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

August 28, 2014

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 second 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 Courtney Cantrell, Ph.D., Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should you have any questions regarding this report. Dr. Cantrell can be contacted at (919) 733-7011.

Sincerely,

Adam Sholar

cc: Dave Richard
Jim Slate
Courtney Cantrell
Jim Jarrard
Pam Kilpatrick
Brandon Greife
Theresa Matula
Denise Thomas
Patricia Porter
Sarah Riser
Kristi Huff
Matt McKillip
Susan Jacobs
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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 second report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

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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)

September 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.

Since January 1, 2014, CCNC has received Medicaid claims data from all of the Local Management Entities-Managed Care Organizations (LME-MCOs). Cardinal Innovations and East Carolina Behavioral Health submit their claims data directly to CCNC, while the rest submit claims data through DHHS. CCNC is in possession of claims data from the LME-MCOs dating back to each LME-MCO's implementation of the 1915(b)(c) waiver. By the 10th of every month, CCNC receives claims data from the prior month for every LME-MCO not directly submitting their data to CCNC. However, the long-term solution, currently in development and testing, is for the Medicaid claims data to be sent to CCNC through NC Tracks. 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. Implementation of the initiative is being planned for Fall 2014. DHHS currently employs a number of performance measures and statistics as a part of routine LME-MCO monitoring. DHHS has implemented an integrated care outcome measures workgroup consisting of LME-MCOs, CCNC, and outside experts to begin development of measures to apply to the current system 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 Total Care initiative is being developed to fit within the current CCNC/LME-MCO collaborative efforts. DHHS has been working closely with behavioral health representatives at CCNC and with the NC Council of Community Programs, as representatives for the LME-MCOs, to define and further clarify expectations under the new Total Care Initiative. DHHS has been hosting LME-MCO/CCNC planning meetings since December 4, 2013. The workgroup has identified a standard population, interventions, and measurements to ensure consistent, measurable statewide implementation. While the workgroup is developing Total Care expectations, LME-

MCOs and CCNC networks have continued with the collaborative efforts already in place. The workgroup expects to have completed the implementation plans by mid-Fall of 2014. Implementation, including evaluation of regional CCNC/LME-MCO plans and shared learning opportunities, is expected late Fall of 2014.

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 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 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 (East Carolina Behavioral Health 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. By the 10th of each month, DHHS submits the prior month's paid Medicaid claims. CCNC has received the data and is in the process of testing the data prior to releasing it through the Informatics Center.

Required NC Tracks system changes were implemented in November 2013. Testing of the submission and accuracy of Medicaid claims data continues to ensure accuracy and completeness. Encounter claims data is loaded from NC Tracks into the Truven data warehouse. Once the claims data is complete in the Truven data warehouse, excluding protected substance abuse data, direct transfer of the data from the Truven warehouse to the CCNC Informatics Center will be implemented, allowing for all LME-MCO Medicaid 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 NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has included measures with expected standards for clinical performance in its DHHS-LME Performance Contracts since State Fiscal Year (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 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 Department leadership regularly. This information is used in decisions about certification of the LME-MCOs pursuant to Session Law 2013-85.

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 to align with LME-MCO merger finalization. DHHS is beginning to develop contractual performance measures and will be engaging with stakeholder groups, including CCNC and the LME-MCOs, for feedback on performance measures.

Development of New Measures on Integrated Care

DHHS has established a workgroup to develop integrated care outcome measures to be applied across the system to foster integration of physical and mental health/substance use/intellectual and developmental disability services. This workgroup includes

representatives from the LME-MCOs, CCNC, the Office of Rural Health and Community Care, and the Center of Excellence in Integrated Care. The workgroup will have developed six recommended integrated care measures by October 2014. These measures will then be presented to additional stakeholders for additional input.

Closing Summary

DHHS has been working closely with CCNC and the LME-MCO's to ensure satisfactory claims data submission to CCNC. With our two partners we will clarify and define the role of Total Care so that it can provide the maximum benefit to individuals served.

We believe this collaborative working relationship will continue to strengthen and allow us to have strong performance measures and the data to accurately access our progress on integrated care objectives. Each entity is committed to the goal of improving care for individuals who have behavioral health needs by treating the whole person. We look forward to reporting significant progress in our next semi- annual report.