

DESCRIPTION OF NORTH CAROLINA'S MODEL

July 5, 2012

North Carolina is generally considered to be at the forefront of states implementing a medical home model, supported by a broader network of providers. They provide a good case study for Connecticut, given that they use a fee-for-service, network based model. Reflecting their successes and advanced medical home implementation, there have been numerous articles about North Carolina's experience and, with support from the Commonwealth Fund, North Carolina has developed a "toolkit" comprised of 16 modules providing suggested activities and approaches for states wishing to implement similar models. The toolkit also contains specific instruments used by the networks in North Carolina. However, it is also important to point out that as noted on its home website, North Carolina's program did not rise up as a finished vision; rather it evolved slowly and steadily over 25 years.

The basic model followed in North Carolina is one where there are 14 geographically based networks, comprised primarily of primary care providers, but also containing other health care service providers. These networks are supported by a central office. Following is a description of some of their basic structural elements and implementation suggestions and reflections, drawn mostly from the toolkit.

One lesson North Carolina stresses is that the planning and implementation processes can be as important as designing the right model. They strongly suggest pilot implementation, understanding that a network system will not be developed quickly or easily, that such a system requires strong physician and other champions, and that it is critical for physicians to feel like they have ownership in the system in order to assure acceptance. They suggest an advisory board of physicians and other health care leaders to help develop the program framework. They faced the same questions as Connecticut in designing their system: characteristics of the network (size, providers, structure, etc.), network functions and services, enrollment, performance measurement, partner agreements, information infrastructure, etc. They also focus on the need to support the planning and fledgling network development efforts – financially, technically – with communications, with training and with feedback. The original implementation included primarily children and families.

Building Networks

To start the process of building networks, all 37 large primary care case management (PCCM) practices were contacted to see if they wanted to participate; the state received a high rate of positive response. Participants appreciate that there is not a middleman between them and the state. The relatively high payment rates (discussed further below) also helped to create interest. Two network options were available: a community network, which would include PCCM practices, the county health department, a hospital and the county department of social services (because the system was undergoing a major redesign, mental health agencies did not join until later in the process), or the option of a "horizontal" PCCM practice only network. The horizontal model was

DESCRIPTION OF NORTH CAROLINA'S MODEL

Page 2

the primary model used initially, but was downplayed as aged, blind and disabled (ABD) enrollees were added to the program, requiring more complex services and supports.

Network development was supported using a community development process and start up financing of approximately \$30,000 was provided to each network. This was accompanied by a start up guide, access to technical and clinical consultants and various cross network groups, including a clinical director's group. Consultants included experts in community development, clinicians, quality improvement experts, process improvement specialists, as well as practicing physicians, to serve as program "ambassadors." In retrospect, North Carolina would have added business operations and management support (financial, personnel, boards) to help networks as most of them created new nonprofit entities.

North Carolina made a conscious decision to roll out the program largely "under the radar," a decision they feel served them well by avoiding high, and potentially unrealistic, expectations. They also started the program by addressing a single problem, one where they were confident they could make progress – asthma – and worked to find opportunities to provide positive feedback to providers.

Over time, to better address chronic and more complex illness, North Carolina developed community networks – physician led "local associations of health care professionals and support service providers who share resources and execute care improvement initiatives" that help to "connect patients with a range of specialists and ensure coordination across the patient's health care team."

North Carolina recommends building a network around the needs of your target population. Each North Carolina network has a steering committee with, at a minimum, representation from PCPs, hospitals, county health and social services departments. They recommend including mental health representation, as well. Each initiative may require new partners (although leadership should remain stable). North Carolina sees the role of the state as supportive, not prescriptive, beyond setting broad ground rules. One such rule is that the network must serve at least 30,000 enrollees to ensure adequate resources. Networks must also cover contiguous counties. Providers in each county could choose which network to form or join, but there is only one network per county. Typically networks are built around urban medical centers and fan out from that central point. The selection process for most counties went smoothly.

While there is flexibility, all networks include care managers (RNs and social workers), who are the core staff, steering and medical management committees, an administrator, a medical director, a pharmacist and a psychiatrist. Some specialists, such as psychiatrists, may not be full time.

Given the autonomy of the networks, North Carolina has had to determine ways to ensure consistent performance. To do this, there are regular meetings, training, performance reports and performance agreements. To minimize the risk of waste or mismanagement, North Carolina works to ensure that the management team, the board and network management, have the skills to handle financial and operational management.

Enrollment

As discussed above, North Carolina started with the least complex populations and added more complex groups over time.

North Carolina recommends mandatory enrollment when allowable. This has allowed them to gain 70-75% participation for Medicaid-only enrollees. They have only achieved about 12% enrollment for dual eligibles, where enrollment is voluntary. North Carolina is pursuing an opt-out approach with CMS.

North Carolina chose to use county departments of social services to perform the enrollment function, rather than an independent contracted enrollment broker. Enrollment must be accompanied by patient outreach and education, with associated funding.

Central Office

North Carolina encourages the use of a central office to ensure consistency, learning and coordination among the networks. This office plays a strong role in coordinating the clinical and quality activities of the independent networks and designs and tests new initiatives. The office also provides legal and communications support. Initially, the central office was part of the state structure, but an opportunity arose to apply for a Medicare "646" waiver (see below) to provide services to dual eligibles, with the plan to serve Medicare only beneficiaries later. Only a nonprofit could apply for that program, so one was created. Additionally, providing care management services through a contracted agency offered an opportunity to maximize federal Medicaid match in states where the program match rate is higher than 50% (the administrative match rate). This is not an issue for Connecticut where both match rates are currently the same.

Now the state uses a hybrid model – a nonprofit runs the program, but with strong ties to, coordination with and oversight by the state. The nonprofit focuses on program and the state on fiscal and administrative issues. NC-CCN, the nonprofit, is not a payer and does not contract with provider.

Informatics and Analytics

Approximately 70% of the central office staff is dedicated to developing North Carolina's Informatics Center and providing data and analytic support to the networks. While originating with Medicaid claims only, the Center now includes pharmacy, lab, hospital, care management data and care alerts in its analysis. Medicare data is being added. North Carolina provides quite a bit of information beyond the scope of this summary paper, in that they provide an overview of user applications hosted within the Informatics Center, including: the Case Management Information System (CMIS); Pharmacy Home, Reports Site; Chart Review System and Provider Portal. They also discuss the Center's functions including: quality measurement and feedback; population needs assessment; risk stratification and identification of patients for targeted initiatives; analysis of hospital and emergency department utilization patterns; clinical decision support, including patient information sharing, care team communication, and program evaluation and accountability. Finally, they discuss staffing, technical environment, privacy, and security. There is also some real time pharmacy data for Medicare enrollees from the number one national

DESCRIPTION OF NORTH CAROLINA'S MODEL

Page 4

prescription claims adjudicator, and chart audit data, to the extent available. Issues regarding cross network communication remain.

Funding

In North Carolina, PCPs receive \$2.50 PMPM for the “easier” populations – typically families – and \$5 PMPM for the ABD population. This builds upon higher than average Medicaid compensation – 95% of the Medicare rate. The networks are funded similarly – through “enhanced care management payments,” paid as PMPMs, using service match paid by the fiscal intermediary. Parties must be careful to ensure that only services that are allowable for service match are paid this way. These rates are \$3.72 for family populations and \$13.72 for ABDs. The central office is supported by the networks, each paying \$2 PMPM for each ABD enrollee from the enhanced care payments they receive. Some foundation support has also helped fund informatics development.

Integrating Physical and Mental Health Care Management

Mental health services were not originally integrated into North Carolina’s networks because the mental health system in North Carolina was undergoing a major restructuring at the time the program began. North Carolina is working to now close that gap, although there is still some distance to go. The goal of the program is to help PCPs identify mental health issues, treat to the extent of their expertise and comfort, refer when appropriate, and to improve information sharing.

Network psychiatrists will serve as behavioral health leads and will lead the efforts to develop training, identify evidence-based models, and develop related network processes, among other tasks. Psychiatrists are provided with a set of tools to use to help train PCPs. They will be supported by behavioral health coordinators who will act as a liaison with the care managers. A survey of PCPs indicated that they saw their highest needs around mental health service provision to be access, collaboration and crisis services.

Adding Dual Eligibles

When North Carolina began its 646 demonstration in January 2010 after four years of development, it retained its focus on acute, rather than long-term care. They built this model on the one they had used to provide services to the ABD population, which they expected to be particularly relevant to the younger disabled population. Eight of the 14 networks participated. In this model, they had a shared savings arrangement with Medicare. They did very well on quality measures, but have not, to date, accrued savings to share. However, North Carolina does not consider the pilot to have had a fair opportunity to earn savings – Medicare data critical to risk assessment was not available until month 20 and enrollment was low because of the requirement that all enrollees affirmatively opt into the program.

Although the focus was on acute care, North Carolina is starting a long-term care pilot centering on physician practices dedicated to servicing nursing homes. Goals include limiting unnecessary hospital admissions, improving patient care, improving information flow and supporting networks. The nursing facility would serve as the medical home. Despite being one of the first in the nation to have a program serving dual eligibles in an integrated manner, they still have issues with multiple (but siloed) programs. The Program of All Inclusive Care for the Elderly, Medicare Special

Needs Plans and Home and Community Based waivers have not been integrated, leaving what may still be a confusing array of services for providers and beneficiaries.

The state now has a duals demonstration proposal before CMS, in which they propose to suspend their 646 demonstration and use the duals authority under the Affordable Care Act to provide integrated services to this population. They are requesting authority to use "opt-out" enrollment. They would like to use this demonstration to implement three overarching goals:

- To continue and expand the use of the medical home model for duals in the community and extend medical home offerings to duals in nursing homes and other residential settings (not including those already enrolled in the state's mental health managed care plan). Those in residential settings will be a priority for enrollment.
- To develop an integrated functional needs assessment and the related resource allocation system, regardless of setting or program
- To improve communications for beneficiaries and providers

One interesting feature of their proposal is "capacity development incentives," which would be used to encourage providers to practice at the top of their scope, using a tiered PMPM. The first tier would be constant and would cover fixed costs such as assessment, basic care management and information infrastructure, and the second piece would vary, based on responsibilities assumed by various team members.

Annotated Bibliography

Bella and Palmer. Encouraging Integrated Care for Dual Eligibles, Center for Health Care Strategies, Inc., July 2009.

The authors recommend components that should be common to integrated care models. They also provide brief overviews of New York, Minnesota and North Carolina integrated care programs.

Community Care of North Carolina. The Community Care of North Carolina Toolkit, May 2011, Supported by the Commonwealth Fund.

Numerous modules provide information for states and others who are interested in understanding and/or replicating North Carolina's approach to medical homes and the community care networks that support them.

North Carolina Department of Health and Human Services, Division of Medial Assistance. North Carolina State Demonstration to Integrate Care for Dual Eligible Individuals, May 2, 2012.

This is North Carolina's proposal to CMS to integrate care for dual eligible individuals under the financial alignment demonstration.

Verdier, Au and Gillooly. Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans, Mathematica Policy Research, MedPAC, June 2011.

The states reviewed were Arizona, Maryland, Massachusetts, Minnesota, New Mexico, North Carolina, Oklahoma, Vermont, and Virginia. The authors note: "There are substantial commonalities in how integrated programs coordinate care for dual eligibles, but the programs' overall structure varies, reflecting differences in the structure of the state Medicaid programs on which they are based."