

## Community Care of North Carolina

### Background:

The Community Care of North Carolina program (formerly known as Access II and III) is building community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. By establishing regional networks, the program is establishing the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.

### Problem Encountered:

Medicaid managed care in North Carolina consists of two initiatives: the Carolina Access Program and Community Care of North Carolina (Access II & III). Since April 1991, North Carolina has operated the Carolina Access program, a Medicaid primary care case management (PCCM) program currently operating in every county of the State. Carolina Access was developed to enhance recipient access to primary care, to improve the coordination of care, and to reduce recipient reliance on hospital emergency departments. To learn more about Carolina Access, please visit [www.dhhs.state.nc.us/dma/mangcarewho.html](http://www.dhhs.state.nc.us/dma/mangcarewho.html).

### Solution Developed:

Community Care Of NC (CCNC), initiated in July of 1998, is the most recent option available under Medicaid managed care. Currently, out of 1,391,130 Medicaid eligibles, there are approximately 944,667 enrolled in Carolina Access and 874,788 of those are also participating in the CCNC program.

While there is no question that the Carolina Access program has accomplished its original objective of providing Medicaid recipients with a medical home, it was never intended to be an integrated delivery system that could manage large populations. Although primary care providers working alone can effectively render patient care, they rarely have the tools, information, or support to effectively manage the care of an enrolled population. CCNC networks are intended to help primary care providers (PCPs) develop the capacity to manage the health care needs of the Medicaid population and to improve the quality of their care by taking a group management approach. Under CCNC, PCPs are given the opportunity to work together and with other community providers and network case managers to develop the tools, information and support needed to meet the health care needs of Medicaid recipients.

As both the State and health care providers analyzed how best to build an optimum health care system for Medicaid recipients that could improve quality and access and could contain costs, five key concepts emerged:

1. The importance of a public / private partnership that would bring all the key local health care and social service providers together;
2. The importance of local control and physician leadership in building sustainable community care systems;
3. A primary focus on improving the quality of care through population management approaches;
4. A shared State/local responsibility to develop the tools and support needed to manage the Medicaid population; and,
5. A system of shared incentives that better aligns State and community goals with desired outcomes.

The CCNC program, begun in July 1998, is designed to support the development of community care systems that can create programs and infrastructures to manage the care of an enrolled Medicaid population that include the following components:

- Medical and administrative committees that provide direction on care management activities.
- Dedicated case managers to carry out such population management activities as risk assessment, case management, and disease management.
- Care management processes that apply both new and existing resources, such as health department support services, in meeting the needs of enrollees.
- Regular reporting and profiling of target initiatives that allow networks to monitor their progress in achieving target goals.

**Successes:**

CCNC delivers improved quality and cost savings to the State through three critical elements:

- Primary care physicians serve as “true medical homes” for patients where the patients are known, care is coordinated, and quality is the first priority.
- Local networks serve as “virtual” integrated health care systems that link the medical home and patients to the rest of the local providers and support agencies. These networks, by leveraging existing community resources and relationships, provide the needed physician leadership and collaboration to create local solutions for improving care management and quality to meet statewide goals.
- The State funds the medical home through an additional monthly fee and also funds the network to provide additional local resources such as case managers/care coordinators, clinical pharmacists, part-time medical directors, and the local quality improvement infrastructure to work with and support medical homes. This assures optimal supports are provided to patients and that improvement goals are achieved.

Two external evaluations of the CCNC program have occurred:

- Analysis by the Mercer consulting group found that in every year examined (FY2003-FY2006), CCNC achieved savings relative to what the state would have spent under its previous primary care case management (PCCM) program. Estimated savings for FY2006 were \$150-\$170 million.
- The University of North Carolina evaluation of asthma and diabetes patients in CCNC versus the state’s PCCM program found the state achieved \$3.3 million in savings for people with asthma and \$2.1 million in savings for people with diabetes between 2000-2002. Further, asthma patients experienced improved care as evidenced by greater reductions in in-patient hospital admissions and emergency room visits. Diabetes patients had fewer hospitalizations and achieved high rates of performance measures, such as primary care visits, blood pressure readings, foot exams, and lipid and A1C tests.

**Lessons Learned:**

1. Primary care physicians and the medical home are essential to providing improved access to care and prevention.
2. Public-private partnerships that develop and strengthen local health care systems are important.
3. Providers are best motivated when the focus is on quality, population health, and how care is delivered locally.
4. A shared responsibility and shared incentives are important.
5. The program must have flexibility that allows communities to organize themselves based on their unique characteristics and resources.
6. Strong physician leadership is needed.
7. To create meaningful and lasting improvement physicians and other community providers who care for the patients must be engaged.
8. A portion of the savings must be reinvested to further develop local systems and programs.

In summary, while improving health information technology, payment reform, and expansion of health insurance coverage are important, what is essential is a sustained effort in organizing the health care delivery system to achieve needed access, quality, and efficiency goals.

**Funding:**

The program office is based in Raleigh at the North Carolina Office of Rural Health and Community Care. The program office is sponsored by the Office of the Secretary, the Division of Medical Assistance (the state’s Medicaid Agency) and the North Carolina Foundation for Advanced Health Programs, Inc. Additional grant funding has been obtained for start-up and for pilot demonstrations from Kate B. Reynolds Health Care Trust, The Commonwealth Fund, and the Center for Healthcare Strategies. The North Carolina Foundation for Advanced Health Programs, Inc. is a private non-profit organization that also serves to provide staffing and grant funding opportunities.

Sources: <http://www.communitycarenc.com/>; <http://www.kff.org/medicaid/upload/7899.pdf>  
Kaiser Family Foundation Policy Brief; Testimony – Dr. Dobson on behalf of Community Care of North Carolina to the Committee on Health, Education, Labor, and Pensions – January 22, 2009