

**NORTH CAROLINA STATE DEMONSTRATION
TO INTEGRATE CARE FOR DUAL
ELIGIBLE INDIVIDUALS**

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A. Executive Summary

North Carolina's Dual Eligible Beneficiary - Integrated Delivery Model has the triple aims of improving responsiveness to beneficiary goals, improving care quality and achieving shared savings. This new way of doing business is a model designed to meet needs rather than simply provide services; a model where the investment of public funds acknowledges the:

- individual differences in the conceptualization of quality of life,
- wisdom of preventive services and high quality care,
- realization that needed supports must vary according to changing goals of individual beneficiaries and their caregivers, and the variation of resources available in communities.

North Carolina's vision is for a cohesive, equitable and sustainable approach to meeting the needs of dual eligible beneficiaries. It is premised on the knowledge that providing the right care, to the right person, at the right time results in better access and care. Through the hard work of more than 180 volunteer beneficiaries and stakeholders, North Carolina (NC) has fashioned a strategic framework to build on what works well, and to define systemic improvements needed to integrate Medicare and Medicaid services and supports to assist dual eligible beneficiaries.

The strategic framework for this Integrated Delivery Model builds on natural supports and community resources and the statewide medical home and population management infrastructure currently serving more than 1.24 million NC Medicaid recipients, and others. Developed and implemented through the Community Care of North Carolina (CCNC) Program, this model offers beneficiary-centered primary care physician-led medical homes to help enrollees achieve their goals through the use of evidence-based approaches to enhance care quality, access to information and the use of actionable data. Evidence of the success of this strategy can be seen in comparative health effectiveness performance measures (HEDIS) which place CCNC in the top 10 percent nationally for diabetes, asthma and heart disease, when compared with commercial managed care plan performance in the U.S. Other dimensions of the overarching strategic framework address independent assessment of need; functional need-based resource allocation; development of incentives and tools that encourage providers and beneficiaries to grow and maximize their capacity; and flexible use of public funds for supports to dual eligible beneficiaries.

North Carolina will work with the Centers for Medicare and Medicaid Services (CMS) to begin implementation of this Integrated Delivery Model. Implementation activities beyond the demonstration will be driven by ongoing program and policy adaptations to current systems that must be integrated to achieve full model implementation. Under this three-year demonstration initiative with CMS, North Carolina will:

- use Medicaid funds to support medical homes for community-residing dual eligible beneficiaries and extend medical home offerings to dual eligible beneficiaries in nursing home and non-medical residential care (adult care home) settings;
- develop integrated independent needs assessment and functional need-based resource allocation processes for medical need/level of care determination and authorization;

- develop cross-stakeholder opportunities for communication through greater access to electronic information and state, regional and community-level opportunities for beneficiary, provider and other stakeholder education and collaboration.

Table 1: North Carolina Dual Eligible Beneficiary -Integrated Delivery Model

Target Population	Full Benefit Dual Eligible Beneficiaries (duals) age 21 and older
Total Number of Full Benefit Medicaid-Medicare Enrollees Statewide	222,753 (Dec 2010, Medicaid)
Total Number of Beneficiaries Eligible for Demonstration	176,050 (Dec 2010, Medicaid) Includes: All adult duals not enrolled in Medicare Advantage Plans (estimated n=15,000) and PACE (n=127) Excludes: Full benefit duals under 21 years of age (n=455); full benefit duals incarcerated with suspended Medicaid benefits (n=141); duals receiving services and supports through specialty behavioral health plans (estimated n= 35,250)
Geographic Service Area	Statewide, includes all 100 counties of North Carolina
Summary of Covered Benefits	All Medicare, Medicaid and Waiver funded services
Financing Model	Managed Fee for Service
Summary of Stakeholder Engagement/Input	Core Leadership Team: representatives from the Divisions of Medical Assistance, Aging and Adult Services, Vocational Rehabilitation, Mental Health, Developmental Disability, and Substance Abuse Services, Public Health and Health Services Regulation, along with Community Care of North Carolina began weekly meetings in June 2011 and currently meet bi-weekly. Statewide Partners Group: representatives from over 50 partner organizations have met to date on August 18, October 17, and December 16, 2011, February 21 and March 20, 2012. Work Groups: Planning Grant Work Groups focusing on Medical/Health Homes and Population Management, Long Term Services and Supports, Transitions Across Settings and Providers and Behavioral Health Integration, co-lead by Core Leadership Team members, with broad beneficiary and stakeholder membership, convened in September 2011 and began submitting recommendations in December 2011. Payment and Delivery System Integration and Community Stakeholder and Beneficiaries Work Group began in late 2011, early 2012 and will continue throughout implementation, along with other work groups. Beneficiary Conversations: From October 2011 to February 2012, nine beneficiary conversations were convened in eight different communities. Public Information and Input: Dual Eligible Planning Website http://www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/ and dedicated email: Dualfutures@n3cn.org Public Hearing Dates: In-person and call in: March 20 and March 27, Toll free evening call in: April 16, 2012.
Proposed Implementation Date	January 2013

B. Background

i. Overall vision/rationale for the proposed design

Buoyed by the hope of a federal and state partnership, stakeholders in North Carolina are embracing the opportunity to rethink how best to meet the needs of dual eligible beneficiaries. The Integrated Delivery Model outlined here is the product of more than 180 stakeholders thinking and working together to formulate overarching guidance for North Carolina Medicaid policy.

The vision is for a cohesive, equitable and sustainable approach to meeting the needs of dual eligible beneficiaries. It is premised on the knowledge that providing the right care, to the right person, at the right time results in better access and care for us all. This delivery model approaches integration through working with beneficiaries as they define and refine their goals and offers beneficiary-centered medical home supports to assist in the achievement of those goals. The approach builds on an infrastructure that currently supports medical homes for over 1.24 million Medicaid recipients, of whom more than 100,000 are community-residing dual eligible beneficiaries. These primary care led medical homes facilitate screening and in-depth in-person health assessment with enrollees. Other medical home supports include care management, transition support, medication reconciliation and review, chronic disease self-management, behavioral health, patient and caregiver education, consultation and referral for palliative care and other supports to assist beneficiaries with complex needs. When fully implemented, all dual eligible beneficiaries, working with their medical homes, will have access to quality health care services, network supports and wrap-around services, and information and resources that build on beneficiaries' strengths, regardless of their functional capacity, clinical needs, or living arrangements. Medical homes are described in greater detail in *Section C.1: Beneficiary-centered Medical Homes*

Health care and supportive services for dual eligible beneficiaries in North Carolina are often delivered through a complex and fragmented delivery system. Absent an explicit, proactive shared vision, the evolution of policy and program priorities has produced a dizzying array of service systems that fail to meet the needs of those they intend to serve. Furthermore, these systems result in perverse expectations and incentives, making it difficult for well-intentioned providers to deliver the best care. Regulatory and financial interests of providers are in direct conflict with the preferences and clinical best interests of beneficiaries at multiple junctions of these fragmented systems. As a consequence, there is a lack of trust and little dialogue between and among beneficiaries, providers and policy makers. The untoward outcomes are beneficiary dissatisfaction, sub-optimal care and inefficient use of public funds. Examples of the fragmentation experienced by beneficiaries and their families, frustrations faced by providers and advocates and examples of wasteful use of public funds are well known to all stakeholders.

Over the past 20 years, North Carolina has invested in the development and implementation of a statewide medical home and population management strategy, now known as the Community Care of North Carolina (CCNC) Program. The Community Care approach has become a national model of population management. This model includes: care and disease management; stratification to identify the most impactful members and those at highest risk and with highest care needs; transitional care across providers and settings; quality improvement efforts and quality reporting; self-management of chronic conditions and enrollee supports and education; pharmacy management including poly-pharmacy, poly-

prescriber and medication reconciliation; integration of behavioral health care; robust informatics center with web-based tools for care managers, networks and providers; and, referrals to and support of palliative care.

Focused work on the complex needs of dual eligible beneficiaries began in January 2010 under a Medicare 646 Quality Demonstration Project funded by the Centers for Medicare and Medicaid Services. Under this initiative, 8 of the 14 regional CCNC Networks began rapid-learning pilots with approximately 206 participating primary care practices and over 900 providers.

Premised on the availability and use of actionable data for targeting beneficiaries that would benefit from the interventions, the Medicare 646 Quality Demonstration recently completed its second year of operation. Remarkably, this initiative was successful in meeting the quality improvement benchmarks on 14 of the 18 performance measures and showed some improvement in 17 of the 18 measures. Hobbled by the absence of Medicare claims data for risk stratification and targeting until month 20, it is not surprising that these pilot efforts have yet to show evidence of anticipated cost-savings. In addition, the program uses a retrospective “attributed enrollment” logic, which makes it difficult to ensure and measure beneficiary enrollment and receipt of the benefits inherent in the medical home and population management model.

Utilizing the lessons learned, the quality metrics and evaluation processes developed, along with the substantive experience of this demonstration, North Carolina is committed to exploring new ways to better meet the needs of dual eligible beneficiaries. Examples of promising pilot practices include the following.

- A CCNC Network and Home Health provider have established clear expectations for collaboration in the development of acute care transition supports using tele-health technology to monitor beneficiaries’ chronic disease self-management activities. Implemented protocols are being refined for structured “hand-offs” to assure continuity of care when home health services are concluded, home health-owned tele-health technology is removed and primary care medical home teams assume primary responsibility for ongoing monitoring and support for beneficiaries’ chronic disease self-management activities.
- A primary care practice has extended their Project REACH guided care work to residents of adult care homes (non-medical residential care settings). Through the creation of new relationships, communication materials and educational supports for residents and staff of adult care homes, primary care practices are encouraging residents and staff to use practices’ 24/7 call capacity to reduce the use of emergency department and county ambulance resources for non-urgent conditions.
- Dialysis nurses and CCNC Networks are testing initiatives to encourage patients with kidney insufficiency to pursue outpatient shunt placements. Non-emergent placement of shunts is expected to help avert serious health crises and concomitant intensive care hospital stays, and emergency-driven initiation of dialysis.

INTEGRATED DELIVERY MODEL STRATEGIC FRAMEWORK

North Carolina's Integrated Delivery Model for Dual Eligible Beneficiaries is designed to integrate all Medicare and Medicaid funded services and supports for all full benefit dual eligible beneficiaries. The overarching strategic framework for this model, outlined below, serves as a guide for North Carolina's program and policy development, as well as this three-year CMS-supported implementation demonstration. It is apparent that full implementation of this Integrated Delivery Model will require time and resources in addition to this three-year implementation demonstration. With this in mind, readers are advised that the information presented here focuses on initial implementation. Other Integrated Delivery Model improvements will be introduced as resources become available and opportunities arise for program and policy adjustments that are a part of ongoing North Carolina Medicaid and State-funded program operations.

During this three-year demonstration initiative, in partnership with CMS, North Carolina will focus on three initial implementation priorities.

1. North Carolina will use Medicaid funds to support medical homes for community-residing dual eligible beneficiaries and extend medical home offerings to dual eligible beneficiaries in nursing home and non-medical residential care (referred to hereafter as adult care home) settings (*Appendix C, Program Definitions*). This will enable North Carolina to begin realigning incentives to rectify inefficiencies created when provider financial goals are in conflict with the achievement of beneficiary goals and evidence-based clinical best-practices. Immediate improvements will be attained through a combination of targeting beneficiaries at greatest risk for care management, medication review and transitional supports and opportunities for provider and beneficiary capacity building. In turn, these care improvements can be expected to improve beneficiary outcomes, reduce potential medication therapy problems (Trygstad, Christensen, Wegner et al. 2009; Trygstad, Christensen, Garmise, et al. 2005) and improve cost-efficiencies through reductions in non-urgent use of emergency departments and potentially avoidable hospital use (Walsh, Bragg, and Ouslander et al. 2010).
2. Current processes for allocating Medicaid funds for long-term services and supports use disparate criteria, definitions and processes that have evolved over the past 30 years. These systems rely on assessment and authorization tools, like the FL-2, that are widely regarded as subjective. In response, North Carolina will develop an independent integrated assessment and functional need-based resource allocation process. This will replace the current eligibility determination and service authorization processes that allocate resources based on service or care setting, with need and resources thresholds that vary substantially by programs and across recipient groups.
3. Integration of services and supports for dual eligible beneficiaries will require new avenues for communication and mechanisms to foster community collaboration. Underlying barriers to integration include the absence of effective communication, unequal access to information, imbalances among those in the conversation and the

use of language developed within a discipline (acronyms, jargon and technical terminology), that have different meanings for different people and create confusion. North Carolina will further develop cross-stakeholder opportunities for communication through greater access to electronic information and state, regional and community-level opportunities for beneficiary, provider and other stakeholder education and collaboration.

These priorities for initial implementation address existing barriers to integration and needed improvements identified through North Carolina's Dual Design contract cross-stakeholder planning and model development process. Highlights of barriers addressed, opportunities for immediate improvements and background on these short and longer-term structural improvements priorities are discussed in further detail in *Section C.i: Proposed Delivery System and Programmatic Elements*.

What follows is a brief rendering of the overarching Strategic Framework for North Carolina's Integrated Delivery Model.

BENEFICIARY GOAL CENTERED

North Carolina's Integrated Delivery Model is centered on support for beneficiaries' achievement of their self-defined goals for quality of life and is designed to build on beneficiaries' strengths, natural supports, and available community resources. The model's goal has the triple aims of improving responsiveness to beneficiary goals, improving care quality, and achieving shared savings to support full implementation and refinement of the model and achieve sustainable supports for dual eligible beneficiaries.

This new way of doing business is a model designed to meet needs rather than simply provide services, a model where private homes are the default setting of care and the investment of public funds acknowledges the:

- individual differences in the conceptualization of quality of life,
- wisdom of preventive services and high quality care,
- realization that needed supports must vary according to changing goals of individual beneficiaries and their caregivers, and variation of resources available in communities.

From a beneficiary's perspective, when the Integrated Delivery Model is fully implemented, the following are some of the expected improvements:

- I know what a medical home team is and I am a part of mine.
- I am comfortable asking questions and discussing my goals and preferences with my medical home team.
- I have help with my medications and understand how and when to take them.
- My important health information is available to me and I have help understanding what it means.
- I have a primary care provider who knows my goals and helps me navigate my care with specialists.
- My specialists communicate with my primary care providers so my care is coordinated.

- When I have a change in my health or circumstances my medical home team provides me support. They help make sure everything is in place when I get out of the hospital or change providers.
- I know who to call if I need help or have questions, anytime of the day or night.
- I have access to information about what is available in my community and help finding the right type of care and supports to meet my needs.
- I have opportunities to participate in programs that will help me do all I can to take good care of myself and live well with my chronic health challenges.
- I have flexibility and help budgeting public funds that are available to help me meet my daily needs. This helps me get glasses or technology and be more self-sufficient.
- I know what it means to file an appeal and I know where to turn for help.
- I feel empowered about my health care.

MEDICAL HOME INFRASTRUCTURE

This Integrated Delivery Model builds on North Carolina's managed fee for service primary care medical home and population management infrastructure. When fully implemented, this model will offer all dual eligible beneficiaries the opportunity to enjoy the benefits of primary care led medical home. Through this team-based approach, beneficiaries will serve as team members, with professionals and para-professionals who will provide services and supports to help them articulate and achieve their evolving personal health goals.

The Dual Eligible Integrated Delivery Model builds on CCNC's information infrastructure. This analytic and reporting capacity, available to authorized users through the statewide CCNC-supported Informatics Center, was developed in collaboration with primary care providers, hospitals, public health departments and other community organizations. This infrastructure has demonstrated success in improving access, care outcomes and cost efficiencies in meeting the needs of Medicaid recipients. Additional information on the CCNC Networks is included in *Section C: Care Model Overview and Section G: Infrastructure and Implementation*.

The remainder of this section provides a brief overview of key dimensions of the strategic framework and systemic changes underlying this Integrated Delivery Model, including:

- independent assessment of need
- functional need-based resource allocation
- flexible use of public funds
- capacity incentives
- broader use of actionable data

INDEPENDENT ASSESSMENT OF NEED

Improved targeting of public funds will be advanced through the introduction of an integrated independent process for the assessment and determination of dual eligible beneficiaries' medical and functional needs. Independence in medical eligibility determination assures that those assessing need are free of conflicts of interest that have contributed to overutilization of services when assessors are employed by providers of direct services.

Trained assessors will use standardized, tested tools and definitions during meetings with beneficiaries identified as at-risk. Targeting assessment efforts will include primary care physician visit screening, automated risk-stratification, transitional care initiatives, and inter-agency and self-referral. While assessing needs, care managers will begin discussions regarding enrolled beneficiaries' strengths, needs and goals, and review available natural and community resources. Assessors will use tested protocols to keep medical home team members informed of beneficiaries' current status. This information will provide key communication to assure integration of services and supports, and will be incorporated, along with other beneficiary data in the Informatics Center that supports medical home team electronic communication. Additional information on these Informatics Center resources can be found in *Section G: Infrastructure and Implementation*.

FUNCTIONAL NEED-BASED RESOURCE ALLOCATION

A new process for the determination of need and the attendant allocation of public funds for supports and services will rely on a functional need-based definition that encompasses all dual eligible beneficiaries, regardless of their diagnosis, living arrangements or combination of co-morbidities. This functional need-based definition will provide an objective basis for the allocation of resources in a manner that is both equitable and transparent.

At its root, this process integrates various dimensions known to impact daily functioning, including:

- physical health capacity/impairment in activities of daily living and instrumental activities of daily living;
- mental health and emotional impairments and limitations in cognitive capacity;
- conditions requiring professional or specialized resource; and
- availability and adequacy of natural supports.

In discussing this type of functional need-based approach, North Carolina's stakeholder volunteers recommended incorporating the following existing processes and tools:

- minimum data set (MDS)/resource utilization groups (RUGS) that define the level of resources required to meet the needs of skilled nursing facility residents;
- four- quadrant classification of co-occurring mental and physical health conditions; and
- Program for All-Inclusive Care for the Elderly (PACE) assessment domains.

This approach represents an important shift away from the allocation of public funds for supports and services, based on the constellation of services assembled in response to beneficiaries' living arrangements.

FLEXIBLE USE OF PUBLIC FUNDS

Flexibility in the use of public funds pertains to two dimensions of this Integrated Delivery Model: individual and systemic.

1. *Greater flexibility in the individual use of funds allocated to meet beneficiaries' needs is designed to be instituted following development and full implementation of the independent assessment and needs-based resource allocation components of the model.*

This first dimension of flexibility is incorporated at the suggestion of our beneficiary and stakeholder work groups. They expressed concern about barriers to acquiring devices to assist with communication, in-home care technology and cost-effective purchasing of appliances that reduce dependence on others. In addition to beneficiary preferences, this approach has demonstrated enhanced beneficiary satisfaction and cost savings, as evidenced by evaluation findings supplied by the Cash & Counseling demonstration program (Brown, Lepidus-Carlson, Dale et al 2007).

2. *Flexibility in the systemic use of public resources is designed to assure the consistent quality and statewide availability of key Integrated Delivery Model functions.*

North Carolina has a growing urban population. However, a greater proportionate share of dual eligible beneficiaries resides in rural communities compared with the distribution of the state's total population. This geographic distribution, along with stark differences in access to services and supports in resource-rich and resource-poor communities and the diversity of the dual eligible beneficiaries' needs, require CCNC Networks and community providers to find innovative solutions to assure statewide consistency. By focusing on defined functions, with explicit expectations and measurable capabilities and standards, North Carolina has successfully built a robust CCNC Network infrastructure that adapts to the needs of enrollees, and the strengths and weaknesses in the community resources and healthcare delivery system in their communities. Continuation of this function, expectation and capabilities/standards-based approach is incorporated in the Integrated Delivery Model design.

One example of local variations in delivery that assures consistency is how CCNC Networks deploy care management resources. Nurses and social workers employed by CCNC Networks to manage care in urban areas may be embedded in and work exclusively with a single primary care practice or as an embedded transitional support person in a single hospital system. In contrast, care managers, in rural communities routinely work with multiple hospitals or practices that serve fewer enrollees.

As medical homes are extended to beneficiaries in different living arrangements and new capacity is being encouraged to improve quality and capacity, flexibility will both ensure consistency of offerings, and encourage/permit creative responses in the development of more dynamic system responses.

CAPACITY INCENTIVES

Support for Provider Capacity Building

Beneficiary-centered medical homes will be supported by Medicaid per member per month (PMPM) payments, to primary care practices at the State negotiated Aged, Blind and Disabled (ABD) Medicaid recipient rate. This structure encourages primary care practices to take responsibility for and work with dual eligible beneficiaries with the most complicated circumstances and complex health conditions. Similarly, CCNC Networks supporting beneficiaries' medical home teams will receive Medicaid Aged, Blind and Disabled (ABD) PMPM for enrolled dual eligible beneficiaries.

Incentive payments for provider capacity development will be made to qualified providers participating in the program. Capacity development incentives would be structured to encourage providers to operate at the 'top' of their license, using a tiered incentive PMPM. This tiered mechanism would include two components. The first component is a fixed rate payment to cover independent needs assessment, contributions to support the statewide electronic and human information infrastructure, as well as routine care management and medical home functions. The second component, a flexible amount, is to incentivize provider participation and practice improvements to meet both beneficiary and Integrated Delivery Model capacity enhancement and cost saving goals. Allocation of this portion of the PMPM would vary based on responsibilities assumed by various team members and their demonstrated capacity as evidenced by achievement of contractually defined capabilities/standards and quality metrics. This tiered approach for provider development is designed to support raising the capabilities of all medical home team providers and to incent development of new provider capacity.

This incentive structure requires up-front investment of Medicare resources toward the PMPM that may not be available during the three year implementation demonstration. During the implementation demonstration, North Carolina will rely on a combination of Medicaid-funded Primary Care Practice (PCP) & Network PMPM payments and provider-initiated improvements. These improvements will be developed collaboratively with the Division of Medical Assistance and CCNC and in response to financial and regulatory incentives. These incentives will draw on defined functions and capabilities for the broader tiered approach envisioned for full implementation of the Integrated Delivery Model. Providers who meet or exceed defined capabilities/standards and pre-defined outcome and cost targets will be eligible to participate in retrospective performance payment financial incentives that are subject to further discussion and negotiation with CMS.

Support for Beneficiary Capacity Building

Throughout the beneficiary and stakeholder processes, we repeatedly heard about distrust of providers by beneficiaries and their family caregivers, and their reluctance to share honest opinions for fear of reprisals. While clinicians and providers are well-intentioned in their efforts, all too often beneficiaries are intimidated and unable to make their needs, goals and preferences heard. Avoidance of difficult conversations by providers and beneficiaries alike serve to exacerbate these communication gaps and undermine the shared goals of a more responsive, high quality and cost-efficient delivery system. In response, supports for beneficiary capacity building will encompass new modes of communication and information sharing.

We propose development of a user-friendly Beneficiary Portal, developed within the broader context of North Carolina's Health Information Exchange efforts. This beneficiary portal will provide beneficiaries access to information materials, resources and their personal health information. At the same time, we will be building capacity for achievement of beneficiary-defined goals through motivational interviewing, building trusted relationships and engaging beneficiaries as members of their medical home teams. Supports to beneficiary participation will also be developed through information exchange, learning opportunities and enhanced communication among beneficiaries, providers and other stakeholders. Shifting away from a history of imbalance among providers as well as between providers and beneficiaries will require commitment, diligence and patience.

BROADER USE OF ACTIONABLE DATA

The final structural element of this model is the expanded use of actionable data by all parties. Beneficiaries and their medical home care team will have access to online actionable data to inform choices and shared decision-making and to monitor progress and outcomes. Beneficiaries will have the opportunity to learn more about their healthcare and to become more active partners in managing their health through access to their health information, evidence-based chronic disease self-management programs and related educational support from their medical home teams. They will also participate in defining the metrics used to measure progress toward the achievement of their goals. Development and implementation of the Informatics Center Beneficiary Portal will increase access to information and support in understanding the short and long-term implications of biometric and other clinical indicators of their health status.

Information integration to support Integrated Delivery Model implementation will also draw on actionable data from the Informatics Center and Division of Medical Assistance information systems.

ii. Description of the Medicaid-Medicare Enrollee Population

Through the demonstration, North Carolina will focus on 176,050 full-benefit dual eligible adults. Excluded from the target population are full-benefit dual eligible beneficiaries who are under the age of 21 (n=455) and those with suspended Medicaid due to incarceration (n=141) as well as those enrolled with Medicare Advantage Plan (estimated n=15,000) and PACE (n=127). Due to the significant systemic changes currently underway, as described in *Section C.v.(c): Existing specialty behavioral health plans*, individuals with mental health, developmental disabilities and substance abuse needs receiving services under Medicaid Prepaid Inpatient Health Plan (PHIP)/1915 (b)/(c) Medicaid Waiver are considered outside the scope of this three year demonstration. These beneficiaries are subject of concurrent pilot and development work, referred to in North Carolina as the Integrated Care Model, which is focused on the integration of the behavioral health and primary care systems. This work will provide experience and data to inform future implementation of Integrated Delivery Model features. Based on 2010 Medicaid claims data, we estimate this group includes approximately 35,250 full-benefit dual eligible beneficiaries.

In December 2010, full-benefit dual eligible beneficiaries represented 15% of all Medicaid recipients. Analysis of Medicaid data provides a glimpse into the demographic characteristics of the population. Dual eligible beneficiaries are by definition low income, with 60% living below the federal poverty level and almost 94% living below 200% of poverty level. The majority of dual eligible beneficiaries are age 65 or older (54.2%) and female (65.5%). Compared with the overall population in North Carolina, dual eligible beneficiaries are less likely to be White, Non-Hispanic (52.1% of duals, 65.3% of NC population), Hispanic (2.0% of duals, 8.4% of NC population) or Asian (1.4% of duals, 2.2% of population), and dual eligible beneficiaries more likely to be Black, Non-Hispanic (38.2% of duals, 21.5% of NC population) or Native American (1.4% of duals compared with 1.3% in the total population).

Dual eligible beneficiaries are widely recognized as having complex medical needs, as well as functional and cognitive limitations. In December 2010, approximately 39,800 or 17.9% of the dually eligible population in North Carolina had a severe and persistent mental illness and roughly one-third had two or more chronic conditions. The majority, 72%

(159,799), live in the community, while 14% (31,588) were receiving long-term services and supports in institutional settings and 5.4% (12,083) were receiving long-term services through Waivers or PACE while living at home (Table 2). As a result of being in poor health and having multiple chronic conditions, they also tend to use high-cost health services such as emergency room visits and inpatient hospitalizations at a higher rate than the general population. In 2010, 29.5% of dual eligible beneficiaries visited the Emergency Department at least once, and 22% had at least one hospital inpatient stay.

Table 2: Dual Eligible Enrollee Population

	Overall	**Individuals receiving LTSS in institutional settings	***Individuals receiving LTSS in HCBS settings
Overall	222, 151(100%)	31,588(14.2%)	12,083 (5.4%)
Individuals ≥65	120,530(54.2%)	26,028(82.3%)	7,272(60.2%)
Individuals <65years	101,648(45.8%)	5,530 (17.5%)	4,811(39.8%)
SPMI*	39,863(17.9%)	4,893(15.5%)	1,371(11.3%)

Serious and Persistent Mental Illness (SPMI). SPMI includes Schizophrenia(icd9-295), Bipolar or major depression (icd9 296), Schizoaffective disorder (icd9-3012) or inpatient stay in a mental hospital

** LTSS in institutional settings living arrangements: skilled nursing, ICF, ICF-MR/DD and mental institution

*** LTSS in Home and Community Based Services (HCBS) include beneficiaries in Waiver services and PACE

C. Care Model Overview

i. Proposed Delivery System & Programmatic Elements

North Carolina’s Integrated Delivery Model, when fully implemented, will provide beneficiary-centered medical homes to all full benefit dual eligible beneficiaries in all 100 counties of the state. Programmatic elements included in this three-year demonstration proposal address three implementation priorities.

1. Medical homes offerings for community-residing dual eligible beneficiaries and extension of medical homes to dual eligible beneficiaries who live in nursing homes and adult care homes. (For further definition, please see *Appendix C, Program definitions*). Primary care led medical homes will work with beneficiaries in all settings to achieve their goals. For beneficiaries with complex needs, medical home care management teams will mobilize transitional supports, medication therapy management and consultation, and referral and coordination assistance to improve beneficiaries’ experience, care outcomes and cost-efficiencies.
2. An independent assessment process will be developed to ascertain beneficiaries’ strengths, natural supports, and functional and medical needs. This process will communicate beneficiaries’ needs for care planning and management. Data gathered during this process will inform development of a new methodology for the allocation of public funds for supports to beneficiaries who have a need for assistance from others.
3. Cross-stakeholder opportunities for communication and information sharing will be developed through greater access to electronic information and state, regional and community-level opportunities for beneficiary, provider and stakeholder

collaboration. During this demonstration, training and education efforts will focus on topics of critical importance identified in work group discussions, including the importance of advance directives for physical and mental care to make personal care preferences known to others.

1) Beneficiary-centered Medical Homes

This model builds on North Carolina's fully operational, statewide program of medical and community resources collectively known as Community Care of North Carolina or CCNC. Community Care of North Carolina is a private-public collaborative effort through which the State has partnered with community physicians, hospitals, health departments and other community organizations to build regional CCNC Networks and infrastructure to improve the quality, efficiency and cost-effectiveness of care for Medicaid recipients. This system serves the state's most vulnerable and high cost populations through access to primary care medical homes, vigilant care management and provider collaboration.

As previously noted, regional CCNC Networks currently serve more than 1.24 million Medicaid enrollees of whom more than 100,000 are community-residing dual eligible beneficiaries.

Additional dual eligible beneficiaries enrolled through this demonstration will be assigned to their beneficiary-centered medical homes through an opt-out process piggy-backing the current Medicaid medical home enrollment structure. Priority enrollment will begin with Part A, B and D Medicare claims-based targeting of dual eligible beneficiaries with the most complex care needs who reside in North Carolina's nursing facilities and adult care homes with high concentrations of high-risk dual eligible beneficiaries.

Education and training programs will assist beneficiaries, their families and medical home team members as they learn the processes necessary for shared decision-making regarding services and creation of support plans.

Implementation funded Dual Eligible Liaison staff within each CCNC Network will facilitate communications with the 4,300+ existing and new primary care providers and develop/strengthen relationships with the 400+ nursing facilities and 1,200+ adult care homes, to coordinate enrollment and supports for dual eligible beneficiaries in these residential care settings. The Liaisons will also coordinate with beneficiary and community stakeholder development processes described further below.

Medical Home Functions:

Each CCNC Network will continue to contract with primary care practices (PCPs) to support medical home functions for all dual eligible beneficiary enrollees including:

- primary care physician leadership,
- routine medical screening,
- preventive health care informed by automated alerts based on enrollees' health history and current conditions,
- in-depth assessment of potential problems identified through screening,
- team-based care,
- education, support, referral for self-management skill-building of newly diagnosed conditions, and

- beneficiary-centered-care that is based on beneficiaries' needs, pharmacy management, behavioral health, and palliative care consultation and referrals.

Augmenting this infrastructure are CCNC Networks' partnerships with local health care delivery systems, including hospitals, county health departments, local safety net providers, community-based organizations and specialty practices, including behavioral health providers. Continuing development of increased provider capacity and communication structures with these resources will be important to improving responsiveness to beneficiary goals, improving outcomes and reducing non-urgent care use of emergency department services and potentially avoidable hospital stays. Examples of these collaborative efforts are noted below, under the discussion of benefit enhancements.

Due to the intensity of care needs of high-risk beneficiaries living in nursing homes and adult care home settings, initial implementation efforts will rely on care management tools specific to these improvements, and will emphasize:

- risk-stratification to target care and disease management interventions,
- pharmacy management strategies and interventions, and
- coordinated care delivery with an emphasis on improving transitions.

Other care management tools employed to achieve quality, utilization, and cost savings goals for dual eligible beneficiaries include:

- evidence-based best practice programs in the medical homes,
- motivational interviewing, beneficiary education and self-management skill building,
- improved management of chronic illness care through use of actionable data and automated beneficiary-specific alerts, and
- a structured environment from which community providers can work collaboratively to improve care and health outcomes of enrollees.

Initial implementation will benefit from the 14 regional CCNC Networks' capacity to work together to test and implement new practices and statewide information management systems that provide shared analytic support and advanced informatics capacity. The CCNC Networks supported Informatics Center infrastructure provides medical home teams authorized user access to information through three primary components:

1. A Provider Portal that supplies beneficiary-level data from administrative claims for care provided, Pharmacy Home functionality and clinical information (lab, x-ray) to guide utilization of evidence-based practices. In over half the State, live feeds that identify when beneficiaries are admitted to the hospital or seen in an emergency department are also available.
2. The Case Management Information System (CMIS) contains current beneficiary goals, plans of care and support, progress notes regarding challenges encountered, remedies,

and progress toward achievement of beneficiary goals. In addition, the CMIS provides the care managers with electronic population management tools and resources.

3. A broad compendium of practice, county, network and state-level reports to monitor and manage quality, performance and population health targets.

Within this Integrated Delivery Model implementation demonstration, new online information infrastructure capacity will be designed and implemented to create a user-friendly Beneficiary Portal. This Beneficiary Portal will provide resource links, access to educational materials and beneficiary access to their own personal health information. These enhancements will be constructed in alignment with related North Carolina Health Information Exchange efforts. Further details about current Informatics Center capacity are described in *Section F: State's ability to monitor, collect and track data on key metrics and Section G: Infrastructure and Implementation*.

2) Independent Integrated Needs Assessment and Functional Needs-Based Resource Allocation Methodology

Development and testing of an independent functional need-based assessment and resource allocation methodology will include review and adoption of uniform integrated assessment criteria and definitions. The conceptual framework for this methodology recommended by the Needs Determination Work Group suggests anchoring this methodology in existing tested tools and methods and using the existing nursing home minimum data set (MDS) assessments, definitions and resource utilization groupings (RUGS) to define the highest levels of need. Other recommendations include incorporating measures of ability/disability related to activities of daily living, physical and emotional, cognitive and mental health; drawing on the four quadrant model for level of care integrated behavioral health classification; and addressing the availability and reliability of beneficiaries' natural supports.

Trained assessors will conduct assessments with a sample of dual eligible beneficiaries' representative of those residing in all settings. Assessment data will be linked with claims data to develop relative need clusters and to analyze current spending patterns for services and supports to meet the needs of beneficiaries with varying functional capacity. These estimates in turn will inform development and testing of needs determination algorithms and related preliminary resource allocation estimates. The adequacy of these estimates will then be assessed through comparison of projected and actual care plan expenditures.

3) Cross-Stakeholder Information Sharing, Communication and Collaboration

Greater access to electronic information will reduce inequities in access to information. Information access improvements will include creation of a Beneficiary Portal with user-friendly access to resource links, educational materials and personal health information; extension of Provider Portal access for new authorized medical home team providers; and other Informatics Center analytic support for beneficiary-centered medical homes and Integrated Delivery Model implementation, monitoring and refinement. These enhancements will be informed by Stakeholder Work Groups.

These and other information integration activities will be developed in alignment with the work of North Carolina's Health Information Exchange. We also are mindful of the needs of providers whose electronic information needs fall outside the purview of the Health Information Exchange.

Statewide opportunities for cross-stakeholder dialog and collaboration, which began during the Integrated Delivery Model planning process, will be enhanced to help guide, monitor and refine model implementation. Along with regional and local engagement strategies noted below, these opportunities will also help foster the development of a common language as well as common expectations. These shared understandings will evolve along with the changing roles, relationships and responsibilities associated with this new approach to meeting beneficiaries' needs.

Existing regional and community collaborative structures will be tapped and new partnerships encouraged to bring together community resources and coordinate opportunities for dialog, education and training on key topics of importance. The initial focus recommended by stakeholders was the importance of making care preferences known to loved ones and care providers through periodic discussions and documentation of care preferences well in advance of physical and mental health care crises.

Development of these regional and community-level communication and collaboration activities will be facilitated with implementation demonstration funded support to the Division of Aging and Adult Services and 16 regional Area Agencies on Aging. The Division of Aging and Adult Services oversees the Administration on Aging and State-funded home and community-based supports, including family caregiver programs. It is also responsible for the development of Aging and Disability Resource Centers, known as Community Resource Connections in North Carolina. These agencies also implement several related initiatives including Healthy Living evidence-based programs, the Stanford Chronic Disease Self-Management program, the Matter of Balance falls prevention program and Healthy IDEAS depression training.

These regional facilitators will coordinate efforts with regional CCNC Network Dual Eligible Liaisons and other community services and supports. Implementation funded support for state and regional Area Agency on Aging staff will provide facilitation and coordination to strengthen existing support and begin development of new regional and community-level beneficiary, provider and other stakeholder dialog, collaboration and educational opportunities.

The state-level coordinator will also work to strengthen statewide capacity with other programs serving dual eligible beneficiaries. For example, another vital component of the NC Department of Health and Human Services serving younger adults with a disability is the Division of Vocational Rehabilitation, with expertise spanning Community Living Services, Assistive Technology and Employment and Training. The 33 Vocational Rehabilitation Regional Offices and 16 Independent Living Centers have established collaborative relationships at the state and local level with the aging network and are currently developing a shared resource information base for adults with disabilities.

ii. Benefit design

Benefit Enhancements

This Integrated Delivery Model differs from current benefit design by offering medical home supports to all dual eligible beneficiaries, including residents of nursing homes and adult care homes. At present, nursing home residents are excluded from enrollment in medical homes. Examples of how these supports will make a difference in care outcomes for dual eligible beneficiaries are available from Medicare 646 Quality Demonstration pilots that have begun to demonstrate improvements as a result of introducing medical home support for residents of nursing homes and adult care homes. For example, as dual eligible residents and nursing facilities enroll, CCNC Network care manager/pharmacist teams perform medication reviews focusing upon both accuracy and appropriateness of drug regimens for those residents having a recent care transition experience. Concerns and recommendations from these reviews are then addressed with the resident's primary care physician. Pilot findings with this process have shown significant results. Improvements were noted in both the identification of errors and concerns representing serious clinical risk and in the resolution of concerns.

While we are aware that consultant pharmacist services are already required to be available to nursing homes and adult care homes, we also realize that the activities of consultant pharmacists in these traditional roles are primarily driven by avoidance of regulatory deficiencies for the facility. Our plan includes leveraging these existing consultant pharmacist resources through CCNC Network collaboration and incentives designed to achieve improved alignment with our Integrated Delivery Model goals. Work in this area will draw on our prior experience with the NC Long Term Care Polypharmacy Initiative (Trygstad, Christensen, Wegner et al. 2009; Trygstad, Christensen, Garmise, et al. 2005). The success of this approach validates the plausibility of achieving such alignment, as well as the value in doing so.

In implementing the Integrated Delivery Model, CCNC Networks will also work with long-term care facility medical directors, staff, consulting pharmacists and other medical home team members to facilitate communication and collaboration to improve the accuracy and appropriateness of medication regimens, and to promote information sharing through the CCNC Informatics Center Pharmacy Home application. This technology will be especially valuable when beneficiaries are transitioning out of acute care hospitals. Care managers and beneficiaries will benefit from timely access to beneficiaries' historical, pre-admission and discharge medications lists and reconciliation consults, aiming for meaningful information to follow the beneficiaries across providers and delivery settings.

Another Medicare 646 pilot working with five nursing facilities demonstrated success when a CCNC Network team, including a nurse care manager with pharmacist support, introduced and trained nursing facility staff in the INTERACT model (Ouslander, Lamb, Tappen et al. 2011). Use of the INTERACT template is designed to enhance care and reduce avoidable hospitalizations and emergency room visits for nursing home residents. As a result of this 18-month effort, compared with the baseline period, hospitalization rates in participating facilities were reduced by 50% overall, with some facilities experiencing even higher reductions in the rate of ≤ 30 day re-hospitalizations.

A final example of explicit impact and benefit for dual eligible residents of adult care homes, based on Medicare 646 experience, that will be implemented statewide, involves the expanded options for support when residents experience after hours (evening and weekend) health concerns. Currently, aide-level onsite staff has limited capacity and residents frequently call the ambulance and go to the emergency department to obtain advice and care for non-urgent conditions. With beneficiary-centered medical homes, residents gain access to 24/7 support, have established care plans with their medical home teams that anticipate and address their care needs and preferences in the event of abrupt change in their needs, and beneficiaries, facility staff and other medical home team members have an understanding of who to call when, and how best to respond to health concerns whenever they arise.

With these benefits, alignment of Medicare and Medicaid services will rest with dual eligible beneficiaries and their medical home teams. Core medical home team function will include new communication protocols and information sharing resources to support dual eligible beneficiaries in all settings.

Accountability for managing services and supports included in beneficiary-centered plans will rest with the beneficiaries and their healthcare team. Explicit goals, services/supports and measures of quality and satisfaction will be included in the plan, with designated responsible parties identified for each task or action step identified.

Clinical oversight is the responsibility of the primary care physician, and oversight of the assurance of delivery and compliance of other provider plan elements is the responsibility of the CCNC Networks. As appropriate, beneficiaries, primary care providers and CCNC Networks may share responsibility for managing care with qualified medical home team members through contracts or other written agreements. Shared responsibility will require advanced certification of provider capacity.

Explicit care capacity, performance standards, and goal-related outcome targets will be well-documented, understood and agreed upon by the primary care provider, care manager and other providers integral to the medical home. The aim of continuous quality improvement to support the needs of beneficiaries will be integrated in this model, and North Carolina is committed to setting and monitoring the appropriate performance metrics.

ii. Supplemental benefits and/or other ancillary/supportive services

With full implementation, the Integrated Delivery Model will provide greater flexibility in the use of public funds. During the 3 year implementation demonstration this approach, however, will be limited as defined in the current Community Alternatives Program “Choice” option, described below in *Section C.v. (a): Current Medicaid Waivers*.

iii. Utilization of evidence-based practices will be employed as part of the overall care model.

The CCNC Provider Portal provides access to a compendium of low-literacy beneficiary education materials and evidence-based practice tools for screening and assessment, health coaching and disease management. In addition, the Informatics Center tools provide a comprehensive enrollee-level view of clinical and claims information in a searchable Chronic Care enrollee snapshot database which facilitates triage when referrals are made for care management by providers or at the time of hospital admission and discharge.

Specific reports are generated for special initiatives and targeting, e.g., identification of those with newly diagnosed asthma, heart failure, and diabetes; identification of individuals receiving controlled substance prescriptions from multiple sources; and/or identification of patients with poor adherence to their blood pressure medications. In addition, quality measurement and performance feedback monitoring reports occur at several levels. At the individual practice level to help engage providers in the quality improvement process and to monitor progress; at the network and county level to help clinical leaders and care managers identify where to deploy resources and supports; and at the statewide level to help evaluate the program's impact. These reports are an integral component of CCNC's quality improvement initiatives related to the complex co-morbidities of dual eligible beneficiaries. Quality measures based on evidence-based care guidelines currently encompass diabetes, asthma, hypertension, cardiovascular disease and heart failure. Additional community-based healthy living evidence-based practice programs are described in *Section C.i: Proposed Delivery System & Programmatic Elements and Appendix, C.e. Evidence-Based Programs*.

iv. Description of how the proposed model fits with:

(a) Current Medicaid waivers and/or State plan services available to this population

The North Carolina Medicaid Program also operates several 1915(C) Home and Community-Based Waiver Programs and specific in-home supports for eligible Medicaid recipients and dual eligible beneficiaries. Responsibility for medical home functions for dual eligible enrollees, including coordination with programmatic supports for beneficiaries served through waivers for disabled adults (excluding the 1915(b)/(c) Waiver, as previously noted), will rest with PCPs and CCNC Networks. Beneficiary-goal driven care plans will delineate medical home team member roles and responsibilities to assure appropriate assessment and monitoring. The care plans will support adjustment in response to changes in beneficiaries' needs or availability of natural supports. CCNC Network and community-provider agreements will be developed to assure the effective delivery of beneficiaries' supports, care management and service coordination functions. In addition, the agreements will define structured hand-offs for beneficiaries moving into and out of these and other service programs.

- *Community Alternatives Program/Disabled Adults (CAP/DA)* provides adult day health, case management, institutional respite, assistive technology, home modifications and mobility aids, meal preparation and delivery, non-institutional respite, participant goods and services, personal care aide, personal emergency response services, training and education, transitional support, waiver supplies for those ages 65 or older.
- *Community Alternatives Program Choice (CAP CHOICE)* provides adult day health, respite institutional, in-home aide, personal assistant, care advisor, financial management services, consumer-directed goods and services, home modifications and mobility aids, preparation and delivery of meals, respite (in-home), telephone alert and waiver supplies for disabled adults aged 18 to 64 and those aged 65 or older.
- *Personal Care Services (PCS)* provides supervision or hands-on assistance with activities of daily living. The service does not include skilled medical or skilled nursing care.
- *Home health care* encompasses in-home nursing, aide services, therapies and a wide array of medically necessary health care services provided in the residence of recipients.

(b) Existing managed long-term care programs

PACE is North Carolina's only managed long-term care program, see below.

(c) Existing specialty behavioral health plans

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services established a pilot Medicaid-managed care vendor through the use of 1915(b) and 1915(c) Medicaid Waivers to serve individuals with mental health, developmental disability and substance abuse needs who are eligible for Medicaid. In 2005, while remaining responsible for state allocated funds including federal block grants and for all applicable rules and policies, the Piedmont Behavioral Health pilot site began managing Medicaid State Plan funded mental health and substance abuse services through the Piedmont Cardinal Health Plan. This Plan operates under a capitated pre-paid inpatient health plan (PIHP) which includes coverage for services to recipients with need in Cabarrus, Davidson, Rowan, Stanly, and Union counties.

In 2009, at the direction of the North Carolina General Assembly (S.L. 2008-107), the NC Department of Health and Human Services initiated a collaborative effort with the NC Division of Medical Assistance and Division of Mental Health, Developmental Disabilities and Substance Abuse Services, in partnership with the local management entities, to restructure the management system for Medicaid funded mental health, substance abuse and developmental disabilities services, building on the Piedmont Behavioral Health Waiver experience, with the intention to phase in PHIP capitated services statewide.

Since February 2010, the Department of Health and Human Services twice solicited applications for local management entities to participate as Medicaid PHIP vendors under the State's 1915 (b)/(c) Medicaid Waiver, in addition to their state-funded responsibilities. The Department of Health and Human Services selected 11 local management entities to manage Medicaid funded services as Division of Medical Assistance contracted vendors through this capitated plan. Division of Medical Assistance and Division of Mental Health, Developmental Disabilities and Substance Abuse Services will each contract with the selected local management entities. Through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services contract, local management entities will continue current obligations and commitment to the management of state and federally funded mental health, substance abuse and developmental disabilities services. Through the Division of Medical Assistance contract, the local management entities will expand their roles and responsibilities as PHIP contractors. All selected PHIP contractors must be fully operational by January 2013. Thereafter, the Department of Health and Human Services will assign counties that remain uncommitted at that time to fully operational PHIP contractors, with full expansion and Department of Health and Human and Services assignment expected to be completed by July 2013.

(d) Integrated programs via Medicare Advantage Special Need Plans (SNP's) or PACE programs

Special Needs Plans

There are 10 Special Needs Plans (SNP's) in North Carolina, including a Preferred Provider SNP for Chronic and Disabling Conditions that targets beneficiaries with End Stage Renal Disease. There are no enrollees in the later plan, according to the CMS March 2012

report of plan enrollment. This report cites 2,276 enrollees in 4 Medicare Advantage “Institutional” SNP’s and 8,694 enrollees in 5 Medicare Advantage “Dual Eligible” SNP’s.

Identification and referral/structured hand-offs for beneficiaries who wish to enroll/disenroll in Medicare Advantage- Special Needs Programs and other similar programs and projects will require development and refinement. Of particular importance will be the creation of electronic communication and timely sharing of information regarding enrollee assignment managed at the federal level. In addition to working with CMS to develop these mechanisms, every effort will be made to develop agreements for cooperation and continuity of beneficiary care at the local level to address individual needs as they arise.

Program of All-Inclusive Care for the Elderly (PACE)

North Carolina PACE is a traditional, adult day health program-based, capitated managed care program for frail older adults, with services provided on site and supplemented by in-home and referral services in accordance with each participant’s needs. Most PACE participants are dual eligible beneficiaries, and all are certified eligible for nursing facility level of care. There are currently five PACE sites serving portions of 13 counties. Three new programs are slated to open in 2012, and three additional sites are expected to open in 2013, bringing the total number of PACE programs to 11 sites by late 2013. Five more program sites are in preliminary development. The Integrated Delivery Model development process has worked closely to align efforts with PACE sites and to learn best practices and maximize available resources.

Identification of beneficiaries wishing to enroll or dis-enroll from PACE will be managed at the local level. Based on collaborative relationships already in place, we expect locally defined protocols for structured hand-offs will assure continuity of care for beneficiaries and clear assignment of responsibilities to either PACE or Integrated Delivery Model beneficiary-centered medical homes.

(e) Other State payment/delivery efforts underway (e.g., bundled payments, multi-payer initiatives, etc.)

(f) Other CMS payment/delivery initiatives or demonstrations

The CCNC Networks and infrastructure serve as the platform for both the CMS Multi-Payer Advanced Primary Care Demonstration and the CMS Medicare Health Care Quality 646 Demonstration.

Multi-Payer Advanced Primary Care Demonstration

The North Carolina Department of Health and Human Services was awarded the project by CMS. Community Care of North Carolina (CCNC) is operating the demonstration collaboratively with Medicare, the Division of Medical Assistance, Blue Cross Blue Shield of North Carolina, and the North Carolina State Health Plan for Teachers and State Employees in this seven county demonstration. All participating payers will contribute resources to PCPs and CCNC Networks to support practice transformation to medical homes, and to improve quality of care, care coordination, access, education, community based support, and other care support services.

CMS Medicare Health Care Quality 646 Demonstration

In January 2010, CCNC initiated the Medicare 646 Quality Demonstration program with eight CCNC Networks, more than 200 primary care practices and over 900 providers

working in 26 counties, to address gaps in care, quality and efficiency. The project completes its third year of demonstration in December of 2012.

The Integrated Delivery Model builds on these efforts and lessons learned from ongoing Medicare 646 Demonstration pilots, as noted in examples above in *Section B: Background*. When North Carolina is approved for participation in the three year Integrated Delivery Model implementation demonstration described in this proposal, the 646 Demonstration will be terminated and ongoing development will commence under this statewide initiative. As negotiations between North Carolina and CMS regarding implementation support for North Carolina's Dual Eligible Beneficiary - Integrated Delivery Model progress, explicit understandings will be specified for the processes and plan to suspend the Medicare 646 Quality Demonstration prior to implementation of the Integrated Delivery Model. This will include mapping the timing and workflow for providing 60 day notice to CMS of intent to terminate, as appropriate, in the late fall of 2012. We will work further with CMS to address any additional concerns to assure compliance with all conditions set forth under authorizations for both programs.

Other CMS Initiatives

We are aware of multiple pending applications submitted to CMS from North Carolina and proposals under development pertaining to Health Homes, Community Care Transition Programs, Accountable Care Organizations, Innovation Challenge and demonstration grants to Reduce Potentially Avoidable Hospitalizations, to name a few. We will continue to work with state and local entities engaged in these and other new initiatives as they progress and, with CMS assistance, define protocols for communication as they become operational.

D. Stakeholder Engagement and Beneficiary Protections

i. Internal and External Stakeholder Engagement

North Carolina's active engagement of stakeholders and beneficiaries is led by the Division of Medical Assistance with support from the Core Leadership Team, formed in June 2011 and multi-stakeholder perspectives provided by the Statewide Partners' Group, initiated in August 2011. Four topic-specific Planning Grant Work Groups began meeting in September 2011 with final draft recommendations issued in December 2011 and January 2012. In addition, since October 2011, nine local sessions with beneficiaries and beneficiary caregivers have been conducted. Two development work groups were mobilized later in the process. The full Beneficiary and Community Stakeholder work group began meeting in December 2011 as recommendations began to emerge. Finance and Payment Work Group discussions began in February 2012.

Core Leadership Team: The NC Division of Medical Assistance assembled the Leadership Team drawing on Department of Health and Human Services Division leaders and Community Care of North Carolina (CCNC). The overall charge of the Core Leadership Team is to guide development of the Statewide Partners' Group, develop and co-lead work groups and advise on the development and implementation of North Carolina's Integrated Delivery Model. Core Leadership meetings shifted from a weekly to a bi-weekly schedule following the launch of work group meetings in September 2011. Dates and agenda for their 25 meetings held between June 2011 and March 2012 are summarized in *Appendix D, Meeting Dates and Agenda*.

In addition to work group co-leads from the various Divisions of the Department of Health and Human Services and Community Care of North Carolina noted below, other members of the Core Leadership Team include the Division of Medical Assistance leaders: Melanie Bush, Assistant Director for Administration; Sandra Terrell, Assistant Director for Clinical Policy and Programs; Tracy Linton, Chief, Clinical Policy; Roger Barnes, Assistant Director for Financial Management; and Jeff Horton, Chief Operating Officer, Division of Health Services Regulation, Ruth Petersen, Chronic Disease and Injury Section Chief, Division of Public Health.

Statewide Partners' Group: Following a brief orientation to the initiative and review of work group needs in August, this group assisted with recruitment of work group volunteers and dissemination of information to stakeholders throughout the state. Meeting bi-monthly, this group serves as the forum for cross-interest discussion and advice on overarching matters. Meeting agendas have ranged from vetting and further developing suggestions for effectively engaging and gathering input from beneficiaries and other stakeholders to small group vetting of the strategic framework and recommendations for the implementation plan. Most recently, this group convened to conduct a Public Hearing on this implementation proposal on March 20, 2012.

With support from this group, approximately 180 individuals and more than 50 North Carolina based beneficiary organizations, state and community agencies, and statewide stakeholder associations, have worked together in work groups and other discussion venues to inform the development of this Integrated Delivery Model.

Beneficiary Perspectives are represented by: *Beneficiary and Family Caregiver Groups:* National Alliance on Mental Illness (NAMI – NC), Friends of Residents in Long Term Care, NC Consumer Advocacy, Networking, and Support Organization (CANSO); *State and County Advisory Councils:* NC Governor's Advisory Council on Aging, Wake County Consumer and Family Advisory Council; and *Advocacy Groups:* Senior Tar Heel Legislature, AARP North Carolina.

Service and Support Network Perspectives are represented by: *Home and Community-Based Care Resources:* NC Association of Area Agencies on Aging, North Carolina Adult Day Services Association, NC Program for All-Inclusive Care (PACE) Directors, NC Statewide Independent Living Council, Easter Seals UCP North Carolina & Virginia, Inc; Association for Home & Hospice Care of North Carolina, Carolinas Center for Hospice and End of Life Care, North Carolina Association on Aging, NC Association of Directors of Social Services, NC Long Term Care Ombudsman Program; *Residential Care Providers:* North Carolina Health Care Facilities Association, NC Association, Long Term Care Facilities, North Carolina Assisted Living Association, NC Providers Council Association; *Acute Care Providers:* North Carolina Hospital Association, *Primary Care Providers:* NC Academy of Family Physicians, NC Community Health Center Association, and representatives of the 14 regional CCNC Networks and statewide NC Community Care Network staff and consultants, including Clinical Directors, Network Directors, aging continuum coordinators, transitional support, pharmacy, behavioral health and palliative care leaders; and *Aging & Disability Information Resources:* (ADRC) Chatham-Orange Community Resource Connection & Forsyth Community Resource Connection, Department of Insurance Senior Health Insurance Information Program (SHIIP).

More information on participants, partner links, agenda and related documents for the Statewide Partners' meetings are available online at: <http://www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/dates-and-directions/>. This dedicated Dual Planning Initiative website went live in October 2011 and serves as a communication tool for Planning Grant Work Groups and Statewide Partners' Group meeting notices, agendas and material dissemination. The website directs viewers to a dedicated email address, which is promoted along with the website, at local beneficiary conversations, conferences and other public gatherings.

Planning Grant Work Groups: The Planning Grant Work Groups noted below began meeting in September 2011, operating under a common set of core values, to address both overarching and topic-specific foci, as described by their working titles. These four work groups met as a full-group and in sub-groups, in person or by conference call, 10 to 15 times each during the fall and early winter, their mission being to:

- gather information on the needs of dual eligible beneficiaries, including issues specific to this cohort and possible innovations to be considered,
- establish priorities and review the evidence regarding key model elements, and
- recommend elements for inclusion in the Strategic Framework and implementation considerations for the Integrated Delivery Model for dual eligible beneficiaries.

Work group volunteers brought experience with numerous existing initiatives underway in North Carolina, including CCNC's Medicare 646 Demonstration program, falls prevention and chronic disease self-management initiatives, hospital, nursing facility and community-based transitional care demonstration projects, and emerging models and evidence-based practices spanning the behavioral health, aging and disability communities.

Questions, ideas and strategies suggested by the Core Leadership Team and Statewide Partners' Group, along with materials from the CMS Innovation Center, technical assistance contractors and peer-reviewed literature were the subject of discussion and debate among the work groups. Sub-groups were created to delve more deeply into particularly complex aspects of the Integrated Delivery Model. Work groups, their Co-Leads and sub-groups with narrowed focus for conceptual development are:

Medical/Health Home and Population Health Co-leads: Randall Best, MD, Chief Medical Officer, DMA and Denise Levis, Director of Clinical Programs and Quality Improvement, Community Care of North Carolina (CCNC)

Sub-group foci: Medical Homes for Adult Care Home Residents, Medical Homes for Nursing Home Residents, Palliative Care and Needs Determination

Behavioral Health Integration Co-leads: Nena Lekwauwa, Medical Director, Division of Mental Health/Developmental Disability & Substance Abuse Services; Amelia Mahan, Behavioral Health Section DMA/CCNC; Mike Lancaster, Director of Behavioral Health Integration, CCNC

Sub-group foci: Provider Participation & Access, Continuum of Care

Long-Term Services and Supports Co-leads: Pamela Lloyd-Ogoke, Vocational Rehabilitation Community Services Chief; Heather Burkhardt, Division of Aging and Adult Services Planning and Evaluation Coordinator

Sub-group foci: Community Living, Nursing Homes & Residential Care

Transitions Across Settings and Providers Co-leads: Trish Farnham, Project Director, Money Follows the Person Demonstration Project DMA; Sabrena Lea, Human Services Supervisor Division of Aging and Adult Services; Jennifer Cockerham, Chronic Care Program Coordinator, CCNC

Sub-group foci: Transitions from Acute Care to Community, Transitions from Nursing Home to Other Long-Term Settings and Transitions among Providers

Sub-group recommendations were aggregated to the work group level for review, discussion and further development by the Core Leadership Team and Statewide Partners' Group. Consolidation and integration of Planning Grant Work Group and Beneficiary conversation input was used to develop the draft Integrated Delivery Model strategic framework and implementation plan presented here. As this work progressed, the Core Leadership Team, Statewide Partners' Group, Planning Grant Work Group volunteers, and beneficiaries and other interested stakeholders reviewed, raised questions, discussed and made suggestions regarding the feasibility and practicality of proposed model elements, implementation strategies and related improvements. Membership and Planning Grant Work Group recommendations are presented in *Appendix E, Work Group Recommendations*.

Dual Eligible Beneficiary and Community Stakeholders Work Group

In December 2011, this work group was convened under the leadership of Dennis Streets, Director of the Division of Aging and Adult Services. Membership includes beneficiaries, their families and other stakeholders, including representatives from NC Consumer Advocacy, Network and Support Organization (NC CANSO), National Alliance on Mental Illness (NAMI-NC), ARC of North Carolina, NC AARP, NC Association of Area Agencies on Aging, the Division of Vocational Rehabilitation, Division of Medical Assistance - Money Follows the Person Program, NC Department of Insurance Senior Health Insurance Information Program, NC Association of County Directors of Social Services, NC Governor's Advisory Council on Aging, and NC Statewide Independent Living Council.

With the help of beneficiary and community stakeholder volunteers, a new approach to sub-state beneficiary and community stakeholder engagement was instituted, resulting in a series of 7 information gathering conversations in early 2012. With input from stakeholders and beneficiaries, conversation protocols (guiding questions, consent forms, and background information forms) were prepared and reviewed during beneficiary and community stakeholder volunteer training conducted prior to individual sessions. Additional information and a summary of these and other sessions are included in *Appendix F, Beneficiary Conversations*.

Key themes identified include the following.

- Most dual eligible beneficiaries were satisfied with the current level of care that they are receiving.
- Many have been receiving Medicaid and Medicare for several years.
- Most duals were aware that they have both Medicaid and Medicare. However, while they knew they have both sets of coverage, though, most were not clear on the full extent of their benefits.

- Those duals that had family and social support were able to navigate the system, seek and access the needed care without any trouble. Those individuals who did not have natural social supports found the process difficult.
- A few have had trouble with coverage issues associated with Medicare and Medicaid. About half have experienced difficulties locating a doctor who accepts both Medicaid and Medicare, particularly dentists, counselors and ophthalmologists.
- Most beneficiaries who have a care coordinator were very happy with the support they received. They used the care coordinator as the first point of communication in resolving a health or related issue.
- Most felt that their doctors and specialists did not actively communicate with each other or with them. They felt that the doctors did not have the time to explain the problem and the solution to them.
- Considerable difficulty was identified in finding mental health services in private practice (psychologists and counselors) who take Medicaid /Medicare.
- Universal concerns expressed in every group of beneficiaries included:
 - Unable to keep appointments due to lack of transportation
 - Unable to get dental care
 - Unable to get prescription medications on time due to co-pays, and
 - Unable to get eye glasses and other assistive devices that will enable them to lead an independent life in the community.

ii. Beneficiary Protections: Through the Department of Health and Human Services, Division of Medical Assistance, there are processes already in place for beneficiary protection and appeals. G.S 108A-70.9A governs the process used by a Medicaid recipient to appeal an adverse determination made by the Department in North Carolina along with the Social Security Act, 42 C.F.R 431.200 et. seq. There are three phases to the appeal process: (1) a mediation process which should be completed within 25 days of receipt of hearing; (2) an Office of Administrative Hearings proceeding completed in 55 days; and (3) the final agency decision to be completed within 20 days of receipt of case from Office of Administrative Hearings. Through coordination and collaboration with the Division of Medical Assistance, CCNC, the Division of Aging and Adult Services and CMS, current provisions will be enhanced to further augment and ensure the protection of beneficiary health, safety, access to high quality care, robust appeals and grievances process and most of all a user friendly and responsive customer service system.

iii. Ongoing Stakeholder Input and Beneficiary Engagement: The beneficiary engagement and conversations initiated during the planning and design phase of the project are the beginning of an ongoing development process. While beneficiary and stakeholder discussions to date have been fruitful, *Appendix B, Glossary* offers a glimpse of the jargon encountered by beneficiaries and providers and why stakeholder input and beneficiary engagement are essential to developing a shared language with common definitions to foster true communication.

As North Carolina moves from design and planning to implementation, this process will expand to strengthen regional and local communication processes that will provide an

important base for beneficiary and provider education and discussion. This engagement will encompass multiple functions including, but not limited to developing:

- shared language and communication materials to assure open dialog between beneficiaries and their medical home team colleagues and between beneficiaries and the broader natural support and community resources;
- mechanisms for multi-stakeholder dialog and monitoring of implementation and development activities at the local and regional level; and
- quality indicators that are responsive to the priorities and concerns of each sub-population of dual eligible beneficiaries and various stakeholder interests.

Development of these relationships will foster community connections and collaborative communication conduits.

Public Comment: Two public hearings were held in Raleigh on March 20 and 27, 2012 with official notice postings. Draft strategic framework and proposal materials were posted on the Dual Eligible website <http://www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/>. Notice of draft proposal materials posted and requests for input were solicited through Statewide Partners' dissemination of information to their constituencies.

In addition to the two formal public hearings, public comments were also solicited through project staff and Core Leadership Team member presentations of the strategic framework, design elements and implementation plan to various statewide groups including the Coalition on Aging, Governor's Commission on Aging and the Senior Tar Heels Legislature. An evening toll-free phone comment session was held on April 16. Additional organizations and interested parties provided comment, input and questions during the public comment period and included representatives of the NC AIDS Action Network, NC Department of Public Health Infectious Disease section, NC Justice Center, State Employees Association of NC, experienced care providers Elizabeth City (Hospice) and Wilmington (PACE), American Health Care Association, National Association of Chain Drug Stores, PhRMA, and Eli Lilly, the Florida-based pharmaceutical company. Written comments jointly submitted by Disability Rights North Carolina, North Carolina Justice Center and National Multiple Sclerosis Society as well as comments from PhRMA are included in *Appendix L, Written comments in response to public comments*.

E. Financing and Payment

i. Description of proposed state-level payment reforms

North Carolina's Integrated Delivery Model is building upon the existing Medicaid managed fee-for-service primary care medical home and population health management infrastructure for community residing dual eligible beneficiaries as well as those living in nursing homes and adult care homes.

ii. Proposed payment types; financial incentives; risk sharing arrangements

Implementation demonstration activity will use Medicaid aged, blind and disabled PMPM fees to primary care providers and CCNC Networks. A negotiated portion of the retrospective performance payments will be used to provide incentives for eligible providers to enhance their capacity, improve care outcomes, achieve shared savings and further reduce potential avoidable hospital use. Eligibility for participation in these financial incentives will

require providers to meet defined capabilities and achieve beneficiary responsiveness, quality and cost targets. Specifics of these arrangements will be developed in concert with CMS.

As noted in *Section B: Background*, North Carolina's original plan had been to encourage provider capacity improvements through financial incentives made possible through a request for up-front Medicare PMPM to supplement the Medicaid PMPM. North Carolina remains open to further discussion and negotiation of this approach.

F. Expected Outcomes

i. State's ability to monitor, collect and track data on key metrics

Informatics Center: North Carolina Community Care's Informatics Center is an electronic data exchange infrastructure maintained in connection with health care quality initiatives for the State of North Carolina sponsored by the Department of Health and Human Services, the Division of Medical Assistance and CMS. Currently, the Informatics Center contains health care claims data provided by Medicaid, as well as health information about program participants obtained directly from health care providers, care managers and/or the primary care medical record. Since 2010, additional data sources integrated into the Informatics Center include: Medicare claims and Surescripts pharmacy data for dual eligible beneficiaries, LabCorp (laboratory results), and real-time hospital admission/discharge/transfer data from 49 large NC hospitals.

In March 2012, CCNC received 2007-2010 Medicare Part A and B claims data from CMS for care coordination and the work of this demonstration project. A second COBA has also been instituted pertaining to future access of full cross-over and Medicare claims data. A request for Medicare Part D is in final review at CMS.

These data will be used to target and estimate utilization and expenditure trends, quality and performance targets, identify population management opportunities, and are central to the development and evaluation of the Integrated Delivery Model.

The Medicare Part A, B and D data will be used with risk-stratification algorithms to identify the highest risk beneficiaries during the implementation demonstration. Information on beneficiaries at greatest risk will enable CCNC Networks to facilitate priority targeting for disease management, transition management, and pharmacy management supports. Claims data will also be used to monitor quality of care, expenditures, utilization trends and outcomes, and to provide performance feedback at the beneficiary, primary care practice, and network levels. The Informatics Center supports to medical home operations are described in greater detail in *Section G: Infrastructure and Implementation*. The following are Informatics Center programs central to collecting, monitoring and tracking key metrics.

- **Quality Measurement and Feedback Chart Review System**

Chart audit, quality measurement and performance feedback are an integral component of CCNC's clinical quality improvement initiatives. CCNC conducts over 26,000 medical record reviews in over 1,250 primary care practices statewide on an annual basis to gather process measures that are meaningful to providers but absent on administrative claims data. To manage the expanding scope of the chart review process, this process moved from a paper chart abstraction tool to a fully electronic, streamlined system in 2009. Medicaid claims data are used to generate a random sample of eligible recipients and to pre-populate the audit tool elements according to an individual's identified chronic conditions.

- **Informatics Center (IC) Reports Site**

The IC Reports Site was created to allow the efficient and secure distribution of reports through a secured web-based report access and management application, with report access permissions determined by the appropriate scope of access of individual users. Network-level administrators authorize their own employees and providers by customizing their scope of access by practice or region. A report built at the statewide level can be distributed readily according to the permission tree structure, such that only the appropriate individual's information is visible to each end user. Various functions are served by our analytics and reporting capacity:

Population Needs Assessment: Identification of demographic, cost, utilization, and disease prevalence patterns by service area. The Community Care Chronic Care database contains over 80 data elements and is updated quarterly to reflect the current Aged, Blind, and Disabled (ABD) enrolled population. Users can readily obtain information about the demographic characteristics, prevalence of chronic medical and mental health conditions, spending by category of service, and rates of hospital, emergency department, and other service use within their service areas. This aids in program planning and resource allocation; identification of outlier patterns (such as unusually high rates of service uses); and tracking of utilization over time.

Tracking of Care Quality Indicators. In addition to the quality measures tracked in the annual chart review process, the Informatics Center tracks a number of quality measures using claims data alone, with quarterly updates. Results can be viewed in spreadsheet format for easy comparative view across practices, or as a comprehensive practice-level, county-level, network-level or program-level report with trend information. Reports include a variety of indicators including measures related to diabetes, asthma, heart failure, cardiovascular disease and colorectal cancer screening. These reports provide actionable information to providers and can be drilled down to provide patient level information.

Program Evaluation and Tracking of Key Performance Indicators. The Informatics Center reporting capability enables key metrics and performance tracking. This longitudinal analysis of performance metrics can assure stakeholders that efforts are aligned toward the overarching goals of the integrated system and that there is accountability in the program to achieve the triple aims. Key indicators include both process measures such as percent of targeted hospitalized enrollees receiving medication reconciliation, and outcome measures such as hospitalization, emergency department, and readmission rates.

Consumer Assessment of Health Care Providers and Systems (CAHPS Survey): The Division of Medical Assistance, in partnership with the University of North Carolina at Charlotte, periodically conducts the Consumer Assessment of Healthcare Providers and Systems survey among NC Medicaid recipients. This national survey program is a multi-year initiative of the federal Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. The survey is able to assess the patient/person-centeredness of care, compare and report on performance indicators from the beneficiary perspective around the quality of and access to care. Conducted in English and Spanish, the survey respondents are drawn from a stratified random sample with sufficient representation to allow analysis at the CCNC Network level. The sampling structure for the next CAHPS survey, scheduled for administration in fall of 2012 (September-November) is being changed to include dual eligible beneficiaries. This instrument will contain a series of

supplemental questions that are of specific interest to this Integrated Delivery Model, in addition to the core AHRQ questions. These data elements will help establish some baseline benchmarks for monitoring and evaluating this demonstration. Along with the CAHPS survey, focus groups and key informant interviews will be utilized to obtain input from beneficiaries and information on their engagement and satisfaction with the new Integrated Delivery Model.

ii. Potential targets for improvement

Quality measures used with the Medicare 646 Demonstration Project described in *Appendix G, Quality Measures* encompass diabetes care, heart health, ischemic heart disease, hypertension and transitional care. These quality measures are intended to reflect the level and success of care coordination for dual eligible beneficiaries enrolled in the medical homes. In addition to these measures, the demonstration will also monitor and evaluate:

- a) beneficiary satisfaction with care received,
- b) potentially avoidable hospitalizations,
- c) hospital readmission rates,
- d) emergency department use/admissions, and
- e) impact on expenditures and utilization patterns over time.

Targets and benchmarks for these quality and outcome measures will be claims-based and set in consultation with CMS and with statewide and local stakeholders' input.

iii. Expected impact of the proposed demonstration on Medicare and Medicaid costs

Drawing upon North Carolina's experience providing medical homes for Medicaid recipients who are aged, blind or disabled, we anticipate that there will be short-term increases in costs associated with pharmacy and physician visits to address unmet beneficiary needs. Savings associated with reductions in potentially avoidable hospitalizations, readmissions and non-urgent use of emergency department services are expected to accrue 12 to 18 months following the introduction of medical homes and population management functions. Details of financial projections encompassing short-run increased expenditures, longer-run reductions in expenditures and allocation plans will be developed using linked Medicare and Medicaid claims data and mutually agreed upon methodologies refined during negotiations between North Carolina and the Centers of Medicare and Medicaid Services.

G. Infrastructure and Implementation

i. North Carolina's Current Capacity

The Community Care of North Carolina Informatics Center houses multiple systems that support the implementation of medical homes for dual eligible beneficiaries and development of other key Integrated Delivery Model information needs. This section describes the systems that inform the work of primary care practices and other medical home team members throughout the state and provide oversight of services and supports to dual eligible beneficiaries. The following brief summary describes current and fully operational capacity. Further information on the infrastructure for monitoring, collecting and tracking key metrics and capacity to receive and analyze Medicare data is described in *Section F: Expected Outcomes*. Additional information of project implementation and management, staffing and use of other contractors is included in *Section I: Implementation Support Budget*.

- **Care Management Information System (CMIS)** is a web-based portal accessible to all CCNC Networks, allowing care managers to maintain a health record and single care plan that stays with the enrollee as he or she moves across provider settings. Thus, CMIS enables a continuity-of-care record as their eligibility status changes. CMIS provides a standardized framework for care manager workflow management and documentation, incorporating tools for evidence-based screening and assessment, goal setting, and health coaching. In addition, CMIS has report-designing capability for monitoring caseloads and activities of the care management workforce.
- **Pharmacy Home** was created to support CCNC pharmacy management initiatives, and address the need for aggregating information on drug use and translating it to the Network pharmacist, care manager and primary care provider in a manner best suiting their care delivery needs. The system provides an individual level profile and medication history for point-of-care activities, as well as a population-based reports system to identify individuals who may benefit from additional pharmaceutical care support. The Pharmacy Home drug use information database is used prospectively for multiple purposes: identification of care gaps and problem alerts; targeting of at-risk individuals; development of the pharmaceutical care plans; and proactive intervention to assist providers and recipients with therapeutic substitution required by state Medicaid policy.
- **Informatics Center (IC) Reports**

Risk Stratification, Identification of Individuals at Greatest Risk. The size and complexity of the enrollee population, in terms of physical health, mental health and socioeconomic needs, necessitates intelligent mechanisms for identifying enrollees most appropriate for care management interventions. The use of historical claims data to target care management intervention improves the efficiency of the care team. Through a combination of mechanisms including, application of pharmacy data algorithms and contracting with Treo Services for their Clinical Risk Groups (CRG) application, enrollees who meet specified priority criteria may be flagged.

Monitoring of Emergency Department (ED) and Inpatient Visits. A number of detailed utilization reports are generated automatically from the data warehouse, updating with every claims payment cycle. These can be easily navigated by local managers and clinicians who may not be technologically savvy. As an example, the authorized user can readily access a listing of ED visits by their enrolled population. The report can be parameterized by hospital, PCP, enrollee or visit characteristics; and can tally visit counts by enrollee or practice. A similar report is available for inpatient hospitalizations.

- **Provider Portal**
This portal was built with the treating provider in mind, offering elements of CMIS, Pharmacy Home, and the Reports Site and tailored to the target user. Through a secure web portal, treating providers in the primary care medical home, hospital, emergency room, or mental health system can access their enrollees' health records, which includes patient information, care team contact information, visit history, pharmacy claims history and clinical care alerts. Importantly, the use of claims data provides key information typically unavailable within the provider chart or electronic health record. For example, providers are able to see encounter information (hospitalizations, Emergency Department visits, primary care and specialist visits, laboratory and imaging) that occurred outside of

their local clinic or health system. Contact information for the enrollee’s care manager, pharmacy, mental health therapy provider, durable medical equipment supplier, home health or personal care service providers are readily available. Providers can discern whether prior prescriptions were ever filled, and what medications have been prescribed for the enrollee by others. Built-in clinical alerts appear if the claims history indicates an individual may be overdue for recommended care (e.g. diabetes eye exam, mammography).

- **Non-claims data sources**

Non claim data sources for dual eligible beneficiaries are used to help fill the gaps in needed information to maximize population management activities. These sources include:

Surescripts –to acquire prescription fill history data for dual eligible beneficiaries. The feeds return a twelve-month prescription history and come from multiple pharmacies or prescription benefit plans. This is particularly helpful for practices that do not yet have an e-prescribing tool certified with Surescripts for fill history transactions. Ensuring access to Medicare Part D data will be important to fully integrate and manage the pharmaceutical and healthcare of dual eligible beneficiaries.

Lab Data- the Informatics Center receives historical and monthly lab results for Medicaid recipients, including dual eligible beneficiaries, whose lab claims were billed to LabCorp. Results for 125 selected tests are displayed as part of the enrollee record in the Provider Portal.

Hospital Admission, Discharge and Transfer (ADT) Data - CCNC contracts with Thompson-Reuters to supply twice-daily feeds of inpatient, outpatient, and emergency room admissions. Transactions include the chief admission complaint and identify the attending physician. Transactions are immediately reported to CCNC care managers in the Case Management Information System and are consolidated into reports housed in the Informatics Center report site. Thus far, CCNC is receiving admission, discharge and transfer data from 49 North Carolina hospitals, representing over 60% of emergency department and inpatient visits for the NC Medicaid and dual eligible population.

This infrastructure brings engaged physician leaders throughout the state together to identify program priorities, adopt and implement quality and utilization performance metrics and spread best practices to community providers and agencies. The development of this new delivery model for dual eligible beneficiaries will further develop infrastructure, expand collaborative efforts and establish new partnerships and relationships with dual eligible beneficiaries, their natural and community support systems and other stakeholders throughout the state.

Discussion of North Carolina’s infrastructure and ability to receive, process and analyze Medicare data is addressed in *Section F: Expected Outcomes*.

- i. Medicaid and Medicare rules that need to be waived**

Needed policy changes are the subject of ongoing review and will be developed in concert with CMS. Anticipated changes include submission of a state plan amendment to enable CCNC enrolled and Medicaid supported beneficiary-centered medical homes for nursing home residents and a request for waiver of the three-day prior hospitalization requirement for

Medicare skilled nursing facility payment. Other rule changes are the subject of ongoing review and assistance from CMS.

ii. Plans to expand to other populations and/or service areas

No other populations or additional service areas will be added during the three-year implementation demonstration. Over time, with full implementation, the Integrated Delivery Model will encompass all dual eligible beneficiary populations, including those receiving services and supports through the specialty behavioral health plan currently in development.

iii. Overall implementation strategy and anticipated timeline

The overall implementation strategy is subject to further discussion and negotiation with CMS. The preliminary key tasks and timeline are described in *Appendix I, Work Plan*.

H. Feasibility and Sustainability

i. Potential barriers/challenges and/or future State actions

Of particular concern is the timely access to Medicare data and information on emerging initiatives funded by CMS. Perceived and real limitations placed on providers and beneficiaries participating in other CMS programs and initiatives must be addressed proactively. Any restrictions limiting provider participation pose the threat that North Carolina's dual eligible beneficiaries will have unequal access and choice in a two-tiered delivery system with provider-dominant urban markets and less well-resourced rural delivery systems. North Carolina will encourage continued development of multi-payer systems that can help bridge these concerns and advocate for urban/rural sensitive development of new approaches to the delivery of health care for all North Carolinians.

ii. Statutory and/or regulatory changes needed

Offering medical homes to dual eligible beneficiaries who reside in nursing homes will require a state plan amendment. Other regulatory changes needed for the implementation of the Integrated Delivery Model will be under continuous review and development during the demonstration period.

iii. New State funding commitments or contracting processes necessary

We anticipate that a three year contract will be developed and executed between the Division of Medical Assistance and CCNC with CMS review and concurrence. This approach will necessitate sub-contractual agreements between the CCNC statewide entity and each of its fourteen Networks as well as Providers and other sub-contractors. Estimates of additional expenditures to offer medical homes to eligible dual beneficiaries have been developed and assurances provided that funding will be available for implementation activities to begin by January 2013, pending approval and support from CMS and formal agreements pertaining to shared savings. The DMA and CCNC agreements for the programmatic management of this demonstration implementation and subcontracts to the Networks and others will be ready for signature prior to start-up. Development of agreements regarding distribution of incentive payments to qualifying providers funded with a portion of anticipated retrospective performance payments will be subject of further discussion and negotiation with CMS.

iv. Scalability of the proposed model and its replicability

North Carolina's Integrated Delivery Model is a statewide initiative that will begin with pilot testing and rapid-learning in the implementation of each new protocol and workflow process. This approach has proven successful over the past 20 years of medical home development and can be expected to serve dual eligible beneficiaries and federal and state interests equally well. This development process will ensure that all the necessary processes and system changes are in place to support and sustain replication of the model.

In addition to sharing lessons learned with other States and jurisdictions, quarterly updates in the CCNC Toolbox and annual reports will be developed and disseminated. Recent Commonwealth Foundation support for development of the CCNC Toolbox and replication activity will serve as models for sharing North Carolina's experience with other states.

I. CMS Implementation Support Budget:

North Carolina's budget request (*Appendix, H*) to support the implementation of this demonstration request include:

- Project Implementation and Administration
- State Medicaid Policy and Actuarial Services
- Beneficiary and Community Engagement
- Education and Training
- Information and Analysis
- Assessment and Resource Allocation Process Development
- Risk Stratification and Targeting

J. Additional Documentation:

North Carolina Division of Medical Assistance will provide additional documentation, as needed, upon CMS request.

K. Interaction with Other HHS/CMS Initiatives

The Partnerships for Patients, Action Plan to Reduce Racial and Ethnic Health Disparities and Million Hearts Campaign embody the sorts of health promotion and educational programs that are fundamental to the collaborative approach underlying North Carolina's Integrated Delivery Model. Relationships between these efforts and the Integrated Delivery Model have begun to emerge. In January 2012, the Integrated Delivery Model strategic framework was presented at the NC Partnership for Patients' Summit. This summit brought together hospital and healthcare leaders, physicians, nurses, home and community-based long-term service and support providers and advocates and offered an early opportunity for strategic framework review and discussion of implementation among those who work with beneficiaries in transition. In addition, many Statewide Partners are already actively engaged in Partnership for Patients' and Million Hearts Campaign educational activities across the state. We welcome CMS' support in working with these and other initiatives as they evolve.

Appendices are not included in this version of the Proposal