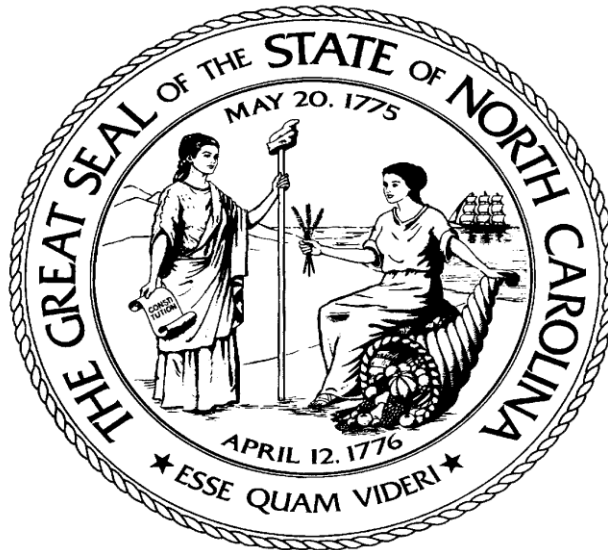


Behavioral Health Clinical Integration and Performance Monitoring

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, 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 third 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 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 early implementation 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 been working together to clarify 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 "locally grown" initiatives. The 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 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. The relevant portion of the contract is pasted below:

Four Quadrant Model for Collaboration with CCNC

The Four Quadrant Care Management Model determines whether a consumer's primary concerns are related to physical health (PH) or behavioral health (BH) and assists in determining whether the Primary Care Case Management (PCCM) network or Prepaid Inpatient Health Plan (PIHP) takes the lead on high risk/high cost Enrollees. Determination of appropriate Quadrant for a given Enrollee is a clinical judgment that can be reached in consultation with partner agencies (e.g., PCCM) based on the Enrollee's current Medical and MH/DD/SA condition complexity and risk level. Enrollees may move throughout the Quadrants over time and as conditions change. Whenever an Enrollee is receiving Care Coordination, PIHP shall determine whether the Enrollee is also being managed by a PCCM care manager and collaborate with that PCCM care manager.

1) Four Quadrants

a. Quadrant I

- i. Defined as Enrollees with low MH/DD/SA and low physical health complexity or risk.
- ii. Enrollees determined to fall into Quadrant I are not likely to need Care Coordination, but are likely best served through AccessLine/STR referral services.

b. Quadrant II

- i. Enrollees with high MH/DD/SA health complexity or risk and low physical health complexity or risk.
- ii. Enrollees in Quadrant II are the sole responsibility of PIHP and the BH provider to meet MH/DD/SA needs, as well as to arrange for appropriate referrals for identified physical health needs.

c. Quadrant III

- i. Defined as Enrollees with low MH/DD/SA and high physical health complexity or risk.
- ii. Enrollees determined to fall into Quadrant III are not likely to need intensive Care Coordination, and may be served through AccessLine/STR referral services, depending on level of need and risk for developing significant behavioral health complications.

d. Quadrant IV

- i. Enrollees in Quadrant IV have a high level of both MH/DD/SA and physical health complexity or risk.
- ii. Enrollees in Quadrant IV are the joint responsibility of PIHP and the BH Provider as well as the physical health providers involved in care (including Primary Care Provider and PCCM network if enrolled in PCCM). If an Enrollee is receiving care management through PCCM, PIHP Care Coordination and PCCM Care Managers will jointly determine primary responsibility. If not enrolled in PCCM, PIHP shall involve any applicable healthcare providers in coordination of care.
- iii. When PIHP is determined to be the lead Care Coordinator, PIHP is responsible for updating the PCCM Care Manager on any medical issues and engaging the Care Manager for assistance as needed. PCCM Care Managers will retain responsibility for medical aspects of care management in

conjunction with PIHP Care Coordinators.

iv. When PIHP is not determined to be the lead for Care Coordination, PIHP shall collaborate with the primary PCCM Care Manager, offering Care Coordination functions as needed and monitoring the Enrollee's MH/DD/SA engagement. PIHP shall continue to communicate enrollee status to the assigned PCCM Care Manager.

2) Referrals:

- a. Referral pathways shall be developed between PCCM and PIHP.*
- b. PIHP shall receive Care Coordination referrals from PCCM Care Managers, determine what level of Care Coordination services are needed, if any, and provide referral status feedback to referring Care Manager.*
- c. PIHP shall initiate Care Management and physical health referrals to PCCM as such needs are identified, and receive and document feedback from PCCM regarding the referral status.*
- d. If Care Coordination is not warranted, PIHP shall notify referral source and offer other options for assistance from PIHP in getting the Enrollee connected to treatment.*

3) Coordination with PCCM:

- a. A minimum of monthly meetings between PIHP and PCCM to facilitate communication is required.*
- b. PIHP shall ensure the coordination of care with each Enrollee's primary care Provider/PCCM physician /Health Home for Enrollees receiving care coordination.*
- c. PIHP shall include any assigned PCCM Care Managers in the development of an Enrollee's Individual Service Plans.*
- d. PIHP shall involve any assigned PCCM Care Managers in the development and implementation of crisis plans so that both parties may respond appropriately to Enrollee crises.*
- e. PIHP, with the assistance of PCCM, will encourage, support and facilitate communication between Primary Care Providers and BHPs regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem solving as well as identification of medical home for persons determined to have need.*

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. Many LME/MCO CEOs participate on local CCNC boards. 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:

Joint Efforts around Emergency Departments

Smoky Mountain Center and Carolina Community Health Partnership (CCHP)
CoastalCare and Community Care of Lower Cape Fear (CCLCF), Community Care Plan of Eastern Carolina (CCPEC)
Cardinal Innovations and Community Care Partners of Greater Mecklenburg (CCPGM)
Alliance and Community Care of Wake/Johnston Counties (CCWJC), Northern Piedmont Community Care (NPCC), Carolina Collaborative Community Care (4C)
ECBH and CCPEC
CenterPoint and Northwest Community Care Network (NCCN)
Partners BHM and Community Health Partners (CHP)
Eastpointe and Community Care of Sandhills (CCS), CCLCF, CCPEC, AccessCare

Integrated Healthcare and Transitional Care Teams (formal and informal)

Alliance and 4C, CCWJC, NPCC
Partners BHM and AccessCare, CHP
Sandhills and Partnership for Community Care (P4CC)
Cardinal Innovations and CCPGM, Community Care of Southern Piedmont (SPCC), AccessCare
ECBH and CCPEC

Joint Efforts around Prescribing/Education for Practices

Alliance and 4C
CoastalCare and CCLCF
Eastpointe and CCLCF, CCPEC
Cardinal and CCPGM
CenterPoint and NCCN, P4CC
Partners BHM and CHP, CCHP, AccessCare
Sandhills and CCPGM, P4CC, CCCS

Behavioral Health and Primary Care Provider Meet and Greet Events

Smoky and CCHP, NCCN
Partners and CCHP, NCCN, AccessCare

Alliance and CCWJC,4C
CenterPoint and NCCN
CoastalCare and CCLCF, CCPEC
Eastpointe and CCLCF
Sandhills and CCPGM

Joint Efforts around Chronic Pain – Naloxone, Treatment, Community

CoastalCare and CCLCF
Alliance and CCWJC, NPCC, 4C
CenterPoint and P4CC, NCCN
Cardinal and SPCC, NCCN
Partners and NCCN, AccessCare, CHP, CCHP
Smoky and NCCN

Joint Projects around Children/Adolescents/Foster Care

Cardinal and NPCC, CCPGM
CenterPoint and NCCN
Alliance and 4C
Smoky and CCHP, Community Care of Western North Carolina (CCWNC)
ECBH and CCPEC
Sandhills and CCPGM, P4CC, CCCS
Eastpointe and 4C

Joint Projects around Pregnant and Opiate Addicted Women

CoastalCare and CCLCF

Regional LME/MCO and Network meetings

Eastpointe and CCPEC, CCLCF, CCS, AccessCare
Smoky/Partners/CPHS and CCWNC, AccessCare, CHP, CCHP, NCCN

Concerted effort with Regional Psychiatric Hospitals (including UNC WakeBrook)

Eastpointe and CCPEC, CCLCF, CCS, AccessCare
Sandhills and P4CC

Alliance and CCWJC

Pharmacy and Medication Reconciliation

Cardinal Innovations and CCSP, CCPEC

Smoky Mountain Center and CCWNC

Sandhills and P4CC

Eastpointe and CCS, CCLCF, CCPEC, AccessCare

Alliance and NPCC, 4C

Healthy Ideas (depression management for geriatric populations)

CenterPoint and P4CC

Community Resource and Access to Care

Alliance and 4C

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 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
- MCOs use Informatics to provide medical information to behavioral health providers with consumer referrals
- 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

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 survey and summarize the Total Care Initiatives that have been in development since the initiation of the CCNC behavioral health initiative more than five years ago. DHHS has been hosting LME-MCO/CCNC planning meetings since December 4, 2013. Rather than develop a new, one-size-fits-all initiative to impose on all LME-MCO/CCNC partnerships, everyone agreed to document current partnerships and more intentionally track and assess the outcomes of these partnerships. LME-MCOs, CCNC, providers, consumers, and DHHS greatly value the importance in the flexibility to tailor local

initiatives to meet the local needs.

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 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 submitting claims data directly to CCNC (East Carolina Behavioral Health and Cardinal Innovations) and continue with this process while others were brought on o 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. Simultaneously, the 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. 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. Additionally, the Integrated Care Steering Committee Outcomes Workgroup has been meeting since Fall 2014 to identify potential measures that would promote integrated care. DHHS hosted a small workgroup including LME-MCOs, CCNC and integrated care experts that 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

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.