Health and Human Services

Richard O. Brajer
Secretary

Courtney M. Cantrell, Ph.D.
Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

March 1, 2016

The Honorable Marilyn Avila, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
2217 Legislative Building
Raleigh, NC 27601

The Honorable Josh Dobson, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
301N Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Louis Pate
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
1028 Legislative Building
Raleigh, NC 27601

Dear Chairmen:

Session Law 2013-360, Section 12F.4A.(e) requires the Department of Health and Human Services to report on the progress, outcomes, and savings associated with the implementation of clinical integration activities with Community Care of NC (CCNC) every six months, beginning March 1, 2014. Pursuant to the provisions of law, the Department is pleased to submit the fifth report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on March 1, 2016.

The attached report details the work and progress made by the Department with CCNC and the Local Management Entity – Managed Care Organizations.

Should you have any questions, please contact me at (919) 733-7011.

Sincerely,

Courtney Cantrell
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Director

Health and Human Services

Richard O. Brajer
Secretary

Courtney M. Cantrell, Ph.D.
Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Attachment

cc:

Andy Munn	Kolt Ulm	Marjorie Donaldson
Brian Perkins	Theresa Matula	Rod Davis
Denise Thomas	Sarah Newton	reports@ncleg.net
Pam Kilpatrick	Susan Jacobs	Dale Armstrong
Patricia Porter	Joyce Jones	Courtney Cantrell

Health and Human Services

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Courtney M. Cantrell, Ph.D.
Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

March 1, 2016

Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
619 Legislative Office Building
Raleigh, NC 27603-5925

Dear Director Trogdon:

Session Law 2013-360, Section 12F.4A.(e) requires the Department of Health and Human Services to report on the progress, outcomes, and savings associated with the implementation of clinical integration activities with Community Care of NC (CCNC) every six months, beginning March 1, 2014. Pursuant to the provisions of law, the Department is pleased to submit the fifth report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on March 1, 2016.

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Behavioral Health Clinical Integration and Performance Monitoring

Session Law 2013-360, Section 12F.4A.(e)

Semi-Annual Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

by

North Carolina Department of Health and Human Services

March 1, 2016

Executive Summary

Session Law 2013-360, Section 12F.4A.(e) requires the NC Department of Health and Human Services (Department or DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the progress, outcomes, and savings associated with the implementation of clinical integration activities with Community Care of NC (CCNC) every six months starting March 1, 2014. This is the fifth report.

Since January 1, 2014, CCNC and the Local Management Entity/Managed Care Organizations (LME/MCOs) have entered into data agreements to ensure that critical information is shared and mutually available. CCNC is in possession of claims data from each LME/MCO dating back to the implementation of the 1915(b)(c) waiver. The process for sharing data is currently inefficient. DHHS is currently testing processes that would allow CCNC to access Medicaid claims data directly from NC Tracks.

DHHS has required LME/MCOs to engage in integration activities with local CCNC networks since the implementation of the 1915(b)(c) waivers. This is identified in each of the Division of Medical Assistance's (DMA's) contract provisions. DHHS, LME/MCO representatives, and CCNC meet regularly to collaborate on the Total Care initiative named in legislation. The group documents local initiatives to integrate care for individuals with complex physical and mental health needs. DHHS currently employs standardized performance measures and statistics as a part of routine LME/MCO monitoring. DHHS convened an integrated care outcome measures workgroup consisting of LME/MCOs, CCNC, and outside experts to develop measures that will incentivize and measure mental health, substance use disorder, intellectual/developmental disability, and physical health integration.

Total Care Implementation

SECTION 12F.4A.(a) *The Department of Health and Human Services shall require local management entities, including local management entities that have been approved to operate the 1915(b)/(c) Medicaid Waiver (LME/MCOs), to implement clinical integration activities with Community Care of North Carolina (CCNC) through Total Care, a collaborative initiative designed to improve and minimize the cost of care for patients who suffer from comorbid mental health or substance abuse and primary care or other chronic conditions.*

The DMA contract with the LME/MCOs requires each LME/MCO to partner with local CCNC networks. In response to these contractual requirements, CCNC networks and their LME/MCO partners have developed innovative, collaborative projects to integrate physical and mental healthcare. These projects reflect the needs of consumers and the unique needs of the communities in which they live. LME/MCOs and CCNC have also entered in data agreements to ensure that critical information is shared and available. The information on the next page is a point in time sampling of some of the projects underway through these partnerships. While not an exhaustive listing, the activities in

this report provide a snapshot of integrated care efforts for Medicaid recipients across the state.

There are 28 different overlaps between CCNC networks and LME/MCOs. The number of partnerships that each CCNC network has with LME/MCOs varies. For example, four of the CCNC networks only work with one LME/MCO, whereas one LME/MCO works with six CCNC networks. This creates different types of opportunities. Multiple partnerships facilitate opportunities for innovation and growth, while limited numbers of individual partnerships promote more effective coordination.

Below is a list of targets of joint efforts between LME/MCOs and CCNC local networks:

- Emergency Departments
- Prescribing Education for Practices
- Chronic Pain Treatment (including Naloxone)
- Children and Adolescents in Foster Care
- Pregnant Women with Opioid Addiction

Other promising practices facilitated by LME/MCOs and CCNC local network partnerships include:

- Integrated Healthcare and Transitional Care Teams (formal and informal)
- Behavioral Health and Primary Care Provider “meet and greet” Events
- Regional LME/MCO and CCNC Network Meetings
- Concerted Coordination Efforts with Regional Psychiatric Hospitals
- Pharmacy and Medication Reconciliation
- Healthy Ideas (depression management for geriatric populations)
- Community Resources and Access to Care

Noteworthy collaborations include the following:

- Embedded primary care in selected behavioral healthcare practices and offering behavioral health screening and collaboration in primary care practices in several LME/MCO catchment areas, including collaborations between Alliance Behavioral Healthcare and Duke UNC Wakebrook
- Fully integrated program for behavioral health, primary care and substance use services in Mecklenburg County
- Embedded behavioral health services in community health centers in the CenterPoint catchment area
- Co-located behavioral and primary health practices
- Collaborative Care Conference for Mental Health and Substance Use sponsored by Trillium and Community Care Plan of Eastern Carolina
- Telephonic psychiatric consultation to primary care by Trillium and Community Care of Lower Cape Fear

LME/MCOs and CCNC recognize the importance of data sharing in effectively coordinating care for the Medicaid population. Data is key in communication between primary and behavioral healthcare, both at the individual consumer level and at the population level. LME/MCOs and CCNC continue to use data effectively in a number of ways:

- Information sharing through CCNC's Provider Portal and Informatics Center
- Use of CCNC's Provider Portal to research primary care information on a patient-by-patient case
- Development of reports to assist in care coordination and population management
- LME/MCOs use Informatics to provide medical information to behavioral health providers with consumer referrals
- LME/MCO use of CCNC data to identify high risk consumers
- Sharing of LME/MCO care coordination admission and discharge data
- Use of Informatics data to correct/clarify clinical areas of concern that present financial risk

Implementation of Data Sharing Requirements

SECTION 12F.4A.(b) *The Department shall ensure that, by no later than January 1, 2014, all LME/MCOs submit claims data, including to the extent practical, retrospective claims data and integrated payment and reporting system (IPRS) data, to the CCNC Informatics Center and to the Medicaid Management Information System. Upon receipt of this claims data, CCNC shall provide access to clinical data and care management information within the CCNC Informatics Center to LME/MCOs and authorized behavioral health providers to support (i) treatment, quality assessment, and improvement activities or (ii) coordination of appropriate and effective patient care, treatment, or habilitation.*

Ensuring Standardization of Encounter Claims Data Submissions

DHHS explored data submission options that would be able to meet legislated timelines as well as ensure the standardization of data submissions. CCNC, the LME/MCOs and DHHS agreed that submission of claims encounter data through NC Tracks was optimal to ensure consistency of data used by all parties, the integrity of the data, and the protection of substance abuse data per the requirements of federal law, 42 CFR Part 2, which prohibits re-disclosure of protected health information for individuals receiving substance abuse treatment.

Although it was determined that claims data would be submitted to CCNC Informatics Center via Medicaid encounter data through NC Tracks, a contingency plan was developed to ensure the legislated timeframe was met. As specified in the previous report, the contingency plan involved gathering flat files of Medicaid claims data from the LME/MCOs, removing protected information, and submitting the claims data to

CCNC. Two LME/MCOs were already, and continue, directly submitting claims data to CCNC – Trillium (formally ECBH) and Cardinal Innovations). To date, CCNC has received all Medicaid claims data from LME/MCOs, dating back to each LME/MCO's implementation of the 1915(b)(c) waiver.

Testing of LME/MCO Medicaid claims data submissions continues. Encounter claims data is loaded from NC Tracks into the Truven data warehouse. As claims data is populated in the Truven data warehouse, protected substance abuse data is excluded and the data is transferred directly to the CCNC Informatics Center. This allows for LME/MCO Medicaid claims data to flow through DHHS to CCNC. DHHS manually submits encounter files to CCNC while the LME/MCOs and DHHS ensure the data flowing through NC Tracks and Truven is fully complete and accurate.

Quality and Performance Statistics

SECTION 12F.4A.(c) *The Department, in consultation with CCNC and the LME/MCOs, shall develop quality and performance statistics on the status of mental health, developmental disabilities, and substance abuse services, including, but not limited to, variations in total cost of care, clinical outcomes, and access to and utilization of services.*

Historical Inclusion of Performance Measures in LME/MCO Contracts

DHHS continues to involve stakeholders in the development of performance and outcome measures. The contracted expectations currently include measures on (1) prevention and early intervention, (2) access to care, (3) availability and use of services (utilization), (4) clinical effectiveness of care (clinical outcomes), (5) coordination of care, (6) health plan stability, (7) consumer health and safety, and (8) consumer and provider satisfaction. These include several measures that address the relationship between behavioral health and primary health services.

The Department is planning for the next major revision of LME/MCO contracts for both state/federal block grant funds and for Medicaid to occur in July of 2016. DHHS continues to develop contractual performance measures and engages stakeholder groups, including CCNC and the LME/MCOs, for feedback on performance measures.

Development of New Measures on Integrated Care

Over the past year, the Total Care workgroup, consisting of LME/MCOs, CCNC, and DHHS, have agreed to measure the total cost of care and number of emergency department (ED) visits for individuals with comorbid physical health and mental health conditions, particularly those targeted in joint integrated care projects between the LME/MCOs and CCNC. DHHS hosted a small workgroup including LME/MCOs, CCNC and integrated care experts that drafted six integrated care measures: two physical healthcare measures to apply to LME/MCOs, two integrated care measures to apply to both physical healthcare entities and LME/MCOs, and two behavioral health measures to apply to physical healthcare entities. These measures will be shared with other stakeholders for additional input and recommendations.

Closing Summary

DHHS continues to work closely with CCNC and the LME/MCOs to implement clinical integration activities through the Total Care initiative. Claims data and integrated payment and reporting system (IPRS) data have been shared with CCNC and CCNC Informatics Center data has been made available to the LME/MCOs to support treatment, quality assessment and improvement activities and the coordination of appropriate and effective patient care, treatment and habilitation. DHHS has also worked collaboratively with the LME/MCOs and CCNC to develop quality and performance statistics on the status of mental health, developmental disabilities and substance abuse services.