Community Care of North Carolina:

A Provider-Led Strategy for Delivering
Cost-Effective Primary Care to Medicaid Beneficiaries

Executive Summary
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Executive Summary

Community Care of North Carolina (CCNC) is a Medicaid care management program that has demonstrated significant cost savings, improved health outcomes, and increased access to care for almost 700,000 Medicaid beneficiaries. Evolving from the Medicaid managed care programs of case management and capitated HMOs of the 1990s, CCNC has become a proven model of community-based, integrated care coordination and management.

Background

North Carolina has a rich history of developing community-based health care systems. The core belief guiding the state's role in providing health care to underserved populations is that if improvement in health care and service is the goal, those responsible for making it happen must have true ownership of the improvement process. While most states were considering a more traditional managed care option for Medicaid in the 1990s, North Carolina's Office of Research, Demonstrations and Rural Health Development, in concert with the North Carolina Academy of Family Physicians and the North Carolina Pediatric Society, decided in 1991 to pilot an alternative to traditional managed care—an expansion of the primary care case management model known as Carolina Access. By 1998, Carolina Access had grown to include nine networks and 20 primary care practices, prompting the state to require Medicaid recipients in those locations to choose an Access practice/primary care provider.

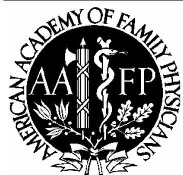
That same year the state piloted Community Care of North Carolina in the nine Access networks with the aim of further improving quality and containing costs. The objective was to develop health care systems able to support programs and infrastructures that manage the Medicaid population through "integrated community management." These pilot programs identified several core components for such systems, including disease and care management, population management, utilization management, quality improvement, and guidelines for evidence-based practice.

Principles, Planning and Payment

As state government and health providers analyzed how best to build an optimum health care system for Medicaid recipients, four key concepts emerged:

- The importance of local control and physician leadership in building sustained community care systems;
- A primary focus on improving quality of care through population management;
- The necessity of creating a true public/private partnership that brings together all the key local healthcare and social service providers, or face control by 'outside forces;' and
- A shared state/local responsibility to develop tools needed to manage the Medicaid population, including a system of new incentives that better align state and community goals with desired outcomes.

Through local networks, primary care physicians work with other community providers and case managers to develop tools, information and support needed to coordinate prevention, treatment, referral and institutional services for Medicaid beneficiaries.



Today, Community Care of North Carolina consists of 15 local networks across the state, including more than 3,000 physicians practicing in collaboration with local health departments, hospitals, social service agencies, and other community providers, that manage the care of about 74 percent of all eligible Medicaid beneficiaries in the state.

Through CCNC, the state provides resources, information and technical support to the local networks, enabling them to take responsibility for planning and developing programs to manage the care of these enrollees—from the provision of preventive services to the development of processes by which at-risk patients are identified and their care managed before high cost interventions are necessary. All CCNC networks are 501(c)(3) non-profit organizations that receive a $2.50 per member per month (PMPM) Medicaid enhanced care management fee which is used to hire local case managers or otherwise pay for the resources necessary to manage enrollees. Each network elects a physician to serve as their medical director. Local medical directors participate on a statewide board of clinical directors responsible for steering disease and case management initiatives of the CCNC program. These medical directors have designed and implemented program-wide clinical improvement initiatives in several areas, including:

- Asthma and diabetes management
- Congestive heart failure
- Pharmacy initiatives addressing cost and utilization
- Hospital emergency department utilization
- Management of enrollees and services at highest risk and cost

CCNC primary care providers (PCPs) are required to participate in network activities, including following recommended clinical practice guidelines, assessing patients and developing treatment plans, educating patients about how to manage their own care and using appropriate medical equipment, providing clinical information for management systems, providing '24/7' coverage under program rules, and carrying minimum liability insurance. PCPs receive an enhanced case management fee of $2.50 PMPM, and are paid 95 percent of the Medicare fee schedule for Medicaid covered services.

Case Management

Case management is a critical component of CCNC. Case managers are responsible for helping identify patients with high risk conditions or needs, assisting the providers in disease management education and/or follow-up, helping patients coordinate their care or access needed services, and collecting data on processes and outcomes measures. Case managers may serve as a patient advocate and intervene with other community-based health and social service organizations to assure the patient receives all necessary and coordinated services for optimal health outcomes.

Case managers also utilize a web based case management information system to document interventions. A case identification data base, which enables case managers to identify individuals who might benefit from their services, contains claims information on network enrollees, such as diagnosis, cost, procedure/drug information and utilization. Each case, once identified and recorded in the CCNC Care Management Information System or similar data base, provides a clear illustration of problems, interventions, goals and cost savings. The data base is examined to identify implementation of best practice guidelines, achievement of clinical outcomes (e.g., reduction in HbA1c in patients with diabetes), and changes in utilization patterns (e.g., reduction in hospital emergency room visits).

Demonstrated Cost Savings and Quality Improvement

To date, two major evaluations of the CCNC and Carolina Access programs reveal considerable cost savings and quality improvement. A study performed by Mercer Government Human Services Consulting found ***the Carolina Access program***, when compared to historical fee-for-service program benchmarks, ***saved the state $195 to $215 million in 2003 and between $230 and $260 million in 2004***.
In comparison to what the Carolina Access program would have cost with any concerted effort to control costs, Mercer also found the program ***saved between $50 and $70 million in 2003 and between $118 and $130 million in 2004***.

Moreover, an evaluation of CCNC disease management initiatives performed by the University of North Carolina found the costs to CCNC of caring for Medicaid patients with asthma and diabetes to be much less than for those Medicaid patients served in the Access program. ***The study concluded that over three years (2000-2002) the state would have saved about $3.3 million for CCNC enrollees with asthma (especially individuals 45 years of age and older) and approximately $2.1 million for CCNC patients needing diabetes care, both associated with significant changes in utilization and other practice measures (i.e., reduction in hospital emergency room visits).*** The evaluation focused primarily on the effects of disease management and adherence to practice guidelines; no evaluation of the effect of case management services independent of disease management has been performed.

In 2006-2007, CCNC plans to implement additional disease management programs, including managing enrollees with congestive heart failure and chronic pulmonary disease. In 2005, four local CCNC networks also began piloting a collaborative approach to managing Medicaid enrollees with both behavioral and physical health needs to serve them in the most appropriate setting.

Conclusion

Primary care physicians interviewed reported their Medicaid patients received overall better care, and caring for Medicaid patients was more desirable, due to their participation in CCNC, particularly for the following reasons:

- Added services of case managers;
- Added PMPM care management fee *and* enhanced Medicaid fee-for-service payment (95% of the Medicare fee schedule); and the
- Opportunity to participate in development/application of evidence-based clinical guidelines.

Nationwide, family medicine is in a unique position to improve the quality and lower the cost of care delivered to Medicaid patients by advocating that states re-design their Medicaid care management programs based on this proven CCNC model.