North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

February 28, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Session Law 2013-360, Section 12F.4A.(e) requires the NC 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 first report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

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

Please contact Dave Richard, Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should you have any questions regarding this report. Mr. Richard can be contacted at (919) 733-7011.

Sincerely,

Adam Sholar

cc: Matt McKillip Denise Thomas Susan Jacobs

Jim Slate	Patricia Porter	Theresa Matula
Dave Richard	Sarah Riser	Joyce Jones
Jim Jarrard	Kristi Huff	Rod Davis
Pam Kilpatrick	Brandon Greife	reports@ncleg.net

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SENT VIA ELECTRONIC MAIL

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

Dear Mr. Trogdon:

Session Law 2013-360, Section 12F.4A.(e) requires the NC 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 first report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

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Adam Sholar

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Behavioral Health Clinical Integration and Performance Monitoring

Semi-Annual Report to
Joint Legislative Oversight Committee on Health and Human Services
and
Fiscal Research Division
Session Law 2013-360, Section 12F.4A.(e)

March 1, 2014

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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 first report.

DHHS, Local Management Entity-Managed Care Organizations (LME-MCOs) and CCNC agreed on a plan for submission of claims data to CCNC in November 2013. To meet the legislated deadline of January 1, 2014, the initial solution involves the LME-MCOs submitting electronic files of claims data to DHHS, which will compile the data and send to CCNC. However, the long-term solution in development is for the LME-MCOs to submit claims data to NC Tracks, which will then transfer the data to CCNC. Regarding integration activities, DHHS already requires LME-MCOs to engage in integration activities with local CCNC networks. DHHS, LME-MCO representatives, and CCNC are currently working together to further define and clarify the new Total Care initiative in order to standardize and implement the initiative statewide. The DHHS currently employs a number of performance measures and statistics as a part of routine LME-MCO monitoring. DHHS will be further refining and developing new measures in the Spring of 2014, at which time consultation will be sought with the LME-MCOs and CCNC.

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.*

LME-MCOs operating the 1915 *(b)/(c)* Medicaid Waivers and CCNC have already been working collaboratively to improve and minimize the cost of care for individuals who suffer from comorbid mental health and chronic medical conditions.

Prior to this legislation, the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) included elements in each LME-MCO contract that explicitly require integration activities and co-management of behaviorally and medically complex beneficiaries. These requirements include, at minimum, monthly meetings between each LME-MCO and each CCNC network with overlapping counties, Informatics Center access, inclusion of CCNC care managers in developing service plans and crisis plans, and communication with primary care practitioners. Each LME-MCO and CCNC network varies with respect to their particular collaborative

relationships and chosen initiatives, including ProACT, Screening, Brief Intervention and Referral to Treatment (SBIRT) projects, and integrated primary care and co-location services. The DMA contract further outlines the roles of CCNC and LME-MCOs in sharing care and determining lead care managers using the National Council's Four Quadrant Model.

The Total Care initiative is being developed to fit within the current collaboration expectations. The DHHS has been working closely with behavioral health representatives at CCNC and with the NC Council of Community Programs, as representative for the LME-MCOs, to define and further clarify expectations under the new Total Care Initiative. A collaborative DHHS/LME-MCO/CCNC planning meeting was held in November 2013, and the resulting workgroup first convened on December 4, 2013. The workgroup is identifying a standard population, interventions, and measurements to ensure consistent statewide implementation. While the workgroup is developing Total Care expectations, LME-MCOs and CCNC networks are expected to continue with the collaborative efforts already in place.

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

The 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 redisclosure 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 encounter data through NC Tracks, a contingency plan was developed to ensure the legislated timeframe was met. The DHHS consulted with CCNC as to the data element specifications sought and worked with the LME-MCOs to design reports that would incorporate these same data elements into a flat file (Microsoft Excel type file). The LME-MCOs submitted the flat file reports directly to DHHS, which then removed the substance abuse data. The flat file method will be utilized until automation of encounter data is flowing directly from the Truven warehouse to the CCNC Informatics Center System. As of January 1, 2014, data from all but two LME-MCOs was submitted to CCNC. DHHS submitted data from Eastpointe on January 2nd due to

formatting issues that needed more time for resolution. Western Highlands Network (WHN) data was still being collected as this report was being written. There were issues with the integrity of the WHN data that required more intensive work.

Simultaneously, the NC Tracks system changes were implemented in November 2013. Testing of encounter claims began in December 2013 with three LME-MCOs, although all LME-MCOs were prepared to submit encounter data as soon as NC Tracks could receive the data. Encounter claims data is loaded from NC Tracks into the Truven data warehouse. As of the writing of this report, DHHS is working with Truven to create an interface of claims data, excluding the substance abuse data, which will allow for direct transfer of the data from the Truven warehouse to the CCNC Informatics Center. This interface should be completed by the end of January 2014, allowing for all LME-MCO claims data to flow through DHHS to CCNC.

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

The DMH/DD/SAS has included measures with expected standards for clinical performance in its DHHS-LME Performance Contracts since SFY 2006-07. As LMEs have become managed care organizations for the Medicaid 1915*(b)/(c)* Waiver, their contracts with the Division of Medical Assistance have also included performance measures. In State Fiscal Year (SFY) 2012-13 the two Divisions worked to align performance measures across funders. Selected measures were also chosen to address national expectations of performance to allow North Carolina to compare its public MH/DD/SA service system to those of other states.

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.

In addition to contractual performance measures, the two Divisions regularly track and review the LME-MCOs' administrative processes, including timeliness in processing service claims and responding to consumers' and providers' requests for services, complaints, and adverse events. The two Divisions also track the cost of care for both Medicaid and State-funded services and the financial stability of each LME-MCO. Measures currently include tracking of total expenses, the current ratio of assets to liabilities, the LME-MCO's defensive interval, medical loss ratio, fund balance and excess revenues.

Performance expectations for administrative functions and efficient use of funds are reviewed with the DHHS Secretary each month. This information is used in decisions about certification of the LME-MCOs pursuant to Session Law 2013-85 (Senate Bill 208).

Development of New Measures on Integrated Care

The Department is currently developing LME-MCO contracts to begin in July 2014. Revision of clinical performance measures is a part of this annual process. Most measures are renewed with a higher expected performance standard based on the previous year's statewide average. When issues emerge or additional national measures are available, new measures are added.

As measures are reviewed and recommended for the SFY 2014-15 contracts, the Department will seek input on new measures of integration of primary and behavioral health care from the LME-MCOs and CCNC. This process will take place early in 2014 to allow time for finalizing the Department contracts with LME-MCOs and with CCNC for implementation in July 2014.

In addition to the contractual performance measures, the Department will seek suggestions from LME-MCOs and CCNC on other measures of quality and performance that can be used to evaluate the efficiency and effectiveness of the public service system.

Closing Summary

The DHHS has been working closely with CCNC and the LME-MCOs to ensure satisfactory claims data submission to CCNC, to clarify and define Total Care as a statewide LME-MCO and CCNC partnership for the ultimate benefit of persons served, and to consult on LME-MCO performance measures and statistics.