U.S. Department of Health and Human Services
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Office of Disability, Aging and Long-Term Care Policy

MEDICAID HEALTH HOMES IN NORTH CAROLINA:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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North Carolina's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, 1 chronic condition and at risk of another
Qualifying Conditions	• Blindness • Congenital anomalies • Alimentary system disease • Mental/cognitive conditions, except mental illness or developmental disabilities • Musculoskeletal conditions • Cardiovascular disease • Pulmonary disease • Endocrine/metabolic disease • Infectious disease • Neurological disorders
Enrollment*	559,839
Designated Providers	Community Care of North Carolina (CCNC), Medicaid-enrolled primary care providers (PCPs)
Administrative/ Service Framework	Health home services are coordinated through a pre-existing care management program, CCNC.
Required Care Team Members	The team centers on PCPs, with wraparound clinical services provided and coordinated through the CCNC program. The program includes 3 primary elements: (1) regional, nonprofit networks of health and social service providers that collaborate to pursue common quality, cost, and access goals; (2) a care management infrastructure that assists providers in coordinating care; and (3) a statewide coordinating agency that liaises with the state, networks, and providers to establish and meet common goals.
Payment System	Per member per month (PMPM) care management fee, paid to network and PCPs
Payment Level	PMPM fee based on beneficiary classification: • **Networks**: $12.85 for ABD; $5.22 for pregnant patients; $4.33 for all others • **PCPs**: $5.00 for ABD; $2.50 for all others
Health Information Technology (HIT) Requirements	No HIT requirements. CCNC has a well-developed health information exchange infrastructure. Care teams access and record patient data through a web-based portal known as the Care Management Information System. A Provider Portal allows participating PCPs to access key patient health data. The CCNC website also includes a community health information portal that aggregates health and demographic data from public databases and which networks can use to identify community health trends and target interventions to improve public health and patient access.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

North Carolina's Section 2703 Health Home State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on May 24, 2012, with a retroactive effective date of October 1, 2011. The state offers health home services through its existing statewide medical home program, Community Care of North Carolina (CCNC). To be eligible for services, enrollees must have at least two chronic conditions that fall within one of ten diagnostic categories, or one of eight specific chronic conditions that the state has determined place the beneficiary at-risk for developing a second chronic condition (see Table 1). Patients with one chronic condition who develop a second, pregnancy-related chronic condition are also eligible for health home services.

CCNC (sometimes referred to as Carolina Access II) is the largest of two primary care case management (PCCM) programs that serve the majority of North Carolina's Medicaid beneficiaries. The second PCCM program, Carolina Access I, predates CCNC by several years. Both programs were established under a Section 1915(b) managed care waiver, and both require enrollees to identify a primary care practice that is responsible for managing their care. Medical providers are paid fee-for-service (FFS), and practices receive a per member per month (PMPM) management fee for both categories of enrollee. Enrollment in one of these two PCCM (CA I and CA II) programs is mandatory for most Medicaid beneficiaries. Optional enrollment groups include those dually eligible for Medicare and Medicaid, children receiving Supplemental Security Income or foster care/adoption assistance, members of federally recognized Indian tribes, individuals with end stage renal disease and pregnant women. Those ineligible for enrollment include individuals in nursing homes, those on a deductible, or those receiving limited Medicaid coverage. Beneficiaries may apply for an exemption from PCCM for medical reasons (e.g., in cases where the enrollee is terminally ill, receiving radiation or chemotherapy, or is too cognitively impaired to understand or participate in care management).

Both CCNC and Carolina Access I operate statewide; at present, approximately 300,000 are enrolled in Carolina Access I, while more than 1.2 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries are enrolled in CCNC. The primary distinction between the two programs is in the degree of care management available to enrollees. Medical home providers for Carolina Access I enrollees must offer 24/7 access to care and comply with some other minimal requirements, and receive a very modest fee (reportedly about $1 PMPM) in return. CCNC enrollees, in contrast, have access to care management services that are coordinated by one of 14 regional networks of providers and overseen by a nonprofit organization called North Carolina Community Care Network (NC-CCN), which operates under contract to the state. These services are described in greater detail in the next section, but include care transition support, medications management, and quality of care monitoring, among others. In addition, CCNC also plays a role in several state-supported pilots and demonstration projects.

Implementation Context

North Carolina's health home program has been implemented within a much broader context of care coordination and integration activities, many of which are directly relevant to the provision of health home services. Through its partnership with CCNC, the state is participating in several federally sponsored demonstration pilots and projects, and has spearheaded a range of initiatives targeting sub-populations with special needs. This section provides a brief overview of these initiatives, with special focus on those that are similar to the health home program or have implications for the long-term evaluation.

In 2010, North Carolina received a five-year 646 demonstration waiver from CMS which allowed CCNC to manage care for dual eligibles in 26 counties. The demonstration enrolled more than 40,000 beneficiaries receiving care at over 200 practices. As part of this initiative, CCNC screened enrollees for risk and identifies those in need of enhanced care management services, tracked performance and set quality improvement goals, and tested different care models. These care models included home visits, care management, and palliative care.[1] In May 2011, the state submitted an application for a CMS State Demonstration Grant to Integrate Care for Dually Eligible Individuals (duals grant).[2] In December 2012, the 646 demonstration was discontinued in anticipation of the duals demonstration. However, the state subsequently decided not to pursue the duals grant application.[3]

In November 2010, North Carolina was also selected to take part in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration. As part of this demonstration, CCNC has partnered with Medicare, BlueCross BlueShield of North Carolina (BCBSNC), and the State Health Plan for Teachers and State Employees in seven rural counties, with the goal of aligning incentives for quality improvement and cost containment. Participating practices are required to apply for primary care medical home recognition from the National Committee for Quality Assurance (NCQA), as well as perform a range of care management and coordination services for enrollees.[4]

CCNC also has launched initiatives targeting children and pregnant women, two of which involve federal partners. In 2009 the state received a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant to incorporate and report on child-focused quality measures, enhance its medical home model for children with special health care needs, and evaluate the impact of a pediatric electronic health record (EHR).[5] In June 2012, CCNC received a three-year grant from the Center for Medicare and Medicaid Innovation (CMMI) to implement a program known as the Child Health Accountable Care Collaborative. Under this program, the state will incorporate approximately 50,000 children with complex health needs into its medical home model, embed pediatric care managers in hospitals and specialty clinics, and provide patient navigation assistance to families of children with these complex needs.[6] At the state level, CCNC is partnering with other state agencies on the Care Coordination for

Children (CC4C) initiative, which is an at-risk population management program serving children from birth to age five who meet certain risk criteria (e.g., children with special health care needs, those exposed to severe stress, and children transitioning out of neonatal intensive care).[7] On the maternal health side, CCNC recently launched the Pregnancy Medical Home program, which links obstetric practices to the CCNC regional networks and provides specialized care management services to women during their pregnancy. Since the program began in March 2012, more than 300 practices have signed up to become pregnancy medical homes.[8]

Other state-level initiatives include disease-specific care management programs for asthma, diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease; as well as a Behavioral Health Integration initiative that involves a range of targeted projects. The initiative was launched in February 2010 in order to support the integration of mental health and substance abuse treatment into primary care practices enrolled in CCNC. Current projects include a chronic pain management project (Project Lazarus), a project promoting the integration of substance abuse screening and treatment interventions into primary care, and several projects related to prescribing practice and drug safety.[9] CCNC also works with newly implemented Local Management Entities-Managed Care Organizations (LME-MCOs) to better coordinate the care of enrollees with both medical and behavioral health conditions. LME-MCOs were established under a Section 1915(b)/(c) waiver, and receive a capitated payment for managing care related to mental illness, substance abuse, and developmental disabilities.[10]

Underpinning these initiatives is a well-developed information technology infrastructure (described in greater detail below), which supports both health information exchange (HIE) and the various tools used by participating providers and care managers. CCNC is the first Qualified Organization participating in the state HIE.[11] The earliest adopters of the state platform are those practices involved in the North Carolina Program to Advance Technology for Health, which is a collaboration with the BCBSNC and AllScripts, that provides practices with assistance in EHR adoption and use. CCNC will also collaborate with the HIE to develop platforms that support medical home practices. The first of these will focus on expanding CCNC's medication management program Pharmacy Home. In addition to these statewide information technology initiatives, one CCNC regional network is also a Beacon Community grant recipient. Southern Piedmont Community Care Network received funding to add care managers, pharmacists and mental health counselors to its staff, expand a patient education program into a range of clinics, and test a range of care management technologies.[12]

Implications for the North Carolina Section 2703 Medicaid Health Homes Evaluation

CCNC is a well-established program that has been providing health home-like services for several years, and is involved in other major initiatives to integrate care, including multi-payer initiatives. It does not appear that any significant changes have

been made to the networks' underlying structures and processes as a result of the state's adoption of the health home option. Because of this, and because CCNC acts as the coordinating entity for so many different pilots and programs, many of which target or include beneficiaries who are health home-eligible, it may be difficult--perhaps impossible--to distinguish a "health home effect" from the effects of other ongoing CCNC initiatives. Its statewide coverage and dominant role in serving Medicaid beneficiaries further complicate the ability to identify similar beneficiaries not exposed to health home services or other initiatives for comparison.

Population Criteria and Provider Infrastructure

North Carolina offers health home services to all categorically needy and medically needy Medicaid beneficiaries with two chronic conditions, or one chronic condition and the risk of developing another. (See Table 1 for a full list of the population criteria, designated providers, and the health home team composition requirements.) The state has identified eight specific conditions that qualify a beneficiary as being at risk of developing a second condition, and has further specified that beneficiaries with one qualifying condition will become eligible for health homes if they become pregnant and develop a related chronic condition such as gestational diabetes or gestational hypertension. Mental illness and developmental disability are specifically excluded from the list of conditions, since managing the care of beneficiaries with those conditions is the primarily the responsibility of the newly established LME-MCOs. Health home services will be coordinated through a pre-existing care management program, CCNC, and will be provided through the state's network of designated Primary Care Medical Homes, described in greater detail below.

Community Care of North Carolina

CCNC was officially launched as a statewide PCCM program in 2001, having evolved from a pilot care coordination program established in the 1980s.[13] Though the program was initially state-run, since 2007 most of the program development and management responsibilities have been transferred to a nonprofit, public-private partnership. This partnership acts as the umbrella organization for 14 regional networks, each of which comprises physicians, hospitals, local health departments, and departments of social services (see Figure 1). Each regional network is responsible for managing the care of enrollees within its constituent counties, including linking enrollees to a medical home, providing care management services, managing care transitions, referring patients to social and long-term care supports, and implementing a range of quality improvement initiatives.[14] Statewide, more than 1.2 million Medicaid and NC Health Choice (the state CHIP program) beneficiaries--including roughly 100,000 dual eligible--are currently enrolled in CCNC.

Once enrolled, each beneficiary is linked to one of more than 1,500 participating primary care medical homes. In addition to providing acute, chronic, and preventive care, these medical homes are also responsible for comprehensive care management

and referral to specialty care, long-term care support, and social and community services. Medical homes are supported in this endeavor through their involvement in a regional network, which provides a range of different resources and support to practices, depending on their needs and the existing care infrastructure.

Each regional network employs a staff of care managers who work to augment the care management services provided by the medical home team. Care managers may work at either the network or practice level, and they serve a number of roles, including home visits, medication reconciliation, care planning and referral coordination, and practice redesign. Networks also employ a pharmacist, who directs medication management and e-prescribing initiatives, and a psychiatrist, who directs behavioral health integration efforts and provides support to practices in managing patients with behavioral health needs.[15] Networks also employ dedicated quality improvement staff to work directly with enrolled practices, and may also obtain their own grant funding for discrete initiatives (as in the case of the aforementioned Southern Piedmont, which is a Beacon Community grant recipient).[16]

The central CCNC agency provides a range of support to practices as well. For example, though formal certification as a medical home is not required for practices not participating in the MAPCP demonstration, CCNC does provide resources and tools to practices wishing to obtain NCQA certification. CCNC frequently serves as the coordinating body for pilot initiatives and demonstrations that may later be rolled out statewide. The Pregnancy Care Management (PCM) program is one example of this. Beneficiaries who become eligible for health home services during pregnancy will be served through this program, which includes local care management in collaboration with obstetrics providers. The program also provides supplemental, specialized care management related to obstetric care needs.

CCNC and Carolina Access I enrollees typically select their medical home when they apply for Medicaid (a process which is handled by county Department of Social Service offices), choosing from a list of providers who are participating in each program. It does not appear that this procedure is any different for the health home-eligible. From the beneficiary's perspective, participation in the health home initiative is "invisible" (i.e., beneficiaries are not notified of their eligibility or treated differently from any other CCNC enrollee). For the purposes of correctly allocating the enhanced funding available for services provided to the health home population, however, the state identifies health home beneficiaries primarily through Medicaid claims data, though beneficiaries may also be identified and enrolled through direct referral, chart review, or screenings and assessment.

Service Definitions and Provider Standards

Health home services do not differ substantively from those of the broader CCNC program. The division of roles is flexible, and CCNC care managers may play an active part in all six defined services. Their role is most explicitly defined in comprehensive

care management and transitional care (see Table 2). The estimated average caseload per care manager ranges 5,000-7,000 for the Aid to Families with Dependent Children, and 1,500-3,000 for the Aged, Blind, and Disabled (ABD) population. The state bases this caseload on the assumption that only 5%-10% of a given population will need care management services at any one time and that services will vary in terms of intensity, ranging from home visits to telephonic intervention.

Regional CCNC networks also have a mandated role to play in service provision, most notably in facilitating relationships between hospitals and primary care, ensuring timely notification of admission and sharing of patient records post-discharge. In hospitals with high rates of admission among the Medicaid ABD population, transitional care nurses (56 statewide) are embedded full-time to manage the care transition process. In other cases, CCNC care managers visit patients in the hospital and then conduct follow-up home visits that include medication reconciliation. Network-employed pharmacists also review medication lists post-discharge and alert the primary care provider (PCP) of any discrepancies or other findings.

Network psychiatrists assist in the implementation of the state's behavioral health integration model, which aims to improve care coordination through screening and treatment of mental health conditions in the primary care setting and enhancement of the referral processes for patients with more complex needs. Regional networks also play a role in helping practices conduct health promotion activities and connect patients to long-term support services, both by including local social service agencies within the network and by producing resource manuals for providers.

In addition to meeting the basic requirements of any Medicaid provider, practices that wish to participate in a CCNC network must agree to collaborate with that network on a range of care management activities. Specifically, these include:

- Developing and utilizing care management systems and tools for Medicaid enrollees, including identification of a "practice champion," participation in network meetings, the development of a transitional care process, and sharing necessary clinical information with the network.

- Complying with policies and procedures developed by network leadership to improve quality and reduce cost.

- Cooperating with the network's patient risk assessment process for identifying and tracking patients who need disease and care management, and participating in inter-disciplinary teams to help manage their care.

- Coordinating with the CCNC care managers and participating in the implementation of care management plans.

- Collaborating with the Network to:
  - develop strategies to address special needs of the Medicaid population;
  - develop referral processes and communication with other providers;
  - promote patient self-management;
  - meet utilization and budget targets;
  - evaluate and implement appropriate changes in service utilization; and
  - develop and refine CCNC measures, utilization reports, management reports, quality improvement goals, and care management initiatives.

Use of Health Information Technology

CCNC has a well-developed HIE infrastructure--referred to as the Informatics Center--sponsored by both the state and CMS. The Informatics Center uses data from many sources to perform a range of functions and includes several different platforms that CCNC networks and providers can use to manage the health of enrolled Medicaid patients. Current Informatics Center data includes Medicaid claims data, patient record data, laboratory data, hospital data, and Medicare and pharmacy claims for those dual eligibles who are participating in certain demonstrations. For 56 of the state's 123 hospitals, admissions and emergency department visit data are automatically sent to the Informatics Center through real-time feeds.

Care managers (as well as other network-employed providers such as pharmacists and social workers) access these real-time feeds and other data through a web-based portal known as the Care Management Information System (CMIS). CMIS acts as a centralized care management tool, allowing care managers to access and manually update key patient health and PCP information (including inpatient admissions and emergency department visits for patients who visit one of the 67 hospitals that do not have automated real-time feeds), develop and implement care plans, identify care gaps through chart audits, and access health promotion and patient self-management tool kits. All care management information is recorded in CMIS and can be used to report on a range of queries related to a patient's care, as well as to monitor and evaluate the performance of care managers.

CCNC also maintains a Provider Portal, which incorporates elements of CMIS and allows authorized providers to access a range of Medicaid patient data. This includes visit history, pharmacy claims, lab and imaging records, care team contact information, and encounter information that occurred outside the local health system. Providers are also able to access population management reports and quality metrics for their patient population. In addition to data from CMIS, the Provider Portal incorporates data from Pharmacy Home, a separate database that provides patient profiles and medication histories, and Informatics Center Report Site, which allows networks to conduct population needs assessments, identify high-need patients, monitor utilization, and track performance indicators. The CCNC website also includes a community health information portal that aggregates health and demographic data from public databases

and which networks can use to identify community health trends and target interventions to improve public health and patient access.

This health information technology (HIT) infrastructure plays an important role in CCNC's ongoing quality improvement monitoring and evaluation process. For example, the Informatics Center produces quarterly reports on over 70 data elements related to the ABD population, which are used to identify individuals in need of additional screening. CCNC also conducts regular chart audits using an electronic audit tool that randomly selects patients based on diagnosis and pre-populates an audit report that can be reviewed by outside auditors. The results of these audits are then made available to practices and networks through the Informatics Center Report Site.

Payment Structure

North Carolina made no changes to its CCNC payment system as part of its implementation of the health homes option. Instead, the enhanced federal match is used to offset state funding of services provided to health home beneficiaries enrolled in CCNC. In addition to the base Medicaid FFS schedule, CCNC medical homes receive a tiered PMPM payment for each enrolled beneficiary. CCNC networks also receive a tiered PMPM for the provision of services to all health home enrollees, a portion of which is retained by the central CCNC office to support its activities.

The PMPM is higher for the ABD population, and networks can also receive add-on payments for services related to the PCM program (see Table 3). The rates are based on estimated costs at the practice and network level, which are regularly re-evaluated and include staffing, facilities, and infrastructure.

Of this PMPM, the central office retains $3.75 and $0.65 for each ABD and non-ABD enrollee, respectively.[17] Payment of the health home PMPM is triggered for a given patient when all four criteria below have been met:

- The patient is identified as meeting health home eligibility criteria on both the Medicaid Management Information System and the CCNC care management system.
- The patient is enrolled as a health home member.
- The patient has received care management monitoring or another health home service.
- The health home has recorded the service on a monthly activity report, which will track and record whether CCNC or another provider performed the service, the provider number, the beneficiary number, and the date of service.

Quality Improvement Goals and Measures

North Carolina has selected 38 quality improvement measures shown in Table 4. Fourteen are goal-based, and 24 are service-based. Twelve measures target children, and the rest are adult measures. The majority of these measures are scores from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which will be administered for both adults and children. The rest will be derived primarily through claims, though the state will also survey CCNC providers and conduct chart review for certain measures. Some of the measures identified in the SPA (such as those related to admissions, readmissions, and blood pressure control) are made available to practices and care managers through CCNC's information technology system.

Evaluation Measures and Methods

North Carolina has a developed a substantial data collection and reporting infrastructure for its CCNC program, which is used to monitor networks and providers throughout the year as well as set targets for achievement. In addition, some of this data is made available to networks at the patient, practice and network level through the Provider Portal. Measures tracked include avoidable hospital readmissions, admissions for asthma and heart failure, and emergency department visit rates, among others. These measures are generally collected monthly and reported quarterly and are stratified by health home and nonhealth home patients as part of the state's ongoing monitoring and evaluation strategy. Table 5 reproduces this strategy as detailed in the SPA. The state's measures are based on the ABD population not dually eligible for Medicare and Medicaid, with notations that for claims-based measures, "dually eligible Medicare claims [will be] included to extent CMS develops capacity to share them as currently proposed" and that targets for the dual eligibles will be established based on experience.

The state plans to use claims analysis to measure overall cost savings and acute care cost savings--excluding behavioral health costs and residential services--by date of service, and will report them separately for health home enrollees. Costs, to be reported on an annualized basis, include PMPM payments, acute care costs, and emergency department costs. The SPA is not clear on any plan to identify a comparison group of similar beneficiaries not enrolled in health homes.

FIGURE 1. Organizational Structure of CCNC

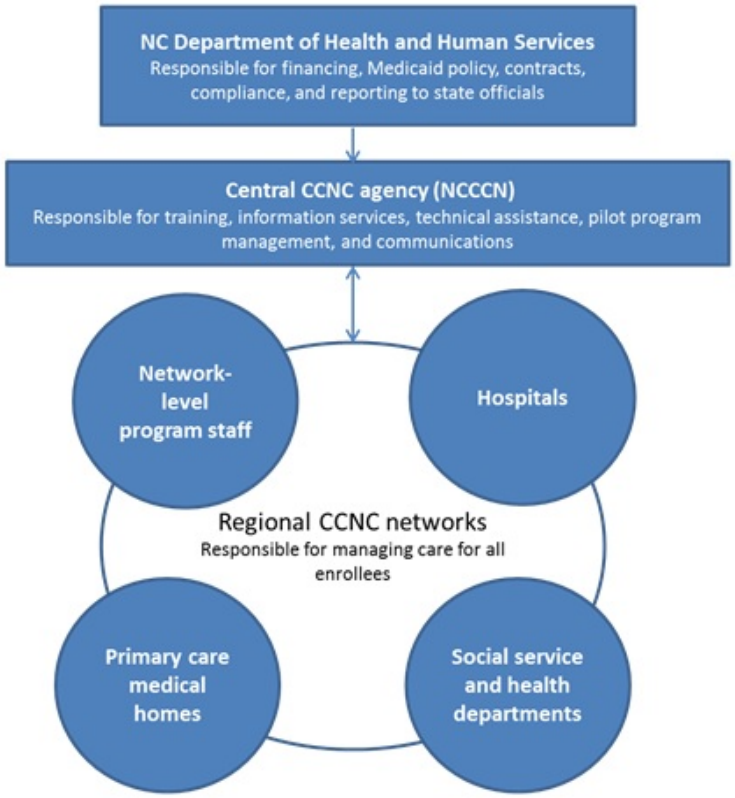

TABLE 1. Target Population and Designated Providers--North Carolina	
SPA Approval (Effective Date)	May 24, 2012 (October 1, 2011)
Designated Provider(s)	Primary care medical homes participating in the CCNC program
Health Home Team Composition	The team centers on PCPs, with wraparound clinical services provided and coordinated through the CCNC program. The program includes 3 primary elements: (1) regional, nonprofit networks of health and social service providers that collaborate to pursue common quality, cost, and access goals; (2) a care management infrastructure that assists providers in coordinating care; and (3) a statewide coordinating agency that liaises with the state, networks, and providers to establish and meet common goals.
Target Population	Beneficiaries must have: • 2 chronic conditions • 1 chronic condition and the risk of developing another
Qualifying Chronic Conditions	• Blindness • Congenital anomalies • Chronic alimentary system disease • Chronic mental and cognitive conditions, excepting mental illness or developmental disability • Chronic musculoskeletal conditions • Chronic cardiovascular disease – Hypertension* – Anemia/chronic blood disorder* • Chronic pulmonary disease – Asthma* – Pulmonary disease/chronic bronchitis* • Chronic endocrine and metabolic disease – Diabetes* – BMI over 25* • Chronic infectious disease – Perinatal infections* • Chronic neurological disorders – Chronic pain*
* Indicates conditions for which the state will presume the patient is at-risk for a second chronic condition.	

TABLE 2. Health Home Service Definitions--North Carolina	
Care Coordination	The implementation of the individualized care plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital-discharge processes and communicating with other providers and clients/family members. Care Managers or PCP team members are responsible for conducting care coordination activities across providers and settings, and CCNC care manager coordination interventions are identified and documented in the CMIS.
Comprehensive Care Management	Involves active participation from PCPs, care managers, and patient and family/caregivers and includes: • Patient identification and comprehensive assessment. • Developing an individualized care plan. • Care coordination: The care manager ensures the patient's care plan is implemented, communicating and coordinating across providers and delivery settings. Care manager interventions are identified and documented. • Reassessment and monitoring: The health care team monitors the patient's progress and adjusts care plans, as needed. • Outcomes and evaluation: The health care team uses quality metrics, assessment and survey results, and utilization of services to monitor and evaluate the impact of interventions.
Health Promotion	PCPs, their care teams, and/or CCNC care managers help patients participate in the implementation of their care plan and place a strong emphasis on skills development for management and monitoring chronic health conditions. Services include health education and coaching specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, and promoting lifestyle interventions such as nutrition counseling and smoking cessation.
Comprehensive Transitional Care	Every CCNC hospital admission is assessed for transitional care need, in some cases using real-time data from multiple sources. Transitional care is initiated for patients with chronic conditions at high-risk of readmission and for conditions in which the admission is for an ambulatory care sensitive condition. Networks also ensure timely transmission of patient information to the relevant providers upon discharge. The primary role of the care manager in the transitional care process is to: • Facilitate inter-disciplinary collaboration among providers during transitions. • Encourage the PCPs, patients, and family/caregivers to play a central and active role in the formation and execution of the care plan. • Promote self-management skills and direct communication among the patient and/or caregiver, the PCP, and other care providers. • Achieve medication reconciliation by consulting with the network pharmacist, hospital, PCP, specialists, and the patient and his/her caregiver.
Individual and Family Support Services	Provided by care teams or CCNC care managers, these services include, but are not limited to, advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources to support individuals in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services and access to long-term care and support services.
Referral to Community and Social Supports	CCNC works to increase access to appropriate community and social support services, and to utilize and organize community resources. Locally-based care managers share their knowledge of local resources with network providers by providing resource manuals containing relevant contact information for an array of community and social support services.

TABLE 3. PMPM Rates for Health Home Services as of March 2011--North Carolina		
	CCNC-Enrolled Medical Homes	**CCNC Central Offices and Regional Network**
ABD	$ 5.00	$ 12.85
Non-ABD	$ 2.50	$ 4.33
PCM	---	$ 5.22

TABLE 4. Health Home Goals and Quality Measures--North Carolina	
Goal-Based Measures	
Reduce Avoidable Emergency Department Utilization	Clinical outcome measures: • Emergency department visit rate for nondual ABD and non-ABD per 1,000 member months Experience of care measures--adult: • CAHPS Core Question 4: In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it? • CAHPS Core Question 6: In the last 6 months, not counting the times you/your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought you needed it? • CAHPS Core Question 21: In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan? Experience of care measures--child: • CAHPS Core Question 4: In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought you needed it? • CAHPS Core Question 6: In the last 6 months, not counting the times your child needed care right away, how often did your child get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed it? • CAHPS Core Question 24: In the last 6 months, how often was it easy to get the care, tests, or treatment you thought your child needed through your health plan?
Reduce Avoidable Hospitalizations	Clinical outcome measures: • Inpatient admissions for enrolled nondual ABD members per 1,000 member months • Asthma hospitalization for enrolled nondual ABD members per 1,000 member months • Heart failure admissions for enrolled nondual ABD members per 1,000 member months
Increase Integration of Primary Care and Behavioral Health Care	Experience of care measures--adult: • CAHPS Supplemental Question CC6: In the last 6 months, were any decisions made about your health care? • CAHPS Supplemental Question CC7: In the last 6 months, how often were you involved as much as you wanted in these decisions about your health care? Experience of care measures--child: • CAHPS Core Question CC1: In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers? Quality of care measures: • Percent of practices with co-located behavioral health providers
Service-Based Measures	
Comprehensive Care Management	Quality of care measures: • Percent of patients meeting CCNC priority criteria who received a Comprehensive Health Assessment or an Intervention

TABLE 4 (*continued*)	
Service-Based Measures (*continued*)	
Care Coordination	Experience of care measures--adult: • CAHPS Supplemental Question OHP5: How satisfied are you with the help you received to coordinate your care in the last 6 months? • CAHPS Supplemental Question MH2: In the past 6 months, did you need any treatment or counseling for a personal or family problem? • CAHPS Supplemental Question MH3: In the past 6 months, how often was it easy to get the treatment or counseling you needed? Experience of care measures--child: • CAHPS Core Question CC17: In the last 6 months, did your child get care from more than 1 kind of health care provider or use more than 1 kind of health care service? • CAHPS Core Question CC18: In the last 6 months, did anyone help coordinate your child's care among different providers or services? • CAHPS Core Question CC14: In the last 6 months, did you get or try to get counseling for your child for an emotional or behavioral problem? • CAHPS Core Question CC15: In the last 6 months, how often was it easy to get this treatment or counseling for your child?
Comprehensive Transitional Care	Clinical outcome measures: • Percent of avoidable admission in the enrolled nondual ABD population, stratified by mental health and nonmental health population • Heart Failure 30-day readmissions Experience of care measures--adult: • CAHPS Supplemental Question CC18: In the last 6 months, have you been a patient in a hospital overnight or longer? • CAHPS Supplemental Question OHP3: In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among other doctors or health providers? Experience of care measures--child: • CAHPS Supplemental Question OHP3: In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your care among other doctors or health providers? Quality of care measures: • Percent of patients with Medication Reconciliation or Medication Review documented in CMIS with 30 days post-discharge

TABLE 4 (*continued*)	
Service-Based Measures (*continued*)	
Health Promotion	Clinical outcome measures--adult: • Mammography rates among women 40-69 • Pap smear rates among women 21-64 • Colorectal cancer screening rate among men and women 50-75 Clinical outcome measures--child: • Well-child visits in the first 15 months of life • Well-child visits among children aged 3-6 • Adolescent well-care visits Experience of care measures--adult: • CAHPS Supplemental Question H1: In the last 6 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness? Experience of care measures--child: • CAHPS Supplemental Question H1: In the last 6 months, how often did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child? Quality of care measures: • Percent of hypertensive patients whose most recent blood pressure is less than 130/80 • Percent of diabetic patients whose most recent blood pressure is less than 130/80

TABLE 5. Evaluation Methodology--North Carolina	
Avoidable Hospital Readmissions	• Potentially preventable readmissions within 30 days as a percent of potentially preventable hospital admissions, any diagnosis, excluding mental health. Data will be reported quarterly from baseline year 2010. The target is a 4% reduction from baseline rate by end of year 1 (state fiscal year 2011); maintained from baseline rate by end of year 2 and year 3. These targets are currently for ABD nonduals. Duals targets will be set after additional experience and spread statewide. • Hospital admissions within 30 days of prior discharge date with CHF as the primary or secondary diagnosis, as a percentage of CHF hospital discharges. Reported quarterly on a rolling 12 month basis.
Hospital Admissions	In addition to measures specific to health homes enrollees, Community Care uses information in its Informatics Center to evaluate health home performance related to hospital admission rates for the Community Care program that will be made available to the program evaluation. The Informatics Center contains Medicaid health care claims data and also real-time hospital data from 56 large North Carolina hospitals. Network targets are set annually and performance toward the targets is reviewed throughout the year to identify if improvement plans need to be developed. In addition to measures cited above and in Table 4, the state will also track mental health readmissions within 30 days.
Emergency Department Visits	In addition to the emergency department measures already cited, the state will also measure the asthma emergency department visit rate per 1,000 member months.
Skilled Nursing Facility (SNF) Admissions	SNF Admission rate per 1,000 member months.
Chronic Disease Management	Community Care captures Chronic Disease Management process of care measures across all recipients receiving care management, and also captures disease-specific outcomes for disease management initiatives. Standardized processes for care managers who provide care management services to these patients are monitored routinely by supervisors, using reports from CMIS. Specific quality measures that are monitored include chart review and claims-based measures included in the CCNC Quality Measurement and Feedback (QMAF) program (see Assessment of Quality Improvements and Clinical Outcomes section below for further details) and other measures identified by NC-CCN and Network that impact cost and quality. In addition, Community Care has several disease management initiatives in place in every network, and CCNC has the capacity to capture and measure outcomes by diagnosis for disease-specific measures as needed. Current disease management initiatives include asthma, diabetes, ischemic vascular disease, and CHF. Evaluation of these initiatives is conducted on a routine basis through monitoring clinical, utilization, and cost measures for targeted patients at the practice, Network, and program-wide level.
Care Coordination	Community Care captures care manager performance in Care Coordination using the Care Management Standardization Plan developed by CCNC. The Care Management Standardization Plan provides definitions and specificity in care management priorities, care management actions steps, medication management steps, components of the transitional care model, and care management intensity levels. A standardized care management plan will facilitate evaluation of performance in coordination of care. Community Care monitors and evaluates the performance and activities of all care managers through CMIS. Networks and the central office have the ability to create parameterized queries at the patient, practice, network or care manager level. For example, Community Care can generate a report on all heavy-intensity patients at a practice or those who are served by a specific care manager. These reports enable both care managers and supervisors to examine activities and interventions on a macro level and compare progress and outcomes of interventions.

TABLE 5 (*continued*)	
Assessment of Program Implementation	The Community Care program has been implemented statewide, across all regional networks. The state has the capacity to assess and monitor ongoing performance of the Community Care program across networks through NC-CCN. CCNC develops a comprehensive statewide assessment of progress and results of implementing the quantitative, analytical, utilization, quality, cost containment, and access goals and deliverables established each year. Similar evaluation of program implementation is a required activity of networks, whose role it is to work with practices to continuously improve the care they provide.
Processes and Lessons Learned	There are continuous opportunities within Community Care to evaluate processes and lessons learned, supported by Community Care's extensive reporting infrastructure and its regional network organization. The state Medicaid Agency, practices and networks receive monthly, quarterly, and annual feedback on process, cost, utilization, and quality metrics that will be useful for evaluation purposes.
Assessment of Quality Improvements and Clinical Outcomes	Since its beginning in 1998, CCNC has used performance measurement and feedback to help meet its goals of improving the quality of care for Medicaid recipients while controlling costs. Quality measurement is intended to stimulate or facilitate quality improvement efforts in CCNC practices and local networks, and to evaluate the performance of the program as a whole. CCNC's QMAF program was substantially expanded in 2009, in response to the needs of an expanded ABD enrolled population with multiple chronic conditions, and in response to requests from providers and practices to seek alignment in quality measures across multiple payer or stakeholder entities. A work group with representation from all 14 CCNC networks was convened in 2007, and met over the course of a year for in-depth review of candidate measures. Goals were to identify a broad set of quality measures with: • Clinical importance (based on disease prevalence and impact, and potential for improvement). • Scientific soundness (strength of evidence underlying the clinical practice recommendation. • Evidence that the measure itself improves care; and the reliability, validity, and comprehensibility of the measure). • Implementation feasibility, and synergy with other state and national quality measures or quality improvement programs. Measures are not intended to capture every aspect of good clinical care. Reports on QMAF measures are available through the Informatics Center Provider Portal for CCNC staff and providers. Where possible, reports include relevant benchmarks, both internal (network and program-wide) and external (HEDIS mean and 90th percentile, NCQA and North Carolina Healthcare Quality Alliance targets). Approximately 50 quality measures are currently tracked in the QMAF system.
Cost Savings	The state will capture both overall cost savings and acute care cost savings measures that exclude behavioral health costs. These will be reported for health homes enrollees as separate from other Community Care enrollees. Costs will be captured using date of service, and cost trends will be reported on an annualized basis. Cost measures will include: • Total PMPM costs (subtracting behavioral health costs and residential services). • Acute care costs. • Emergency department costs.

APPENDIX: Pre-Existing Initiatives in North Carolina								
	Medicare 646 Demonstration[1,19]	**Dual Eligible Beneficiary--Integrated Delivery Model**	**MAPCP Demonstration[20,21]**	**CHIPRA Quality Demonstration[5,22]**	**Child Health Accountable Care Collaborative[6,23]**	**CC4C[6,24]**	**Pregnancy Medical Home[8,25]**	**Behavioral Health Initiative[9]**
Timeline	Original timeline was January 2010-May 2014; program has since ended	Application approval pending; proposed start date was January 2013	October 2011-September 2014	February 2010-February 2015	July 2012-June 2015	Emerged in 2011 as the replacement for a child-focused targeted case management program	Launched in April 2011	Launched in February 2010
Geographic Area	26 counties	Statewide	7 rural counties	Statewide, with certain activities taking place in 8 networks	Statewide	Statewide	Statewide	Statewide
Sponsors	CCNC and CMS	CCNC, CMS, and the North Carolina Department of Health and Human Services	CMS, CCNC, North Carolina State Health Plan, BCBSNC	CCNC and CMS	CMMI	CCNC, North Carolina Medicaid, and the North Carolina Department of Public Health	CCNC, North Carolina Medicaid, and North Carolina Department of Public Health	CCNC
Scope	• 200+ practices • 900+ providers • 8 regional networks	• All 14 networks • 176,000+ full-benefit dual eligibles	• 95,000 patients • 154 practices • 490+ providers	24-27 practices participating in Learning Collaboratives, statewide reporting of measures and testing of pediatric EHR models	• All 14 networks • 5 academic medical centers • 7 tertiary care hospitals • Enrolled children with complex medical conditions	• All 14 networks • Local Health Departments • Enrolled children from birth to age 5 who meet certain risk factors	• 350 pregnancy medical homes (private practice, federally qualified health centers, hospital-based clinics) • 1,500 providers, including obstetrics, midwives, physician assistants, and nurse practitioners	• All 14 networks • LME-MCOs • Behavioral health agencies

APPENDIX (*continued*)								
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Goals	Improve quality of care and patient outcomes for dually eligible and Medicare-only beneficiaries	• Improve quality of care and patient outcomes for dually eligible beneficiaries • Reduce system fragmentation and costs	Improve quality, reduce spending, and decrease costs through use of HIT-supported care management and coordination	• Report all 24 CHIPRA quality measures to both CMS and CCNC • Strengthen the pediatric medical home model • Develop and test a pediatric EHR model	• Improve access and continuity of care • Reduce emergency department visits, hospitalizations, and pharmacy costs for children with complex medical conditions	Improve health outcomes and reduce costs for enrolled children	• Improve care for pregnant women • Improve health outcomes • Reduce maternal care costs	• Integrate behavioral health into primary care and share best practices • Collaborate with LME-MCOs and behavioral health providers • Improve prescription monitoring
Payment Approach	Medicare savings shared with NC-CCN; contingent on meeting performance benchmarks and capped at a percentage of overall savings.	• Tiered PMPM for care management • Provider capacity development incentive payment • Retrospective performance payment to providers	• Tiered PMPM for Medicaid and Medicaid enrollees • Enhanced FFS for evaluation and management codes billed to BCBSNC	No information found	No information found	No information found	Participating Pregnancy Medical Homes receive an add-on payment for care management, and financial incentives for performing screenings and evaluations	No information found
Technical Assistance (TA)	No information found	No information found	CCNC and BCBSNC offer practices support in obtaining NCQA recognition	Quality improvement specialists work with all networks on Quality improvement activities; will work intensely with Learning Collaborative practices	No information found	No information found	Practices receive Quality improvement support from CCNC	CCNC-employed psychiatrists provide consultations and guidance to providers

APPENDIX (*continued*)								
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HIT Use	Medicare data for enrollees was integrated into the Informatics Center	Medicare data will be integrated into the Informatics Center	BCBSNC and Medicare data integrated into Informatics Center	It is expected that: • Measures will be integrated into CCNC's system • Pediatric EHRs will interface with CCNC and the state HIE	Pediatric care managers will have access to Informatics Center data through CMIS	CC4C care managers will have access to Informatics Center data through CMIS	Informatics Center was augmented to include obstetric-related data such as pre-term birth rates, caesarian rates, etc.	HIE varies; some networks share data with their regional LME-MCO and behavioral health agencies, others do not
Evaluation Methods	• Comparison group composed of beneficiaries receiving a qualifying service • from a PCPs in 78 counties in 5 other states	The state has selected a range of quality measures that it will track on an ongoing basis to evaluate performance	CMS has contracted with a vendor to evaluate the effects on Medicare patients	CMS has contracted with a vendor to evaluate a range of outcomes for the national CHIPRA demonstration	No information found	Evaluation measures focus on reducing emergency department and hospital utilization, and increasing primary care and prevention access	CCNC will track practice-level performance related to birth weight and caesarian rate goals.	CCNC is tracking a range of measures focusing on reducing inpatient and emergency department utilization, and improving care coordination and transitions

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
- Executive Summary: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf

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