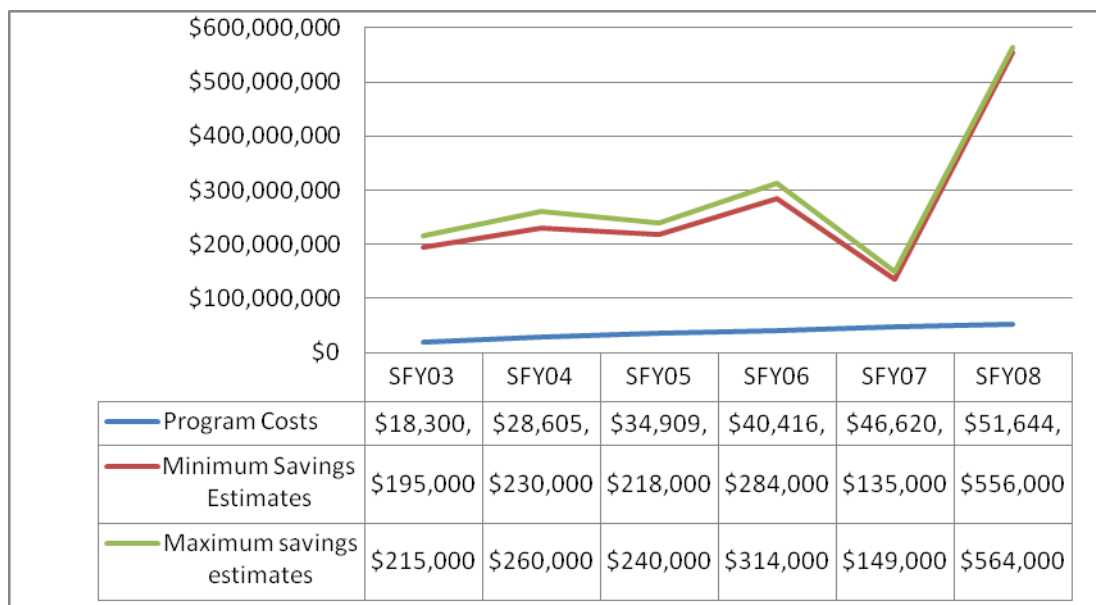


Community Care Highlights and Facts!

Facts on the Financial Analyses:

- According to the National Governors Association/National Association of State Budget Officers State Expenditure Report (published Dec 2009), North Carolina was one of only three states in the nation to have a DECREASE in total Medicaid spending between FY 2008 and FY 2009. Total Medicaid spending decreased by 2.5% in North Carolina, while increasing by 7.8% nationwide. State spending for Medicaid decreased by 12% during this time frame.
- Every independent actuarial assessment of Community Care commissioned by the state has attributed hundreds of millions of cost savings to the program.



- From 2003 – 2007, CCNC has saved \$568 million for AFDC and \$400 million for ABD (Mercer).
- Through January 2010, per-member-per-month (pmpm) costs have been running 5.3% below 2009 pmpm costs. The state projected a 5.8 percent increase in 2009, but with a 5.3% decrease, overall savings of 11% (equaling approximately \$ 1.2 billion) have been achieved.

Facts on the Delivery System:

- The patient-centered medical home model is the national aspiration for a delivery system based on “best practices”. Community Care has >990,000 of North Carolina’s 1.4 million Medicaid recipients enrolled in medical homes, serving our most vulnerable population. Unlike some commercial managed care entities, there is no “cherry picking” in Community Care, and the very highest-risk and highest-cost patients are enrolled and welcome regardless of their disability, disease burden or risk profile.

- Community Care is in all 100 North Carolina counties; most managed care companies will serve only densely-populated urban areas.
- All of North Carolina’s academic medical centers and largest health care systems are involved in and supportive of Community Care.
- Every network has a local organization (hiring local residents) to provide care managers, pharmacists, medical directors and other professionals to improve the healthcare delivery system. Solutions are locally driven.
- Community Care networks have almost 500 employees and provide access for Medicaid recipients to over 4,200 primary care providers statewide.
- All 14 networks work collaboratively and in partnership with local hospitals, health departments, local management entities (LMEs) and departments of social services (DSS offices). These collaborations maximize Medicaid dollars by eliminating duplicative services and enhancing patient and family-centered care.

Facts Comparing Enhanced PCCMs and HMOs:

- Mathematica Policy Research examined NC and four other states with enhanced PCCM (Primary Care Case Management) models and found that “enhanced PCCM programs may equal or exceed capitated MCO (managed care organizations) programs on measures of access, cost and quality, but only if states devote substantial resources to designing, implementing, managing and funding the enhancements”, similar to NC’s investment.
- Mathematica Policy Research evaluated Oklahoma’s enhanced PCCM model (“SoonerCare”) and found “with sufficient resources and leadership commitment, state Medicaid agencies can manage care at lower costs than MCOs and with similar outcomes. Annual per-member-per-month costs in Oklahoma have been significantly below the average of states operating MCOs”. Oklahoma modeled their program after Community Care.
- Mercer Government Human Services Consulting performed a comparative cost analysis between Pennsylvania’s PCCM (ACCESS Plus) and their voluntary HMO and found the following results (Pennsylvania modeled their PCCM after CCNC):
 - Access Plus has sicker members than does voluntary managed care;
 - Access Plus risk-adjusted medical expenses were 4% less than the voluntary HMO’s;
 - Access Plus administrative costs were almost 50% lower than the HMO’s.

Facts on Quality Improvement:

- CCNC performs as well as, or better than, 90% of commercial Medicaid managed care organizations nationally on quality measures related to diabetes care (glycemic control and cholesterol management), cholesterol management in cardiovascular disease, asthma care, and childhood immunizations.

- Community Care’s performance is in the top 10% nationally in HEDIS measures for diabetes, asthma and heart disease compared to Medicaid managed care organizations.

Facts on Community Care’s National Reputation:

- North Carolina’s Community Care program has received widespread national acclaim, with accolades in leading health policy journals, medical journals, congressional testimony, and major media outlets (see resources below).
- Community Care represents a 20-year investment by NC and has been recognized nationally as the best practice available – North Carolina truly is the “home of the medical home”!
- Community Care received the Innovation in American Government Award from the Ash Institute, John F. Kennedy School of Government at Harvard University; and the “Innovations Award in Children and Family System Reform” from the Annie E. Casey Foundation in 2007.
- North Carolina has been featured as a “best practice state” by the Agency for Healthcare Research and Quality (AHRQ) for Medicaid quality improvement and Medicaid care management.
- Many states are actively developing models based on Community Care. Officials from over 35 states and several national organizations have requested guidance from North Carolina in replicating the program’s success. The Commonwealth Fund has provided a grant to the NC Foundation for Advanced Health Programs to build online resources to assist other states and organizations.
- Issues Research, Inc. (McCarthy and Mueller, 2009) wrote a case study for the Commonwealth Fund entitled “Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnerships”, highlighting the program’s success in cost savings while promoting improvements in care of patients with chronic conditions.
- The Kaiser Commission on Medicaid and the Uninsured featured CCNC in a policy brief in May 2009, highlighting the program as an enhanced medical home model and the program’s success in impacting quality and costs.
- The Center for Health Care Strategies, in collaboration with the California Department on Health Care Services with support from the California HealthCare Foundation, identified North Carolina as a best practice state due to the program’s impact on quality performance measurements.
- The Commonwealth Fund supported a publication by Issues Research, Inc. that highlights fifteen best-practice studies on organized health care delivery systems able to demonstrate improved performance. Community Care was one of the 15 delivery systems chosen, including others such as Geisinger Health System, Group Health Cooperative, Kaiser Permanente, Mayo Clinic and Intermountain Health Care.

Health Care Reform Facts:

- FMAP (Federal Medical Assistance Percentages) increases will decrease the state appropriation through 2018 if acted upon correctly, while increasing the number of residents eligible for Medicaid.
- FMAP increases will also increase revenue into the state in the form of income tax and services.
- Federal funds will cover the additional costs to states to increase Medicaid payment rates to primary care physicians to 100% of Medicare in 2013 and 2014.
- Federal Medicaid matching payments will be provided for the costs of services to newly eligible individuals at the following rates: 100% in 2014, 2015 and 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% thereafter. The FMAP “cliff” is greatly diminished as a result.

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