DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

DAVE RICHARD
DEPUTY SECRETARY FOR MEDICAL ASSISTANCE

March 1, 2017

SENT VIA ELECTRONIC MAIL

The Honorable Louis Pate, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 311, Legislative Office Building
Raleigh, NC 27601

The Honorable Josh Dobson, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 301N, Legislative Office 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 March 1, 2017.

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: Lindsey Dowling, Rod Davis, Joyce Jones, reports@ncleg.net, Kolt Ulm, Theresa Matula, LT McCrimmon, Sarah Pfau, Marjorie Donaldson, Virginia Niehaus, Pam Kilpatrick, Denise Thomas, Ben Popkin, Susan Jacobs, Steve Owen

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March 1, 2017

SENT VIA ELECTRONIC MAIL

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 March 1, 2017.

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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

March 1, 2017

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' seventh report submission. For the full provision, please see *Appendix A.*

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. The Department continues to maintain contracts with the LME-MCOs and CCNC to ensure clinical integration and coordination of care for Medicaid beneficiaries; however, the Total Care initiative, as described in Session Law 2013-360 Section 12F.4A.(a), no longer exists.

There are currently 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 B.*

Table 1: LME-MCOs and Collaborating CCNC Networks
The following table lists LME-MCOs paired with collaborating CCNC networks. For the full names of abbreviated CCNC Networks, see *Appendix B.*

LME-MCOs	CCNC Networks
Vaya Health	• 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 (Northampton, 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. Both levels have been strengthened and expanded over the years since Session Law 2013-360 was passed, so that collaboration is becoming routine. 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. Two statewide projects are underway. CCNC, thorough its behavior health section, is working with primary care practices across NC to assess current behavioral health capability and build capacity for primary behavioral healthcare delivery. DHHS sponsored a multidivisional Care Coordination Improvement Team to address variation in care coordination among the LME-MCOs and improve efficiency and collaboration. There have also 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 B* for a CCNC network abbreviation legend.

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

The following table lists some examples of joint efforts between the LME-MCO and the CCNC networks. Collaboration has also led to a number of promising practices intended to promote comprehensive, integrated care. For the full names of abbreviated CCNC Networks, see *Appendix B.*

Emergency Departments	• Vaya Health: CCHP, CCWNC • Cardinal: CCPGM, NPCC, 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 • Alliance: CCWJC, NPCC, 4C • Cardinal: SPCC, NCCN, NPCC, P4CC, • Partners: NCCN, AccessCare, CHP, CCHP • Vaya Health: NCCN, CCWNC • Eastpointe: CCPEC • Sandhills: P4CC
Children and Adolescents in Foster Care	• Cardinal: NPCC, CCPGM, NCCN • Alliance: 4C • Vaya Health: CCHP, CCWNC • Trillium: CCPEC • Sandhills: CCPGM, P4CC, CCCS • Eastpointe: 4C, CCPEC
Pregnant Women with Opioid Addiction	• Trillium: CCLCF, CCPEC • Cardinal: CCSP • Alliance: 4C • Vaya Health: CCWNC

Table 3: Promising Practices Facilitated by LME-MCO and CCNC Collaboration
The following table lists some of these promising practices and the collaborating LME-MCOs and CCNC networks. For the full names of abbreviated CCNC Networks, see *Appendix B*.

Integrated Healthcare and Transitional Care Teams (formal and informal)	• Alliance: 4C, NPCC (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 • Vaya Health: CCWNC
Behavioral Health and Primary Care Provider Meet and Greet Events	• Vaya Health: CCHP, NCCN • Partners: CCHP, NCCN, AccessCare, CHP • Alliance: 4C, NPCC • Eastpointe: CCLCF • Sandhills: CCPGM • Cardinal: CCPGM, NCCN, P4CC
Regional LME-MCO and Network Meetings	• Eastpointe: CCPEC, CCLCF, CCS, AccessCare • Vaya Health: 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 • Vaya Health: CCWNC
Pharmacy and Medication Reconciliation	• Cardinal: CCSP, CCPEC • Vaya Health: 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 • Vaya Health/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 NC Tracks 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. LME-MCOs report encounter data to the State (information related to the receipt of any item or service by an enrollee under a managed care contract) through NC Tracks. DMA is working with the LME-MCOs to improve the quality of the data being submitted through NC Tracks. The new Medicaid Managed Care Rules, published in April 2016, place a stronger focus on encounter data reporting. This will be reflected in the State Fiscal Year (SFY) 2017-18 LME-MCO contracts and will help strengthen the data reporting already available. The new regulatory requirements are found in 42 C.F.R parts 438.242 and 438.818 (see *Appendix C*).

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 began monitoring quality and performance statistics through performance measurement for LME-MCOs in 2013. 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.

The Department has collaborated with the LME-MCOs, CCNC, and other stakeholder groups to draft eight additional integrated care measures. These near-final measures have been shared with other stakeholder groups, including providers and consumers of behavioral health services, for feedback and recommendations. This feedback is being incorporated into the final integrated care measures. These measures will be reflected in the SFY 2017-18 LME-MCO contracts with DMA.

The proposed integrated care measures are listed below.

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 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 – Session Law 2013-260, Section 12F.4A.

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.

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.

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.

SECTION 12F.4A.(d) The Department shall, within available appropriations and as deemed necessary by the Department, expand or alter existing contracts by mutual agreement of all parties to the contract in order to implement the provisions of this section.

SECTION 12F.4A.(e) 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 this section.

Appendix B – 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

Appendix C – 42 C.F.R parts 438.242 and 438.818

§438.242 Health information systems.

(a) *General rule.* The State must ensure, through its contracts that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(b) *Basic elements of a health information system.* The State must require, at a minimum, that each MCO, PIHP, and PAHP comply with the following:

(1) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

(2) Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

(3) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data, including data from network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments.

(ii) Screening the data for completeness, logic, and consistency.

(iii) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

(4) Make all collected data available to the State and upon request to CMS.

(c) *Enrollee encounter data.* Contracts between a State and a MCO, PIHP, or PAHP must provide for:

(1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.

(2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.

(3) Submission of all enrollee encounter data that the State is required to report to CMS under §438.818.

(4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

(d) *State review and validation of encounter data.* The State must review and validate that the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP, meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted under paragraph (c) of this section is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP.

(e) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, PAHPs, and PCCM entities beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.242 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

§438.818 Enrollee encounter data.

(a) FFP is available for expenditures under an MCO, PIHP, or PAHP contract only if the State meets the following conditions for providing enrollee encounter data to CMS:

(1) Enrollee encounter data reports must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System.

(2) States must ensure that enrollee encounter data is validated for accuracy and completeness as required under §438.242 before submitting data to CMS. States must also validate that the data submitted to CMS is a complete and accurate representation of the information submitted to the State by the MCOs, PIHPs, and PAHPs.

(3) States must cooperate with CMS to fully comply with all encounter data reporting requirements of the Medicaid Statistical Information System or any successor system.

(b) CMS will assess a State's submission to determine if it complies with current criteria for accuracy and completeness.

(c) If, after being notified of compliance issues under paragraph (b) of this section the State is unable to make a data submission compliant, CMS will take appropriate steps to defer and/or disallow FFP on all or part of an MCO, PIHP, or PAHP contract in a manner based on the enrollee and specific service type of the noncompliant data. Any deferral and/or disallowance of FFP will be effectuated utilizing the processes specified in §§430.40 and 430.42 of this chapter.