A History of CCNC

The Evolution of Community Care of North Carolina

While North Carolina is widely recognized for its innovative statewide medical home and care management system, few individuals outside of the program understand the evolutionary process by which North Carolina developed this program. Community Care of North Carolina (CCNC) did not rise up as a finished vision; rather, it evolved slowly and steadily over 25 years, adjusting to changing needs and constantly refining its approach. That cycle of continuous quality improvement continues as CCNC prepares for the new Medicaid system and partnerships with health plans on Medicaid, Medicare and commercial populations.

What follows is an overview of CCNC's origins and development to this point.

Founding Organizations

Over this quarter-century, a wide range of organizations has contributed to CCNC's success. Four of those groups have been involved at every stage of the program's development.

North Carolina Office of Rural Health and Community Care (ORHCC)

Under the leadership of Jim Bernstein, its founder and long-time director, the Office of Rural Health and Community Care (ORHCC) has for more than 35 years helped North Carolina's rural and underserved communities develop health services for low-income and vulnerable populations. In addition to developing a statewide network of Rural Health Centers, ORHCC has worked with the Division of Medical Assistance (NC's Medicaid agency) and other agencies within the North Carolina Department of Health and Human Services to develop community-based approaches to improving care and care outcomes for underserved populations. These efforts have included statewide or regional efforts to improve primary care, behavioral health, long-term care, and hospital and school health services. ORHCC has been responsible for program operations, technical assistance, training, data, and reporting for early development phases in the creation of CCNC.

North Carolina Division of Medical Assistance (DMA)

North Carolina's Medicaid agency has worked closely with ORHCC in promoting and supporting public, private, state, and community partnerships to improve the quality, efficiency and cost-effectiveness of care for Medicaid recipients. DMA provided financing and aligned policy and regulation to support the development and operation of CCNC.

North Carolina Foundation for Advanced Health Programs, Inc.

The Foundation is a non-profit organization established in 1982 to facilitate the development of public-private programs that improve access to efficient and high-quality care for North Carolina's low-income and underserved populations. Since its inception, the Foundation has served as an important catalyst, promoting public and private state and local development efforts. Much of CCNC's piloting and testing has been sponsored by the Foundation.

Kate B. Reynolds Health Care Trust

One of North Carolina's oldest and largest health care philanthropies has used its voice and resources to support organizations that address the health needs of the vulnerable, underserved and economically disadvantaged. At each critical juncture in CCNC's evolution, Kate B. Reynolds (KBR) could be counted on for encouragement and vital seed funds to develop and test key innovations. During the program's early development, KBR provided six grants totaling more than $1.6 million.

Early Development Steps Prior to the Launching of CCNC

A look at steps prior to launching CCNC's current business model.

Wilson County Health Plan (1983-88)

In 1983, North Carolina's Medicaid program was a fee-for-service program that sought to encourage more physician participation in Medicaid, thereby improving access and reducing recipient reliance on the hospital emergency room. In an effort to test approaches for improving primary care physician participation in Medicaid, the North Carolina Foundation for Advanced Health Programs, in partnership with DMA and ORHCC,

submitted a proposal to KBR to pilot North Carolina's first effort at developing medical homes for Medicaid recipients. The Foundation received a KBR grant to work with health organizations in Wilson County, a mostly rural county about one hour east of Raleigh.

With a population of approximately 100,000 residents and located in the heart of tobacco country, Wilson County's health infrastructure included two mid-size multi-specialty group practices, a 250-bed community hospital, a county health department and a county department of social services. The grant provided funding that enabled these health organizations to work with the state and the Foundation to develop the Wilson County Health Plan.

Under the Wilson County Health Plan, systems and processes were designed and implemented to enable Wilson County Medicaid recipients to enroll with Wilson County's primary care and group practices. These practices agreed to assume responsibility for providing direct services and coordinating enrollee care. A key goal of the project was to reduce the reliance on the hospital emergency room for non-emergency care. The Wilson County Department of Social Services handled recipient education and enrollment while DMA made the changes to the state's eligibility and payment systems that were needed to operate the pilot.

During the implementation phase, 1,500 Medicaid recipients became members of the Wilson County Health Plan. An evaluation of the plan's first year showed a 58 percent decline in emergency room use among enrollees and a savings to the state of $300,000 for the 12-month period. Although the basic operation was considered a great success, a proposed segment of the plan was never implemented. As originally proposed, participating providers would receive a monthly prepaid payment for each enrollee. This proposed payment was designed to cover all outpatient expenses and incent practices to provide more care within the primary care office. Unfortunately, the state's payment system could not accommodate this payment change within the demonstration period.

Carolina Access (1989-1997)

With the success of the Wilson County Health Plan, KBR approached the Foundation, ORHCC and DMA in 1989 to gauge interest in expanding the medical home model to additional North Carolina counties. The response was immediate and enthusiastic, and KBR agreed to provide a three-year grant to help make it happen.

From 1989 to 1991, the Foundation (in concert with DMA and ORHCC and with funding from KBR) began expanding the medical home program, which was to become known as Carolina Access, to 12 counties (Beaufort, Burke, Durham, Edgecombe, Greene, Henderson, Madison, Moore, Nash, Pitt, Wayne and Wilson). While built on the Wilson

County Health Plan, the Carolina Access program adopted a new payment mechanism from Kentucky's Ken Pac program. Participating primary care providers would receive $3 per-member per-month payment for each Carolina Access enrollee they served. For this payment, the physician agreed to provide and coordinate an enrollee's care and authorize specialty referrals. As part of this expansion, DMA/ORHCC secured a 1915(b) federal waiver to operate this "Primary Care Case Management" (PCCM) program and to develop the needed state support and system changes.

With the successful launch of Carolina Access, DMA (with support from the North Carolina General Assembly and the Health Care Financing Administration) began to expand Carolina Access statewide in 1992. By mid-1993, 45,649 Medicaid recipients were enrolled in Carolina Access, and 469 primary care physicians were participating in the program. By the end of 1997, Carolina Access was in place in 99 out of 100 North Carolina counties (Mecklenburg County remained a managed-care-only county). More than 650,000 Medicaid beneficiaries were enrolled, and more than 2,000 primary care physicians were participating in the program. The Carolina Access program had achieved its primary goals of providing the majority of eligible enrollees (more that 70 percent of women and children recipients were enrolled) with a medical home and in decreasing emergency room visits in non-emergency situations (a reduction of 30 percent).

Early Days of Community Care of North Carolina (1997-2001)

Piloting a new system

In the mid-1990s, a number of federal proposals circulating in Washington, D.C. called for shifting more of the financial responsibility for Medicaid to the states. With this looming prospect, the Secretary of the North Carolina Department of Health and Human Services asked senior leadership from the Office of Rural Health and DMA to work with the Foundation and other organizations to plan a next-generation Medicaid program that could provide better budget predictability and control. With the assignment came two design directives from the Secretary. First, organizers were asked to build on Carolina Access by creating a medical home model that could improve the quality and cost-effectiveness of care as it improved access. Second, organizers were asked to retain physician support and participation and to achieve lasting improvements in care and care outcomes, focusing design efforts on improving the quality of care rather than seeking quick cuts in program costs. Then-Secretary of Health and Human Services Dr. David Bruton, a pediatrician, was convinced that quality care would be cost-effective care.

In designing the new program, planners worked with state and local medical and government leaders. From this planning effort came the conviction that to improve quality and cost-effectiveness of care, the program must strengthen the medical home by enhancing the ability of the primary care physician to improve care and care outcomes for

patients with chronic illnesses through four new program elements.

- *The Formation of Networks*
  Physicians would be encouraged to work together locally and with other community health organizations that provide direct patient care (e.g., public health departments, hospitals, social services departments and mental health agencies) to cooperatively plan for meeting recipients' care needs. The primary focus was on recipients with chronic conditions. Chronic illness accounted for a majority of Medicaid expenditures and the local systems through which these patients received care needed major reform.

- *Introduction of Population Management Tools*
  To arm the primary care physician and practice with the support and tools to improve care outcomes, the new program would include population management approaches: evidenced-based programs and protocols; disease management programs; care management tools; pharmacy management tools; and practice-based improvements.

- *Case Management and Clinical Support*
  The new program would also provide the care and case management support needed by physicians to help manage those patients with complex medical, social and behavioral health conditions who tended to get lost in the existing system.

- *Data and Feedback*
  Because until this point physicians had limited information on either patient outcomes or progress in improving care, the new program would focus on providing timely and relevant information on how patients and interventions were faring and highlighting opportunities for improvement.

After the Secretary endorsed the draft plan in 1997, a statewide meeting was convened with health and civic leaders to discuss the plan, solicit feedback and secure support for conducting a pilot. There was near unanimous support for the approach. The next step was to gauge the level of interest of key physicians participating in the Carolina Access program. In early 1998, the Secretary asked all Carolina Access practices with at least 2,000 enrollees (36 practices) to indicate their interest in partnering with the State. The response was overwhelming – all but one practice wanted to participate.

Practices were given two options: (1) they could work together as physician groups and form a horizontal network that would cross many communities; or (2) they could join with other local practices and health organizations to form a community network. Twenty-six practices, almost all of them pediatric, applied to work together to form a statewide physician's network. Nine practices wanted to form community networks (Pitt, Durham,

Surry, Guilford, Cabarrus, Buncombe, Gaston and Cleveland counties). Each of these new networks represented a different lead provider (private physician groups, Academic Health Center, Health Department, FQHC, PHO), but all formed under a similar principle of being not-for-profit and collaborative.

In early 1998, the state received approval from the Health Care Financing Administration to amend its 1915(b) federal waiver to develop the successor program to Carolina Access, which was initially known as Carolina Access II and Access III. With federal approval secured, the new program began as a pilot in July of that year.

Community Care of North Carolina (2001-present)

The official launch

January 2001 marked the beginning of a new administration for North Carolina and DHHS, as incoming Governor Mike Easley appointed Carmen Hooker Odom Secretary of Health and Human Services. Secretary Hooker Odom asked Jim Bernstein, the long-time leader of the ORHCC, to join her as Assistant Secretary of Health and Human Services. The first year saw major budget pressure on Medicaid because of a state economic downturn. While there were excellent early results in quality improvement and cost savings with the Access II and III program, the program involved only 10 counties plus the large pediatric network, far from a statewide program.

After a careful review, Secretary Hooker Odom determined that Access II and III should be expanded statewide as the major initiative to manage Medicaid cost and quality and renamed the program Community Care of North Carolina (CCNC). The next four years saw the expansion of local networks to adjoining counties and the organization of new networks covering the majority of North Carolina. As of May 2011, 14 CCNC networks cover all 100 counties in the state, serving more than one million enrollees (1,000,024 Medicaid recipients and 70,000 low-income uninsured residents through the HealthNet Program).

In 2005, Dr. Allen Dobson, an early leader of CCNC, succeeded Jim Bernstein as Assistant Secretary of Health and Human Services and the state's Medicaid Director. Although CCNC had achieved good results in managing the Aid to Families with Dependent Children (AFDC) population, the Medicaid budget still experienced high yearly cost growth. Dr. Dobson asked CCNC to begin to manage the most costly Medicaid recipients, i.e., the aged, blind and disabled. The General Assembly appropriated $6 million of state funds for the program to extend its community-based model to aged, blind, and disabled recipients. After two years of intense work on this pilot, the major chronic care initiative was rolled out program-wide with excellent results.

Late in 2005 Secretary Hooker-Odom, Dr. Dobson, Torlen Wade, the head of the ORHCC and early leader of CCNC, and Dr. Bill Roper, dean of the UNC School of Medicine and former administrator of the Health Care Financing Administration, presented to Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan a plan to extend CCNC's role to the management of recipients dually eligible for Medicare and Medicaid and at-risk Medicare recipients. This group proposed a shared savings demonstration with Medicare and led to the formation of a central organization representing all 14 CCNC networks to apply to the CMS for the demonstration project.

Through its new central organization, CCNC in late 2006 applied to the CMS to participate in a five-year Medicare Quality Demonstration (646) to "improve the equality of care and service delivered to Medicare beneficiaries through major system redesign." Under this demonstration, CCNC managed approximately 44,000 dually eligible beneficiaries in the first two years. At the beginning of the third year, an estimated 173,808 Medicare-only beneficiaries were added to the demonstration.

In 2006, the Governor's health policy staff and DHHS began work on a statewide public-private quality initiative that brought together the state's largest insurers (Blue Cross and Blue Shield of North Carolina, the State Employee Health Plan and Medicaid) and providers (the North Carolina Medical Society, the North Carolina Pediatric Society, the North Carolina Academy of Family Physicians and the University of North Carolina School of Medicine) to collaboratively develop and implement a common set of best medical quality standards and measures for five diseases and/or conditions (asthma, diabetes, congestive heart failure, hypertension and post myocardial infarction care). All participants agreed to implement the Governor's Quality Initiative through the CCNC system, and the initiative was launched in 2008.

In 2007, CCNC received the prestigious Annie E. Casey Innovations in American Government Award from the Ash Institute at the Kennedy School of Government at Harvard University for its work in improving health care services for Medicaid and other populations.

In late 2007 a decision was made to gradually transfer much of the responsibility of additional CCNC program development and support from the state to the new central not-or-profit organization representing all 14 CCNC networks. This would allow for the development of a robust informatics support system to help networks manage recipients and to provide for stability of leadership as CCNC became the key foundation for many of the state's health care initiatives. Fortunately today, many of the early CCNC leaders are still actively involved in this important program: Drs. Dobson, Bruton, Jones, Wegner, Willson, Earl, Tilson, Ponzi and Clements, along with Torlen Wade and Denise Levis-Hewson, among others. As health care reform discussions have sparked much activity across the country, CCNC remains a foundational element in much of the work in North

Carolina to achieve improved quality at lower costs.

These efforts have been estimated to save millions of dollars each year, as calculated by external evaluations. A June 2011 analysis from Treo Solutions, found that CCNC saved nearly 1.5 billion dollars in 2007, 2008 and 2009 alone. A report issued in 2015 by the North Carolina State Auditor estimated CCNC savings at 9 percent, working out to approximately a 3-1 return on investment for the Medicaid program.

Earlier studies by Mercer, Inc. estimated CCNC savings as:

State Fiscal Year	Estimated Savings*
SFY05	$77M-$81M
SFY06	$154M-$170M
SFY07	$135M-$149M
SFY08	$156M-$164M
SFY09	$186M-$194M