Community Care of North Carolina

2011
End of Year Report

to the
North Carolina General Assembly

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Reporting Requirement: S.L. 2011—145, 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."

Format of the Report

This End of Year report to the North Carolina General Assembly was prepared in a manner so as to provide the North Carolina General Assembly a comprehensive overview of the various efforts of the North Carolina Community Care Networks, Inc. (CCNC) to strengthen the primary care delivery system, improve the health care and health outcomes of vulnerable populations, and contain the growth of healthcare costs in North Carolina. During the past five years CCNC has grown to become an integral part of the State's public and private healthcare infrastructure. This partnership has woven CCNC into the fabric of the State's policy development and service delivery activities for which it and the State's policymakers can be equally proud.

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Overview

The mission of Community Care of North Carolina (CCNC) is to strengthen the primary care delivery system, improve the health care and health outcomes of vulnerable populations, and contain the growth of healthcare costs in North Carolina. This mission is accomplished through a statewide infrastructure of medical homes and community-based population management that focuses on care management strategies for its enrolled population of SCHIP and Medicaid enrollees, including the dual eligible population. To monitor its accomplishments and provide needed information to guide improvement initiatives, CCNC is constantly gathering quality and utilization metrics on the enrolled population from healthcare practices, hospitals, and facilities statewide.

As of December 2011, CCNC was serving 1.2 million Medicaid enrollees, including 241,000 aged, blind and disabled (ABD) and an additional 135,000 child and adolescent enrollees of Health Choice, through a statewide system of 14 Community Care regional networks, nearly 1,600 medical homes, and more than 4,300 primary care providers.

The clinical leadership provided by CCNC's networks comes not only from the participating medical homes and primary care providers, but from the more than 600 care managers, 19 pharmacists, 14 psychiatrists, 14 privacy officers, and Clinical and Executive Directors in each network to support the population health management activities. Augmenting this infrastructure are the networks' partnerships with local health care delivery systems, including hospitals, health departments, safety net providers, community-based organizations, and specialty practices, including mental health and substance abuse treatment entities.

Because of CCNC, North Carolina enjoys the unique position among the 50 States of having over 90 percent of its primary care physicians serving both Medicaid and private- and employer-insured patients. In most States, there is a quasi-two tier system of healthcare, where one tier primarily serves the Medicaid and uninsured populations and a second tier serves the insured population.

Because CCNC is built upon primary care physicians and practices it is playing a critical leading role in changing how healthcare is delivered in North Carolina. The vehicle by which CCNC is affecting this change is Care Management and Patient Centered Medical Homes for the public health insurance program—Medicaid. But the effect of CCNC's efforts and accomplishments is on the entire healthcare system—Private and Public. Thus CCNC's efforts and accomplishments to contain healthcare spending have a positive effect on the business community's bottom line, and its ability to grow the State's economy.

Realizing the business community's recognition of the strength of its medical home and care management infrastructure CCNC launched "First in Health," a public-private partnership that will enable private-sector employers to tap into that medical home infrastructure. Partners in the First in Health effort include Community Care of North Carolina (CCNC), GlaxoSmithKline (GSK), the State Health Plan of North Carolina (SHP), local pharmacy chain Kerr Drug, business analytics company SAS and Blue Cross and Blue Shield of North Carolina (BCBSNC), the State's largest health insurer.

The care management tools employed by CCNC's infrastructure to achieve its positive results in quality, utilization, and cost savings include:

1. Patient-centered medical homes;
2. Evidence-based best practice programs;
3. Targeted care and disease management interventions;
4. Coordinated care delivery with an emphasis on improving transitions;
5. Patient self-management skills;
6. Improved management of chronic illness care;

7. Pharmacy management strategies and interventions; and
8. Structured environments from which community providers can work to improve care and health outcomes.

CCNC has built its program on a "patient-centric care" approach that addresses the patient's physical, social, emotional and behavioral health care needs. To address the needs of the many enrollees with chronic illnesses, the networks have established processes for visiting patients prior to discharge, followed by home visits and joint visits at the patient centered medical home, when needed. Care managers work closely with their network pharmacists and the information provided in Pharmacy Home to achieve medication reconciliation and assist patients with medication management. Several networks are utilizing paraprofessional staff to gather data, make telephone calls, and conduct other preliminary work for the Care Managers, enabling healthcare staff to function at the top of their license. Enhanced reporting from the CCNC's Informatics Center provides real-time utilization data, including patient care alerts and snapshots that have greatly increased the Networks' ability to manage the ABD population more effectively.

During the past five years CCNC has grown to become an integral part of the State's public and private healthcare infrastructure. This partnership has woven CCNC into the fabric of the State's policy development and service delivery activities for which it and the State's policymakers can be equally proud.

Reduction in Medicaid Expenditures

In late December, the much anticipated study by Milliman Inc. reported that CCNC recipients with a medical home get better care and consumed fewer Medicaid resources than those who lack a medical home. From fiscal year 2007-2010, N.C. Medicaid avoided spending $984 million by having 1.1 million of its members enrolled into medical homes. In just the last two fiscal years of the study – 2009 and 2010 - $677 million was saved. "This is further validation that we are on the right track to ensuring high-quality medical care with the most efficient use of taxpayer dollars," said DHHS Secretary Lanier Cansler.

The key to the success of medical homes approach is a strong emphasis on preventative care, and aggressive care management. Although the cost of frequent office visits and treatment of newly diagnosed conditions adds to program costs initially, the reduction of emergency room visits and hospital admissions, as well as capturing of efficiencies and improving quality of care, results in significant savings and better health for the recipient.

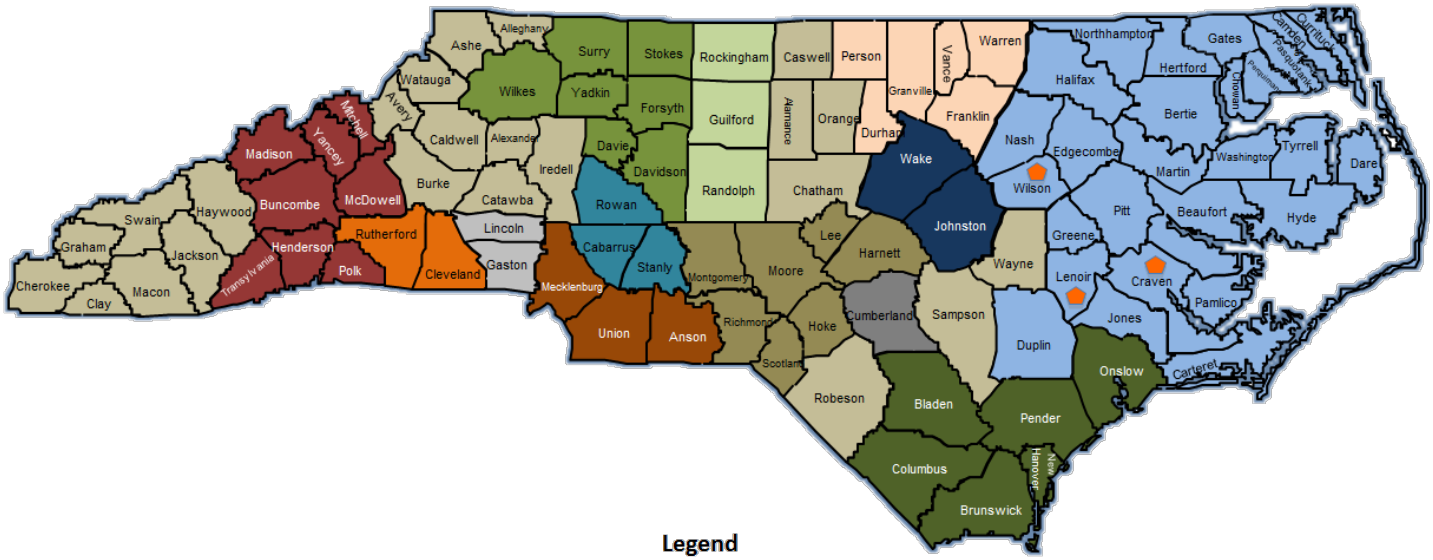
Milliman also reported that N.C. Medicaid is on a successful path to decrease cost by enrolling aged, blind or disabled (ABD) members into a medical home. Those Medicaid populations are generally the least healthy overall and costliest to treat. Enrollment into medical homes initially would add to the cost of caring for them but pays off in the long term. Indeed, Milliman found that in FY 2006, medical home enrollment of ABD populations cost the State an additional $82 million. But by FY 2010, enrollment of ABD Medicaid recipients into medical homes had paid off with the State avoiding $53 million in costs.

In addition, to the continuing cost savings of CCNC's medical home and care management infrastructure. The SFY 2011-12 Budget adopted by the North Carolina General Assembly sought additional savings through the following CCNC activities. The expected savings in the following table were arrived at through meetings between the DHHS Division of Medical Assistance (DMA) and CCNC.

Table 1—Initiatives undertaken in 2011, specific to the SFY 2011-12 Budget

Initiative	Expectation	Savings
Enroll up to 180,000 ABD and non-ABD Medicaid recipients into CCNC		
• County Social Service Agencies will enhance their efforts to enroll eligible Medicaid recipients • North Carolina Hospital Association, Association of Home and Hospice, LMEs, CABHAs, and Adult Care Homes have pledged to assist in enrollment	15% decrease in ABD expenditures 6 mos. post enrollment	$30.8 million
Use risk-adjusted analysis to identify the "most impactable" Medicaid recipients		
• TREO Solutions risk-adjusted analysis • Stratify the Medicaid enrollees to identify the "most impactable" patients • Implement a Network "SWAT Team" approach	Decrease in ED use & avoidable hospitalizations	$ 3 million
Implement a Call Center to follow-up on high ED users		
• Centralized Call Center to follow-up & educate high ED users • ED physicians provide data on recent visits and services • Provide transitional care and coordinate with behavioral health, as appropriate	Decrease in ED utilization	$ 1 million
Implement a Chronic Pain Initiative for narcotics and ED prescribing		
• Enroll all ED Physicians in Controlled Substance Reporting System (CSRS) • Advise ED Physicians to consult CSRS and IC Provider Portal before prescribing • Recommend ED communication with PCP, pharmacy, and CCNC care manager	Decrease ED & inappropriate imaging utilization	$ 7.1 million
Implement an evidence-based best practice initiative on MH specialty prescriptions		
• Focus on best practices & safety of high use/cost drugs • Implement professional education efforts to reduce practice variation	Reduce Pharmacy costs & Off-label use	$5.6 million
Maximize Preferred Drug Utilization		
• Enhance efforts to maximize prescribing off the Preferred Drug List (PDL) • Stress use of point-of-sale web applications & pre-policy switching assistance	Reduce Pharmacy costs	$3.4 million

Community Care of North Carolina Networks



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

CCNC Networks
Administrative and Demographic Overview

Access Care

Director: Marci Miles
Clinical Director: Dr. Steve Wegner

Counties Covered: **24**
Primary Care practices: **290**
Number of Hospitals: **29**
Enrollees: **224,955**

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 Plan of Eastern Carolina:

Director: Jim Baluss
Clinical Director: Dr. Lawrence Cutchin

Counties covered: **27**
Primary Care practices: **206**
Number of Hospitals: **21**
Number of enrollees: **133,542**

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 Care of Western North Carolina:

Director: Jennifer Wehe
Clinical Director: Dr. Richard Hudspeth

Counties covered: **8 Counties**
Primary Care practices: **74**
Number of Hospitals in our counties: **9**
Number of enrollees: **53,301**

Buncombe, Henderson, Madison, Mitchell, McDowell, Polk, Transylvania and Yancey

Community Health Partners:

Director: Lynne Perrin
Clinical Director: Dr. Vann Stitt

Counties covered: **2**
Primary Care practices: **51**
Number of Hospitals: **6**
Number of enrollees: **33,399**

Gaston and Lincoln

Community Care of Lower Cape Fear:

Director: Lydia Newman
Clinical Director: Dr. Robert Rich

Counties covered: **6**
Primary Care practices: **137**
Number of Hospitals: **7**
Number of care managers: **29**
Number of enrollees: **60,000**

Bladen, Brunswick, Columbus, New Hanover, Onslow and Pender

Northern Piedmont Community Care:

Director: Fred Johnson
Clinical Directors: Dr. Thomas Koinis
Dr. Dennis Clements

Counties covered: **6**
Primary Care practices: **51**
Number of Hospitals: **11**
Number of Enrollees: **49, 375**

Durham, Franklin, Granville, Person, Vance and Warren

Carolina Collaborative Community Care:

Director: Brenda Sparks
Clinical Director: Dr. Rueben Rivers

Counties covered: **1**
Primary Care practices: **85**
Number of Hospitals: **2**
Number of enrollees: **48,000**

Cumberland

Northwest Community Care Network:

Director: Jim Graham
Clinical Director: Dr. Jane Foy

Counties covered: **6**
Primary Care practices: **120**
Number of Hospitals: **10**
Number of enrollees: **77,000**

Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin

Carolina Community Health Partnership:

Director: Debbie Clapper
Clinical Director: Dr. William Casp

Counties: **2.**
Primary Care Practices: **22**
Number of hospitals: **3**
Number of enrollees: **23,808**

Cleveland and Rutherford

Partnership for Health Management:

Director: Claudette Johnson
Clinical Director: Dr. Marian Earls

Counties Covered: **3**
Primary Care Practices: **82**
Number of Hospitals: **9**
Number of Enrollees: **72,568**

Guilford, Randolph and Rockingham

Community Care Partners of Greater Mecklenburg:

Director: Anita Shambach
Clinical Director: Dr. John Baker

Counties covered: **3**
Primary Care practices: **163**
Number of Hospitals: **8**
Number of enrollees: **122,650**

Anson, Mecklenburg, Union

Community Care of the Sandhills:

Director: Tammie McLean
Clinical Director: Dr. Robert Cummings

Counties covered: **7**
Primary Care practices: **96**
Number of Hospitals: **7**
Number of enrollees: **55,234**

Harnett, Hoke, Lee, Montgomery, Moore, Richmond and Scotland

Community Care of Wake and Johnston Counties:

Director: Susan Davis
Clinical Director: Dr. Betsey Tilson

Counties covered: **2**
Primary Care practices: **119**
Number of Hospitals: **8**
Number of enrollees: **80,500**

Wake, Johnston

Community Care of Southern Piedmont:

Director: Cindy Oakes
Clinical Director: Dr. Jim Cooke

Counties Covered: **3**
Primary Care Practices: **74**
Number of Hospitals: **3**
Number of Enrollees: **52,317**

Cabarrus, Rowan and Stanly

Enrollment and Demographics

During 2011, CCNC Networks and PCPs experienced an increase of 42,375 Medicaid enrollees, of which 12,273 were aged, blind, or disabled (ABD) individuals.

TABLE 2—Enrollment in CCNC—2011			
	2010	**2011**	**Increase**
CCNC Total Enrollment	1,060,011	1,187,491	12.0%
CCNC ABD Enrollment	195,005	241,454	23.8%

During the past four years CCNC has placed an increasing emphasis on enrolling the ABD Medicaid population into CCNC and providing them a medical home. The ABD enrollment, as a percentage of total CCNC enrollment has increased from 14.2% in January 2007 to 20.3% by December 2011. The ABD population, like all other Medicaid recipients is enrolled into the CCNC program and chooses or is assigned a PCP by either the Division of the Medical Assistance (DMA) or the county social service agencies. During CY 2010 the enrollment of ABD recipients was hampered due to an order from the Federal Centers for Medicare and Medicaid Services (CMS) to cease the practice of automatically enrolling dual eligibles into the CCNC program, through an "opt-out" enrollment process. However, DMA was able to work with CMS and the cease and desist order of the automatic enrollment was removed in late April 2011. To further enhance the State's efforts to enroll ABD patients and bring their care under CCNC's care management, CCNC offered its assistance to DHHS in this ABD enrollment effort. However, DHHS chose the contractor Public Consulting Group to assist in enrollment.

With this increase in enrollment, CCNC Networks have experienced an increasing influx of ABD patients with multiple and complex chronic medical needs. This phenomenon is consistent with the DMA's experience during the past 18 to 24 months, with newly enrolled non-ABD Medicaid recipients. In general, newly enrolled Medicaid recipients are accessing more patient services; more than likely because, prior to enrollment, they have gone for an extended period without access to healthcare services. Concurrently, the increase in the number of ABD patients affects the health acuity levels of the CCNC enrolled membership and the level of health services required, as will be discussed later in this report (See Informatics Center, Page 31). A demographic profile of CCNC's total, ABD and Non-ABD Enrollment—follows in Tables 3, 4, and 5 respectively.

Table 3--CCNC Enrollment

Network	Enrolled in NCCCN			Not Enrolled in NCCCN			Total Medicaid	% Enrolled
	ABD	Non-ABD	Total	ABD	Non-ABD	Total		
Access Care Network	44,055	201,950	246,005	30,768	53,814	84,582	330,587	74.4%
Community Care of Western Carolina	12,429	45,392	57,821	9,426	13,327	22,753	80,574	71.8%
Community Care of Lower Cape Fear	16,654	46,991	63,645	7,823	13,247	21,070	84,715	75.1%
Carolina Collaborative Community Care	11,433	41,115	52,548	3,274	7,460	10,734	63,282	83.0%
Community Care of Wake and Johnston Counties	4,653	21,171	25,824	4,923	5,785	10,708	36,532	70.7%
Community Care Partners of Greater Mecklinburg	22,730	111,832	134,562	10,096	25,403	35,499	170,061	79.1%
Carolina Community Health Partnership	14,002	76,657	90,659	11,403	19,762	31,165	121,824	74.4%
Community Care Plan of Eastern Carolina	42,341	103,833	146,174	21,930	31,245	53,175	199,349	73.3%
Community Health Partners	7,547	30,315	37,862	4,825	8,856	13,681	51,543	73.5%
Northern Piedmont Community Care	13,799	45,205	59,004	6,502	11,692	18,194	77,198	76.4%
Northwest Community Care	18,564	67,457	86,021	6,722	14,839	21,561	107,582	80.0%
Partnership for Health Management	10,337	62,231	72,568	18,010	25,342	43,352	115,920	62.6%
Community Care of the Sandhills	13,553	48,928	62,481	6,256	11,686	17,942	80,423	77.7%
Community Care of Southern Piedmont	9,357	42,960	52,317	4,171	8,213	12,384	64,701	80.9%
Totals	**241,454**	**946,037**	**1,187,491**	**146,129**	**250,671**	**396,800**	**1,584,291**	**75.0%**

Table 4--CCNC Enrollment--ABD

Network	Enrolled in NCCCN			Not Enrolled in NCCCN				
	ABD Population			ABD Population			TOTAL ABD	% Enrolled
	Dual	Non-Dual	Total	Dual	Non-Dual	Total		
Access Care Network	20,509	23,546	44,055	23,367	7,401	30,768	74,823	58.9%
Community Care of Western Carolina	6,542	5,887	12,429	7,309	2,117	9,426	21,855	56.9%
Community Care of Lower Cape Fear	8,109	8,545	16,654	6,161	1,662	7,823	24,477	68.0%
Carolina Collaborative Community Care	4,934	6,499	11,433	2,214	1,060	3,274	14,707	77.7%
Community Care of Wake and Johnston Counties	1,856	2,797	4,653	3,912	1,011	4,923	9,576	48.6%
Community Care Partners of Greater Mecklinburg	10,606	12,124	22,730	6,725	3,371	10,096	32,826	69.2%
Carolina Community Health Partnership	5,337	8,665	14,002	8,777	2,626	11,403	25,405	55.1%
Community Care Plan of Eastern Carolina	21,884	20,457	42,341	16,286	5,644	21,930	64,271	65.9%
Community Health Partners	3,484	4,063	7,547	3,659	1,166	4,825	12,372	61.0%
Northern Piedmont Community Care	6,589	7,210	13,799	4,990	1,512	6,502	20,301	68.0%
Northwest Community Care	9,833	8,731	18,564	5,452	1,270	6,722	25,286	73.4%
Partnership for Health Management	4,437	5,900	10,337	12,043	5,967	18,010	28,347	36.5%
Community Care of the Sandhills	6,541	7,012	13,553	4,848	1,408	6,256	19,809	68.4%
Community Care of Southern Piedmont	4,568	4,789	9,357	3,399	772	4,171	13,528	69.2%
Totals	**115,229**	**126,225**	**241,454**	**109,142**	**36,987**	**146,129**	**387,583**	**62.3%**

Table 5--CCNC Enrollment--Non-ABD								
Network	Enrolled in NCCCN Non-ABD Population			Not Enrolled in NCCCN Non ABD Population			TOTAL Non-ABD	% Enrolled
	Dual	Non-Dual	Total	Dual	Non-Dual	Total		
Access Care Network	53	201,897	201,950	14,258	39,556	53,814	255,764	79.0%
Community Care of Western Carolina	18	45,374	45,392	4,127	9,200	13,327	58,719	77.3%
Community Care of Lower Cape Fear	28	46,963	46,991	3,720	9,527	13,247	60,238	78.0%
Carolina Collaborative Community Care	13	41,102	41,115	1,331	6,129	7,460	48,575	84.6%
Community Care of Wake and Johnston Counties	7	21,164	21,171	2,010	3,775	5,785	26,956	78.5%
Community Care Partners of Greater Mecklinburg	25	111,807	111,832	4,187	21,216	25,403	137,235	81.5%
Carolina Community Health Partnership	20	76,637	76,657	3,263	16,499	19,762	96,419	79.5%
Community Care Plan of Eastern Carolina	46	103,787	103,833	9,061	22,184	31,245	135,078	76.9%
Community Health Partners	6	30,309	30,315	2,728	6,128	8,856	39,171	77.4%
Northern Piedmont Community Care	14	45,191	45,205	2,847	8,845	11,692	56,897	79.5%
Northwest Community Care	23	67,434	67,457	5,192	9,647	14,839	82,296	82.0%
Partnership for Health Management	12	62,219	62,231	5,387	19,955	25,342	87,573	71.1%
Community Care of the Sandhills	21	48,907	48,928	3,551	8,135	11,686	60,614	80.7%
Community Care of Southern Piedmont	17	42,943	42,960	2,775	5,438	8,213	51,173	84.0%
Totals	**303**	**945,734**	**946,037**	**64,437**	**186,234**	**250,671**	**1,196,708**	**79.1%**

Care Management of Persons with Chronic Illnesses

According to CCNC data, more than 20 percent CCNC's enrolled population have multiple or dominant chronic conditions, accounting for about 60 percent of the total Medicaid spending. Because of this, CCNC has concentrated its care management efforts on the cohort of Medicaid patients with chronic illnesses.

Chronic Care—Transitional Support

Since April 2010, the CCNC has expanded its workforce to embed care managers in hospitals, medical homes and LMEs. Networks share and adopt best practices in an effort to constantly improve overall care management.

Interventions to improve transitions in care, e.g. from hospital to home, are a high priority. Networks have established processes for visiting patients prior to discharge, followed by home visits and joint visits at the patient centered medical home, when needed. Care managers work closely with their network pharmacists and the information provided in Pharmacy Home to achieve medication reconciliation and assist patients with medication management. Several networks are utilizing paraprofessional staff to gather data, make telephone calls, and conduct other preliminary work for the Care Managers, enabling healthcare staff to function at the top of their license. Enhanced reporting from the CCNC's Informatics Center provides real-time utilization data, patient care alerts and patient snapshots has greatly increased the Networks' ability to manage the ABD population more effectively.

Each month, CCNC provides transitional care support to over 4,000 Medicaid recipients. During the most recent 6-month period, May-October 2011, post-discharge support was provided to 25,420 individuals across the State.

- Less resource-intensive interventions, such as assurance of a follow-up appointment, were provided to over 21,000 during this time period.
- Medium-intensity interventions, such as hospital visits, medication reconciliation by a nurse care manager, and service coordination, were each received by approximately 10,000 patients.
- Higher intensity transitional care management services, such as home visits, medication reviews by a clinical pharmacist, and preparation of customized patient self-management notebooks, were each delivered to approximately 6,000 patients.
- The above numbers sum to more than 25,420 because some individuals received multiple interventions during the six-month period, e.g. high then medium, or medium then less.

These 25,420 individuals were discharged to 10 CCNC Networks from 153 hospitals and 56 nursing facilities, and returned to 1,420 different primary care medical homes.

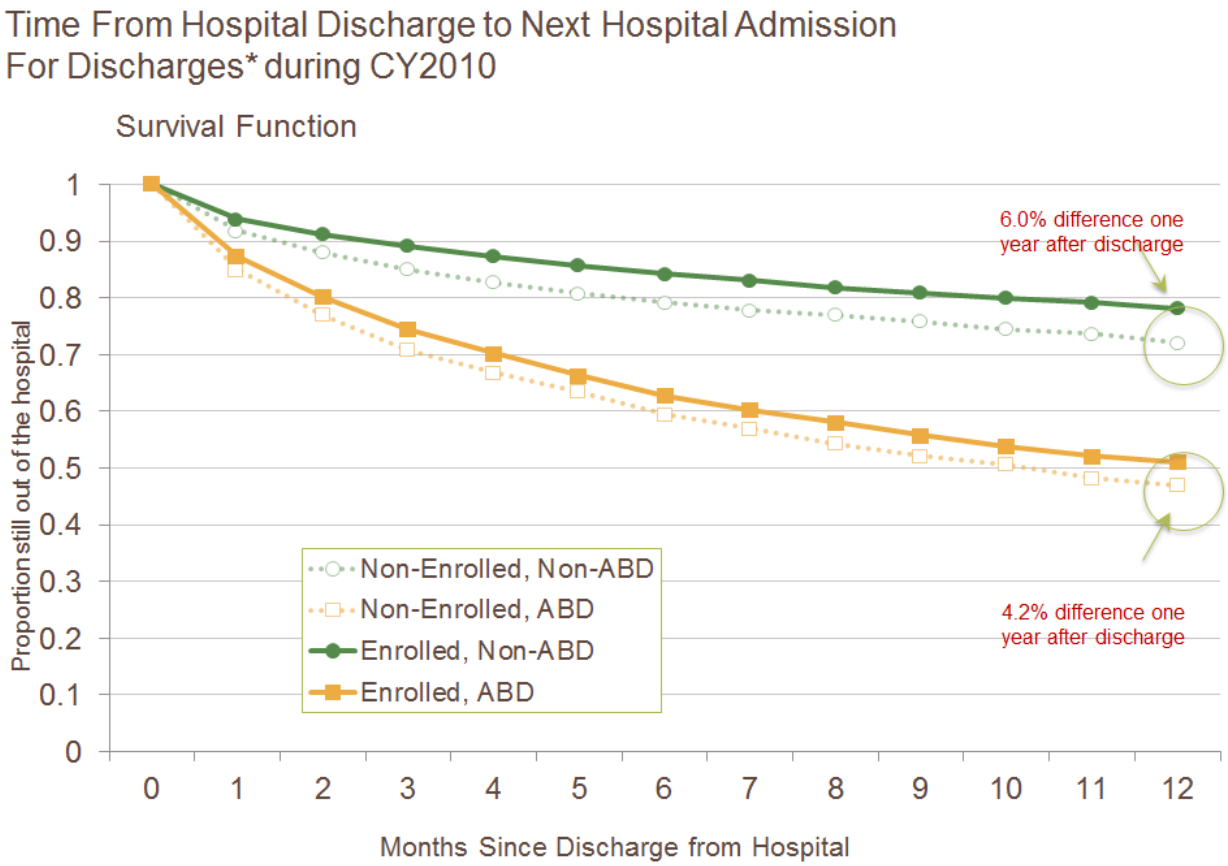
The CCNC Transitional Care Program reached its current staffing capacity by early 2011, but continues to gain efficiencies through new partnerships and refined workflow processes. The impact of current transitional care efforts at full scale cannot be fully measured until more time has elapsed for claims data processing, but effects on time to rehospitalization are already discernible.

The information in the following table illustrates the impact of transitional care on overall hospitalization. CCNC analyzed hospital discharges during 2010 to estimate the impact of enrollment in care management on readmission rates during the 12 months after a previous hospitalization. The analysis indicated that discharged individuals enrolled in a CCNC medical home were statistically significantly less likely to be readmitted to a hospital compared to those patients not enrolled in CCNC, even when looking at readmission rates as much as 12 months post discharge. The results suggest a 6% and a 4.2% absolute difference, or a 22% and 8% relative reduction for non-ABD and ABD,

respectively, in readmission rates for CCNC-enrolled individuals compared to non-CCNC-enrolled individuals during the year after hospital discharge.

For the State policymaker, the significance of this analysis is that for every 100,000 hospital admissions, CCNC was able to advert more than 6,000 non-ABD and more than 4,200 ABD admissions up to a year following the initial hospital admission.

TABLE—6
Time From Hospital Discharge to Next Hospital Admission



Draft of 10/20/11; N=52,474 unique individuals; Non-duals only, all ages, excludes obstetrics, newborns, malignancies, burns, traumas, and transfers; only includes members enrolled with Medicaid in December 2010.

Chronic Care—Health Home for Chronically Ill

Section 2703 of P.L. 111-148, The Patient Protection and Affordable Care Act established a program to assist States in the management of Medicaid patients with chronic conditions. DMA is partnered with CCNC to submit a Medicaid State Plan Amendments (SPA) identifying support services eligible for an enhanced Federal reimbursement rate. The SPA covers plans for programs that are currently part of the CCNC framework. A second SPA describing plans to integrate programs for people with disabilities and other special health care needs into the whole-person Health Home model was subsequently not needed. The reason is that DHHS' expansion of the managed care Section 1915b/c waiver for the State and its Four Quadrant Model to address Mental Health, Developmental Disability, and Substance services.

The SPA was submitted to CMS in October and has yet to be approved.

Once approved, DHHS will receive a 90% FMAP for the following eight fiscal quarters that the SPA is in effect for health home services provided to recipients who have two or more chronic conditions, or one chronic condition and may be at risk for a second or a single, or one serious and persistent mental health condition.

The goals of the Health Homes for the Chronically Ill are to:

1. Reduce Emergency Department visits and costs;
2. Reduce Avoidable Hospital Admissions and Readmissions
3. Increase the co-location of primary care and behavioral healthcare services

To evaluate the attainment of these goals, CCNC will collect and analyze data on the following metrics:

1. Hospital Admissions
    a) Inpatient admissions/1000/Per Member Months (excluding mental health diagnoses)
    b) Potentially Preventable Admissions (PPA) within 30days, excluding diagnosis mental illness
    c) MH Readmissions within 30days of admission
    d) Hospital admits and readmits for Chronic Heart Failure, primary or secondary diagnosis Per Member Months
    e) Hospital admits and readmits for Asthma, primary Diagnoses/Per Member Months

2. ED visits
    a) ED visits per 1000/PMM

3. Skilled Nursing Facilities
    a) SNF admits/1000/PMM

Dual Eligibles

In April 2011, North Carolina received a Federal 18-month planning grant from CMS to develop a strategic framework and implementation plan for a statewide demonstration to integrate healthcare for Dual Eligibles. The plan must outline the structure, implementation plan, payment model, and potential shared savings that will accrue to CMS and the State should the implementation plan get approved. The State plans to build on the CCNC medical home and population management infrastructure and enhancements to serve the most high risk and high cost dual eligible across all health care settings, including skilled nursing facilities and adult care homes. North Carolina is one of 15 States afforded this opportunity. North Carolina's response to the Centers for Medicare & Medicaid Services is due April 5, 2012.

Since this past July CCNC, DMA, and other relevant DHHS Divisions have been developing a strategic framework and implementation plan for a statewide demonstration program to improve the quality and reduce the costs of care for dual eligibles.

More than 175 volunteers representing stakeholders, including State agencies, healthcare associations, providers, consumers and advocates were enlisted into the effort and they have formed six work groups. Each group has its own page on the CCNC website, where one can obtain further information on the workgroups activities. The website is http://www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/

Dual Eligible Planning Grant Work Groups

1. Medical/Health Homes and Population Management
2. Long Term Services and Supports
3. Transitions Across Settings and Providers
4. Behavioral Health Integration
5. Payment and Delivery System Integration
6. Beneficiaries and Community Stakeholders

As of late-December four of the six works groups have completed their work and finalized their draft recommendations: B*ehavioral Health Integration, Medical/Heath Homes and Population Management, Transitions and Long Term Services and Supports Work Group*. The Beneficiaries and Community Stakeholders Workgroup expects to complete its work by the end of February 2012. The Payment and Delivery System Integration work group is beginning their work which will be based on the recommendations of the other five work groups.

Concurrently, CMS has retained Mercer, Inc. to conduct the financial analysis and cost modeling for the State's demonstration program, so as to determine the shared savings that will accrue to CMS and the State. It's anticipated that the State's share of the savings will accrue to the General Fund, DMA, and a portion will be reinvested in the model to achieve further savings.

Between January and September 2012, NC stakeholders at the State, county, and local level will build on the current medical home and population health management infrastructure to develop a patient-centered model of care for dually eligible beneficiaries that is viable in all 100 counties. It's anticipated that North Carolina's model can and will be replicated in other States. The focus of this effort is to provide care for the over 284,160 dual eligible individuals, including 235,000 in their own homes, 30,000 in nursing homes, and over 19,000 in adult care homes. Along with beneficiaries, this process must engage and seek input from their families, informal and professional caregivers, and the networks and communities already working diligently to meet their needs. Participation in all aspects of this development process by state-level agencies and organizations responsible for the policies, programs, and payments that support dual eligibles is essential and it is part of the development process

Chronic Care--Beacon

In April 2010 Community Care of Southern Piedmont was recognized by the U.S. Department of Health and Human Services as a Beacon Community -- one of only 15 communities nationwide to receive that honor. The recognition includes a $15.9 million dollar grant, funded through the American Recovery and Reinvestment Act (ARRA) that is designed to strengthen the Beacon communities' health IT infrastructure and health information exchange capabilities.

Community Care of Southern Piedmont was chosen in part because the region's three non-profit hospitals, local VA facilities, and more than 60 percent of the ambulatory practices have adopted electronic health records. Upon this foundation Southern Piedmont is building greater health IT capabilities that support early detection of disease and improved management of chronic illness.

The network will use information technology, including health information exchanges, to improve provider communication and increase patient access to health records. The aim is to improve care coordination, encourage patient involvement in their own medical care, and obtain better health outcomes while controlling cost. The improvements made with the Beacon funding will then be spread and applied to all 14 networks. The enhanced analytics will be built in the CCNC Informatics Center and available and beneficial to all networks and enable rapid spread of best practice for all enrollees.

Specific elements of the initiative include:

- Adding care managers and pharmacists, and mental health counselors to the care team for patients with diabetes, congestive heart failure, hypertension, and other chronic diseases in the area to help establish a more seamless, integrated health care experience
- Expanding opportunities for patient education and involvement through a specialized program and clinics in the community including schools
- Expanding health IT to support increased communication and collaboration among members of the care team including patients

Behavioral Health and Health Care Integration

Behavioral health integration (BHI) is a long-term effort by CCNC to establish and enhance the capacity of primary care practices to identify mental illness and substance use amongst their patients, so that evidence-based treatment can be provided. Nationwide research indicates that the majority of psychiatric prescriptions are written by primary care physicians. This issue is complicated by the fact that in many regions of North Carolina the Primary Care Physician may be the only behavioral treatment provider/prescriber for mental health; and often the physician has had a minimum of detailed training in the field.

The integration of behavioral health and primary care is aimed at breaking the "silo," separated system of care that fails to consider that patients frequently possess mental and physical co-morbidities—up to 30% of the ABD population have a diagnosis of mental illness, along with other chronic health conditions. CCNC is committed to changing a healthcare delivery system that currently splits the mind and body by providing the necessary resources and expertise to align the efforts of primary care and behavioral health care professionals.

In mid-2010, CCNC embarked on three behavioral health initiatives in an effort to:

1. Decrease mental health admissions to hospitals,
2. Increased the co-location behavioral health resources in practices, and
3. Increase the use of evidenced based practices.

Behavioral Health Co-location

All Networks have hired psychiatrists and behavioral health specialists. Some Network care managers have been co-located at LMEs to serve as patient navigators for treatment. CCNC conducted 17 training workshops across the state to facilitate medication reconciliation for patients with behavioral health medications. Attending the workshops were nurse care managers, network pharmacy staff, and network behavioral health care managers from all 14 Networks. Following the last workshop, the CCNC network nurse care managers and network pharmacy staff believed that such competency enhancement training was needed to allow them to both identify and then follow-up on potential behavioral health problems which were identified through the medication reconciliation process.

In January 2011, CCNC published the following data on the implementation of the Behavioral Health initiative to increase the co-location of behavioral health resources in Primary Care Practices. The data was to provide CCHC and DHHS a baseline for the subsequent efforts. However, DHHS directed CCNC to focus on efforts that would result in more immediate cost savings and the co-location effort and resurvey of networks and practices has been postponed to mid-2012.

Table 6—Co-Location of Behavioral Health Specialists in Primary Care Practices--2010			
Network	Primary Care Practices		Pct. Of Total
	Total	With BH Specialist	
Access Care	282	11	3.91%
Community Care of Western North Carolina	70	12	17.39%
Community Care of Lower Cape Fear	136	12	8.89%
Carolina Collaborative Community Care	84	1	1.22%
Community Care of Eastern Carolina	214	3	1.41%
Community Health Partners	47	4	8.70%
Northern Piedmont Community Care	41	14	36.84%
Northwest Community Care	115	5	4.59%
Carolina Community Health Partnership	21	3	14.29%
Community Care Partners of Greater Mecklenburg	162	4	2.55%
Community Care of Wake and Johnston Counties	102	5	5.15%
Partnership for Health Management	60	8	13.33%
Community Care of the Sandhills	92	3	3.37%
Southern Piedmont Community Care Plan	65	7	10.77%
TOTALS	1,462	92	6.29%

Evidenced-based Best Practices in Treatment of Mental Illness and Substance Abuse

The Area Health Education Centers (AHECs) conducted 16 statewide training sessions on Motivational Interviewing for all Network psychiatrists, behavioral coordinators, and the 600 care managers across the state. The goal of Motivational Interviewing is to engage the patient in taking responsibility for their treatment and care, especially as it relates to a chronic illness or behavioral health diagnosis. Concurrently, healthcare providers were made aware of the availability of these resources to support integrated care. The CCNC Networks' 600 care managers will continue to receive coaching and technical assistance in their efforts throughout 2012.

The Substance Abuse and Mental Health Services Administration awarded a five year federal grant of $8 million to two of CCNC's Networks—Community Care of the Sandhills and Northwest Community Care to train primary care physicians in the use of SBIRT (Screening, Brief Intervention, Referral to Treatment) and thus increase the use of this evidenced-base model in the screening and brief treatment for alcohol and drugs.

A CCNC workgroup of central office staff and Network and community physicians collaborated to develop a depression guideline for Primary Care Practices to use the PHQ 2/9 screening tool for the identification and treatment of depression and anxiety disorders. The guideline and the use of PHQ 2/9 are both evidenced based practices that will improve the early identification and appropriate treatment for depression. Implementation of the use of the guideline and PHQ 2/9 screening is planned for April 2012.

To educate Network pharmacists on the unique issues posed by behavioral health medications trainings were conducted across the 14 Networks by the CCNC Behavioral Health pharmacist. These

trainings were developed to support the medication reconciliation process in an effort to prevent hospital readmissions due to patient's medication compliance or confusion between prescriptions.

Chronic Pain Initiative

While doctors and nurses have a major role to play in treating chronic pain and preventing overdose deaths, the responsibility for action goes beyond the clinic. Working with the non-profit organization, Project Lazarus, utilizing many of the strategies from the successful pilot program in Wilkes County, CCNC has recently launched the Chronic Pain Initiative (CPI). The cornerstones of the CPI are:

- Community organization and activation;
- Prescriber education and behavior;
- Supply reduction and diversion control;
- Pain patient services and drug safety;
- Drug treatment and demand reduction;
- Harm reduction;
- Community-based prevention education, and
- Epidemiologic surveillance to enhance community awareness and monitor project outcomes.

CCNC staff will help coordinate these community based interventions among local individuals; law enforcement, medical care, emergency room physicians, mental health and public health agencies and other like-minded organizations by leveraging existing resources or helping raise awareness and funds for new programs. The multiple levels of prevention efforts and community-based education are intended to impact the local community and health care delivery system, including pain patients without exacerbating any associated stigma. School-based prevention education targets vulnerable populations and aims to shift general patterns of substance abuse.

In 2011, the psychiatric departments of The University of North Carolina at Chapel Hill and East Carolina, Duke, and Wake Forest Universities partnered in an effort to change psychotropic medication prescribing trends in our State. The intent is to both improve the quality of psychiatric care and at the same time save money. Often times very expensive non-FDA approved medications are used for some psychiatric conditions when safer, less expensive alternatives are readily available. Their efforts led to the establishment of the North Carolina Community Care, the North Carolina Academic Consortium for Cost Effective Psychopharmacologic Treatment (NC-ACCEPT) program. The program is an educational effort that employs expert psychiatric professionals from the four State medical schools to train primary care and behavioral health professionals in models of best practice care throughout the State.

Antipsychotics for Kids—A+Kids

The use of antipsychotic medications by children is an issue confronting parents, caregivers, healthcare providers, and related healthcare agencies. Many antipsychotic prescriptions do not have U.S. Food and Drug Administration approved-labeling/use for children. Of increasing concern is the fact that children and adolescents appear to be at greater risk than adults for a variety of side effects. As a result, DMA has developed a policy titled "Off-Label Antipsychotic Monitoring in Children through Age 17"

CCNC's A+ KIDS initiative has brought it together with DMA to implement a web-based registry for providers to document the use of antipsychotic therapy in Medicaid eligibles ages 0 through 17. This registry is supported by an advisory panel consisting of child psychiatrist representatives from North Carolina's four medical universities. This prior documentation registry, called A+KIDS (Antipsychotics-Keeping It Documented for Safety) encourages the use of appropriate baseline and follow-up

monitoring parameters to facilitate the safe and effective use of antipsychotics in this population, while maintaining open access to any antipsychotic agent currently available in the United States.

CCNC Relationship with Waiver MCOs and LMEs

CCNC continued its strong commitment to integrated health and behavioral health care. One CCNC's primary goals to collaborate with the LME/MCO and behavioral health providers to optimize care of patients with co-occuring physical and behavioral health illnesses.

Currently, CCNC is working closely with DMA and DMH to identify and address these barriers in providing integrated care in CCNC primary care practices. In late-November CCNC established a pilot project that enrolls CABHAs as CCNC partners. The goal is to directly provide actionable patient information in timely manner to providers. Providing critical patient information providers, at the point of treatment will enhance the development of timely treatment interventions. CCNC will continue to work with the state's 11 MCOs in clarifying their individual needs in order to provide integrated care at the PCP level as a best practice model of care.

Care Management of Women, Infants, and Children

Pregnancy Home Model

The Pregnancy Medical Home (PMH) Program launched in March 2011 with a goal of improving birth outcomes in the Medicaid population by focusing on quality of care and population management. The initial program focus is on preterm birth prevention and reduction of the incidence of low birth weight, as these issues drive infant mortality and morbidity, contribute to long-term developmental and medical complications, and are associated with increased costs of care. In FY2011, 11.1% of Medicaid recipients covered during the prenatal period had a low birth weight infant, weighing less than 2500 grams (5.5 pounds). In the first quarter of FY2012, the rate of low birth weight was 11.0%.

By the end of 2011, approximately 300 healthcare entities were serving as PMHs, including:

- Private practices (OB/GYN, family medicine, multi-specialty, nurse midwifery),
- Hospital-based clinics,
- Local health departments,
- Federally-qualified health centers, and
- Rural health clinics.

More than 1,000 individual providers are associated with PMH practices, including obstetricians, maternal-fetal medicine specialists, family physicians, nurse midwives, nurse practitioners and physician assistants. Approximately 75% of practices and clinics providing prenatal care have joined with their local CCNC network as a PMH site.

To participate in the PMH program, practices must agree to meet performance expectations, including:

- performing no elective deliveries before 39 weeks of gestation,
- offering and providing 17p progesterone injections to patients at risk for premature births,
- maintaining the risk-adjusted primary C-section rate (women having their first C-section among patients with a full-term gestation and a singleton, vertex fetus) at or below 16%, and
- Completing standardized risk screening of all new prenatal patients.

They must also complete a postpartum visit that includes depression screening, reproductive life planning, and referral for ongoing care, if the patient will not continue to receive care from the maternity care provider beyond the postpartum period. A signed PMH contract entitles a practice to a package of benefits, including an increased Medicaid reimbursement rate for vaginal deliveries, incentive payments for completing risk screening and postpartum visits, and waiver of prior authorization requirements for obstetric ultrasound. PMH practices also receive support from their local CCNC network and access to data reflecting perinatal quality metrics.

During the first nine months of the program, more than 23,000 pregnant Medicaid patients had an initial risk screening, using the CCNC-developed standardized pregnancy risk screening tool, to identify the “priority OB population”. By the end of 2011, PMH practices were conducting standardized risk screening on more than 60% of the pregnant Medicaid population. Medicaid provides maternity coverage for roughly 50,000 women annually. As the remaining maternity providers sign contracts with their CCNC network to become PMH sites, and as individual practices improve processes to ensure all of their patients receive risk screening, the number of patients receiving risk screening will continue to increase.

Early PMH program data indicate that 70% of pregnant Medicaid patients have at least one risk factor associated with a greater likelihood for preterm birth and other complications. Tobacco use is one of the most prevalent risk factors for poor birth outcome, with 34% of patients reporting tobacco use at

the time they learned they were pregnant; and 19% were still smoking at the time of the risk screening. Timely entry to prenatal care is another concern, with 22% of patients not receiving prenatal care until the second trimester of pregnancy. Addressing this risk factor will involve focusing on access to care and patient education about the importance of early prenatal care. Chronic conditions that may complicate pregnancy, from asthma to mental illness to hypertension, are identified among more than 10% of the patient population.

Pregnancy Care Management: Patients with a positive risk screening are automatically referred to a pregnancy care manager at their local health department for evaluation and follow-up. Additional strategies to locate priority patients include utilizing real-time data from NC hospitals to identify patients with obstetric-related ED/triage visits and hospital admissions, as well as collaborating with the PMHs and community agencies serving low-income pregnant women.

CCNC works in close partnership with the Division of Public Health (DPH) to develop, oversee, and evaluate the pregnancy care management program. CCNC OB nurse coordinators and DPH regional social work consultants from across the state meet monthly with the statewide PMH and pregnancy care management project managers. DPH regional consultants and CCNC network teams jointly conduct local meetings with the health department staff providing pregnancy care management. As of September 2011, local health departments report quarterly to the CCNC network on the use of the PMPM funding received for this program and on program successes and challenges.

In 2011, DPH and CCNC collaborated on two separate series of regional training sessions at six locations across the state for pregnancy care management staff and supervisors. DPH produces a monthly pregnancy care management training webinar for local health department staff, with content developed in collaboration with CCNC. In 2012, DPH plans to conduct statewide training on motivational interviewing skills, which is expected to enhance the effectiveness of the pregnancy care management workforce in engaging at-risk pregnant Medicaid recipients and will mirror the motivational interviewing training model that was implemented in CCNC networks in 2011.

Care Coordination for Children—CC4C

CC4C is a new CCNC-model population management program that began in March 2011 to replace the targeted case management program—Child Service Coordination—for children at-risk. Here to, DMA, DPH, and CCNC collaborated to build on the strengths of the CCNC program to create an integrated and collaborative model.

CC4C serves children from birth to age 5, who meet one of the following risk factors:

1. Special Health Care Needs
2. Exposure to Toxic Stress, i.e. extreme poverty, physical or emotional abuse, chronic neglect, parental substance abuse.
3. CCNC Enrollment/Access for Children in Foster Care, and
4. High-cost or frequent users of Healthcare System

Referrals to CC4C originate from medical homes, hospitals, community organizations, CCNC care management staff or families and can be submitted in a variety of ways including CCNC's Care Management Information System (CMIS). Referrals are also identified through CCNC Informatics Center reports based on claims data.

The performance metrics of the program include:

- Ensure at-risk infants (graduates of Neonatal Intensive Care) have medical home visit within a month
- Reduce the rate of hospital admissions and readmissions

- Reduce the rate of emergency department visits
- Increase the percentage of CC4C children receiving comprehensive health assessments
- Increase appropriate referrals to Early Intervention
- Increase the Life Skills Progression Assessments on children upon enrollment and every six (6) months thereafter and/or upon closing

Beginning in February, CC4C conducted six trainings across the State for approximately 600 CCNC & CC4C staff—administrators, care management supervisors/staff; and others—followed by three on-line webinar trainings to prepare staff for implementation of the program. In March, children were transitioned to the CC4C program. During May 2011, CC4C care managers received training on "Building Strong Collaborative Relationships with Medical Homes" and were encouraged to link with their CCNC colleagues in making practice visits to establish these relationships. Best practices and updates are shared through monthly CC4C webinars. Trainings and technical assistance have been provided to assist staff through the learning curve of providing this new population management model of care management. A CC4C workgroup meets monthly and is actively involved in program development.

CC4C services are provided based on patient-need and according to risk stratification guidelines. A comprehensive health assessment, including the Life Skills Progression, assists the care manager in identifying the child's needs, plan of 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. In the near future, all documentation for CC4C services will be entered online in the CCNC Case Management Information System (CMIS). CC4C care managers work in close collaboration with CCNC care managers to meet the needs of the population.

CMIS has been enhanced to incorporate CC4C tools, expand the breadth of information in the Comprehensive Health Assessment and to ensure that CMIS data needed to demonstrate performance outcomes can be collected.

CC4C and Informatics Center staff collaborated to:

- Develop a methodology for measuring CC4C Performance Outcomes;
- Conduct the data analysis to establish baseline measures (where possible);
- Ensure that the data needed to demonstrate performance outcomes is collected in CMIS or through claims;
- Initiate the development of monitoring reports, and
- Provide informational resources that will help the CC4C care managers impact the outcomes being measured.

The IC staff recently created reports for local health department CC4C Programs that identifies and flags children ages birth to 5 by county of residence with above-expected potentially-preventable hospital costs or due to recent hospital admissions, readmissions, use of the emergency department, and other priority factors.

Health Choice

Health Choice is North Carolina's State Children's Health Insurance Program (SCHIP) authorized under Title XXI of the Social Security Act. Families with children between the ages of 6-18 who have annual incomes between 100% and 200% of Federal Poverty Guidelines ($23,050/year to $46,100/year for a family of 4) may enroll their children for healthcare coverage. Eligibility is determined by the county Social Service agency.

In July 2010, DMA assumed administration of the program from the State Health Plan. In June 2011, the General Assembly enacted legislation calling for CCNC to manage the healthcare of children enrolled in Health Choice, just as it manages the care of children in Medicaid.

As of October, Health Choice children received a new enrollment card listing their designated Carolina Access (CA) or CCNC healthcare provider. New enrollees have to choose a CCNC provider, but children linked with existing CA providers did not have to switch.

In October 2011, Primary Care Practices and Networks began receiving reimbursement for the care management of the approximately 129,000 Health Choice children already enrolled with CCNC providers. The Per Member Per Month (PMPM) reimbursements are:

- $2.50 to the PCP
- $3.62 to the CCNC Network where the child lives
    - $0.62 of this amount is returned to the North Carolina Community Care Networks, Inc. to the support the Informatics Center's reporting and monitoring capabilities
- Carolina Access- providers receive only a $1.00 PMPM because they are not linked to a CCNC Network.

Providers have to enroll with Medicaid to serve the Health Choice population, but do not have to serve Medicaid clients. DMA is trying to contact and enroll approximately 580 Health Choice providers that are not currently enrolled in Medicaid.

Pharmacy Management

CCNC's pharmacy management focuses on maximizing the effectiveness and judicious use of medications, that are often a healthcare providers first line of defense to prevent disease progression and undesirable and costly medical events such as a stroke, heart attacks, asthma attacks, mental health crises, or complications from diabetes such as loss of sight, amputation or chronic kidney disease. Yet medication management often requires a great deal of individualized prescribing, coordination, and patient re-enforcement. CCNC enrollees are meant to always have, at a minimum, a Care Manager, a Pharmacist, and Behavioral Health Specialist looking after, and available to them.

CCNC's pharmacy management programs typically involve multiple types of credentialed providers (PharmD, MSW, RN, LPN and many others) working in concert with a variety of physician-providers involved in a patient's care to assist the (Primary) PCMH provider in optimizing medication use. Approximately 80% of a CCNC Pharmacist time is currently invested in transitional care-hospital to home activities. The focus is on preventing both short-term (30 day) and long-term (365+ day) readmissions. The most prominent direct patient care activity in which CCNC Pharmacists engage is a very comprehensive version of Medication Reconciliation that extends the activity into the community and the patient's Medical Home practice. The reconciliation process typically involves the hospital discharge list being reconciled versus the prescription fill history from the pharmacy being reconciled with the Medical Home provider's medical chart, where the Active Medication List resides. It has been a very successful endeavor, but requires a substantial portion of the existing CCNC pharmacists' time with well over 100,000 Medicaid Discharges every year, roughly a third to half of them in need of the more comprehensive version performed by a CCNC Pharmacist. Additionally, the CCNC Pharmacists act in a supportive and consultative role with the more than 600 CCNC Care Managers to assist and enhance their own Medication Management activities such as home visit assessments and activities related to adherence and re-enforcement of patient drug use plans.

Each of the 14 networks has a Lead Network Pharmacist, who is responsible for facilitating and managing all pharmacy related activities for his or her network. In addition, CCNC currently has 24.6 Pharmacist FTE across 54 pharmacists devoted to clinical pharmacist activities that include direct patient care. They work very closely with CCNC care managers and CCNC Medical Home providers as an ancillary support for the larger set of services and goals for each CCNC enrolled patient. Each patient who is enrolled with CCNC has a pharmacist who is responsible for taking referrals for medication management from case managers and physician providers as well as addressing medication-related care gaps generated by the Informatics Center that prompt particular action related to an opportunity to improve patient care.

CCNC Pharmacist and Pharmacy Programs fall into two general programmatic areas and activity sets: Pharmacy Administration and Clinical Pharmacy Activities. The unique aspect of CCNC Pharmacist program as it relates to the PCMH model is that while Pharmacy Admin activities are distinctly different from Clinical Pharmacy activities, each CCNC Pharmacist engages in both types of activities at the service of their assigned Medical Homes. Thus, the key relationship is between the Pharmacist and the Medical Home, not the Pharmacist and the specific activity. This allows the Medical Home to establish a closer, more inter-professional and interpersonal relationship with their respective PCMH providers rather than having scattershot relationships with many pharmacists engaging in many different activities.

Pharmacy Administration Programs Update

Pharmacy Administration refers to all activities unrelated to direct patient care. Includes activities such as Preferred Drug List Support and Education, Electronic Prescribing Support, Prior Authorization support, support and education of Special Patient-Pharmacy Programs (lock-in, rx limit), prescription

registries (A+Kids), generic utilization and associated academic detailing, and other non-direct patient care programs as prescribed by the enrollee's payer. Below is an update of the most germane Pharmacy Admin activities during the past year:

Antipsychotics – Keeping It Documented for Safety (A+KIDS) for Medicaid and North Carolina Health Choice

The A+KIDS program, which was first implemented in the 0-12 year old Medicaid population in April 2011 and then expanded to 13-17 year olds in August 2011, now includes NC Health Choice recipients. A+KIDS is a quality prescribing and monitoring program that utilizes a pharmacy stop that prevents prescription filling for antipsychotics in children <18 years old without submission of symptom identification, management and monitoring of adverse effects. CCNC created and sponsors the website that enables documentation and provides widespread education of policy and best practices as well as a call center that notifies pharmacies and prescribers who have not submitted documentation to ensure that patients receive their medication.

Generic Medications as Percent of All Fills Update and BRANDS program

The BRANDS program is designed to encourage the use of generics by requiring documentation of side effects from the use of brand name products when a generic is available. BRANDS utilizes a web-based application where providers can request a brand name medication by electronic submission of an FDA Medwatch form. CCNC created and sponsors the website that enables documentation and provides widespread education of policy and best practices as well as a call center that notifies pharmacies and prescribers who have not submitted documentation to ensure that patients receive their medication.

The information in the following Table demonstrates the substantial improvement that has been made during the past four years in the fulfillment of prescriptions with Generic Medications—59.3% to 75.6%. As for SFY 2011, all 14 Networks and thus the total program met their SFY 2011 targets on a YTD basis. For the total program, there has been a 5.1% improvement since SFY 2010.

Network	Network Name	SFY2008 % Generic	SFY2009 % Generic	SFY2010 % Generic	SFY2011 % Generic	SFY 2012 % Generic
6701006	AccessCare	59.2%	64.0%	70.3%	74.4%	75.3%
6701013	Carolina Collaborative Community Care	57.8%	62.4%	68.9%	72.6%	73.6%
6701010	Carolina Community Health Partnership	58.6%	64.0%	70.7%	74.9%	76.1%
6702003	Community Care of Southern Piedmont	59.2%	64.5%	69.7%	72.8%	73.5%
6702004	Community Care of the Lower Cape Fear	59.8%	64.3%	70.8%	74.5%	75.7%
6702005	Community Care of the Sandhills	59.6%	64.3%	70.4%	74.2%	75.3%
6701011	Community Care of Wake and Johnston Counties	59.4%	63.1%	68.8%	72.0%	73.2%
6701007	Community Care of Western North Carolina	60.8%	65.4%	70.4%	73.8%	74.7%
6701009	Community Care Partners of Greater Mecklenburg	59.6%	63.0%	69.3%	73.4%	74.1%
6702000	Community Care Plan of Eastern Carolina	60.4%	65.2%	71.2%	74.5%	75.2%
6701003	Community Health Partners	58.1%	62.8%	69.6%	73.6%	75.2%
6702007	Northern Piedmont Community Care	62.6%	66.1%	71.1%	74.8%	75.6%
6702006	Northwest Community Care	61.6%	65.9%	70.4%	73.5%	74.0%
6701012	Partnership for Health Management	59.3%	64.7%	70.5%	73.3%	73.8%
	Total	**60.3%**	**64.8%**	**70.5%**	**74.1%**	**75.0%**

Electronic Prescribing Support and Adoption

CCNC has engaged in an electronic prescribing support and adoption program since the summer of 2007 with the goal of improving preferred drug list adherence as well as reducing medication errors. Both are improved by electronic prescribing since decision support is made available at the point of prescribing. For Preferred Drug List adherence, CCNC loads the Medicaid formulary to the Surescripts nationwide electronic prescribing network to show which drugs are preferred and non-preferred as well as which drugs require a Prior Authorization within their Electronic Medical Record or with a stand-alone eRx utility. CCNC also provides prescription fill history to the Surescripts network as part of the Pharmacy Home Project to better inform prescribers of the other drug therapies and prescribers involved in a patients care to provide more coordinated prescribing. CCNC provides extensive support and adoption services to all Medicaid providers within the state who have prescriptive authority. NC Medicaid is benefiting greatly from this service now that roughly two-thirds of CCNC practices and over half of the state's Medicaid providers have at least one active e-prescriber in their practice. CCNC has been recognized with a SafeRx award three years in a row for these efforts.

The steps taken to accomplish this goal 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 LLC on their e-prescribing web-site, e-prescribing adoption metrics in the state show a pattern of growth as follows:

Clinical Pharmacy Programs Update

Clinical Pharmacy Programs involves all programs involved with direct patient care, regardless of the credentials of the person on the care team. CCNC Clinical Pharmacists are heavily engaged in patient care delivery and coordination of medication management, working either directly with patients or in concert with a multi-disciplinary care team. Part of the role of CCNC Pharmacist team is to support, train, and collaborate with care managers, surrogates, pharmacist program assistants, physicians, extenders, as well as medication management related activities in programs such as CC4C, Pregnancy Home, Palliative Care and Behavioral Health.

Medication Therapy Management Program

The North Carolina General Assembly directed the Department of Health and Human Services to develop a two-year medication therapy management pilot program to be administered through Community Care of North Carolina (CCNC) in order to determine (i) the best method of adapting the ChecKmeds program to the Medicaid program and CCNC's Medical Homes and (ii) the most effective and efficient role for community-based pharmacists to become an active members of CCNC's care management teams. ChecKmeds is a fee-for-service program that reimburses community pharmacists for providing face-to-face medication consultations (medication treatment management, MTM) to Medicare enrollees.

During the fall of 2011, CCNC modified the existing ChecKmeds program to fit within the CCNC Medical Home infrastructure and care management activities. The existing CCNC infrastructure can

accommodate the encounter-based patient, provider, pharmacist activities in concert with the population-based activities, such as the ABD Medicaid enrollee, who is linked to Care Manager and PCMH.

Reporting details and evaluation will focus first on the success of the program in engaging Pharmacy Practices Sites, their level of coordination with the CCNC Care team (including physicians) and their ability to identify and resolve drug therapy-related problems. The second will focus on patient outcomes, with intermediate outcomes such as incidence of therapeutic duplications and adherence that lead to terminal outcomes such as adverse events and hospitalizations. The first 4.3 Pharmacist FTE devoted to this program's activities is to be deployed in February of 2012.

Palliative Care

CCNC's Palliative Care Initiative seeks to advance the understanding of end-of-life planning and care to improve patient outcomes and to promote efficient use of health resources. Palliative Care is a special care that helps patients and their families live as comfortably and fully as possible when faced with an advanced illness, even during curative treatment. It differs from hospice and can be provided in a variety of settings including, the home, hospital, or long-term care facility.

The initiative supports CCNC medical homes by:

- Providing training and clinical tools to support palliative care and end of life treatment strategies
- Providing trained care managers to assist patients with articulating and documenting end-of-life wishes
- Working with the community to identify area where gaps in services may require new collaborative strategies for serving patients.

A lead physician was hired at CCNC and all networks have identified part-time palliative care coordinators. Palliative Care Coordinators and Physician Champions are in place at each of the 14 networks. Primary care providers were surveyed on their comfort level and confidence levels in various aspects of palliative care. The survey results have guided CCNC's efforts to define practice improvements and training needs for physicians. CCNC is working with the AHEC system and statewide palliative care educators to design provider-targeted materials and events. Currently, care managers are identifying patients that may benefit from palliative care and "starting the conversation."

To measure the efficacy of CCNC's palliative care efforts, CCNC measures the inpatient cost and utilization for enrollees during the 90 days prior to the date they were deceased. Results illustrate a sharp change in the cost and utilization trajectory at the time the initiative began. Additionally, CCNC has continued to maintain those gains in subsequent report periods.

Clinical Integrity

Clinical Integrity involves the identification and analysis of outliers in Medicaid paid claims and reports from Network Case Managers of potential fraud, abuse or waste to identify opportunities for:

- Policy changes or system edits by DMA that would promote improved quality and decreased cost of care
- DMA's Program Integrity unity to follow-up on potential fraud, abuse, and waste of Medicaid funds.

CCNC clinical staff—two part-time physicians—utilize information from analytical data mining software on a quarterly basis to identify outlier Medicaid claims. Network case managers are reminded quarterly to report potential fraud, waste, or abuse to the CCNC Clinical Integrity program.

Twice monthly meetings are held with DMA Program Integrity to review the results of claims data reviews and establish a plan to pursue outliers identified by CCNC clinicians. DMA Clinical Policy staff also attends these meetings, when policy changes or MMIS system edits appear to be needed. CCNC continues its diligence in this through an in-house tracking system to document and monitor follow-up efforts.

CCNC Clinical staff peruses new, evidence-based policies from Medicare and private insurers that Medicaid might adopt to improve care and save money. As a result CCNC has recommended to DMA that it consider modifying its Clinical Policies to align them more closely 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 procedures and codes.

A partnership is being discussed with the UNC School of Public Health to have Health Policy students assist CCNC and DMA to proactively identify emerging evidence-based policies from Medicare Part B carriers and private insurers nationally that might make clinical and financial sense for DMA to consider as well**.**

Overview of Recent CCNC Clinical Integrity Activities that are being pursued by either CCNC or DMA

- During the past year, CCNC case managers and primary care physicians have identified and reported questionable billing practices by behavioral health providers providing questionable care to recipients, mostly children. In many cases these children were assigned mental health diagnoses pertaining to clinical conditions they did not have and in some cases "Medicaid-provided Afterschool" or "Medicaid-provided Summer camp" programs were billing for counseling and mental health services that were reportedly not being provided.

- Personal Care Services providers have been reportedly billed for services: not rendered; while the patient was hospitalized or incarcerated; or that were not medically necessary.

- A provider was billing for HIV care management when the patient did not have HIV. Further analysis found that the provider in question was billing 100 patients for "HIV counseling" and those patients had no evidence in 4 years of claims of any other providers mentioning a diagnosis of HIV.

- Three Primary Care Practices were reported for suboptimal care. One practice did not appear to be providing patients with timely access to basic primary care services, and their patients

were seeking care in the Emergency Department. A second provider was discovered to be performing tests and procedures that were excessive and/or not indicated for the diagnoses provided. A third provider was reported for abandonment of patients and immunization practices that do not follow established guidelines.

- Three Durable Medical Equipment providers contacted a physician directly for equipment not requested by the patient/recipients (power wheelchair, glucose strips, bedside commode and walker). The recipients were Medicare patients, but it is expected that this investigation will affect Medicaid patients, as well.

- In July, the Clinical Integrity began an effort to identify and educate Medicaid recipients who may have received high levels of radiation from having received numerous CT scans. Upon further examination, it was found that several hospitals appeared to be using their Emergency Department CT scanners at much higher rates than the hospital rates in the rest of the State. Physicians from Clinical Integrity met with the NC Radiological Society and DMA's Chief Medical Officer to plan educational sessions for the outlier hospitals. The goal of these sessions was to review evidence-based ordering of CT scans in the Emergency Department. CCNC is currently reanalyzing the data at the level of the ordering physician so that educational efforts may be focused to where it is most needed. In other such instances, educational efforts have resulted in reductions of up to 10% in CT scans.

- Clinical Integrity staff assisted DMA in an investigation where it appeared a physician was performing nerve conduction studies on patients without adequate training. In addition, duplicate billing was identified by CCNC, along with other issues. The investigation led to CCNC identifying $1.2Million in nerve conduction studies being billed per year by providers who do not have nationally approved training to perform the studies. CCNC is now working with clinical policy to bring NC DMA's policies in line with other public and private insurers which only allow certified providers to perform nerve conduction studies.

- During the past two years, Medicare and DMA have made changes to two different CPT codes for urine drug screens. Providers would have had to change their billing of drug screens, as result. Concurrently, DMA would have needed to alter its MMIS system of the edits and audits to assure proper billing. CCNC staff is working with DMA's Clinical Policy staff to develop optimal enforceable language and identify overpayments. It's anticipated that in future years DMA will be able to avert up to $16 million.

- Medicaid recipient misuse has been reported:
    - In two cases a recipient appeared to be using someone else's card. In one case it was reported that a recipient was using valid Medicaid cards from NC or Virginia "whichever covers it."
    - In another case, a child was receiving disability checks when he was not disabled ($764/mo., $69,000 in payments averted if he were paid only until adulthood).
    - In three cases recipients were reportedly abusing the system (>12 ED visits per month, threatening PCP, trying to get around the narcotic lock-in system, etc).

Informatics Center

The Informatics Center (IC) is continuously 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 to improve care and reduce costs. CCNC employs 47 FTEs to support informatics infrastructure, including data integration, analysis and reporting; and development and maintenance of four web-based user applications, the:

- Care Management Information System,
- Pharmacy Home,
- Provider Portal, and
- Reports Site.

Each of the 14 networks have a network administrative manager to promote the use of these systems, and to oversee account management and user training for IC applications, as well as a designated privacy and security officer.

In 2011, CCNC completed a major expansion of its Care Management Information System to incorporate new CMIS functionalities and open CMIS access to public health case managers involved in care management for pregnant women (PHM program) and children with special healthcare needs (CC4C program). To date, CCNC has trained 580 new CMIS users in local health departments, who now have a shared, secure, web-based patient record for case management documentation and coordination of care management activities for children with special health care needs and women with high-risk pregnancies. New screening tools and documentation screens to monitor processes and outcomes have been developed in CMIS to support these programs.

Through the joint efforts of CCNC, DHHS, and the North Carolina Hospital Association (NCHA), CCNC receives twice daily notification of Medicaid recipient Inpatient and ED visits from 51 hospitals as of December 2011, with additional hospitals soon to be added. These 51 hospitals served 55% of all Medicaid inpatient admissions across the state. This 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. In addition, CCNC is receiving a daily data feed of inpatient, and ED visits as well as outpatient labs and prescribed medications for Medicaid patients served by UNC Hospitals. Also available are the discharge summaries for inpatient admissions. The data received from UNC is used for reports and is available to Networks and practices through the CCNC Provider Portal.

Informatics Center applications continue to gain widespread use by providers and care managers throughout the State, facilitating “right information in the right hands at the right time” during care encounters for over 100,000 Medicaid recipients each month. Active users of IC applications now include 2,225 primary care providers or practice staff; 514 hospital-based providers; 500 users in local public health departments; 369 users in mental health Local Management Entities (LMEs); and 63 users in State psychiatric facilities.

Table 12—Informatics Center Usage Statistics

Informatics Center Usage Statistics Update

CARE MANAGEMENT INFORMATION SYSTEM (CMIS)

Time Period	September 2010	January 2011	July 2011	January 2012
Number of unique user log-ins	654	732	1,325	1,653
Total log-ins	16,379	16,418	24,061	36,966
Number of unique patients accessed	73,369	71,984	84,205	121,373
Total pages viewed	2.3 million	2.4 million	7.5 million	12.8 million

PROVIDER PORTAL

Time Period	September 2010	January 2011	July 2011	January 2012
Number of unique user log-ins	99	548	1,551	1,875
Total log-ins	654	4,062	4,806	5,050
Number of unique patients accessed	444	5,749	17,343	26,334
Total pages viewed	data unavailable	48,868	138,436	209,465

Risk-Adjusted Scorecard Measures

Because each Medicaid enrollee comes with a different disease burden, with its associated healthcare cost and utilization, comparisons across networks and time periods can only be conducted to the extent that that the mix of enrollees is similar. Since disease burden is not evenly distributed across networks, and since the disease burden changes over time as CCNC takes on higher-risk enrollees, each network and time period carries a unique cost and utilization risk. Partnering with TREO Solutions (www.treosolutions.com), CCNC is now able to apply 3M's Clinical Risk Group (CRG)-risk adjusted analytics to improve the accuracy of monitoring cost and utilization metrics over time, for each of the four key indicators of cost and utilization:

- Total Costs Per Member/Per Month
- Inpatient Admissions
- Potential Preventable Readmissions
- Emergency Department Utilization

Similar in concept to Diagnosis Related Groups (DRGs), CRGs can be used to identify clinically meaningful groups of individuals who require similar amounts and types of resources. CRGs are the basis of a hierarchical clinical model that uses standard claims data – including inpatient, outpatient, physician, and pharmacy data – to assign each patient to a single mutually exclusive risk category. For chronic illnesses and conditions, the CRG is further subdivided into explicit severity of illness levels.

Each individual's CRG is associated with a weight - a reflection of how sick the person is, and hence how much they would be expected to spend. Each Network's Case Mix Index is a product of the individual CRG weights for each member, and how long they were associated with that network; a Case Mix Index of ONE is the "average" for all CCNC enrollees – greater than one indicates sicker than average, less than one indicates healthier than average. Finally, Risk-adjusted Indices are calculated by dividing actual costs(or utilization) by the costs(or utilization) that would be expected given the population's case mix. A risk-adjusted index >1.0 indicates costs (or utilization) *higher* than expected, given the disease burden of the population. As networks improve performance, the risk-adjusted indices will go down.

Examining the Risk-adjusted Indices over time (the last column within each SFY), one can see clearly that CCNC has demonstrated improvement over time on all 4 cost/utilization metrics, going from 1.002 to 0.923 for PMPM spending, 0.971 to 0.925 for admissions, 0.956 to 0.906 for readmissions for readmissions, and 1.004 to 0.961 for ED visits, during State fiscal years 2009 and 2011 respectively for each measure. Additionally*, every network* demonstrated improvement over time when looking at PMPM spending. In nearly every case, networks also showed improvement in each of the 3 utilization measures over time. This confirms that networks and CCNC as a whole have done an exceptional job at reducing cost and utilization in the face of managing an increasingly more complex/higher risk population.

Total Spending PMPM

PMPM

	SFY 2009			SFY 2010			SFY 2011		
Network Name	**PMPM**	**Case Mix Index**	**PMPM Index**	**PMPM**	**Case Mix Index**	**PMPM Index**	**PMPM**	**Case Mix Index**	**PMPM Index**
					All Enrolled				
AccessCare	$ 320.16	0.97	0.977	$ 316.11	0.98	0.949	$ 317.41	1.04	0.904
Carolina Collaborative Community Care	$ 348.21	1.11	0.934	$ 342.63	1.12	0.909	$ 331.70	1.15	0.865
Carolina Community Health Partnership	$ 385.66	1.16	0.987	$ 362.97	1.15	0.935	$ 375.75	1.20	0.933
Community Care of Southern Piedmont	$ 355.76	1.00	1.063	$ 349.07	0.98	1.052	$ 350.11	0.99	1.046
Community Care of the Lower Cape Fear	$ 436.05	1.28	1.014	$ 434.25	1.31	0.988	$ 406.18	1.32	0.916
Community Care of the Sandhills	$ 368.48	1.10	1.003	$ 338.90	1.06	0.951	$ 326.66	1.07	0.898
Community Care of Wake and Johnston Counties	$ 312.59	0.92	1.013	$ 304.37	0.93	0.971	$ 301.49	0.96	0.928
Community Care of Western North Carolina	$ 368.15	1.16	0.937	$ 362.27	1.13	0.933	$ 381.61	1.15	0.926
Community Care Partners of Greater Mecklenburg	$ 346.93	0.97	1.048	$ 345.29	0.95	1.055	$ 333.82	0.97	1.005
Community Care Plan of Eastern Carolina	$ 413.14	1.19	1.025	$ 397.60	1.22	0.965	$ 356.47	1.21	0.878
Community Health Partners	$ 400.94	1.19	1.001	$ 390.24	1.23	0.953	$ 376.61	1.24	0.907
Northern Piedmont Community Care	$ 371.84	1.04	1.062	$ 378.07	1.06	1.049	$ 351.43	1.10	0.939
Northwest Community Care	$ 343.03	1.01	1.007	$ 346.07	1.03	0.993	$ 340.83	1.06	0.946
Partnership for Health Management	$ 274.18	0.89	0.914	$ 277.36	0.92	0.898	$ 271.77	0.90	0.889
CCNC	**$ 352.62**	**1.04**	**1.002**	**$ 347.08**	**1.05**	**0.973**	**$ 337.01**	**1.08**	**0.923**

Inpatient Admissions

Admissions

	SFY 09				SFY 10				SFY 11			
Network Name	**Admits**	**Rate Per 1000 MM**	**Case Mix Index**	**Admit Index**	**Admits**	**Rate Per 1000 MM**	**Case Mix Index**	**Admit Index**	**Admits**	**Rate Per 1000 MM**	**Case Mix Index**	**Admit Index**
						All Enrolled						
AccessCare	12,205	4.93	0.97	0.959	11,934	4.67	0.98	0.875	12,956	5.13	1.04	0.906
Carolina Collaborative Community Care	2,324	5.23	1.11	0.859	2,667	5.53	1.12	0.867	3,066	6.06	1.15	0.941
Carolina Community Health Partnership	1,251	5.44	1.16	0.839	1,289	4.97	1.15	0.785	1,413	5.34	1.20	0.824
Community Care of Southern Piedmont	2,275	5.33	1.00	0.965	2,284	4.73	0.98	0.852	2,344	4.64	0.99	0.867
Community Care of the Lower Cape Fear	3,578	7.02	1.28	0.915	4,253	7.34	1.31	0.921	4,272	7.15	1.32	0.903
Community Care of the Sandhills	3,037	7.59	1.10	1.150	3,640	6.66	1.06	1.064	3,959	6.64	1.07	1.039
Community Care of Wake and Johnston Counties	3,135	4.24	0.92	0.903	3,553	4.28	0.93	0.868	3,749	4.17	0.96	0.838
Community Care of Western North Carolina	2,438	6.26	1.16	0.965	2,913	5.70	1.13	0.885	3,209	5.68	1.15	0.879
Community Care Partners of Greater Mecklenburg	6,222	5.47	0.97	1.042	6,873	5.45	0.95	1.035	6,967	5.29	0.97	1.024
Community Care Plan of Eastern Carolina	7,549	6.72	1.19	1.009	8,721	6.93	1.22	0.983	8,826	6.58	1.21	0.950
Community Health Partners	2,186	7.09	1.19	1.007	2,458	7.00	1.23	0.966	2,496	6.76	1.24	0.937
Northern Piedmont Community Care	2,334	4.96	1.04	0.921	2,534	4.92	1.06	0.870	2,862	5.33	1.10	0.887
Northwest Community Care	3,814	5.45	1.01	0.966	4,321	5.43	1.03	0.922	4,704	5.63	1.06	0.930
Partnership for Health Management	1,955	4.70	0.89	0.979	2,441	4.77	0.92	0.932	2,709	4.24	0.90	0.904
CCNC	**54,303**	**5.56**	**1.04**	**0.971**	**59,881**	**5.47**	**1.05**	**0.925**	**63,532**	**5.53**	**1.08**	**0.925**

Potentially Preventable Readmissions

Readmissions

Network Name	SFY 09 Readm. Chains	SFY 09 Avg Readms. / Chain	SFY 09 Rate per 1000 MM	SFY 09 Case Mix Index	SFY 09 Readm. Index	SFY 10 Readm. Chains	SFY 10 Avg Readms. / Chain	SFY 10 Rate per 1000 MM	SFY 10 Case Mix Index	SFY 10 Readm. Index	SFY 11 Readm. Chains	SFY 11 Avg Readms. / Chain	SFY 11 Rate per 1000 MM	SFY 11 Case Mix Index	SFY 11 Readm. Index
	All Enrolled														
AccessCare	828	1.44	0.33	0.97	0.926	840	1.36	0.33	0.98	0.853	937	1.37	0.37	1.04	0.875
Carolina Collaborative Community Care	194	1.35	0.42	1.11	0.920	225	1.64	0.45	1.12	0.910	249	1.83	0.48	1.15	0.931
Carolina Community Health Partnership	81	1.32	0.35	1.16	0.724	91	1.38	0.35	1.15	0.750	101	1.40	0.38	1.20	0.797
Community Care of Southern Piedmont	151	1.26	0.35	1.00	0.864	164	1.46	0.33	0.98	0.852	172	1.41	0.33	0.99	0.877
Community Care of the Lower Cape Fear	259	1.31	0.49	1.28	0.823	307	1.39	0.52	1.31	0.802	313	1.40	0.51	1.32	0.809
Community Care of the Sandhills	230	1.54	0.57	1.10	1.096	267	1.36	0.48	1.06	1.015	310	1.42	0.51	1.07	1.059
Community Care of Wake and Johnston Counties	209	1.42	0.28	0.92	0.860	247	1.34	0.29	0.93	0.823	282	1.34	0.31	0.96	0.865
Community Care of Western North Carolina	193	1.34	0.49	1.16	0.994	220	1.31	0.42	1.13	0.863	252	1.34	0.44	1.15	0.863
Community Care Partners of Greater Mecklenburg	494	1.41	0.43	0.97	1.087	525	1.41	0.41	0.95	1.036	510	1.51	0.38	0.97	0.984
Community Care Plan of Eastern Carolina	620	1.38	0.54	1.19	1.034	739	1.37	0.57	1.22	1.012	716	1.51	0.52	1.21	0.911
Community Health Partners	166	1.37	0.53	1.19	0.971	169	1.44	0.48	1.23	0.838	192	1.57	0.51	1.24	0.897
Northern Piedmont Community Care	166	1.37	0.34	1.04	0.869	192	1.65	0.36	1.06	0.882	235	1.50	0.43	1.10	0.941
Northwest Community Care	310	1.58	0.44	1.01	1.049	383	1.42	0.48	1.03	1.073	376	1.66	0.44	1.06	0.947
Partnership for Health Management	116	1.78	0.28	0.89	0.837	185	1.45	0.36	0.92	0.990	188	1.62	0.29	0.90	0.901
CCNC Enrolled	**4,017**	**1.42**	**0.40**	**1.04**	**0.956**	**4,554**	**1.41**	**0.41**	**1.05**	**0.921**	**4,833**	**1.48**	**0.41**	**1.08**	**0.906**

ED Visits

ED Visits

Network Name	SFY 09 ED Visits	SFY 09 Rate Per 1000 MM	SFY 09 Case Mix Index	SFY 09 ED Index	SFY 10 ED Visits	SFY 10 Rate Per 1000 MM	SFY 10 Case Mix Index	SFY 10 ED Index	SFY 11 ED Visits	SFY 11 Rate Per 1000 MM	SFY 11 Case Mix Index	SFY 11 ED Index
	All Enrolled											
AccessCare	156,338	62.37	0.97	0.961	164,461	63.68	0.98	0.970	157,254	61.54	1.04	0.920
Carolina Collaborative Community Care	32,752	71.47	1.11	1.059	34,878	70.13	1.12	1.041	39,184	75.17	1.15	1.107
Carolina Community Health Partnership	18,946	81.06	1.16	1.144	22,255	84.66	1.15	1.195	23,260	86.81	1.20	1.211
Community Care of Southern Piedmont	29,447	67.55	1.00	1.006	33,359	67.84	0.98	1.015	32,019	62.24	0.99	0.926
Community Care of the Lower Cape Fear	38,955	74.40	1.28	0.978	43,659	73.55	1.31	0.964	41,581	68.11	1.32	0.897
Community Care of the Sandhills	30,517	74.97	1.10	1.049	40,430	72.89	1.06	1.063	41,660	68.90	1.07	1.009
Community Care of Wake and Johnston Counties	45,502	60.76	0.92	0.989	48,961	58.32	0.93	0.954	53,463	58.83	0.96	0.944
Community Care of Western North Carolina	24,453	61.61	1.16	0.843	31,235	60.17	1.13	0.848	32,573	56.86	1.15	0.808
Community Care Partners of Greater Mecklenburg	77,028	66.35	0.97	1.037	83,242	64.73	0.95	1.011	82,072	61.29	0.97	0.952
Community Care Plan of Eastern Carolina	83,811	72.63	1.19	1.028	97,239	75.32	1.22	1.057	98,072	71.39	1.21	1.009
Community Health Partners	24,644	78.65	1.19	1.056	28,581	80.33	1.23	1.063	29,379	78.69	1.24	1.050
Northern Piedmont Community Care	31,936	66.32	1.04	1.020	32,118	60.96	1.06	0.930	35,952	65.63	1.10	0.985
Northwest Community Care	50,994	71.98	1.01	1.102	56,706	70.34	1.03	1.058	57,814	68.35	1.06	1.018
Partnership for Health Management	23,578	56.24	0.89	0.903	30,554	59.22	0.92	0.941	34,042	52.98	0.90	0.854
CCNC	**668,901**	**67.24**	**1.04**	**1.004**	**747,678**	**67.22**	**1.05**	**1.000**	**758,325**	**64.93**	**1.08**	**0.961**

Currently, risk adjustment analyses do not include encounter claims data from Piedmont Behavioral Health (PBH) within the Community Care of Southern Piedmont Network claims data. Consequently, Southern Piedmont Network's case mix is underestimated. The absence of behavioral health claims data means the population looks healthier than it really is, while Medicaid spending for PBH capitation payments add to the actual PMPM spending. (The net effect is to artificially inflate the risk-adjusted index; so results for this network must be interpreted with caution). Additionally, these measures do not include enrollees who are dually enrolled with Medicaid and Medicare, due to lack of availability of complete Medicare claims data for these individuals. Finally, because all women who have a delivery have an actual and expected admission rate of at least 1.0, and account for a disproportionately large percent of hospital admissions paid for by Medicaid, we have excluded from the inpatient admissions measure all women who delivered a baby during the reporting period in which the delivery happened.

The value of this risk adjusted information – and all data – lies not in the absolute index number or the dollar values at a specific time or date. Rather, it is the trend – and as shown favorable trend – over a period of time for each network and CCNC as a whole that is important. It's also critical to note that many factors affecting PMPM spend are not under the control of a network. While each of the 14 networks is focused on population, disease and case management initiatives, other factors such as varying facility rates for identical services or variation in the local health care delivery model can affect PMPM. For instance, a patient may be admitted to a hospital outside the network that has a higher DRG for the procedure to be performed than the hospital in the patient's network. Certainly, risk adjusted data and information is an improvement over reporting of raw data, yet it too is only a part of the story.