State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

North Carolina

Summary: In 2011, North Carolina was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The North Carolina Department of Health and Human Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., June 3, 2012. You may submit comments on this proposal to NC-MedicareMedicaidCoordination@cms.hhs.gov.

NORTH CAROLINA STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS

Submitted to
CENTER FOR MEDICARE AND MEDICAID INNOVATION
Contract Number: HHSM-500-2011-00037C

North Carolina Department of Health and Human Services
Division of Medical Assistance
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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.

iii. 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*.

iv. 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.*

v.   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 aged18 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 to15 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 Lily, 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 performances 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*.

ii. 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.

iii. 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.

iv. 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.

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

J. 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

APPENDIX A
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APPENDIX B
Glossary

AARP	Association of American Retired Persons
ABD PMPM	Aged, Blind and Disabled per Member Per Month
ACO	Accountable Care Organization
ACH	Adult Care Home
ACE Inhibitor	Angiotensin-Converting-Enzyme inhibitor
ADRC	Aging and Disability Information Resources
ADT	Admission, Discharge and Transfer
ARC	Association of Retarded Citizens (Organization for Individuals with Intellectual Disabilities)
AHRQ	Agency for Healthcare Research and Quality
AQA	Assessment and Qualifications Alliance
AHRQ-PQI	Agency for Healthcare Research and Quality-Prevention Quality Indicators
ARB Therapy	Angiotensin Receptor Blocker Therapy
A1C	Glycated Hemoglobin
BP	Blood Pressure
CAP	Community Alternative Program
CAPHS	Consumer Assessment of Health Care Providers and Systems
CAP/DA	Community Alternatives Program/ Disabled Adults
CANSO	NC Consumer Advocacy, Networking, and Support Organization
CCNC	Community Care of North Carolina
CMIS	Case Management Information System
CMS	Centers for Medicare and Medicaid Services
COBA	Coordination of Benefits Agreement
CHF	Congestive Heart Failure
DAAS	Division of Aging and Adult Services
DHHS	North Carolina Department of Health and Human Services
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DMA	North Carolina Division of Medical Assistance
DPRP	Diabetes Physician Recognition Program
ED	Emergency Department
ESRD	End Stage Renal Disease
HCBS	Home and Community-Based Services
HSRP	Heart Stroke Recognition Program
HEDIS	Healthcare Effectiveness Data and Information Set
ICF	Intermediate Care Facility
ICF-MR/DD	Intermediate Care Facility for Mental Retardation or Developmental Disabilities
IC	Informatics Center

LDL-C	Low-Density Lipoprotein
LTSS	Long-Term Services and Support
LME	Local Management Entity
LME-MCO	Local Management Entity-Managed Care Organization
MDS	Minimum Data Set
MA	Medicare Advantage
NAMI	National Alliance on Mental Illness
NH	Nursing Home
NCQA	National Committee on Quality Assurance
NQF	National Qualifications Framework
OAH	Office of Administrative Hearings
PCP	Primary Care Provider
PACE	Program for All-Inclusive Care for the Elderly
PMPM	Per Member Per Month
PCPI	Physician Consortium for Performance Improvement
PQRI	Physician Quality Reporting Initiative
PHIP	Public Health Improvement Partnership
PERS	Personal Emergency Response Service
PCS	Personal Care Services
PBH	Piedmont Behavioral Health
PIHP	Prepaid Inpatient Health Plan
RUGS	Resource Utilization Groups
SPMI	Serious and Persistent Mental Illness
SNP	Special Need Plans
SHIIP	Senior Health Insurance Information Program

APPENDIX C
Program Definitions

A. Medical Home

While North Carolina is developing beneficiary-centered medical homes, we have yet to develop a shared vernacular. This approach is building *on patient-centered medical home* concepts. In deference to this history, the following definition uses the language of the medical community.

The American Academy of Physicians, American Academy of Family Physicians, American College of Physicians, representing approximately 333,000 physicians, has developed the following joint principles to describe the characteristics of the ***Patient-Centered Medical Home:***

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the right care.

B. Adult Care Homes

Adult care homes are assisted living facilities licensed by the Division of Health Service Regulation and enrolled by the Division of Medical Assistance as a provider of basic or enhanced personal care services and non-emergency medical transportation. Adult care homes for 2 to 6 beds are called family care homes. Nursing facilities and hospitals may have designated adult care home beds.

An adult care home (ACH) provides room and board and 24-hour supervision and services for people needing assistance with activities of daily living (ADLs) and some health care needs due to normal aging, a chronic illness, a cognitive disorder, or a disability. Adult care homes bridge the gap between independent living and nursing facility care that provides medical and nursing care in addition to help with ADLs. The adult care home is not a substitute for the nursing facility, but rather another level of care appropriate for those who cannot live by

themselves and need assistance with bathing, dressing, ambulation, eating, toileting, and/or medication administration.

C. Skilled Nursing Facility

Skilled care is health care given when a beneficiary needs skilled nursing or rehabilitation staff to manage, observe, and evaluate their care. Examples of skilled care include intravenous injections and physical therapy. A Skilled Nursing Facility could be part of a nursing home or hospital. Medicare certifies these facilities if they have the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

D. Cash and Counseling

The Cash & Counseling grant program introduced *participant-directed* programs into the Medicaid programs of 15 states. Under Cash & Counseling people with disabilities, including older adults, have the option to manage a flexible budget and decide what mix of goods and services best meet their personal care needs. Participants may use their budget to hire personal care workers, purchase items and make home modifications that help them live independently. Those participants who don't feel confident making decisions on their own may appoint a representative to make decisions with or for them. North Carolina currently has two participant directed programs built on the Cash and Counseling model.

a) Community Alternatives Program for Disabled Adults (CAP-DA)
b) Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD)

E. Evidence Based Programs

Evidence-based programs are proven programs that work. In order to be considered "evidence-based," programs must be extensively evaluated using control/comparison group, with documented and published outcomes. Programs that are considered "best practices" have not undergone this rigorous evaluation, but are based closely on existing research on effective approaches.

The North Carolina Division of Adult and Aging Services currently implements the following evidenced based programs for the disabled and elderly partnering with the Area Agencies on Aging:

- **A Matter of Balance:** Falls Management Program for Older Adults. The program's goal is to reduce fear of falling, stop the fear of falling cycle, and increase activity levels among community-dwelling older adults. ✧ Approved by AoA ✧

- **Chronic Disease Self-Management Program (CDSMP):** (In North Carolina, the program is called *Living Healthy*): CDSMP helps individuals with chronic conditions

learn how to manage and improve their own health. The program focuses on problems that are common to individuals suffering from any chronic condition, such as pain management, nutrition, exercise, medication use, emotions, and communicating with doctors. ✧Approved by AoA and CDC ✧

- **Diabetes Self-Management Program (DSMP):** (In North Carolina, the program is called *Living Healthy with Diabetes*) DSMP helps individuals with diabetes learn how to manage and improve their own health. The program focuses on problems that are common to individuals suffering from diabetes, such as pain management, nutrition, exercise, medication use, emotions, and communicating with doctors. ✧Approved by AoA and CDC ✧

- **Arthritis Foundation Exercise Program:** A course that promotes self-management of arthritis through exercise. ✧ Approved by CDC ✧

- **Arthritis Foundation Aquatics Program:** A course that promotes self-management of arthritis through water-based exercise. ✧ Approved by CDC ✧

- **Arthritis Foundation Tai Chi Program:** A course that promotes self-management of arthritis through Tai Chi, an ancient practice proven to reduce pain and improve mental and physical well-being. ✧ Approved by CDC ✧

- **Walk With Ease:** Walking program targeting arthritis; group-assisted and self-directed options. ✧ Approved by CDC ✧

- **Fit and Strong!:** Physical activity/behavior change program for people with lower body osteoarthritis designed to facilitate arthritis symptom management, confidence in ability to exercise safely with arthritis, and commitment to lifestyle change. ✧Approved by CDC✧

- **Healthy IDEAS:** Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. ✧Approved by AoA✧

APPENDIX D
Meeting Dates and Agenda

Additional meeting notes, agendas, workgroup member list and recommendations are available at https://www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/. The summary workgroup recommendations are also available in Appendix D.

A. **Core Leadership Team Meeting:** The Core Leadership Team met 25 times between June 2011 and March 2012. Presented in the table below is a sample of dates and agenda items

Date	Sample Agenda Items
June 23, 2011	Development of leadership structure; work group organization and development; statewide partners invitee list.
July 7, 14, 21, 2011	Operationalizing work groups, identifying leadership, defining work groups' scope and charge; identification of potential Statewide Partners' Group members, agenda, scope and responsibilities.
August 4, 11, 25, 2011	Statewide Partners' engagement plan; work group development; Statewide Partners' initial meeting agenda development.
September 1, 8, 15, 22, 2011	Work group development, work group topics, review criteria and prioritization process, development of co-lead guidelines; sub-state beneficiary and community stakeholder listening session development.
October 6, 13, 20, 27, 2011	Cross-work group topic discussion and work group updates; Statewide Partners' meeting presentations preparation.
November 17, 2011	Work group updates
December 1, 8, 15, 2011	Work group reports; beneficiary conversations

Date	Sample Agenda Items
	debrief and planning; draft recommendations and considerations building blocks for the strategic framework from each workgroup.
January 5, 12, 19, 2012	Beneficiary conversation debriefs; work group final recommendations report, review and comment; Appeals, Grievances and Consumer Protections work group.
February 16, 2012	Review of Strategic Framework; preparation for Statewide Partners' meeting
March 15, 29, 2012	Draft proposal discussion; public hearings and comments.

B. Statewide Partners' Group Meeting

Date	Sample Agenda Items
August 1, 2011	• Overview of the grant • Work group definition, development & recruiting
October 17, 2011	• Grant update • Work group updates
December 16, 2011	• Work group – preliminary recommendations • Ideas for beneficiary and stakeholder engagement • Informatics Center Demonstration
February 21, 2012	• Dual Eligible Beneficiaries – Integrated Delivery Model Strategic Framework • Small group review and discussion of work group recommendations • Preparation for public comment
March 20, 2012	• Presentation of draft proposal • Public comments

C. Work Group Meetings
Shown below is a sample of dates and meeting discussion topics.

i.   Medical/Health Homes and Population Management Work Group
This Work Group and its 4 sub-groups, Needs Determination, Adult Care Homes, Palliative Care and Nursing Homes, met 24 times between October 2011 and February 2012.

Dates	Sample Agenda items
October 3, 19, 27, 24, 25, 2011	Sub-group organization; cross-cutting issues/integration of topics; identification of gaps among topics; areas of concerns, barriers, examples of best practice; work group data needs.
November 7, 14, 18, 28, 29, 2011	Continuity of care, medical and nursing coverage; decreasing inappropriate hospitalizations and saving hospital days; financial incentives for providers; development of a functional needs-based model; maximizing patient's functional health; review of current assessment processes and tools, and need determination and resource allocation process; patients' goal or preferences
December 8, 14, 19, 2011	Sub-group reports, nursing home continuum
January 4, 6, 9, 17, 24, 2012	Development of functional needs matrix; adult care home continuum; palliative care recommendations
February 3, 14, 29, 2012	Palliative care in nursing homes; review of final recommendations from each sub group.

ii.   Transitions Across Settings and Providers Work Group

This Work Group and its 2 sub-groups, Acute Care Transitions and Transitions across Settings, met 14 times between September 2011 and January 2012. On several occasions both sub-groups met on the same days as the large workgroup meetings.

Dates	Sample Agenda items
September 15, 2011	Review of ideas, innovations, issues and challenges
October 4, 14, 24 2011	Emerging themes, scope of sub-group, information gathering, presentations by North Carolina acute care/home health and nursing home/community transition initiatives
November 15, 28, 2011	Priority setting, framework development, strategy discussion

December 16, 2011	Development of recommendations
January 10, 2012	Identification of priorities and parking lot items, review of final recommendations

iii.   Long Term Supports and Services Work Group

This Work Group and its 2 sub-groups: Community Living and Nursing Home/Adult Care Homes met 11 times between October 2011 and January 2012. On several occasions both sub-groups met on the same days as the large workgroup meetings.

Dates	Sample Agenda items
October 3, 21, 31, 2011	Scope and review criteria, review of work group membership, avoidable hospitalizations, resources available to facilities, flexibility in use of resources, palliative care in facilities, assistive technology, care for beneficiaries with dementia, presumptive eligibility, advance directives, beneficiary self-determination, presentation of Western Carolina initiative
November 7, 29, 2011	Work group discussions
January 9, 11, 2012	Identification of priorities and parking lot items, review of final recommendations

iv.   Behavioral Health Integration Work Group

This Work Group and its 2 sub-groups, Provider Participation and Access and Continuum of Care, met 13 times between October 2011 and January 2012. Sub-groups met on the same days as the large work group meetings.

Dates	Sample Agenda items
October 3, 17, 31, 2011	Establishing scope of the work group; licensure-current and proposed**;** payment/billing delays and process improvements**;** implications of behavioral health waiver**;** recovery focus, peer services, range of services from vocational rehabilitation and housing through formal services, service gaps. Movement through recovery without loss of benefits

November 10, 14, 2011	Work group discussions credentialing
December 1, 14, 2011	Development of recommendations, and group consensus; identification of evidence for recommendations
January 10, 2012	Identification of priorities and parking lot items and review of final recommendations

v.   Beneficiaries and Community Stakeholders Work Group

Dates	Sample Agenda items
December 12, 2011	Scope, charge, identification of opportunities; establishing timeline
January 4, 5, 2012	Review of protocols and other tools; facilitator orientation/training

vi.   Beneficiary and Stakeholder Sessions

Date	Location	Audience	Beneficiaries	Facilitators
10/18/11	NC Conference on Aging Hotel	State and Community Stakeholders	2 and 7 Stakeholders)	Division of Aging Staff & Volunteer
11/18/11	Charlotte Housing Auth. Apt. Building	16 African American & 1 Native American older adults	17	Division of Aging Staff & Volunteer
01/23/12	Forsyth County Mental Health Offices	Mental health and substance abuse service consumers	3	CANSO/ Coker
01/24/12 / & 02/07/12	Orange County Senior Center	Older adults	6 & 10	Orange County Senior Volunteers Maiden & Konrad
01/26/12	Burnt Swamp Association, Pembroke Lumbee Tribe	Younger adults with a disability, older adults and mental health consumers)	31	NC Commission on Indian Affairs - Brayboy
01/31/12	Stellar Peer Recovery Center,	Mental health and substance abuse service	33	Wake County Consumer and Family Advisory

	Knightdale	consumers		Council - Jacques
01/31/12	Tsali Manor, Cherokee Reservation	Younger adults with a disability, including intellectual disability)	4	NC Department of Insurance/ SHIIP - Bova
02/02/12	Lenoir County	Older adults	23	Lenoir Council of Aging - Hill

vii.   Appeals, Grievances and Consumer Protections Work Group

The appeals, grievances and consumer protections workgroup met on January 31, 2012. The work group reviewed current statutory and judicially defined processes for consumer appeals and protections in North Carolina, and opportunities and resources for future community outreach and education activities.

Dual Eligible Planning Grant Work Group Recommendations
The recommendations of the work groups are also available at
https://www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/

1. **Medical/Health Homes and Population Management**
   Sub Groups: Nursing Homes [Denise Levis Hewson, Randall Best]
   Palliative Care [Jonathan Fischer]
   Needs Determination [Marsha Fretwell, Elizabeth Tilson, Teresa Piezzo]
   Adult Care Homes/Assisted Living Facilities [Tim Daaleman, Lou Wilson]

Work Group Co-leads: Denise Levis Hewson (Community Care of North Carolina), Randall Best (Division of Medical Assistance)

Work Group Membership:

Randall Best	*NC Division of Medical Assistance*
Sheila Black	*Senior Health Connection*
Cathie Beatty	*Buncombe County Department of Social Services*
Judy Brunger	*The Carolinas Center for Hospice & End of Life Care*
Kenny Burrow	*NC Association of Long Term Care Facilities*
Melanie Bush	*NC Division of Medical Assistance*
Jennifer Cockerham	*Community Care of North Carolina*
Tracy Colvard	*Home and Hospice Care of NC & SC*
Timothy Daaleman	*University of North Carolina at Chapel Hill*
Deby Dihoff	*National Alliance on Mental Illness (NAMI) NC*
Regina Dickens	*NC Foundation for Advanced Health Programs*
Palmer Edwards	*NC Medical Society*
Patricia Fields	*Community Care of Lower Cape Fear*
Becky Finney	*Davie County Department of Social Services*
Jonathan Fischer	*Community Care of North Carolina*
Marsha Fretwell	*NC Program for All-inclusive Care for the Elderly (PACE)*
Ron Gaskins	*Northwest Community Care Network*
Larry Greenblatt	*Northern Piedmont Community Care*
Sandi Grey-Terry	*Community care Partners of Northern Piedmont*
Sandy Gregory	*NC Baptist Aging Ministry*
Nikki Griffin	*NC Association of County Directors of Social Services*
Laura Hanson	*University of North Carolina at Chapel Hill*
Debra Harris	*Wilson County Home Health Agency*
Akelo Harris	*Northwest Community Care*

Michael Howard   *Division of Medical Assistance*
Robin Huffman   *NC Psychiatric Association*
Claudette Johnson   *Partnership for Health Management*
Fred Johnson   *Northern Piedmont Community Care*
Elizabeth Junak   *Craven County Health Department*
Pamela Lloyd-Ogoke   *NC Division of Vocational Rehabilitation*
Ginger Marshall   *Carolinas Health Care System*
Tammie McLean   *Community Care of the Sandhills*
Ben Money   *NC Community Health Center Association*
Dan Mosca   *Governor's Advisory Council on Aging*
Jeremy Moseley   *Wake Forest Baptist Health*
Laurie Nelson   *Community Care Plan of Eastern Carolina*
Cindy Oakes   *Community Care of Southern Piedmont, Inc.*
Teresa Piezzo   *Community Care of North Carolina*
Swarna Reddy   *NC Division of Aging and Adult Services*
Lynette Rivenbark Tolson   *NC Alliance of Public Health Agencies, NC Association of Local Health Directors, NC PHA*
Susan McCraken   *NC Association of County Directors of Social Services*
 Carson Rounds   *NC Academy of Family Physicians*
Anita Schambach   *Community Care Partners of Greater Mecklenburg*
Jeanine Shupp   *St Joseph of the Pines*
Chris Skowronek   *NC Hospital Association*
Gerri Smith   *Family Caregiver*
Kathy Smith   *NC Providers Council*
John S. Snow   *Iredell Health System*
Jeff Spade   *NC Hospital Association*
Louis Stein   *Western Highlands Network*
Beat Steiner   *University of North Carolina at Chapel Hill*
Dennis Streets   *NC Division of Aging and Adult Services*
Kim Sturkey   *Community Care Partners of Greater Mecklenburg*
Sandra Terrell   *NC Division of Medical Assistance*
Elizabeth Tilson   *Community Care of Wake & Johnston Counties*
Nicholas Turkas   *Arthritis Foundation*
Torlen Wade   *Community Care of North Carolina*
Jennifer Wehe   *Community Care of Western North Carolina*
Polly Welsh   *NC Health Care Facilities Association*
Lou Wilson   *NC Association of Long Term Care Facilities*
Gayla Woody   *Centralina Council of Governments*
Tony Zizzamia   *Liberty Homecare and Hospice*

Work Group/Sub Group Meeting Dates:
Medical Homes Work Group: October 3, 27; December 8

Nursing Homes: October 24; November 14 and 30
Adult Care Homes: November 4, 18; December 19; January 6, 13, 17, 24; February 3, 29
Palliative Care: October 25, November 29; February 14
Needs Determination: October 19; November 7, 28; December 14; January 4, 9

Strategic Framework Recommendations:

- Building upon the current Patient Centered Medical Home (PCMH) processes and infrastructure, develop beneficiary-centered medical homes for all dual eligible beneficiaries to improve access, quality and cost across all residential settings.
- Develop a Functional Needs Matrix that can stratify dual eligible population based on their need. The function-based model will identify both physical health impairment/disability and mental health/cognitive/emotional and impairment/disability and will assist to identify needs based on abilities and available natural support systems. Ultimately the tool can be used for the independent assessment that links needs and allocation of resources. The range is from intact to requiring specialized care.
- Foster open and ongoing beneficiary & family/caregiver discussions of care preferences, including palliative care options, well in advance of extenuating circumstances. Develop Palliative Care consult capacity statewide, for dual eligible beneficiaries in all care settings: hospital, nursing home, and adult care home, private homes. Create incentives to align the organizational culture of residential and home-based long term service and support providers to incorporate palliative care options.

Implementation Plan Considerations:

Create regulatory and quality incentives to enhance primary care provider, network and home and community based care team members to work collaboratively with beneficiaries and their families to better meet beneficiary-defined goals for their care.

Create financial, regulatory and quality incentives for primary care provider, network and of nursing facility care team members to work collaboratively with residents and their families to better meet beneficiary-defined goals for their care. See nursing home resident medical home support graphic.

Create financial, regulatory and quality incentives for primary care provider, network, adult care home facility and other community provider care team members to work collaboratively with residents and their families to better meet beneficiary-defined goals for their care. Note: adult care home resident medical home support graphic in development.

Incorporate expectation of screening question in annual health visit with primary care provider (PCP), e.g. PCP to consider appropriateness of palliative care discussions and referral for consult

Create incentives and processes to encourage completion, updating and online access to NC Medical Order for Scope of Treatment (MOST) Forms.

Develop training opportunities for palliative care-related conversations initiated by medical home team members, examples suggested include:

- targeted/mentored training professionals, para-professional and lay medical home support team members with defined expectations regarding roles, responsibilities and refresher programs
- incentives for and easy access for PCP & professional continuing education unit (CEU's) on palliative care

Create opportunities for community members, beneficiaries & their families, physicians, providers and medical home support team members (all settings, all staff levels) discussions and education regarding how to make care wishes known, advanced directives and NC MOST form full spectrum of options (e.g. can specify full code)

New Entrants - Initial Screening:

- Recommend use of Medicare Visit Guidelines for the dual population PCP visit:
  - Patients with potential complexities are referred to Care Management
  - Care Managers complete current Comprehensive Health Assessment Tool which includes modules for in-depth assessment
- Need to consider the issue of volume and capacity of referrals to CCNC care managers for the dual population
- Need to identify the most impactable target population via Medicare/Medicaid claims data and TREO
- Beneficiaries Currently Receiving Services - assess using respective existing assessment and level of care tools such as the Minimum Data Set (MDS), and the State FL2, MR2 processes
- Will need cross walk existing tools to the Functional Needs Matrix
  - Need to crosswalk with Eligibility
  - Need to crosswalk with Medicaid Clinical Coverage policies (for resource allocation purposes)
- Need to define common assessment definitions for services and supports

Proposed Primary Care Screening for Duals:
Follow Medicare Visit Guidelines and utilize appropriate evidence-based screening tools:

- Medical/family history
- List of current providers and suppliers
- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP
- Detection of any cognitive impairment (e.g. mini-cog)
- Individual's potential for depression (e.g.PHQ-2/9)

- Review of the individual's functional ability and level of safety (e.g. Get UP and Go test)
- Written screening schedule for the individual, such as a checklist for the next 5 to 10 years (per US Prevention Services Task Force (USPSTF) or CDC Advisory Committee on Immunization Practices (ACIP) Recommendations)
- List of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway and a list of treatment options
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs
- To identify those with potential need for Palliative Care. PCP would consider: "Would I be surprised if this patient died within the year?" If yes, begin the dialogue regarding advance planning. Refer to Palliative Care as indicated. May utilize Five Wishes or similar tools.

If anything is positive, next steps options available to PCP would be:

1. Second tier screen/assessment in office– e.g. Instrument of Active Daily Living/Active Daily Living, potential tool Boston Partnership for Older Adults
2. Refer to existing community resource to which patient is not linked (e.g. PT to assess ADLs)
3. Refer to/share information with existing services of patient to which they are linked
4. CCNC Care Management - Comprehensive Health Assessment. Assessment may identify more needs and can determine level of need and resource eligibility.

2. **Long Term Supports and Services**
   Sub groups: Nursing Homes and Adult Care Homes [Heather Burkhardt]
   Community Living [Pamela Lloyd-Ogoke]

Work Group Co- Leads: Pamela Lloyd-Ogoke (Division of Vocational Rehabilitation), Heather Burkhardt (Division of Adult and Aging Services)

Work Group Membership:

Jeaneen Beckham	*Northern Piedmont Community Care*
Mary Bethel	*NC AARP*
Sheila Black	*Senior Health Connection*
Elise Bolda	*Community Care of North Carolina*
Jessalyn Bridges	*Community Resource Center - Senior Services Inc*
Heather Burkhardt	*NC Division of Aging and Adult Services*
Jennifer Cockerham	*Community Care of North Carolina*
Tracy Colvard	*Association of Home and Hospice Care of NC & SC*
Timothy Daaleman	*University of North Carolina at Chapel Hill*
Cynthia Davis	*NC Association on Aging*
Lydia Dickens	*Easter Seals UCP of NC & VA, Inc*
Jonathan Fischer	*Community Care of North Carolina*
Angela Floyd	*Community Care of North Carolina*

Jim H Graham	*Northwest Community Care Network*
Michelle Green	*Community Care of the Sandhills*
Sandy Gregory	*NC Baptist Aging Ministry*
Sandi Grey-Terry	*Community Care Partners of Northern Piedmont*
Nikki Griffin	*NC Association of County Directors of Social Services*
Gregory Griggs	*NC Academy of Family Physicians*
Don Herring	*Western Highlands Network*
Bill Herzog	*Carolina Villages Project*
Leslie Hocking	*Wake County Human Services*
Jeffrey Horton	*NC Division of Health Service Regulation*
Kristi Huff	*NC Health Care Facilities Association*
Claudette Johnson	*Partnership for Health Management*
William Lamb	*Friends of Residents in LTC*
Kathryn Lanier	*NC Division of Aging and Adult Services*
Annette Lauber	*NC Assistive Technology Program*
Susan McCraken	*NC Association of County Directors of Social Services*
Hank Maiden	*Volunteer*
Jeremy Moseley	*Wake Forest Baptist Health*
Raquel Rey	*Hospice & Palliative Care of Alamance-Caswell*
Dave Richard	*ARC of North Carolina*
Nan Rideout	*Carolinas Village Project*
Ursula Robinson	*All-inclusive Care for the Elderly (PACE) of the TRIAD*
Chris Skowronek	*NC Hospital Association*
George Smith	*Senior Tar Heel Legislature Delegate, Johnston County*
Peggy Smith	*NC Assisted Living Association*
Jeff Spade	*NC Hospital Association*
Kim Sturkey	*Community Care Partners of Greater Mecklenburg*
Cynthia Temoshenko	*NC Division of Vocational Rehabilitation*
Scott TenBroeck	*Graduate Student*
Alice Watkins	*Alzheimer's North Carolina Inc.*
Jennifer Wehe	*Community Care of Western North Carolina*
Lou Wilson	*NC Association of Long Term Care Facilities*

Work Group/Sub Group Meeting Dates:
The **Long Term Services and Supports Work Group**: October 3, 21; November 7, 29; January 9, 2012.

Nursing Homes and Adult Care Homes and Community Living Sub Groups: November 7, 29 and January 11th

Strategic Framework:

- The need to increase flexibility in the area of services, coverage, and provider options in a manner consistent with person centered principles.
- The importance of providing assistive technology which has a direct impact on the success of a person living well and safely in their community of choice.
- The need to provide education and information to clients, providers, facilities etc. that lead to appropriate services geared to serving the "whole" person
- Streamline access into services including presumptive eligibility
- Support for Dementia Care across all settings
- Provide support and clarity for Hospice and Palliative Care Services

Recommendations

1) Create a program in which individuals get the services they need, based on Instruments of Active Daily Living's, Active Daily Living's, transportation and supervision.

2) Change the current definition in policies around 'medical home billing' to ensure equity in access to services to all age groups.

2. a.) Allow independent practitioners who are contracted with Medical Homes to provide and bill for services such as Occupational Therapy, Physical Therapy, Speech and Language Pathologists and Assistive Technology (AT) services.

3) Change or expand language in policies to say "services provided in the home and in the community" (example Adult Day Care).

4) Support caregivers through provision of billable services such as respite care, counseling, education, bereavement, anticipatory grieving and purchase of durable medical equipment (DME).

5) Increase allowable coverage for items that will assist a person to remain functional in the community.

5. a.) Allow flexibility in payment options and vendors so products that are needed by a person for their health, safety, and well-being and allow them to live in the community can be obtained (e.g. microwave to heat delivered meals).

6) Utilizing a community collaborative approach to increase public awareness about advance directives (MOST and long term care planning)

7) Promote the use of the MOST form and advance directives across all care settings

8) Fund evidence-based health and wellness promotion programs across settings

(physical and mental exercise, fall prevention)

9) Provide educational programs to dual eligible beneficiaries on Medicaid and Medicare (including such topics as benefits/coverage, fraud and abuse, and health literacy)

10) To ensure appropriate discharge planning and follow up is carried out in a timely manner during transition between settings and providers.

11) Provide education to medical homes around the value of assistive technology and geriatrics

12) Allow presumptive eligibility when a person is discharged from an acute care hospital to the community. This should be seamless and provided without any delay.

13) Provide adequate training to PCP and staff (medical homes) to ensure that they have capacity to serve and support individuals with dementia.

14) Design a benefit that clearly defines hospice and palliative care benefits.

3. **Behavioral Health Integration**
    Sub Groups: Provider Participation and Access [Peggy Balak, Deby Dihoff]
    Continuum of Care [James Graham, Barbara Smith]

    Work Group Co-leads: Mike Lancaster (Community Care of North Carolina), Nena Lekwauwa (Division of Mental Health), Amelia Mahan (Division of Medical Assistance)

    Work Group Membership:
Erica Arrington	*Easter Seals UCP of NC & VA, Inc.*
Peggy Balak	*Saguaro Group LLC/ Triumph*
Jeaneen Beckham	*Northern Piedmont Community Care*
Jehan Benton-Clark	*Kate B. Reynolds Healthcare Trust*
Randall Best	*NC Division of Medical Assistance*
Heather Brewer	*Easter Seals UCP of NC & VA, Inc.*
Jessalyn Bridges	*Community Resource Center - Senior Services Inc*
Laurie Coker	*NC Consumer Advocacy, Networking, and Support Organization, (CANSO)*
Timothy Daaleman	*University of North Carolina at Chapel Hill*
Deby Dihoff	*National Alliance on Mental Illness (NAMI) NC*
Marsha Fretwell	*NC Program for All-inclusive Care for the Elderly (PACE)*
Jim H Graham	*Northwest Community Care Network*

James Graham   *NC Program for All-inclusive Care for the Elderly (PACE)*
Sandi Grey-Terry   *Community care Partners of Northern Piedmont*
Gregory Griggs   *NC Academy of Family Physicians*
Don Herring   *Western Highlands Network*
Robin Huffman   *NC Psychiatric Association*
Tyehimba Hunt-Harrison *NC Psychiatric Association and the NC Council of Child and Adolescent Psychiatry.*
Marc Jacques   *Wake County CFAC*
Claudette Johnson   *Partnership for Health Management*
Christal Kelly   *Division of Medical Assistance*
Eric Kivisto   *NC Health Care Facilities Association*
Debi Lee   *NC Ombudsman Association*
Densie Lucas   *Cumberland County Local Management Entity*
John S. Morris   *Four Seasons*
Jeremy Moseley   *Wake Forest Baptist Health*
Susan Osborne   *NC Association of County Directors of Social Services*
Ashwin Patkar   *Duke University*
Jody Riddle   *Upper Coastal Plain Area Agency on Aging*
Sarah Rivelli   *Duke University*
Peter Rives   *Northwest Community Care Network*
Pamela Shipman   *Piedmont Behavioral Health LME*
Chris Skowronek   *NC Hospital Association*
George Smith   *Senior Tar Heel Legislature Delegate, Johnston County*
Barbara Smith   *UNC Center for Excellence in Community Mental Health*
Kathy Smith   *NC Providers Council*
Steven Smith   *Transylvania County Department of Public Health*
Jeff Spade   *NC Hospital Association*

Work Group/Sub Group Meeting Dates:
The **Behavioral Health Integration Work Group**: October 3, 17, 31; November 14; December 1, 14; January 10, 2012.

Provider Participation and Access and Continuum of Care Sub groups: October 24, 31; November 10, and 14

STRATEGIC FRAMEWORK/OVERARCHING POLICY:

The Behavioral Health Work Group believes that improving access to integrated care that is recovery-focused for dual eligibles may lead to short-term increases in cost but will lead to long-term savings and a healthier population. We believe that North Carolina has the infrastructure necessary and that we can build on the existing health home model and utilize and expand peer support options.

A. Recommendations for immediate implementation:

1) Streamline the billing process to make it more efficient –
      a) Ensure providers are paid in a timely fashion,
      b) For services that Medicare does not cover, providers should be able to submit
      claims directly to Medicaid without having to first get a denial from Medicare.
This recommendation, if implemented will increase access, as more providers would be willing to accept Medicare/Medicaid.

2) Create a state-wide repository of original credentialing documents
      Providers can submit the credentialing documents once and then the credentialing agencies can get the information from the repository. This has been done before in NC and could be done again.
3) Better integrate with existing Gero-teams and expand if needed into the health home.
4) Build on existing centralized resource lines and resource centers to provide a single outlet for information
      Ensure that those answering the phones and those working there have up-to-date information on dual benefits and resources as well as behavioral health-specific resources. This could be done locally, but it would also be useful to have a statewide resource number/webpage.
5) Build on existing care coordination/care management models –
      Expand focus to include "Integrated Care Coordinators" with smaller caseloads who work specifically with the dual eligible population with BH diagnosis.
      Care coordinators should be cross-trained and should have access to specialists for consultation.
6) Increase and encourage collocation and reverse collocation between primary care and specialty behavioral health.

B. Recommendations for mid to longer term implementation

1) Development of a flexible system that allows individuals to engage in services based on their needs and allows them to move through the system without fear of losing their benefits (allows them to work, engage in recovery, etc.).

2) System should include social needs in addition to healthcare needs (housing, transportation, etc.) which will greatly reduce healthcare costs long-term and will improve quality of life for the dual population.

3) Focus on Recovery Education Centers that allow for walk-ins for a recipient, regardless of what phase of recovery that they are in – could be peer-operated wellness center that utilizes peer wellness/health coaches.

4. Transitions Across Settings and Providers
      Subgroups: Transitions from Acute Care to Community (Patricia Farnham)

Workgroup Co-leads: Patricia Farnham (Division of Medical Assistance), Sabrena Lea, (Division of Aging and Adult Services) and Jennifer Cockerham, (Community Care of North Carolina)

Workgroup Membership:

Evan Ashkin	*UNC Dept. of Family Medicine ACCESS Care*
Ada Atkinson	*Community Care of Lower Cape Fear*
Jeaneen Beckham	*Northern Piedmont Community Care*
Robert Bilbro	*Community Care of Wake & Johnston Counties*
Denise Bordeman	*Aging and Disability Community Resource Connections-Mecklenburg County*
Jessalyn Bridges	*Community Resource Center - Senior Services Inc*
Judy Brunger	*The Carolinas Center for Hospice & End of Life Care*
Peter Brunnick	*Hospice & Palliative Care Charlotte Region*
Margaret Brunson	*Northern Piedmont Community Care*
Kenny Burrow	*NC Association of Long Term Care Facilities*
Tonya Cedars	*Area Agency on Aging, Eastern Carolina Council*
Connie Christopher	*First Health Home Care*
Jennifer Cockerham	*Community Care of North Carolina*
Timothy Daaleman	*University of North Carolina at Chapel Hill*
Susan Davis	*Community Care of Wake & Johnston Counties*
Peggy Dorfman	*NC Medical Society/NC Psychiatric Association*
Trish Farnham	*NC Division of Medical Assistance*
Patricia Fields	*Community Care of Lower Cape Fear*
Elizabeth Gamble	*Northwest Community Care Network*
Miriam Godwin	*Moye Medical Center Eastern Carolina University*
James Graham	*NC Program for All-inclusive Care for the Elderly (PACE)*
Larry Greenblatt	*Northern Piedmont Community Care*
Sandi Grey-Terry	*Community care Partners of Northern Piedmont*
Nikki Griffin	*NC Association of County Directors of Social Services*
Gregory Griggs	*NC Academy of Family Physicians*
Sam Hedrick	*NC Providers Council*
Jill Hinton	*Easter Seals UCP of NC & VA, Inc*
Teresa Johnson	*North Carolina Adult Day Services Association*
Elizabeth Junak	*Craven County Health Department*
Susan King-Cope	*National Alliance on Mental Illness (NAMI) NC*
Margaret Kirkman	*NC Adult Foster Care Association*
Kelly Livengood	*Northwest Community Care Network*

Beth Lopez	*Community Care Partners of Greater Mecklenburg*
Laura Maynard	*NC Hospital Association*
Tammie McLean	*Community Care of the Sandhills*
John S. Morris	*Four Seasons*
Paul Morrow	*NC Division of Medical Assistance*
Dan Mosca	*Governor's Advisory Council on Aging*
Jeremy Moseley	*Wake Forest Baptist Health*
Kevin Nale	*Disability Rights and Resources*
Lydia Newman	*Community Care of Lower Cape Fear*
Lynne Perrin	*Community Health Partners*
Gwen Phillips	*Chatham Orange Community Resources Corrections*
Jennifer Polo	*Community Care Plan of Eastern Carolina*
Marsha Ring	*Western Highlands Network*
Kevin Robertson	*NC Department of Insurance*
Michelle Roseman	*All-inclusive Care for the Elderly (PACE)*
Lorrie Roth	*NC Division of Aging and Adult Services*
Erin Russell	*NC Division of Vocational Rehabilitation*
Janet Schanzenbach	*NC Association of Long Term Care Facilities*
Cynthia Sexton	*NC Statewide Independent Living Council*
Chris Skowronek	*North Carolina Hospital Association*
John S. Snow	*Iredell Health System*
Kim Sturkey	*Community Care Partners of Greater Mecklenburg*
Scott TenBroeck	*Graduate Student*
Patty Upham	*First Health Home Care*
Polly Welsh	*NC Health Care Facilities Association*
Amy Whited	*NC Medical Society*
Neil Williams	*Community Care of North Carolina*
Lou Wilson	*NC Association of Long Term Care Facilities*

Work Group/Sub Group Meeting Dates:

Transitions Across Settings and Providers Work Group: September 15; October 4, 14, 24; November 15; December 16; January 10, 2012.

Transitions from Acute Care to Community and **Transitions from Nursing Home to Other Long Term Settings and Transitions Among Providers:** November 15, 28; December 16; and January 10, 2012

Final Recommendations for the DEPG Transitions Workgroup

This document reflects the synthesized recommendations of two sub groups convened during the meetings of the Transitions Workgroup, Transitions from Acute Care to

Community and Transitions from Nursing Home to Other Long Term Settings and Transitions Among Providers

Over-Arching Policy Recommendations

The model developed and implemented should:

- o Position person/beneficiary using the services at the center of the transition process;

- o Result in support systems and service structures that encourage thoughtful, coordinated planning that mitigate the "3am" crisis call and reactionary decision-making by both service recipients and service providers;

- o Promote improved coordination among medical, behavioral health, long-term care, social, and community services and supports, accommodating effective preparation/ pre-planning that maximizes informed decision making and transition coordination;

- o Require prompt follow-up with beneficiary by receiving service providers after transition occurs;

- o Include education and training to prepare all members of the care transition team to be effective in their role in the transition process;

- o Use technology to facilitate and support successful transition from the acute care setting to the next care provider for recovery and/or palliative car

APPENDIX F
Beneficiary and Stakeholder Conversations

The summaries of each of the nine beneficiary conversations conducted as part of the ***Dual Eligible Planning*** grant is presented below:

1. **October 18, 2011, at the Hilton Charlotte University Place, Charlotte, NC, in connection with the NC Conference on Aging, facilitated by Division of Aging and Adult Services**

Participants: 9 stakeholders and dually eligible beneficiaries, including 7 self-identified as White and 2 as African Americans

Key findings:

a. There are both serious time and service gaps. For example, it may take at least 6-10 weeks from the point of receiving a referral for home care (personal care) before it is assessed and approved. This has serious implications for the frail client. If the client doesn't have an advocate, they may often get lost in the system.
b. There was expressed interest/support for 'presumptive eligibility' to pre-qualify clients and mitigate time gaps
c. There is a need to simplify the Medicaid application and eligibility process.
d. A population at particular risk is those without family supports. It is of particular importance to connect people with natural supports. It is also important to support family caregivers, when they are present.
e. The evolving Community Resource Connection for Aging and Disability is a very important development—an interagency, person-centered collaboration striving to address gaps (e.g., for the homeless veterans) in serving the whole person. An especially useful component is the e-tool allowing cross-referral and tracking.
f. Strength of the Community Alternatives Program (Medicaid HCBS Waiver) is its case management, (a single point person to help coordinate services). A similar single point person is necessary to help coordinate the care of the extremely vulnerable individuals.
g. Technology can make some aspects of the care/access extremely impersonal to the vulnerable dual population. For example, it was noted that the DSS had responded to client: "we don't have time now to discuss; the best way to contact us is via email." The importance of providing access to personal, hands-on assistance and reassurance was stressed given literacy issues and vulnerability.
h. There is a need to do a better job of educating consumers and keeping them engaged in decisions about their own care.
i. Older Adults Health Insurance Information Program is a key resource—not only for those on Medicare but also those who are eligible for Medicare and Medicaid.

2. **November 18, 2011, Charlotte Housing Authority HUD ROSS Program Site, Charlotte, NC, facilitated by the Division of Aging and Adult Services**

Participants: 17 dual eligible older adult beneficiaries, including 7 self-identified as African American and 5 as Native American older adults and 5 white older adults.

Key findings:
   a. Most people were comfortable with their physician, found them to be helpful and caring. Often people depended on their social worker and pharmacists for assistance.
   b. Beneficiaries did not fully understand the insurance plans they had- Medicaid and Medicare. There is considerable ambiguity about the benefits they receive. They often receive conflicting information.
   c. Sometimes beneficiaries on Medicaid get bills from their doctor's office and they pay them.
   d. Obtaining approval for medications and going through the appeals process when denied is very difficult for beneficiaries.
   e. Most people try to understand their benefits only when they become sick and have an immediate need. It's good to understand your health plan and benefits before you need them so you can plan accordingly.
   f. Some beneficiaries fall victim to scams easily because of low literacy and their vulnerability. Participants reported that one group came to the building and offered residents $10 to sign-up for their plan. They often are not able to tell what they are signing and accepting.
   g. There is a need for a single place they can go to where the advice they receive is trustworthy. People often go to their Social Security office but the lines there are long; you are not able to speak with a live person, one has to resort to dealing with answering machines.

3. **January 23, 2012, Forsythe County Mental Health Building, Winston-Salem, NC, facilitated by Consumer Advocacy, Networking and Support Organization (CANSO)**

Participants: 3 dually eligible mental health and substance abuse consumers, 1 male and 2 female.

Key findings:
   a. Most people have access to physicians but it is difficult to get an appointment with the provider you want when there is an emergency. Sometimes there is a three week wait for an appointment, often making the beneficiary seek immediate care from the emergency department.
   b. The co-pay attached to psychiatric services is very high ($30-$60 per visit), which is a deterrent in getting psychiatric care.
   c. Sometimes the practice will send a person to the hospital emergency department because they do not have the time to see the beneficiary.

d. Mental health/substance abuse consumers get care from two different places. There is very little coordination between the general practitioner and the psychiatrist.
e. There is no continuity in who you see within a practice, it is often who is available. It is difficult to depend on a physician that you may not see again.
f. There are transportation services available in the community, so keeping appointments are not too difficult. CANSO also provides pick up services.
g. There is considerable difficulty in finding counselors/therapists (other psychiatry services) who take Medicare/Medicaid.
h. There is very little alternative to chemical treatment. Beneficiaries who look for alternative to that are often left to themselves till a crisis. A lot of community services have lost funding and the peer support program is also falling short in the state.
i. A mental health/substance abuse consumer is always treated for the mental disability first and foremost. There is so much focus on the mental health issues that there is very little resource devoted to the physical health care. No advice is given about self-care, maintaining healthy diet, exercise, preventive care, etc.
j. There is a need for verbal coordination between the physical health physician and the mental health physician; when that is missing the patient suffers.

4. **January 24, 2012, February 7, 2012, Orange County Older Adults Center, facilitated by older adult dual beneficiary and community volunteer.**

    Participants: Older adult beneficiaries - 6 older adults in session 1 and 10 older adults in session 2, including 5 self-identified as African American in session 1, and 3 self-identified as African American in session 2.

    Key findings:

    a. Most beneficiaries depend on their natural supports when they need help with their health. When there are natural supports they are able to get the information they need, get to appointments and get medical attention as needed.
    b. Those without natural supports are left to navigate the system by themselves and are unable to get the care they need.
    c. Most beneficiaries do not understand the benefits they have.
    d. It's difficult to get appointments with the physician as needed; there is often a wait to get an appointment. Physician offices make appointments three months ahead and beneficiaries have to make sure to keep the appointment.
    e. There are often concerns with medications not agreeing with the individual and it's hard to get it changed immediately. Each person is on more than 6-7 medicines at a time.
    f. There is concern with co-pays, which are often high, and a deterrent to seeking care. There is also the cost of medications that make beneficiaries stretch out the time between refills.
    g. Beneficiaries often do not understand the physicians and find it difficult to ask questions.

h. Beneficiaries are not able to receive assistive tools like eye glasses and wheel chairs they need which allow them to be independent in the community
i. There is great difficulty in getting dental care when needed.

5. **January 26, 2012, Burnt Swamp Association, Lumbee tribe, facilitated by Commission on Indian Affairs staff.**

Participants: 31 dually eligible beneficiaries including younger adults with a disability, older adults and mental health consumers including 31 self-identified as Native American.

Key findings:

a. Beneficiaries have a great deal of concern about the loss of services that were previously available through Medicaid and Medicaid. There have been considerable cut-backs on availability of therapy, CNA hours and in-home assistance.
b. There is a need for education on the prescription drugs. People often don't understand why they are taking a medicine, how to take it and the consequences of not taking the medicine as prescribed.
c. There is a great deal of dissatisfaction with the process associate with obtaining Medicare/Medicaid and with appeals when denied.
d. There is no communication between doctors (primary care and specialists) who provide different kinds of care and also between the patient and the physicians. The results of tests (X-rays, blood tests) are not communicated to the patient. Physicians don't take the time to sit down and explain their illness, and the treatment to the consumer.
e. There is great difficulty in obtaining transportation for medical appointments. If appointments are missed then there is difficulty in getting a new appointment.
f. Physicians do not advise on self-care and disease management. Beneficiaries would benefit from access to nutritionists and others who can answer specific questions a person has. It would also help if beneficiaries had access to fitness centers and rehabilitation facilities.
g. There is a need for more assistance in obtaining rehab equipment and other assistive technologies. It is very difficult to obtain eye-care, and eye glasses as well as dental care
h. Medicaid/Medicare policies are stacked up against people who want to work and those who are on a fixed income. There is an immediate need to revise some of these policies.

6. **January 31, 2012 Stellar Peer Recovery Center, facilitated by Wake County Consumer and Family Advisory Council/NAMI member/dual eligible beneficiary,**

Participants: 33 dually eligible beneficiaries including mental health and substance abuse consumers, young adults with disabilities including 26 self-identified as African American.

Key findings:

a. Beneficiaries have considerable trouble in obtaining the services they need when they need it
b. Individuals with a social worker or care manager are better able to navigate the system.
c. Mental health consumers have to work with two different systems- the physical health world and the mental health world. It is difficult to manage both appropriately
d. Transportation is a concern in getting to medical appointments. Often appointments are missed due to lack of transportation. Physician practices are hesitant to give new appointments when more than one appointment has been missed. Appointments with medical transportation have to be made 7-9 days in advance.
e. Co-payment is another deterrent to seeking the care beneficiaries need
f. Beneficiaries are not able to get eye-care, eye glasses and dental care; a lot of dentists do not take Medicare/Medicaid
g. There is very little coordination between primary care physicians and specialists. There is a wait time of more than 3-4 weeks between needing and obtaining an appointment with a specialist. The results of a specialist visit are often not communicated back to the primary care physician.
h. It is difficult to get access to therapists and counselors who take Medicare/Medicaid
i. The people who depend on these services cannot afford to have any more loss of funding to services.
j. There has to be a 'one stop and shop' place where you can get all the services you need and you are able to get to in an emergency. A 24-hour support place for information and care.

7. **January 31, 2012, Tsali Manor, Cherokee Community, facilitated by Older Adults Health Insurance Information Program (SHIIP) volunteer serving the community**

Participants: 4 dually eligible beneficiaries, including 4 self-identified as Native American.

Key findings:

a. Most of the time people get help in navigating the system and obtaining answers to questions regarding their health from their family members
b. Beneficiaries have difficulty in obtaining and keeping medical appointments
c. Transportation to and from appointments are difficult unless there are family members or friends to assist you.
d. Need to confirm – was this a positive statement – interesting contrast with others ->Doctors provide information and support on self-care and management, particularly on how to eat, need to exercise and managing their conditions
e. Most beneficiaries are comfortable with their physician if they are able to see the same person consistently
f. Difficulty in getting eyeglasses and dental care is a problem to most beneficiaries

8. **February 2, 2012, Lenoir Council on Aging, Kinston, NC, Council on Aging**

   Participants: 16 dually eligible beneficiaries including younger adults with disabilities, mental health/substance abuse consumers, older adults; and 7 non dual older adults, including participants 20 self-identified as African American.

   Key findings:

   a. Most beneficiaries are happy with their physicians and the care they receive
   b. There is a need for more information on their health condition, how to manage their own care, pharmacy benefits and insurance coverage
   c. There is some coordination between physicians and other providers but more is needed. Most patients appreciate it when the physicians communicate clearly with them- but most hesitate to ask questions.
   d. Majority stated that their physicians do not normally focus on issues regarding diet, nutrition and exercise, mostly because there is not time from managing their more serious health concerns.
   e. Issues with getting care included lack of transportation, care giver support, and co-payments.
   f. There is more need for supplemental benefits that would allow beneficiaries to obtain things like eye glasses
   g. Difficulty is obtaining supplemental benefits, such as dental care, physical therapy and psychological therapy was mentioned

Quality Measures Used in North Carolina's 646 Demonstration
Please see Appendix B for full list of Acronyms

Description	Quality Measures
Diabetes Care	1. 1 hemoglobin A1c measurement in one year (NCQA, NQF, AQA) 2. Lipid profile done in measurement year (LDL-C) (NCQA DPRP) 3. Documented retinal or dilated eye exam by an eye care professional (NCQA DPRP) 4. Foot exam (NCQA HEDIS, NCQA DPRP) 5. Smoking status and cessation advice and/or treatment (NCQA HEDIS, NCQA DPRP) 6. Hemoglobin A1c < 8(NCQA HEDIS, NCQA DPRP) 7. Nephropathy screening or evidence of nephropathy management (NCQA HEDIS, NCQA DPRP) 8. A1C Control > 9.0 (aiming to decrease % with poor control) 9. LDL cholesterol control > 130 (aiming to decrease % with poor control) 10. Avoidable Hospitalization Rate: Diabetes short-term admissions (AHRQ-PQI indicator)
Heart Health -Congestive Heart Failure (CHF)	1. Patients with left ventricular function assessment in claims history (NCQA, ACC/AHA,PCPI) 2. ACE Inhibitors / ARB Therapy (percentage of patients with EF < 40%, prescribed ACEI or ARB Therapy) (ACC/AHA/PCPI, CMS PQRI) 3. Beta Blocker Therapy (% of patients with EF < 40% prescribed a Beta Blocker) (ACC/AHA/PCPI, CMS PQRI) 4. Smoking Status 5. BP Control (<140/90) (NCQA HEDIS, PQRI) 6. Weight measurement in most recent medical visit
Ischemic Vascular Disease (IVD)	1. Lipid measurement (lipid panel or LDL within past year) (NCQA HSRP, NCQA HEDIS, ACC/AHA/PCPI) 2. BP Control (<140/90) (NCQA HSRP) 3. Aspirin Use (NCQA HSRP, ACC/AHA/PCPI) 4. Smoking status and cessation advice and/or treatment
Hypertension	1. BP Control (<140/90) (NCQA HSRP; NCQA HEDIS) 2. Smoking Status
Transitional Care	1. Potentially Preventable Readmission Rate (30 day readmissions) 2. Patients hospitalized for CHF having an outpatient visit within 30 days post discharge

Work Plan (Subject to review and revision)

Timeframe	Work plan Key Activities/Milestones	Responsible Parties
May 2012	• Proposal submitted to CMS • Implementation Work Group development begins Medicare Claim analyses and cost-savings estimation begin; CMS review begins MOU Review Process Begins	DMA, Dual Eligible Integrated Delivery Model Staff (DE Staff), Core Leadership Team, Finance Work Group, Analytic Team, CMS
June – July 2012	• Operational development underway • State Plan Amendment in development • Federal 30-day public comment period commenced (5/10 – 6/10); • MOU Development with CMS – including comparison group methodology • CMS MOU Signing target 7/25-7/29 • Negotiation of Final Agreement with CMS	CMS, DMA, CCNC Leadership, DE Staff, Core Leadership Team, Stakeholder Work Groups, NC Negotiating Team
August – October 2012	• CMS Final Agreement signing target 8/30 – 9/03 • Readiness Review with CMS 9/1 – 9/10 • With CMS, finalize plan to terminate Medicare 646 Quality Demonstration • PCP & Network Contract Drafting • Review of Waiver needs with CMS, Waiver drafting • CMS and Internal NC Readiness Review • Develop Stakeholder Implementation Work Groups • Quality Metrics & Data/Reporting Details Clarified	CMS, DMA, CCNC Leadership, DE Staff, NC Negotiation Team Analytic Team, Implementation Team, CCNC 646 staff & participating CCNC Networks, Stakeholder Work Groups
November – December 2012	• Medicare 646 notification plan implemented • Data use agreements readied, existing state assessment data obtained • PCP & Network Contract review with CMS	CMS, DMA, CCNC Leadership, DE Staff, CCNC Leadership, staff and consultants CCNC Networks, Finance Work Group, Analytic

Timeframe	Work plan Key Activities/Milestones	Responsible Parties
	• Agreements with CCNC and sub-contractors drafted • Revise/finalize implementation demonstration work plan and timeline	Team, Implementation Team, Informatics Team, Stakeholder Work Groups
January - March 2013	• Mobilize demonstration work group structures. • Finalize contracts for implementation demonstration management and issue sub-contracts • Conduct CCNC Network and contactor orientation • Institute Medicare and Medicaid claims-based beneficiary risk-stratification process • Finalize preliminary agreements for development of medical homes for dual eligible beneficiaries residing of nursing homes and adult care homes. • Test baseline and change-over-time data reports • 6 month monitoring with CMS	Delineation of responsibility for demonstration work plan tasks is subject of refinement pending review of final proposal provisions. DMA is responsible for overall policy and payment elements and will contract with CCNC for overall program development & implementation, Informatics Center functions and coordination of Beneficiary and Stakeholder processes.
April - June 2013	• Begin enrollment of high-risk beneficiaries and high dual eligible resident concentration nursing homes and adult care homes • Training and education plans and draft curricula disseminated for review and refinement. • Convene Statewide Partners' Group • Conduct regional stakeholder orientation sessions	
July –September 2013	• Review initial dual eligible beneficiary enrollment and priorities for improvement. • Prepare, review and revise draft reports on quality and outcome metrics • Finalize selection of uniform integrated independent assessment tools and definitions	

Timeframe	Work plan Key Activities/Milestones	Responsible Parties
	• Begin mobilizing regional and community-level beneficiary, provider and stakeholder dialog and community resource coordination activities.	
October –December 2013	• Begin conducting independent functional assessments and data gather for development of a functional needs-based allocation of resources methodology. • Begin formalizing local/regional beneficiary, provider and community stakeholders processes and communications • Conduct focus groups and gather input on language, contents and priority features for Beneficiary Portal • 12 month monitoring with CMS	
January – June 2014	• Conduct year-1 review with work groups and Leadership team; revise work plans and time lines as appropriate. • Begin development of Beneficiary Portal. • Year 1 data submission for performance incentive & quality calculation (due 90 days after end of year 1) • Begin analysis of functional assessment data to develop needs clusters for functional need-based resource allocation estimation. • Develop orientation and training modules for Beneficiary Portal and • Beta test Beneficiary Portal • With CMS prepare estimates of cost savings and retrospective performance payments	
July – December 2014	• Launch Beneficiary Portal • Conduct mid-year review and course corrections with CMS and work groups	

Timeframe	Work plan Key Activities/Milestones	Responsible Parties
	• Finalize preparations for receipt and dissemination of incentive payments funded through retrospective performance payments [September 2014 – 9 month into year 2 is the earliest possible start date for retrospective payments from CMS] • Begin analysis and testing of linked functional assessment and claims data to develop expenditure estimates for needs clusters • Begin preliminary design of system interface and regulatory changes required for implementation of functional need-based eligibility and resource allocation authorization	
January – July 2015	• Conduct Year 2 review, revise plans as appropriate • Begin documenting business case for on-going integrated Medicare/Medicaid funding of beneficiary-centered medical homes for dual eligible beneficiaries. • Assess and review functional need-based resource allocation estimates and proposed authorization processes and begin system design and regulatory change processes	
August – December 2015	• Conduct mid-year and final review of implementation activity • With CMS clarify opportunities and expectations for transitions to steady state and implementation of remaining Integrated Delivery Model features • Prepare final reports	

646 Counties

Updated: October 1, 2009

APPENDIX K
Map of CCNC Networks

Community Care
of North Carolina

Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership

- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

APPENDIX L
Written Responses to Public Hearings

Dear CCNC Dual-Eligibles Team:

We are organizations that advocate for older adults and all people with disabilities in North Carolina and we appreciate the opportunity to comment on the recently submitted Draft of the strategic framework and implementation plan for a statewide demonstration model of care for dual eligibles in our state. We support the goal of high quality person-centered care and supports for this most vulnerable population, and we look forward to the incorporation of the viewpoints and perspectives of the populations we represent in the future.

We also have confidence in the strong base of care coordination and support for children and families on Medicaid built by Community Care of North Carolina. We are pleased with the general approach of building care for dual eligibles on this foundation.

Below we have some comments about what we think is critical to incorporate in the design of a plan for care of dually eligible beneficiaries as well as some of our specific concerns about North Carolina's Draft Plan submitted for public comment last month.

Critical Features of the Plan:

1) Participants, their families, and caregivers must be provided with education, assistance, and support as they enter the new system of care, as the plans of care are created and implemented, and throughout the grievance/appeal process. As recognized in the Draft Plan (Section A, Background), "[H]ealth care and supportive services for dual eligible beneficiaries in North Carolina are often delivered through a complex and fragmented delivery system. . [and] . . .the evolution of policy and program priorities have produced a dizzying array of service systems that fail to meet the needs of those they intend to serve." The Draft Plan's reliance on the existing systems for beneficiary protection is insufficient given this background, the diverse needs of the population to be served and considering the many new choices and procedures beneficiaries will have to navigate. We urge the formal incorporation of a consumer assistance service that is supported by dedicated funds.

2) It is also essential that consumers have meaningful choice and control over their lives and healthcare. How will beneficiaries participate in a meaningful way in the assessment process?

3) The Plan must provide the greatest degree of consumer protections found in both Medicaid and Medicare. For example, the Plan should leave no doubt that beneficiaries may appeal

a reduction, modification or termination of services resulting from the "functional needs based resource allocation" and that benefits will not be interrupted until a final decision is rendered on appeal.

4) Transition into the Plan will be a critical time for beneficiaries and without adequate safeguarding, continuity in treatment could suffer. We urge that prior authorized services and supports, even if provided outside the network, continue for a pre-determined time sufficient to allow an orderly and safe transition. We recommend that the pre-determined amount of time be six (6) months, with the ability to request a further extension in unique circumstances.

In several areas the Draft Plan fails to provide sufficient detail for us to conclude that beneficiaries will receive adequately broad and coordinated services and supports. For example:

1) On pages 14 – 15 of the Draft Plan several agencies for which collaboration is essential to provide safe and supportive long term care and behavioral health supports are identified or listed, but the Draft Plan does not describe how CCNC and the agencies will work together in support of the beneficiaries or be accountable to the beneficiaries. Each of these agencies has a separate administration, and as noted in Section A. "Background" of the Draft Plan, a result of our fractured system of services is that ". . .misery sustained by beneficiaries and their families, frustrations faced by providers and advocates and examples of wasteful use of public funds are well known to stakeholders from all perspectives." Today's landscape and the very real negative impact it has had on the lives of older people and people with disabilities in North Carolina demands that the Draft Plan detail how collaboration will be achieved.

2) How will consumer outcomes be measured? It is essential that outcomes be measured in a meaningful way. Do you plan to track employment, housing, and/or life satisfaction?

3) We are unclear how dually eligible beneficiaries who do not live in Adult Care Homes or Nursing Homes will be served during Phase One.

4) We hope and anticipate that the person-centered approach will result in greater compliance with the Americans with Disabilities Act and that some beneficiaries will move out of congregate residential settings into their own homes in the community. It seems that the services and supports available in Phase Two may be funded and made possible in part by the savings created when beneficiaries are moved from institutional settings into the community during Phase One. Given our State's experience of moving people out of institutions before there are adequate services and supports in the community, the Draft Plan should provide greater detail about how the people transitioned during Phase One will be supported in the community.

5) We know that skilled transition coordinators are essential to the successful transition of people from institutions to the community. The Plan should address in detail how this expert support will be provided to beneficiaries.

6) Comprehensive benefits will be required to help people stay in their homes and communities. A broad commitment to the community based model should be reflected in the array of flexible services and supports provided through the Plan including a commitment to individualized person centered assessment and care planning and care coordination that includes functional support with flexibility. The Plan must ensure adequate and appropriate support for behavioral health issues. Support for community living could include: vocational support, transportation or taxi vouchers; cell phones in place of ambulance calls; network flexibility and the ability to pay for aspects of support that will help people function and stay safely in their homes. Currently the Draft Plan lacks sufficient detail regarding flexible and innovative functional/behavioral supports. (See for example Section iii. *Supplemental benefits and/or other ancillary/supportive services*.) The Draft
Plan must be more specific regarding this important area of support.

Thank you for considering our comments. We look forward to a system of care that provides long term services and supports that positively impacts people with disabilities, incorporates participant choice and direction and maximizes participant independence and integration in the community.

Sincerely,

Corye Dunn	Adam Searing	Abby Emanuelson
Director of Public Policy	Director, Health Access Coalition	VP Public Policy- NC & SC
Disability Rights NC	NC Justice Center	National MS Society

April 19, 2012

Sandra Terrell
Assistant Director, Clinical Policies and Programs
North Carolina Department of Health and Human Services

Randall Best,
MD Chief
Medical Officer

Denise Levis Hewson, RN, BSN, MSPH
Director of Clinical Programs and Quality Improvement
Community of Care of North Carolina

VIA ELECTRONIC SUBMISSION

Dear Ms. Terrell, Dr. Best, and Ms. Hewson:

The Pharmaceutical Research and Manufacturers of America ("PhRMA") appreciates the opportunity to submit comments regarding the North Carolina State Demonstration to Integrate Care for Dual Eligible lndividuals.[1] PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA strongly supports North Carolina's efforts to improve care coordination for individuals that are eligible for both Medicare and Medicaid by building on its existing, statewide medical home and community care Networks through the Community Care of North Carolina ("CCNC") program. We recognize the achievements of CCNC and believe this model may offer dual eligible beneficiaries the opportunity to enjoy the benefits of primary care led medical homes and to achieve "the triple aims of improving responsiveness to beneficiary goals, improving care quality, and achieving shared savings."

North Carolina intends to use the Managed Fee-for-Service ("FFS") financial model outlined in CMS guidance issued in July 2011 to implement its proposals.[3] In this approach, current Medicare and Medicaid FFS coverage and provider reimbursement remain in place and the demonstration will add medical home providers and other mechanisms to better coordinate the delivery of care. Specifically, North Carolina proposes to improve care management through the use of patient-centered, primary care physician-led medical homes established within regional community care Networks under the CCNC program. CCNC uses a variety of care management tools to achieve improved quality of care and cost savings, including: "evidence-based best practice programs, risk-stratification to target care and disease management interventions, coordinated care delivery with an emphasis on improving transitions, motivational interviewing, patient education and self-management skill building, improved management of chronic illness care through the use of actionable data and

automated patient-specific alerts, and pharmacy management strategies and interventions."[4] In the CCNC model, accountability for managing services and supports for the beneficiary lies with the beneficiary and his or her medical home team, and oversight to ensure that the beneficiary has access to services according to his or her needs may be shared by the beneficiary's primary care provider and the Network.[5]

Adding Medicare-covered services and claims information to the CCNC program would be a great step forward. North Carolina proposes that it will first expand the use of medical homes to those dual eligible individuals who live in nursing homes, adult care homes and other supported residential settings ("Phase 1"). The proposal states that North Carolina will use shared Medicare and Medicaid savings achieved through Phase 1 to expand access to medical homes to dual eligible individuals in all settings ("Phase 2").[6] In addition to relying on current medical home functions and care management tools to improve care coordination for dual eligible individuals, North Carolina also proposes to introduce an independent assessment of beneficiaries' medical and support needs that will define a beneficiary's needs using objective, function-based measures, to increase beneficiaries' capacity to make decisions about their own care by engaging them as members of their medical home teams, and to enhance the use of claims data and other data for quality monitoring and care management by the medical homes.[7]

North Carolina Should Clarify Its Approach for Coordinating Pharmacy Care

PhRMA applauds the CCNC program's ongoing commitment to medication management for Medicaid beneficiaries through its medication reconciliation program and its use of the Pharmacy Home drug use information database.[8] While the proposal is not detailed on the delivery of the drug benefit, we assume, but North Carolina should confirm in its proposal, that beneficiaries will remain in their Part D plans. Since 2006, the Medicare Part D prescription drug program has effectively provided access to robust prescription drug coverage for Medicare beneficiaries with high levels of beneficiary satisfaction, and at far lower costs than initially projected.[9] It has also resulted in substantial savings for other parts of the Medicare program. A recent study published by the Journal of the American Medical Association ("JAMA") found annual savings of $1,200 on other, non-drug Medicare costs for seniors who previously had no drug coverage, or limited drug coverage, prior to the creation of Medicare Part D.[1] Cost-savings are also achieved with respect to the drug benefit itself through the Medicare Part D competitive bidding process. In a managed FFS program, there is no reason to change the use of Part D prescription drug plans as those Part D plans currently operate in a Medicare fee for service environment.

We note, however, that this proposal does not specifically address how medical homes will provide medication management or coordinate with Medicare Part D prescription drug plans providing pharmacy coverage to dual eligible beneficiaries. Accordingly, we recommend the State clarify how medical homes will interact with Part D benefits, and how services provided by the medical home (such as medication management) will be coordinated. In particular, we urge North Carolina to expressly confirm that demonstration enrollees will continue to receive their prescription drug benefits through their current Medicare Part D plan, and that medical home pharmacy management activities for dual eligible individuals are carefully designed to complement Part D's existing infrastructure and quality assurance mechanisms.

For example, given that a significant component of the care management provided by medical homes involves pharmacy management initiatives supported by the Pharmacy Home drug use information database,[11] and that Medicare Part D plans similarly have well-established mechanisms for medication management, it will be important to ensure that the medical home care management activities by primary care providers and pharmacists complement Part D medication management activities, and that the two do not unnecessarily duplicate or contradict each other.

We thank you for your consideration of these comments on the draft proposal of the North Carolina State Demonstration to Integrate Care for Dual Eligible Individuals. We urge North Carolina to revise its proposal in a manner that enhances coordinating care without either unnecessarily disrupting care for North Carolina's most vulnerable beneficiaries, or compromising prescription drug benefits for all Medicare beneficiaries in the State. We look forward to the opportunity to continue working with North Carolina in the development of this demonstration. Please contact me if you have any questions regarding these comments. Thank you again for your attention to these important issues.

Respectfully submitted,

Sharon Brigner, MS RN
Deputy Vice President
State Advocacy

APPENDIX M
Letters of Support

Letters of support have been received from the following agencies and organizations:

    Office of the Governor, North Carolina
    Office of Secretary of Department of Health and Human Services, North Carolina
    Community Care of North Carolina (CCNC)

North Carolina Department of Health and Human Services Divisions
    Division of Aging and Adult Services
    Division of Vocational Rehabilitation
    Division of Mental Health, Developmental Disabilities and Substance Abuse Services
    Division of Public Health

Partner Organizations
    NC American Association of Retired Persons (AARP)
    Alzheimer's, Inc., NC
    Arthritis Foundation--Mid-Atlantic Region
    The Carolinas Center for Hospice & End of Life Care
    Centralina Council of Governments
    Chatham Orange Community Resources Connections
    Easter Seals of North Carolina and Virginia
    Eastern Carolina Council
    Home and Hospice Care of North Carolina
    Kate B. Reynolds Charitable Trust
    National Alliance on Mental Illness (NAMI) NC
    NC Health Care Facilities Association
    NC Hospital Association
    NC Academy of Family Physicians
    NC Association of Area Agencies on Aging
    NC Adult Day Services Association
    NC Association on Aging
    NC Association of County Directors of Social Services
    NC Association of Long Term Health Care facilities
    NC Baptist Aging Ministry
    NC Center for Public Policy Research, Inc
    NC Consumer, Advocacy, Network, and Supports Organization
    NC Commission on Indian Affairs
    NC Department of Insurance
    NC Governor's Advisory Council on Aging
    NC Foundation for Advanced Healthcare Programs
    NC Program for All Inclusive Care for the Elderly (PACE)
    NC Psychiatric Association
    NC Senior Tar Heel Legislature

North Carolina Community Care Networks

Carolina Community Health Partnership
Community Care of the Sandhills
Community Care Plan of Eastern Carolina
Carolina Collaborative Community Care
Partnership for Health Management
Community Care of Wake/Johnston Counties
Community Care of Southern Piedmont
Northern Piedmont Community Care
Community Care of Western North Carolina
Access Care, North Carolina
Community Health Partners
Community Care of the Lower Cape Fear
Community Care Partners of Greater Mecklenburg
Northwest Community Care Network