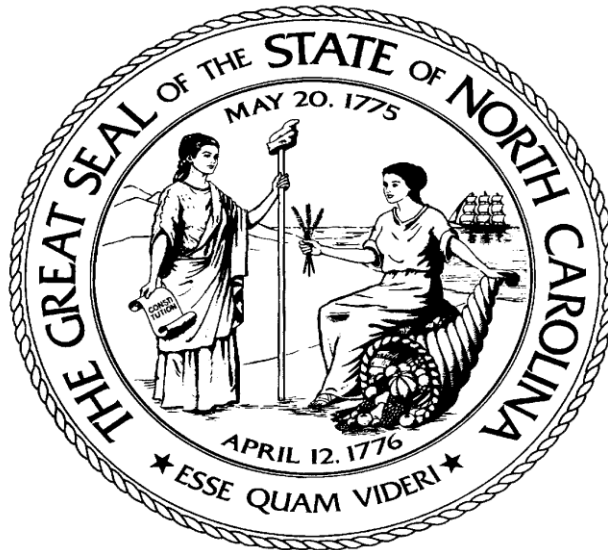


# **Behavioral Health Clinical Integration and Performance Monitoring**

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, 2015**

**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 fourth report.

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 10<sup>th</sup> 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 the testing and validation stage, 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 as identified in each division's contract provisions. DHHS, LME/MCO representatives, and CCNC have clarified the Total Care initiative named in legislation. As a result, all agreed to document the local solutions to integrate care for individuals with complex physical and mental health needs and standardize measurement of the success of these local initiatives. DHHS currently employs a number of performance measures and statistics as a part of routine LME/MCO monitoring. DHHS has concluded an integrated care outcome measures workgroup consisting of LME/MCOs, CCNC, and outside experts to develop 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 contract between the Division of Medical Assistance (DMA) and the LME/MCOs includes provisions related to the partnership between each LME/MCO and 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 successfully entered in data agreements to ensure that critical information is shared and

available. The information below 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 29 different overlaps between CCNC networks and LME/MCOs. Every LME/MCO partners with at least one CCNC network and every CCNC network partners with at least one LME/MCO. Below is a list of initiatives with the LME/MCO – local CCNC network partnerships. Please refer to the March 2015 report for details on which LME/MCO-CCNC partners are involved in each:

- Joint Efforts around Emergency Departments
- Integrated Healthcare and Transitional Care Teams (formal and informal)
- Joint Efforts around Prescribing/Education for Practices
- Behavioral Health and Primary Care Provider Meet and Greet Events
- Joint Efforts around Chronic Pain – Naloxone, Treatment, Community
- Joint Projects around Children/Adolescents/Foster Care
- Joint Projects around Pregnant and Opiate Addicted Women
- Regional LME/MCO and Network meetings
- Concerted effort with Regional Psychiatric Hospitals (including UNC WakeBrook)
- Pharmacy and Medication Reconciliation
- Healthy Ideas (depression management for geriatric populations)
- Community Resource and Access to Care

New, noteworthy collaborations include the following:

- Joint effort between CCNC, Alliance, and the three (3) CCNC networks focused on an integrated healthcare team for individuals with complex medical and behavioral health comorbidities, supporting identified primary care practices in managing their complex patients, and working with identified behavioral health providers to explore possibilities around a behavioral health home
- Successful joint effort between CoastalCare LME/MCO and Community Care of Lower Cape Fear around implementing Psychiatric Consultation to Primary Care via the B3 service
- Joint effort between Partners LME/MCO and AccessCare to create a health “Hub” in Burke County
- Upcoming August 14<sup>th</sup> CCNC-led training for Cardinal Innovations care coordinators around value and process for working with CCNC care managers and primary care providers
- Efforts occurring in Carolina Community Health Partnership (CCHP), Partnership for Community Care (P4CC), Northwest Community Care, and Sandhills networks around creating local behavioral health provider partnerships, expanding upon the Artemis project and a successful local pilot in Mecklenburg County

LME/MCOs and CCNC recognize the importance of data sharing to effectively

coordinate 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 MCO care coordination admission and discharge data
- Sharing of MCO encounter claims
- 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 (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 10<sup>th</sup> of each month, DHHS submits the prior month's paid Medicaid claims.

Simultaneously, testing of the submission of LME/MCO Medicaid claims data continues to ensure accuracy and completeness. Encounter claims data is loaded from NC Tracks into the Truven data warehouse. As claims data is populated in the Truven data warehouse, excluding protected substance abuse data, direct transfer of the data from the Truven warehouse to the CCNC Informatics Center is implemented, allowing for all LME/MCO Medicaid claims data to flow through DHHS to CCNC. DHHS continues to manually submit 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 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**

Over the past year, the TotalCare 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 has 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 soon be brought to multiple stakeholders for further input and recommendations.

## **Closing Summary**

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.