



About Community Care of North Carolina

Community Care of North Carolina is a care management health care program that contracts with the NC Department of Health and Human Services (DHHS) to provide enhanced primary care case management and other features of a primary care medical home for approximately 1.6 million Medicaid beneficiaries.¹ The statewide system comprises a nonprofit central CCNC office that oversees and supports 14 independent, regional Community Care networks, together serving all 100 counties in North Carolina.² This state/local partnership is designed to leverage local resources and relationships to meet the need of higher-risk, higher-cost Medicaid enrollees through patient-centered medical homes.²

CCNC as it exists today evolved from North Carolina's initial Medicaid primary care case management (PCCM) program called Carolina Access that began in 1989. This medical home model was intended to improve access to primary care for Medicaid beneficiaries, thereby reducing emergency department utilization. As North Carolina continued to explore opportunities to make Medicaid costs more predictable, Community Care of North Carolina was developed in 1998 to link Medicaid's higher risk beneficiaries to a primary care medical home, while also improving the quality of care and controlling costs. This PCCM program sought to create a community-based model with providers enrolling into a local network and working with other community health agencies to provide high quality care, care coordination, and quality improvement. Gradually, the regional networks formed and expanded, covering every county by 2011. The central CCNC office was established in 2006 to provide overarching structure and support to the networks.³

^a A map of the 14 regional networks can be found at <https://www.communitycarenc.org/our-networks/>.

^b Ancillary services are diagnostic or therapeutic services provided as a supplement to basic medical care or surgical

Community Care of North Carolina's Role in Influencing Health

The CCNC Model

The CCNC model acknowledges that many factors affect health and that health care providers, hospitals, social services, local health departments, federally qualified health centers, and other community resources must work together to positively impact the health of the enrolled population. The stakeholders involved in the partnerships facilitated by each network vary depending on the resources in the region, but these cross-system relationships serve to better meet patient needs, reduce duplication of services, and deliver high-quality care while mitigating financial risk.⁴ Accordingly, the CCNC networks enroll local primary care providers (PCPs) to serve as medical homes, and beneficiaries are assigned or select a primary care physician.⁵ In order to contract with a local CCNC network, a PCP must first be enrolled as a NC Medicaid Carolina Access provider through the Division of Medical Assistance (DMA).⁶ To be a Carolina Access PCP, a provider must:

- Provide primary care services, including certain preventive and ancillary services;^b
- Cultivate and maintain a relationship with each patient;
- Provide a minimum of 30 office hours per week of direct patient care;
- Provide 24/7 access to medical services and advice;
- Refer patients to specialists or other providers when the service cannot be performed by the PCP; and,
- Provide oral interpretation for all non-English speaker at no cost to the beneficiaries.⁷

When enrolling with CCNC, a PCP agrees to additional requirements, primarily related to CCNC's population management and quality improvement goals. In exchange, a PCP receives \$2.50 per member per month

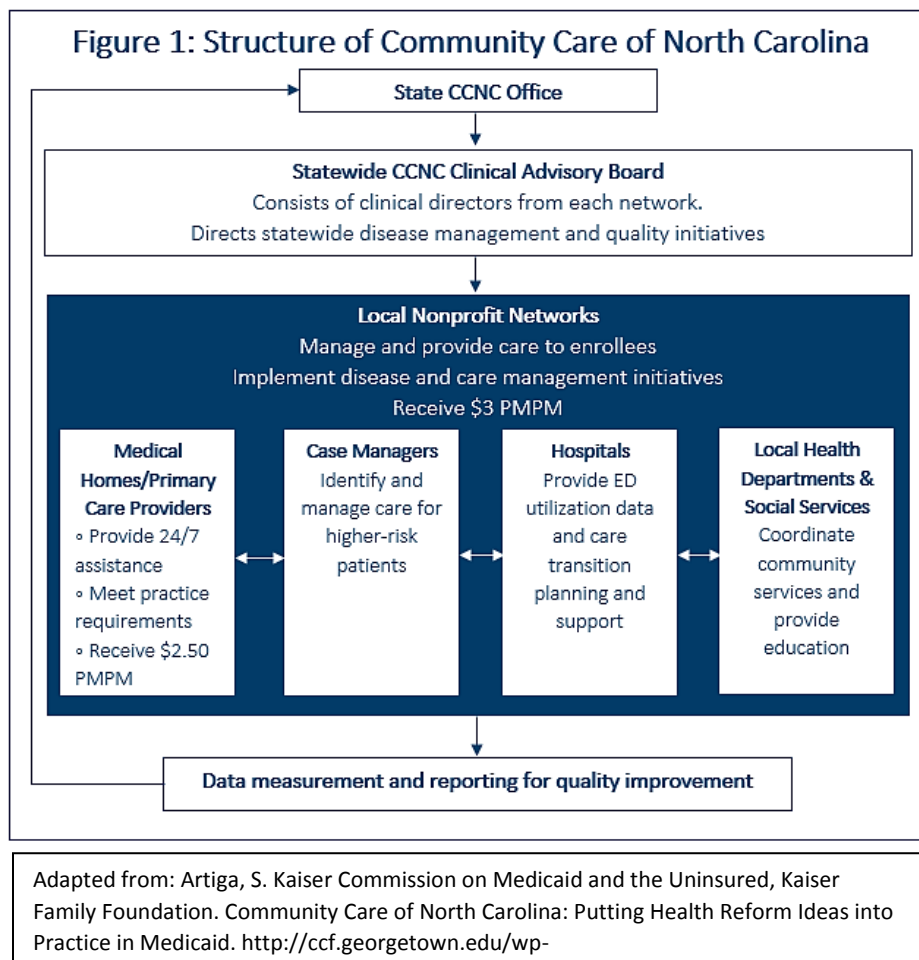
services. Examples include laboratory testing, radiology, physical therapy, audiology, and social work services.

(PMPM) for care management activities for Medicaid and NC Health Choice beneficiaries, and \$5.00 per member per month aged, blind, and/or disabled (ABD) Medicaid beneficiaries.⁷

The 14 regional networks engage local providers and agencies and direct care management for their members by connecting them to a primary care medical home, providing case management services, and implementing quality improvement and other initiatives to improve the health of their region.⁸ The network organizations serve as a link between the local health care providers in a clinical setting and human services agencies and other community-based organizations that provide services that affect members' health. Each network receives a network management fee of \$3.00 per member per month for care management activities and hiring staff, including a program director, a part-time medical director, pharmacists, and case managers.² Case managers provide individualized interventions and ongoing support to higher-risk patients to help them manage medications and chronic diseases, improve health behaviors, and address social and financial barriers to health.⁹ Case managers also

collaborate with and provide referrals to other community agencies and serve as a conduit for communication between the PCP and the member.¹⁰

The statewide office supports the regional networks, particularly as it relates to data analytics. State CCNC staff work with DMA to analyze Medicaid claims data to identify Medicaid patients with complex health needs who would benefit from case management services. CCNC also maintains a web-based case management information system (CMIS), a central repository for patient information, reports on guideline compliance, care planning, and messaging among staff that is used by all case managers across the networks. The networks report data based on standard performance measures back to the state office that is then analyzed for continual program quality improvement.² In addition to data support, CCNC's state office facilitates coordination among the 14 networks; each network must elect a physician to serve as a clinical director, who works with the state board of directors to develop and oversee statewide disease and care management activities.⁸



Population Management and Quality Improvement Initiatives

CCNC coordinates several statewide programs designed to address complex health problems and reduce health care costs. Key programs include:

- Assuring Better Child health and Development (ABCD) – a model that includes best practices to assist PCPs with identifying and coordinating services for young children (aged five or younger) with developmental delays.¹¹
- Behavioral Health Integration – licensed behavioral health professionals in each network provide screenings and basic treatments for mental health and substance use disorders in the primary care setting, and a behavioral health coordinator provides referrals to specialty behavioral health services.¹²
- Community Pharmacy Enhance Services Network – integrates pharmacists into the medical home team to offer enhanced services including synchronizing medication refill dates, adherence coaching and monitoring, and home delivery.¹³
- Care Coordination for Children (CC4C) – children aged 0-5 receive care management services at their local health departments if they fall into one or more priority categories: special health care needs; chronic physical, behavioral, developmental, or emotional condition; exposure to toxic stress in early childhood; foster care; NICU admission; and/or high ED utilization.¹⁴
- Pregnancy Medical Home – supports prenatal care providers in increasing access to prenatal care, improving the quality of care, and improving maternal and infant health outcomes with the primary goal of preventing preterm births.¹⁵
- Transitional Care – a model designed to ensure coordination and continuity of care for patients, particularly ABD Medicaid recipients and high risk/high cost individuals, to prevent rehospitalization.^{4,16}

In addition, the networks may operate region-specific initiatives to address issues prevalent among their members and can also exercise control over how statewide initiatives are implemented locally.¹⁷

Who is eligible for CCNC?

Participation in CCNC may be mandatory, optional, or not permitted depending on an individual's Medicaid program aid category. CCNC enrollment is required for most beneficiaries, including infants, children, and their families, beneficiaries receiving Work First Family Assistance, and those who are blind and/or disabled, although individuals can apply for an exemption.^c Pregnant women and foster children have the option of enrolling, while refugees and Medicare-qualified beneficiaries are ineligible for CCNC.^{d,18,19} Eligible beneficiaries enroll in CCNC through their local Department of Social Services (DSS) agency at any time during their eligibility for the Medicaid program.¹⁸

Upon enrollment in CCNC, all members are assigned to a case manager for monitoring, although not all members receive case management services at all times. With over 600 case managers across the state, each is responsible for monitoring a few thousand members, typically with an active caseload of 150 to 200 individuals.^{2,20} Patients are identified for case management services through a referral from the PCP or hospital, or through claims data analyzed by the state CCNC office.⁹

Funding

Medicaid funding for CCNC is included in DMA's budget. State and federal Medicaid dollars support CCNC through three primary avenues:

- Networks receive \$3.00 PMPM for each beneficiary;
- Enrolled providers receive \$2.50 and \$5.00 PMPM for each non-ABD and ABD beneficiary, respectively; and
- Enrolled providers are reimbursed on a fee-for-service basis at 95% of Medicare rates.²¹

The state's share of this funding is consistent with the Medicaid program's Federal Medical Assistance Percentage (FMAP)—as of FY 2018, the federal government pays 67.61% of North Carolina's costs for

^c Work First is North Carolina's Temporary Assistance for Needy Families (TANF) Program

^d North Carolina operates the Program of All-Inclusive Care for the Elderly (PACE) for Medicare-Medicaid dual beneficiaries

medical services provided through Medicaid.²² In addition to allocating Medicaid dollars for services, DMA provides financing and structures policies to support the CCNC office and data collection and analysis.^{3,17} Regional CCNC networks may supplement the capitated payments they receive from the state with public or private grant funding for initiatives specific to the needs of their enrolled population.²

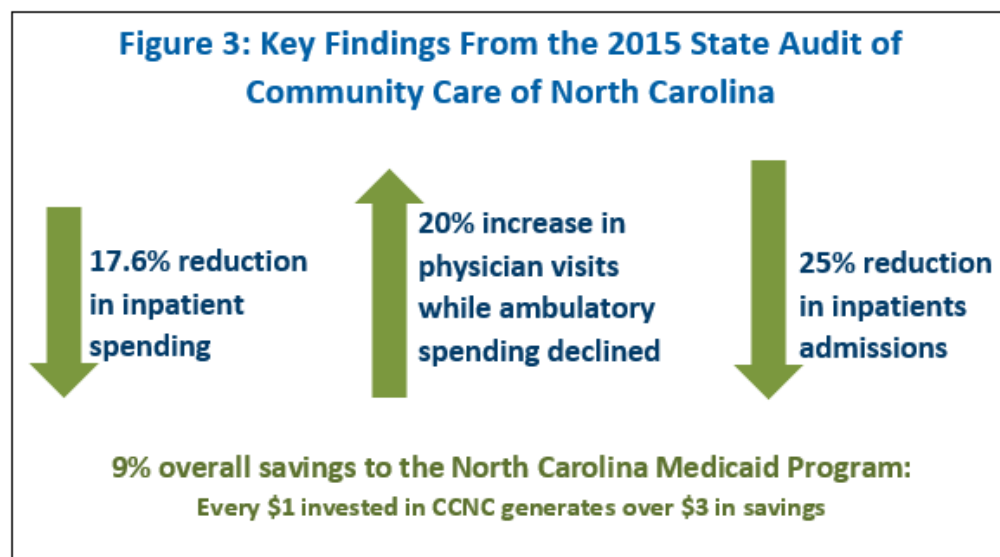
Impact

CCNC encompasses over 1,800 enrolled primary care practices serving over 1.6 million Medicaid beneficiaries. Providers participating in CCNC networks benefit from information-sharing among partners, the availability of tools and resources around best practices, and an enhanced capacity to use data for practice improvement activities.²³ CCNC-enrolled Medicaid beneficiaries benefit from increased access to care, including primary care and referrals to specialists; improved care coordination and transitional care; and individualized case management services to address medical and other health-related needs.^{4,10}

Several studies have analyzed the impact of CCNC's care management initiatives on patient outcomes as well as

Although multiple studies have shown savings to the Medicaid program due to CCNC's approach to managed care, DMA funding to CCNC has gradually increased as the number of Medicaid beneficiaries in North Carolina has grown.

the cost and quality of care, including a 2015 state audit mandated by the General Assembly—key findings of which are summarized in **Figure 3**. Increased access to primary care as a result of the medical home model has led to significantly higher rates of non-acute physician visits for beneficiaries enrolled in CCNC compared to non-enrolled beneficiaries.²⁴ CCNC's population management initiatives have proven to effectively reduce hospitalizations and potentially preventable readmissions, as well as significantly reduce emergency department utilization among patients with asthma. These reductions in hospitalizations and emergency department utilization, as the most expensive levels of care, account for the majority of savings achieved through the CCNC program.¹



Source: State of North Carolina Office of the State Auditor. Community Care of North Carolina. Financial Related Audit. Study conducted by Michael Chernew, PhD, of Harvard School of Government, August 2015. Available online at <http://www.ncauditor.net/EPSTWeb/Reports/FiscalControl/FCA-2014-4445.pdf>. Accessed March 21, 2018.

While CCNC has managed to demonstrate meaningful savings to the state's Medicaid program, there are challenges to the program's effectiveness, particularly as it relates to the small PMPM network management fee and its adequacy in funding care management activities for the enrolled population.² At any given time, CCNC only has the resources necessary to provide intensive care management support to approximately 1% of members.¹⁰ Additional challenges include involving specialists to treat complex care needs and reducing variability in outcomes across the networks due to geographic differences in resources.^{2,17}

Despite these challenges, CCNC has demonstrated effective use of data and continuous assessment to maximize its funds to meet the needs of highly impactable patients.¹⁰ These quality improvement

efforts and success of targeted initiatives to improve health outcomes and achieve savings have received national recognition and can offer considerations for North Carolina's current Medicaid transformation efforts. If approved, North Carolina's Medicaid Section 1115 waiver and subsequent shift to a managed care model would end CCNC's current contract with DHHS to serve as the enhanced PCCM program for North Carolina's Medicaid beneficiaries. According to the amended Section 1115 Demonstration Waiver Application, DHHS is working with CCNC to formulate a transition plan for Medicaid managed care.²⁵ As North Carolina's Medicaid landscape evolves, CCNC will serve as a promising model for providing coordinated, cost-effective care for individuals with complex health needs.

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