Responses for the Legislative Report

Section 10.36 (e)

The Department shall report to 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 no later than December 31, 2009, on the performance measures adopted pursuant to subsection (d) of this section.

Section 10.36 (d)

Consistent with subdivision (1) of subsection (c) of this section, *Identify priority diseases, conditions and patients for care management*, the Department shall: (i) identify baseline data on priority diseases, conditions, patients, and populations, and on physicians and networks; (ii) identify patient, physician, and network performance measures, and (iii) develop and implement data systems to gather, analyze, and report on those performance measures.

Identification of priority diseases, conditians and patients for care management

Each Community Care of North Carolina (CCNC) network has at least one designated clinical director who takes the lead in spreading quality improvement initiatives throughout their network. Over the past ten years, the clinical directors have met regularly to review and analyze meaningful data and information about their enrolled population, to share best practices, and to collectively choose initiatives, performance measures and goals.

Community Cares' Clinical Directors have established the following guiding principles in selecting a quality improvement (QI) initiative:

- There are enough Medicaid enrollees with the disease to obtain a "return on investment".
- Evidence exists that best practices lead to predictable and improved outcomes.
- Appropriate evidence-based practice guidelines are available.
- Physicians will support the process.
- Patient education and support can improve outcomes.
- Best practices and outcomes are measurable, reliable and relevant.
- Evidence exists that the quality measures themselves improve care.
- There is room for improvement – a gap exists between best practice and everyday practice.
- Baselines for need and performance can be measured and improvement can be measured longitudinally.

The Clinical Directors, in concert with the Community Care program office, review and analyze claims data to determine where opportunities for improvement exist and where population management strategies (treatment, disease and care management, prevention, etc) have the potential to positively impact both the quality and utilization of health care.

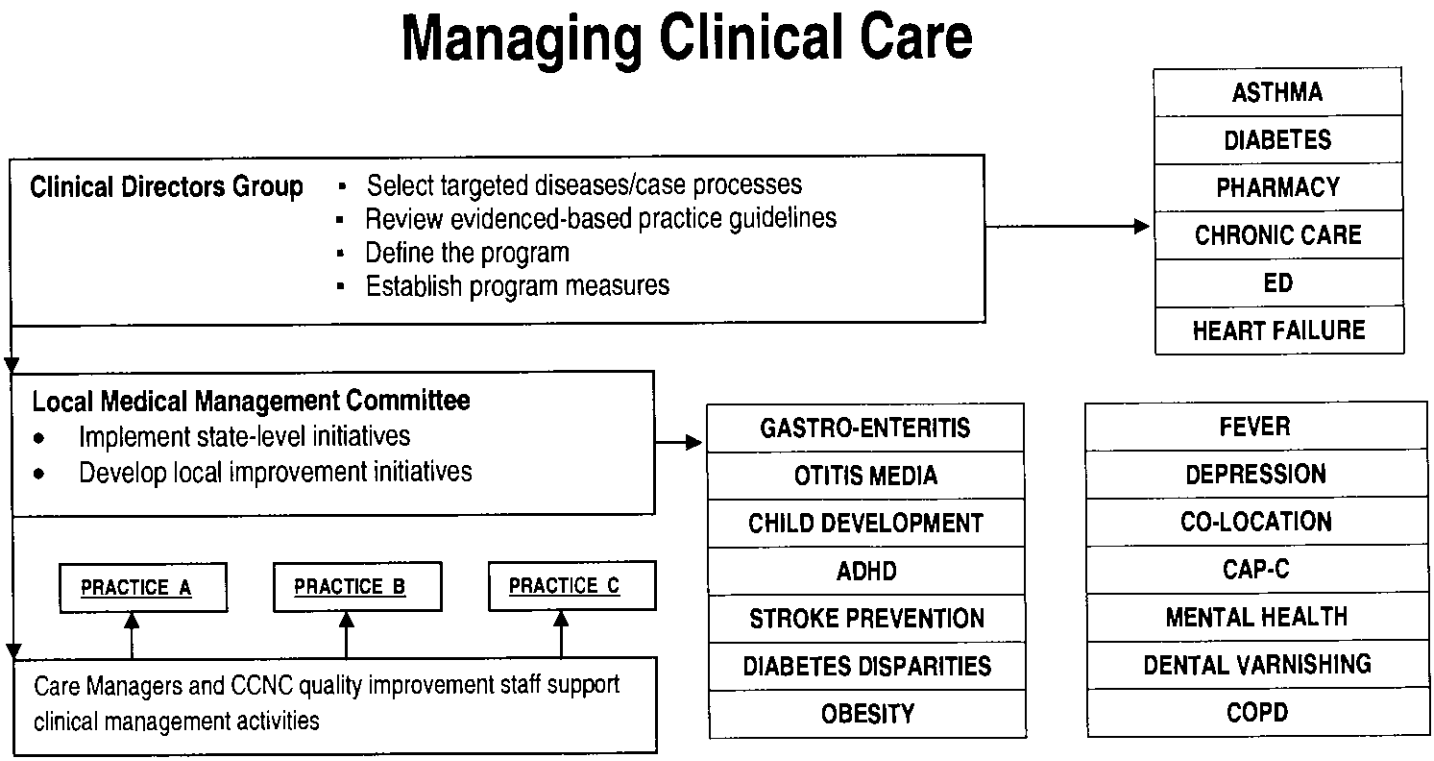
Each network designates clinical champions and QI team leaders to employ the model of rapid cycle quality improvement developed by the Institute of Healthcare Improvement (IHI). This model stresses setting aims, establishing measures, and making system changes that remove barriers and support excellent care. The networks have joined together to do the following:

- Review initial data obtained from claims and chart audits
- Choose disease management initiatives
- Develop program expectations
- Define goals, objectives and performance measures
- Identify methods of information collection
- Create plans for implementation, assessment and monitoring

- Share best practices
- Develop and implement an evaluation strategy for the initiative

Each network has regular "medical management committee" meetings chaired by their clinical director and with clinical representation from participating practices. In networks that cover a large geographic area, the Clinical Directors may choose different strategies to engage their community providers and in some instances this may require going to all the practices for face-to-face time with participating physicians. These local meetings provide a forum to obtain provider input and buy-in and to implement a process for spreading quality improvement (QI) initiatives to all participating practices. Both the clinical director's meetings and the local medical management committee meetings serve as catalysts for this model of improvement.

The flow chart below depicts the clinical directors group at the top where they are responsible for selecting initiatives, determining the needed program components and defining the performance measures. The Clinical Directors are responsible for engaging the physicians that are participating in their network and ensuring that quality performance metrics are demonstrating improvement. They will use various reports to share with physicians in medical management committee meetings, such as practice profiles, gaps in care analysis and chart audit results.



Community Care has the following disease and care management initiatives in place in every network: asthma, diabetes and congestive heart failure disease management; high cost and high risk care management; pharmacy management and prescribing initiatives; emergency room utilization; transitional support and chronic care (managing the co-morbid aged, blind and disabled population).

Identification of baseline data on priority diseases, conditions, patients, and populations, and on physicians and networks

Community Care provides each network with reports that describe disease prevalence, cost and utilization patterns at the network and county level (with drilldown to patient level detail). Reports also identify the network's enrolled Medicaid population (identification and stratification) that might benefit from targeted disease and care management interventions.

To support care improvement efforts, Community Care provides various reports to networks including, but are not limited to the following:

- Case identification reports – using Medicaid claims data identify enrollees with:
  - asthma and emerging asthma
  - diabetes and emerging diabetes
  - frequent emergency department use
  - heart failure

- Additional reports obtained from claims and provided to each network outlines those enrollees with:
  - highest cost
  - history of hospitalizations
  - readmissions
  - poly-pharmacy and poly-prescriber issues
  - co-morbid conditions, including mental health conditions

- Reports identifying gaps in care analysis for our targeted initiatives, include but are not limited to:
  - patients with congestive heart failure without a Beta Blocker medication fill
  - patients with diabetes and lacking an eye exam in the most recent twelve months
  - patients with hypertension without an antihypertensive medication fill
  - patients with a chronic condition and lacking a visit to their primary care provider
  - patients with medication adherence issues

- Summary information on quality audit results on the evidence-based clinical practice guidelines at the network and practice level

In addition to the standard reports that support disease-specific quality improvement initiatives, such as diabetes, heart failure, ED overuse, and asthma, the program office uses claims data to guide most efficient use of care management resources for Community Care's intensive chronic care program for the aged, blind and disabled population. Networks receive a new dataset every quarter, with detailed patient-level information (90 data elements) describing service utilization, cost categories, diagnoses, and case management status. Additional quarterly reports describe in detail the hospitalization history of patients who have had hospital readmissions; Personal Care Service and Home Health Provider costs and patient load by service provider and PCP practice; and trends in cost, ED and hospital use by county and network.

Evidence-based algorithms flag patients who meet criteria for care management assessment. As serious and persistent mental illness is prevalent in this population, these reports also flag individuals who may be most appropriate for intensive mental health case management. Networks then facilitate the coordination of that patient's care with the LME. Current screening and priority criteria for CCNC and LME care management assessment are as follows:

CCNC Screening: Patient has 2 or more of the above listed chronic conditions and meets 2 or more of the following criteria:

* 1 or more inpatient admissions within the past 6 months (included acute, mental health, and long term care admissions)
* 3 or more ED visits within the past 6 months
* 8 or more prescriptions over the past month or 24 over the past 3 months
* 3 or more outpatient providers in the past 6 months
* No PCP visit within the past year

CCNC Priority: Patient meets all of the following criteria:

* Three or more chronic conditions within the past 12 months
* Greater than one inpatient admission in the past 12 months
* More than 11 prescriptions in the past 12 months
* Top 10% of Cost within the past 12 months

OR

Patient id dual and meets 3 of the following 4 criteria:

* One or more inpatient admissions within the past 6 months
* Two or more ED visits within the past 6 months
* One or more key target conditions: CHF, DM, IVD, Asthma or COPD
* No PCP visits within the past year

LME Priority: Patient meets any of the following criteria:

* MH/DD/SA inpatient without a therapist or enhanced MH service provider
* Three mental health target conditions without an enhanced MH service provider
* Top 5% of MH/DD/SA cost
* 3 or more Emergency Department visits with a primary diagnosis of mental health or substance abuse

Identification of patient, physician, and network performance measures

Since its beginning in 1998, Community Care has used performance measurement and feedback to help meet its goals of improving the quality of care for Medicaid recipients while controlling costs. Quality measurement is intended to stimulate or facilitate quality improvement efforts in CCNC practices and local networks, and to evaluate the performance of the program as a whole. Under the direction of the Clinical Directors, this measurement and feedback process has evolved over time to meet the changing needs of the program. Several factors necessitate a continuing need to evolve, such as 1) expansion of Community Care's enrolled population and increasing focus on aged, blind, and disabled patients with multiple chronic conditions, 2) practice participation in other quality initiatives (such as PQRI, NCQA HSRP and DPRP, Bridges to Excellence, NCHQA), and desire that measures be aligned as much as possible, and 3) changes to evidence-based clinical practice guidelines over time. A Quality Measurement and Performance workgroup, with representation from all fourteen (14) networks, meets periodically to review performance measures. Goals are to identify measures with: 1) clinical importance (based on disease prevalence and impact, and potential for improvement), 2) scientific soundness (strength of evidence underlying the clinical practice recommendation; evidence that the measure itself improves care; and the reliability, validity, and comprehensibility of the measure), and 3) implementation feasibility. Workgroup recommendations are presented to the CCNC network leaders, and final measures are chosen by vote of the Clinical Directors.

As of January 2009, patients are eligible for chart review on the basis of asthma, diabetes, ischemic vascular disease, and heart failure. Chart review measures pertain to: appropriate asthma management; diabetes glycemic control and foot care; management of blood pressure, cholesterol, and tobacco use; appropriate aspirin use; and assessment of LV function in heart failure. During calendar year 2009, Community Care has contracted with Area Health Education Centers (AHECs) to perform independent randomized chart reviews for >26,000 recipients in >1250 CCNC practices,

with an electronic data abstraction tool. Practice-level results with patient-level detail are available to the networks by secure internet reporting services on a next-day basis. Program-level results will be reported annually.

An additional set of quality of care measures are derived from Medicaid claims data, pertaining to: medication therapy for asthma, heart failure, and post-MI patients; adult preventive services (breast, cervical, and colorectal cancer screening); and pediatric preventive services (dental care and well child exams). Claims measures are reported quarterly at the practice, county and network level. A "care alert" system to readily identify patients in default of recommended services is currently under development.

Practices and networks receive monthly, quarterly, or annual feedback on process, cost, utilization, and quality metrics. A critical element to Community Care's success centers on the ability of the networks to locally implement system changes needed to improve quality in practices. The network Clinical Directors are instrumental in engaging community providers to implement the quality initiatives. Providing credible and provider friendly reports are powerful tools, particularly when accompanied with benchmarks and comparisons to peers, helping to motivate providers to improve processes that will enable them to provide best care. The focus is on implementing evidence-based best practices in the medical home.

At the request of the Department to assist in the current budget crisis, our focus has recently shifted from quality measures in our priority diseases and conditions to key process measures expected to convey nearer-term cost savings. Most recently, Community Care of North Carolina has developed a benchmark report for the Division of Medical Assistance, to be reported on a quarterly basis, to track new process and outcome metrics across these major program categories:

Utilization

- Preventable Readmissions as Percent of Total Admissions, enrolled nonduals
- Inpatient Admissions per 1000 MM, enrolled nondual ABD
- ED Rate per 1000 MM, enrolled ABD

Care Management

- % of ABD patients meeting high risk criteria who received a care management assessment or intervention
- % of ABD hospitalized patients meeting care management screening criteria who have had a complete assessment

Pharmacy Management

- Generic Medications as Percent of all fills, all Medicaid non-duals
- % of providers actively e-prescribing
- Medication Reconciliation after hospital discharge of targeted patients

****Baseline findings related to newer CCNC initiatives and target conditions are included at the end of this report.**

Development and implementation of data systems to gather, analyze, and report on those performance measures

Community Care has invested in a web-based Case Management Information System (CMIS) and in the development of a robust Informatics Center (IC) for the purpose of gathering, analyzing, and reporting on Medicaid data. The CMIS is a user built, patient-centric, case management software package that resides on a secure web site offering multiple layers

of security. Community Care began using CMIS as their electronic record of case management activities in 2001, with several major enhanced releases in 2005, 2006, and 2009. The CMIS contains demographic and claims data on all of our enrolled Medicaid population. Care management processes and terms in CMIS follow the nursing case management model which is a nationally recognized standard. Care managers and other network staff maintain a single care plan that stays with the patient when he or she moves from one area of the state to another, ensuring continuity of care. All the tools to manage a population are embedded in the program and support the care managers in their daily tasks and maximize efficiencies.

The IC also houses reporting services for the networks, where standard, ad hoc, and user-defined reporting can be deployed in an automated fashion. Performance reports can be accessed directly by network personnel within their scope of access. CCNC physicians may also directly access their practice reports through a secure web portal as of December 2009. A Pharmacy Home application developed in 2007 has proven to be of substantial benefit to networks pharmacists and care managers, to readily access prescription fill history; monitor care alerts related to medication omissions, interaction potential, or therapeutic recommendations; and perform medication reconciliation activities across settings of care. A provider portal will be rolled out in 2010, to allow providers direct access to this key clinical information, claims history, and care team contact information as they carry out medical home responsibilities for Medicaid recipients.

Most recently, the IC is developing processes to obtain "real time" data from hospitals on all their Medicaid enrollees that are hospitalized. This is a critical step in the implementation of transitional support and working to ensure needed community support and resources are in place upon discharge so that unnecessary readmissions are prevented. Further efforts are underway to receive lab results on select tests that would assist care mangers and physicians in identifying patients for targeted care coordination, and for facilitating quality improvement initiatives in chronic disease management care of North Carolina Medicaid recipients with chronic kidney disease, diabetes, hyperlipidemia, and cardiovascular conditions.

CCNC Quality and Performance Measures
State Fiscal Year 2008 - Baseline

Network	Network Name	Preventable Readmissions as a percent of total admissions, enrolled nonduals	Inpatient Admissions per 1000 MM, enrolled nondual ABD	ED Rate Per 1000 Member Months among enrolled ABD, any diagnosis
6701003	Community Health Partners	12.3%	32.8	94.9
6701006	AccessCare	13.6%	25.6	82.3
6701007	Access II Care of Western NC	12.3%	27.0	81.9
6701009	Community Care Partners of Greater Mecklenburg	13.7%	28.8	100.8
6701010	Carolina Community Health Partnership	10.4%	25.4	106.5
6701011	Community Care of Wake and Johnston Counties	14.0%	22.6	81.2
6701012	Partnership for Health Management	14.1%	25.3	77.2
6701013	Carolina Collaborative Community Care	14.1%	24.8	58.2
6702000	Community Care Plan of Eastern Carolina	15.6%	26.2	81.5
6702003	Southern Piedmont Community Care Plan	12.2%	23.4	92.7
6702004	Access III of Lower Cape Fear	13.2%	26.7	96.3
6702005	Sandhills Community Care Network	14.4%	32.5	89.9
6702006	Northwest Community Care	18.0%	33.1	97.7
6702007	Northern Piedmont Community Care	15.0%	25.2	84.1
	CCNC	14.1%	26.8	85.9

Pharmacy Management

1. Generic Medications as Percent of all fills, all Medicaid non-duals

% Generic Fills **(CCNC Enrollees, Jan 2007 December 2008*)**

	2007				2008			
Network	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Access II Care of WNC	59%	59%	62%	64%	64%	65%	67%	68%
Access III of Lower Cape Fear	58%	59%	62%	63%	64%	65%	66%	67%
AccessCare	60%	59%	62%	64%	65%	65%	67%	68%
Carolina Collaborative Community Care	56%	56%	59%	61%	62%	62%	64%	65%
Carolina Community Health Partnership	58%	58%	61%	62%	63%	63%	66%	67%
Community Care of Eastern Carolina	59%	60%	63%	64%	65%	66%	67%	68%
Community Care of Wake / Johnston Counties	58%	59%	62%	62%	63%	64%	65%	66%
Community Care Partners of Greater Mecklenburg	58%	58%	61%	63%	64%	64%	66%	66%
Community Health Partners	56%	57%	61%	61%	62%	62%	65%	65%
Northern Piedmont Community Care	62%	62%	65%	65%	67%	68%	69%	69%
Northwest Community Care	61%	60%	63%	64%	66%	66%	68%	69%
Partnership for Health Management	60%	59%	62%	63%	65%	65%	67%	68%
Sandhills Community Care Network	60%	60%	63%	64%	65%	66%	68%	68%
Southern Piedmont Community Care	59%	59%	62%	63%	64%	65%	67%	67%
Total	**59%**	**59%**	**62%**	**63%**	**64%**	**65%**	**67%**	**68%**

Amount Paid/Prescription Fill **(CCNC Enrollees, Jan 2007 – Dec 2008)**

	2007				2008			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
% fills Generic	59%	59%	62%	63%	64%	65%	67%	68%
% of cost Generic	18%	18%	19%	19%	19%	18%	20%	21%

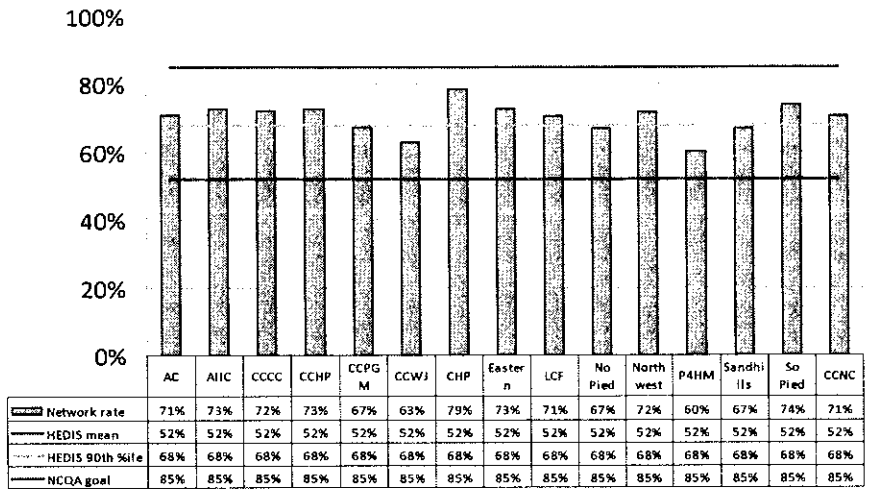
			Brand-Multi	Generic
2008	**CCNC Totals**			
	Number of Fills	**9,021,220**	3,070,194	5,951,026
	Amount Paid	**$ 679,192,971**	$ 546,230,117	$ 132,962,854
	Percentage of Generic Fills		**34%**	**66%**

2. % of providers actively e-prescribing

Network Name	q12007	q22007	q32007	q42007	q12008	q22008	q32008	q42008
Southern Piedmont Community Care	3%	3%	3%	3%	5%	36%	46%	46%
Northern Piedmont Community Care	11%	11%	17%	22%	25%	28%	28%	39%
AccessCare	11%	14%	16%	18%	19%	21%	27%	37%
Carolina Community Health Partnership	11%	11%	11%	11%	11%	11%	11%	16%
Partnership for Health Management	23%	23%	19%	19%	19%	19%	26%	35%
Carolina Collaborative Community Care	8%	10%	10%	11%	11%	13%	14%	32%
Access II Care of Western North Carolina	9%	11%	9%	15%	19%	20%	24%	35%
Sandhills Community Care Network	13%	16%	20%	23%	24%	26%	26%	33%
Community Care of Wake / Johnston Counties	13%	12%	13%	15%	13%	16%	21%	32%
Community Care Plan of Eastern Carolina	10%	10%	11%	10%	13%	15%	19%	26%
Northwest Community Care	7%	7%	7%	9%	10%	7%	9%	29%
Community Health Partners	7%	7%	7%	7%	7%	7%	14%	26%
Access III of Lower Cape Fear	9%	11%	12%	13%	14%	13%	16%	25%
Community Care Partners of Greater Mecklenburg	3%	5%	5%	4%	7%	9%	17%	19%
Average of the Averages	**10%**	**11%**	**11%**	**13%**	**14%**	**17%**	**21%**	**31%**

3. Medication Reconciliation after hospital discharge of targeted patients – 0% for all networks as of December 2008

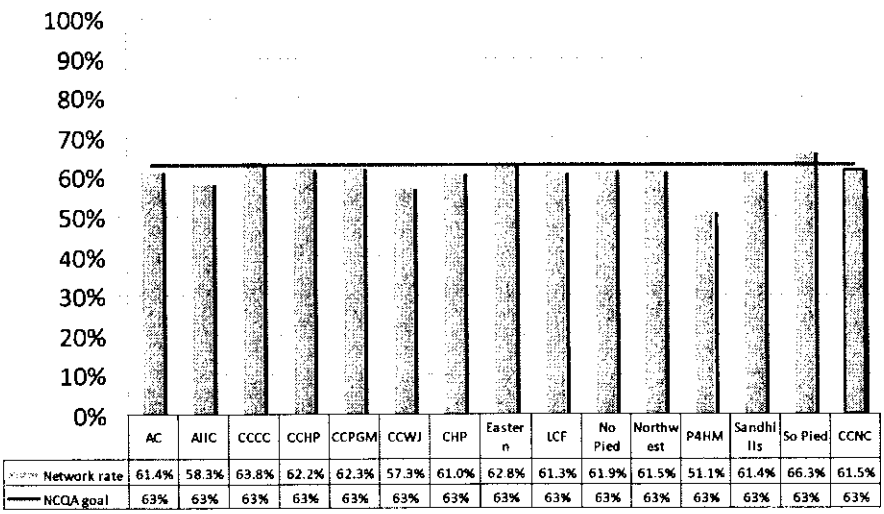
Diabetes: A1C <=9.0



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	Northwest	P4HM	Sandhills	So Pied	CCNC
Network rate	71%	73%	72%	73%	67%	63%	79%	73%	71%	67%	72%	60%	67%	74%	71%
HEDIS mean	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%
HEDIS 90th %ile	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%
NCQA goal	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

2009 CCNC Chart Review Results

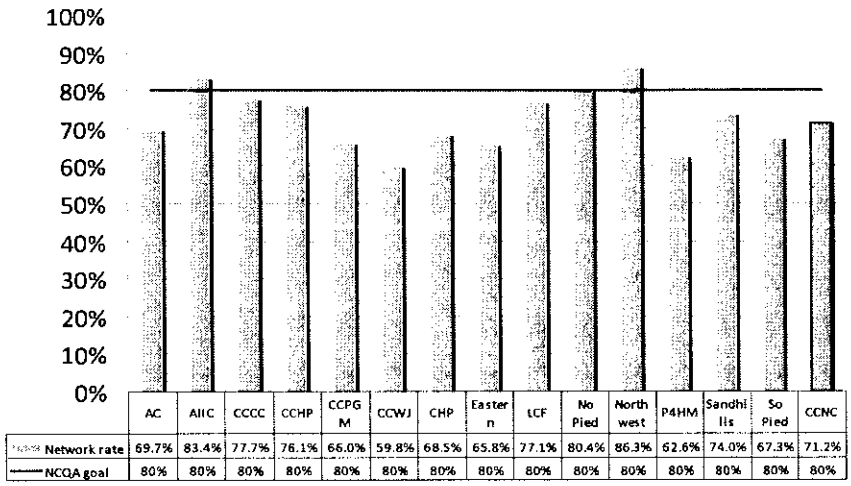
Diabetes: LDL Cholesterol Control <=130



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	Northwest	P4HM	Sandhills	So Pied	CCNC
Network rate	61.4%	58.3%	63.8%	62.2%	62.3%	57.3%	61.0%	62.8%	61.3%	61.9%	61.5%	51.1%	61.4%	66.3%	61.5%
NCQA goal	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%

2009 CCNC Chart Review Results

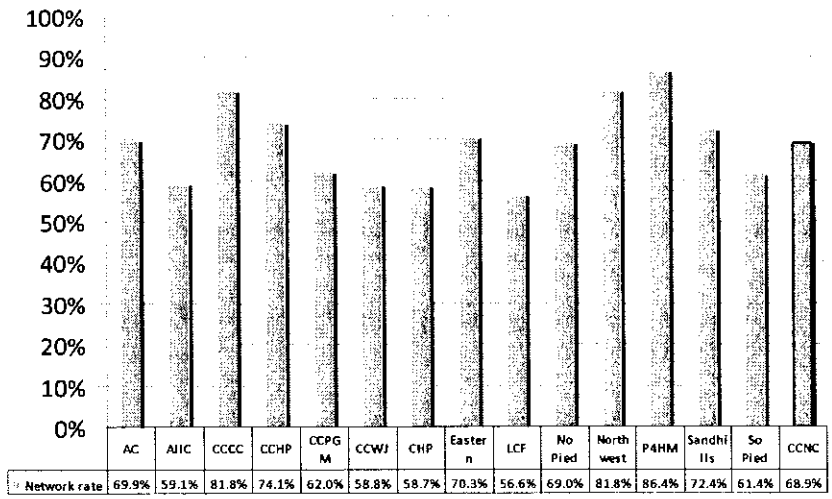
Diabetes: Foot Exam



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	69.7%	83.4%	77.7%	76.1%	66.0%	59.8%	68.5%	65.8%	77.1%	80.4%	86.3%	62.6%	74.0%	67.3%	71.2%
NCQA goal	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

2009 CCNC Chart Review Results

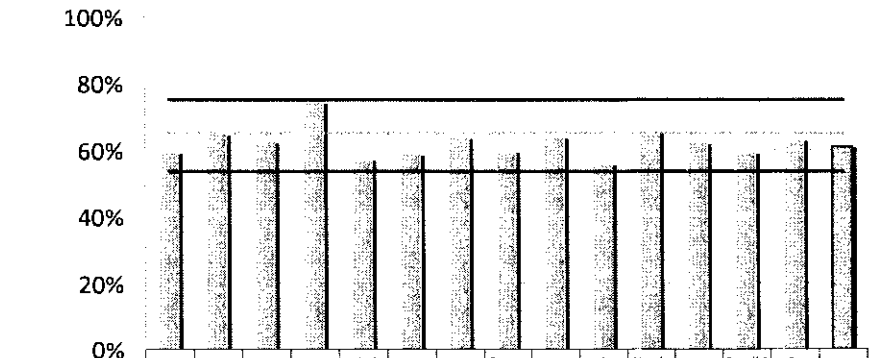
Asthma: Continued Care Visit with Assessment of Symptoms



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	69.9%	59.1%	81.8%	74.1%	62.0%	58.8%	58.7%	70.3%	56.6%	69.0%	81.8%	86.4%	72.4%	61.4%	68.9%

2009 CCNC Chart Review Results

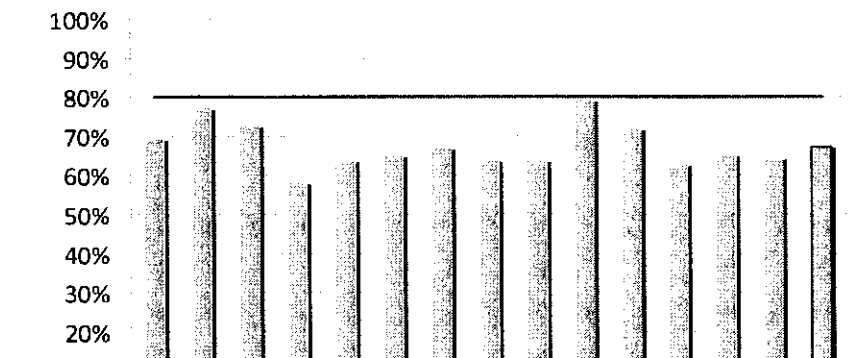
Cardiovascular: BP <140/90



	AC	AJIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	59.3%	64.7%	62.5%	74.2%	57.3%	58.8%	63.8%	59.5%	63.7%	55.7%	65.5%	62.0%	59.4%	63.3%	60.7%
HEDIS mean	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%
HEDIS 90th %ile	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
NCQA goal	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

2009 CCNC Chart Review Results

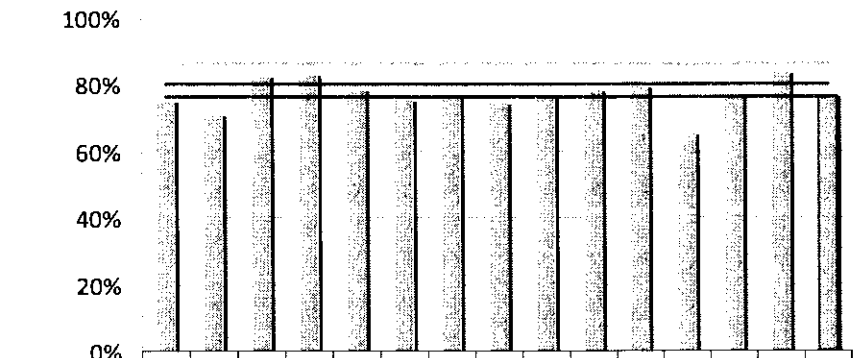
Cardiovascular: Aspirin use



	AC	AJIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	69.5%	77.4%	72.8%	58.1%	63.8%	64.9%	66.8%	63.9%	63.7%	79.1%	71.9%	62.7%	65.1%	64.4%	67.2%
NCQA goal	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

2009 CCNC Chart Review Results

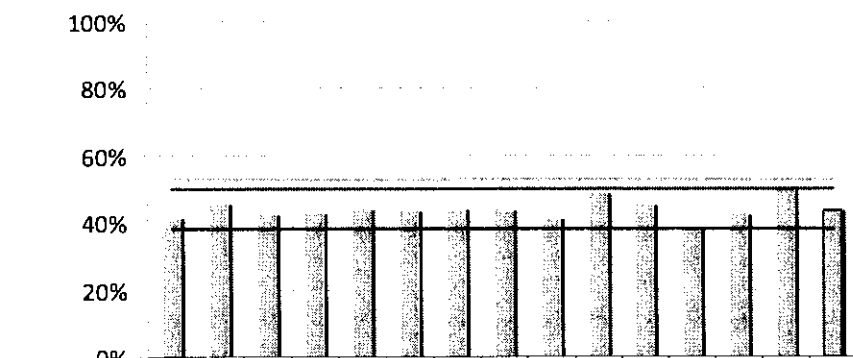
Cardiovascular: Lipid Testing



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	Northwest	P4HM	Sandhills	So Pied	CCNC
Network rate	75.1%	70.8%	82.5%	83.0%	78.5%	75.5%	77.1%	74.3%	77.0%	78.6%	79.6%	65.4%	76.8%	83.5%	76.4%
HEDIS mean	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%
HEDIS 90th %ile	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
NCQA goal	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

2009 CCNC Chart Review Results

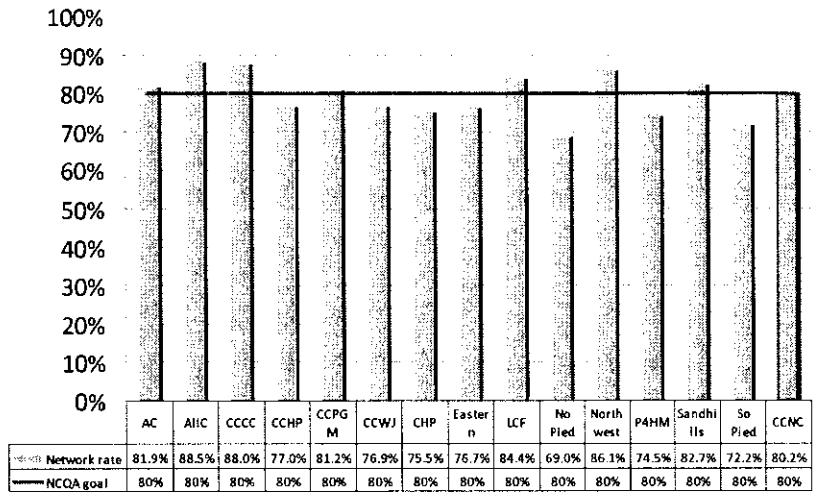
Cardiovascular: LDL Control < 100



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	Northwest	P4HM	Sandhills	So Pied	CCNC
Network rate	41.8%	45.8%	42.6%	43.0%	44.2%	43.6%	44.3%	43.9%	41.4%	49.1%	45.6%	38.8%	42.5%	50.0%	43.7%
HEDIS mean	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%
HEDIS 90th %ile	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%
NCQA goal	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

2009 CCNC Chart Review Results

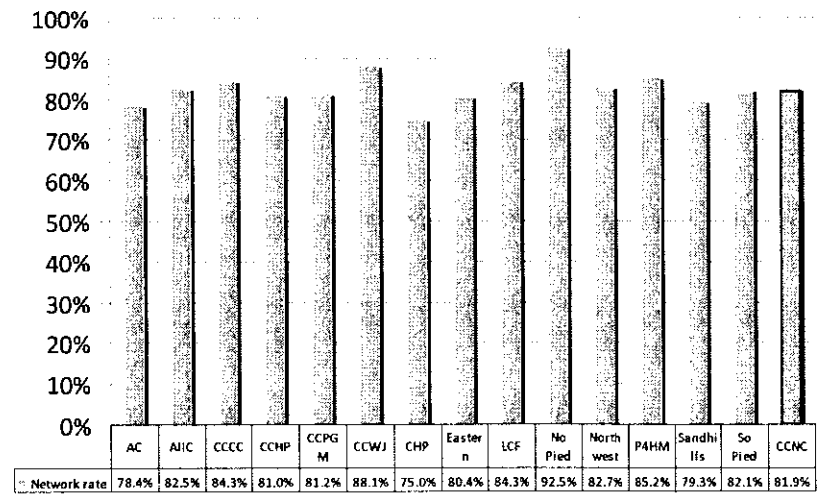
Cardiovascular: Smoking Status & Cessation Advice



	AC	AHC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	81.9%	88.5%	88.0%	77.0%	81.2%	76.9%	75.5%	76.7%	84.4%	69.0%	86.1%	74.5%	82.7%	72.2%	80.2%
NCQA goal	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

2009 CCNC Chart Review Results

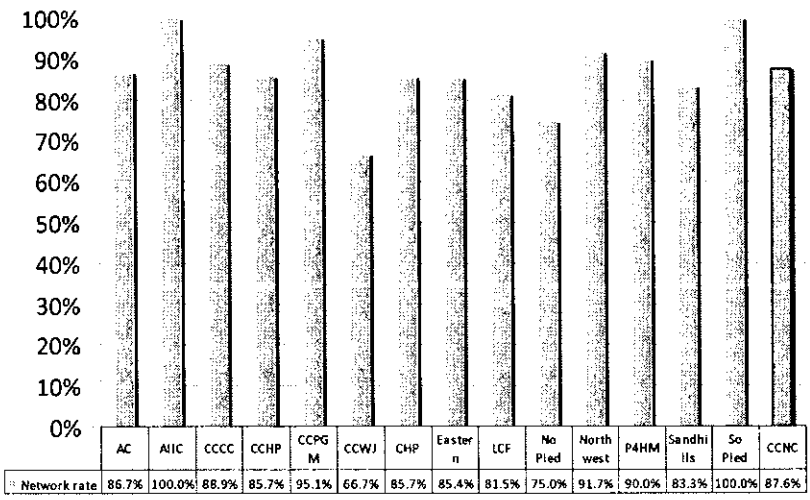
Heart Failure: LVEF Documented In PCP chart



	AC	AHC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	78.4%	82.5%	84.3%	81.0%	81.2%	88.1%	75.0%	80.4%	84.3%	92.5%	82.7%	85.2%	79.3%	82.1%	81.9%

2009 CCNC Chart Review Results

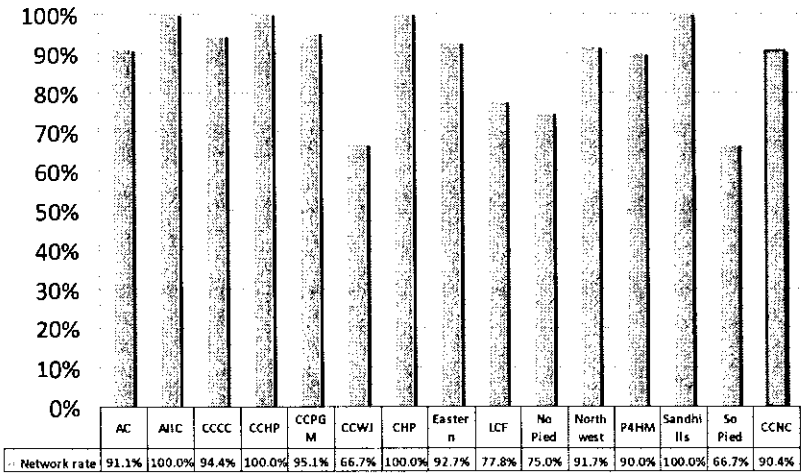
Heart Failure: ACE/ARB use



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	86.7%	100.0%	88.9%	85.7%	95.1%	66.7%	85.7%	85.4%	81.5%	75.0%	91.7%	90.0%	83.3%	100.0%	87.6%

2009 CCNC Chart Review Results

Heart Failure: Beta Blocker use



	AC	AIIC	CCCC	CCHP	CCPGM	CCWJ	CHP	Eastern	LCF	No Pied	North west	P4HM	Sandhills	So Pied	CCNC
Network rate	91.1%	100.0%	94.4%	100.0%	95.1%	66.7%	100.0%	92.7%	77.8%	75.0%	91.7%	90.0%	100.0%	66.7%	90.4%

2009 CCNC Chart Review Results

NETWORK SUMMARY

QMAF CLAIMS MEASURES

ASTHMA

NETWORK	YEAR QUARTER	ASTHMA PATIENT COUNT	MEMBER MONTHS	IP ASTHMA VISITS	ED ASTHMA VISITS	BETA AGONIST OVERUSE NUM	BETA AGONIST OVERUSE DEN	IP ASTHMA PER 1000 MM	ED ASTHMA PER 1000 MM	BETA AGONIST OVERUSE PERCENT
Access II Care of Western NC	2008Q4	736	8,494	8	40	8	728	0.9	4.7	1.1%
Access III of Lower Cape Fear	2008Q4	988	11,238	17	95	8	969	1.5	8.5	0.8%
AccessCare	2008Q4	5,143	60,092	56	450	59	5,029	0.9	7.5	1.2%
Carolina Collaborative Community Care	2008Q4	840	9,808	21	197	11	820	2.1	20.1	1.3%
Carolina Community Health Partnership	2008Q4	492	5,711	1	33	9	483	0.2	5.8	1.9%
Community Care of Wake and Johnston Counties	2008Q4	1,043	11,696	32	169	12	1,024	2.7	14.4	1.2%
Community Care Partners of Greater Mecklenburg	2008Q4	1,543	18,013	36	227	20	1,515	2.0	12.6	1.3%
Community Care Plan of Eastern Carolina	2008Q4	2,349	27,417	31	364	32	2,300	1.1	13.3	1.4%
Community Health Partners	2008Q4	506	5,912	8	57	3	494	1.4	9.6	0.6%
Northern Piedmont Community Care	2008Q4	757	8,788	10	118	21	740	1.1	13.4	2.8%
Northwest Community Care	2008Q4	1,241	14,317	23	180	20	1,212	1.6	12.6	1.7%
Partnership for Health Management	2008Q4	729	8,455	16	81	6	714	1.9	9.6	0.8%
Sandhills Community Care Network	2008Q4	725	8,374	13	92	10	713	1.6	11.0	1.4%
Southern Piedmont Community Care Plan	2008Q4	633	7,374	14	72	10	623	1.9	9.8	1.6%
All Networks Total	**2008Q4**	**17,725**	**205,689**	**286**	**2,175**	**229**	**17,364**	**1.4**	**10.6**	**1.3%**

Definitions

Patients: identified as having asthma

Non-Dual status: Medicaid only patients

Enrollment Eligibility: 10+ months enrollment with Carolina Access

Anchor Date: CCNC enrolled December 2008

Excluded: Recipients with third party major medical insurance

Member Months: Carolina Access II (CCNC)

Asthma IP Visits: Hospital admissions with asthma primary diagnosis while enrolled with CCNC

Asthma ED Visits: Emergency Dept. visits with asthma primary diagnosis while enrolled with CCNC

Beta Agonist Overuse: Patients with >5 canister fill dates in any 90 day period during CY2008 with claims paid date prior to 1/1/2009

NETWORK SUMMARY

QMAF CLAIMS MEASURES

DIABETES

NETWORK	YEAR QUARTER	DIABETES PATIENT COUNT	A1C TESTING NUM	A1C TESTING DEN	EYE EXAM NUM	EYE EXAM DEN	CHOLESTEROL SCREENING NUM	CHOLESTEROL SCREENING DEN	NEPHROPATHY SCREENING NUM	NEPHROPATHY SCREENING DEN	A1C PERCENT	EYE EXAM PERCENT	CHOLESTEROL SCREENING PERCENT	NEPHROPATHY SCREENING PERCENT
Access II Care of Western NC	2008Q4	455	395	455	226	449	285	430	354	449	87%	50%	66%	79%
Access III of Lower Cape Fear	2008Q4	889	772	889	480	882	678	855	747	882	87%	54%	79%	85%
AccessCare	2008Q4	2,294	2,014	2,294	1,181	2,271	1,539	2,132	1,839	2,271	88%	52%	72%	81%
Carolina Collaborative Community Care	2008Q4	593	524	593	326	586	452	560	497	587	88%	56%	81%	85%
Carolina Community Health Partnership	2008Q4	357	327	357	204	355	261	341	288	355	92%	57%	77%	81%
Community Care of Wake and Johnston Counties	2008Q4	591	499	591	280	582	366	553	478	583	84%	48%	66%	82%
Community Care Partners of Greater Mecklenburg	2008Q4	1,203	1,017	1,203	560	1,190	865	1,142	1,034	1,190	85%	47%	76%	87%
Community Care Plan of Eastern Carolina	2008Q4	2,126	1,844	2,126	1,159	2,104	1,464	2,018	1,726	2,105	87%	55%	73%	82%
Community Health Partners	2008Q4	364	325	364	172	358	275	347	307	358	89%	48%	79%	86%
Northern Piedmont Community Care	2008Q4	591	486	591	306	590	405	556	496	590	82%	52%	73%	84%
Northwest Community Care	2008Q4	760	609	760	390	753	487	712	629	753	80%	52%	68%	84%
Partnership for Health Management	2008Q4	325	271	325	153	320	198	306	261	320	83%	48%	65%	82%
Sandhills Community Care Network	2008Q4	577	484	577	334	576	391	560	477	576	84%	58%	70%	83%
Southern Piedmont Community Care Plan	2008Q4	405	361	405	205	399	306	375	343	399	89%	51%	82%	86%
All Networks Total	**2008Q4**	**11,530**	**9,928**	**11,530**	**5,976**	**11,415**	**7,972**	**10,887**	**9,476**	**11,418**	**86%**	**52%**	**73%**	**83%**

Definitions

Patients: identified as having diabetes

Non-Dual status: Medicaid only patients

Enrollment Eligibility: 10+ months enrollment with Carolina Access

Anchor Date: CCNC enrolled December

Excluded: Recipients with third party major medical insurance

HbA1c: Nondual patients with an HbA1c claim (12 months)

Eye Exam: Nondual patients age 10+ with an eye exam claim (15 months)

Cholesterol Screening: Nondual patients age 18+ with LDL cholesterol screening (12 months)

Nephropathy Screening: Nondual patients age 10+ screened for nephropath or evicence of nephropath based on any one of the following: dx to tx for nephropath,

ACE inhibitor/ARB therapy during year 10/1/2007 - 12/31/2008 (15 months)

Paid Date:

NUM = numerator

DEN = denominator

NETWORK SUMMARY

QMAF CLAIMS MEASURES

HEART FAILURE

NETWORK	YEAR QUARTER	HEART FAILURE PATIENT COUNT	MEMBER MONTHS	IP CHF VISITS	IP CHF 30 DAY RE-ADMINTS	LVF ASSESSMENT	IP CHF RATE PER 1000 MM	IP CHF 30 DAY RE-ADMISSION PERCENT	LVF ASSESSMENT PERCENT
Access II Care of Western NC	2008Q4	64	726	14	1	59	19.3	7.1%	92.2%
Access III of Lower Cape Fear	2008Q4	152	1,789	39	5	139	21.8	12.8%	91.4%
AccessCare	2008Q4	326	3,704	149	65	309	40.2	43.6%	94.8%
Carolina Collaborative Community Care	2008Q4	92	1,055	36	7	87	34.1	19.4%	94.6%
Carolina Community Health Partnership	2008Q4	45	510	20	5	42	39.2	25.0%	93.3%
Community Care of Wake and Johnston Counties	2008Q4	100	1,088	36	10	99	33.1	27.8%	99.0%
Community Care Partners of Greater Mecklenburg	2008Q4	212	2,488	92	14	205	37.0	15.2%	96.7%
Community Care Plan of Eastern Carolina	2008Q4	320	3,742	134	33	308	35.8	24.6%	96.3%
Community Health Partners	2008Q4	52	590	17	5	52	28.8	29.4%	100.0%
Northern Piedmont Community Care	2008Q4	112	1,303	55	11	105	42.2	20.0%	93.8%
Northwest Community Care	2008Q4	105	1,195	67	24	101	56.1	35.8%	96.2%
Partnership for Health Management	2008Q4	41	479	15	2	39	31.3	13.3%	95.1%
Sandhills Community Care Network	2008Q4	99	1,120	43	10	90	38.4	23.3%	90.9%
Southern Piedmont Community Care Plan	2008Q4	54	630	21	4	52	33.3	19.0%	96.3%
All Networks Total	**2008Q4**	1,774	20,419	738	196	1,687	36.1	26.6%	95.1%

Definitions

Patients: identified as having heart failure

Non-Dual status: Medicaid only patients

Enrollment Eligibility: 10+ months enrollment with Carolina Access

Anchor Date: CCNC enrolled December 2008

Age: 18+ December

Excluded: Recipients with third party major medical insurance

LVF Assessment: no time limit imposed

Member Months: Carolina Access II (CCNC)

CHF IP Admissions: Hospital admissions with CHF promary or secondary diagnosis while enrolled with CCNC

30 Day CHF IP Readmissions: Hospital admissions withinb 30 days of prior discharge date with CHF primary or secondary diagnosis while enrolled with CCNC

Claims paid date prior