Health and
Human Services

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

September 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, Co-Chair
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 attached report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on September 1, 2016.

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

Sincerely,

Dave Richard

Attachment

cc:

Andy Munn	Kolt Ulm	Marjorie Donaldson	Brian Perkins
Rod Davis	Theresa Matula	Virginia Niehaus	Susan Jacobs
Joyce Jones	Hannah Tedder	Pam Kilpatrick	Steve Owen
Trey Sutten	reports@ncleg.net	Sarah Pfau	

Health and
Human Services

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

September 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 attached report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on September 1, 2016.

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Behavioral Health Clinical Integration and Performance Monitoring

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

Semiannual 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

September 1, 2016

Executive Summary

Session Law 2013-360, Section 12F.4A.(e) states: “By no later than March 1, 2014, and semiannually thereafter, the Department shall submit a 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 CCNC pursuant to Section 12F.4A.” This is the Department of Health and Human Services’ sixth report submission.

Total Care Implementation

Since the inception of Local Management Entity-Managed Care Organizations (LME-MCOs) and the implementation of the 1915(b)(c) waivers, DHHS has required the LME-MCOs and CCNC to coordinate care for Medicaid beneficiaries with co-occurring behavioral health disorders and chronic health conditions. Session Law 2013-360 Section 12F.4A.(a) further requires LME-MCOs to implement clinical integration activities with 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 use disorders and primary care or other chronic conditions.

Total Care represents collaborative efforts between the seven LME-MCOs and fourteen CCNC local networks. The geographic regions for the local CCNC networks and the LME-MCOs do not match exactly. As such, each LME-MCO shares counties with three to seven CCNC local networks. *Table 1* lists LME-MCOs paired with collaborating CCNC networks. For the full names of abbreviated CCNC Networks, please see *Appendix A*.

Table 1: LME-MCOs and Collaborating CCNC Networks

LME-MCOs	CCNC Networks
Smoky Mountain	• CCWNC (McDowell, Mitchell, Yancey, Madison, Buncombe, Henderson, Transylvania, Polk) • CCHP (Rutherford) • AccessCare (Cherokee, Graham, Clay, Macon, Swain, Jackson, Haywood, Alleghany, Ashe, Watauga, Avery, Caldwell, Alexander) • NCCN (Wilkes)
Partners Behavioral Health Management	• CHP (Lincoln, Gaston) • CCHP (Cleveland) • AccessCare (Burke, Catawba, Iredell) • NCCN (Yadkin, Surry)
Alliance Behavioral Healthcare	• CCWJC (Wake/Johnston) • NPCC (Durham) • 4C (Cumberland)
Sandhills Center	• CCS (Montgomery, Richmond, Moore, Hoke, Lee, Harnett) • CCPGM (Anson) • P4CC (Guilford, Randolph)
Eastpointe	• CCLCF (Bladen, Columbus) • CCPEC (Duplin, Lenoir, Greene, Wilson, Nash, Edgecombe) • AccessCare (Robeson, Sampson, Wayne, network sites in Lenoir) • CCS (Scotland)
Trillium Health Resources	• CCPEC (Northhampton, Hertford, Gates, Chowan, Perquimans, Pasquotank, Camden, Currituck, Bertie, Martin, Washington, Tyrell, Dare, Hyde, Pitt, Beaufort, Craven, Pamlico, Jones, Carteret) • CCLCF (Brunswick, New Hanover, Pender, Onslow)
Cardinal Innovations Healthcare Solutions	• CCSP (Rowan, Cabarrus, Stanly) • CCPGM (Union, Mecklenburg) • NCCN (Davidson, Davie, Forsyth, Stokes) • AccessCare (Caswell, Alamance, Orange, Chatham) • NPCC (Person, Granville, Vance, Franklin, Warren) • CCPEC (Halifax) • P4CC (Rockingham)

Collaboration between the LME-MCOs and the CCNC local networks occurs at two levels. One level of collaboration occurs when staff from both organizations meet as an interdisciplinary team to discuss complex cases. This is an efficient way to optimize the resources of both organizations to promote the best health outcomes for the individual.

The other level of collaboration is the development of innovative projects and practices that integrate physical and behavioral healthcare. There have been joint efforts in a number of areas, including emergency departments and chronic pain management. *Table 2* lists some of these joint efforts. Collaboration has also led to a number of promising practices intended to promote comprehensive, integrated care. *Table 3* lists some of these promising practices and the collaborating LME-MCOs and CCNC networks. Again, please see *Appendix A* for a CCNC network abbreviation legend.

Table 2: Targets for Joint Efforts between LME-MCOs and CCNC Networks

Emergency Departments	• Smoky Mountain: CCHP, CCWNC • Cardinal: CCPGM, NPCC (new effort), NCCN • Alliance: CCWJC, NPCC, 4C • Trillium: CCPEC • Partners BHM: CHP • Eastpointe: CCS, CCPEC, AccessCare
Prescribing Education for Practitioners	• Alliance: 4C, NPCC • Trillium: CCLCF, CCPEC • Eastpointe: CCLCF, CCPEC • Cardinal: CCPGM, NCCN, P4CC • Partners BHM: CHP, CCHP, AccessCare • Sandhills: CCPGM, P4CC, CCCS
Chronic Pain Treatment (Naloxone)	• Trillium: CCLCF, CCPEC (new effort) • Alliance: CCWJC, NPCC, 4C • Cardinal: SPCC, NCCN, NPCC (new effort), P4CC, • Partners: NCCN, AccessCare, CHP, CCHP • Smoky Mountain: NCCN, CCWNC • Eastpointe: CCPEC • Sandhills: P4CC (new effort)
Children and Adolescents in Foster Care	• Cardinal: NPCC, CCPGM, NCCN • Alliance: 4C • Smoky Mountain: CCHP, CCWNC • Trillium: CCPEC • Sandhills: CCPGM, P4CC, CCCS • Eastpointe: 4C, CCPEC (new effort)
Pregnant Women with Opioid Addiction	• Trillium: CCLCF, CCPEC • Cardinal: CCSP • Alliance: 4C • Smoky Mountain: CCWNC

Table 3: Promising Practices Facilitated by LME-MCO and CCNC Collaboration

Integrated Healthcare and Transitional Care Teams (formal and informal)	• Alliance: 4C, NPCC (New effort: Integrated Care Pilot at a NPCC practice—shared Alliance/NPCC staff) • Partners BHM: AccessCare, CHP • Sandhills: P4CC, CCS • Cardinal: CCPGM, AccessCare, SPCC (Maternal Depression, Care Coordination) • Trillium: CCPEC • Smoky Mountain: CCWNC
Behavioral Health and Primary Care Provider Meet and Greet Events	• Smoky Mountain: CCHP, NCCN • Partners: CCHP, NCCN, AccessCare, CHP (new effort) • Alliance: 4C, NPCC • Eastpointe: CCLCF • Sandhills: CCPGM • Cardinal: CCPGM, NCCN, P4CC
Regional LME-MCO and Network Meetings	• Eastpointe: CCPEC, CCLCF, CCS, AccessCare • Smoky Mountain: CCWNC, AccessCare, , NCCN • Trillium: CCLCF, CCPEC • Sandhills: CCPGM, CCS, P4CC • Cardinal: NPCC
Concerted Coordination Efforts with Regional Psychiatric Hospitals (including UNC WakeBrook)	• Eastpointe: CCPEC, CCLCF, CCS, AccessCare • Sandhills: P4CC • Alliance CCWJC – specifically pilot with Central Regional Hospital • Smoky Mountain: CCWNC (new effort with one hospital)
Pharmacy and Medication Reconciliation	• Cardinal: CCSP, CCPEC • Smoky Mountain: CCWNC • Sandhills: P4CC • Eastpointe: CCS, CCLCF, CCPEC, AccessCare • Alliance: NPCC, 4C
Healthy Ideas (depression management for geriatric populations)	• Cardinal: P4CC
Community Resource and Access to Care	• Alliance: 4C
Behavioral Health Provider Partnerships	• Cardinal: CCPGM, NPCC (new effort), P4CC • Smoky Mountain/Partners: CCHP, CCWNC (new effort) • Alliance: NPCC
Collaborative Care Conference for Mental Health and Substance Abuse	• Trillium: CCPEC
Telephonic Psychiatric Consultation in Primary Care (funded by MCO)	• Trillium: CCLCF
MCO Primary Care Liaison/CCNC Joint Practice Visits	• Trillium: CCLCF
Integration of Health Systems and Providers	• Partners: AccessCare (Burke Integrated Health)
LME-MCO CEOs Serving on CCNC boards	• Various

Implementation of Data Sharing Requirements

Section 12F.4A.(b) of Session Law 2013-360 requires the Department to ensure that 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 and (ii) coordination of appropriate and effective patient care, treatment, or habilitation.

LME-MCOs and CCNC continue to share data in a collaborative effort to coordinate and improve care for Medicaid enrollees. LME-MCOs share behavioral health data with CCNC through an agreement with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The LME-MCOs submit claims data through NCTracks to ensure the consistency and integrity of the data. The data are loaded into the Truven data warehouse and uploaded into the CCNC informatics system. In accordance with 42 C.F.R. Part 2, protected substance abuse data are excluded. The Division of Medical Assistance (DMA) provides LME-MCOs with primary care, fee-for-service data. The LME-MCOs share this primary care data with a subcontracted "population health management organization" for use in advanced data analytics. LME-MCOs are also able to access information through CCNC's Provider Portal and Informatics Center. Encounter data will be available for use by July 2017.

Data sharing impacts effective care at both the individual and population level. Some examples include providers' ability to:

- Research primary care or behavioral health information on an individual patient to complete quality assessments and better coordinate treatment;
- Create reports and dashboards that inform care coordination, utilization management, provider network management, public education efforts, and population management;
- Identify high risk and/or high cost patients; and
- Clarify and correct areas of concern that present financial or other administrative risk.

Quality and Performance Statistics

Section 12F.4A.(c) of Session Law 2013-360 requires the Department, in consultation with CCNC and the LME-MCOs, to 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.

The Department monitors quality and performance statistics through performance measurement. Performance measures are included in the LME-MCO contracts with both DMA and DMH/DD/SAS. LME-MCOs report on these measures quarterly to DMA and

DMH/DD/SAS. Subject matter experts and contract managers at DMA and DMH/DD/SAS monitor performance measures and review progress during quarterly intra-departmental monitoring team meetings. Concerns are reported to Division and Department leaders. *Table 4* contains a list of these measures. As a result of performance monitoring, DMA and DMH/DD/SAS have adjusted these performance measures.

Table 4: Performance Measures in LME-MCO Contracts

Areas of Measurement	Measures
Clinical Effectiveness of Care	• Readmission Rates for Inpatient Mental Health Treatment • Readmission Rates for Inpatient Substance Abuse Treatment • Ambulatory Follow-Up within 7 Calendar Days of Discharge for Substance Abuse • Ambulatory Follow-Up within 7 Calendar Days of Discharge for Mental Health
Access/Availability	• Initiation and Engagement of Alcohol and Other Drug Dependency Treatment • Call Answer Timelines • Call Abandonment • Gap Analysis / Service Need Assessment • Payment Denials • Out of Network Services
Patient and Provider Satisfaction	• Grievances / Appeals
Use of Services	• Mental Health Utilization – Inpatient Discharges and Average Length of Stay • Mental Health Utilization – Percent of Beneficiaries Receiving Inpatient, Day/Night Care, Ambulatory, and Other Support Services • Chemical Dependency Utilization – Percent of Beneficiaries Receiving Inpatient, Day / Night Care, Ambulatory, and Support Services • Identification of Alcohol and Other Drug Services (Penetration) • Identification of Mental Health Services (Penetration) • Integrated Care
Health Plan Stability	• Network Capacity
Patient Health and Safety	• Critical Incident Reports
Plan Descriptive Information	• Unduplicated Count of Medicaid Beneficiaries • Medicaid Beneficiary Diversity

The Department has collaborated with the LME-MCOs and CCNC to draft eight additional integrated care measures. These measures have been shared with other stakeholder groups, including providers and consumers of behavioral health services, for feedback and recommendations. DMA and DMH/DD/SAS are currently reviewing this feedback.

The proposed integrated care measures include the following:

1. **30-day Readmission Rates for Psychiatric Patients**
   Description: Rate of readmission to psychiatric hospitals within 30 days.
2. **Follow-up after Hospitalization for Mental Illness**
   Description: Percent of beneficiaries aged 6+ hospitalized for treatment of select mental health disorders who have an outpatient visit, an intensive

outpatient encounter, or partial hospitalization with a mental health practitioner within 7 and 30 days of discharge.

3. **Integrated Care**
   Description: Percent of continuously enrolled beneficiaries with at least one MH/DD/SA visit who had a primary care or preventive care visit during the measurement year (reported separately for children 3-20 and adults 21+).

4. **Composite Score for Receiving Treatment Quickly**
   Description: Percent of patients who reported how often they get treatment quickly, reported separately for children/adolescents and adults.

5. **Metabolic Monitoring for Children and Adults Taking Antipsychotic Medications**
   Description: For patients who were taking an antipsychotic medication at any point in the past 12 months, the percent with a lipid and glucose screening.

6. **SBIRT Alcohol and Substance Abuse Screening for Children and Adults in Brief Intervention Services Provided in Primary Care and Outpatient Settings**
   Description: SBIRT (Screening, Brief Intervention, and Referral to Treatment) services provided in primary care and outpatient settings. Services received in emergency departments and mental health settings (with the exception of co-located mental health and primary care services) are excluded from the measure.

7. **Medical Assistance with Smoking Cessation**
   Description: Percent of patients aged 18+ who were screened for tobacco use one or more times within 24 months and, if identified as a tobacco user, received cessation counseling intervention.

8. **Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (Test Measure)**
   Description: Percent of beneficiaries aged 12+ with a diagnosis of major depressive disorder or dysthymia who had a PHQ-9 or PHQ-A tool administered at least once during a 4 month period.

Closing Summary

Consistent with Session Law 2013-360, the Department continues to collaborate with the LME-MCOs and CCNC to implement clinical integration activities through Total Care 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.

Appendix A – CCNC Network Names and Abbreviations

CCNC Network Name	***Abbreviation***
AccessCare (23 NC Counties)	AccessCare
Community Care of Western North Carolina (Buncombe, Henderson, Madison, McDowell, Mitchell, Polk, Transylvania, and Yancey Counties)	CCWNC
Community Care of the Lower Cape Fear (Bladen, Brunswick, Columbus, New Hanover, Onslow, and Pender Counties)	CCLCF
Carolina Collaborative Community Care (Cumberland County)	4C
Community Care of Wake Johnston Counties (Wake and Johnston Counties)	CCWJC
Community Care Partners of Greater Mecklenburg (Anson, Mecklenburg, and Union Counties)	CCPGM
Carolina Community Health Partnership (Rutherford and Cleveland Counties)	CCHP
Community Care Plan of Eastern Carolina – Access East (27 NC Counties)	CCPEC
Northwest Community Care (Davie, Davison, Forsyth, Stokes, Surry, Wilkes, and Yadkin Counties)	NCCN
Partnership for Community Care (Guilford, Randolph, and Rockingham Counties)	P4CC
Community Care of the Sandhills (Harnett, Hoke, Lee, Montgomery, Moore, Richmond, and Scotland Counties)	CCS
Community Care of Southern Piedmont (Cabarrus, Rowan, and Stanly Counties)	CCSP
Community Health Partners (Lincoln and Gaston Counties)	CHP
Northern Piedmont Community Care (Durham, Franklin, Granville, Person, Vance, and Warren Counties)	NPCC