCNC's favorable impact on both cost and access in this population suggests significant potential benefit to expanding CCNC's role to serve Medicare patients statewide.

CCNC taking on more patients with complex, expensive health needs

CCNC enrollment of the ABD non-dual population increased by 33 percent (from 54,291 to 72,297 individuals) between 2007 and 2010[1]. These ABD non-dual enrollees have more complex medical needs overall than the non-dual ABD population that is not enrolled in CCNC. Figure 1 shows the distribution of the Medicaid population by ABD and non-dual ABD adult and child. While the adult ABD population only accounts for 10 percent of the non dual enrollment, it consumes 36 percent of the spend and 62 percent of the potentially preventable inpatient spend (including both potentially preventable admissions and readmissions).

Figure 1: Distribution of members and spend for 7/09-6/10 (2010):

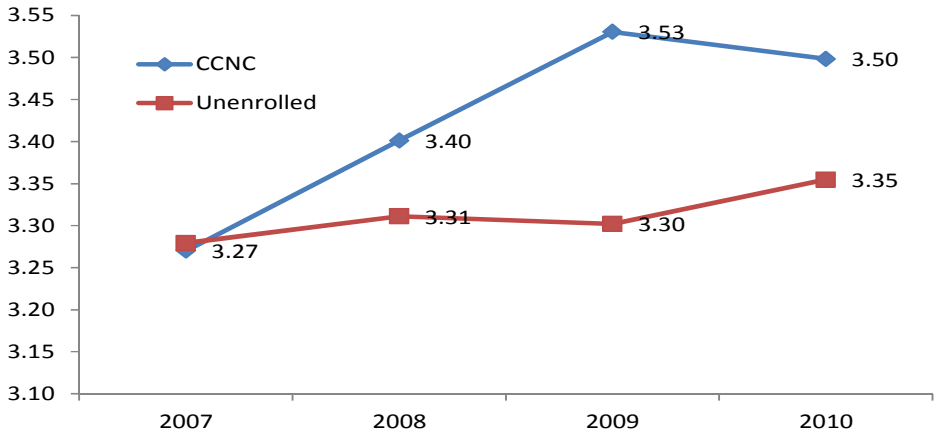


It is important to understand that CCNC is reducing costs for enrolled members even as they are enrolling increasingly sicker individuals with complex and chronic health care

[1] Note: 2010 data in this report reflect the 12-month period ending June 2010, the most recent 12-month period for which complete data are currently available).

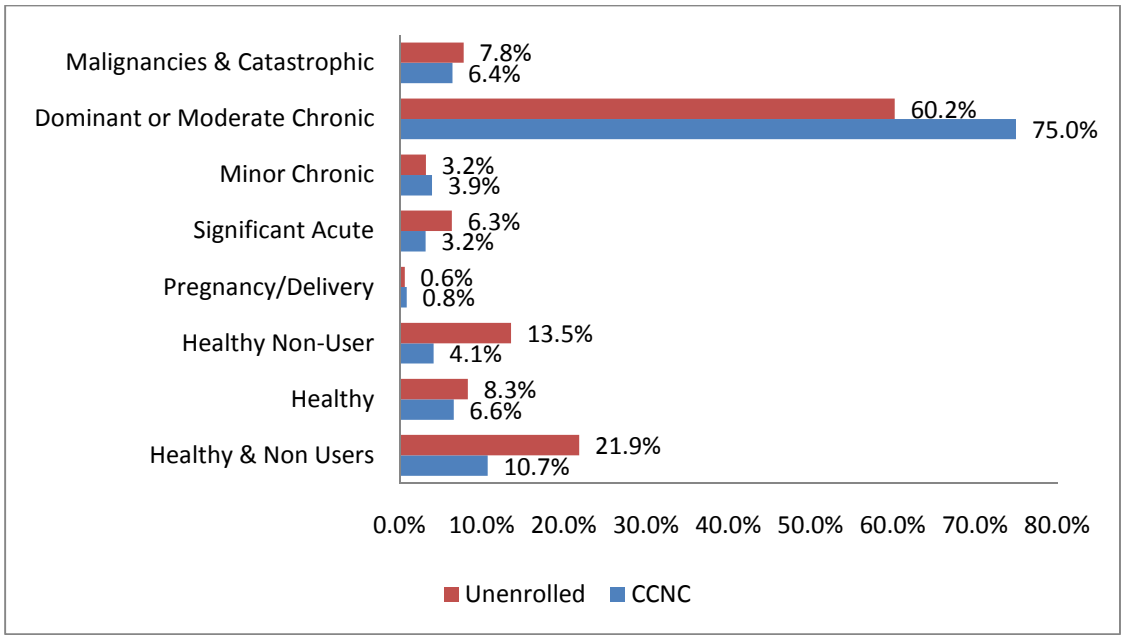
conditions. While the overall risk scores for the CCNC and the unenrolled populations were similar (3.27, 3.28) in 2007, the overall "risk score" among CCNC enrollees now is 3.50 versus 3.35 for the unenrolled. **See Figure 2**.

Figure 2: Risk scores of adult ABD Medicaid recipients, CCNC enrolled vs. unenrolled.



In fact, a full 81.4 percent of CCNC enrollees have either a dominant or moderate chronic condition, a malignancy, or a catastrophic health condition, compared to 68 percent of the unenrolled population. Similar trends are evident within the adult, non-dual ABD population. **See Figure 3**.

Figure 3. Adult, non-dual ABD population breakdown, CCNC vs. Unenrolled.



Better access, lower spending

Given this population's health status, providing ready access to health care service is extremely important. Among CCNC enrollees, only 4.1 percent are not using the health care system at all, compared to 13.5 percent of the unenrolled population. This strongly suggests that among relatively healthy non-dual ABD adult recipients, those enrolled in CCNC are experiencing better access to care.

It is enlightening to compare the actual spend per member, per month (PMPM) for the adult ABD population with the expected PMPM spend. Despite broadening access to care, total spending for the CCNC adult enrolled population (adjusted for clinical risk) has been *less than expected* for all years reviewed. **See Figure 4.** In contrast, spending for the unenrolled population has been significantly *higher than expected* since 2008. In the most recent 12-month period, spending for the enrolled population was 1.5% *less than expected* versus 10.1 percent *higher than expected* actual spend for the unenrolled group.

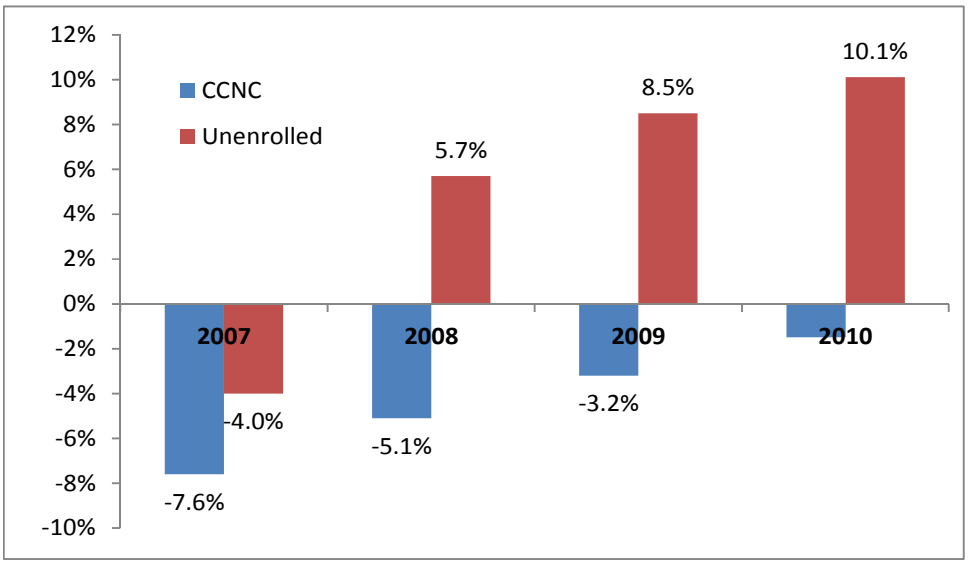
Figure 4. PMPM costs for Adult ABD Population

CCNC	**2007**	**2008**	**2009**	**2010**
Total PMPM	$1,377	$1,408	$1,487	$1,447
CRG Weight[2]	3.2702	3.4011	3.5304	3.4981
Expected PMPM	$1,490	$1,483	$1,537	$1,468
Variance	-7.6%	-5.1%	-3.2%	-1.5%
Unenrolled				
Total PMPM	$1,434	$1,526	$1,559	$1,551
CRG Weight	3.2793	3.3112	3.3020	3.3547
Expected PMPM	$1,494	$1,444	$1,437	$1,408
Variance	-4.0%	5.7%	8.5%	10.1%

The nearly 12% delta between PMPM costs for CCNC and unenrolled populations is apparent when this information is presented graphically. **See Figure 5.**

[2] CRG – clinical risk group. A claims-based classification system that assigns individuals to a single, mutually-exclusive risk group based on historical, clinical and demographic characteristics.

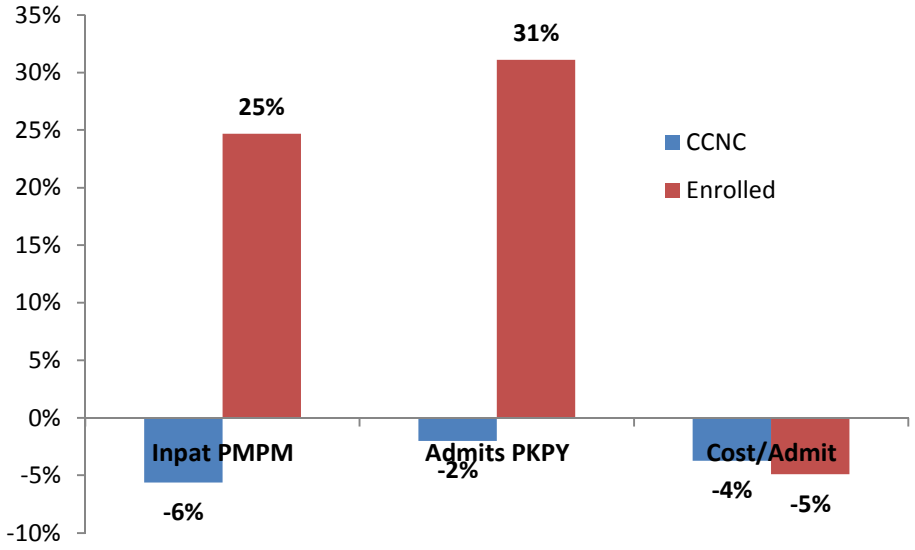
Figure 5. Actual versus expected costs for CCNC vs. unenrolled population



Inpatient efficiencies

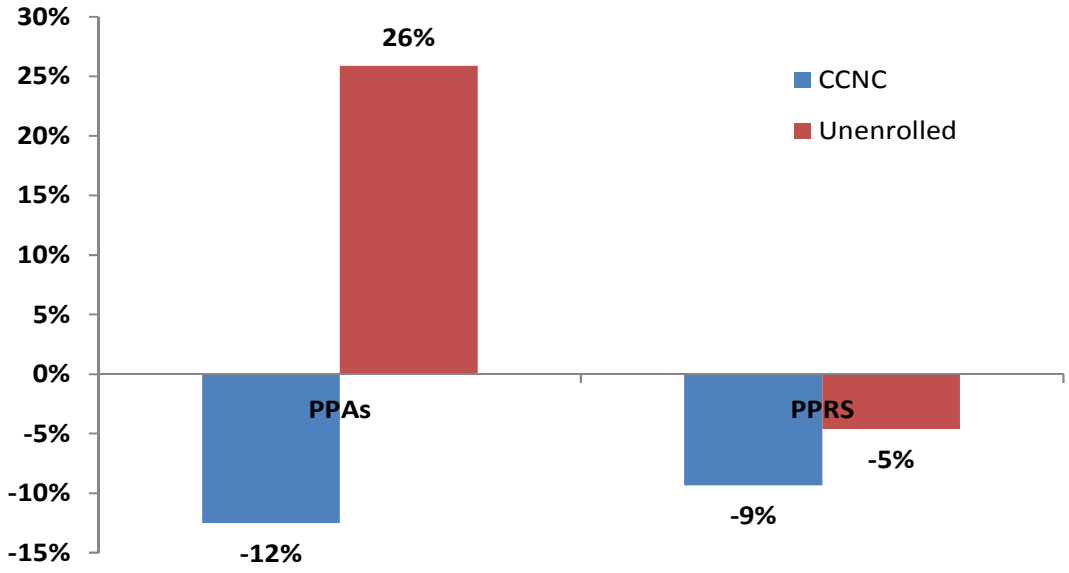
Reducing hospitalizations in the enrolled group appears to be a significant factor in these savings. Over a four-year period, CCNC enrolled inpatient PMPM spend has shown a 6% decrease. This decrease is a combined result of reduction in utilization (2%) and reduction in the cost per admission(4%). Admission rates have declined by 2.0 percent, and inpatient spending has declined by 5.6 percent. **See Figure 6**.

Figure 6. Four-year % Change for Adult ABD Population: Inpatient Spending, Inpatient Admissions Per Thousand members per year (PKPY) and cost per admission:



In contrast, inpatient spend PMPM for unenrolled adult ABD non-duals have increased by 25%. While the unenrolled adult ABD population has also seen a decrease in the cost per admit (5%) the 31% trend in the utilization rate PKPY has resulted in a 25% increase in the spend PMPM. Reduction in inpatient utilization has been even more impressive for preventable admissions." **See Figure 7**. Potentially preventable *admissions* have declined by 12.5 percent among CCNC-enrolled population, while increasing by 25.9 percent among the unenrolled. Potentially preventable *readmissions* have declined by 9.3 percent among CCNC enrollees, compared to a 4.6 percent decline among the unenrolled.

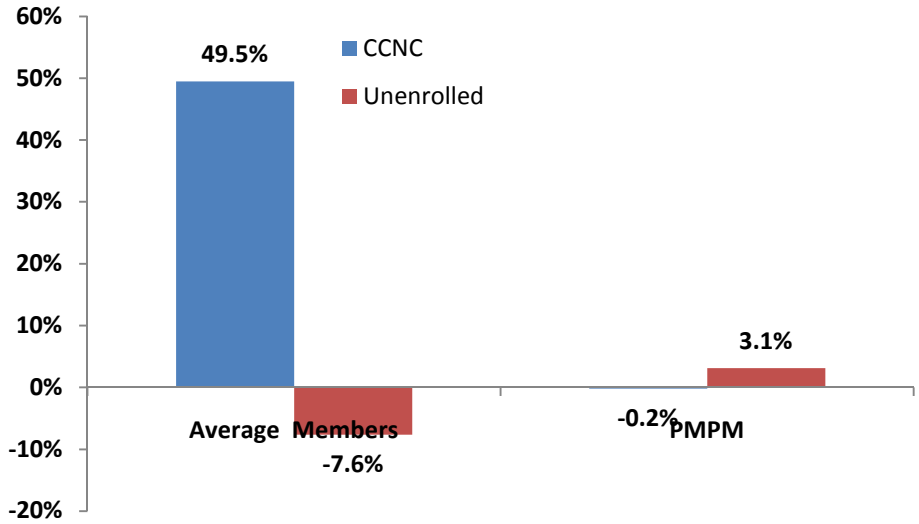
Figure 7. Four-year % Change for Adult ABD Population: Preventable Admissions, Readmissions PKPY



Impact on behavioral care

There is also evidence that CCNC's system of care has produced favorable results in the treatment of mental illnesses. Medicaid recipients with serious, chronic mental illness have moved into the CCNC program at a faster rate than the non-chronic mentally ill population. **See Figure 8**. CCNC enrollment of these members has increased by 49.5 percent over the past 4 years, while the population with serious mental illness has decreased by 7.6 percent in the unenrolled population. In the most recent 12 month period, nearly a third of the adult non-dual ABD population – 21,070 of 72,297 CCNC enrollees – has a serious and chronic mental illness. Yet per-member, per-month spending for this population within CCNC has *declined* by 0.2 percent while *increasing* by 3.1 percent outside of CCNC

Figure 8. Four-year Trends in the Adult ABD Population with a Serious Chronic Mental Health Condition:



A similarly favorable impact on this population's hospitalization rate is also evident, with both *total* inpatient admission rates and *potentially preventable* admission rates decreasing in the CCNC population. **See Figure 9.** Among non-enrolled members with a serious, chronic mental illness, both inpatient admittances and potentially preventable admissions are rising. Potentially preventable readmittances among the non-enrolled are decreasing, but they remain significantly higher than the CCNC-enrolled group.

Figure 9. Preventable Admissions and Readmissions for adult ABD population chronic mental illness