Enhanced Primary Care Case Management System

Legislative Report

North Carolina Community Care Networks, Inc.

Quarterly Report

As of January 1, 2011

Community Care *of* North Carolina

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Reporting Requirement (Section 10.36(h))

"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. Beginning July 1, 2010, NCCCN, Inc., shall submit a quarterly report 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 report the plan to DMA within 30 days after taking any action to implement the plan."

Fourth Quarter 2010 Highlights

The fourth quarter 2010 witnessed steady and continuing progress by NCCCN and its fourteen Networks in to developing of the Enhanced Primary Care Case Management.

A number of indicators also reflect that Community Care is achieving substantial savings despite the increased complexity of the patients it serves.

Highlights:

- Statewide, Total Medicaid enrollment grew, as did the portion of beneficiaries eligible as Aged, Blind and Disabled (ABD).
- Despite an increase in aged, blind and disabled Medicaid patients with extremely complex and expensive health conditions, the monthly cost of care for all Medicaid patients (often referred to as "per member per month (pmpm) costs" went down substantially in comparison to last year.
- For the first three months of SFY 2011, monthly cost for aged blind and disabled patients were $1,281, a 13% decrease from the prior year number of $1,453, and a 5% decrease from SFY 2009 costs.

This reduction in costs continues a trend identified by payment and performance experts Treo Solutions in analyzing CCNC data from 2007 to 2009. Among the firm's findings:

- Patient cost per member per month for patients enrolled in Community Care decreased from $397 to $391 – even though CCNC assumed responsibility for a more complex, high-risk population with more chronic medical conditions.
- Community Care's costs were 7 percent lower than expected after adjusting for severity.
- In contrast, costs for the Medicaid population not enrolled in Community Care were higher than expected by 15 percent in 2008 and 16 percent in 2009.

For the first time, Community Care can report risk adjusted information that takes into consideration the severity of the medical problems of Medicaid patients. This is important because providing care – and saving money - for children on Medicaid, for example, is often less difficult than other groups of patients, such as those with mental illness or the elderly. Moving forward, this ability will enable NCCCN to perform longitudinal studies of population health as well as facilitate comparisons between different CCNC networks.

Key findings in this initial risk adjusted analysis include:

- Community Care took on more complex, and higher-risk patients between 2007 and 2009
- CCNC's networks have held costs in check despite the increasing level of illness in the patients Community Care serves.
- Adjusting for severity of illness, spending in all CCNC networks is lower than expected. In contrast, costs for patients not enrolled in Community Care were over budget by 15% in 2008 and 16% in 2009.

Separately, Mercer Associates recently reported that Community Care saved the NC Medicaid program approximately $190 million for SFY 2009 for the Aid to Families with Dependent Children (AFDC) Medicaid population. These are net

savings after all program costs have been recognized. Savings for the aged, blind and disabled population are likely considerably greater, but are difficult to capture with reliability at this time.

The Mercer report also includes chart review information for SFY 2010.. This part of the report shows significant improvement versus 2009 performance and also demonstrates the substantial extent to which North Carolina's Medicaid recipients in the Networks enjoy better quality of care than that received by the average HMO Medicaid recipient nationally.

Operational statistics for Community Care's Informatics Center show the continuing value the Center provides in making key medical information available to North Carolina's medical community.

Although not yet finalized by executed contract, agreement has been reached with the Division of Medical Assistance as to NCCCN, Network and DMA responsibilities, performance metrics and capitated payment amounts. During 2011, the contract will also address two new initiatives: the Pregnancy Medical Home and Care Co-ordination for Children which DMA is implementing through the Community Care of North Carolina Program.

Introduction

NCCCN Inc. is a not-for-profit administrative entity designed to (a) work with Community Care Networks assisting them to establish, support, and maintain provider-network case management relationships with local providers to develop an organized health care delivery system for Medicaid Network enrollees such that services provided are coordinated across a full continuum of care and (b) develop processes and formal programs to promote population health management principles, community development, quality improvement and cost containment efficiencies, service utilization, budget analytics and forecasting to address the challenges of providing health services to the Medicaid population in the state of North Carolina, including all rural and underserved areas such that cost and quality of care delivery is influenced favorably.

Under the Community Care system approach to health care delivery, certain clinical, disease and case management services are purchased for enrollees and disease and care management support systems are established which implement quality improvement initiatives and test new approaches to population management. Further, the approach is based on a fee-for-service model with an enhanced services case management fee. Community Care Networks coordinate health care services with the Primary Care Providers (PCPs) who function as the enrollees' Medical Homes while achieving budget performance goals and benchmarks.

Pursuant to Session Law 2010-31 §10.36(h) regarding Community Care in North Carolina, the North Carolina Community Care Networks Inc. is submitting this quarterly report to document the results of its efforts with regard to the implementation of a statewide Enhanced Primary Care Case Management System as well as associated goals and objectives. Contractual deliberations between NCCCN, Inc. and the Division of Medical Assistance are being conducted currently and this report includes information with regard to chart review and claims based performance measurements which NCCCN believes with be set forth in the contract when it is executed between DMA and NCCCN, Inc.

The Total and the Aged, Blind and Disabled (ABD) member enrollment in the Community Care Networks as of December 2010 was 1,060,007 and 195,337, an increase of 2.0% and 1.5% from the September 2010 amounts, respectively. The total number of practices enrolled in Community Care was 1,455, 2% increase from September, 2010. The overall profile of the Community Care system and its fourteen (14) networks as of December, 2010 is as follows:

Community Care of North Carolina Networks

Access Care: Alamance, Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Caswell, Catawba, Chatham, Cherokee, Clay, Davidson, Graham, Haywood, Iredell, Jackson, Macon, Orange, Robeson, Sampson, Swain, Watauga, and Wayne.
December 2010 Enrollment: Total – 229,149; ABD – 35,305 281 Practices

Community Care of Western North Carolina: Buncombe, Henderson, Madison, Mitchell, McDowell, Polk, Transylvania and Yancey
December 2010 Enrollment: Total – 53,425; ABD – 10,996 68 Practices

Community Care of Lower Cape Fear: Bladen, Brunswick, Columbus, New Hanover, Onslow and Pender
December 2010 Enrollment: Total - 57,602; ABD – 14,576 130 Practices

Carolina Collaborative Community Care: Cumberland
December 2010 Enrollment: Total – 47,562; ABD – 9,847 82 Practices

Carolina Community Health Partnership: Cleveland and Rutherford
December 2010 Enrollment: Total = 23,836; ABD – 4,090 21 Practices

Community Care Partners of Greater Mecklenburg: Anson, Mecklenburg, Union
December 2010 Enrollment: Total – 119,356; ABD – 17,917 157 Practices

Community Care of Wake and Johnston Counties: Wake, Johnston
December 2010 Enrollment: Total – 79,235; ABD – 10,844 97 Practices

Community Care Plan of Eastern Carolina: Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington and Wilson
December 2010 Enrollment: Total – 130,770; ABD – 35,975 210 Practices

Community Health Partners: Gaston and Lincoln
December 2010 Enrollment: Total – 33,502; ABD – 5,776 46 Practices

Northern Piedmont Community Care: Durham, Franklin, Granville, Person, Vance and Warren
December 2010 Enrollment: Total – 50,075; ABD – 9,738 41 Practices

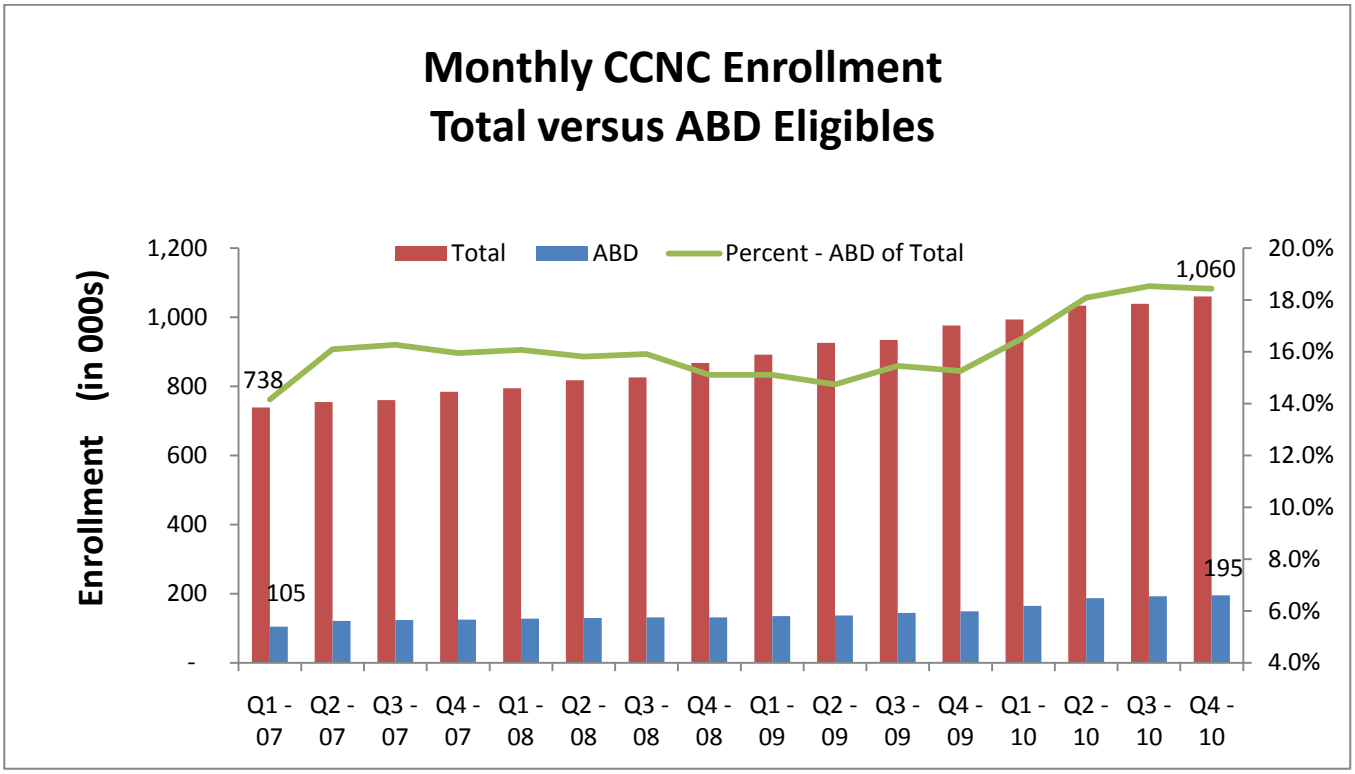
Northwest Community Care Network: Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin
December 2010 Enrollment: Total – 77,746; ABD – 15,083 108 Practices

Partnership for Health Management: Guilford, Randolph and Rockingham
December 2010 Enrollment: Total – 56,203; ABD – 7,169 60 Practices

Community Care of the Sandhills: Harnett, Hoke, Lee, Montgomery, Moore, Richmond and Scotland
December 2010 Enrollment: Total – 55,120; ABD – 10,337 90 Practices

Southern Piedmont Community Care Plan: Cabarrus, Rowan and Stanly
December 2010 Enrollment: Total – 46,246; ABD – 7,684 64 Practices

The increase in both ABD and total enrollment witnessed during the fourth quarter of 2010 is an on-going trend. Total and ABD enrollees increased from 738K and 105K at the end of 1Q2007 to 1,060K and 195K at the end of 4Q2010. ABD enrollment as a percentage of total enrollment has increased from 14.2% at 1Q2007 to 18.3% at 4Q2010. This growth pattern with the relatively greater influx of ABD patients who have more complex and chronic medical needs has had an impact on the health acuity levels of the enrolled membership as discussed later in this report. The growth is depicted visually as follows:



ABDs are enrolled into the CCNC program through the efforts of DMA and the county social service agencies, and the rate of ABD enrollment has declined during 2010 as a result of CMS' (Center for Medicare and Medicaid Services) temporary order to DMA to cease actively moving the dual eligibles to an opt-out status. It is uncertain whether the 'flattening' of the percentage curve above is a permanent phenomenon or whether ABDs as a percentage of total enrollees will begin to increase again.

Quarterly Reported Measures and Improvement Targets

Quality of Care Measures – Patient Chart Reviews

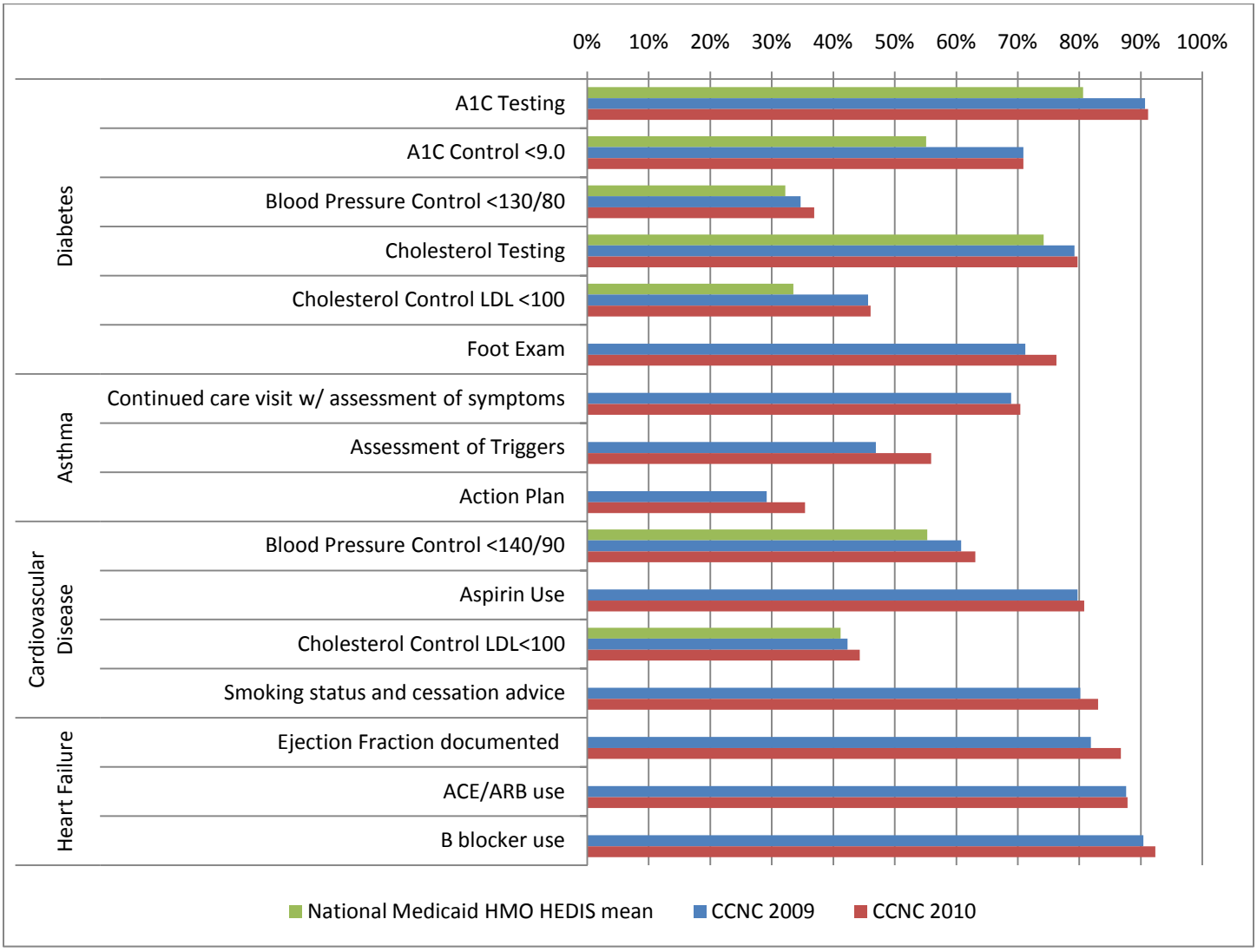
Since its beginning in 1998, the Community Care system has used performance measurement and feedback to help meet its goals of improving the quality of care for Medicaid recipients while controlling costs. Quality measurement is intended to facilitate quality improvement efforts in Community Care practices and local Networks as well as to evaluate the performance of the program as a whole. Under the direction of Network Clinical Directors, this measurement and feedback process has evolved over time to meet the changing needs of the Community Care program and it is expected that this evolutionary process will continue to address issues such as:

- Continued expansion of the Community Care system's enrolled population and increasing focus on the ABD population who suffer frequently from multiple chronic conditions,
- Development of additional quality initiatives,
- Changes in evidence based clinical practice guidelines,
- Decisions rendered by the Community Care system's Quality Measurement and Performance workgroup whose Network representatives meet periodically to review and improve performance measures. The workgroup's goals are to develop performance measures with:
    - clinical importance based on disease prevalence and potential for improvement,
    - scientific soundness (the strength of the evidence underlying the clinical practice recommendation and evidence the measure improves care based on its reliability, validity and comprehensibility), and
    - feasibility of implementing the performance measure

Chart reviews are performed on an annual cycle for patients with medical conditions involving diabetes, asthma, cardiovascular disease and heart failure. Chart reviews are used when the desired performance metrics cannot be obtained from administrative claims data. The Community Care system continues to contract with Area Health Education Centers to perform independent and random chart reviews using an electronic data abstraction tool. Chart review measures pertain to:

- Asthma management (assessment of symptoms and continued care)
- Diabetes (foot-care, and control of glycemia, blood pressure and cholesterol)
- Management of blood pressure, cholesterol, appropriate use of aspirin and tobacco use
- Assessment of LV function in heart failure

The chart review activity for the SFY 2010 cycle was completed during December, 2010 and is depicted visually as follows:



Several points need emphasis:

-CCNC achieved state-wide improvements in Medicaid Recipient quality of Care with improvement in 14 of 15 chart review measures in 2010 compared with 2009

-CCNC's performance exceeds Medicaid managed care performance nationally in six out of six measures for which HEDSIS benchmarking is available

This last point needs to be put into context. If CCNC's recipients were to receive the same quality of care as Medicaid HMO enrollees nationally, they would have poorer health and health outcomes as well as a poorer quality of life and North Carolina would experience

-3,000 more recipients with poor diabetes control

-2,500 more recipients with poor diabetes and cholesterol control

-1,670 more recipients with cardiovascular disease and poor blood pressure control.

As chart reviews for the practices are completed, practice-level results with patient-level details are available to the Networks via a **secure** internet reporting service on a next day basis. Providing credible and provider friendly reports,

accompanied with benchmarks and peer comparisons is crucial in motivating providers to improve processes that will enable them to provide "best" health care in a cost effective manner. These quality metrics are critical to the ability to implement locally the systemic changes needed to improve quality and care outcomes in practices. Network Clinical Directors are instrumental in engaging community providers and motivating them to implement Community Care quality initiatives.

Network level results and a detailed comparison of 2010 performance versus 2009 are included in this quarterly report as Attachment A.

Operational Measures - Medicaid Claims Review

Medicaid claims data is analyzed and claims derived performance metrics are developed which generally are reported monthly at the Network and practice levels as well as by County. These performance metrics have associated performance targets[1] and are classified as:

Per Member Per Month Metrics which originated with efforts during 2008 to enroll ABD recipients into the CCNC program to provide them with a medical home. Per contract with DMA, the baseline for these metrics is SFY 2009-2010 and these metrics involve performance targets to:

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

Enhanced Plan Metrics which relate to the Enhanced Plan for which the Networks begin receiving an enhanced PMPM fee during April, 2010. Per contract with DMA, the baseline for these metrics is SFY 2009-2010 and these metrics performance targets to:

1. Reduce Preventable Readmissions (within 30 days) as Percent of Total Admissions (non-Dual)
2. Reduce Readmissions (within 30 days) – Psychiatric Diagnoses (non-Dual)
3. Decrease Program-level PMPM inpatient costs - (last three months of life reported on a rolling 12 month basis) (non-Dual ABD)
4. Increase Percentage of Practices with Co-located Behavioral Health Providers (**reported annually**)
5. Generic Medications as Percent of all Fills (non-Dual)
6. Report on Clinical Integrity Efforts (**reported quarterly**)
7. Decrease ABD per member per month costs (alternative to metrics 1, 2 and 3)

Through deliberations with the Division of Medical Assistance, methodological specifications for several Enhanced Plan metrics have recently been finalized. Programming and quality assurance testing for measures #2 Reduce Readmissions (within 30 days) – Psychiatric Diagnoses (non-Dual), and #3 Decrease Program Level PMPM Inpatient Costs (last three months of life) – non-Dual ABD is underway during the first quarter of 2011 and we anticipate initial results will be reported in the April 1, 2011 quarterly report. In addition, it has been determined that the only viable method to collect data for metric #4, Co-Located Behavioral Health Providers is to employ an annual survey. It is anticipated that the results of the first survey will be obtained during February, 2011, and the survey results also will be reported in the April 1, 2011 quarterly report.

[1] Performance targets are identified for each metric as appropriate below.

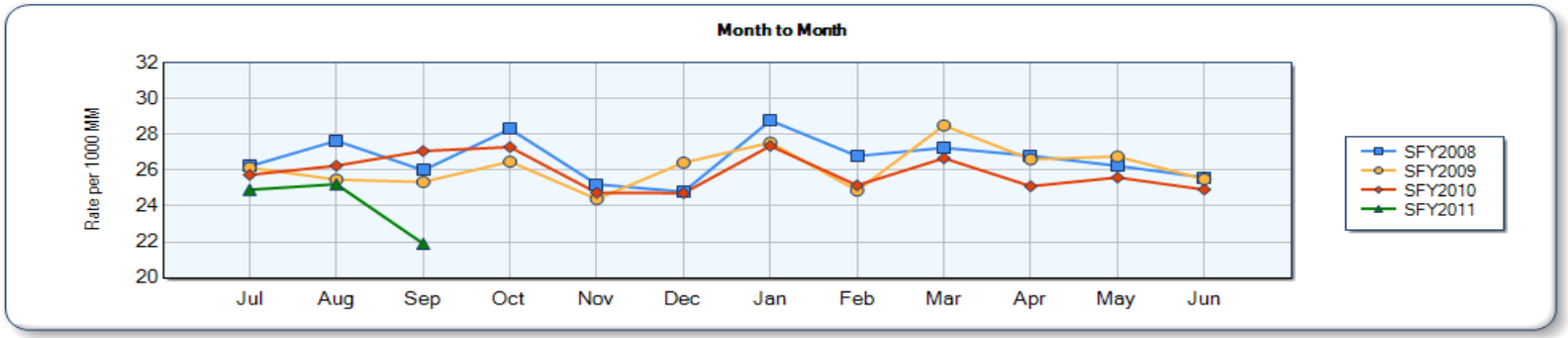
Reporting for the remainder of the Enhanced Plan and PMPM measures is ongoing. The following tables show unadjusted, program-level, results for these measures from July 2008 through September 2010. Dates refer to date of service, and a three-month lag time is allowed for claims processing before measures are calculated. Thus far, SFY 2011 rates for inpatient admissions (page 11) and emergency department utilization (page 13) are tracking well below the SFY2010 experience. The preventable readmission rate (page 15) has remained fairly stable, near 15% for the past three years. This measure reflects what proportion of all hospital admissions represented a preventable readmission which occurred within 30 days of a prior discharge and can be somewhat misleading when the total number of admissions is declining as has been the case with the overall CCNC population. Also, preventable readmission rates among patients without a mental health or substance abuse condition have been declining and this is identified in greater detail on page 33 of this report (item #12 in the Treo information).

The preferred use of generic prescriptions instead of more costly alternatives continues to rise. The success of CCNC's generic prescription initiative has been quite remarkable, with an overall increase from 60% to 73% during the past three years, exceeding the Enhanced Plan target rate (page 17).

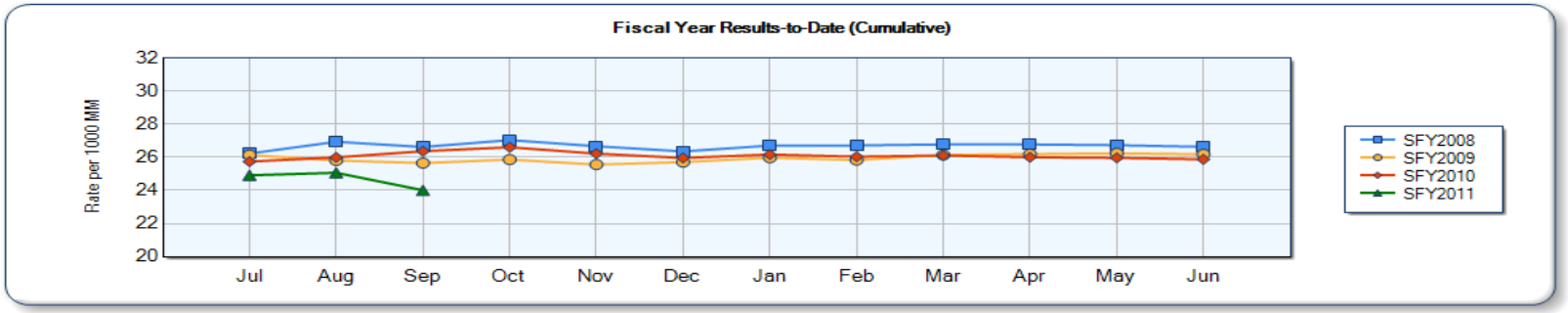
Most importantly, the overarching aim of the Enhanced Plan, to reduce unnecessary spending for the Aged, Blind and Disabled Medicaid population is proving successful. Monthly PMPM costs in SFY 2011 are tracking well below the SFY2010 experience (page 21).

PMPM Metrics

Inpatient Admissions per 1000 Member Months – Enrolled non-Dual ABD



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	26.2	27.6	26.0	28.3	25.2	24.8	28.8	26.8	27.2	26.8	26.2	25.6
SFY2009	26.1	25.5	25.3	26.5	24.4	26.4	27.5	24.9	28.5	26.6	26.8	25.5
SFY2010	25.7	26.3	27.1	27.3	24.7	24.7	27.4	25.2	26.7	25.1	25.6	24.9
SFY2011	24.9	25.2	21.9	-	-	-	-	-	-	-	-	-



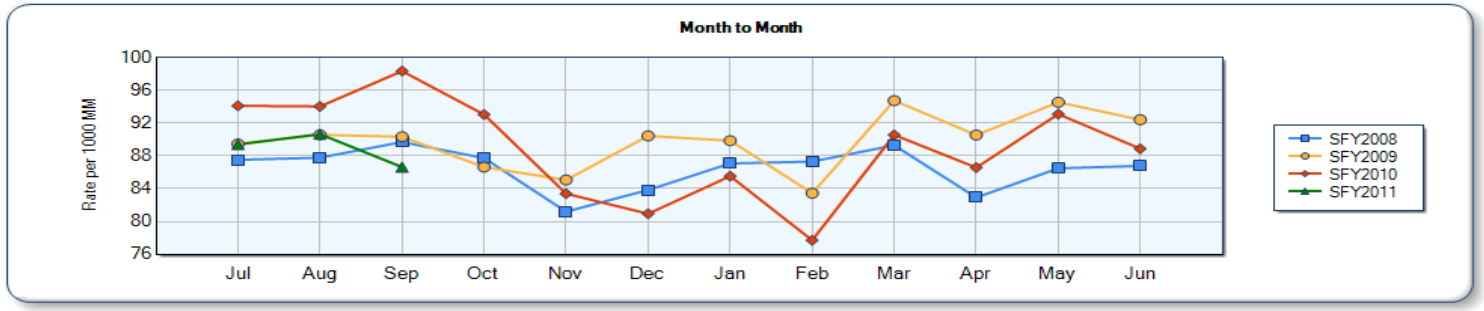
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	26.2	26.9	26.6	27.0	26.7	26.4	26.7	26.7	26.8	26.8	26.7	26.6
SFY2009	26.1	25.8	25.7	25.9	25.6	25.7	26.0	25.8	26.1	26.2	26.2	26.2
SFY2010	25.7	26.0	26.4	26.6	26.2	26.0	26.2	26.0	26.1	26.0	26.0	25.9
SFY2011	24.9	25.1	24.0	-	-	-	-	-	-	-	-	-

Inpatient Admits per 1000 Member Months – Enrolled non-Dual ABD

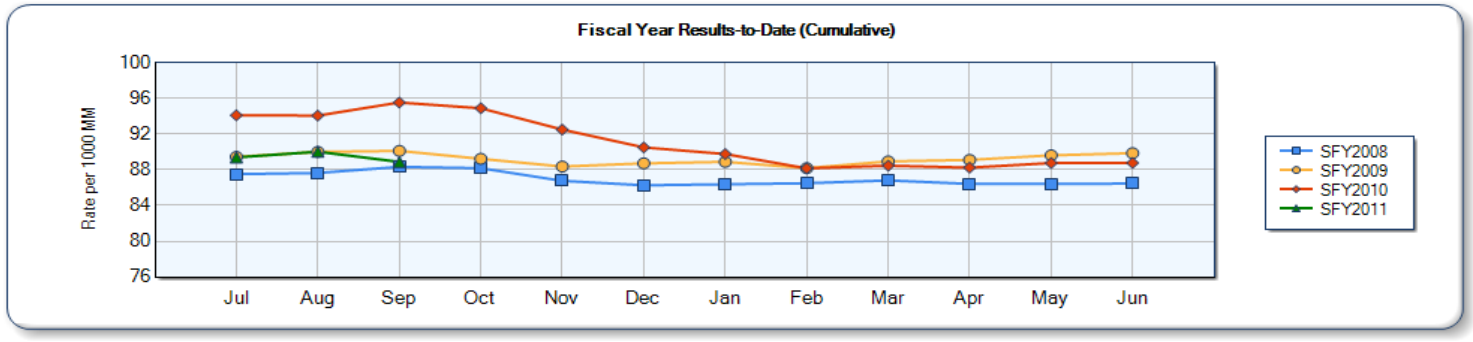
Network	Historical			Actual SFY 11 (Year - to - Date)												
	SFY 08	SFY 09	SFY 10 Baseline	Target*	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of Western NC	26.7	26.6	25.8	25.3	27.8	28.0	26.8									
Community Care of the LCF	25.9	25.3	26.3	25.8	26.8	27.0	27.1									
Access Care	25.6	24.7	23.3	22.8	22.7	22.6	21.7									
Carolina Collaborative Community Care	25.0	22.9	23.7	23.2	24.3	24.8	23.6									
Carolina Community Health Partnership	25.5	25.9	24.0	23.5	28.5	27.4	26.0									
Community Care - Wake/Johnston	22.8	22.8	23.2	22.7	18.0	19.3	19.8									
Community Care of Greater Mecklenburg	28.5	27.9	28.5	27.9	27.7	29.3	27.2									
Community Care of Eastern Carolina	25.7	25.6	25.8	25.3	24.1	23.7	22.5									
Community Health Partners	33.9	31.8	32.1	31.5	30.4	30.6	28.1									
Northern Piedmont Community Care	25.5	24.1	24.4	23.9	23.0	22.9	22.0									
Northwest Community Care	33.1	30.2	30.2	29.6	28.1	27.8	27.9									
Partnership for Health Management	26.6	30.2	29.3	28.7	27.3	25.9	23.8									
Community Care of the Sandhills	32.5	33.9	29.1	28.5	27.4	28.6	26.7									
Southern Piedmont Community Care	21.8	24.4	22.4	22.0	23.1	22.3	20.4									
CCNC Total	26.6	26.2	25.9	25.4	24.9	25.1	24.0									

* Target is a 2% Reduction from 2010 Baseline Rate

ED Rate per 1000 Member Months – Enrolled ABD



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	87.5	87.8	89.7	87.7	81.2	83.8	87.1	87.3	89.3	82.9	86.5	86.8
SFY2009	89.4	90.6	90.3	86.6	85.1	90.4	89.8	83.4	94.7	90.5	94.5	92.4
SFY2010	94.1	94.0	98.3	93.0	83.4	80.9	85.5	77.7	90.5	86.6	93.1	88.9
SFY2011	89.4	90.6	86.6	-	-	-	-	-	-	-	-	-



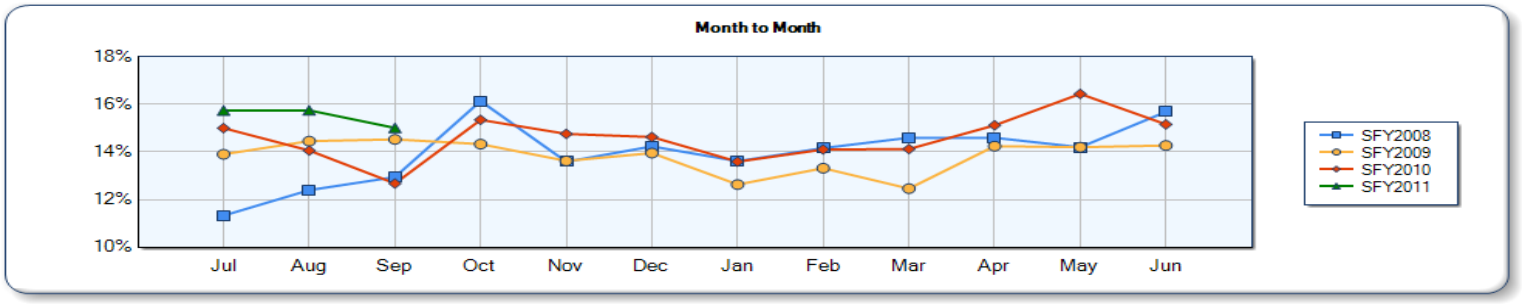
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	87.5	87.6	88.3	88.2	86.8	86.3	86.4	86.5	86.8	86.4	86.4	86.5
SFY2009	89.4	90.0	90.1	89.2	88.4	88.7	88.9	88.2	88.9	89.1	89.6	89.9
SFY2010	94.1	94.1	95.5	94.9	92.5	90.5	89.8	88.2	88.5	88.2	88.8	88.8
SFY2011	89.4	90.0	88.9	-	-	-	-	-	-	-	-	-

ED Rate per 1000 Member Months – Enrolled ABD

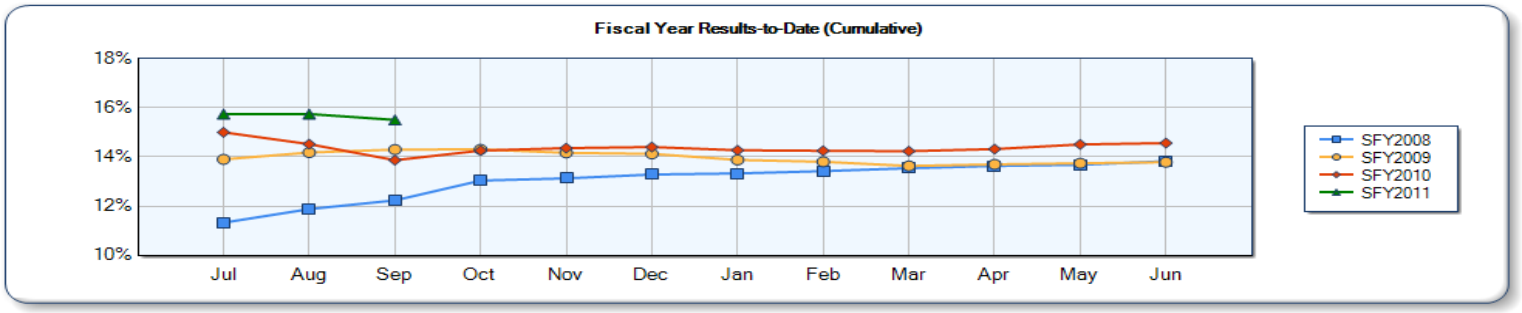
Network	Historical SFY 08	Historical SFY 09	SFY 10 Baseline	Target*	Actual SFY 11 (Year - to - Date) Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of Western NC	81.9	81.2	81.5	79.9	84.1	86.2	88.5									
Community Care of the LCF	96.8	99.6	91.7	89.9	89.7	90.6	88.3									
Access Care	83.2	86.1	85.8	84.1	88.5	88.9	89.1									
Carolina Collaborative Community Care	58.6	52.0	55.2	54.1	49.0	45.6	47.0									
Carolina Community Health Partnership	108.8	127.7	124.1	121.6	127.4	129.7	129.8									
Community Care - Wake/Johnston	83.2	86.7	80.5	78.9	72.0	76.4	76.6									
Community Care of Greater Mecklenburg	100.4	100.6	95.1	93.2	95.9	95.2	94.3									
Community Care of Eastern Carolina	81.6	83.7	85.4	83.7	89.9	89.5	87.7									
Community Health Partners	96.4	114.3	107.8	105.6	103.2	107.4	101.9									
Northern Piedmont Community Care	85.6	92.1	93.0	91.1	92.6	95.0	92.7									
Northwest Community Care	97.9	100.2	99.1	97.1	103.5	102.2	100.6									
Partnership for Health Management	78.4	85.0	87.0	85.3	86.6	84.5	84.7									
Community Care of the Sandhills	90.7	97.0	95.9	94.0	93.4	96.5	93.8									
Southern Piedmont Community Care	91.3	100.2	98.0	96.0	94.8	99.0	96.6									
CCNC Total	86.5	89.8	88.8	87.0	89.4	90.0	88.9									

* Target is a 2% reduction from 2010 Baseline Rate

Preventable Readmissions – Enrolled non-Duals



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	12.4%	12.9%	16.1%	13.6%	14.2%	13.6%	14.2%	14.6%	14.6%	14.2%	15.7%
SFY2009	13.9%	14.4%	14.5%	14.3%	13.6%	13.9%	12.6%	13.3%	12.5%	14.2%	14.2%	14.3%
SFY2010	15.0%	14.1%	12.7%	15.3%	14.8%	14.6%	13.6%	14.1%	14.1%	15.1%	16.4%	15.2%
SFY2011	15.7%	15.7%	15.0%	-	-	-	-	-	-	-	-	-



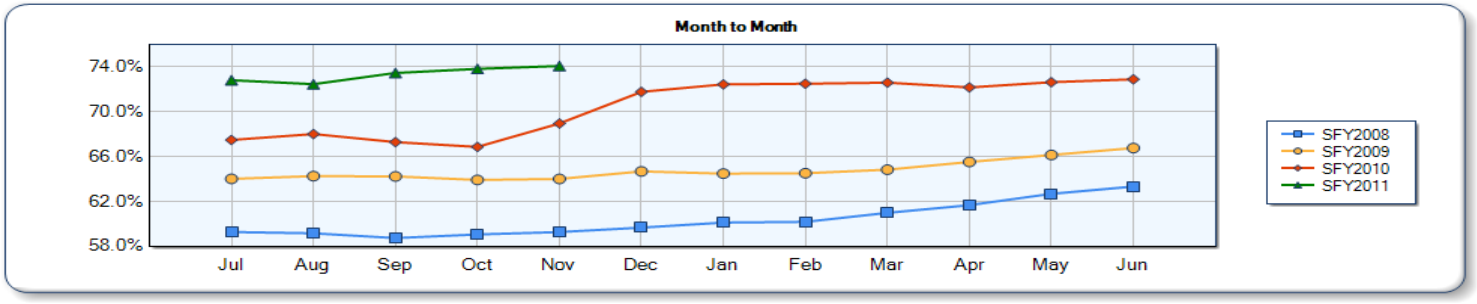
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	11.9%	12.2%	13.0%	13.1%	13.3%	13.3%	13.4%	13.5%	13.6%	13.7%	13.8%
SFY2009	13.9%	14.2%	14.3%	14.3%	14.2%	14.1%	13.9%	13.8%	13.6%	13.7%	13.7%	13.8%
SFY2010	15.0%	14.5%	13.9%	14.3%	14.4%	14.4%	14.3%	14.2%	14.2%	14.3%	14.5%	14.6%
SFY2011	15.7%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

Preventable Readmissions – Enrolled (non-Duals)

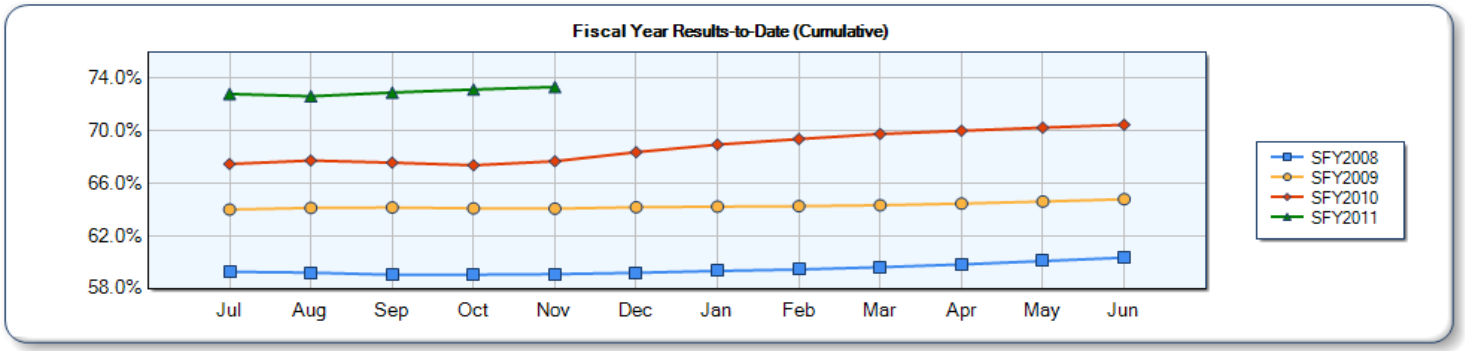
Network	Historical			Actual SFY 11 (Year - to - Date)												
	SFY 08	SFY 09	SFY 10 Baseline	Target*	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Care of Western NC	12.0%	13.0%	12.8%	12.3%	14.2%	15.6%	15.7%									
Community Care of the LCF	12.7%	12.2%	13.9%	13.3%	13.4%	13.8%	14.6%									
Access Care	13.5%	12.3%	12.9%	12.4%	14.6%	13.6%	12.6%									
Carolina Collaborative Community Care	13.4%	15.4%	19.7%	18.9%	20.2%	20.0%	19.7%									
Carolina Community Health Partnership	11.6%	11.6%	12.3%	11.8%	9.4%	10.9%	10.7%									
Community Care - Wake/Johnston	13.5%	12.9%	13.2%	12.7%	13.9%	14.5%	14.5%									
Community Care of Greater Mecklenburg	13.2%	14.9%	15.0%	14.4%	16.8%	16.2%	15.3%									
Community Care of Eastern Carolina	14.9%	14.5%	15.6%	15.0%	16.4%	15.8%	16.5%									
Community Health Partners	12.5%	13.6%	13.7%	13.2%	15.1%	15.0%	13.2%									
Northern Piedmont Community Care	14.4%	13.2%	16.9%	16.2%	13.5%	15.8%	16.5%									
Northwest Community Care	18.0%	16.3%	17.3%	16.6%	19.9%	20.6%	19.9%									
Partnership for Health Management	14.8%	13.9%	15.2%	14.6%	21.2%	19.9%	20.0%									
Community Care of the Sandhills	14.5%	14.5%	13.1%	12.6%	14.4%	14.9%	15.4%									
Southern Piedmont Community Care	11.2%	12.4%	13.3%	12.8%	13.3%	16.5%	15.9%									
CCNC Total	13.8%	13.8%	14.6%	14.0%	15.7%	15.7%	15.5%									

* Target is a 4% Reduction from 2010 Baseline Rate

Generic Prescriptions as Percent of All Fills – All Medicaid non-Duals



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	59.3%	59.2%	58.7%	59.1%	59.3%	59.7%	60.1%	60.2%	61.0%	61.7%	62.7%	63.3%
SFY2009	64.0%	64.3%	64.2%	63.9%	64.0%	64.7%	64.5%	64.5%	64.8%	65.5%	66.1%	66.8%
SFY2010	67.5%	68.0%	67.3%	66.9%	68.9%	71.8%	72.4%	72.5%	72.6%	72.2%	72.6%	72.9%
SFY2011	72.8%	72.4%	73.4%	73.8%	74.1%	-	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	59.3%	59.2%	59.1%	59.1%	59.1%	59.2%	59.3%	59.5%	59.6%	59.8%	60.1%	60.3%
SFY2009	64.0%	64.1%	64.2%	64.1%	64.1%	64.2%	64.2%	64.3%	64.3%	64.5%	64.6%	64.8%
SFY2010	67.5%	67.7%	67.6%	67.4%	67.7%	68.4%	68.9%	69.4%	69.8%	70.0%	70.2%	70.5%
SFY2011	72.8%	72.6%	72.9%	73.1%	73.3%	-	-	-	-	-	-	-

Generic Prescriptions as Percent of All Fills

Network	Historical SFY 08	Historical SFY 09	Historical SFY 10 Baseline	Target*	Actual SFY 11 (Year - to - Date) Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
No Network	61.5%	66.0%	71.1%		73.5%	73.4%	73.6%	73.8%	74.0%							
Community Care of Western NC	60.8%	65.4%	70.4%	71.8%	72.1%	72.1%	72.5%	72.8%	73.0%							
Community Care of the LCF	59.8%	64.3%	70.8%	72.2%	73.3%	73.0%	73.2%	73.4%	73.6%							
Access Care	59.2%	64.0%	70.3%	71.7%	72.6%	72.4%	72.8%	73.1%	73.5%							
Carolina Collaborative Community Care	57.8%	62.4%	68.9%	70.3%	71.0%	70.5%	71.1%	71.4%	71.6%							
Carolina Community Health Partnership	58.6%	64.0%	70.7%	72.1%	72.6%	72.3%	73.0%	73.2%	73.6%							
Community Care - Wake/Johnston	59.4%	63.1%	68.8%	70.2%	70.5%	70.4%	70.6%	70.9%	71.0%							
Community Care of Greater Mecklenburg	59.6%	63.0%	69.3%	70.7%	72.5%	72.3%	72.6%	72.8%	72.9%							
Community Care of Eastern Carolina	60.4%	65.2%	71.2%	72.6%	73.4%	73.1%	73.3%	73.5%	73.7%							
Community Health Partners	58.1%	62.8%	69.6%	71.0%	72.2%	72.2%	72.4%	72.7%	73.0%							
Northern Piedmont Community Care	62.6%	66.1%	71.1%	72.5%	73.7%	73.7%	73.8%	73.9%	74.1%							
Northwest Community Care	61.6%	65.9%	70.4%	71.8%	72.5%	72.4%	72.7%	72.8%	72.9%							
Partnership for Health Management	59.3%	64.7%	70.5%	71.9%	72.3%	71.9%	72.3%	72.3%	72.5%							
Community Care of the Sandhills	59.6%	64.3%	70.4%	71.8%	73.5%	73.0%	73.3%	73.5%	73.6%							
Southern Piedmont Community Care	59.6%	64.5%	69.7%	71.1%	72.0%	71.7%	72.0%	72.2%	72.4%							
CCNC Total	60.3%	64.8%	70.5%	71.9%	72.8%	72.6%	72.9%	73.1%	73.3%							

* Target is a 2% increase above 2010 Baseline

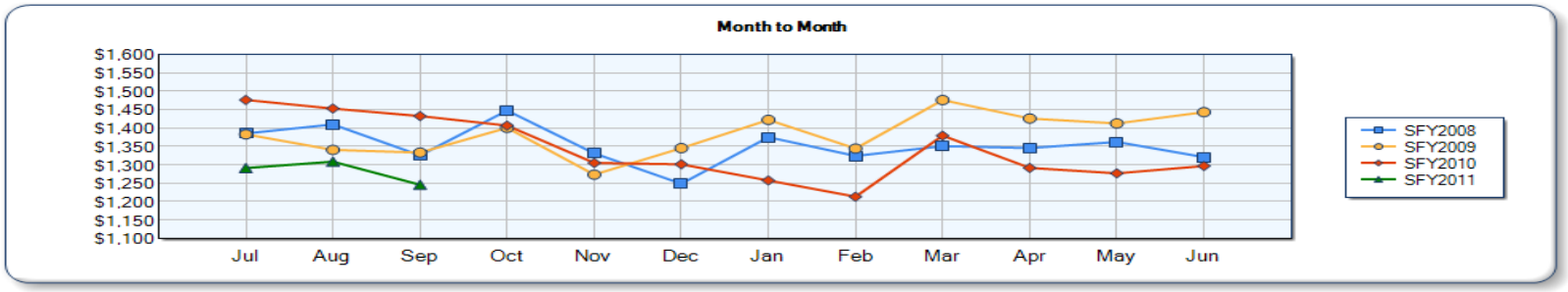
Clinical Integrity Efforts

Monthly meetings are held between DMA's Program Integrity organization and NCCCN to review the results of NCCCN efforts to identify questionable billing practices based on information NCCCN has received from Network personnel as well as review of claim billing details by NCCCN's physician consultant. A tabulation of results as of 12-29-2010 is as follows:

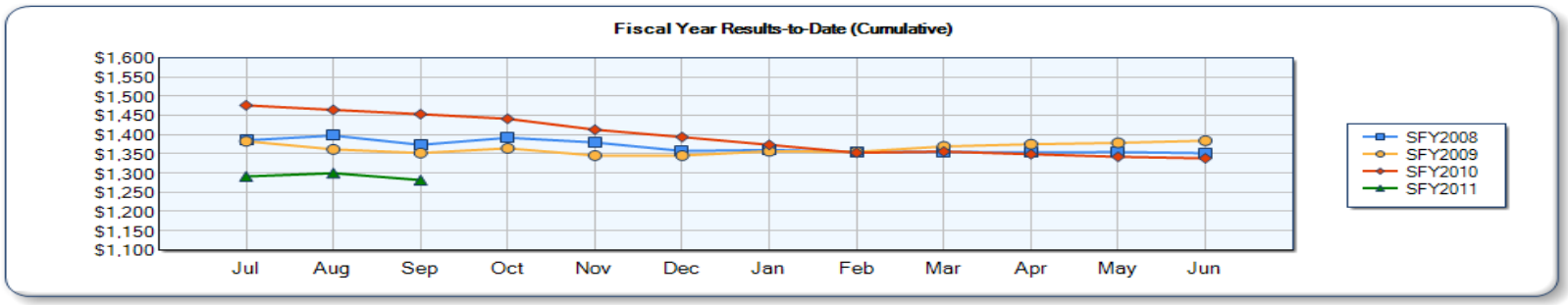
Provider Type	Referral Source	Reason referred	$ Amount ID'd Cases	Comments
PCS Agencies	CCNC Care Managers from 4 networks	Agencies billed for PCS services not provided, services supposedly provided while the patient was an inpatient, 2 agencies billing for the same patient, patient getting PCS services not approved by PCP b/c not medically indicated, PCS services provided where PCP did not sign approval --possible forgery. These 10 individuals' cases have led to larger cases against 8 different agencies	$70,000	PCS cases are being worked by various Program Integrity teams including PCG to which PI contracted some cases to assist work on backlog. Per PI, amounts being pursued from these PCS providers total well over $3 Million. Cases are open and ongoing, one since Sept 2007.
Pain Clinics	Outlier data & Phys Consultant	Drug screen units billed much higher than usual billed amount	$6,719	Subject to investigation results
Providers of Allergy Care	Outlier data & Phys Consultant	Large amount of units billed for observation, abnormal amount of units recorded given, thousands of dollars for a few office visits that didn't seem to warrant it.	$17,085	Found a small group of 5 clinics run by mid-level providers whose official supervising MD let NC license lapse in 12/2009. May recoup all billing from these places.
Dermatologist	Outlier data & Phys Consultant	Large billing for pathology-2 claims	$1,852	In queue for PI review
Child Development Service Agencies	Outlier data & Phys Consultant	Billed 26 hours of nutritional consult for mental retardation, billed 8 hours of ADHD care in 1 day for a 3 yr old.	$2,230	In queue for PI review
Social Services Organizations	Outlier data & Phys Consultant	Billed abnormally high #s of Targeted Case Mgmt units in single day for multiple individuals, no diagnosis code for these services.	$20,833	Cases being reviewed at PI.
Neurologists	Outlier data & Phys Consultant	Provider billing for 80 units of a steroid medication injected into a neck joint instead of 80mg (Which is 4 units)-- has been doing so for 2 years. On further examination, there is another physician in NC found to have been doing this even longer. MEDICARE established an upper limit of 8units for this service in Oct 2010, Medicaid has no upper limit.	$2,860	Case open, also reported to M. Powell at DMA Clinical Policy for establishment of upper maximum limits. Letter of recoupment sent to one provider for $2,860 Second request for records send to others.
Anesthesiologist	Outlier data & Phys Consultant	Check units and modifiers	$621	This large medical center stands out as having 1/4 of all the flagged outlier codes for Anesthesia we have seen. Will look at a few individual cases looking for patterns.
DME - Diabetes	Outlier data & Phys Consultant	Charging more on average for diabetic supplies routinely	$195	Being investigated - looking for patterns
DME - Respiratory	Outlier data & Phys Consultant	Overcharged for Sterile Water- $696.92 per unit?	$1,394	Being investigated - looking for patterns

Provider Type	Referral Source	Reason referred	$ Amount ID'd Cases	Comments
DME – Home Health	Outlier data & Phys Consultant	Maybe overcharging for diapers- $11 per day.	$343	Waiting on records to arrive from provider
Oncologist	Outlier data & Phys Consultant	Double billed for bag of chemo	$5,762	Letter sent to provider by PI, being repaid
Pathology lab	Outlier data & Phys Consultant	$1010 per prostate biopsy?	$3,030	In queue at PI, may need to look at upper limits for Medicare
Parenteral Nutrition	Outlier data & Phys Consultant	More than $30,000 to feed 6 individuals for a month-- isn't there a TPN solution that might be more affordable over the long term?	$30,021	Physician is looking into whether there are more affordable options for TPN
Community Psychiatrists	Outlier data & Phys Consultant	11 providers appear to be billing 8hours worth of Master's-level provider counseling in one day per month per patient. Looked over this with our BHI team, who did not feel it represented evidence-based good psychiatric care, looking into these cases.	$15,180	In queue for PI review
TOTAL as of 12/29/2010			**$182,670**	**Over $4Million based on broader provider reviews**

PMPM Cost – Enrolled (non-Dual) ABD



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,410	$1,325	$1,447	$1,331	$1,248	$1,375	$1,324	$1,351	$1,345	$1,362	$1,321
SFY2009	$1,383	$1,340	$1,333	$1,400	$1,273	$1,345	$1,422	$1,344	$1,476	$1,426	$1,412	$1,443
SFY2010	$1,476	$1,453	$1,432	$1,406	$1,305	$1,301	$1,257	$1,213	$1,379	$1,291	$1,277	$1,297
SFY2011	$1,291	$1,308	$1,246	-	-	-	-	-	-	-	-	-



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

Risk Adjusted Analyses

The preceding metrics report clinical and financial results on a "raw" basis since the metrics ignore the acuity level of the Networks' enrolled populations. To address this deficiency, NCCCN has contracted with a data analytics firm, Treo Incorporated, which specializes in the analysis of health care delivery organizations and their enrolled populations, particularly state Medicaid populations. Treo has assisted NCCCN in understanding the acuity level (risk score) of its enrolled population (excluding dual eligibles), cost trends and the results of both Network operations and the CCNC enrolled population as well as the Medicaid un-enrolled population receiving services on a fee-for-service basis. The analysis focused on trends between 2007 and 2009 and the conclusions reached are as follows:

1. **CCNC enrolled a more complex, higher-risk population between 2007 and 2009 than fee-for-service. (this does not include dual enrollees)**

   The overall risk status of the NC Medicaid population increased slightly between 2007 and 2008, and then remained stable between 2008 and 2009. Over the two-year period however, a greater proportion of higher risk patients -- those with greater numbers of chronic medical conditions and more severe disease-- shifted from the fee-for-service (not enrolled in CCNC) program into CCNC enrollment. On average, CCNC enrollment grew by more than 167,000 during these 2 years, with a 4.9% increase in risk score, while the risk score of the un-enrolled population increased by 1.0%.

	Average Members					Risk Scores of Populations				
	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend
FFS	376,942	361,055	343,853	-4.8%	-8.8%	1.2140	1.2379	1.2264	-0.9%	1.0%
CCNC	669,436	739,561	836,901	13.2%	25.0%	0.8973	0.9198	0.9411	2.3%	4.9%
Total	1,046,379	1,100,616	1,180,754	7.3%	12.8%	1.0114	1.0242	1.0242	0.0%	1.3%

2. **Risk burden by Child vs. Adult:** Overall, it appears in the previous table that the CCNC enrolled population has a lower risk burden than that of the FFS population (0.9411 versus 1.2264), but it is important to look at these populations by adult versus child. Almost 80% of the CCNC population is children, compared to 52% for FFS. This distribution makes the overall weight for the CCNC population less than the FFS. Of particular importance going forward however, the CCNC risk burden for adults and seniors is higher than for that of the fee-for-service population.

		Average Members				Clinical Risk Groupings Weight			
		2007	**2008**	**2009**	**2 YR Trend**	**2007**	**2008**	**2009**	**2 YR Trend**
CCNC	Child	534,976	587,563	662,468	**23.8%**	0.6121	0.6213	0.6304	**3.0%**
	Adult	134,398	151,735	174,205	**29.6%**	2.0323	2.0752	2.1223	**4.4%**
	Senior	261	263	229	**-12.4%**	1.8133	1.3378	1.2165	**-32.9%**
Total		**669,635**	**739,561**	**836,901**	**25.0%**	**0.8976**	**0.9198**	**0.9411**	**4.8%**
FFS	Child	210,366	196,040	178,729	**-15.0%**	0.7370	0.7531	0.7335	**-0.5%**
	Adult	162,471	160,892	161,535	**-0.6%**	1.8387	1.8353	1.7813	**-3.1%**
	Senior	4,105	4,123	3,589	**-12.6%**	0.9330	0.9762	0.7923	**-15.1%**
Total		**376,942**	**361,055**	**343,853**	**-8.8%**	**1.2140**	**1.2379**	**1.2264**	**1.02%**

3. **Nonuser Analysis:** CCNC has a much lower nonuser percentage than the fee-for-service population. (A nonuser is an individual who had no interaction with the health care system during the incurred time period). A lower nonuser percentage is favorable because it indicates better access to care. Additionally, from 2007 to 2009 CCNC managed to reduce the percentage of enrolled members that are non users.

Nonuser Percentage

Adult	**2007**	**2008**	**2009**
CCNC	5.3%	5.3%	5.1%
FFS	16.3%	16.4%	16.8%
Child	**2007**	**2008**	**2009**
CCNC	6.2%	5.8%	5.0%
FFS	20.2%	20.7%	20.8%

4. **Aggregated Clinical Risk Grouping (CRG) analysis:** Almost 50% of the adults in the CCNC population are tagged as having a chronic condition by the CRG grouper, compared to 28% in the FFS population. This is what is driving the higher risk score for the adult CCNC population.

	2007		2008		2009	
Child Populations	**CCNC**	**FFS**	**Enrolled**	**FFS**	**CCNC**	**FFS**
Healthy	47.3%	44.6%	48.2%	44.5%	48.4%	44.6%
Healthy Non-User	6.2%	20.2%	5.8%	20.7%	5.0%	20.8%
Pregnancy and Delivery	0.6%	2.0%	0.6%	1.9%	0.6%	1.8%
Significant Acute Disease/Illness	20.6%	13.7%	20.4%	13.3%	20.8%	13.6%
Minor Chronic	8.2%	6.0%	7.9%	5.7%	7.9%	5.6%
Chronics	16.7%	13.1%	16.6%	13.4%	17.0%	13.1%
Malignancies and Catastrophic	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%
	2007		**2008**		**2009**	
Adult Populations	**CCNC**	**FFS**	**CCNC**	**FFS**	**CCNC**	**FFS**
Healthy	16.0%	18.4%	16.2%	18.8%	16.3%	19.3%
Healthy Non-User	5.3%	16.3%	5.3%	16.4%	5.1%	16.8%
Pregnancy and Delivery	11.3%	21.0%	11.3%	21.0%	10.5%	20.5%
Significant Acute Disease/Illness	7.8%	7.9%	8.0%	8.0%	7.8%	8.1%
Minor Chronic	8.4%	5.1%	8.4%	5.1%	8.1%	5.0%
Chronics	48.4%	28.5%	48.0%	28.1%	49.2%	27.7%
Malignancies and Catastrophic	2.8%	2.7%	2.8%	2.6%	2.9%	2.5%

5. **Chronic conditions are highly prevalent among CCNC-enrolled adults.** The following table shows the prevalence of chronic conditions in the adult population in 2009. Asthma, diabetes, Alzheimer's and mental health rates PKPY (per 1000 member months per year) are almost double in the CCNC population compared to FFS.

Adult Population - Rate of Chronic Conditions (PKPY)

Condition category	CCNC	FFS
Alzheimer's and Dementia	12.3	5.1
Asthma	30.0	13.8
Cerebrovascular Disease	5.8	5.3
Chronic Gastrointestinal	0.1	0.1
Chronic Renal Failure	7.2	5.1
Congestive Heart Failure	11.9	8.3
COPD	27.0	14.0
Coronary Artery Disease	7.7	4.0
Diabetes	96.0	51.0
Disc Disease and Chronic Back	3.2	1.3
Epilepsy	5.0	2.1
Hypertension	42.9	32.1
Mental Health	109.0	57.0
Obesity	4.4	3.1
Osteoporosis	0.3	0.2
Other	108.0	61.6
Peripheral Vascular Disease	0.3	0.2
SA and Alcoholism	21.2	12.4
Grand Total	**492.5**	**276.7**

6. **Despite assuming the responsibility for managing a more complex, higher-risk population, CCNC has held costs in check.**

From 2007 to 2009 the cost per member per month (PMPM) for the entire CCNC enrolled population has decreased from $397 to $391, despite the increasing level of illness in the enrolled population.
The following table compares actual to expected PMPM spend from 2007 to 2009 for the child and adult populations (seniors excluded). In 2009 the actual PMPM for both the child and the adult CCNC population are below expected. Note also that actual exceeds expected PMPM for the fee-for-service populations, both child and adult.

	Actual PMPM			Expected PMPM			Variance		
Child	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**
CCNC	$288	$261	$264	$281	$276	$281	2.5%	-5.4%	-5.9%
FFS	$414	$393	$384	$338	$334	$327	22.6%	17.7%	17.7%
Adult	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**
CCNC	$833	$840	$875	$931	$920	$945	-10.6%	-8.7%	-7.4%
FFS	$916	$909	$901	$843	$814	$793	8.8%	11.7%	13.6%

7. CCNC is performing better than expected with respect to total costs.

Adjusting for the severity of illness of the population, total spending for the entire CCNC enrolled recipients (including seniors) was 7% LOWER than expected in 2008 and 2009. Actual costs are lower than expected costs for each of the fourteen Networks. In contrast, actual costs EXCEEDED expected costs in the unenrolled population by 15% in 2008 and 16% in 2009.

	Enrollment Chg		CRG Weight -less admin PMPM					Variance from Expected		
Includes Child Adult and Seniors	2 Yr Trend	1 Year Trend	2007	2008	2009	2 Yr Trend	1 Year Trend	2007	2008	2009
FFS	-8.8%	-4.8%	1.2140	1.2379	1.2264	1.0%	-0.9%	14.3%	15%	16%
CCNC	25.0%	13.2%	0.8973	0.9198	0.9411	4.9%	2.3%	-3.5%	-6.9%	-6.6%
Grand Total	*12.8%*	*7.3%*	*1.0114*	*1.0242*	*1.0242*	*1.3%*	*0.0%*	*4.2%*	*1.6%*	*1.2%*

8. Inpatient spend PMPM has declined in both the enrolled and FFS population. This trend in the FFS population is a result of both a reduction in utilization and cost per admit, 2% and 2.8 % respectively. The negative 0.6% trend in the CCNC population inpatient PMPM spend is a result of a 5.7% reduction in utilization while the cost per admit has increased. Further analysis is required to determine if the increased cost per CCNC admit is a result of the increase in risk burden, a shift in population, providers being utilized or some combination thereof. The favorable comparison of CCNC versus fee-for-service experience should also be noted.

	IP PMPM					IP Admits PKPY					Cost Per IP Admit				
Total	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend
CCNC	$53	$52	$52	-0.6%	-1.5%	177.7	174.6	164.7	-5.7%	-7.3%	$3,551	$3,581	$3,775	5.4%	6.3%
FFS	$130	$128	$122	-4.8%	-6.0%	325.4	322.7	315.9	-2.1%	-2.9%	$4,785	$4,766	$4,634	-2.8%	-3.2%
Adult	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend
CCNC	$141	$137	$131	-4.0%	-6.8%	335.4	333.6	322.3	-3.4%	-3.9%	$5,041	$4,921	$4,889	-0.7%	-3.0%
FFS	$219	$240	$236	-1.8%	7.6%	526.9	705.3	770.7	9.3%	46.3%	$4,988	$4,080	$3,668	-10.1%	-26.5%
Child	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend
CCNC	$30	$30	$31	2.2%	1.7%	138.1	133.5	123.2	-7.7%	-10.8%	$2,639	$2,715	$3,007	10.8%	13.9%
FFS	$63	$61	$58	-6.3%	-8.7%	177.7	170.7	162.4	-4.9%	-8.6%	$4,254	$4,314	$4,250	-1.5%	-0.1%

9. **Inpatient admissions and Preventable ED Visits have decreased in the CCNC enrolled population.** Despite a higher risk burden over time, the number of inpatient admissions in the CCNC enrolled population DECREASED from 178 PKPY (per 1000 members per year) in 2007 to 165 PKPY in 2009. This downward trend in inpatient utilization was most prominent among children (-10.8%), but was also realized among adults (-3.9%).

	IP Admits PKPY					PPA PKPY				
Child	**2007**	**2008**	**2009**	**1 Yr Trend**	**2 Yr Trend**	**2007**	**2008**	**2009**	**1 Yr Trend**	**2 Yr Trend**
CCNC	138	134	123	-7.7%	-10.8%	18	17	17	2.8%	-5.2%
FFS	178	171	162	-4.9%	-8.6%	18	16	16	-4.3%	-12.2%
Adult										
CCNC	335	334	322	-3.4%	-3.9%	57	55	53	-2.9%	-6.6%
FFS	527	705	771	9.3%	46.3%	58	100	119	19.1%	104.0%

Preventable ED visits fell by 9% during this time period.

	Avg Members			OP PMPM					OP Visits PKPY					Preventable OP Visits PKPY				
	2007	2008	2009	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend
CCNC	669,635	739,561	836,901	$51.22	$52.15	$54.46	4.4%	6.3%	2,683	2,710	2,773	2.3%	3.3%	456	414	417	0.8%	-8.6%
FFS	376,942	361,055	343,853	$94.83	$96.30	$99.47	3.3%	4.9%	4,801	4,884	4,824	-1.2%	0.5%	555	505	478	-5.3%	-13.8%

10. CCNC is taking on the challenge of improving care for a growing population with a chronic mental health/substance abuse condition (MHSA).

From 2007 to 2009, the number of CCNC enrollees with a chronic MHSA condition increased by 30% (from 105,552 to 137,520). During this time, PMPM spending for CCNC enrolled adults with MHSA conditions decreased by 10%. Adjusting for risk level, spending for the MHSA population was 4.5% lower than expected in 2009. The non-enrolled FFS population continues to have an actual spend PMPM above expected.

	Population Dist.			CRG Weight				Actual PMPM Spend				Expected PMPM			
CCNC Child	2007	2008	2009	2007	2008	2009	2 Year Trend	2007	2008	2009	2 Year Trend	2007	2008	2009	2009 Variance
MHSA	11.0%	11.1%	11.1%	2.1650	2.2029	2.2482	3.8%	$1,223	$945	$928	-24.1%	$992	$977	$1,001	-7.3%
Non MHSA	89.0%	88.9%	88.9%	0.4208	0.4238	0.4290	1.9%	$172	$175	$181	5.3%	$193	$188	$191	-5.0%
CCNC Adult															
MHSA	34.8%	35.5%	36.8%	3.3635	3.4359	3.4719	3.2%	$1,458	$1,440	$1,489	2.1%	$1,541	$1,524	$1,546	-3.7%
non MHSA	65.2%	64.5%	63.2%	1.3205	1.3271	1.3354	1.1%	$499	$511	$518	3.8%	$605	$589	$595	-13.0%
CCNC Total															
MHSA	15.8%	16.1%	16.4%	2.6969	2.7604	2.8192	4.5%	$1,327	$1,169	$1,190	-10.4%	$1,236	$1,224	$1,256	-4.5%
non MHSA	84.2%	83.9%	83.6%	0.5605	0.5664	0.5716	2.0%	$223	$228	$234	5.1%	$257	$251	$255	-9.1%
FFS Child	2007	2008	2009	2007	2008	2009	2 Year Trend	2007	2008	2009	2 Year Trend	2007	2008	2009	2009 Variance
MHSA	12.5%	12.9%	12.8%	2.6469	2.6976	2.7123	2.5%	$1,702	$1,505	$1,506	-11.5%	$1,213	$1,197	$1,208	24.7%
Non MHSA	87.5%	87.1%	87.2%	0.4642	0.4644	0.4438	-4.4%	$230	$228	$220	-4.4%	$213	$206	$198	11.4%
FFS Adult															
MHSA	25.3%	25.2%	24.6%	3.6533	3.6715	3.6254	-0.8%	$1,856	$1,831	$1,862	0.3%	$1,674	$1,629	$1,615	15.3%
Non MHSA	74.7%	74.8%	75.4%	1.2253	1.2162	1.1811	-3.6%	$599	$598	$589	-1.7%	$562	$539	$526	11.9%
FFS Ttoal															
MHSA	18.1%	18.5%	18.4%	3.2603	3.2970	3.2919	1.0%	$1,796	$1,706	$1,732	-3.6%	$1,494	$1,462	$1,466	18.1%
non MHSA	81.9%	81.5%	81.6%	0.7667	0.7752	0.7673	0.1%	$377	$381	$382	1.3%	$351	$344	$342	11.7%

11. Success in decreasing inpatient utilization and readmissions has been most prominent among CCNC enrollees without mental health diagnoses, improvements are beginning to be realized among enrollees with mental health diagnoses as well. From 2007 to 2009, inpatient admissions decreased by 7.1% among enrollees without mental health diagnoses and readmissions decreased by 5.8% over this period. A different pattern exists for enrollees with a mental health diagnosis. Admissions decreased by 2.6% from 2007 to 2009 but there was an increase of 1.4% from 2008 to 2009. For readmissions, there was an increase of 3.1% over the two-year period but a slight decrease between 2008 and 2009

	PPA PKPY					PPR PKPY				
	2007	2008	2009	1 Yr Trend	2 Yr Trend	2007	2008	2009	1 Yr Trend	2 Yr Trend
CCNC	**26.0**	**24.6**	**24.8**	**0.6%**	**-4.8%**	**6.6**	**6.8**	**6.8**	**-0.6%**	**2.4%**
MH or SA	54.0	51.8	52.6	1.4%	-2.6%	26.7	27.6	27.5	-0.1%	3.1%
Non MH or SA	20.8	19.4	19.3	-0.4%	-7.1%	2.8	2.8	2.7	-5.1%	-5.8%
FFS	**35.6**	**68.0**	**78.7**	**15.7%**	**121.0%**	**15.0**	**15.6**	**15.2**	**-2.7%**	**1.7%**
MH or SA	84.4	165.6	200.3	20.9%	137.4%	54.1	55.0	53.5	-2.8%	-1.1%
Non MH or SA	24.9	46.1	51.6	11.9%	106.7%	6.4	6.8	6.7	-1.6%	4.3%

Status of Enhanced Primary Care Case Management Initiatives

The Enhanced Primary Care Case Management Program, launched in April of 2010, directed NCCCN and the Networks to undertake a set of eight initiatives which are funded through an increase in the per member per month amounts paid to Community Care by the Division of Medical Assistance.

Initiative	Status as of 01-01-2011
Transitional Support and Intensive Care Management A multi- project initiative which focuses on the ABD population to effect comprehensive care management. Workgroups involving Network personnel include Screening Assessment and Care Planning, Polypharmacy, Pediatric Chronic Care, Hypertension/Coronary Artery Disease, Mental Health, Data and Evaluation, the Care Management Information System (CMIS), and Self Management of Chronic Illnesses. Networks aim to reorganize delivery of care in ways that enhance appropriate access, increase service delivery options, improve efficiencies in the identification, assessment and care planning processes, reduce the rate of institutionalization and reduce unnecessary inefficiencies and expenses inherent in the current system. Specific targets include: • Embed chronic care support staff in large ABD practices • Embed chronic care support staff in large hospitals • Develop a central call center to support network activities • Hire additional care managers	All networks have implemented the following care management initiatives and processes in the chronic care program: • Transitional support – 50 care managers have been embedded in practices with high volume Medicaid members and 43 care managers have been embeded in hospitals with high volume Medicaid admissions. The hospital based care managers are working as part of the discharge planning team and beginning to assess, educate and support the patients in their transition out of the hospital setting • 60 new care management positions have been filled • Medication reconciliation – is being performed in the homes of high risk patients within 5 business days from hospital discharge. • Health Care Team – practices are implementing patient centered care planning as part of a health care team when managing the highest risk and cost patients. • Call center work group meets regularly to make recommendations and is visiting potential call center vendors. • A draft RFP will be developed to distribute to potential call centers.

Initiative	Status as of 01-01-2011
Behavioral Health Integration / Coordination This initiative supports the integration of behavioral health services, including mental health and substance abuse, into the 1,400+ primary care practices of the fourteen Networks across North Carolina. The initiative aims at integrating care to consumers in their medical homes across the state. Specific targets include: • Hire Lead psychiatrist at NCCCN • Hire Network psychiatrists & behavioral health specialists • Adopt evidence-based treatment protocols in practices	Accomplishments include: • A lead psychiatrist has been hired at NCCCN as well as a part time pharmacist. • All Networks have hired psychiatrists & behavioral health specialists • Standardized processes and expectations in behavioral health care have been developed across the 14 networks, including evidence based treatment guidelines for depression, ADHD and substance abuse • Providers have been educated as to resources available to support integrated care and training has been conducted for all psychiatrists, coordinators and care managers in Motivational Interviewing **See additional comments in Behavioral Health Initiative – Update (page 38)**
Palliative Care This focuses on addressing the needs of patients and their families involved in end-of-life care. Specific targets include: • Hire part-time physician at NCCCN and 5 additional FTEs to lead a statewide initiative across the 14 CCNC Networks	• A physician lead was hired at NCCCN; all Networks have identified part-time palliative care coordinators • Palliative care training sessions will continue to be conducted across the state through February 2011
Enhance Existing Management of Pharmacy This expands upon existing infrastructure to advance the number of practices engaged in e-prescribing and continues efforts to increase generic prescriptions as a percentage of total prescriptions filled. Specific targets include: • Hire 1 FTE pharmacist at NCCCN and 9 pharmacist FTEs across the 14 CCNC Networks • National benchmarking with Medicaid generic	• 9 FTE's (18 pharmacists) hired to cover the 14 Networks • Enhanced pharmacy program efforts utilizing MD easy, medication reconciliation and e-prescribing • Implemented a contract with SureScripts to secure fill history and fill gaps in pharmacy data

Initiative	Status as of 01-01-2011
Clinical Integrity (analysis of potential Medicaid outliers) NCCCN is assisting DMA's Program Integrity to identify potential outliers situations involving Medicaid services and providers. Specific targets include: • NCCCN, Inc to hire clinical staff to support IBM Software to identify outliers • Each Network to hire a part-time local physician to assist effort	• NCCCN opted to use data analytics tools from Ingenix Inc. rather than IBM to review claims data. • Monthly meetings are held with a dedicated team at DMA Program Integrity to review the results of claims data reviews and PI has begun pursuing potential outliers identified by NCCCN clinicians. • NCCCN has developed a tracking tool to document and monitor follow-up efforts. • A part time physician was hired at NCCCN.
Informatics Center (IC) Enhancements The NCCCN IC is expanding its efforts to integrate data from various sources and provide clinically relevant information to networks, providers and care management partners at the point of care. Specific targets include: • NCCCN to hire 12 FTEs in 2010 and an additional 4 FTEs in 2011 • Develop infrastructure to integrate data and provide clinical information to Networks	• More than 12 FTEs have been brought onboard since inception of the Enhanced initiative to support network infrastructure, data integration and analysis, as well as expand the CMIS and Provider Portal capabilities. Additional hires are scheduled for 2011. • IC has contracted with SureScripts, Lab Corp and TREO to improve and increase data available for population management activities • Integrated enhancement to the Care Management Information System • Launched and upgraded the Provider portal application to support meaningful information exchange across providers and delivery settings • In contract discussions to provide real time data on admissions, discharges and transfers
Privacy Officers and Network Administrators This involves expanding the CCNC Networks' infrastructure to expand the reach of IC capabilities by securing data-use agreements, the creation of IC data user profiles, and the training and support of users. Specific targets include: 16 FTEs to be hired across 14 Networks	• A privacy officer was hired at NCCCN • 12 of the 14 Networks have hired privacy officers • All Networks have hired network administrators • Networks are in the process of signing new data use agreements with external providers. To date, agreements signed with 21 LMEs (local management entities), 270 PCPs (primary care providers) and 21 HDs (health departments)

Initiative	Status as of 01-01-2011
Care Management Collaboration with PCPs Efforts focus on achieving a higher level of clinical integration by having private providers coordinate their clinical case management services with the Networks so that on a case by case basis, patient profiles and key clinical data can be exchanged thereby effecting a more comprehensive plan of care for the individual. Specific targets include: • 12 FTEs to be hired across 14 CCNC Networks to decrease duplication of effort and improve integration of services	• Clinical and data analysis staff have been hired to support the implementation of the pregnancy medical home and coordinated care for children initiatives

Informatics Center- Update

Case Management Information System (CMIS) – A web-based, secure, case management application which contains demographic and claims data on more than 2 million Medicaid recipients (more than 1 million enrolled currently). The application's components reflect a nursing care management model such that care managers and Network staff maintain a single care plan that stays with the recipient when the recipient changes location within the state. The CMIS includes standardized health assessment and screening tools, disease management and coaching modules as well as workflow management features. Operational statistics are as follows:

Time Period	September 2010	October 2010	November 2010	December 2010
Number of unique user log-ins	654	668	679	689
Total successful log-ins	16,379	16,536	15,903	14,571
Number of unique patients accessed	73,369	72,444	68,992	68,418
Average duration of visit	216 minutes	218 minutes	219 minutes	251 minutes
Total pages viewed	2.3 million	2.2 million	2.2 million	2.1 million

Provider Portal – Providers treating patients in various settings can utilize a web-portal to access a Medicaid patient's health record, Medicaid claims history and clinical care alerts, including information generated outside of the provider's local clinic or health system to obtain a "total" perspective. Contact information for the patient's case manager, pharmacist, mental health therapy provider, durable equipment supplier, home-health or personal care service provider is readily available. The roll-out of this application to primary care practices and hospitals is on-going and has been very successful to date. In addition to medical providers, all Local Management Entities (LMEs) now have access to the Portal to enable care coordination and quality improvement in the care of Medicaid recipients with mental health needs. Operational statistics are as follows:

Time Period	September 2010	October 2010	November 2010	December 2010
Number of unique user log-ins	99	127	346	420
Total successful log-ins	654	821	1,581	2,477
Number of unique patients accessed	444	608	2118	3,377
Average duration of visit	unavailable	unavailable	7 minutes	7 minutes
Total pages viewed	unavailable	unavailable	18,969	27,148

Pharmacy Home Application - This medication management platform uses a process of gathering and organizing drug use information from multiple sources (patient medical chart, prescription history, discharge instructions) and sharing this information with providers to identify and resolve urgent and emergent prescription drug duplications, interactions, possible adverse events, poor adherence or other suboptimal drug-taking behaviors. Operational statistics are as follows:

Time Period	September 2010	October 2010	November 2010	December 2010
Number of unique user log-ins	243	234	258	265
Total successful log-ins	unavailable	unavailable	2,451	2,283
Number of unique patients accessed	4,410	4,239	4,581	3,755
Average duration of visit	unavailable	unavailable	8 minutes	9 minutes
Total pages viewed	unavailable	unavailable	20,459	18,798

Data Infrastructure – The Informatics Center has achieved several major enhancements to its data infrastructure and user applications over the past quarter:

Surescripts - The Informatics Center has successfully certified with Surescripts for the MEDS transaction and is now acquiring prescription fill history data for dual Medicare/Medicare clients who are part of the 646 Waiver project. The feeds return a twelve month prescription history and come from multiple pharmacies or prescription benefit plans. Prior to this connection between the Informatics Center and Surescripts, North Carolina did not have visibility into medication information for the Dually Eligible population. Now the Informatics Center will be able to provide prescription fill history to the Pharmacy Home, the Provider Portal and CMIS for care coordination and medication reconciliation. This is particularly helpful for practices that do not yet have an e-prescribing tool that is certified with Surescripts for fill history transactions.

In addition to this inbound flow of information to the Informatics Center, an outbound connection was established with Surescripts so that Medicaid could contribute the Fill History for recipients who have drug coverage with Medicaid. Thus, practices and hospitals that have systems that allow for fill history will be able to see Medicaid enrollees alongside private payors such as Blue Cross and Blue Shield.

Lab Data - NCCCN has completed the process to receive historical and monthly lab results for Medicaid recipients whose lab claims were billed to LabCorp. LabCorp provided six million rows of lab results for billing dates March 2009 – September 2010. This historical data represented labs for 230,000 Medicaid recipients and LabCorp provides an ongoing monthly data feed. Results for 125 selected tests are displayed as part of the patient record in the NCCCN Provider Portal.

Care Alerts - The Community Care Provider Portal now displays care alerts. The care alert rules engine, developed by Clinica, uses three years of claims and eligibility data to identify clients who have not received recommended care for

diabetes, asthma, heart failure, or ischemic heart disease, or who are having preventable ED and inpatient visits for chronic conditions. Other alerts include the need for preventive services such as mammograms, pap smears, colorectal cancer screening, well child visits, dental visits, and fluoride varnishing. Panel-based care alerting is available directly to primary care practices, to enable providers to generate at any time a list of their patients who are overdue for recommended services. The alerts are updated weekly as new claims data is added to the NCCCN data warehouse.

Hospital Admission, Discharge and Transfer (ADT) Data - Through a joint project with the North Carolina Hospital Association, NCCCN is contracting with Thompson-Reuters to supply twice daily feeds of inpatient, outpatient, and emergency room admissions. Additional transaction on the patient may be added later in the day or week and could indicate discharge time and status or movement from the emergency room to an inpatient setting. Transactions include the chief admission complaint and identify the attending physician. Transactions are immediately reported to CCNC care managers in the NCCCN Case Management Information System (CMIS) and are consolidated into reports housed in the NCCCN report site. Thus far, twenty-eight NC Hospitals have signed on to participate in this data sharing relationship, to improve care coordination for Medicaid recipients post-discharge. Once the rollout is complete, NCCCN will receive ADT data from 48 North Carolina hospitals.

646 Medicare Claims Data - NCCCN received enrollment and claims data for the dual Medicaid/Medicare population CMS identified as associated with the practices which are part of the 646 Waiver project. These Medicare claims cover the period October 2008-October 2010 and will be refreshed monthly. The data provides all Medicare Part A and Part B claims for 43,869 dual eligible clients identified by CMS. CMS will also supply pharmacy claims for these participants on an annual basis.

Behavioral Health Initiative – Update

In February 2010, the Division of Medical Assistance (DMA) approved a proposal regarding the integration of behavioral health services into North Carolina's Community Care Network, the **Community Care Enhanced Implementation Proposal**. This Behavioral Health Integration Initiative (BHI) speaks to a unique plan that supports the integration of appropriate behavioral health services, including mental health and substance abuse, into the 1,400 primary care practices of the Community Care Networks (CCNC) across North Carolina, as recommended by the US Bureau of Primary Care. In order to focus and direct the implementation of this plan at the State Level, a lead psychiatrist was hired by the North Carolina Community Care Network Inc. (NCCCN). The local networks have moved forward in hiring psychiatrists and behavioral health co-coordinators to implement the proposal at the network and local levels thus establishing a workforce of licensed professionals to support the BHI. Funding for these additional resources was established by an increase in the per member per month payment made by the Medicaid Program to the Networks and took effect during April, 2010.

The strength of the CCNC program has always been the initiative provided by local providers in recognizing each region's and network's unique needs thus enabling them to address these unique needs utilizing a local response supported and guided by local leadership. This strength was utilized in the authorization for the hiring of ten (10) full-time equivalent psychiatrists and fourteen (14) behavioral health coordinators to serve the 14 networks. As a result, each network has access to a psychiatrist and a mental health coordinator dedicated to the implementation of the Behavioral Health Integration Initiative at the local level.

At the present time, thirteen of the fourteen networks have hired psychiatrists in the position of Network Psychiatrist. The remaining network is actively interviewing and recruiting for the position. Currently there are nineteen psychiatrists filling these positions on a part-time basis in our Networks. Eleven of the fourteen networks have hired a full-time behavioral health coordinator, with the remaining three networks actively interviewing. The lead psychiatrist for the NCCCN, Inc at the state level was hired and has been onboard since June 2010, and a pharmacist with specialized training in behavioral health was hired in September 2010 to support the initiative.

An orientation meeting was held on September 22, 2010 for the network teams and was attended by over 50 individuals from around the state, and each Network was represented. At present a monthly meeting is held by conference call to support and monitor the progress of the Network Psychiatrists and Behavioral Health Coordinators in reaching the goals of the Behavioral Health Initiative.

Training for the Network psychiatrists will continue to enhance their knowledge and skill in working with available data from Pharmacy Home, and the Case Management Information System, applications and also with Medicaid claims system data. The utilization of this data will help the psychiatrists and coordinators to identify practices and providers as well as individual cases that will receive intervention from case management and/or psychiatric input in an effort to improve the quality and reduce the cost of care.

The goals of this unique initiative have been defined as an improvement in performance measures such that the mental health and substance abuse populations experience:

1. **An increase in the number of primary care providers adopting evidence based pathways for the diagnostic categories of depression, Attention Deficit Hyperactive Disorder (ADHD), and substance use disorders.**

   Workgroups consisting of stakeholders representing each diagnostic category have identified specific measures to demonstrate quality process goals in primary care offices that lead to the increased use of evidenced based practices.

   The workgroup with a goal of increasing early identification and intervention of depression has recommended the use of the PHQ-9 questionnaire both as a screening tool and to demonstrate progress in treatment modalities. Treatment algorithms are being identified by the workgroup to support primary care physicians in appropriate use of medications (including appropriate use of generics) and therapies, as well as monitoring the progress of patients identified with depression.

   A pilot project has begun to support the use of generic medications in the treatment of depression. The project involves academic detailing and the provision of generic samples to physician's offices for use in their daily office practice. The goal of this pilot is to increase the use of generic medication in the Medicaid population when the initial diagnosis of depression is made. There is substantial evidence supporting the use of generic anti-depressants as a first line treatment for depression given the comparable efficacy and side effects with the vastly more expensive brand name medicines. Making anti-depressant medications easily attainable and affordable in the event the consumer does not maintain Medicaid coverage is also an added benefit.

   The workgroup addressing Attention Deficit Hyperactive Disorder (ADHD) of children is closely aligned with the Children's Health Insurance Program Reauthorization Act (CHIPRA) team at NCCCN, and the quality measures identified by the CHIPRA team will be used in the behavioral health initiative to train and measure the success of ADHD identification and treatment of children in the CCNC pediatric practices.

   The workgroup on substance use disorders has recommended the use of an evidenced based tool called "Screening, Brief Intervention, Referral and Treatment" (SBIRT) as the intervention to be used when substance use issues are identified. The screening tools recommended by the workgroup are the AUDIT-C plus a drug screening questionnaire and the CAGE-AID. Both of these tools commonly are used at the present time and included in many electronic health records. There will be specific training through webinars and visits to PCP offices by the Network psychiatrists to discuss use of these tools. In addition, active engagement of the specialty substance abuse treatment providers in each region has begun to identify local resources available for the treatment of the individuals identified who have substance use disorders.

2. **An increase in the number of co-located behavioral health and primary care providers in practices**.

A survey of each practice by Network is being conducted to identify the current level of behavioral health integration in primary care practices and the survey results will be reported on in the next quarterly report. In addition, this survey has identified the practices that are willing to consider co-location within their practice in the next year. Meetings with local psychiatrists held by each Network psychiatrist are similarly identifying psychiatrists who are willing to co-locate in primary care offices. The Critical Access Behavioral Healthcare Agencies (CABHA) are also being engaged in meetings to discuss their ability to provide licensed professional behavioral services to primary care offices

3. Attain a 1.2% reduction in psychiatric readmissions.

The goal of decreasing preventable re-admissions to community psychiatric inpatient settings will focus on transition planning between the hospital and the community providers. A major concern has been the lack of transition planning at the time of discharge resulting in lack of follow-up appointments and poor understanding and adherence to a patient's medication regimen post-discharge. The Behavioral Health Coordinators in each Network are in the process of establishing transition guidelines for review of and contact with complex cases discharged from the community psychiatric inpatient units.

Programs currently underway to support the Behavioral Health Initiative also include the introduction of Motivational Interviewing (MI) throughout the CCNC system. This training will use the resources of the statewide AHEC system to provide initial training and technical support for 12 months post-training through a learning collaborative model of education. This evidence based practice in the engagement of patients has the potential to positively affect the provision of care in our heath care system. The goal of MI is to support the patient in assuming more responsibility and authority for their own health care, by identifying specific goals of care they feel are important to them. These identified goals then become mutually supported goals by the health team.

Another educational program involves the AHEC centers using a "lunch and learn" format where each center will provide training material to providers across the state. The first program is planned to address sleep problems and the appropriate use of medications. This will be developed and presented by Vaughn McCall, MD, Chairman of the Department of Psychiatry at Wake Forest University. Other topics have also been identified including the use of generic antidepressants as first line treatments for depression, how to treat resistant depression for future presentations.

While education and training are critical in new evidence based practices, it is clear also that there are ongoing quality of care issues that must be addressed in an integrated system of health care. Several activities are taking place to address quality of care issues. First, a consortium of the four Departments of Psychiatry in our state's medical schools (Duke University, East Carolina University, University of North Carolina, and Wake Forest University) has been brought together to address specific issues of concern in the provision of quality care and in the optimal management of scarce resources.

Second, the use of antipsychotic medications in child and adolescent patients is an issue confronting parents, other caregivers, healthcare professionals, and related organized healthcare agencies across the United States. It is recognized that many antipsychotic medications do not have Food and Drug Administration (FDA) approved labeling for use in children. Further, children and adolescents appear to be at similar or greater risk than adults for a variety of significant side effects related to the use of antipsychotic medications. The North Carolina Division of Medical Assistance, partnering with North Carolina Community Care Networks and AccessCare, is developing and implementing a registry to provide clinical documentation regarding the use of antipsychotic therapy in the child and adolescent Medicaid population, and by doing so, encouraging the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of these agents in child and adolescent patients. Objectives of this

registry include improving the use of evidence based safety monitoring for children and adolescent patients for whom an antipsychotic agent is prescribed, reduction of antipsychotic polypharmacy, and reduction in the number of cases which exceed the FDA approved maximum daily dose. The requirement that safety monitoring be documented in the registry by the prescriber will occur when:

- The antipsychotic is prescribed for an indication that is not approved by the FDA (off-label use).
- The antipsychotic is prescribed at a higher dosage than approved for an indication by the FDA.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotics.

Implementation of the registry is planned beginning as early as March, 2011 and it is our intent to report progress on this as well as the activities discussed above in forthcoming reports.

Grant Funding

NCCCN and individual Networks have achieved success in applying for and receiving grant award monies to conduct a variety of research and demonstration projects In many cases, these are collaborative projects in which NCCCN as well as a Network(s) is engaged with other partners. A listing of projects currently being funded through grant awards is as follows:

Grant Name and Description	Grantor Agency	Term	Amount
NCCCN			
Children's Health Insurance Program Reauthorization Act – to establish and evaluate a national quality system for children's healthcare provided through Medicaid and the CHIP program. There are three projects to enhance the health care delivery system for children: -Implement, collect , report and analyze a set of quality measures -Define and provide an integrated patient-centered medical home model -Implement a model pediatric electronic health record	Center for Medicare and Medicaid Services	Five Years	Total Grant Award approximately $9 million NCCCN Award approximately $6.5 million
Research Capability to Study Comparative Effectiveness in Complex Patients – to analyze healthcare needs and services utilization of medically indigent and uninsured patients who have complex medical and psychiatric co-morbidities	Agency for Healthcare Research and Quality	Two Years	Approximately $990 thousand
Telehealth Heart Monitoring – to improve outcomes for high-risk Medicaid recipients with heart failure by using telemonitoring technology.	Agency for Healthcare Research and Quality	Eighteen Months	$20,000
Medicaid Emergency Room Diversion Grant –to reduce non-emergent use of hospital emergency departments.	Center for Medicare and Medicaid Services	Two Years	$2,260,531 (2.2M)
Network			
Northwest Community Care Network			
HealthNet Grant Funds for Indigent Care	NC General Assembly	Two Years	$635,000
Co-located resources in primary care practices	K B Reynolds Foundation	One Year	$260,000
Community Health Partners			
Early Intervention Award		One Year	$41,000
Northern Piedmont & Community Care Partners			
HealthNet Grant Funds for Indigent Care	NC General Assembly	Two Years	$355,000
Co-located resources in primary care practices	K B Reynolds Foundation	One Year	$100,000
Community Care of Wake & Johnston Counties			

Grant Name and Description	Grantor Agency	Term	Amount
Su Hogar Medico Award – to address access to pediatric care by Spanish speaking patients	John Rex Foundation	Four Years	$462,000
Community Care of Western North Carolina			
HealthNet Grant Funds for Indigent Care	NC General Assembly	Two Years	$905,000
Mission Uninsured – to develop and implement a care management program to serve under and uninsured residents of Madison and Buncombe counties.	Mission Hospital Foundation	One Year	$116,000
Near Miss Study – to conduct a study of near-miss event reporting (acts of commission or omission that could have harmed a patient but did not).	Agency for Health Research and Quality		$195,000
Sandhills Community Care Network			
HealthNet Grant Funds for Indigent Care	NC General Assembly	Two Years	$390,000
Carolina Community Health Partnership			
Address Safer Opioid Prescribing – to hold educational sessions with physicians, physician assistants and nurse practitioners and provide toolkits	Governor's Institute on Alcohol and Substance Abuse	Not Applicable	$9,500
Southern Piedmont Community Care – Beacon Community Project – implementing a new generation of health information exchange services	Center for Medicare and Medicaid Services	Three Years	$13 million
State Health Access Grant – to link low income uninsured residents to Community Care Networks and Medical Homes	Office of Rural Health and Community Care	Five Years	$17 million